2017-2018 ANNUAL REPORT

THE GLOBAL FINANCING FACILITY

Country-powered Investments

For Every Woman, Every Child and Every Adolescent

GLOBAL FINANCING FACILITY

SUPPORTED BY WORLD BANK GROUP

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Dear GFF partners and friends,

Mariam Claeson

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.

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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

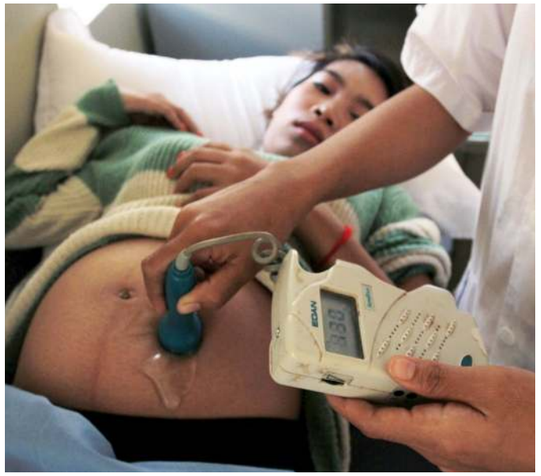
Every year, in 50 countries across the world more than 5 million mothers, children, and adolescents die from mostly preventable conditions, and the economies of these countries lose billions of dollars to poor health and nutrition. It is therefore urgent to accelerate progress on universal health coverage and to contribute to the achievement of the Sustainable Development Goal (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, newborn, 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 RMNCAH-N 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.

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 but 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 alongside World Bank financing through the International Development Association (IDA) and International Bank for Reconstruction and Development (IBRD), aligned external financing, and private-sector resources. Each relatively small external investment is multiplied by the country's own commitments—generating a large return on investment and contributing to lives saved and improved.



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 RMNCAH-N 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, come 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 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 RMNCAH-N, including different parts of the government, civil society, the private sector, and development partners. Where available, the GFF supports the existing multi-stakeholder 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
- Guatemala
- Guinea
- Haiti
- Indonesia
- Kenya
- Liberia
- Madagascar
- Malawi
- Mali
- Mozambique
- Myanmar
- Nigeria
- Rwanda
- Senegal
- Sierra Leone
- Tanzania
- Uganda
- Vietnam

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 all 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 not less than 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 influx 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 Nigeria supported an advocacy mission to the National Assembly. Civil society organizations and the media played a critical role in this advocacy campaign.

Nigeria's 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 Healthcare

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.

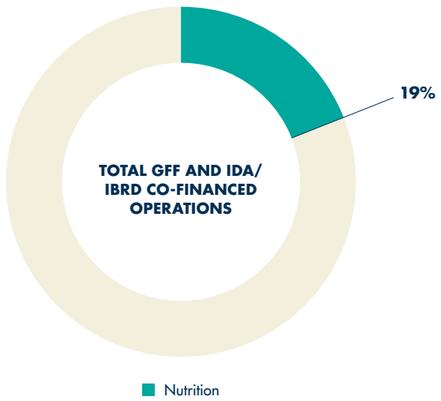
In summary, the GFF platform and the investment case provide a mechanism for partners to jointly support the Government of Nigeria in delivering on its commitment, expressed through its FY2018 appropriation to fund the BHCPF. With this clear commitment, a growing number of development partners are considering cofinancing the BHCPF, which in turn will help to increase harmonization and efficiencies in financing Nigeria's health sector.

All these early country examples from the past three years serve as models for domestic resource mobilization for other countries that are also taking action to increase domestic resources. The GFF, jointly with the World Bank, is supporting countries in reforming tax policies to foster healthy behaviors while also increasing tax revenues for health by providing technical assistance in the design and/or implementation of the taxes, particularly "sin" taxes. Examples include alcohol taxation in Liberia and tobacco taxation in Mozambique, Sierra Leone, and Senegal.

✓ **Concessional Financing** (IDA/IBRD): The GFF directly links GFF Trust Fund grants in all GFF-supported countries to substantially higher amounts of IDA funding than initially expected. The GFF also directly links GFF Trust Fund grants to IBRD funding—such as in Guatemala and Vietnam, buying down interest to more concessional levels. The current ratio of GFF Trust Fund grants to IDA/IBRD 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. GFF 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, DRC, 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 10 countries among the first round of 16 GFF countries.

Nutrition accounts for about 19 percent of total GFF and IDA/ IBRD co-financed operations that have been approved to date



✓ **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 and 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 investment cases 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 investment cases and the names of these GFF liaisons are available on the GFF website. Most importantly,

Private Sector

The role 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 the GFF 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 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 multistate 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-financiers 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 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.

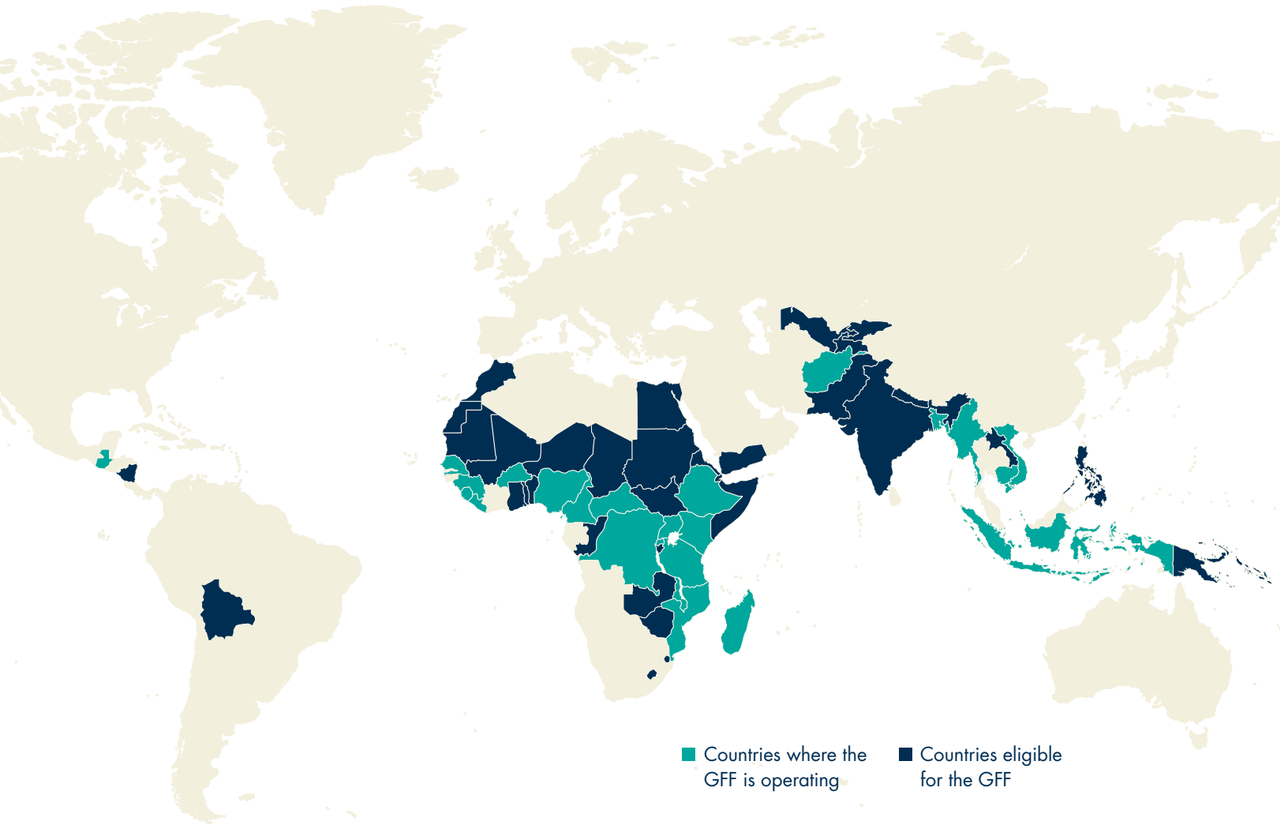
Importantly, the GFF is working with the Partnership for Maternal, Newborn, and Child Health to support civil society organizations in their key roles and functions, building capacity and more meaningful engagement.

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.

Where the GFF Operates, and Where Additional Countries Are Eligible



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 RNMCAH-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 (DHSs) 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 bilaterals, 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)

Core Health Financing Indicators

Data obtainable from the System of Health Accounts or SHA:

- Health expenditure per capita financed from domestic sources
- Ratio of government health expenditure to total government expenditure
- Percent of current health expenditure devoted to primary health care

Data obtainable from population-based surveys:

- Incidence of financial catastrophe due to out-of-pocket payments

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:

- **Identifying complementary funding:** This will be measured as the *share of external funding for health that is pooled or on budget*. The GFF has supported numerous budget mapping exercises for the Investment Case, which can be found in the country profiles, where complete.
- **Securing IDA/IBRD funding linked to the GFF:** This information comes directly from the World Bank operations webpage and is presented for each country that has received World Bank board approval.
- **Mobilizing domestic resources for health:** Indicators include whether the country has done a fiscal space analysis; whether it has taken actions to support domestic resource mobilization; whether it has prioritized health in its budget; whether it has increased overall government revenue; and if it has supported health-specific revenue sources.
- **Catalyzing private-sector investments and leveraging private capacity and expertise:** The GFF is engaged in identifying leveraging opportunities, both globally and at the country level, which are likely to increase the availability of domestic resources, make efficiency gains,

GFF Focal Areas for Routine Performance Monitoring

Intervention areas of focus

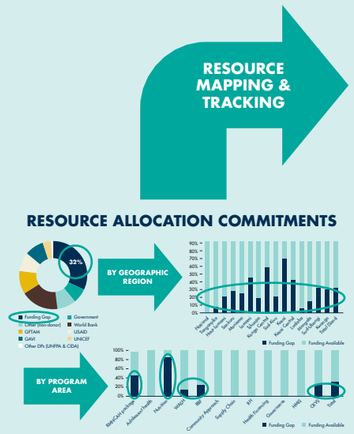
- Family planning & sexual & reproductive health & rights
- Maternal, newborn, child health
- Nutrition & nutrition policy
- Gender
- Adolescents girls
- Early childhood development
- Water, sanitation & hygiene (WASH)

Cross-cutting areas of focus

- Civil registration & vital statistics
- Data systems, quality & use
- Quality of care & service delivery
- Supply chain & commodities
- Community health
- Human resources for health
- Equity

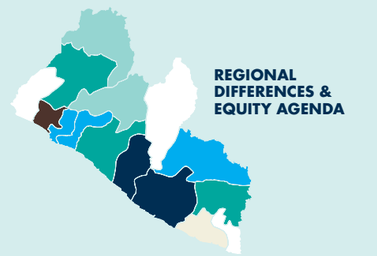
A table of all indicators presented in the country profiles can be found on page 74.

GFF approach: Mapping and tracking financial resources to results at subnational levels



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?



for ANC4 (2015/16)	for ANC4 (2016/17)	District Name	Difference for ANC4 (2015/16)	Difference for ANC4 (2016/17)
-17.8	-7.8	Kabonko District	-23.9	21.7
		Buligiya District	-24.7	-15.5
		Uvinza District	-22.9	-16.1
		Kibondo District	-21.3	-12.2
		Kasulu Town	-18.4	-15.5
		Kasulu District	-16.9	17
		Kigoma District	-14.3	-8.5
		Kigoma Municipal	5.6	-9.5
-13.4	-8.1	Lushoto District	-24.1	-18.2
		Mufindi District	-21.5	-22.4
		Korogwe District	-21.2	-15.5
		Handeni District	-20.4	-9
		Bunduli District	-19.3	-9.4
		Pangani District	-18.8	-22.3
		Mkinga District	-18.6	-8.2
		Korogwe Town	-17	-10.6
		Tanga City	-12.4	2.9
		Kilindi District	-3.3	11.7
		Handeni Town	NA	18.1
-10	-5.4	Kondoa District	-19.6	-11
		Babi District	-16.5	-23.2
		Chemvaiu District	-13.5	-11.3
		Kongwa District	-14.5	-1.3
		Chamba District	-5.8	-0.2
		Dodoma Municipal	-5.7	0.9
		Mpwapwa District	-2.9	2.9
		Kondoa Town	NA	31.6

Resource Mapping & Tracking

To inform the investment case and subsequent target setting in the results framework, the GFF has supported the development of RMNCAH-N resource mapping in eight countries to date, with plans to do the same in newly enrolled GFF countries. The countries already resource-profiled, as part of their GFF partnership, in this way are Cameroon, DRC, Ethiopia, Liberia, Mozambique, Senegal, Tanzania, and Uganda (the resource mapping is featured in their country profiles). Resource mapping in other countries is ongoing and for these countries 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 continually 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 this in turn can be used to project the future resource requirements for meeting investment case objectives for improved equity and efficiency.

and leverage greater support from multilateral development banks through buy-downs and co-financing grant mechanisms, all with a focus on results. At the country level, the GFF aims to measure the process needed to ensure more strategic and evidence-based private-sector engagement. This will be done through support to governments to use strategic decision making based on regulatory, policy, and financing analyses (e.g., analyzing care-seeking behavior by income quintile and type of provider; undertaking private-sector assessments) and to identify opportunities to partner with the private sector to reach underserved women, children, and adolescents). This data is not yet presented in the country profiles.

- **Progress in financial protection:** Following the work of WHO and the World Bank, a country's progress in financial protection will be measured through the following output and outcome indicators in the country profiles: whether the country monitors catastrophic and impoverishing health expenditure with data less than three years old; whether it has identified drivers of limited financial protection (especially in relation to RMNCAH-N services); and whether it has implemented reforms to address identified drivers of financial protection (especially as related to RMNCAH-N).
- **Implementation of a comprehensive technical efficiency agenda:** The aim is to determine whether a country has implemented strategies to improve efficiency,

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 varies. 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.

Country Case Studies and Profiles

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 Adamaoua Region, and 36 percent in the East Region.

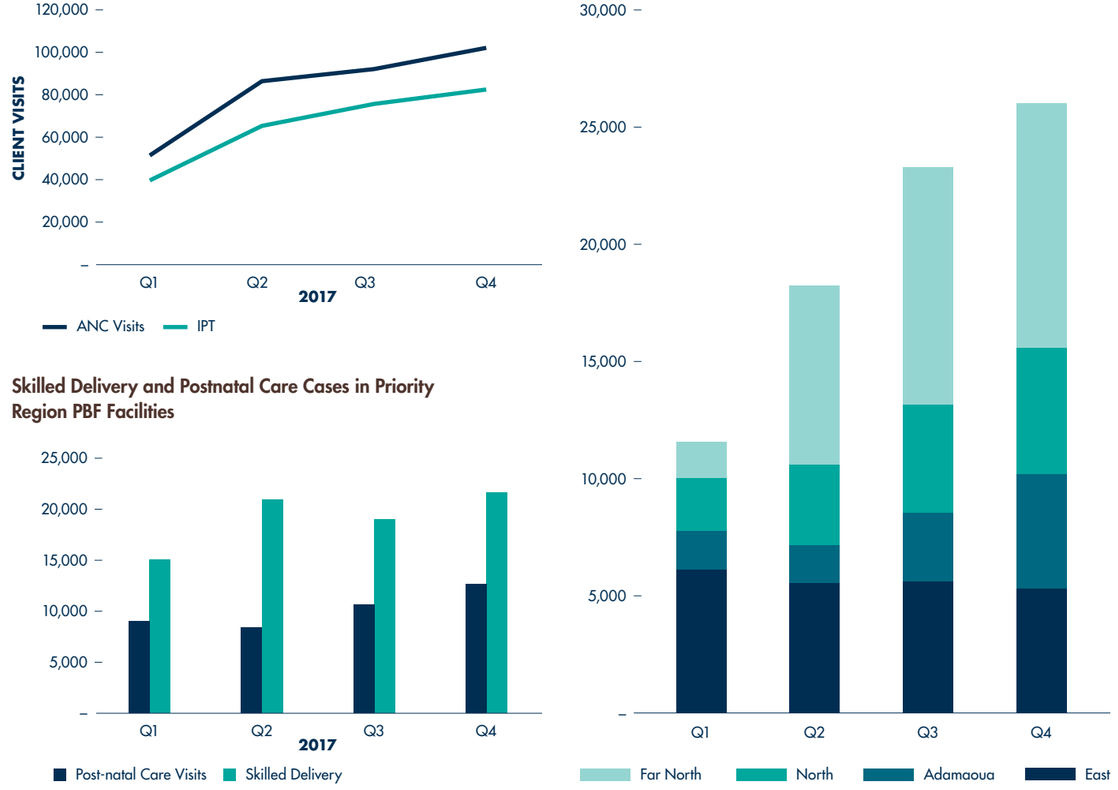
Plan Development, Partnerships, and Investment Case

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.

There are three areas of focus that run through the investment case: (1) improving allocative efficiency, (2) increasing the utilization of priority health services, and (3) strengthening broader health systems. The allocative efficiency and partner alignment efforts focus on two dimensions: rebalancing public health expenditure between the tertiary level and the primary/secondary levels (RMNCAH-N service prioritization being part of this effort) and focusing resources in high-burden and low-resource parts of the country, namely the four priority regions: East Region, Adamaoua Region, North Region, and Far North Region.

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

FIGURE 1
Uptake of Priority Maternal and Child Health Services in Priority Region Facilities Using Performance-based Financing (PBF), by Quarter, 2017



investment case, with Addax Petroleum contributing $155,000 in 2017–18 to equip rural hospital maternal and newborn care units in priority regions.

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 GFF 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 Adamaoua, 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]

> "We didn't have a good water source, we used to have electricity problems, some of our patients did not have sheets on their beds…Now we have a well and we have water flowing at the health center, always."
>
> – Sister Vera Ngalim, St John the Baptist Catholic Health Center

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 2014, 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 Adamaoua Region, and 14.5 percent in the East Region.

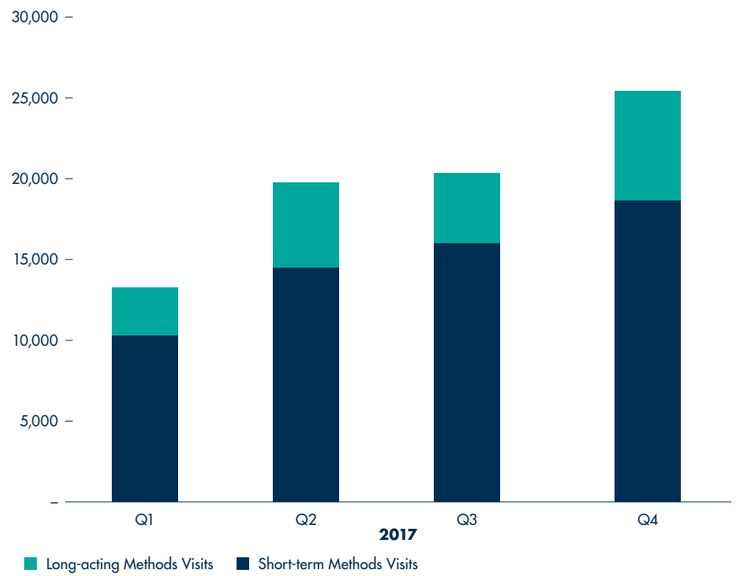
Early progress noted. Family planning visits in facilities using performance-based financing increased over the course of 2017, with growth in visits for both short-term methods and long-acting reversible methods. This progress has been supported by several financiers and technical partners, including 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 ever 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 RMNCAH-N outcomes in Cameroon.

FIGURE 2
Family Planning Visits to Facilities Using Performance-based Financing in Priority Regions, by Quarter, 2017



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://front.fbrcameroun.org/.

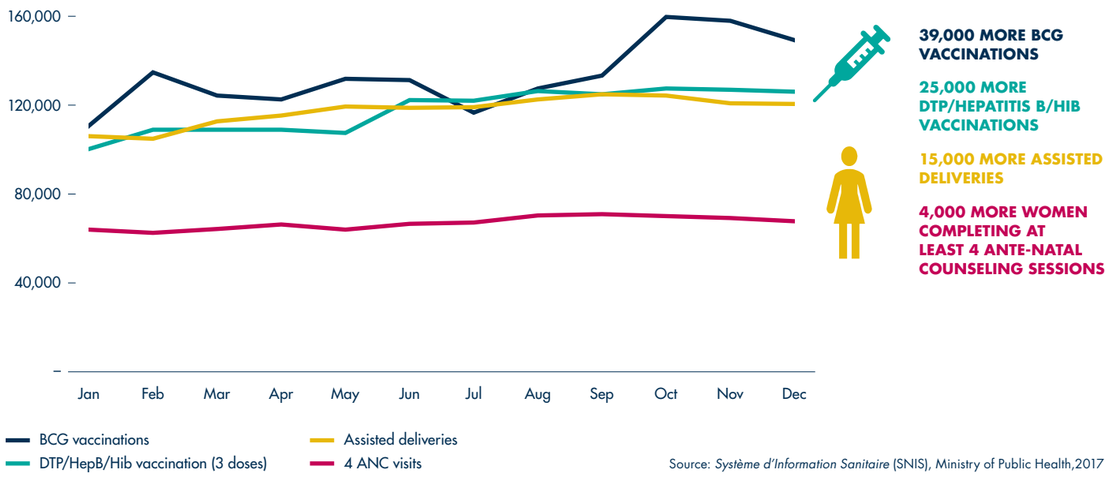
CASE STUDY

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.

FIGURE 3

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



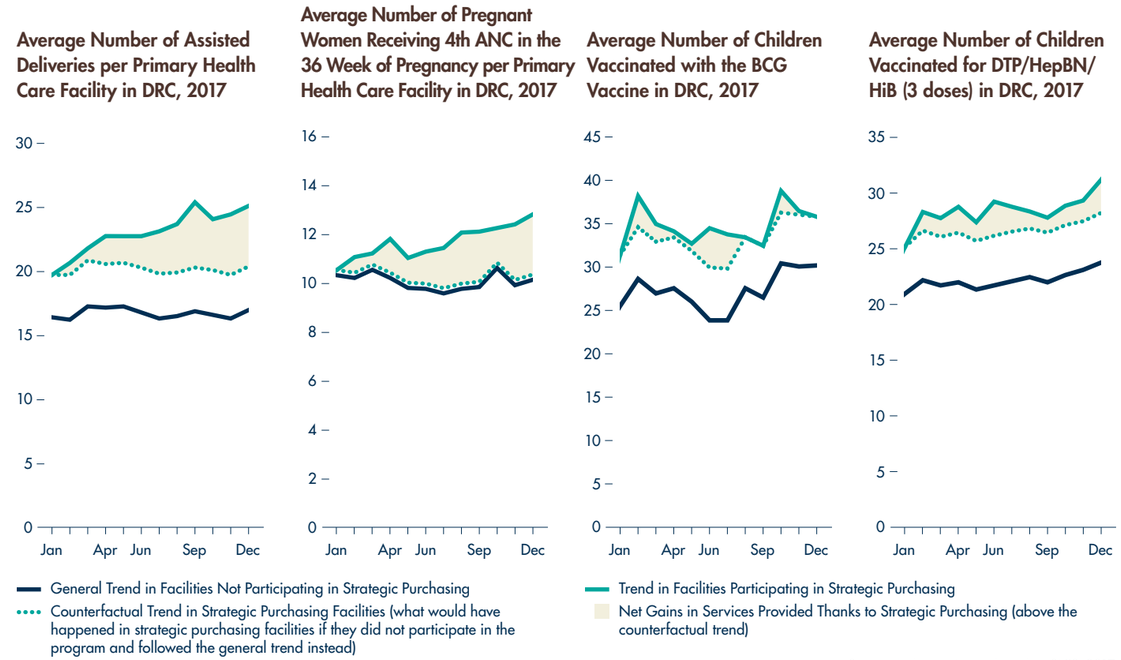
Source: *Système d'Information Sanitaire* (SNIS), Ministry of Public Health,2017

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.[1] 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 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, Kongo Central, Sud-Kivu, Kasaï, Kasaï-Central, Lualaba, 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 children 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, 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 5). 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.

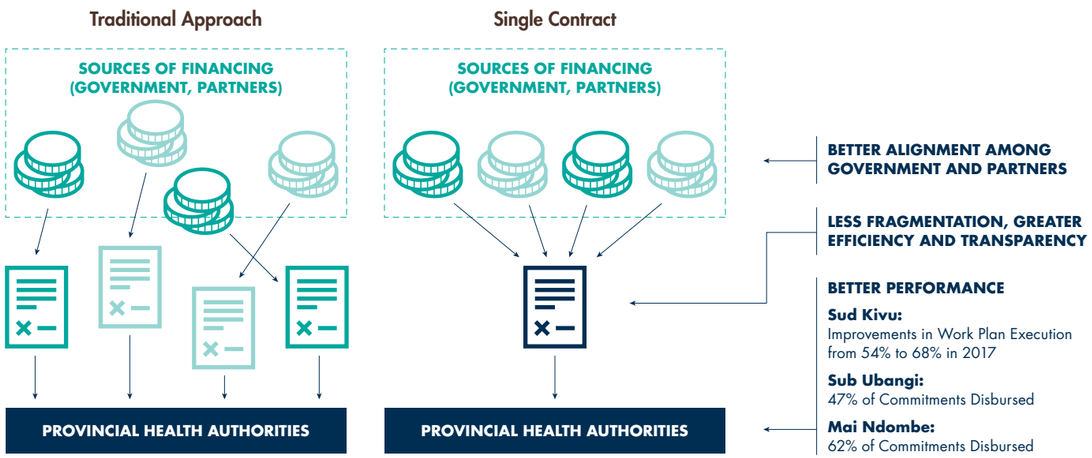
Early progress noted. In January 2018 about 2,940 out of 17,000 health facilities in the DRC were participating in the program. The rationalization of the payment system and the introduction of strategic purchasing have resulted in additional increases in the number of children and women receiving services, above and beyond the positive 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 32 more with the third and final dose of the DTP/Hepatitis B/Hib pentavalent vaccine[2]. 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 consultations[3] 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* as Priority 11. The investment case supports the expansion of the health management information system (*système d'information sanitaire* or SNIS) and its electronic DHIS2 platform with a focus on the provincial and health zone levels.[4]

FIGURE 5
Using a Single-Contract Approach to Better Align Financing and Improve Performance



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 those provinces can be attributed to strategic purchasing.

> "We are well taken care of 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.

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 in 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 6.2 percent for the DTP/Hepatitis B/Hib pentavalent vaccine, 7.1 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 *contrat unique* (CU) (Priority 9). The *contrat 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 *contrat 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 *contrat 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.)

Early progress noted. The *contrat unique* started in 2017 in eight provinces: Nord Kivu, Sud Kivu, Kwilu, Kwango, Mai Ndombe, Sud Ubangi, Lualaba, and Haut Katanga. Regular independent evaluations of its implementation, which focus on mutual accountability of all stakeholders, have begun and are showing promising results. For example, the execution of RMNCAH-N planned activities in Nord Kivu increased from 54 percent to 68 percent between the first and second trimester of 2017. Disbursement on financial commitments from donors and the central government has improved with time, going beyond 50 percent in several provinces.

Further analytical work on domestic resource mobilization is to be conducted to examine potential mechanisms for increasing domestic funding of health services at the provincial level. This is necessary because the financial commitments from provincial health authorities to date remain low as part of the single contract. This analytical work funded by Gavi, the GFF, and the World Bank is all part of the Health Financing Strategy. Given poor budget absorption of existing resources (58 percent), the Health Financing Strategy is focusing its domestic resource mobilization agenda over the short-term on improving the efficiency of existing resources through single-contract, strategic purchasing, public financial management, and human resource reforms. Over the mid- to long-term, the Ministry of Health is to improve the share of the national budget allocated to health (5 percent). The planned study by Gavi, the GFF, and the World Bank will examine the potential and feasibility of earmarked taxes, tax collection reforms, and better prioritization of health at both provincial and national levels, laying out key reforms for the mid- to long-term to leverage more resource for the health sector.

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-lasting 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 those 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—make a substantial contribution outside the investment case's provinces to reach universal health coverage through RMNCAH-N funding.

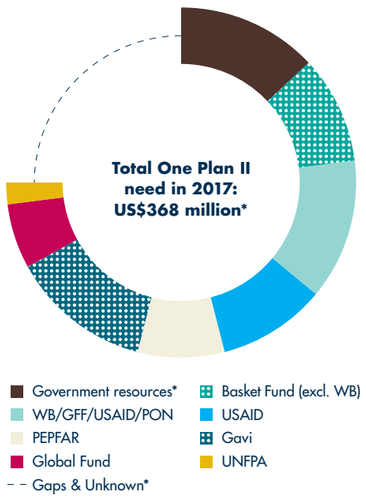
4 Other activities under this Priority Action include the development and implementation of a supply chain and human resource information systems and improvement of the links between the health management information system and the CRVS system.

CASE STUDY

United Republic of Tanzania

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*.

FIGURE 6
Estimated Contributions from Major Financiers as a Percent of One Plan II Budget Need 2017



One Plan II prioritizes pivotal interventions to accelerate RMNCAH-N improvements focused on increased quality, access, and use of RMNCAH-N services. These include antenatal care, use of skilled birth attendants, and a package known as Basic Emergency Obstetric and Newborn Care (BEmONC) and Comprehensive Emergency Obstetric and Newborn Care (CEmONC).

Plan Development, Partnerships, and Funding

The plan 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 67 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 Gap and Government resources do not include HRH spending. One Plan II estimate US$246 million + health facility renovation and equipment cost US$88 million +Malaria and HIV for mothers and children US$34 million.

Moving Toward Universal Health Coverage and Equitable Access

To facilitate long-term sustainability of health gains, the Government of Tanzania is taking critical steps to increase the resources for and sustainability of health financing. The government is currently developing a five-year Health Financing Strategy to move toward universal health coverage, a critical step to ensure financial protections for the poor and reduce catastrophic health expenditures. The GFF supports the government in this effort with technical assistance, capacity development, and analytics to finalize the Health Financing Strategy and promote a related single national health insurance bill.

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[1]).

FIGURE 7
Percent of Low-Income Individuals Identified by Tanzania Social Action Fund Receiving Outpatient Care by Province, Quantity Data April 2016-Dec 2017

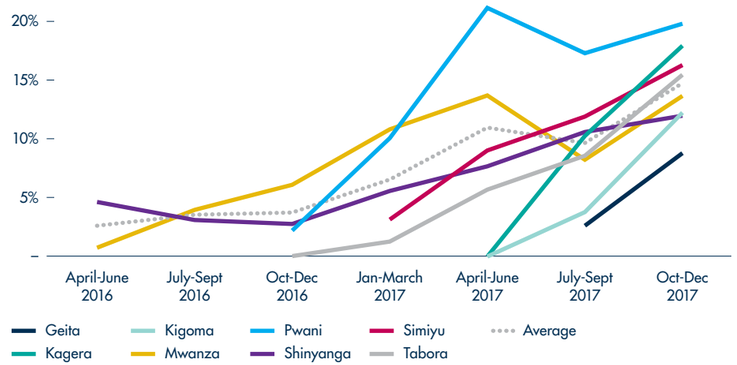
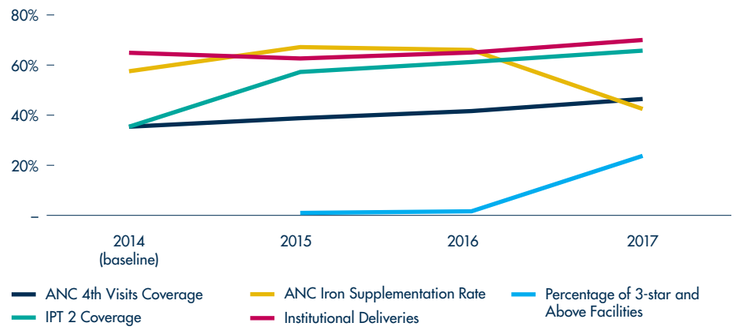


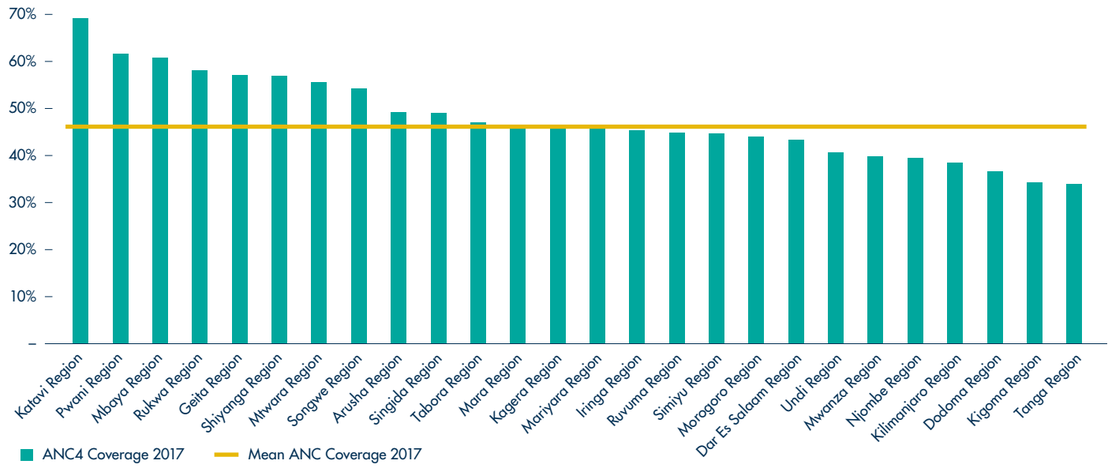
FIGURE 8
Nationwide Coverage of Key District-Level Scorecard Indicators (DHIS2), 2014 -2017



1 Percentages represent percentage of individuals identified by TASAF within each facility's catchment population for a given province.

FIGURE 9

Antenatal Care Coverage by Region, 2017



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 shows 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 quality assessment, and coverage of intermittent preventative 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.

FIGURE 10

Percentage of Facilities Receiving High Ratings (three or more stars) in Initial Reassessed Regions, 2015 vs. 2017

"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 Mayumbavv, registered nurse, Mhandu Dispensary, Shinyanga District

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 for decision making, 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.

Country Profiles

Bangladesh

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.
9. Promote keeping girls in school and reducing drop-out rates among girls in secondary schools.

RMNCAH-N Data

CORE IMPACT INDICATORS

Maternal mortality ratio **194 per 100,000 live births**

Neonatal mortality ratio **28 per 1,000 live births**

Under-five mortality ratio **46 per 1,000 live births**

Adolescent birth rate **113 per 1,000 women**

Percent of births <24 months after the preceding birth **11.3%**

Stunting among children under 5 years of age **36%**

Moderate to severe wasting among children under 5 years of age **14%**

COVERAGE INDICATORS***

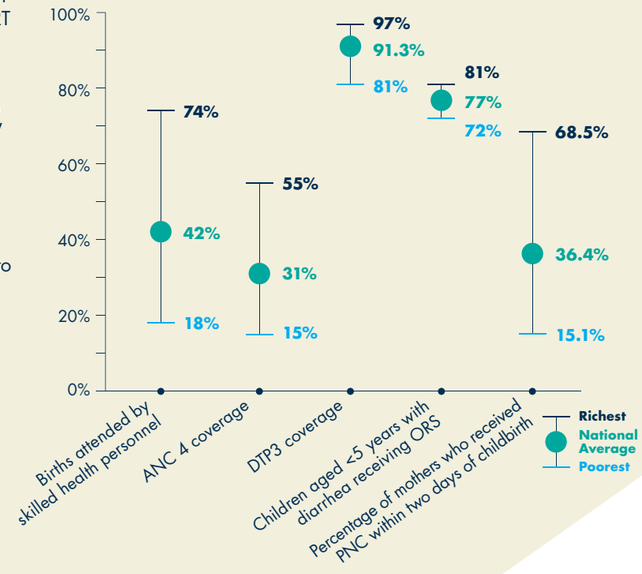
People living with HIV receiving ART **16%**

Coverage of pregnant women who receive ARV for PMTCT **17%**

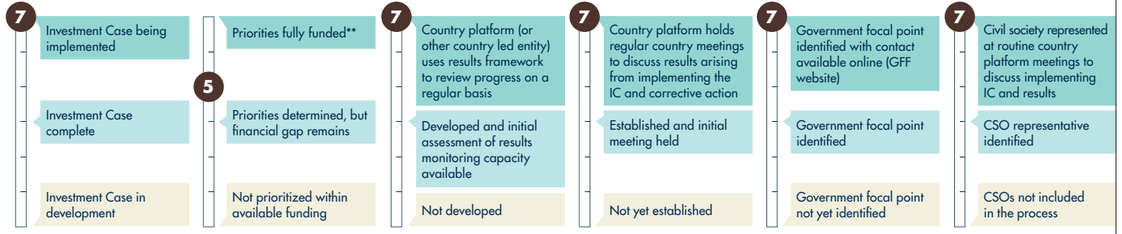
Children aged <5 years with pneumonia symptoms taken to a healthcare provider **42%**

Modern contraceptive prevalence rate **54.1%**

Girls Secondary School Retention Rate
66% Grade 10
46% Grade 12



Monitoring the Country-led Process



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

Health Financing Indicators

CORE HEALTH FINANCING IMPACT INDICATORS

Health expenditure per capita financed from domestic sources **4.68**

Ratio of government health expenditure to total government expenditures **3.37%**

Percent of current health expenditures on primary/outpatient health care **Not available**

Incidence of catastrophic and impoverishing health expenditures **25%** catastrophic **8.1%** impoverishing

OUTPUT INDICATORS

Share of health in total government budget **5.2%**

Monitoring of catastrophic and impoverishing health expenditure with data less than three years old **No**

Country has:
implemented or updated a resource mapping exercise **No**

Identified options for strengthening domestic resource mobilization **Yes**

Implemented strategies to reduce key drivers of inefficiency **Yes**

Identified drivers of limited financial protection (especially In relation to RMNCAH-N services) **No**

Taken actions to support domestic resource mobilization **Yes**

Implemented reforms to address identified drivers of financial protection (especially related to RMNCAH-N) **Yes**

Share of external funding for health that is pooled or on budget **26.78%**

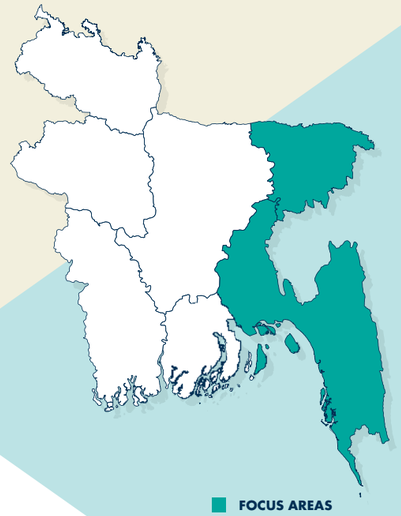
EFFICIENCY

DTP3 dropout rate **5.7%**

ANC dropout rate **51%**

Health budget execution rate **90%**

Geographic Focus Areas

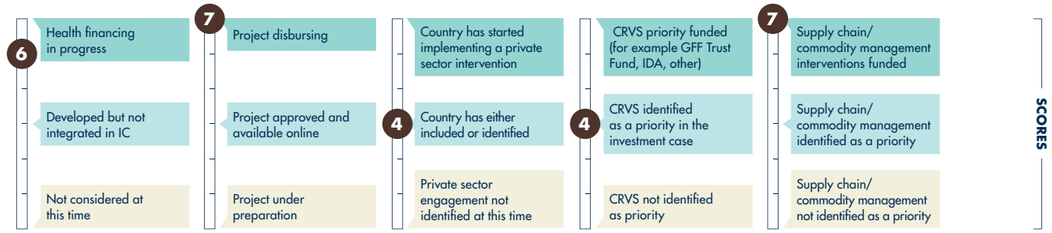


Resource Mapping

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 US$1 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.

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

COUNTRY	Bangladesh (Health)	Bangladesh (Education)
BOARD DATE	7/28/17	12/18/17
GFF APPROVED AMOUNT	$15M	$10M
IDA AMOUNT	$500M	$510M



The Republic of Cameroon

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 (pilot performance-based financing in education)

RMNCAH-N Data

CORE IMPACT INDICATORS

Maternal mortality ratio **596 per 100,000 live births**

Neonatal mortality ratio **28 per 1,000 live births**

Under-five mortality ratio **103 per 1,000 live births**

Adolescent birth rate **119 per 1,000 women**

Percent of births <24 months after the preceding birth **21.3%**

Stunting among children under 5 years of age **32%**

Moderate to severe wasting among children under 5 years of age **5%**

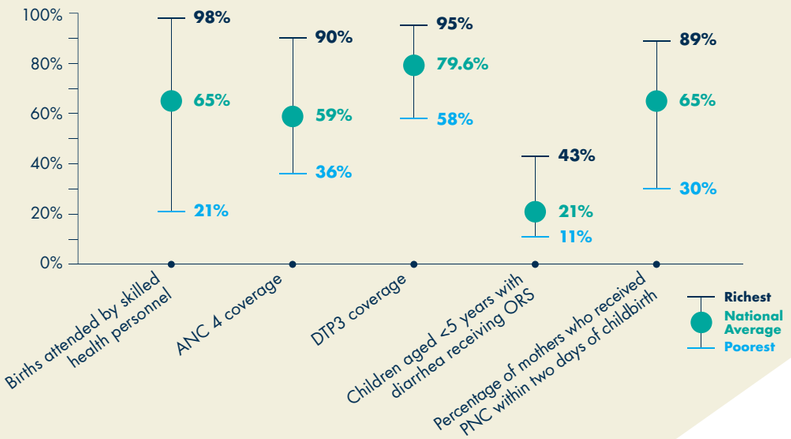
COVERAGE INDICATORS***

People living with HIV receiving ART **37%**

Coverage of pregnant women who receive ARV for PMTCT **74%**

Children aged <5 years with pneumonia symptoms taken to a healthcare provider **28%**

Modern contraceptive prevalence rate **21%**



Health Financing Indicators

CORE HEALTH FINANCING IMPACT INDICATORS

Health expenditure per capita financed from domestic sources **9.2**

Ratio of government health expenditure to total government expenditures **3.11%**

Percent of current health expenditures on primary/ outpatient health care **61.76%**

Incidence of catastrophic and impoverishing health expenditures **10.8%** catastrophic **1.8%** impoverishing

OUTPUT INDICATORS

Share of health in total government budget **4%**

Monitoring of catastrophic and impoverishing health expenditure with data less than three years old **No**

Country has: implemented or updated a resource mapping exercise **No**

Identified options for strengthening domestic resource mobilization **No**

Implemented strategies to reduce key drivers of inefficiency **Yes**

Identified drivers of limited financial protection (especially In relation to RMNCAH-N services) **Yes**

Taken actions to support domestic resource mobilization **No**

Implemented reforms to address identified drivers of financial protection (especially related to RMNCAH-N) **Not available**

Share of external funding for health that is pooled or on budget **56.6%**

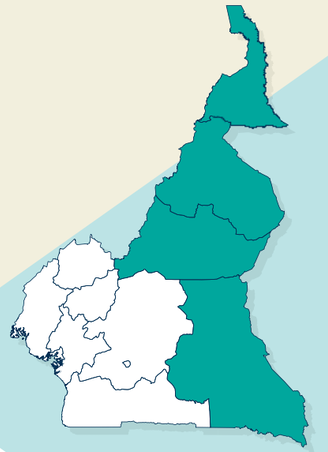
EFFICIENCY

DTP3 dropout rate **7.6%**

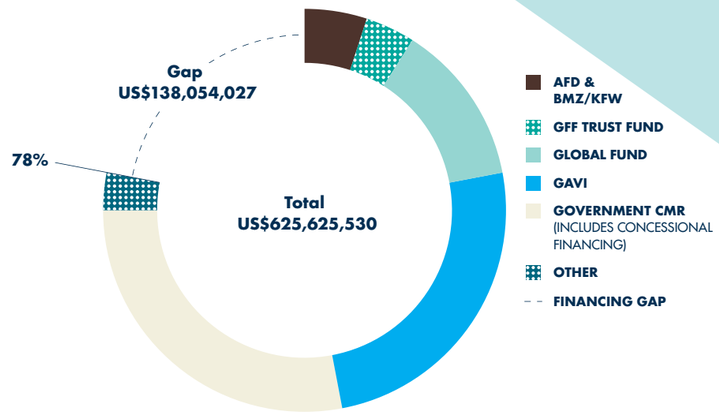
ANC dropout rate **38%**

Health budget execution rate **Not available**

Geographic Focus Areas



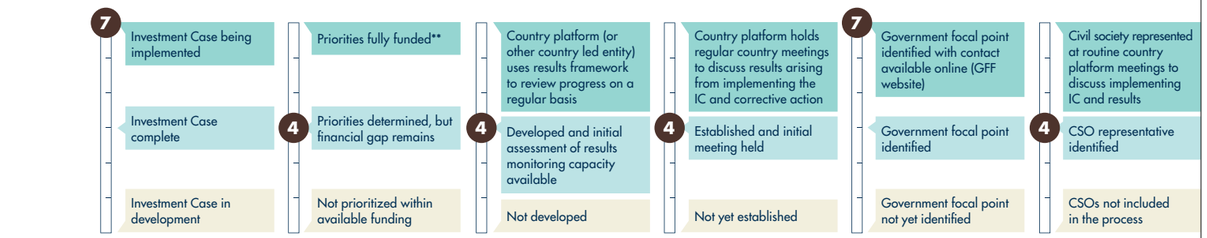
Resource Mapping

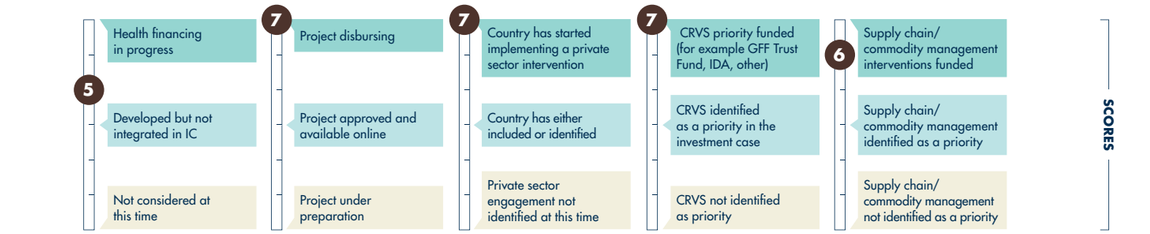


World Bank-funded Project (IDA/IBRD/GFF)

COUNTRY	Cameroon
BOARD DATE	5/3/16
GFF APPROVED AMOUNT	$27M
IDA AMOUNT	$100M

Monitoring the Country-led Process





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***ANC4 = four antenatal care visits; ART = antiretroviral therapy; ARV = antiretroviral; DTP3 = vaccination for Diphtheria, Tetanus, and Pertussis; ORS = oral rehydration solution; PMTCT = prevention of mother-to-child transmission; PNC = postnatal care.

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 efficiency of, and financial access of 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.

RMNCAH-N Data

CORE IMPACT INDICATORS

Maternal mortality ratio **846 per 100,000 live births**

Under-five mortality ratio **104 per 1,000 live births**

Percent of births <24 months after the preceding birth **27.1%**

Moderate to severe wasting among children under 5 years of age **8%**

Neonatal mortality ratio **28 per 1,000 live births**

Adolescent birth rate **138.1 per 1,000 women**

Stunting among children under 5 years of age **43%**

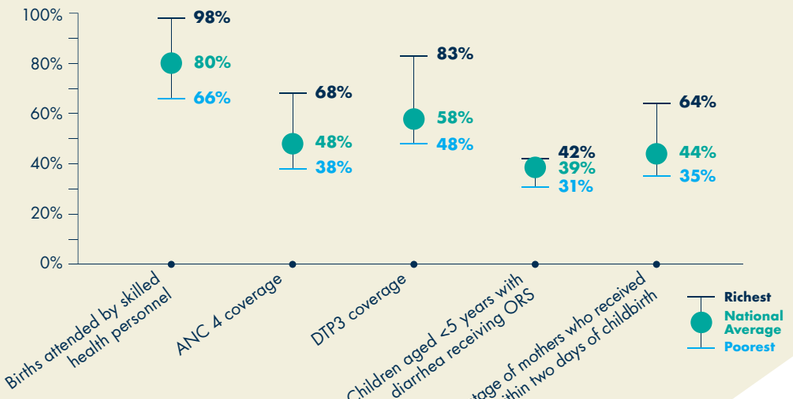
COVERAGE INDICATORS***

People living with HIV receiving ART **42%**

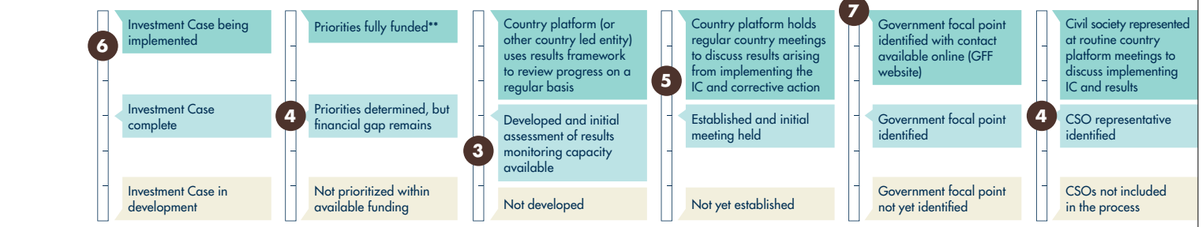
Coverage of pregnant women who receive ARV for PMTCT **70%**

Children aged <5 years with pneumonia symptoms taken to a healthcare provider **42%**

Modern contraceptive prevalence rate **8.1%**



Monitoring the Country-led Process



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Health Financing Indicators

CORE HEALTH FINANCING IMPACT INDICATORS

Health expenditure per capita financed from domestic sources **3.26**

Ratio of government health expenditure to total government expenditures **5.87%**

Percent of current health expenditures on primary/ outpatient health care **43%**

Incidence of catastrophic and impoverishing health expenditures **4.8%** catastrophic **0.8%** impoverishing

OUTPUT INDICATORS

Share of health in total government budget **6.86%**

Identified options for strengthening domestic resource mobilization **Yes**

Taken actions to support domestic resource mobilization **Yes**

Share of external funding for health that is pooled or on budget **71.26%**

Monitoring of catastrophic and impoverishing health expenditure with data less than three years old **No**

Implemented strategies to reduce key drivers of inefficiency **Yes**

Implemented reforms to address identified drivers of financial protection (especially related to RMNCAH-N) **Yes**

Country has: implemented or updated a resource mapping exercise **Yes**

Identified drivers of limited financial protection (especially In relation to RMNCAH-N services) **Yes**

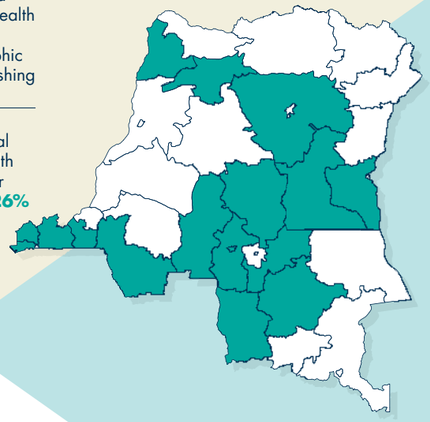
EFFICIENCY

DTP3 dropout rate **25.49%**

ANC dropout rate **46%**

Health budget execution rate **59%**

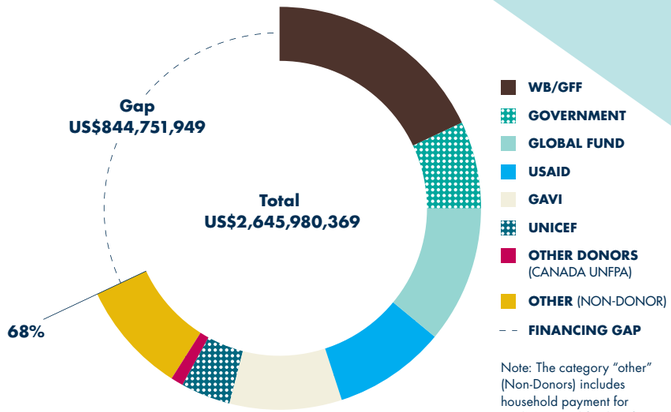
Geographic Focus Areas



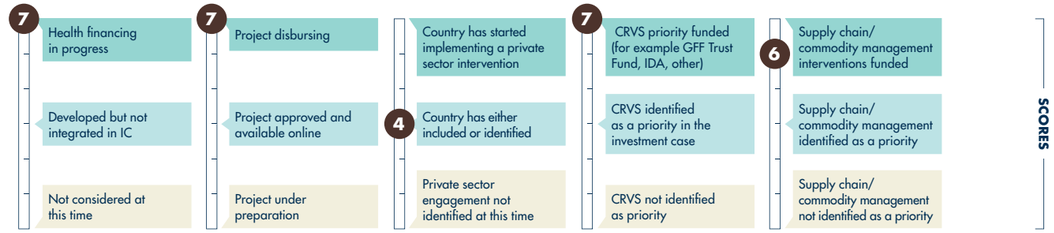
Resource Mapping

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

COUNTRY	DRC (AF)	DRC (AF-CRVS)
BOARD DATE	3/31/17	3/29/16
GFF APPROVED AMOUNT	$40M	$10M
IDA AMOUNT	$320M	$30M



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



Ethiopia

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.

RMNCAH-N Data

CORE IMPACT INDICATORS

Maternal mortality ratio **412 per 100,000 live births**

Under-five mortality ratio **67 per 1,000 live births**

Percent of births <24 months after the preceding birth **21.7%**

Moderate to severe wasting among children under 5 years of age **10%**

Neonatal mortality ratio **29 per 1,000 live births**

Adolescent birth rate **80 per 1,000 women**

Stunting among children under 5 years of age **38%**

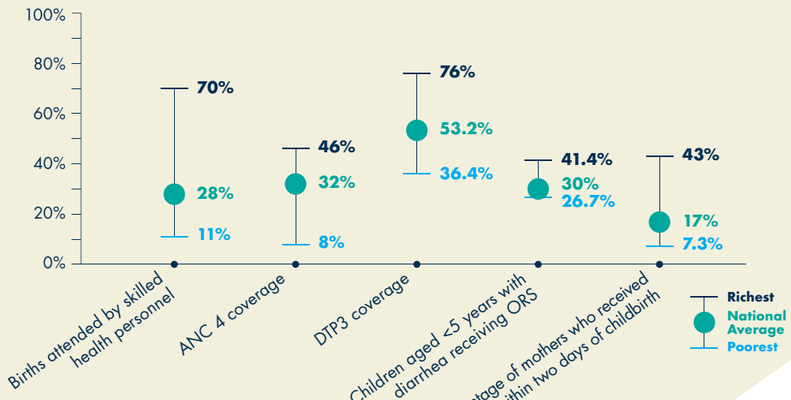
COVERAGE INDICATORS***

People living with HIV receiving ART **59%**

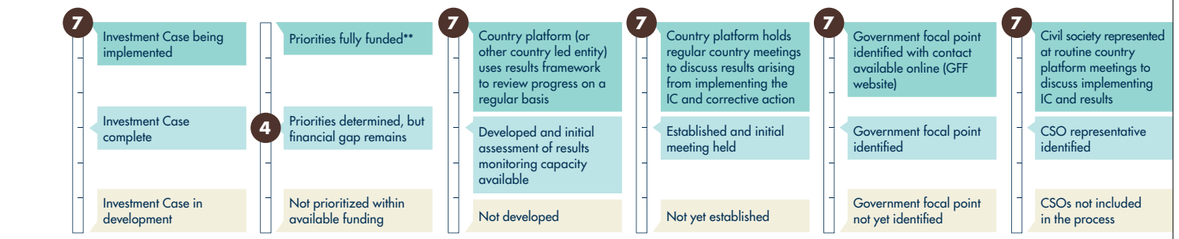
Coverage of pregnant women who receive ARV for PMTCT **69%**

Children aged <5 years with pneumonia symptoms taken to a healthcare provider **31.3%**

Modern contraceptive prevalence rate **24.9%**



Monitoring the Country-led Process



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Health Financing Indicators

CORE HEALTH FINANCING IMPACT INDICATORS

Health expenditure per capita financed from domestic sources **6.52**

Ratio of government health expenditure to total government expenditures **5.98%**

Percent of current health expenditures on primary/ outpatient health care **22%**

Incidence of catastrophic and impoverishing health expenditures **4.9%** catastrophic **0.9%** impoverishing

OUTPUT INDICATORS

Share of health in total government budget **11.7%**

Identified options for strengthening domestic resource mobilization **Yes**

Taken actions to support domestic resource mobilization **Yes**

Share of external funding for health that is pooled or on budget **41.15%**

Monitoring of catastrophic and impoverishing health expenditure with data less than three years old **Yes**

Implemented strategies to reduce key drivers of inefficiency **Yes**

Implemented reforms to address identified drivers of financial protection (especially related to RMNCAH-N) **Yes**

Country has: implemented or updated a resource mapping exercise **Yes**

Identified drivers of limited financial protection (especially In relation to RMNCAH-N services) **Yes**

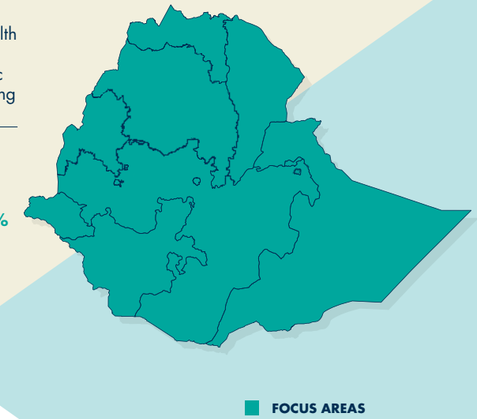
EFFICIENCY

DTP3 dropout rate **27.4%**

ANC dropout rate **22.7%**

Health budget execution rate **96%** federal **89%** regional **96%** local government level

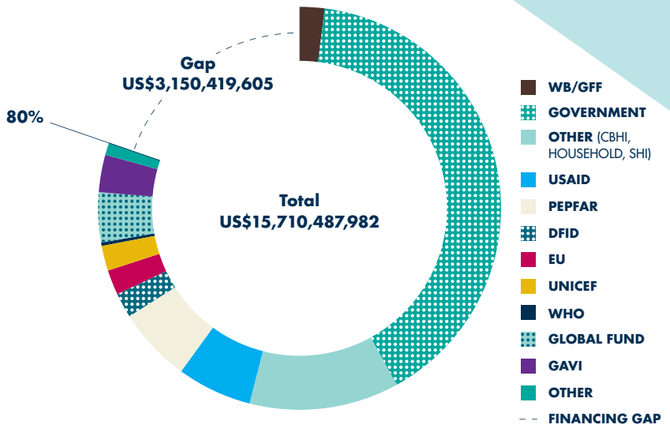
Geographic Focus Areas

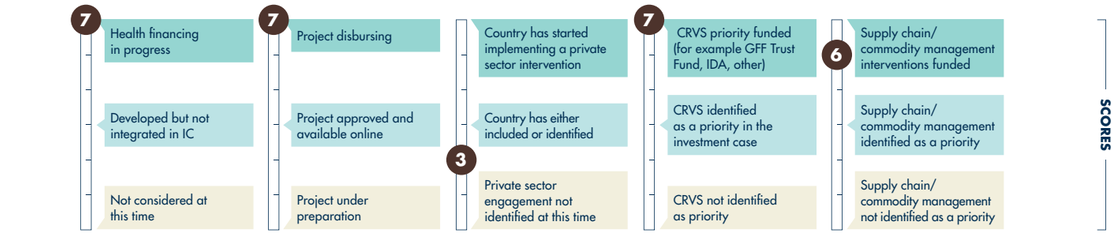


Resource Mapping

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

COUNTRY	Ethiopia
BOARD DATE	5/9/17
GFF APPROVED AMOUNT	$60M
IDA AMOUNT	$150M





Guatemala

Investment Case Priorities

1. Improve access to primary health care and nutrition services, prioritizing the reduction of chronic malnutrition:
   - prioritize an integrated package of interventions in fewer areas and with fewer implementing agencies
   - improve 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 the 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.

RMNCAH-N Data

CORE IMPACT INDICATORS

Maternal mortality ratio **140 per 100,000 live births**

Under-five mortality ratio **35 per 1,000 live births**

Percent of births <24 months after the preceding birth **18.8%**

Moderate to severe wasting among children under 5 years of age **1%**

Neonatal mortality ratio **17 per 1,000 live births**

Adolescent birth rate **92 per 1,000 women**

Stunting among children under 5 years of age **47%**

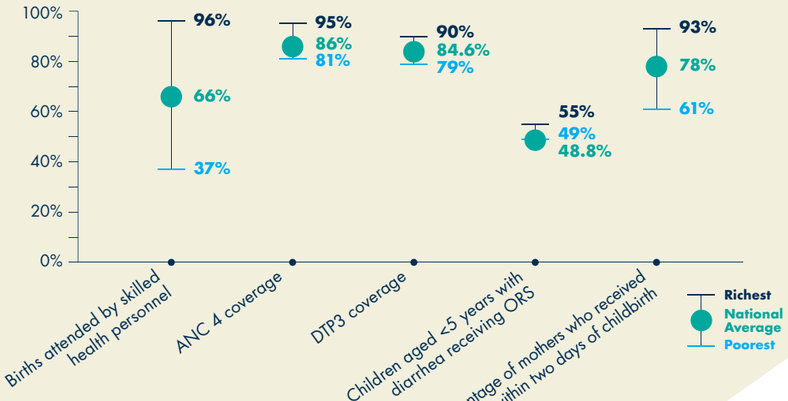
COVERAGE INDICATORS***

People living with HIV receiving ART **36%**

Coverage of pregnant women who receive ARV for PMTCT **19%**

Children aged <5 years with pneumonia symptoms taken to a healthcare provider **52%**

Modern contraceptive prevalence rate **32.2%**



Health Financing Indicators

CORE HEALTH FINANCING IMPACT INDICATORS

Health expenditure per capita financed from domestic sources **71.88**

Ratio of government health expenditure to total government expenditures **14.93%**

Percent of current health expenditures on primary/outpatient health care **Not available**

Incidence of catastrophic and impoverishing health expenditures **1.4%** catastrophic **0.3%** impoverishing

OUTPUT INDICATORS

Share of health in total government budget **Not available**

Identified options for strengthening domestic resource mobilization **Yes**

Taken actions to support domestic resource mobilization **No**

Share of external funding for health that is pooled or on budget **30.4%**

Monitoring of catastrophic and impoverishing health expenditure with data less than three years old **No**

Implemented strategies to reduce key drivers of inefficiency **No**

Implemented reforms to address identified drivers of financial protection (especially related to RMNCAH-N) **No**

Country has: implemented or updated a resource mapping exercise **No**

Identified drivers of limited financial protection (especially In relation to RMNCAH-N services) **No**

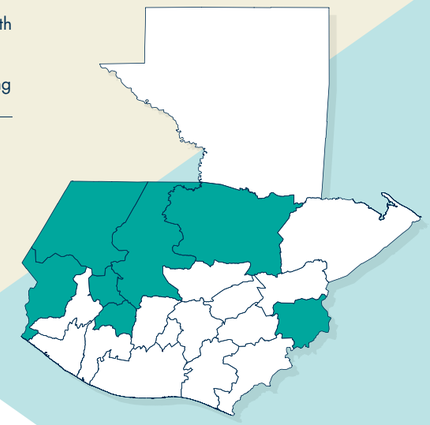
EFFICIENCY

DTP3 dropout rate **13.23%**

ANC dropout rate **6%**

Health budget execution rate **90%** wages **85%** non-wage

Geographic Focus Areas



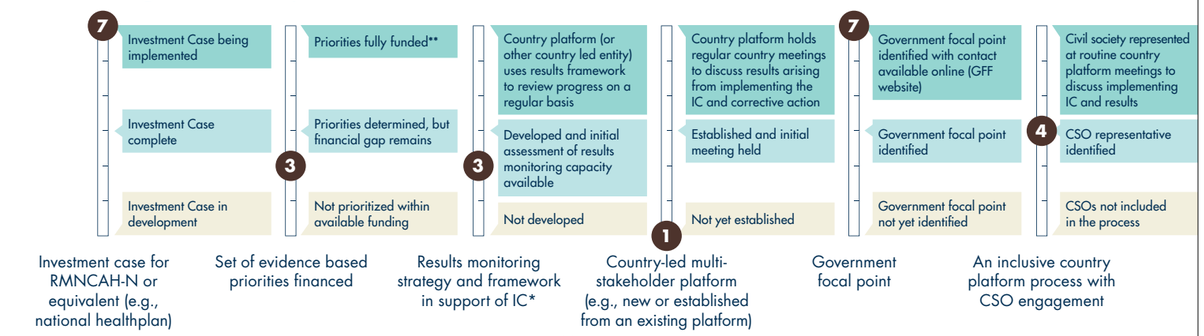
Resource Mapping

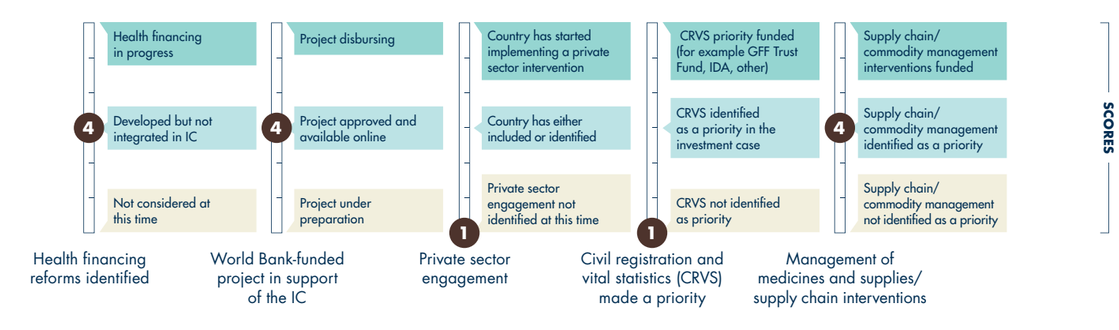
It is important to recognize that Guatemala is different from other GFF countries, with only 2 percent of total health expenditure coming from external financing. Additionally, several development partners are further reducing their investments in Guatemala, as it is now a lower-middle-income country. Thus, GFF'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 GFF 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.

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

COUNTRY	Guatemala
BOARD DATE	3/24/17
GFF APPROVED AMOUNT	$9M
IBRD AMOUNT	$100M

Monitoring the Country-led Process





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Guinea

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. Make targeted investments in monitoring and evaluation activities (for civil registration and vital statistics and for National Health Accounts).

RMNCAH-N Data

CORE IMPACT INDICATORS

Maternal mortality ratio **724 per 100,000 live births**

Neonatal mortality ratio **33 per 1,000 live births**

Under-five mortality ratio **123 per 1,000 live births**

Adolescent birth rate **132 per 1,000 women**

Percent of births <24 months after the preceding birth **12.8%**

Stunting among children under 5 years of age **32%**

Moderate to severe wasting among children under 5 years of age **8%**

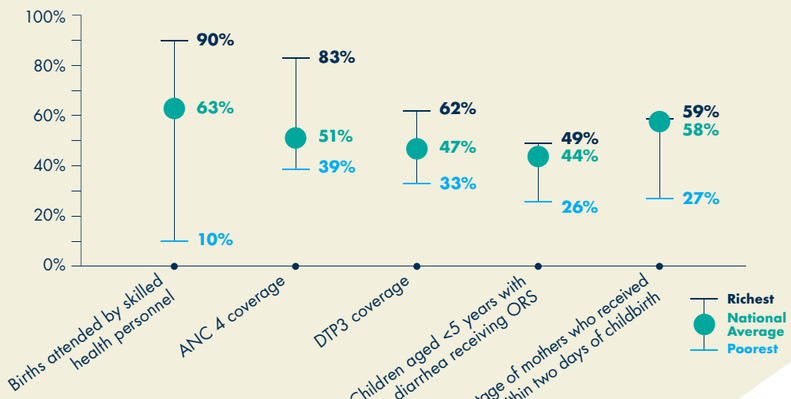
COVERAGE INDICATORS***

People living with HIV receiving ART **35%**

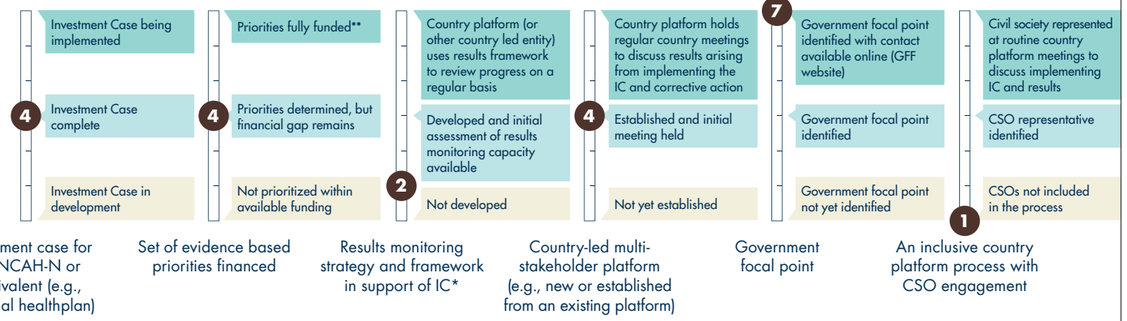
Coverage of pregnant women who receive ARV for PMTCT **43%**

Children aged <5 years with pneumonia symptoms taken to a healthcare provider **30%**

Modern contraceptive prevalence rate **7%**



Monitoring the Country-led Process



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Health Financing Indicators

CORE HEALTH FINANCING IMPACT INDICATORS

Health expenditure per capita financed from domestic sources **4.31**

Ratio of government health expenditure to total government expenditures **2.73%**

Percent of current health expenditures on primary/ outpatient health care **26.8%**

Incidence of catastrophic and impoverishing health expenditures **7%** catastrophic **2.5%** impoverishing

OUTPUT INDICATORS

Share of health in total government budget **8.2%**

Monitoring of catastrophic and impoverishing health expenditure with data less than three years old **No**

Country has: implemented or updated a resource mapping exercise **Yes**

Identified options for strengthening domestic resource mobilization **Yes**

Implemented strategies to reduce key drivers of inefficiency **No**

Identified drivers of limited financial protection (especially In relation to RMNCAH-N services) **Yes**

Taken actions to support domestic resource mobilization **No**

Implemented reforms to address identified drivers of financial protection (especially related to RMNCAH-N) **No**

Share of external funding for health that is pooled or on budget **87.39%**

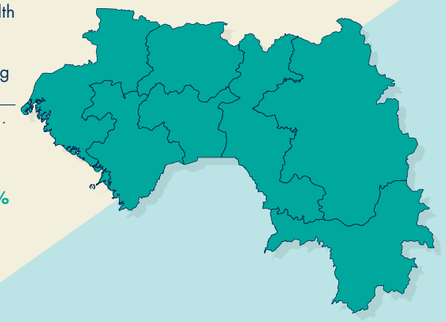
EFFICIENCY

DTP3 dropout rate **34.39%**

ANC dropout rate **40%**

Health budget execution rate **97%**

Geographic Focus Areas



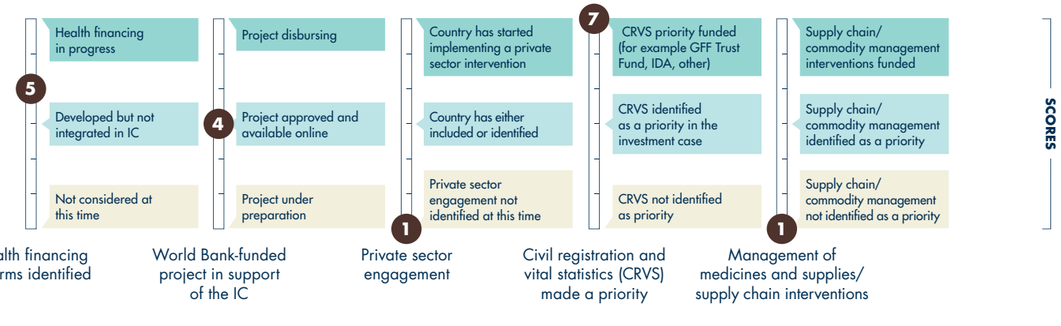
FOCUS AREAS

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 time period, estimated to require US$4,733,279,667. 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.

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

COUNTRY	Guinea
BOARD DATE	4/25/18
GFF APPROVED AMOUNT	$10M
IDA AMOUNT	$50M



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 promotive interventions
   - Expand universal health coverage through subsidized insurance cover for essential primary healthcare services.
3. Address prioritized supply side health system bottlenecks to improve access to efficient, effective, high quality service delivery for high-impact interventions:
   - Maternal and newborn health services: BEmONC, CEmONC, and functional referral systems
   - 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 of cross-sectoral adolescent sexual and reproductive health services.

RMNCAH-N Data

CORE IMPACT INDICATORS

Maternal mortality ratio **362 per 100,000 live births**

Under-five mortality ratio **52 per 1,000 live births**

Percent of births <24 months after the preceding birth **17.9%**

Moderate to severe wasting among children under 5 years of age **4%** moderate **1%** severe

Neonatal mortality ratio **22 per 1,000 live births**

Adolescent birth rate **96.3 per 1,000 women**

Stunting among children under 5 years of age **26%**

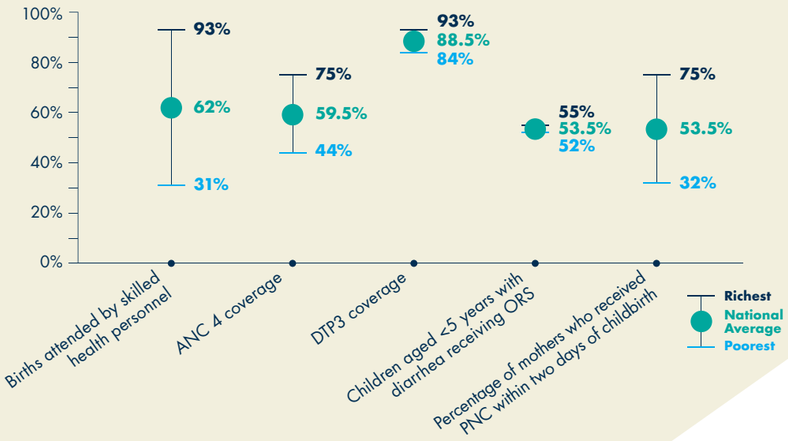
COVERAGE INDICATORS***

People living with HIV receiving ART **64%**

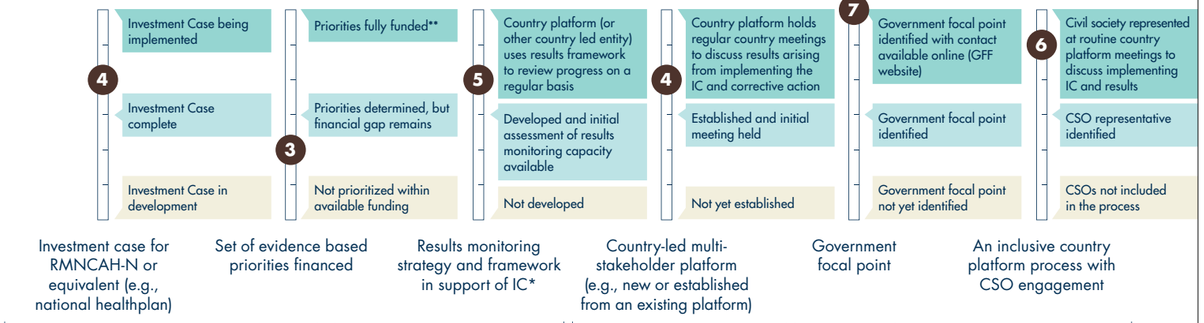
Coverage of pregnant women who receive ARV for PMTCT **80%**

Children aged <5 years with pneumonia symptoms taken to a healthcare provider **66%**

Modern contraceptive prevalence rate **39.1%**



Monitoring the Country-led Process



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Health Financing Indicators

CORE HEALTH FINANCING IMPACT INDICATORS

Health expenditure per capita financed from domestic sources **23.19**

Ratio of government health expenditure to total government expenditures **6.29%**

Percent of current health expenditures on primary/ outpatient health care **40%**

Incidence of catastrophic and impoverishing health expenditures **5.8%** catastrophic **1.4%** impoverishing

OUTPUT INDICATORS

Share of health in total government budget **7.6%**

Identified options for strengthening domestic resource mobilization **Yes**

Taken actions to support domestic resource mobilization **Yes**

Share of external funding for health that is pooled or on budget **31.05%**

Monitoring of catastrophic and impoverishing health expenditure with data less than three years old **No**

Implemented strategies to reduce key drivers of inefficiency **Yes**

Implemented reforms to address identified drivers of financial protection (especially related to RMNCAH-N) **No**

Country has: implemented or updated a resource mapping exercise **Yes**

Identified drivers of limited financial protection (especially In relation to RMNCAH-N services) **No**

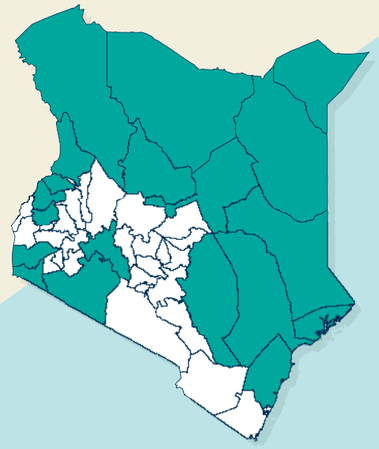
EFFICIENCY

DTP3 dropout rate **7.79%**

ANC dropout rate **40%**

Health budget execution rate **75%**

Geographic Focus Areas



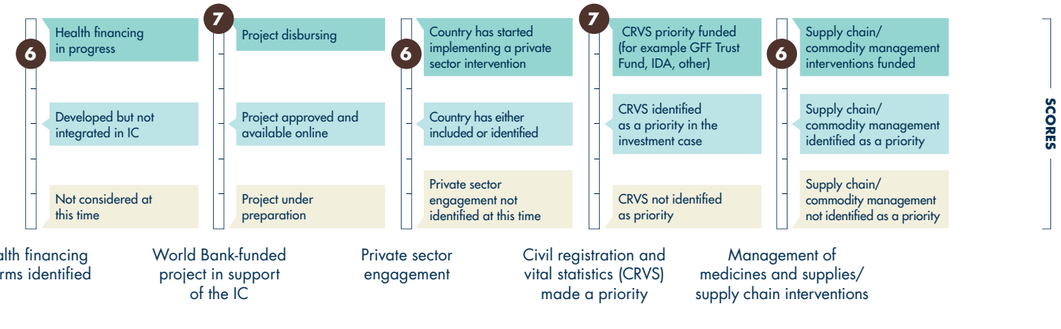
FOCUS AREAS

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$989 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 percent of all health expenditures, households (through out of pocket payments) 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 H6 partners, and the World Bank.

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

COUNTRY	Kenya
BOARD DATE	6/15/16
GFF APPROVED AMOUNT	$40M
IDA AMOUNT	$150M



Liberia

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

CORE IMPACT INDICATORS

Maternal mortality ratio **1,072 per 100,000 live births**

Neonatal mortality ratio **26 per 1,000 live births**

Under-five mortality ratio **94 per 1,000 live births**

Adolescent birth rate **149 per 1,000 women**

Percent of births <24 months after the preceding birth **15.5%**

Stunting among children under 5 years of age **32%**

Moderate to severe wasting among children under 5 years of age **6%**

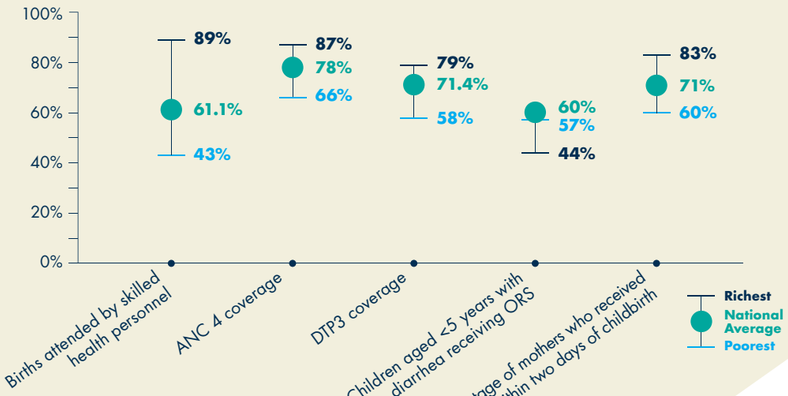
COVERAGE INDICATORS***

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

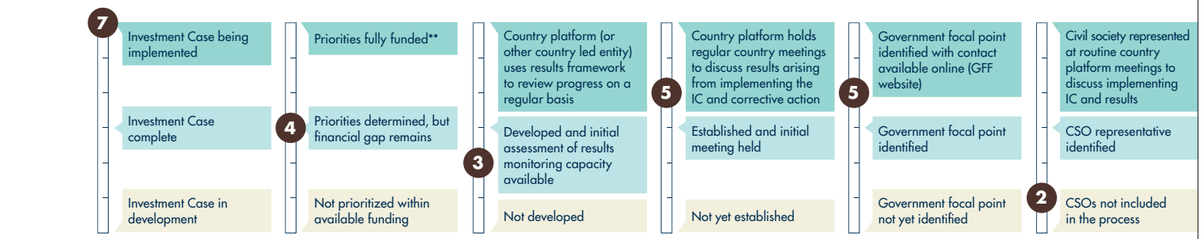
Coverage of pregnant women who receive ARV for PMTCT **39%**

Children aged <5 years with pneumonia symptoms taken to a healthcare provider **50.7%**

Modern contraceptive prevalence rate **20.5%**



Monitoring the Country-led Process



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Health Financing Indicators

CORE HEALTH FINANCING IMPACT INDICATORS

Health expenditure per capita financed from domestic sources **5.13**

Ratio of government health expenditure to total government expenditures **2.68%**

Percent of current health expenditures on primary/ outpatient health care **54%**

Incidence of catastrophic and impoverishing health expenditures **22%** catastrophic **6%** impoverishing

OUTPUT INDICATORS

Share of health in total government budget **15%**

Monitoring of catastrophic and impoverishing health expenditure with data less than three years old **No**

Country has: implemented or updated a resource mapping exercise **Yes**

Identified options for strengthening domestic resource mobilization **Yes**

Implemented strategies to reduce key drivers of inefficiency **Partially**

Identified drivers of limited financial protection (especially In relation to RMNCAH-N services) **No**

Taken actions to support domestic resource mobilization **Yes**

Implemented reforms to address identified drivers of financial protection (especially related to RMNCAH-N) **No**

Share of external funding for health that is pooled or on budget **54%**

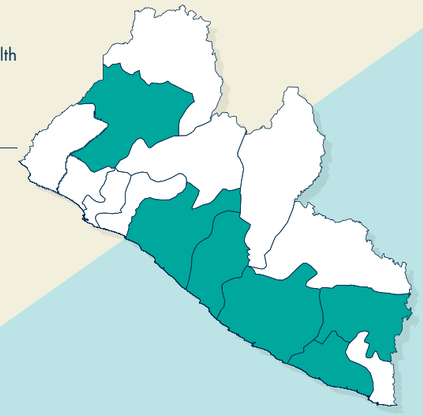
EFFICIENCY

DTP3 dropout rate **23%**

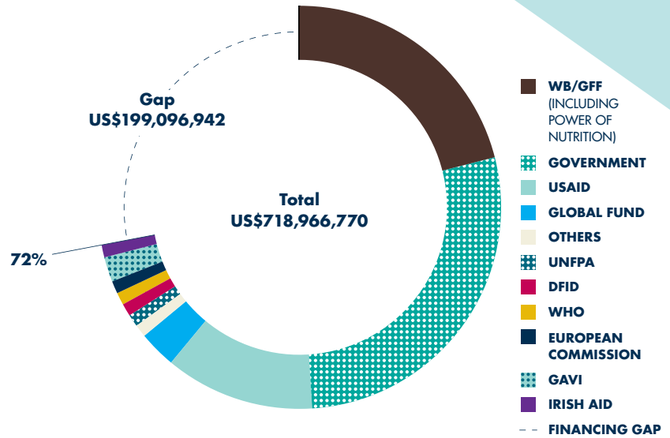
ANC dropout rate **15%**

Health budget execution rate **84%**

Geographic Focus Areas

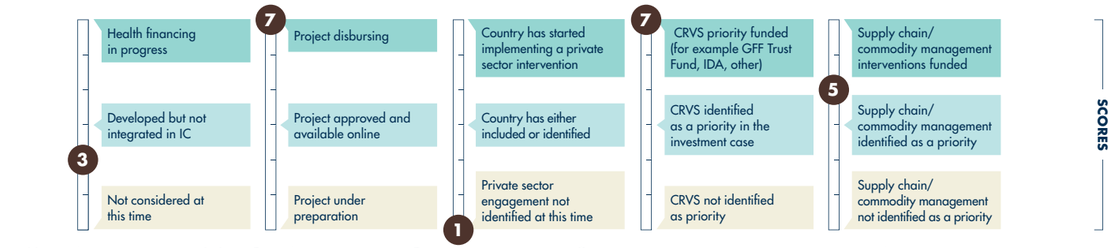


Resource Mapping



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

COUNTRY	Liberia
BOARD DATE	2/23/17
GFF APPROVED AMOUNT	$16M
IDA AMOUNT	$16M



Note: The GFF prioritization areas in Liberia directly align with the districts with the highest rates of wasting in the country.
Source: WHO, Global Database on Child Growth and Malnutrition 2007 Publication Date: 4/9/2018

Mozambique

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 burden). 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 MCH nurses, specialized professionals for ONC and surgical teams; professional motivation and satisfaction)
   - Commodity 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).

RMNCAH-N Data

CORE IMPACT INDICATORS

Maternal mortality ratio **408 per 100,000 live births**

Under-five mortality ratio **97 per 1,000 live births**

Percent of births <24 months after the preceding birth **18.8%**

Moderate to severe wasting among children under 5 years of age **6%**

Neonatal mortality ratio **30 per 1,000 live births**

Adolescent birth rate **194 per 1,000 women**

Stunting among children under 5 years of age **43%**

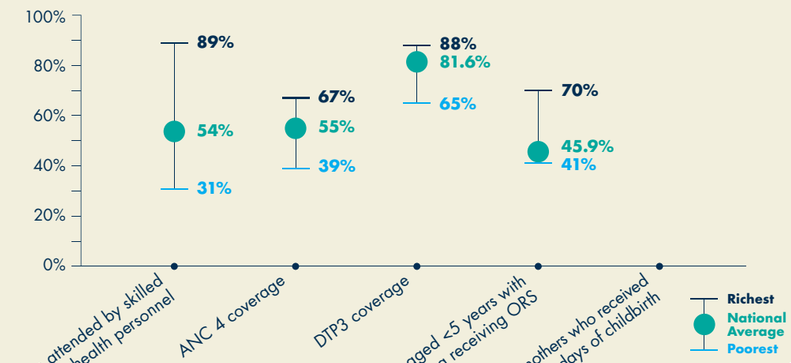
COVERAGE INDICATORS***

People living with HIV receiving ART **54%**

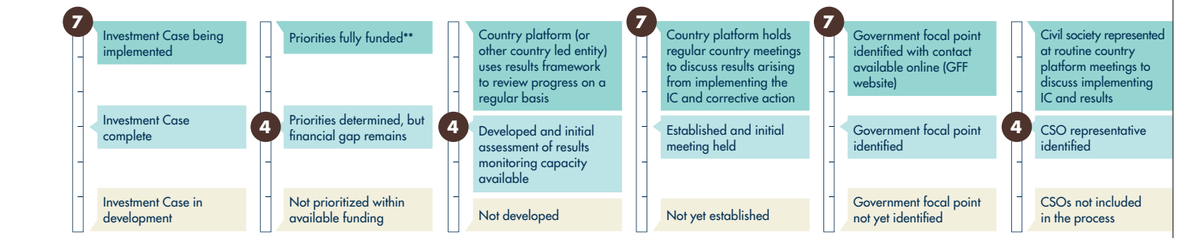
Coverage of pregnant women who receive ARV for PMTCT **80%**

Children aged <5 years with pneumonia symptoms taken to a healthcare provider **56.5%**

Modern contraceptive prevalence rate **25.7%**



Monitoring the Country-led Process



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Health Financing Indicators

CORE HEALTH FINANCING IMPACT INDICATORS

Health expenditure per capita financed from domestic sources **2.29**

Ratio of government health expenditure to total government expenditures **9%**

Percent of current health expenditures on primary/outpatient health care **Not available**

Incidence of catastrophic and impoverishing health expenditures **1.6%** catastrophic **0.5%** impoverishing

OUTPUT INDICATORS

Share of health in total government budget **10.1%**

Identified options for strengthening domestic resource mobilization **Yes**

Taken actions to support domestic resource mobilization **Yes**

Share of external funding for health that is pooled or on budget **55.42%**

Monitoring of catastrophic and impoverishing health expenditure with data less than three years old **No**

Implemented strategies to reduce key drivers of inefficiency **Yes**

Implemented reforms to address identified drivers of financial protection (especially related to RMNCAH-N) **Yes**

Country has: implemented or updated a resource mapping exercise **Yes**

Identified drivers of limited financial protection (especially In relation to RMNCAH-N services) **No**

EFFICIENCY

DTP3 dropout rate **9.33%**

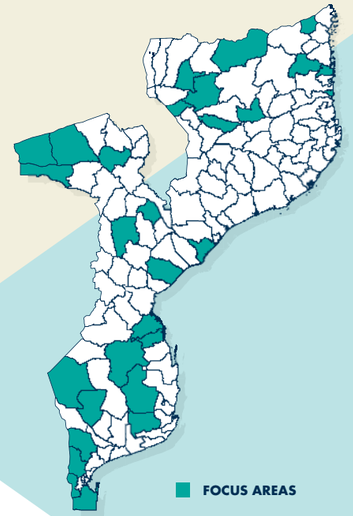
ANC dropout rate **44%**

Health budget execution rate **84%**

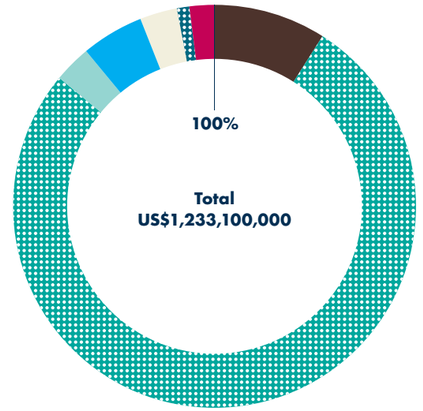
World Bank-funded Project (IDA/IBRD/GFF)

COUNTRY	Mozambique
BOARD DATE	12/20/17
GFF APPROVED AMOUNT	$25M
IDA AMOUNT	$80M

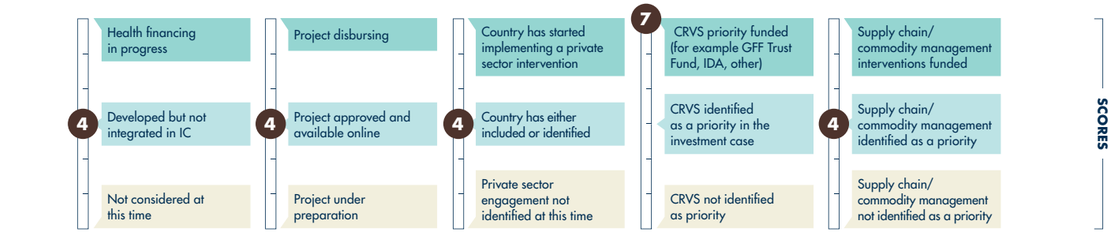
Geographic Focus Areas



Resource Mapping



Note: These are indicative commitments for 2019. All contributions in the pie are channeled through government systems. In addition, there are development partners that are financing the IC through parallel financing (e.g. for 2018 DFID is financing the IC through UN agencies.)



Myanmar

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); financial protection.

3 Create or increase demand for essential services and interventions.

RMNCAH-N Data

CORE IMPACT INDICATORS

Maternal mortality ratio **227 per 100,000 live births**

Under-five mortality ratio **50 per 1,000 live births**

Percent of births <24 months after the preceding birth **13.2%**

Moderate to severe wasting among children under 5 years of age **6.9%**

Neonatal mortality ratio **25 per 1,000 live births**

Adolescent birth rate **36 per 1,000 women**

Stunting among children under 5 years of age **29.2%**

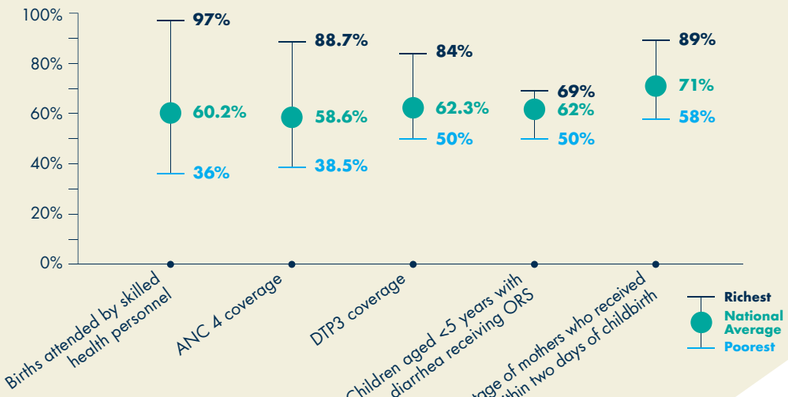
COVERAGE INDICATORS***

People living with HIV receiving ART **55%**

Coverage of pregnant women who receive ARV for PMTCT **87%**

Children aged <5 years with pneumonia symptoms taken to a healthcare provider **58.3%**

Modern contraceptive prevalence rate **31.1%**



Health Financing Indicators

CORE HEALTH FINANCING IMPACT INDICATORS

Health expenditure per capita financed from domestic sources **13.6**

Ratio of government health expenditure to total government expenditures **4.94%**

Percent of current health expenditures on primary/outpatient health care **Not available**

Incidence of catastrophic and impoverishing health expenditures **13.8%** catastrophic **2.2%** impoverishing

OUTPUT INDICATORS

Share of health in total government budget **Not available**

Identified options for strengthening domestic resource mobilization **Yes**

Taken actions to support domestic resource mobilization **No**

Share of external funding for health that is pooled or on budget **17.75%**

Monitoring of catastrophic and impoverishing health expenditure with data less than three years old **Yes**

Implemented strategies to reduce key drivers of inefficiency **Yes**

Implemented reforms to address identified drivers of financial protection (especially related to RMNCAH-N) **No**

Country has: implemented or updated a resource mapping exercise **No**

Identified drivers of limited financial protection (especially In relation to RMNCAH-N services) **Yes**

EFFICIENCY

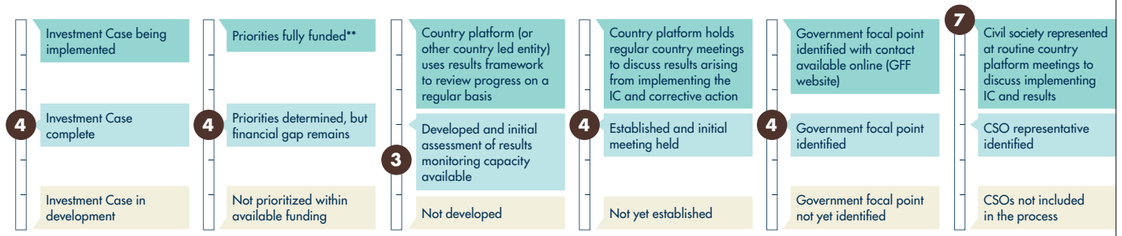
DTP3 dropout rate **28.3%**

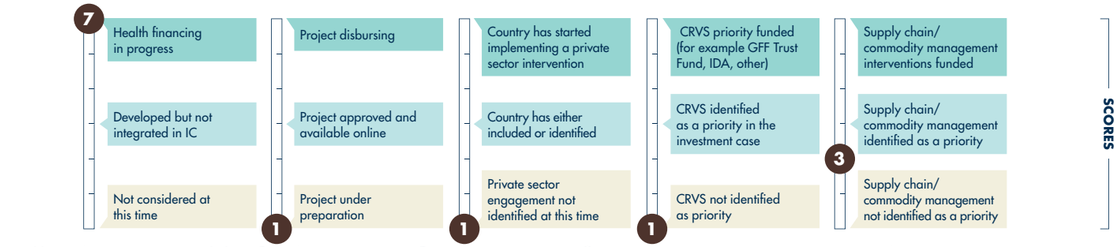
ANC dropout rate **27%**

Health budget execution rate **Not available**

Geographic Focus Areas

Monitoring the Country-led Process





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Nigeria

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.

Footnote: The Basic Minimum Package consists of 57 highly prioritized interventions of the BHCPF bundled into 12 distinct payments for primary health services and 10 secondary health services. These interventions cover the continuum of care required for pregnancy, delivery and postnatal care, treatment under 5 childhood illnesses, reproductive and adolescent health interventions including FP, treatment of malaria; and screening for select NCDS (urinalysis screening test for diabetes and blood pressure check for cardiovascular disease).

RMNCAH-N Data

CORE IMPACT INDICATORS

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

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

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

Moderate to severe wasting among children under 5 years of age **11%**

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

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

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

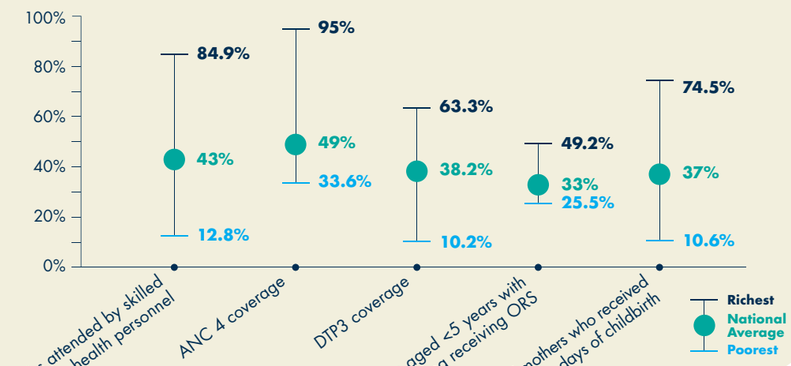
COVERAGE INDICATORS***

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

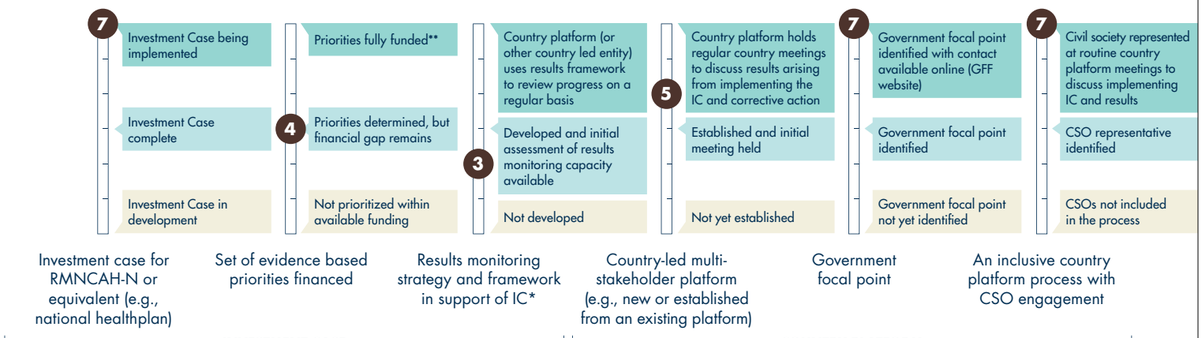
Coverage of pregnant women who receive ARV for PMTCT **32%**

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

Modern contraceptive prevalence rate **11.1%**



Monitoring the Country-led Process



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Health Financing Indicators

CORE HEALTH FINANCING IMPACT INDICATORS

Health expenditure per capita financed from domestic sources **16.08**

Ratio of government health expenditure to total government expenditures **5.3%**

Percent of current health expenditures on primary/ outpatient health care **8%**

Incidence of catastrophic and impoverishing health expenditures **26%** catastrophic **6.5%** impoverishing

OUTPUT INDICATORS

Share of health in total government budget **4.15%**

Identified options for strengthening domestic resource mobilization **Yes**

Taken actions to support domestic resource mobilization **Yes**

Share of external funding for health that is pooled or on budget **27.85%**

Monitoring of catastrophic and impoverishing health expenditure with data less than three years old **No**

Implemented strategies to reduce key drivers of inefficiency **Yes**

Implemented reforms to address identified drivers of financial protection (especially related to RMNCAH-N) **Yes**

Country has: implemented or updated a resource mapping exercise **Yes**

Identified drivers of limited financial protection (especially In relation to RMNCAH-N services) **Yes**

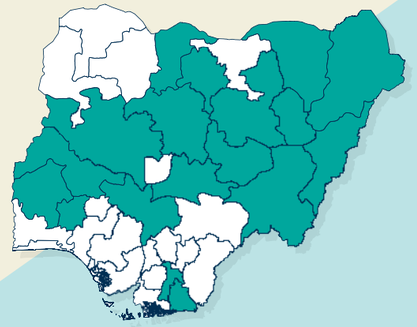
EFFICIENCY

DTP3 dropout rate **24.5%**

ANC dropout rate **25%**

Health budget execution rate **91.33%**

Geographic Focus Areas

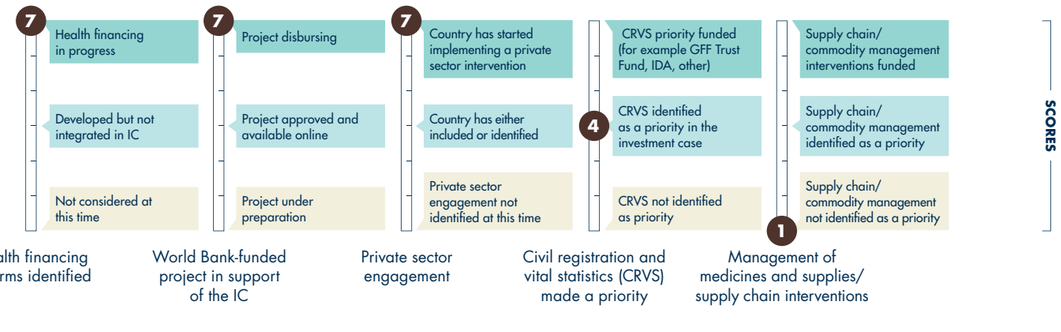


World Bank-funded Project (IDA/IBRD/GFF)

COUNTRY	Nigeria (AF)	Nigeria (ANRIN)
BOARD DATE	6/7/16	6/27/18
GFF APPROVED AMOUNT	$20M	$7M
IDA AMOUNT	$125M	$225M

Resource Mapping

The GFF has enabled the Government of Nigeria to develop a phased, prioritized investment case which has strong ownership from a range of national stakeholders, including from civil society and the private sector. While some financiers, such as the World Bank and the Bill & Melinda Gates Foundation, have aligned some of their financing to the investment case, efforts are currently underway to engage a wider group of financiers to support the investment case. The resource mapping conducted during the preparation of the investment case confirmed that there is potential to generate at least US$200 million from financiers in direct support of the investment case.



Senegal

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 by:
   - Strengthening behavioral change
   - Improving communication interventions
   - Improving community health interventions
   - Scaling up the *Couverture Maladie Universelle* program and demand-side financing programs to target the poor.
3. Improve adolescent health through multisectoral approaches (scaling up adolescent-health-related messages and engaging a policy champion).
4. Strengthen the health supply pillar to improve effective coverage of the RMNCAH-N package by scaling up the Informed Push Model and human resource initiatives.
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 P4H coordinator supporting the ministry
   - Providing innovative and sustainable funding to reach universal health coverage
   - Improving civil registration and vital statistics systems.

RMNCAH-N Data

CORE IMPACT INDICATORS

Maternal mortality ratio **392 per 100,000 live births**

Under-five mortality ratio **51 per 1,000 live births**

Percent of births <24 months after the preceding birth **14.5%**

Moderate to severe wasting among children under 5 years of age **7%**

Neonatal mortality ratio **21 per 1,000 live births**

Adolescent birth rate **72 per 1,000 women**

Stunting among children under 5 years of age **17%**

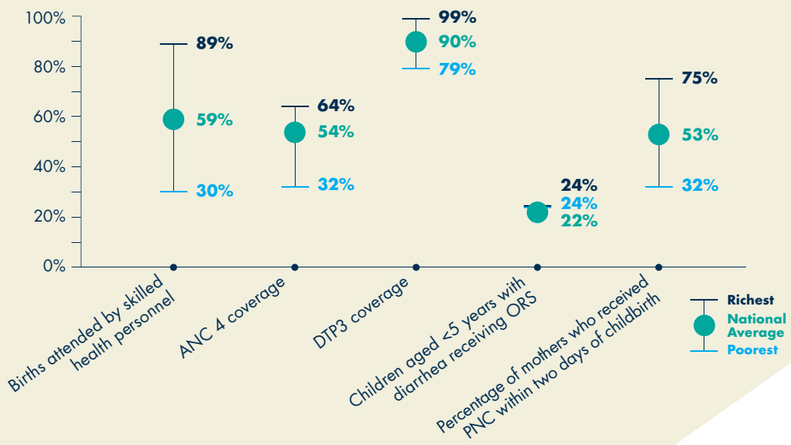
COVERAGE INDICATORS***

People living with HIV receiving ART **52%**

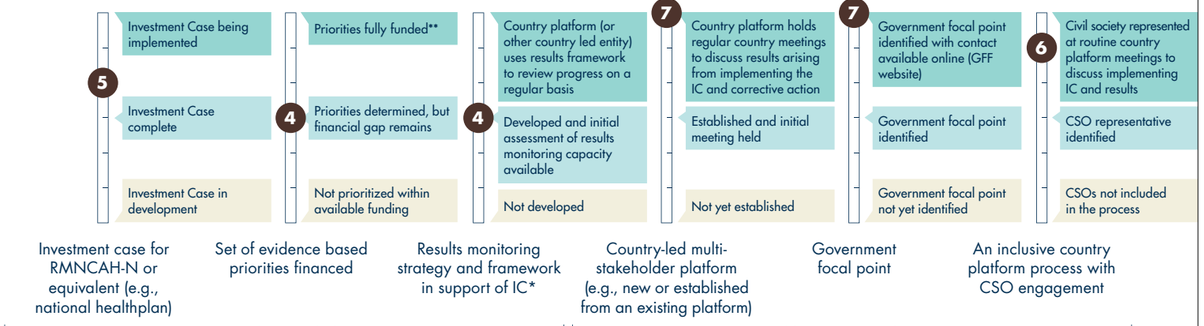
Coverage of pregnant women who receive ARV for PMTCT **55%**

Children aged <5 years with pneumonia symptoms taken to a healthcare provider **48%**

Modern contraceptive prevalence rate **23%**



Monitoring the Country-led Process



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Health Financing Indicators

CORE HEALTH FINANCING IMPACT INDICATORS

Health expenditure per capita financed from domestic sources **15**

Ratio of government health expenditure to total government expenditures **4.2%**

Percent of current health expenditures on primary/ outpatient health care **42%**

Incidence of catastrophic and impoverishing health expenditures **3.33%** catastrophic **1.1%** impoverishing

OUTPUT INDICATORS

Share of health in total government budget **Not available**

Identified options for strengthening domestic resource mobilization **Yes**

Taken actions to support domestic resource mobilization **Yes**

Share of external funding for health that is pooled or on budget **92.88%**

Monitoring of catastrophic and impoverishing health expenditure with data less than three years old **No**

Implemented strategies to reduce key drivers of inefficiency **Yes**

Implemented reforms to address identified drivers of financial protection (especially related to RMNCAH-N) **Yes**

Country has: implemented or updated a resource mapping exercise **Yes**

Identified drivers of limited financial protection (especially In relation to RMNCAH-N services) **Yes**

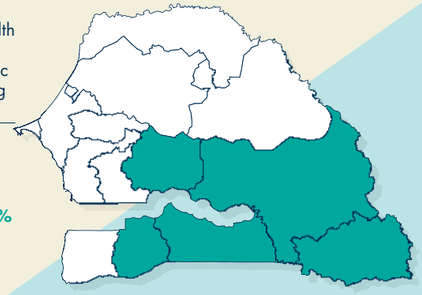
EFFICIENCY

DTP3 dropout rate **5.69%**

ANC dropout rate **43%**

Health budget execution rate **80.5%**

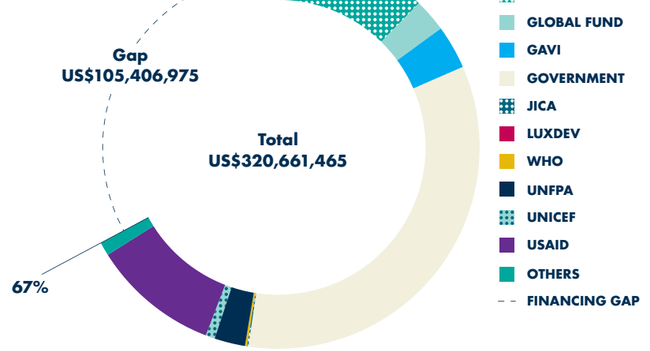
Geographic Focus Areas

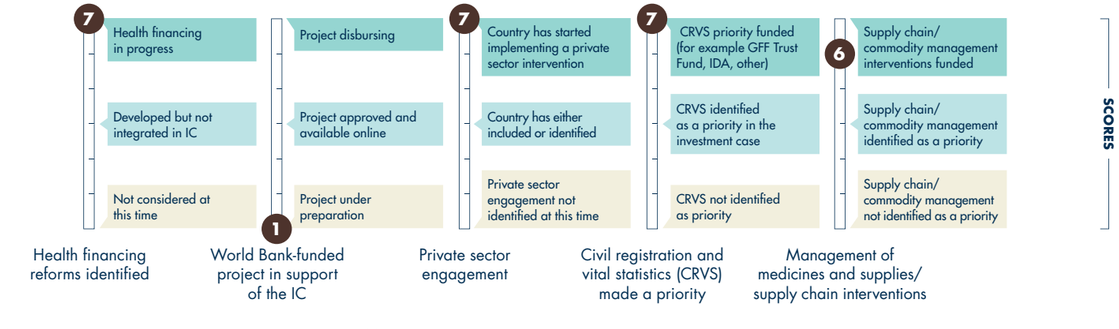


FOCUS AREAS*

*In the future, it is likely that poor districts from Dakar and Dioubel may be included in the priority regions, depending on availability of funding.

Resource Mapping





Sierra Leone

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 maternity care, and MPDSR.
3. Strengthen community systems for effective delivery of RMNCAH-N services. (Address sociocultural, 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 service delivery, and strengthen civil registration and vital statistics systems.

RMNCAH-N Data

CORE IMPACT INDICATORS

Maternal mortality ratio **1,165 per 100,000 live births**

Under-five mortality ratio **156 per 1,000 live births**

Percent of births <24 months after the preceding birth **28.1%**

Moderate to severe wasting among children under 5 years of age **5%**

Neonatal mortality ratio **39 per 1,000 live births**

Adolescent birth rate **125 per 1,000 women**

Stunting among children under 5 years of age **29%**

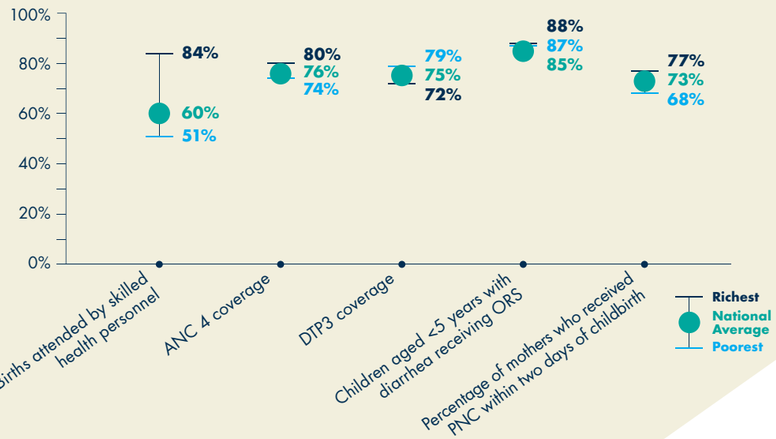
COVERAGE INDICATORS***

People living with HIV receiving ART **26%**

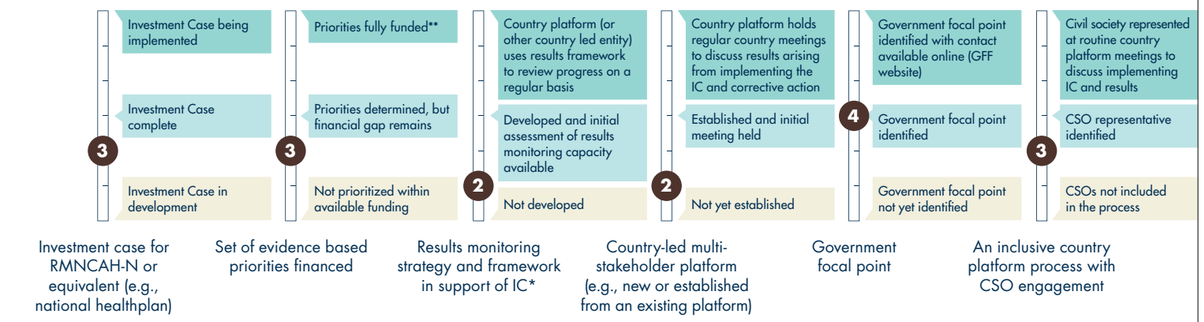
Coverage of pregnant women who receive ARV for PMTCT **87%**

Children aged <5 years with pneumonia symptoms taken to a healthcare provider **72%**

Modern contraceptive prevalence rate **20.9%**



Monitoring the Country-led Process



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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 expenditures 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**

Taken actions to support domestic resource mobilization **Yes**

Share of external funding for health that is pooled or on budget **7.27%**

Monitoring of catastrophic and impoverishing health expenditure with data less than three years old **No**

Implemented strategies to reduce key drivers of inefficiency **No**

Implemented reforms to address identified drivers of financial protection (especially related to RMNCAH-N) **No**

Country has: implemented or updated a resource mapping exercise **Yes**

Identified drivers of limited financial protection (especially In relation to RMNCAH-N services) **No**

EFFICIENCY

DTP3 dropout rate **16.69%**

ANC dropout rate **22%**

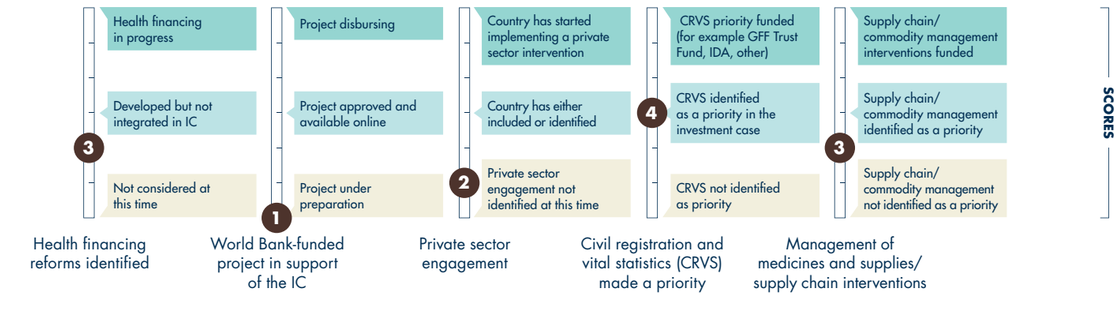
Health budget execution rate **64%**

Geographic Focus Areas

*Prioritization in process

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.



United Republic of 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 Care 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 annual 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).

RMNCAH-N Data

CORE IMPACT INDICATORS

Maternal mortality ratio **556 per 100,000 live births**

Under-five mortality ratio **67 per 1,000 live births**

Percent of births <24 months after the preceding birth **18.8%**

Moderate to severe wasting among children under 5 years of age **4.4%**

Neonatal mortality ratio **25 per 1,000 live births**

Adolescent birth rate **132 per 1,000 women**

Stunting among children under 5 years of age **34%**

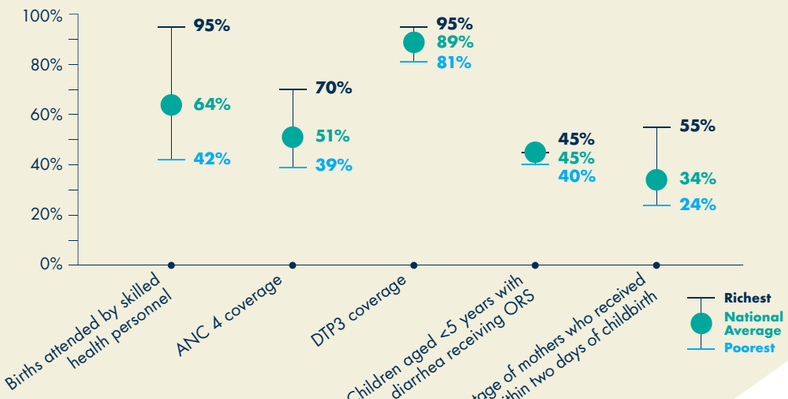
COVERAGE INDICATORS***

People living with HIV receiving ART **62%**

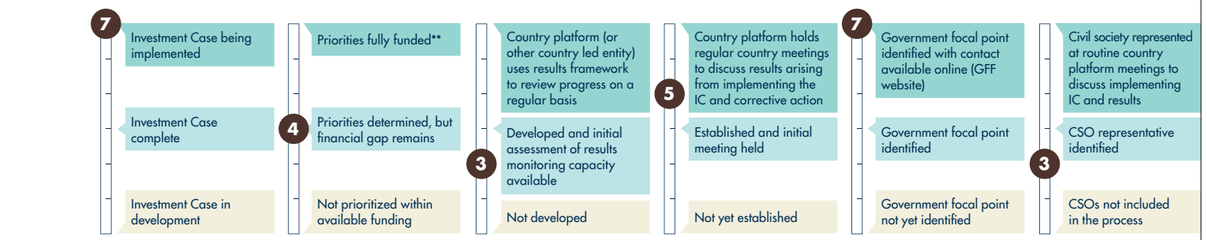
Coverage of pregnant women who receive ARV for PMTCT **84%**

Children aged <5 years with pneumonia symptoms taken to a healthcare provider **55.4%**

Modern contraceptive prevalence rate **27%**



Monitoring the Country-led Process



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***ANC4 = four antenatal care visits; ART = antiretroviral therapy; ARV = antiretroviral; DTP3 = vaccination for Diphtheria, Tetanus, and Pertussis; ORS = oral rehydration solution; PMTCT = prevention of mother-to-child transmission; PNC = postnatal care.

Health Financing Indicators

CORE HEALTH FINANCING IMPACT INDICATORS

Health expenditure per capita financed from domestic sources **11.2**

Ratio of government health expenditure to total government expenditures **7.43%**

Percent of current health expenditures on primary/ outpatient health care **48.64%**

Incidence of catastrophic and impoverishing health expenditures **10.3%** catastrophic **2.8%** impoverishing

OUTPUT INDICATORS

Share of health in total government budget **Not available**

Identified options for strengthening domestic resource mobilization **Yes**

Taken actions to support domestic resource mobilization **No**

Share of external funding for health that is pooled or on budget **32.24%**

Monitoring of catastrophic and impoverishing health expenditure with data less than three years old **No**

Implemented strategies to reduce key drivers of inefficiency **Yes**

Implemented reforms to address identified drivers of financial protection (especially related to RMNCAH-N) **Yes**

Country has: implemented or updated a resource mapping exercise **Yes**

Identified drivers of limited financial protection (especially In relation to RMNCAH-N services) **Yes**

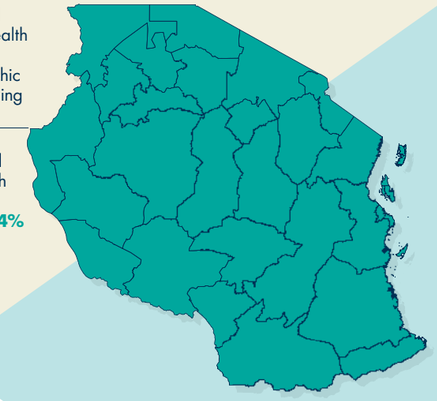
EFFICIENCY

DTP3 dropout rate **2.02%**

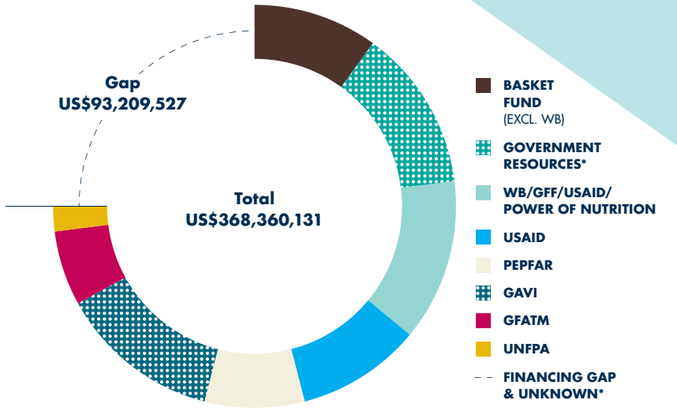
ANC dropout rate **38%**

Health budget execution rate **91.7%**

Geographic Focus Areas



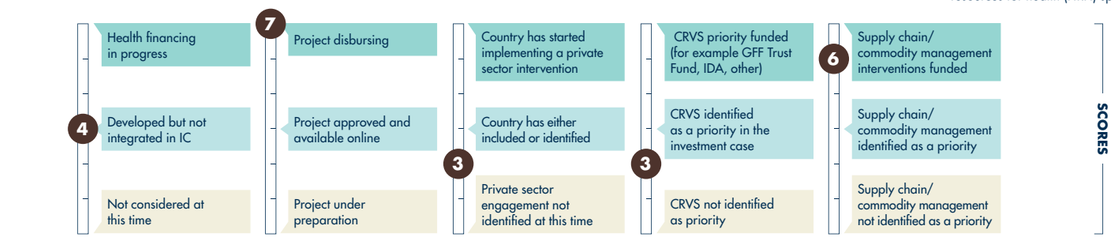
Resource Mapping



*Government resources as well as Gap and Unknown do not include human resources for health (HRH) spending

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

COUNTRY	Tanzania
BOARD DATE	5/28/15
GFF APPROVED AMOUNT	$40M
IDA AMOUNT	$200M



Uganda

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

CORE IMPACT INDICATORS

Maternal mortality ratio **336 per 100,000 live births**

Under-five mortality ratio **64 per 1,000 live births**

Percent of births <24 months after the preceding birth **24.3%**

Moderate to severe wasting among children under 5 years of age **5%**

Neonatal mortality ratio **27 per 1,000 live births**

Adolescent birth rate **132 per 1,000 women**

Stunting among children under 5 years of age **29%**

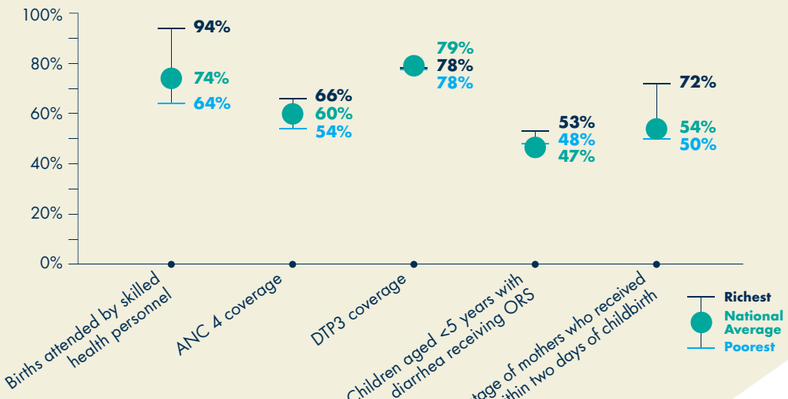
COVERAGE INDICATORS***

People living with HIV receiving ART **67%**

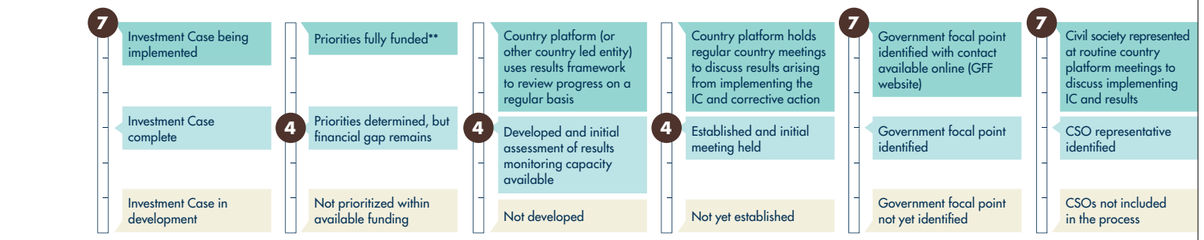
Coverage of pregnant women who receive ARV for PMTCT **95%**

Children aged <5 years with pneumonia symptoms taken to a healthcare provider **80%**

Modern contraceptive prevalence rate **27.3%**



Monitoring the Country-led Process



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***ANC4 = four antenatal care visits; ART = antiretroviral therapy; ARV = antiretroviral; DTP3 = vaccination for Diphtheria, Tetanus, and Pertussis; ORS = oral rehydration solution; PMTCT = prevention of mother-to-child transmission; PNC = postnatal care.

Health Financing Indicators

CORE HEALTH FINANCING IMPACT INDICATORS

Health expenditure per capita financed from domestic sources **6.19**

Ratio of government health expenditure to total government expenditures **5.61%**

Percent of current health expenditures on primary/ outpatient health care **31.55%**

Incidence of catastrophic and impoverishing health expenditures **10.5%** catastrophic **2.7%** impoverishing

OUTPUT INDICATORS

Share of health in total government budget **7.5%**

Identified options for strengthening domestic resource mobilization **Yes**

Taken actions to support domestic resource mobilization **Yes**

Share of external funding for health that is pooled or on budget **36.41%**

Monitoring of catastrophic and impoverishing health expenditure with data less than three years old **No**

Implemented strategies to reduce key drivers of inefficiency **Yes**

Implemented reforms to address identified drivers of financial protection (especially related to RMNCAH-N) **Not available**

Country has: implemented or updated a resource mapping exercise **No**

Identified drivers of limited financial protection (especially In relation to RMNCAH-N services) **Yes**

EFFICIENCY

DTP3 dropout rate **17.2%**

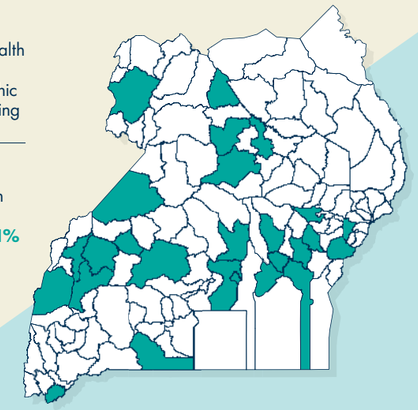
ANC dropout rate **38%**

Health budget execution rate **90%** wages & development grants **100%** non-wages expenditures

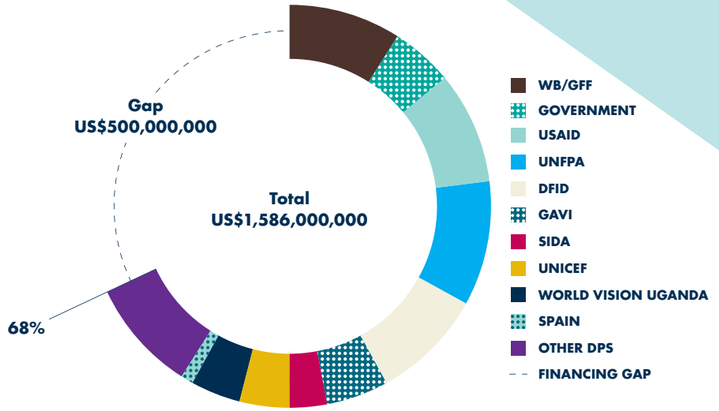
World Bank-funded Project (IDA/IBRD/GFF)

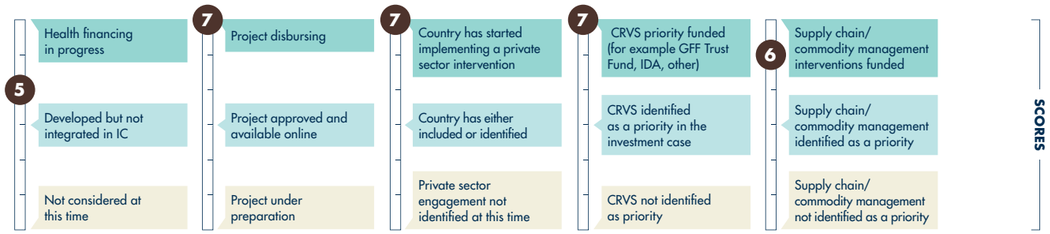
COUNTRY	Uganda
BOARD DATE	8/4/16
GFF APPROVED AMOUNT	$30M
IDA AMOUNT	$110M

Geographic Focus Areas



Resource Mapping





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 obstetric 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 over-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.

RMNCAH-N Data

CORE IMPACT INDICATORS

Maternal mortality ratio **54 per 100,000 live births**

Under-five mortality ratio **21.6 per 1,000 live births**

Percent of births <24 months after the preceding birth **13%**

Moderate to severe wasting among children under 5 years of age **6.4%**

Neonatal mortality ratio **11.5 per 1,000 live births**

Adolescent birth rate **29 per 1,000 women**

Stunting among children under 5 years of age **24.6%**

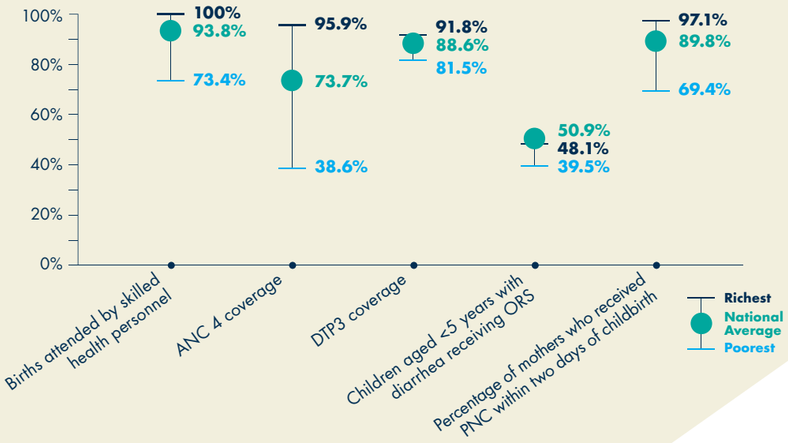
COVERAGE INDICATORS***

People living with HIV receiving ART **47%**

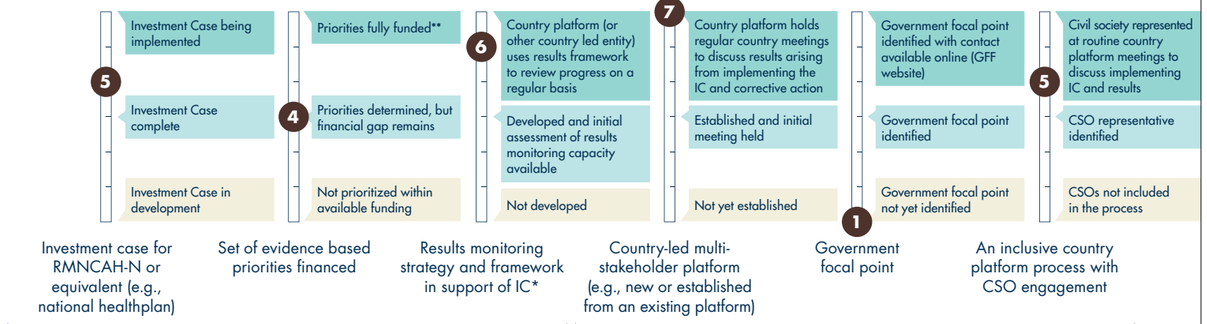
Coverage of pregnant women who receive ARV for PMTCT **66%**

Children aged <5 years with pneumonia symptoms taken to a healthcare provider **81.1%**

Modern contraceptive prevalence rate **57%**



Monitoring the Country-led Process



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Health Financing Indicators

CORE HEALTH FINANCING IMPACT INDICATORS

Health expenditure per capita financed from domestic sources **48.81**

Ratio of government health expenditure to total government expenditures **7.89%**

Percent of current health expenditures on primary/ outpatient health care **46.07%**

Incidence of catastrophic and impoverishing health expenditures **9.8%** catastrophic **0.35%** impoverishing

OUTPUT INDICATORS

Share of health in total government budget **Not available**

Identified options for strengthening domestic resource mobilization **Yes**

Taken actions to support domestic resource mobilization **Yes**

Share of external funding for health that is pooled or on budget **71.09%**

Monitoring of catastrophic and impoverishing health expenditure with data less than three years old **Yes**

Implemented strategies to reduce key drivers of inefficiency **Yes**

Implemented reforms to address identified drivers of financial protection (especially related to RMNCAH-N) **Yes**

Country has: implemented or updated a resource mapping exercise **Yes**

Identified drivers of limited financial protection (especially In relation to RMNCAH-N services) **Yes**

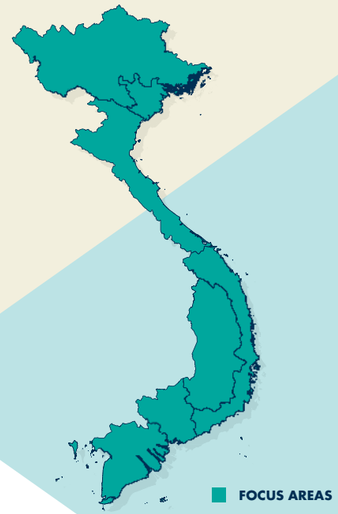
EFFICIENCY

DTP3 dropout rate **8%**

ANC dropout rate **23%**

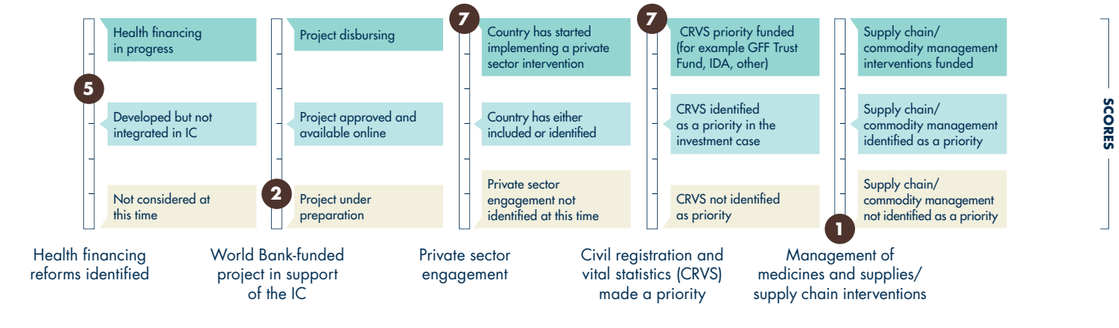
Health budget execution rate **Not available**

Geographic Focus Areas



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 (lent at IBRD terms) for the Investing and Innovating for Grassroots Service Delivery Reform Project (P161283). In a constrained macroeconomic environment, with a high debt-to-GDP ratio, the government is reluctant to use loans, especially loans made at less-concessional IBRD terms and even moreso 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$80 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 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.



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 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 co-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.

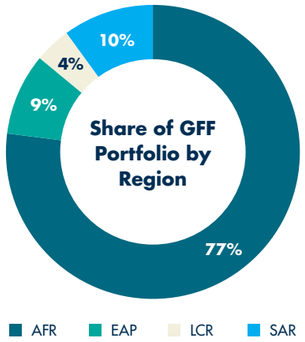
Country	<5 Birth Registration[1]	Death Registration	Cause of Death Availability	Electronic/ Paper-based	CRVS in IC/Health Strategy	CRVS in Project/Advisory Services and Analytics	Status
Bangladesh	●	●	●	▲ [11]	N/A	No	N/A
Cameroon	●	●	●	▲ [12]	Yes	Yes	Implementation
DRC	●	●	●	▲ [12]	Yes	Yes	Implementation
Ethiopia	●	●	●	▲ [12]	Yes	Yes	Implementation
Guatemala	●	● [2]	● [10]	▲ [12]	N/A	No	N/A
Guinea	●	●	●	▲ [12]	Yes	Yes	Awaiting effectiveness
Kenya	●	● [3]	●	▲ [12]	Yes	Yes	Implementation
Liberia	●	● [4]	●	▲ [12]	Yes	Yes	Implementation
Mozambique	●	●	●	▲ [12]	Yes	Yes	Awaiting effectiveness
Myanmar	●	● [5]	● [5]	▲ [12]	No	No	N/A
Nigeria	●	● [6]	●	▲ [12]	Yes	No	N/A
Senegal	●	● [7]	●	▲ [12]	Yes	No	N/A
Sierra Leone	●	● [8]	●	▲ [12]	Yes	No	N/A
Tanzania	●	● [9]	●	▲ [12]	Yes	No	N/A
Uganda	●	●	●	▲ [12]	Yes	Yes	Implementation
Vietnam	●	●	●	▲ [13]	N/A	ASA	Implementation

● No data ● <33% ● 33-66% ● 67%+ ▲ Paper ▲ Paper + Electronic ▲ Electronic

1 Most recent DHS or MICS data
2 WHO, World Health Statistics 2018: Monitoring health data for the SDGs, Geneva, WHO
3 UNSD (United Nations Statistics Division Demographic Statistics), 2016, Status of Civil Registration and Vital Statistics: African English speaking countries, CRVS Technical Report Series, Vol. 3
4 World Bank, 2015, Improving Civil Registration and Vital Statistics in Liberia: Investment Case (2016-2020), Washington DC
5 Data for Health: http://getinthepicture.org/resource/presentations-workshop-operation-civil-registration-vital-statistics-and-identity
6 National strategic action plan on civil registration and vital statistics (2015-2019), Abuja, Nigeria
7 Diouf I & Ndiaye CT, 2015, Completeness and coverage of CRVS in Senegal: analyzing census data to identify barriers to death registration (IUSSP Meeting, Johannesburg. November 28th 2015)
8 CRC4D https://www.crc4d.com/downloads/2014-04-establishing-21st-century-identity-management-sierra-Leone.pdf
9 Hudson E, The National CRVS Improvement Program in Mainland Tanzania, Presentation delivered at the Launch of Tanzania Health Data Collaborative. Dar es Salaam, Tanzania, 2017
10 World Bank https://data.worldbank.org/indicator
11 Government of the Republic of Bangladesh (Ministry of Health and Family Welfare) http://getinthepicture.org/sites/default/files/resources/Comprehensive%20Assessment%20and%20Strategic%20Action%20Plan%20Report%20Bangladesh.pdf
12 UNICEF www.data.unicef.org/resources/crvs
13 UNSD https://unstats.un.org/unsd/demographic-social/.../Vietnam.../Session10-Vietnam.pptx

GFF Financials

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.



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

Country	GFF approved amount	IDA amount	IBRD
Tanzania	$40	$200	
DRC (AF-CRVS)	$10	$30	
Cameroon	$27	$100	
Nigeria (AF)	$20	$125	
Nigeria (Part 2)	$20	$0	
Nigeria (Nutrition)	$7	$225	
Kenya	$40	$150	
Uganda	$30	$110	
Liberia (AF)	$16	$16	
Guatemala	$9		$100
DRC (AF)	$40	$320	
Ethiopia	$60	$150	
Bangladesh	$15	$500	
Bangladesh - Education	$10	$510	
Mozambique	$25	$80	
Rwanda (Health)	$10	$25	
Afghanistan	$35	$140	
Rwanda (SP-AF)	$8	$80	
Guinea	$10	$50	
Indonesia	$20		$400
Total GFF Projects	**$452**	**$2,811**	**$500**

GFF Country-led Investment Case Complementary Financing
(in addition to the governments of each GFF country, the GFF Trust Fund, and IDA or IBRD)

Bangladesh	Governments of Netherlands, Sweden
Cameroon	Bill & Melinda Gates Foundation, ECHO, Gavi, Global Fund, Islamic Development Bank, UNFPA, UNICEF, UNITAID, WHO, and the governments of France (AFD) and Germany (BMZ, KfW)
DRC	Gavi, Global Fund, UNFPA, UNICEF, and the governments of Canada and the United States (USAID)
Ethiopia	Gavi, Global Fund, European Union, UNICEF, WHO, the governments of the United Kingdom (DFID) and United States (PEPFAR, USAID), and other (CBHI, Households and SHI)
Guinea	European Union, Gavi, Global Fund, UNAIDS, WHO, and the governments of France (AFD), Germany (GIZ), Japan (JICA) and the United States (USAID)
Kenya	Bill & Melinda Gates Foundation, Children's Investment Fund Foundation, Clinton Health Access Initiative, and the governments of Canada, Denmark, Germany (KfW, GIZ), Japan (JICA), Netherlands, South Korea (KOICA), United Kingdom (DFID), and the United States (CDC, USAID)
Liberia	Bill & Melinda Gates Foundation, Gavi, Global Fund, UNICEF, UNFPA, WHO, and the governments of Japan, the United States (USAID), and Sweden
Mozambique	Multi-donor Trust Fund (Netherlands and Canada), PROSAUDE (Ireland, Spain, Switzerland, UNICEF, UNFPA), and Single Donor Trust Fund (USAID)[1]
Nigeria	Bill & Melinda Gates Foundation, Dangote Foundation, Power of Nutrition
Senegal	Gavi, Global Fund, JICA, UNICEF, governments of France (AFD) and the United States (USAID), and various UN agencies
Sierra Leone	Gavi, Global Fund, Partners in Health, UNICEF, USAID, and the governments of Germany (KFW), Italy, Japan (JICA), and United Kingdom (DFID)
Tanzania	Power of Nutrition, UNFPA, UNICEF, WHO, and the governments of Canada, Denmark (DANIDA), Ireland, Switzerland, and the United States (PEPFAR, USAID)
Uganda	Global Fund, AMREF, Clinton Health Access Initiative, Gavi, Islamic Development Bank, JSI, Living Goods, Marie Stopes Uganda, PSI, Save the Children Uganda, UPMB, UNFPA, UNICEF, UNOPS, WHO, World Vision Uganda, and the governments of Belgium (BTC), Korea (KOICA), Spain, Sweden (SIDA), United Kingdom (DFID), and United States (USAID)

1 In addition, several partners in Mozambique, including the United Kingdom's DFID and the United States, also channel money through NGOs or UN agencies.

Investors Group Members

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)

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

Government of Japan

Government of Norway

Government of Senegal

Government of United Kingdom

Government of United States

JHPIEGO (representing the civil society constituency)

Government of Kenya

Government of Liberia

MSD for Mothers (representing the private sector constituency)

Partnership for Maternal, Newborn, and Child Health

Philips (representing the private sector constituency)

Plan International (representing the civil society constituency)

Office of the UN Secretary-General

UNFPA

UNICEF

World Bank Group

World Health Organization

List of Acronyms

AFD	Agence Francaise de Dévelopement (France)
BMZ	Federal Ministry of Economic Cooperation and Development (Germany)
ANC	antenatal care
ANC4	four antenatal care visits
BEmONC	Basic Emergency Obstetric and Newborn Care
BHCPF	Basic Health Care Provision Fund
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CSO	civil society organization
DFID	Department for International Development, United Kingdom
DHS	Demographic Health Survey
DRC	Democratic Republic of Congo
HDI	Human Development Index
IBRD	International Bank for Reconstruction and Development
KFW	German Development Bank (government-owned)
IDA	International Development Association
IPT2	intermittent preventative treatment (for malaria)
JICA	Japan International Cooperation Agency
MICS	Multiple Indicator Cluster Survey
PBF	performance-based financing
PMNCH	Partnership for Maternal, Newborn, and Child Health
RMNCAH-N	reproductive, maternal, newborn, child and adolescent health and nutrition
SDG	Sustainable Development Goal
SIDA	Swedish International Development Cooperation Agency
UNFPA	UN Population Fund
USAID	United States Agency for International Development
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 Claeson, GFF Director and Dr. Monique Vledder, Practice Manager. The GFF Secretariat would like to thank the contributors, who gave their time, expertise and energy, in particular: Anna Astvatsatryan, Kimberly Boer, Marion Cros, Jessica Flannery, Brendan Hayes, Jakub Jan Kakietek, Josine Karangwa, Katri Kemppainen-Bertram, Luc Laviolette, Melanie Mayhew, Augustina Nikolova, Olumide Olaolu Okunola, Caleb Rulow, Hadia Samaha, Aissa Socorro, Petra Vergeer, and Sara Walker. Editorial support was provided by Marc Defrancis.

APPENDIX A

Data Sources

INDICATOR / SOURCE (YEAR)	BANGLADESH	CAMEROON	DRC	ETHIOPIA	GUATEMALA*	GUINEA	KENYA	LIBERIA	MOZAMBIQUE	MYANMAR	NIGERIA	SENEGAL	SIERRA LEONE	TANZANIA	UGANDA	VIETNAM
GFF CORE IMPACT INDICATORS																
Maternal Mortality Ratio	Bangladesh Maternal Mortality and Health Care Survey 2010	WDI 2015	DHS 2014	DHS 2016	ENSMI 2014/15	DHS 2012	DHS 2014	DHS 2013	DHS 2011	DHS 2016	DHS 2013	DHS 2015	DHS 2013	TDHS-MIS 2015/16	DHS 2016	UN-MMEIG 2015
Under 5 Mortality Rate	DHS 2014	MICS 2014	DHS 2014	DHS 2016	ENSMI 2014/15	DHS 2012	DHS 2014	DHS 2013	DHS 2011	DHS 2016	MICS 2017	DHS 2016	DHS 2013	TDHS-MIS 2015/16	DHS 2016	UNIGME 2016
Neonatal Mortality Rate	DHS 2014	MICS 2014	DHS 2014	DHS 2016	ENSMI 2014/15	DHS 2012	DHS 2014	DHS 2013	DHS 2011	DHS 2016	DHS 2013	DHS 2016	DHS 2013	TDHS-MIS 2015/16	DHS 2016	UNIGME 2016
Adolescent Birth Rate	DHS 2014	MICS 2014	DHS 2014	DHS 2016	ENSMI 2014/15	MICS 2016	DHS 2014	DHS 2013	AIS, 2015	DHS 2016	MICS 2017	DHS 2016	DHS 2013	TDHS-MIS 2015/16	DHS 2016	WDI 2016
Percent of births <24 months after the preceding birth	DHS 2014	DHS 2011	DHS 2014	DHS 2016	ENSMI 2014/15	DHS 2012	DHS 2014	DHS 2013	AIS, 2015	DHS 2016	MIS 2015	DHS 2016	MIS 2016	TDHS-MIS 2015/16	DHS 2016	MICS 2014
Stunting among children under 5 years of age	DHS 2014	MICS 2014	DHS 2014	DHS 2016	ENSMI 2014/15	MICS 2016	DHS 2014	DHS 2013	DHS 2011	DHS 2016	MICS 2017	DHS 2016	National Nutrition Survey (UNICEF - MOH 2014)	TDHS-MIS 2015/16	DHS 2016	National Institute of Nutrition 2015
Moderate to severe wasting among children under 5 years of age	DHS 2014	MICS 2014	DHS 2014	DHS 2016	ENSMI 2014/15	MICS 2016	DHS 2014	DHS 2013	DHS 2011	DHS 2016	MICS 2017	DHS 2016	National Nutrition Survey (UNICEF - MOH 2014)	TDHS-MIS 2015/16	DHS 2016	National Institute of Nutrition 2015
COVERAGE INDICATORS																
Births attended by skilled health personnel	DHS 2014	MICS 2014	DHS 2014	DHS 2016	ENSMI 2014/15	MICS 2016	DHS 2014	DHS 2013	DHS 2011	DHS 2016	MICS 2017	DHS 2016	DHS 2013	TDHS-MIS 2015/16	DHS 2016	MICS 2014
Equity (Richest/Poorest)	DHS 2014	MICS 2014	DHS 2014	DHS 2016	ENSMI 2014/15	DHS 2012	DHS 2014	DHS 2013	DHS 2011	DHS 2016	MICS 2017	DHS 2016	DHS 2013	TDHS-MIS 2015/16	DHS 2016	MICS 2014
ANC 4 coverage	DHS 2014	MICS 2014	DHS 2014	DHS 2016	ENSMI 2014/15	MICS 2016	DHS 2014	DHS 2013	AIS, 2015	DHS 2016	MICS 2017	DHS 2016	DHS 2013	TDHS-MIS 2015/16	DHS 2016	MICS 2014
Equity (Richest/Poorest)	DHS 2014	MICS 2014	DHS 2014	DHS 2016	ENSMI 2014/15	DHS 2012	DHS 2014	DHS 2013	DHS 2011	DHS 2016	MICS 2017	DHS 2016	DHS 2013	TDHS-MIS 2015/16	DHS 2016	MICS 2014
DTP3 coverage	DHS 2014	MICS 2014	DHS 2014	DHS 2016	ENSMI 2014/15	DHS 2012	DHS 2014	DHS 2013	AIS, 2015	DHS 2016	DHS 2013	DHS 2016	MIS 2016	TDHS-MIS 2015/16	DHS 2016	MICS 2014
Equity (Richest/Poorest)	DHS 2014	MICS 2014	DHS 2014	DHS 2016	ENSMI 2014/15	DHS 2012	DHS 2014	DHS 2013	DHS 2011	DHS 2016	MICS 2017	DHS 2016	National Nutrition Survey (UNICEF - MOH 2014)	TDHS-MIS 2015/16	DHS 2016	MICS 2014
Children aged < 5 years with diarrhea receiving ORS	DHS 2014	MICS 2014	DHS 2014	DHS 2016	ENSMI 2014/15	MICS 2016	DHS 2014	DHS 2013	AIS, 2015	DHS 2016	MICS 2017	DHS 2016	National Nutrition Survey (UNICEF - MOH 2014)	TDHS-MIS 2015/16	DHS 2016	MICS 2014
Equity (Richest/Poorest)	DHS 2014	MICS 2014	DHS 2014	DHS 2016	ENSMI 2014/15	DHS 2012	DHS 2014	DHS 2013	DHS 2011	DHS 2016	MICS 2017	DHS 2016	DHS 2013	TDHS-MIS 2015/16	DHS 2016	MICS 2014
Postnatal care for mothers	DHS 2014	MICS 2014	DHS 2014	DHS 2016	ENSMI 2014/15	MICS 2016	DHS 2014	DHS 2013	data not available	DHS 2016	MICS 2017	DHS 2016	DHS 2013	TDHS-MIS 2015/16	DHS 2016	MICS 2014
Equity (Richest/Poorest)	DHS 2014	MICS 2014	DHS 2014	DHS 2016	ENSMI 2014/15	DHS 2012	DHS 2014	DHS 2013	data not available	DHS 2016	MICS 2017	DHS 2016	DHS 2013	TDHS-MIS 2015/16	DHS 2016	MICS 2014
Modern contraceptive prevalence rate (all women, except Bangladesh, Cameroon, and Vietnam where data is for married women only)	DHS 2014	MICS 2014	DHS 2014	DHS 2016	ENSMI 2014/15	DHS 2012	DHS 2014	MIS 2016	AIS, 2015	DHS 2016	DHS 2013	DHS 2016	DHS 2013	TDHS-MIS 2015/16	DHS 2016	MICS 2014
Children aged < 5 years with pneumonia symptoms taken to a healthcare provider	DHS 2014	MICS 2014	DHS 2014	DHS 2016	ENSMI 2014/15	MICS 2016	DHS 2014	DHS 2013	AIS, 2015	DHS 2016	MICS 2017	DHS 2016	DHS 2013	TDHS-MIS 2015/16	DHS 2016	MICS 2014
People living with HIV receiving ART	UNAIDS 2017	UNAIDS 2017	UNAIDS 2017	UNAIDS 2017	UNAIDS 2017	UNAIDS 2017	UNAIDS 2017	MOH annual report 2016	UNAIDS 2017	UNAIDS 2017	UNAIDS 2017	UNAIDS 2017	UNAIDS 2017	UNAIDS 2017	UNAIDS 2017	UNAIDS 2017
Coverage of pregnant women who receive ARV for PMTCT	UNAIDS 2016	UNAIDS 2016	UNAIDS 2016	UNAIDS 2016	UNAIDS 2016	UNAIDS 2016	UNAIDS 2016	MOH annual report 2016	UNAIDS 2016	UNAIDS 2016	UNAIDS 2016	UNAIDS 2016	UNAIDS 2016	UNAIDS 2016	UNAIDS 2016	UNAIDS 2016
Girls Secondary School Retention Rate	Bangladesh Bureau of Education Information and Statistics; Lola Government Engineering Department (2017)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
HEALTH FINANCING INDICATORS																
Share of health in total government budget	Ministry of Finance 2017-18	DRFP Ministry of Public Health	NHA 2018 (still under review)	APR report 2017	N/A	Initial finance law 2017	National and County Health Budgets Analysis FY 2016/17	National budget FY 17/18	Budget office - GCE, REO, LOE in 2017	N/A	Budget Office 2017	N/A	N/A	N/A	Uganda Budget information website 2017-18	N/A
Share of external funding for health that is pooled or on budget	GHED 2017	GHED 2017	GHED 2017	GHED 2017	GHED 2017	GHED 2017	GHED 2017	Resource mapping FY 16/17	GHED 2017	GHED 2017	GHED 2017	GHED 2017	GHED 2017	GHED 2017	GHED 2017	GHED 2017
DTP3 dropout rate	DHS 2014	WHO 2016	DHS 2014	DHS 2016	ENSMI 2014/15	DHS 2012	DHS 2014	DHS 2013	AIS, 2015	DHS 2016	DHS 2013	DHS 2015	DHS 2013	WHO 2016	DHS 2016	MICS 2014
ANC dropout rate	DHS 2014	MICS 2014	DHS 2014	DHS 2016	ENSMI 2014/15	MICS 2016	DHS 2014	MOH annual report 2016	DHS 2011	DHS 2016	MICS 2017	DHS 2015	DHS 2013	TDHS-MIS 2015/16	DHS 2016	MICS 2014
Health Budget Execution Rate	GFF (2017); Health Financing: Achieving More with the Available Resources	N/A	NHA 2015; Ministry of Health	GFF (2017); Health Financing: Achieving More with the Available Resources	GFF (2017); Health Financing: Achieving More with the Available Resources	GFF (2017); Health Financing: Achieving More with the Available Resources	GFF (2017); Health Financing: Achieving More with the Available Resources	MFDP Budget Book FY 16/17	GFF (2017); Health Financing: Achieving More with the Available Resources	N/A	Federal Government of Nigeria, GIFMIS	Ministry of Health and Social Action 2017	GFF (2017); Health Financing: Achieving More with the Available Resources	GFF (2017); Health Financing: Achieving More with the Available Resources	GFF (2017); Health Financing: Achieving More with the Available Resources	N/A
Health expenditure per capita financed from domestic sources	GHED 2017	GHED 2017	GHED 2017	GHED 2017	GHED 2017	GHED 2017	GHED 2017	GHED 2017	GHED 2017	GHED 2017	GHED 2017	GHED 2017	GHED 2017	GHED 2017	GHED 2017	GHED 2017
Ratio of government health expenditure to total government expenditures	GHED 2017	GHED 2017	NHA 2018 (still under review)	GHED 2018	GHED 2017	GHED 2017	GHED 2017	GHED 2017	Operations and internal investments from the BOOST database from 2009-2015; 2016 expenditures from the Q3 2016 Budget Execution Report	GHED 2017	GHED 2017	GHED 2017	GHED 2017	GHED 2017	GHED 2017	GHED 2017
Percent of current health expenditures on primary/outpatient health care	N/A	PHCPI data and NHA 2011	NHA 2015 (addition of ambulatory care and preventive care)	NHA 2016	N/A	NHA 2010	PER 2014	NHA 2013/14	N/A	N/A	NHA 2016 Analysis	NHA 2012	GFF (2017); Health Financing: Achieving More with the Available Resources	GFF (2017); Health Financing: Achieving More with the Available Resources	PHCPI data and NHA 2014	NHA 2015 (USAID-HFG)
Incidence of catastrophic and impoverishing health expenditures	Bangladesh Household Income and Expenditure Survey (HIES 2016)	Cameroon Fourth Household Survey (ECAM 2014)	Survey 1-2-3 of the Democratic Republic of Congo (E123 2012)	LSM-Ethiopia Socioeconomic Survey (ESM 2015)	National Living Conditions Survey 2014 (ENCOVI 2014)	Poverty Evaluation light Survey (ELEP-2012)	Kenya Integrated Household Budget Household Budget Survey (KIHBS 2004/5)	Household Income Expenditure Survey (2014)	Family Budget Inquiry (IOF 2014/15)	The Myanmar Poverty and Living Conditions Survey (MPLCS 2015)	HIES 2009 Analysis	UHC global report 2017	Sierra Leone Integrated Household Survey (SLIHS 2011)	National Panel Survey (NPS 2014/2015)	The Uganda National Household Survey (2013)	Vietnam Household Living Standard Survey (2014)
ADDITIONAL SOURCES																
Resource mapping pie	N/A	Investment Case to Improve Reproductive, Maternal, Newborn, Child and Adolescent Health in Cameroon (2016)	Investment Framework for Reproductive, Maternal, Newborn, Child and Adolescent Health to Achieve Universal Health Coverage in the Democratic Republic of Congo (2017-2021)	Ethiopia Health Sector Transformation Plan (2015/16-2019/20)	N/A	N/A	N/A	Republic of Liberia Investment Case for Reproductive, Maternal, Newborn, Child, and Adolescent Health (2016-2020)	Investment Case of the Republic of Mozambique (2017-2022)	N/A	N/A	Senegal Investment Case (2018-2022)	N/A	The National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child & Adolescent Health in Tanzania (2016-2020) -One Plan II	Investment Case for Reproductive, Maternal, Newborn, Child and Adolescent Health Sharpened Plan for Uganda (2016/17 –2019/20)	N/A
World Bank-financed project (IDA/IBRD/GFF)	Projects available on WB portal	Project available on WB portal	Projects available on WB portal	Project available on WB portal	Project available on WB portal	Project available on WB portal	Project available on WB portal	Project available on WB portal	Project available on WB portal	Project approval pending	Projects available on WB portal	Project approval pending	Project approval pending	Project available on WB portal	Project available on WB portal	Project approval pending

*ENSMI = Encuesta de Nutricion y Salud Materno Infantil (Survey of Nutrition and Maternal Child Health

APPENDIX B

Indicators Description

Category	INDICATOR	DESCRIPTION
GFF CORE IMPACT INDICATORS	Maternal Mortality Ratio	Number of female deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, expressed per 100 000 live births, for a specified time period
	Under 5 Mortality Ratio	Probability of a child born in a specific year or period dying before reaching the age of 5 years, expressed per 1000 live births
	Neonatal Mortality Ratio	Probability of a child born in a specific year or period dying in the first month of life, expressed per 1000 live births
	Adolescent Birth Rate*	Number of births to females aged 15–19 years per 1000 females in the three years preceding the survey
	Percent of births <24 months after the preceding birth*	Percentage of non-first births in the five years preceding the survey whose previous birth interval is 7-23 months. This excludes the first birth.
	Prevalence of stunting among children under 5 years of age	Percentage of children under five years of age who are below -2 SD of height for age according to the WHO standard
	Moderate to severe wasting among children 5 years of age	Percentage of children aged under five years of age with weight-for-height < -2 SD of the WHO Children Growth Standards median
COVERAGE INDICATORS	Births attended by skilled health personnel*	Percentage of live births attended by skilled health personnel during the five years preceding the survey. Skilled provider includes doctor, nurse, midwife and auxiliary nurse or midwife
	ANC 4 coverage*	Percentage of women aged 15–49 years with a live birth, in the five years preceding the survey, who received antenatal care, four times or more times from any provider
	Modern contraceptive prevalence rate* (all women, except Bangladesh, Cameroon, and Vietnam where data is for married women only)	Percentage of women (all or married women) aged 15–49 years who are currently using at least one method of modern contraception
	DTP3 coverage	Percentage of children 12-23 months who received three doses of diphtheria–tetanus–pertussis (DTP3) vaccine at anytime before the survey
	Children aged < 5 years with diarrhea receiving ORS	Percentage of children ages 0–59 months with diarrhea in the two weeks prior to the survey, receiving oral rehydration salts (oral rehydration solution packets or pre-packaged oral rehydration solution fluids)
	Postnatal care for mothers*	Percentage of mothers who received postnatal care within two days of childbirth for their most recent birth in the two years prior to the survey
	Children aged < 5 years with pneumonia symptoms taken to a healthcare provider	Percentage of children ages 0–59 months with suspected pneumonia, in the two weeks prior to the survey, taken to a health care provider
	People living with HIV receiving ART	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
	Coverage of pregnant women who receive ARV for PMTCT	Percentage of pregnant women living with HIV who received antiretroviral therapy to reduce the risk of mother-to-child transmission of HIV
	Girls Secondary School Retention Rate	Grade 10: Percentage of girls who enrolled in Grade 6 reaching Grade 10 without dropping out or repeating; Grade 12: Percentage of girls who enrolled in Grade 6 reaching Grade 12 without dropping out or repeating
HEALTH FINANCING INDICATORS	Share of health in total domestic government budget	Percentage of government budget, from domestic resources, allocated to health
	Country monitors catastrophic and impoverishing health expenditure with data less than three years old (yes/no)	Yes - country monitors catastrophic and impoverishing health expenditure with household survey data that is no less than three years old. No - country does not monitor catastrophic and impoverishing health expenditure with household survey data that is no less than three years old.
	Country has implemented or updated a resource mapping exercise – (yes/no)	Yes - country has produced and is in the process of implementing a resource mapping exercise. The mapping exercise captures past and forward-looking budget data and expenditures, is annual, integrates its planning with the country's fiscal year, and is tailored to the country's health sector. No - country has not implemented or begun a resource mapping exercise.
	Country has identified options for strengthening domestic resource mobilization (i.e. has done a fiscal space analysis) yes/no	Yes - country has identified guidelines for a fiscal space analysis and/or agreed deadlines for its completion. Fiscal space analysis includes a thorough accounting of foreign and external sources of health financing (including debt relief, borrowing, and/or aid), domestic resource mobilization (e.g. budget reprioritization or tax policies), efficiency gains, and how the country can or has increased the efficiency of its expenditure. No - country has not identified guidelines for a fiscal space analysis and/or agreed deadlines for its completion. Country has not conducted a fiscal space analysis.
	Country has implemented strategies to reduce key drivers of inefficiency (i.e. supply chain/distribution of frontline providers/budget execution, etc.) yes/no	Yes - country has identified strategies to reduce drivers of inefficiency and is in the process of beginning or implementing them (e.g. through the scale up of existing reforms, pushing more resources to the frontline, supply chain improvements, PFM reforms, studies of bottlenecks of poor budget execution, etc.). No - country has not implemented strategies to reduce key drivers of inefficiency
	Country has identified drivers of limited financial protection (especially in relation to RMNCAH-N services) yes/no	Yes - country has identified drivers of limited financial protection through household surveys and similar assessments. No - country has not implemented household surveys or similar assessments to identify drivers of limited financial protection.
	Country has taken actions to support DRM (i.e. efforts prioritized health in the budget, efforts to increase overall government revenue, efforts to support health specific revenue sources)	Yes - country has taken actions to support DRM (e.g. conducted feasibility studies for prioritization of resources, fostered informed dialogue between MoH and MoF, improving PFM for health, through sin (usually tobacco or alcohol) and/or earmarked taxes; proposed other innovating financing mechanisms (e.g. airline tax, mobile phone levy, etc.). No - country has not taken any actions to support DRM.
	Country has implemented reforms to address identified drivers of Financial Protection (especially related to RMNCAH-N)	Yes - country has implemented reforms such as demand side health financing schemes (e.g. maternal vouchers), providing user fee exemptions for the poor, building capacity of frontline health workers, improving the supply chain of public essential medicines, etc. No - country is not in the process of or has not implemented reforms to address drivers of limited financial protection.
	Share of external funding for health that is pooled or on budget	Percentage of external funding for health channeled through Government budget (numerator: Total donor expenditures for health channeled through government budget; denominator: Total donor expenditures for health)
	Dropout Rate Between 1st and 3rd DTP Vaccination	Percentage difference in coverage between DPT1 (Number of surviving infants who received one dose of diphtheria with tetanus toxoid and pertussis containing vaccine over Total number of surviving infants) and DPT3 (Number of surviving infants who received three doses of diphtheria with tetanus toxoid and pertussis containing vaccine over Total number of surviving infants)
	Dropout rate from ANC1 to ANC4	Percentage difference in coverage between ANC1 and ANC4 (Number of women ages 15–49 who were attended one (four or more) time(s) during the pregnancy that led to their last birth in the X years preceding the survey by any provider over Total number of women ages 15–49 with a live birth in the X years preceding the survey)
	Health Budget Execution Rate	Percentage of the government health budget that has been spent (numerator: Total government budget spent on health; denominator: Total government budget allocated to health)
	Health expenditure per capita financed from domestic sources	Government health expenditures per inhabitant (numerator: Total government expenditures for health; denominator: Total population)
	Ratio of domestic government health expenditure to total government expenditures	Share of domestic government health spending to total government expenditures (numerator: Total domestic government expenditures for health; denominator: Total government expenditures from domestic sources)
	Percent of current health expenditures on primary/ outpatient health care	Percentage of current health expenditures spent on primary/outpatient health care (numerator: Total current health expenditures spent on primary/outpatient health care; denominator: Total current health expenditures)
	Incidence of catastrophic health expenditures	Proportion of households with out of pocket health expenditures that exceed 40% of total household expenditures (numerator: Number of households with out of pocket health expenditures ≥40% to total household's expenditures; denominator: Total number of households)
	Incidence of impoverishing health expenditures	Proportion of households with out of pocket health expenditure that caused the households to drop below the poverty line (numerator: Total number of households with impoverishing health expenditure; denominator: Total number of households)

*The definition for these indicators might vary slightly depending on the source of the data and/or the country.

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