



Global Financing Facility
in Support of Every
Woman Every Child

BUSINESS PLAN

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List of acronyms

| | |
|---------------|---|
| CoIA | Commission on Information and Accountability |
| CRVS | Civil registration and vital statistics |
| EWEC | Every Woman Every Child |
| GDP | Gross domestic product |
| GFF | Global Financing Facility |
| HRITF | Health Results Innovation Trust Fund |
| IBRD | International Bank of Reconstruction and Development |
| IDA | International Development Association |
| IFC | International Finance Corporation |
| IHP+ | International Health Partnership+ |
| MMR | Maternal mortality ratio |
| PHC | Primary health care |
| PMNCH | Partnership for Maternal, Newborn and Child Health |
| RMNCAH | Reproductive, maternal, newborn, child, and adolescent health |
| SDGs | Sustainable Development Goals |
| SRH | Sexual and reproductive health |
| UNDP | United Nations Development Programme |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |
| WHO | World Health Organization |



Executive Summary

The past two decades have seen unprecedented progress in improving the lives of women, adolescents, and children. However, as the global community enters a post-2015 world of Sustainable Development Goals (SDGs), a considerable part of the agenda with regard to reproductive, maternal, newborn child, and adolescent health (RMNCAH) remains unfinished. Far too many newborns, children, adolescents, and women still die from preventable conditions every year, and far too few have reliable access to quality health services. A large funding gap remains—US\$33.3 billion in 2015 alone in high-burden, low—and lower-middle-income countries, equivalent to US\$9.42 per capita per year—that can only be addressed by dramatic increases in financing from both domestic and international sources.

The Global Financing Facility in Support of Every Woman Every Child (GFF) was announced in September 2014 to respond to this challenge. The goal of the GFF is to accelerate efforts to end preventable maternal, newborn, child and adolescent deaths and improve the health and quality of life of women, adolescents and children, thereby preventing up to 3.8 million maternal deaths, 101 million child deaths, and 21 million stillbirths in high-burden countries by 2030. The GFF aims to reduce inefficiency in health spending over time, ultimately resulting in a reduction of the incremental resource needs for RMNCAH of approximately 15% by 2030, which would lower the resources required by more than US\$6 billion per year. Additionally, the GFF aims to mobilize more than US\$57 billion from 2015 to 2030 by crowding-in domestic resources, and by attracting new external support and improving coordination of existing assistance. The need for external support is frontloaded, with domestic resources progressively taking over for development assistance. Prompt initiation of GFF support creates more opportunities to plan for economic growth and capture its benefits in ways that shift countries onto trajectories toward sustainable financing, which would enable nearly 20 countries to graduate from receiving GFF funding by 2030 as their resource gaps close completely.

The GFF acts as a pathfinder in a new era of financing for development by pioneering a model that shifts away from a focus solely on official development assistance to an approach that combines domestic financing, external support, and innovative sources for resource mobilization and delivery (including the private sector) in a synergistic way. The GFF will serve as a major vehicle for financing the proposed SDG on healthy lives and will play a special role in scaling up financing to support the UN Secretary-General's renewed "Global Strategy for Women's, Children's, and Adolescents' Health".

The GFF brings partners together to provide smart, scaled, and sustainable financing to achieve and measure RMNCAH results at country level:

- Smart financing ensures that evidence-based, high-impact interventions—whether clinical and preventive interventions, health systems strengthening, or multisectoral interventions—are prioritized and delivered in an efficient, results-focused manner;
- Scaled financing entails mobilizing the additional resources necessary to finance fully the RMNCAH agenda from domestic and international, and public and private sources;
- Sustainable financing secures universal access to essential services for every mother and every child by capturing the benefits of economic growth and addressing the challenges of transitioning from low—to middle-income status.

At the heart of the GFF approach is a rigorous focus on achieving and measuring results. The GFF provides results-focused financing while also supporting the systems needed to monitor progress and measure results, particularly civil registration and vital statistics (CRVS).

The GFF operates as a facility that maximizes the comparative advantages of a broad set of partners. They are engaged at country level through a “country platform” that, under the leadership of national governments, builds on existing structures while embodying two key principles: inclusiveness and transparency. The partners use a number of approaches and mechanisms:

- Investment Cases for RMNCAH;
- Mobilization of financing for Investment Cases:
 - Complementary financing of the Investment Case;
 - Increased government investment in RMNCAH;
 - Linking grant funding to projects from the International Development Association (IDA) and the International Bank of Reconstruction and Development (IBRD);
 - Innovative engagement of global and local private sector resources;
- Health financing strategies focused on sustainability;
- Investments in global public goods that support RMNCAH results at the country level.

Across all of these, the GFF has a particular focus on issues (e.g., family planning, nutrition, CRVS) and target populations (e.g., adolescents) that have historically been under-funded. Equity, gender, and rights underpin and are mainstreamed throughout the GFF’s work. Equity analysis ensures that disadvantaged and vulnerable populations are identified and prioritized.

To complement the work of the broader facility, a multi-donor trust fund—the GFF Trust Fund—has been established at the World Bank. The GFF Trust Fund builds on the experience and management capacity of the Health Results Innovation Trust Fund (HRITF) in providing results-focused financing to support countries to achieve RMNCAH results. It secures additional financing for RMNCAH by linking grant funding to IDA or IBRD financing. The trust fund mobilizes the expertise of the entire World Bank Group, including the International Finance Corporation (IFC), the World Bank Group’s private sector arm.

A total of 62 high-burden, low—and lower-middle income countries are eligible to receive grant resources from the trust fund. The trust fund is phasing in its operations, beginning with an initial set of four “frontrunner” countries. An additional 5–10 countries will be selected as a next step.

The GFF Trust Fund has received pledges of US\$800 million from the governments of Norway and Canada. Under the HRITF, the grant resources from bilateral contributors were combined with IDA financing in an average ratio of 1:4, which the GFF anticipates matching. This enables results to be achieved in a core group of countries, but additional grant resources are required to reach the full set of eligible countries. Reaching all 62 eligible countries with one initial grant each would require US\$2.56 billion in contributions to the GFF Trust Fund (including the resources already pledged).

The GFF as a facility is governed by a GFF Investors Group composed of representatives from participating countries, contributing bilateral donors, multilateral institutions, non-governmental organizations, the private sector, and private foundations. It focuses on mobilizing complementary financing for Investment Cases and health financing strategies. A smaller GFF Trust Fund Committee that is embedded within the Investors Group has decision-making authority for matters related to the operations of the trust fund. The GFF Trust Fund is fully integrated in World Bank operations, which results in low management costs. A small secretariat for the trust fund is based at the World Bank.



1. Why: The Need and the Vision

A. Why a Global Financing Facility Is Needed

The past two decades have seen unprecedented improvements in the lives of women, adolescents, and children. Since 1990, the under-five mortality rate has been cut in half and the maternal mortality ratio has declined by 45 percent. Despite this progress, as the global community enters the post-2015 world of the Sustainable Development Goals (SDGs), there is consensus that a considerable part of the agenda with regard to reproductive, maternal, newborn, child, and adolescent health (RMNCAH) remains unfinished.

Inadequate access to quality services is one of the key bottlenecks to accelerating progress on RMNCAH. This reflects a failure of the information systems required to understand needs, with many pregnancies, births, deaths, and causes of deaths not counted because of the poor state of civil registration and vital statistics systems (CRVS). Slow progress is also the result of inefficient use of existing resources related to poor targeting of the populations with the greatest needs, inadequate use of evidence in selecting interventions, and persistent challenges in service delivery related to supply chains and the health workforce. Several critical and cost-effective issues, such as family planning and nutrition, have historically been neglected, as have the needs of key populations such as adolescents. However, even with more efficient and equitable use of existing resources, a large funding gap for RMNCAH remains. This shortfall is estimated at US\$33.3 billion in 2015 in high-burden, low—and lower-middle-income countries, which amounts to US\$9.42 per capita per year.¹

Business as usual is not an option for addressing these challenges if the SDG targets related to RMNCAH

¹ See Annex 2 for details.

are to be achieved by 2030. An ambitious effort is needed to dramatically scale up the resources available for RMNCAH and to align partners around prioritized investments that generate results, while ensuring that countries are on a trajectory toward universal health coverage and sustainable health financing. The Global Financing Facility in Support of Every Woman Every Child (GFF) was announced in September 2014 to respond to these challenges.

This Business Plan, which has been developed through an intensive, multi-stakeholder collaboration², describes how the GFF operates. Four “frontrunner” countries—the Democratic Republic of the Congo, Ethiopia, Kenya, and Tanzania—have piloted the GFF approach concurrently with the development of the Business Plan, with their experiences contributing significantly to shaping the final document. As the GFF represents an important new platform to drive the financing for development agenda forward at the country level and constitutes a new model for financing the SDGs, it will be launched formally at the Third International Conference on Financing for Development in Addis Ababa, Ethiopia, in July 2015.

B. Vision of the Global Financing Facility

The overall goal of the GFF is to contribute to ending preventable maternal, newborn, child and adolescent deaths by 2030 and improving the health and quality of life of women, adolescents and children. Closing the financing gap entirely will prevent an estimated 3.8 million maternal deaths, 101 million child deaths, and 21 million stillbirths in high-burden

² The process involved a Business Planning Team composed of 48 individuals from 22 institutions working under the guidance of an Oversight Group of 18 senior leaders in global health and development. See Annex 1 for a list of institutions involved.

BRIDGING THE FUNDING GAP FOR RMNCAH

The incremental resource gap for RMNCAH for the 63 countries that are part of the GFF is estimated as US\$33.3 billion (US\$9.42 per capita) in 2015, which represents the amount needed to scale up coverage from current levels to high coverage (as described in Annex 2; the purple line in Figure 1 below). Economic growth fuels domestic resource mobilization (light green line) and this decreases the gap over time, reducing it to US\$16.5 billion (US\$3.90 per capita) in 2030 (the difference between the purple and the light green lines).

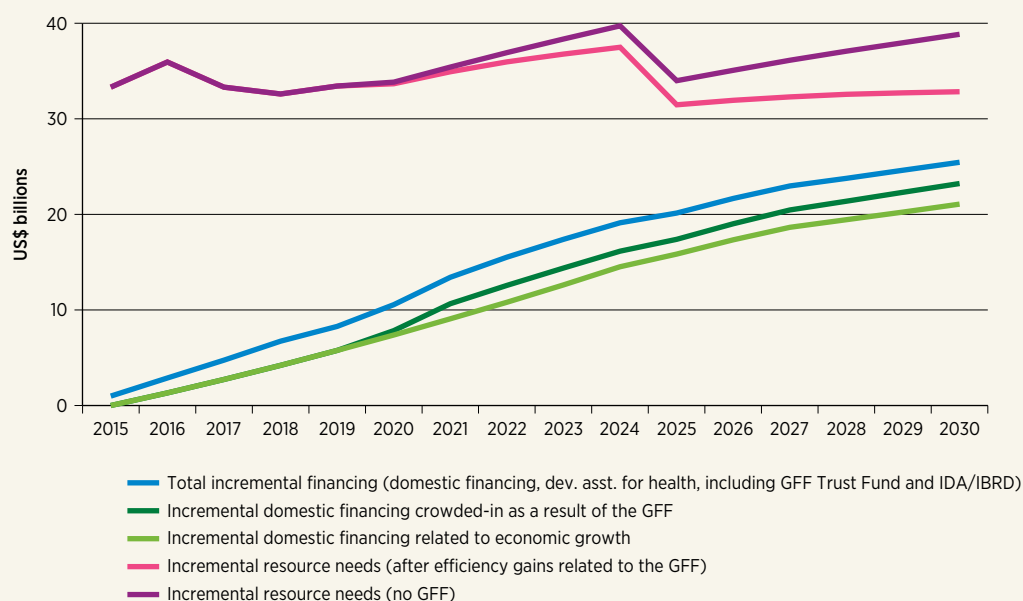
The GFF works to close the gap in three ways:

1. By generating efficiencies through smart financing, which results in a reduction of the incremental resource needs of approximately 15% by 2030 (seen in the reduction the resource needs to the pink line);
2. By crowding in additional domestic resources, which results in the mobilization of more than US\$18 billion cumulatively from 2015 to 2030 (seen in the increase in financing to the dark green line);

3. By further mobilizing development assistance for health and improving coordination of this assistance, resulting in nearly US\$39 billion cumulatively from 2015 to 2030 (seen in the increase in financing to the blue line).

As a result of the combined effect of these, the gap falls to US\$7.4 billion (US\$1.74 per capita) in 2030 (the difference between the pink and blue lines). Cumulatively, the “savings” from the GFF (the difference in the resource gaps between a scenario with and without the GFF) would amount to \$83.5 billion over the period 2015 to 2030. This would enable nearly 20 countries to graduate from receiving GFF funding by 2030 as resource gaps close completely. This financing would also prevent between 24 and 38 million deaths of women, adolescents, and children by 2030 (including the stillbirths that would be averted as a result of family planning).

FIGURE 1



countries by 2030.³ The GFF’s role in this is to provide smart, scaled, and sustainable financing that

makes a major contribution to closing the financing gap for RMNCAH, as described in the box above. Additionally, by financing a large-scale expansion of CRVS the GFF supports countries to measure these

³ See Annex 2 for the source of these figures.

improvements in “real time” such that the lives of all women, adolescents, and children are counted and accounted for. The GFF also prioritizes issues that have traditionally been under-funded (e.g., family planning, nutrition, CRVS) and specific target populations that have historically been neglected (e.g., adolescents), and uses equity analysis to ensure that disadvantaged and vulnerable populations are identified and focused upon.

The GFF acts as a pathfinder in a new era of financing for development by pioneering a model that shifts away from fragmented streams of official development assistance to an approach that combines mobilizing domestic resources, attracting additional external resources and improving the efficiency of their use, and employing innovative strategies for resource mobilization and service delivery, including through strong engagement with the private sector. The GFF will play a key role in scaling up financing to support the UN Secretary-General’s renewed “Global Strategy for Women’s, Children’s, and Adolescents’ Health”, which will be launched in September 2015.

C. The Global Financing Facility and the GFF Trust Fund

The GFF provides complementary financing for evidence-based, high-impact “best-buys” by supporting rigorous, data-driven prioritization. It attracts additional resources to RMNCAH and CRVS from a range of sources, first and foremost through domestic resource mobilization. To complement this, the GFF draws in additional resources from a range of external sources, including the private sector through the use of innovative approaches.

To achieve this, the GFF works as a facility that harnesses the strengths and financial resources of a wide array of partners that are committed to improving RMNCAH. Most importantly, this involves governments assuming their leadership roles in setting the policy agenda and formulating technically sound and financially appropriate RMNCAH strategies and plans. The GFF supports this leadership by drawing

on the comparative advantages of the broad set of stakeholders involved in the RMNCAH response, including the financing of the World Bank Group, Gavi, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and bilateral donors; the technical expertise and normative mandates of UN agencies; the reach and community-connectedness of non-governmental and faith-based organizations; and the capacity and speed of the private sector.

The facility is guided by the following principles:

- *Country leadership and ownership*, based on the International Health Partnership (IHP+) principles and aligned with national health sector strategies and RMNCAH plans, and their budget processes and cycles;
- *Efficiency* through prioritizing the highest impact, evidence-based intervention packages and the capacities required for their effective delivery at scale;
- *Equity* by prioritizing the disadvantaged and most vulnerable;
- *Results focus* and prioritization of high-impact countries, populations and approaches;
- *Simplicity, alignment, and complementarity* that builds on the strengths of existing mechanisms.

To complement the work of the broader facility, a multi-donor trust fund—the GFF Trust Fund—has been established at the World Bank with an initial US\$800 million in commitments. The GFF Trust Fund provides additional financing for RMNCAH links grant funding to IDA or IBRD projects. The trust fund mobilizes the expertise of the entire World Bank Group, including the International Finance Corporation (IFC), the World Bank Group’s private sector arm, and links to emerging efforts around pandemic preparedness and response. It builds on the experience and management capacity of the Health Results Innovation Trust Fund (HRITF) in providing results-focused financing to support countries to achieve RMNCAH results.

Almost all of this Business Plan is concerned with the broader facility (with occasional specific mentions of the role of the trust fund within that), while [Section 5](#) specifically addresses the GFF Trust Fund.



2. What: Smart, Scaled, and Sustainable Financing for Results

The GFF as a facility provides smart, scaled, and sustainable financing to countries to achieve RMNCAH results:

- Smart financing ensures that evidence-based, high-impact interventions are prioritized and delivered in an efficient, results-focused manner;
- Scaled financing entails mobilizing the additional resources necessary to finance fully the RMNCAH agenda, from both domestic and international, and both public and private sources;

- Sustainable financing secures universal access to essential services for every mother and every child by capturing the benefits of economic growth and addressing the challenges of transitioning from low—to middle-income status.

All of these are aimed at achieving RMNCAH results. To complement this results-focused financing, the GFF also supports the systems—particularly civil registration and vital statistics—needed to monitor progress and measure results.

RESULTS-FOCUSED FINANCING IN ACTION

The partners involved in the GFF use a number of different forms of results-focused financing. Some of these focus on the achievement of national-level changes, such as the World Bank's Program-for-Results initiative and its use of disbursement-linked indicators for changes in policy or Gavi's approach of linking funding to performance in increasing immunization coverage. Other approaches address supply-side constraints by providing performance-based financing for facilities or demand-side challenges through the use of conditional cash transfers and vouchers for key target populations. The HRITF—on which the GFF is building—has supported nearly 40 countries in implementing results-based financing, particularly at the service delivery level.

All of these approaches share an emphasis on shifting from counting inputs to tracking what really matters: changes at the output, outcome, and, ideally, impact levels. This reorientation is critical for monitoring progress and for focusing the attention of both those receiving financing and those providing it on results (which aligns the incentives between the two groups).

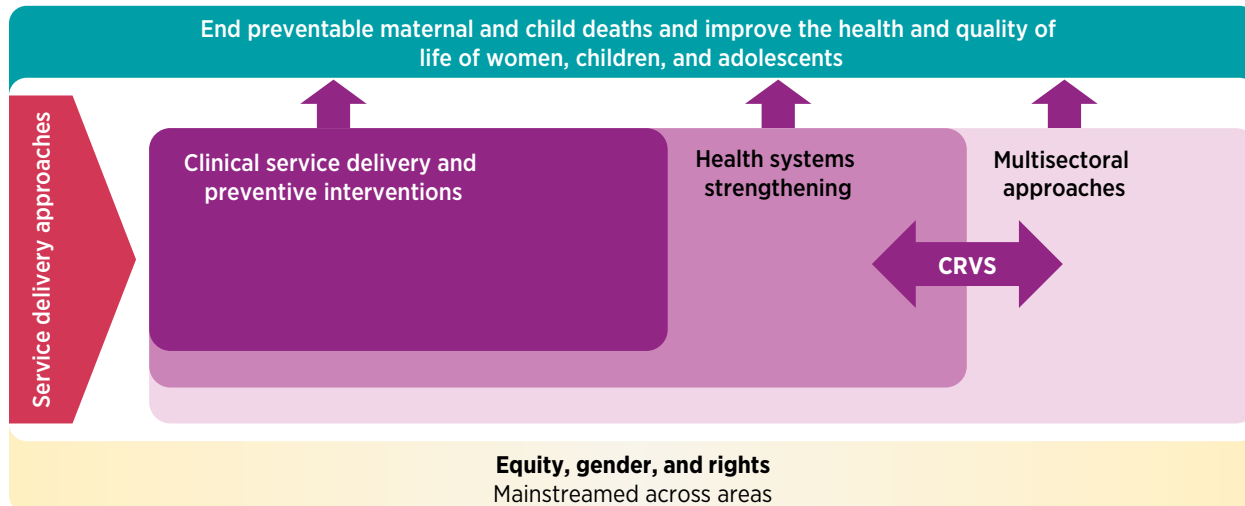
Another critical element of results-focused financing is transparency. Results are verified locally and are then typically made widely available. This strengthens

accountability by allowing a broad set of interested parties—including the intended beneficiaries of the financing—to track how funding has been used and to understand what results have been achieved at what cost.

An example of this in practice has been Ethiopia's experience with the World Bank's Program-for-Results financing for health. This supports the government's aim to scale up national coverage levels of essential maternal and child health and nutrition services with particular attention to the population in the lowest wealth quintile. Disbursement-linked indicators are used to provide financing based on the achievement of verified results. Significant progress has been seen in indicators such as the percentage of women who received antenatal care, the percentage whose delivery was attended by a skilled health provider, and the use of modern methods of contraception, with payments made based on these results.

With the GFF, the Government of Ethiopia is keen to expand this program in the context of decentralization efforts. The government intends to use grant funding to incentivize domestic allocations to health at the sub-national level.

FIGURE 2



A. Smart Financing

The GFF focuses on financing “best-buys”: the evidence-based, high-impact interventions that are required to reduce morbidity and mortality while progressively realizing the rights and entitlements of women, adolescents, and children (Figure 2). The World Health Organization estimates that 20–40% of health spending “is consumed in ways that do little to improve people’s health.”⁴ Through smarter financing, the GFF aims to reduce this progressively over time, ultimately resulting in a reduction of the incremental resource needs for RMNCAH of 15% by 2030, which would lower the resources required by more than US\$6 billion per year (see [Annex 2](#)).

At the heart of this are clinical and preventive interventions for RMNCAH, including family planning and nutrition.⁵ The GFF also finances broader health

systems strengthening, such as the health workforce, financing, supply chain management (including addressing the quality of commodities), and information systems (including CRVS). The GFF has the flexibility to make targeted investments in entirely different sectors, such as education, water and sanitation, social protection, or CRVS (which has both health and multisectoral elements) if these will have a significant impact on RMNCAH results. Evidence shows the importance of these investments to end preventable maternal, adolescent, and child deaths and improve the quality of life of women, adolescents and children.⁶

In areas where the evidence base is less developed, such as around adolescent health, the GFF invests in the research needed to determine which approaches are most effective and supports generally accepted approaches such as the provision of information and education on sexual and reproductive health, the distribution of contraceptives and condoms, and the treatment of sexually transmitted infections. Across all areas, the GFF supports implementation

⁴ World Health Organization, “World Health Report: Health systems financing: the path to universal coverage,” 2010.

⁵ Considerable evidence guides the selection of these interventions. See, for example, the Partnership for Maternal, Newborn, and Child Health, *A global review of key interventions related to reproductive, maternal, newborn, and child health (RMNCH)*, PMNCH, 2011; Stenberg, K., et al., “Advancing social and economic development by investing in women’s and children’s health: a new Global Investment Framework”, *Lancet*, 2014, 383(9925): 1333–1354; Bhutta, Z., et al., “Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost?”, *Lancet*, 2013, 382(9890): 452–477; and “Family Planning High Impact Practice List”, 2014, www.fphighimpactpractices.org.

⁶ See Kuruvilla, S., et al., “Success factors for reducing maternal and child mortality”, *Bull World Health Organ* 2014;92:533–544. This analyzes the factors leading to progress in improving maternal and child mortality from 1990 to 2010 and highlights the need to improve conditions both within and outside the health sector, with interventions inside the health sector accounting about half of the mortality gains and “health-enhancing investments in other sectors” contributing the rest.

research that identifies barriers and bottlenecks in implementation and mechanisms to overcome them.

The GFF approach to smart financing places a premium on “know-how” by identifying innovations in service delivery as well as by systematically investing in approaches that have been shown to be effective. Examples include appropriately supporting frontline or community health workers, task-shifting (e.g., community management of pneumonia), integration of service delivery (e.g., integrated community case management), contracting of private providers, and innovative community mobilization or “demand-side” initiatives. The GFF also improves value for money by focusing on sources of inefficiency in health systems such as inappropriate use of medicines and leakages in the system.

To reflect the fact that the health systems are “mixed”—with a blend of public and private provision—the GFF works across both public and private sectors. It also supports government to assume their stewardship roles over these mixed systems, including strengthening coordination and information-sharing between sectors, improving regulatory regimes (e.g., licensing, accreditation), facilitating access to credit, and streamlining reimbursement mechanisms.

Smart financing entails sensitivity to country context. Thus the GFF approach in a humanitarian setting or a fragile/conflict-affected state differs considerably from the approach in a rapidly growing lower-middle-income country. In the former, for example, the GFF focuses on supporting countries through the transition from response to early recovery and eventually to building resilience through strengthening longer-term institutional capacity. Another important dimension of this is the way in which the GFF operates in the context of decentralization. The flexibility of the GFF’s approach enables it to play an important role in supporting decentralization efforts, such as by creating incentives for sub-national authorities to increase allocations to RMNCAH and to focus these resources on best-buy interventions (as described in the box above on Ethiopia). Experience shows that financing actual performance at sub-national levels can strengthen managerial and executing capacity at these levels, leading to more effective decentralization.

NUTRITION—A KEY DIMENSION OF RMNCAH

It is impossible to end preventable child, adolescent, and maternal health without addressing malnutrition, which is responsible for about 20% of maternal deaths and 45% of deaths in children under five. Maternal malnutrition (stunting, low body mass index, and anemia) increases the risk of maternal mortality, the risk of difficult labor, the risk of fetal growth restriction, and their children’s risk of dying and of being stunted (as much as 20% of stunting in childhood may be attributable to fetal growth restriction). Stunted infants and children have much higher mortality and morbidity rates and stunted adolescent girls become stunted mothers, transmitting the negative consequences of malnutrition to the next generation in a cyclical fashion. For all these reasons, nutrition is an important element of the GFF approach to smarter financing.

Equity, gender, and rights underpin and are mainstreamed throughout the GFF’s work, as described in detail in the relevant sections below. This includes financing targeted interventions in areas such as child marriage, violence against women, and women’s economic empowerment. The GFF also supports efforts by communities to mobilize themselves and advocate for their rights, including reproductive rights.

B. Scaled Financing

The GFF approach to scaling up financing focuses on determining the resource gap between the financing needs to expand coverage of RMNCAH services and the available resources for RMNCAH (from all sources), and mobilizing additional resources and generating efficiencies to close these gaps. Financing is mobilized from three key sources:

- Domestic financing (both public and private);
- GFF Trust Fund and IDA/IBRD resources;
- Donor resources (e.g., Gavi, the Global Fund, bilateral assistance).

As seen in Figure 1, domestic resources play the major role in closing the resource gap for RMNCAH. Economic growth is important for creating opportunities to increase government spending on health, although political commitment is essential for raising revenue and ensuring that RMNCAH is prioritized. Domestic resources for RMNCAH come from both public and private sources, although the emphasis in the GFF approach is on shifting from forms of financing that increase inequities (particularly out-of-pocket expenditures) toward mechanisms that do not disadvantage the poor and vulnerable.

To complement this, the GFF aims to mobilize more than US\$57 billion from 2015 to 2030 by crowding-in domestic resources, and by further mobilizing development assistance for health from a range of sources, and improving coordination of this new external assistance (see the box “Bridging the Funding Gap for RMNCAH”).

In addition, the GFF mobilizes and helps coordinate financing from a range of external sources to fill the gap in financing needed for RMNCAH. This includes bilateral donors, multilateral organizations (such as Gavi and the Global Fund), regional development banks, foundations, and the private sector. Additionally, the GFF will engage the emerging economies that represent some of the fastest growing sources of official development assistance in an effort to raise resources for RMNCAH.

The World Bank Group contributes to this by building on the experience of the Health Results Innovation Trust Fund in attracting IDA and IBRD financing for RMNCAH.

The majority of resources mobilized from the private sector for RMNCAH will come from private sources at the country level. In addition, the GFF is developing innovative financing mechanisms to bring international sources of private capital to the effort to improve RMNCAH results.

C. Sustainable Financing

Between 2015 and 2030, a considerable number of countries are expected to transition from low—to lower-middle—or even upper-middle-income status. This creates important opportunities for countries to capture the benefits of growth and shift onto trajectories toward sustainable financing for the health sector. However, evidence suggests that this will not occur automatically. For example, while for low-income countries, each percentage point increase in economic growth is associated with a growth in government spending on health of more than one percentage point, this drops by more than half in lower-middle-income countries.⁷ At the same time, development assistance for health often begins to fall as countries reach lower-middle-income status. As economies grow, countries rely less on grant financing for health from external sources and instead typically transition first to IDA financing (which is on budget and often a mix of grants and concessional loans⁸) and then increasingly to domestic financing (which often includes loans on commercial terms, such as from the private market or IBRD). This transition is rarely straightforward and requires considerable planning, although the potential benefits are significant: combining assistance on developing health financing strategies with the provision of external financing creates more opportunities to plan for economic growth and capture the benefits of it in ways that shift countries onto trajectories toward sustainable financing. That would enable nearly 20 countries to graduate from receiving GFF funding by 2030 as their resource gaps close completely (see [Annex 2](#)).

The GFF work on financial sustainability encompasses the entire health sector rather than focusing solely on RMNCAH, given the inextricable connections between RMNCAH and the broad health system.

⁷ Xu, K., et al., “The Determinants of Health Expenditure: A Country-Level Panel Data Analysis”, Results for Development and the World Health Organization, 2011.

⁸ IDA financing is provided primarily as concessional loans, but eligible countries that are at moderate or high risk of debt distress receive 50% (moderate risk) or 100% (high risk) of the financing on grant terms. Among the 62 countries eligible for GFF Trust Fund support (see section 5.A), 46 are IDA-only countries (as opposed to IBRD-only or “blend” countries that receive both). Of these, 26 are currently eligible to receive either 50% or 100% of their financing as grants. IBRD financing is purely loans and does not contain grant components.

ACHIEVING SUSTAINABLE FINANCING IN A FRAGILE CONTEXT

The Democratic Republic of the Congo has faced repeated conflicts over the past two decades that have weakened institutions and led to millions of deaths (particularly among women and children), largely as a result of preventable diseases and malnutrition. Health expenditure in the country is quite low, at only half the average of low-income countries.

A recent public expenditure review revealed that addressing this does not require complicated new revenue generation measures, which are likely to be challenging to implement in a context in which institutions are still recovering from prolonged conflict. Instead, a combination of straightforward interventions could more than double the domestic resources currently available for health.

Increasing general tax revenues through better enforcement and administration of existing taxes and from the

natural resources sector could increase government health spending by 0.4% of gross domestic product (GDP). Increasing the share of the government budget that is allocated to health could increase spending by 0.3% of GDP. Better execution of budgets—from making appropriate allocations, to establishing controls to assure proper use of funds and monitoring and reviewing funds to ensure that limits are not exceeded—could increase spending by 0.6% of GDP.

Recent economic growth in the country has exceeded 7% per year, which creates an important opportunity to increase resource mobilization for health. The work toward a health financing strategy will compare and prioritize among the different approaches to translating this growth into resources for health, a process that the GFF is continuing to support.

The GFF supports countries to develop long-term plans that address domestic resource mobilization, risk pooling, and purchasing. The GFF assists in the prioritization between the range of possible approaches to domestic resource mobilization, such as strengthening government tax revenue mobilization (including debt financing), increasing the share of general government expenditure devoted to health, and using innovative financing mechanisms (e.g., the mobilization of private capital to invest in healthcare).

The GFF also assists countries in determining the appropriate approaches to risk pooling, ensuring that pools are large enough to spread risks effectively, avoid duplication of administrative arrangements, and generate sufficient purchasing power.

The focus of the GFF's work on purchasing is on promoting efficiency. The specific areas of emphasis vary considerably depending on where a country falls on the development continuum. In low-income and fragile/conflict-affected countries, the GFF's emphasis is typically on basic public financial management, such as budget execution, monitoring, and accountability, which are critical to ensuring efficient use of resources and thus strengthening

sustainability. In middle-income countries that have separated the purchaser and provider functions (e.g., such that the government focuses less on delivering services and more on acting as a purchaser of health services, as, for example, is largely the case in high-income countries), the GFF focus is on defining explicit benefits packages that include the most cost-effective interventions and are commensurate with available resource envelopes, which is a key element to sustainability. In addition, the GFF helps countries develop payment systems that promote the efficient delivery of quality services.

Across all of these areas, the GFF promotes efforts to improve equity, such as by increasing coverage of prepaid risk pooling mechanisms and other efforts to reduce reliance on out-of-pocket expenditures.⁹

⁹ Reliance on out-of-pocket expenditures creates financial barriers to accessing services, especially for poor women, adolescents, and children, and increases the risk that health expenditures have adverse or “catastrophic” effects on households.

D. Achieving and Measuring Results

Results are at the heart of the GFF approach. The GFF provides financing that incentivizes performance as evidence shows that such approaches, both on the supply and demand sides, have achieved impact in low—and middle-income countries while increasing efficiency.¹⁰ However, inputs such as commodities or capital investments are also financed through the GFF, as long as there are clear links to results.

Additionally, the GFF contributes to improvements in the ability of countries to measure progress on RMNCAH. As described in the box below, weaknesses in civil registration and vital statistics systems have direct effects on RMNCAH. For this reason, the GFF supports strengthening registration of births, deaths, causes of death, and marriage.

The GFF also supports complementary forms of data collection, recognizing that countries have many

data gaps that need to be filled to support RMNCAH outcomes. These include data collection systems that provide routine or ongoing data for determining priorities and assessing progress (e.g., administrative systems such as DHIS2), facility—and population-based surveys (including Demographic and Health Surveys and Multi-Indicator Cluster Surveys), and health surveillance systems. These approaches are broader than RMNCAH and should not be approached in a vertical manner but are essential for improving RMNCAH outcomes and so are important for the GFF. Ensuring complementarity and, ideally, integration between these and efforts to strengthen CRVS is a priority for the GFF.

Taken together, the strengthening of CRVS and other forms of data collection creates a powerful push for improving the measurement of results at both national and peripheral levels. Within this, the GFF places a particular emphasis on the disaggregation of data. This is critical for equity analyses that identify disadvantaged and vulnerable women, adolescents, and children.

STRENGTHENING CRVS AS AN ESSENTIAL ELEMENT OF RMNCAH

The World Health Organization/World Bank Group “Global Civil Registration and Vital Statistics: Scaling Up Investment Plan 2015–2024” describes the poor state of CRVS globally: “More than 100 developing countries still do not have functioning systems that can support efficient registration of births and other life events like marriages and death. Around the world, almost 230 million children under the age of five are not registered... In countries in most need of CRVS, up to 80 percent of deaths that occur outside of health facilities and two-thirds of all deaths globally are not counted.” These weaknesses have direct effects on RMNCAH, as understanding trends in births, mortality, fertility, and life expectancy is necessary both for making evidence-based policy decisions and for planning purposes. It is impossible to ensure that RMNCAH programs expand coverage in an equitable manner if disaggregated data about key indicators such as maternal or newborn mortality are unavailable. Effective monitoring

of program outcomes is significantly impeded by the poor quality of data about causes of death. Similarly, the quest to end child marriage is directly dependent on reliable information about marital status (including age at marriage).

CRVS also has a broader role in strengthening governance in ways that support RMNCAH but extend beyond it. The legal identity provided through birth registration plays an important part in helping individuals realize their rights and obtain the benefits to which they are entitled. As a result, in 2012 the Human Rights Council adopted a resolution on birth registration as a human right, and the Open Working Group on the Sustainable Development Goals proposed including a specific target on achieving universal birth registration by 2030, in addition to a broader one on the availability of disaggregated data.

¹⁰ See, for example, the impact evaluations available at <https://www.rbfhealth.org/impact>.

The combination of results-focused financing and improved measurement systems is a centerpiece of how the GFF contributes to strengthening accountability globally for RMNCAH results. The GFF further supports this by working with countries around

the transparent public release of data relating to performance, building on the experience of HRITF. The global results framework also plays a key role in accountability, as discussed further in [Section 7](#) and [Annex 10](#).



3. How: Key Means to Deliver Results

The GFF uses a number of approaches and mechanisms to deliver smart, scaled, and sustainable financing for results:

- A. Investment Cases for RMNCAH;
- B. Mobilization of financing for Investment Cases:
 - 1. Complementary financing of the Investment Case;
 - 2. Increased government investment in RMNCAH;
 - 3. Linking grant funding to IDA and IBRD projects;
 - 4. Innovative engagement of global and local private sector resources;
- C. Health financing strategies focused on sustainability;
- D. Investments in global public goods that support RMNCAH results at the country level.

This section provides brief introductions to each of these, but considerable additional detail is contained in the Annexes to this document. The way these elements work to deliver smart, scaled, and sustainable financing is a core part of the GFF's theory of change.

A. Investment Cases for RMNCAH

The Investment Case is at the core of GFF country financing. The objective is to have a nationwide, evidence-based, prioritized plan with a clear focus on results that both guides and attracts additional financing from the entire set of GFF partners (including national governments) over a three-to-five-year period. A country-specific approach is essential given the large differences between countries in the existence and quality of evidence and current plans (see the box on different approaches to the Investment

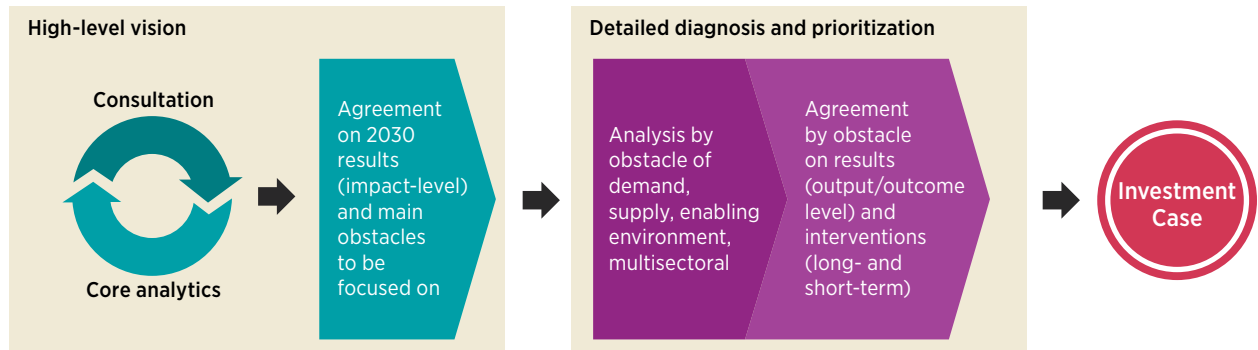
Case in frontrunner countries). Although it covers three to five years, the Investment Case is developed with a long-term perspective that emphasizes the priority obstacles that must be overcome to get a country onto the trajectory needed to attain SDG targets by 2030.

The development of the Investment Case involves several steps, as depicted in Figure 3 and as described in more detail in [Annex 3](#). These build on existing national planning processes, and, in line with the principle of country ownership, the GFF approach is to be flexible and responsive to country contexts and ownership, and therefore it does not insist on rigid application of these steps. Instead, the GFF focus is on the objective—a rigorous analysis of data that enables an inclusive set of stakeholders to identify and prioritize the interventions that set a country on a course to achieving 2030 targets—not on a document.

The first step is a country consultative process that is informed by core analytics. This process leads to agreement on the RMNCAH results to be achieved by 2030 at the level of impact indicators (e.g., maternal mortality ratio, neonatal mortality rate, adolescent birth rate), and the major opportunities for improvement in a country's health systems—at sub-national as well as national level—that facilitate reaching these results. Key multisectoral issues impacting RMNCAH outcomes are also reviewed. The purpose of this exercise is to identify the focus areas that stakeholders, based on their assessment of the data, consider the most important.

There is a particular emphasis in this process on areas that have historically been under-funded (e.g., family planning, nutrition) and on specific target populations that have historically been neglected (e.g., adolescents). CRVS is a key area in this regard and is fully integrated in the Investment Case.

FIGURE 3



As described in [Section 2.A](#), the effectiveness and efficiency of service delivery mechanisms (in both public and private sectors) are also key elements of the GFF approach and are considered at this stage.

The second step in the process is to conduct a detailed analysis of each of the areas identified in the first step. This examines four main dimensions of each obstacle: supply factors, demand factors, the enabling environment, and factors outside the health sector that are nonetheless important to understanding the obstacle, including the social determinants of health (e.g., gender norms, weak sanitation systems undermining the effectiveness of disease control measures, insufficient data for decision-making due to poor CRVS systems). Additionally, a robust resource mapping that covers both domestic and international resources is a critical input, since it determines the parameters for what is feasible.

This process leads to an agreement of what results the country wants to achieve with regard to each area. These results are at a lower level than in step 1, and so are typically at the outcome and output levels rather than impact level. In keeping with the GFF's equity focus, equity analyses are essential at this stage to ensure that disadvantaged and vulnerable populations are identified and prioritized. Attention to gender and rights (including reproductive rights) is also critical.

Clarity on the desired results enables the formulation of a package of interventions required both in the long—and short-terms. These solutions should build on what has been demonstrated to work in a given country as well as on the transformative initiatives

that can accelerate progress. The balance between RMNCAH service delivery, health systems strengthening, and multisectoral responses is dependent on country context and the outcome of the core analytics. In addition to comparing interventions, the prioritization process also addresses the shifts needed in service delivery to overcome the obstacle in question. This encompasses both the mode of delivery (e.g., public, private, or non-profit) and the location of delivery (e.g., facility, community, or household). Complementary elements such as community engagement and advocacy are also included

The Investment Case should contain a clear theory of change that demonstrates how all of the parts contribute to setting a country on the path toward achieving the long-term vision. This also enables the development of a clear results framework that includes indicators, targets, and data sources. This facilitates regular assessments of the progress in following through on an Investment Case, which promotes mutual accountability for results and so is a core element of all Investment Cases. As discussed further in [Section 7](#), a common set of indicators will be included in all Investment Case results frameworks. These will be drawn primarily from international agreements (e.g., the Sustainable Development Goals) but will also include indicators below the impact level so that changes in outcomes (e.g., related to coverage of high-impact interventions) can be tracked across countries.

The final element of the process is costing, which provides critical information that is factored into the decision-making around which solutions feature in the Investment Case. The costing should include all

HOW COUNTRY CONTEXT SHAPES THE PROCESS OF DEVELOPING INVESTMENT CASES

The different processes adopted in Kenya and Tanzania highlight the flexibility built into the GFF approach to the development of Investment Cases.

Prior to the creation of the GFF, Tanzania had undertaken several exercises to improve performance both in RMNCAH and in the broader health sector. The “Sharpened One Plan” was developed in response to concerns about lack of progress in key aspects of RMNCAH, while the “Big Results Now” process identified evidence-based priorities across the health sector, including a number of specific areas related to RMNCAH. Tanzania is also at an advanced stage in the development of a plan for RMNCAH for the period 2016–2020, which is nested within a new health sector strategic plan that covers the same period. A long-term (2015–2025) health financing strategy is also being developed.

The Investment Case process in Tanzania built directly on this country-led work, including by highlighting some areas that needed further focus and refinement, such as strengthening the linkages between the RMNCAH

plan and the minimum benefits package addressed by the health financing strategy, further resource mapping and costing for RMNCAH, and prioritizing the multisectoral elements that contribute to the health of women, adolescents, and children (including CRVS). Because the existing health sector-wide approach is well developed, no separate GFF mechanism was established to develop the Investment Case.

In contrast, in Kenya it was recognized that to drive the prioritization process, a new national steering committee would be useful, and so one was established with representatives of all the key constituencies in the RMNCAH effort, including county government officials, which are critical in light of the recent decentralization process. This body is responsible for overseeing the data-driven process of identifying the results to be achieved and the key obstacles to reaching them. The national Investment Case will be followed by county implementation plans, which highlights how the general GFF approach is tailored to the particular circumstances of the countries in which it operates.

elements necessary to deliver upon the Investment Case (including commodities and human resources) and should be done based on accepted costing methodologies (e.g., the OneHealth Tool, the Marginal Budgeting for Bottlenecks tool).

Technical assistance is important throughout the process of preparing an Investment Case to bring in evidence and good practices from other settings, provide technical guidance based on international standards, share lessons learned, and contribute to the core analytics, as discussed in more detail in [Annex 5](#) (which also covers technical assistance in the course of implementation). As a general principle, the GFF approach prioritizes the delivery of technical assistance in ways that build sustainable capacity and transfer skills, such as through training new staff and building the capacity of existing staff, supporting the strengthening of institutions, and building an environment conducive to capacity development. In doing so, the GFF builds on existing

structures and processes for technical assistance, including in-country processes organized by the H4+ organizations, South-South cooperation, and regional support mechanisms (including for CRVS).

The Investment Case is also subject to a quality assurance process that is intended to help improve the quality of an Investment Case. Building on the lessons learned from Gavi and the Global Fund, this involves an independent review. For the GFF this occurs at country level but international experts are used to ensure that international good practice is appropriately reflected in the Investment Case (e.g., that high-impact interventions are adequately focused upon). It plays a particularly important role in ensuring that issues (e.g., family planning, nutrition) and populations (e.g., adolescents) that have historically been underinvested in are adequately included in Investment Cases. The quality assurance process will be independent but will involve in-country engagement with the stakeholders involved in developing

the Investment Case so as to ensure that the process benefits the country rather than simply serving as a means to pass judgment on an Investment Case. The model for quality assurance is being finalized based on the experience in the frontrunner countries and will include not only quality assurance related to the initial preparatory phase but for ongoing implementation.

B. Mobilization of Financing for Investment Cases

The GFF mobilizes resources for Investment Cases in two ways: improving the efficiency of financing for them and attracting additional resources from a range of sources.

I. COMPLEMENTARY FINANCING OF THE INVESTMENT CASE

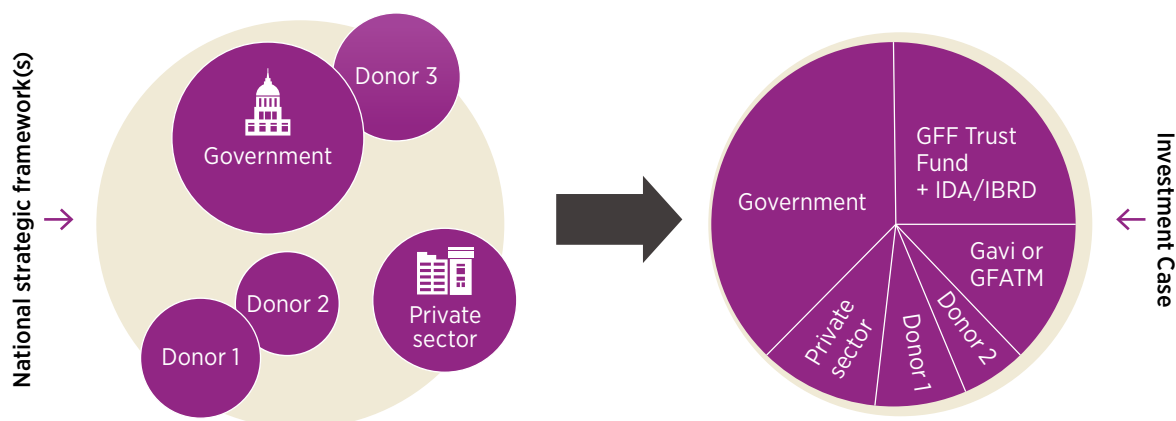
Currently, in many countries national strategic frameworks contain lengthy sets of interventions that are not based on realistic assessments of the resources available. Additionally, financing for RMNCAH is characterized by gaps, overlaps, and funding for areas outside of national priorities. With the GFF, the Investment Case focuses on a more prioritized set of interventions that are appropriate given the resources

available. Once an Investment Case is agreed upon, financiers—both national and international—decide jointly on which elements are to be financed by each partner, in a country-led process. This reduces the gaps and overlaps in financing and ensures that financing is directed to high-impact interventions that are within the scope of the priorities that have been identified, leading to more efficient use of resources and better results (see Figure 4).

Experience has shown that efforts to align financing around a common vision can be challenging. To address this, there are several incentives for financiers to engage in this process. The ability to attract additional resources from IDA/IBRD is appealing to a number of external financiers, since this is both an important means for strengthening domestic commitment to RMNCAH, including from ministries of finance, and often represents additional resources to the sector. The leadership of the national government in the preparation of the Investment Case also provides a key added value, as this strengthens sustainability. The rigor of the Investment Case methodology should improve the quality of implementation for all of the partners that use it as the basis for their investments (something that is likely to be particularly useful in attracting newer donors, which often are not present in-country in significant ways). Finally, the Investment Case is a way to improve the efficiency of each financier's individual contributions by ensuring that they are complementary to

FIGURE 4

The Investment Case drives efficiency by focusing on evidence-based, high impact interventions (beige circles) while also improving alignment, which reduces gaps and overlaps as financiers increase funding for RMNCAH (purple circles)



the resources of other financiers and in line with a long-term direction for the country that has been adopted by key stakeholders, including the national government.

Once the repartition is agreed, each financier ensures compliance with its own funding procedures. In each country, several different modalities may be used to deliver financing, including pooling with the government (which is done by the GFF Trust Fund and IDA/IBRD), single—or multi-donor trust funds established at national level, and parallel financing. For example, in Tanzania USAID is putting resources into a single-donor trust fund that provides complementary financing to the Investment Case alongside resources from the GFF Trust Fund and IDA.

The partners financing the Investment Case then jointly participate in country-led implementation review and support. The form of this coordination varies between countries depending on the particular stakeholders involved and the approaches already in use in the country, but ranges from informal discussions and sharing of information to joint missions and reviews to full-fledged coordination structures (e.g., akin to sector-wide approaches).

This approach builds on an increasing number of examples of how major financiers come together around key priorities. In the Democratic Republic of the Congo, for example, Gavi, the Global Fund, UNICEF, and the World Bank are harmonizing their approaches and aligning their work to support the Ministry of Public Health's objective of reducing fragmentation among partners. To improve RMNCAH results, the partners jointly support a large-scale program that aims to improve the delivery of an essential integrated package of RMNCAH services through performance-based financing and by addressing key bottlenecks in the health system, such as supply chain management. The four agencies work synergistically to complement each other and utilize their comparative advantages to maximize effectiveness, avoid duplication of efforts, and improve efficient use of resources. Joint implementation and financial management manuals are being developed and the partners will also collaborate in the course of implementation, including through joint missions and joint reviews.

To understand the extent to which the process of preparing Investment Cases leads to increased resource mobilization, the GFF contributes to strengthening the tracking of financing flows for RMNCAH. Ideally, national financial monitoring systems would capture resource flows in sufficient detail to account for new funding that has been mobilized by the GFF (from all sources, including domestic [public and private] and external) and for the alignment of existing financing to Investment Cases. As the experience of other efforts to track the additionality of financing (e.g., related to the Global Fund) has revealed, in practice this is a significant challenge, particularly given the methodological issues around distinguishing what is new or incremental from what was already planned. It is important not to create parallel systems in this process, so the GFF focuses on strengthening efforts such as national health accounts that provide comprehensive pictures of health financing. This enables the most important questions with regard to the Investment Cases to be answered, particularly whether the overall envelope for health is increasing and whether the share of this going to RMNCAH is growing.

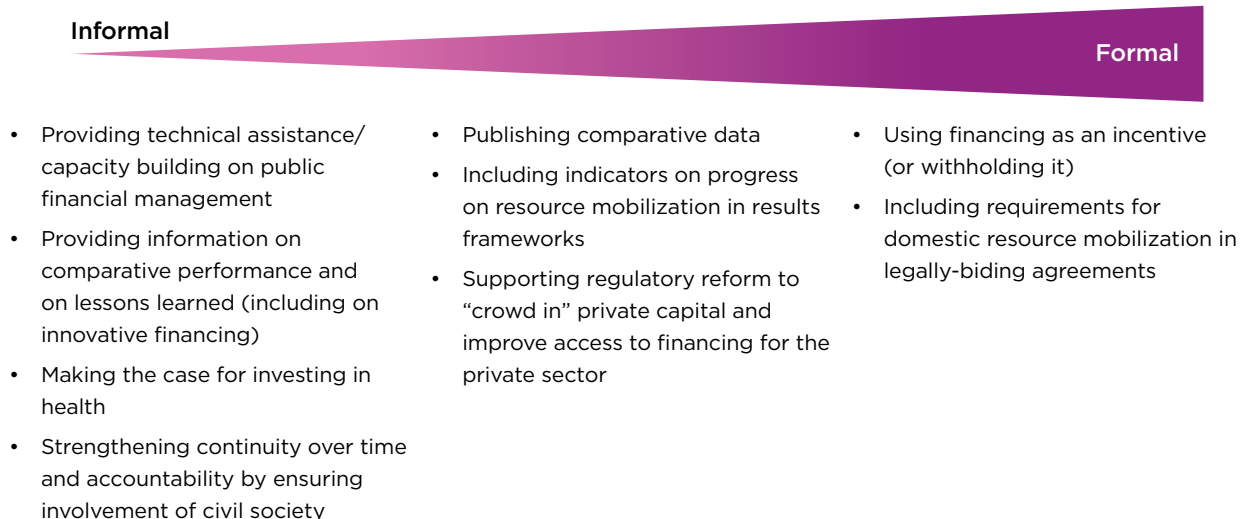
II. INCREASED GOVERNMENT INVESTMENT IN RMNCAH

Domestic sources are by far the largest contributors of financing for RMNCAH at the national level, and significant increases in domestic financing are required to close the resource gap for RMNCAH. Economic growth creates important opportunities for closing the gap, but as noted above the evidence is clear that this does not occur automatically. Moreover, there is a risk that increases in external assistance could displace domestic financing.¹¹

Support for the development of a health financing strategy that contains concrete plans for domestic resource mobilization (see [Section 3.C](#)) is one central way that the GFF assists countries to address these challenges. Additionally, the GFF uses an array of mechanisms to support domestic resource mobilization.

¹¹ See, for example, Lu, C., et al., "Public financing of health in developing countries: a cross-national systematic analysis", *Lancet*, 2010, 375(9723):1375–87, which found that each dollar of development assistance for health to governments resulted in a reduction in domestic spending on health of at least US\$0.43.

FIGURE 5



As seen in Figure 5, at one end of the spectrum are more informal approaches such as the provision of technical assistance or comparative information (such as on experiences with innovative financing) or work with civil society to promote the accountable and equitable use of public resources. More formal mechanisms include using resources as an incentive for domestic resource mobilization (or tying its ongoing disbursement to progress). In between are approaches such as publishing comparative data in an effort to spur reform (much as the benchmarking in the World Bank Group’s “Doing Business Report” has been very effective at spurring competition that resulted in significant improvements in business climates globally) or supporting regulatory reforms that attract private capital to the health sector.

These approaches are typically used in combination, with different partners bringing particular expertise in different areas or playing different roles. Resources from the GFF Trust Fund and IDA/IBRD work to incentivize domestic resource mobilization by supporting the development of health financing strategies, by sharing lessons learned and comparative data, and tying the provision of financing to domestic resource mobilization.

III. LINKING GRANT FUNDING TO IDA AND IBRD PROJECTS

As one of the multiple—both external and domestic—financiers of national RMNCAH priorities identified

in Investment Cases, the GFF Trust Fund provides grant funding to countries in tandem with IDA and IBRD financing.¹² The process of allocating IDA and IBRD financing to countries is determined by existing World Bank Group procedures, which means that the level of IDA and IBRD resources used for RMNCAH is not fixed at a global level or mandated by the World Bank Group. Instead, each government determines how its IDA/IBRD resources are allocated between different national priorities across its development agenda.

The GFF Trust Fund financing is linked to IDA and IBRD projects for several reasons. First, this helps lower transaction costs and increase efficiency, because jointly financed projects are prepared and supervised by the same World Bank staff and because governments do not need to establish duplicate administrative structures. Second, the link situates the trust fund resources in the on-going strategic dialogue between governments (including ministries of finance) and the World Bank, which is important to connect the work on health financing and domestic resource mobilization with broader macroeconomic policy discussions.

Third, it helps ensure that trust fund resources are on-budget and that they are additional to the financing provided IDA and IBRD, rather than substituting

¹² This builds on the experience of the HRITF, which had an average ratio of one dollar of grant resources for four dollars of IDA financing.

for it. Fourth, trust fund resources are also used to support the design of Investment Cases. Since IDA/IBRD financing is based on national priorities, the fact that the trust fund resources contribute to strengthening the quality of the process that identifies these priorities means that the trust fund also contributes to improving the quality of IDA/IBRD financing.

IV. INNOVATIVE ENGAGEMENT OF GLOBAL AND LOCAL PRIVATE SECTOR RESOURCES

The private sector has considerable resources—operational, financial, and technical—that can make significant contributions to RMNCAH results at country level but that are underleveraged in many countries. Three challenges have been identified that the private sector brings particular comparative advantages to addressing:

- Weak supply chains that result in shortages of key commodities;
- Insufficiently adapted and inappropriate use of medical technology;
- Inadequate access to capital for healthcare providers, both in the form of working capital and capital to scale up operations (which limits the ability of these providers to contribute to RMNCAH results).

There is also considerable scope for harnessing the private sector to address current challenges related to insufficient coverage (particularly of poor women, adolescents, and children), inefficient provision, and suboptimal quality of RMNCAH services.

The primary entry points to tap the potential of the private sector are the Investment Case and health financing strategies, both of which include the private sector as part of a mixed health systems approach. However, in many countries, existing approaches to engaging the private sector in national planning processes have not succeeded in mobilizing stronger private sector engagement, for a number of reasons: the private sector is quite diverse and generally highly fragmented, making representation of it in planning processes challenging; dialogue between governments and the private sector is often underdeveloped; a number of the innovative new approaches to engaging the private sector (e.g., social impact bonds) are technically complex; and

the incentive structure in most planning processes does not facilitate the inclusion of new approaches and actors.

To address this, the GFF employs a range of tools. Dedicated expertise is supported through the GFF Trust Fund to broker collaborations at the country level. This entails identifying potential areas for collaboration, providing technical knowledge to determine which solutions are most appropriate, and shepherding deals to completion.

The GFF also assists governments in assuming their stewardship role for the entire health sector, including through building capacity in governments with regard to the private sector. This builds on the experience of the IFC in addressing bottlenecks by strengthening dialogue within the private sector and between it and the government, and by working with governments to improve regulatory regimes.

Another important tool is the flexibility of the financing from the GFF Trust Fund. This flexibility enables resources to be used in ways that address key challenges and crowd in private financing. For example, if an Investment Case highlights that access to capital is a major constraint to purchasing the equipment that will improve the quality of care in the private sector, trust fund resources could be used to establish a revolving loan fund to address this.

Finally, the basic approach of the GFF facilitates drawing in additional resources from the private sector by emphasizing the importance of inclusive planning processes, as described below in [Section 4](#).

To complement these efforts at national level, a number of avenues for engaging with the private sector at the international level to mobilize additional resources are being explored. This could include, for example, leveraging the World Bank's AAA credit rating to issue a bond that would attract private investors that could provide the capital that a government is seeking to finance a large-scale investment related to RMNCAH. Public-private partnerships, such as related to mobile technologies, are another opportunity, particularly given the potential applications of information and communication technologies to expand access to RMNCAH services and information.

C. Health Financing Strategies Focused on Sustainability

Health financing strategies are a cornerstone of the GFF approach to financing at the country level, providing a critical complement to the Investment Case. The objective of the GFF's work on health financing strategies is to assist countries to analyze, plan for, and implement efforts to promote financial sustainability in the context of accelerating progress on RMNCAH and on universal health coverage. The work on financial sustainability encompasses the entire health sector rather than focusing solely on RMNCAH, as it would be inefficient or even impossible to address a number of key components (e.g., establishing or expanding a health insurance scheme, reforming public financial management, or strengthening revenue generation through improved tax systems) exclusively for RMNCAH.¹³ The details of the GFF approach are contained in [Annex 4](#).

The GFF support begins with a health financing assessment that examines all aspects of health financing in a country: the sources of financing, the design of the financing system, the policies and practices governing various health financing functions, the processes and capacities, and political economy considerations. The assessment includes both an analysis of historical trends and a forward-looking element that includes projections of resource needs, health sector allocations, general government revenue, and economic growth. The assessment also highlights efficiency and equity issues. Most countries already have key elements of the health financing assessment, so the GFF approach builds on what exists rather than duplicating efforts and focuses on addressing gaps in data and analysis.

Based on this assessment, the GFF supports countries to develop a health financing strategy that

articulates a long-term vision for the sustainability of financing for the attainment of 2030 targets for RMNCAH in the broader context of the Sustainable Development Goals and universal health coverage. The strategy covers the three health financing functions of revenue mobilization, risk pooling, and purchasing, and includes the legal, policy, and regulatory reforms needed to achieve progress (which in some countries will entail the revision of the mandates of existing institutions or the establishment of new ones, such as an agency responsible for purchasing health services or a regulator). The strategy defines milestones in a financing results framework that enables the monitoring of commitments.

Since the health financing strategy takes a high-level, long-term perspective, it is complemented by a costed implementation plan that sets out the concrete steps over a shorter time period that are needed to achieve the milestones contained in the strategy and the investments needed to put reforms in place (e.g., in capacity building, information systems). These implementation plans typically cover a three-to-five-year period, in line with national political or planning cycles. Ideally, the first implementation plan focuses on the same period addressed by the Investment Case, to ensure that the two work in tandem.

To support the implementation of health financing strategies, the GFF provides financing, technical assistance, capacity building, and institution-strengthening, as discussed in more detail in [Annex 5](#).

There are important connections between the health financing strategy and the Investment Case: an Investment Case includes the health financing initiatives that address immediate bottlenecks related to RMNCAH, but does not systematically address the broader health financing challenges, such as domestic resource mobilization and shifts in the approach to the purchasing of health services. This is a key added value of the health financing strategy: it examines the full set of health financing functions in a comprehensive manner and then develops a long-term approach for moving a country toward the sustainable provision of scaled-up RMNCAH results and universal health coverage. A number of these have been highlighted previously (e.g., efficiency, as discussed in [Section 2.A](#), domestic resource mobilization ([Section 3.B.ii](#)), and

¹³ Even though the work on health financing strategies is broader than RMNCAH, it is nonetheless essential to the overall GFF approach because of the importance of securing sustainable financing to the long-term durability of RMNCAH results. The emphasis in the health financing work is not on establishing a privileged position for RMNCAH but rather on reaching evidence-based conclusions about the appropriate priorities for the broader health sector.

private sector resource mobilization (Section 3.b.iv) but feature in health financing strategies.

D. Investments in Global Public Goods that Support RMNCAH Results at the Country Level

The GFF is focused on in-country financing but there are some areas in which action at the global level can play an important role in improving RMNCAH outcomes and generating better value for money at country-level. Therefore, the GFF supports the development of global public goods¹⁴ based on country demand and potential for impact on RMNCAH outcomes.

The GFF engagement on global public goods will progress in phases. For the initial stage, the focus is on two initiatives that have been identified based on the experience in frontrunner countries and a preliminary assessment of needs and opportunities.

First, the GFF will build on and expand the capacity and experience of the HRITF in the area of knowledge, learning, and evaluation,¹⁵ while also recognizing and supporting the important roles played by other actors in this area. In particular, the GFF will synthesize lessons learned from the development and implementation of Investment Cases and health financing strategies. These will be widely disseminated through a knowledge platform as well as by facilitating knowledge exchanges between countries addressing similar challenges through South-South

cooperation. The GFF will fund research aimed at assessing the impact of RMNCAH and health financing interventions, and at understanding in real-time the operational challenges that threaten progress, as well as the approaches to addressing these. This research should ultimately strengthen the knowledge base underlying Investment Cases and health financing strategies, and it should involve and be relevant to program managers and policy makers. This will be done by allocating grants for operational research and evaluation on a competitive basis, with a particular emphasis on building evidence where gaps exist (e.g., adolescent health).

Second, the GFF will support the development of a “Center of Excellence” on CRVS. This is intended to strengthen national CRVS systems by building a knowledge base, facilitating information exchanges and networks, synthesizing and disseminating good practices, contributing to global tools and standards, and strengthening capacity of CRVS implementers and advocates (e.g., by making links between those seeking support to build capacity in CRVS and those able to provide this kind of capacity building). To do this, the Center of Excellence will engage a broad range of partners, including national governments, multilateral and regional institutions, donors, and academics.

Further GFF involvement in global public goods will depend on the experience with these two initiatives, the demand from countries for global public goods, and the resources available. In addition to further work on knowledge, learning, and evaluation and on data and information systems, two additional areas in which the GFF could support specific initiatives in the future are commodities (e.g., ensuring quality, market shaping, volume guarantees) and innovation.

The determination of which specific initiatives are included in this subsequent phase will be based on an assessment of the GFF’s comparative advantage, the extent to which other actors are able to address the challenges identified, the potential impact, and the relevance to the GFF.

¹⁴ The GFF follows the standard definition of a “public good” in economics: a public good must be “non-excludable” (no one can be excluded from consuming the good) and “non-rivalrous” (consumption by one person does not diminish consumption or availability to another person). Classic examples include clean air, street signs and lighting, and national defense. Because public goods are non-excludable, the private sector typically under-provides them (at least without some form of subsidy or other financial support). Public goods become global public goods when their benefits extend to multiple countries in regions across the world. Examples of global public goods include knowledge and the eradication of a communicable disease.

¹⁵ The HRITF has a core focus on knowledge and evaluation, and has supported impact evaluations in over 40 countries, as well as investing in operational research. For more information see www.rbfhealth.org.



4. Who: The Country Platform

A. Composition

The GFF operates at country level through a multi-stakeholder process that builds on IHP+ approaches. National governments lead the processes with the involvement of the full set of RMNCAH stakeholders, each of which brings a distinct comparative advantage to the process:

Within these constituencies it is important that the right skills and institutions are represented in the process. For example, the ministry of finance is a critical stakeholder in the process and so should be involved in every country. In many countries responsibility for CRVS is split between several government ministries, so each of these need to engage as appropriate. Given the breadth of issues covered in Investment Cases, expertise in different elements

of RMNCAH, health systems strengthening, and the multisectoral issues that affect RMNCAH outcomes should be present. This is particularly critical in areas that have historically been neglected (e.g., family planning, nutrition). In countries with decentralized health structures, relevant sub-national government staff should be involved.

Experience with other multi-stakeholder processes in health has shown that engaging the private sector can be a challenge given the diversity of actors and the very different (and often specialized) ways in which they contribute (e.g., directly delivering services vs. providing commodities vs. supplying financing). There is not a single solution that can address this in every country, but the starting point is an awareness of the complexity of the issue and a commitment to ensuring effective engagement of the private sector.

| GFF Partner | Examples of roles |
|---|--|
| Government | <ul style="list-style-type: none">• Leadership and stewardship• Purchasing and/or providing RMNCAH services• Enabling environment, including clear accountability• Domestic resource mobilization |
| Civil society (not-for-profit) | <ul style="list-style-type: none">• Advocacy and social mobilization• Accountability to strengthen national responses• Service delivery, particularly in hard-to-reach areas, for vulnerable populations, and in fragile settings |
| Private sector | <ul style="list-style-type: none">• Innovative financing mechanisms• Service delivery, system strengthening, manufacturing, etc., including through public-private partnerships |
| Affected populations | <ul style="list-style-type: none">• Advocacy and social mobilization to ensure accountability and strengthen national responses• Unique insights into approaches to service delivery (e.g., based on user experiences) |
| Technical agencies (H4+ and others) | <ul style="list-style-type: none">• Global, regional and country-level coordinated technical assistance in a manner that develops the capacity of in-country partners• Normative guidance• Dissemination of evidence on what works |
| Multilateral and bilateral agencies, and foundations | <ul style="list-style-type: none">• Complementary financing (increasingly over time through pooling or shared management)• Adherence to aid effectiveness principles such as transparency and predictability• Sharing of global good practices |

As noted in [Section 3.B.i](#), engagement in the country platform and the work that it undertakes does not happen automatically. As discussed in that section, the GFF approach creates incentives for participation. The extent to which these are successful at engaging partners at country level will be assessed regularly and discussed at the GFF Investors Group, which has an important role to play in ensuring that country-level staff are following through on commitments made at the global level with regard to partnership and complementary financing.

B. Structure

The GFF is not prescriptive about the particular form that the “country platform” that brings these partners together must take. Drawing on the lessons learned from the experience of, among others, IHP+, Gavi, and the Global Fund, the GFF approach is to build on existing structures while ensuring that these embody two key principles (in addition to respecting the overarching GFF principles described in [Section 1](#)): inclusiveness and transparency.

The expectation is that in most countries existing structures will be used. Some, however, will decide that establishing a new mechanism is preferable. In most countries, it is expected that the government (through the ministry of health) will lead the process, as there is considerable experience around the importance of strong government leadership in priority-setting and ensuring the complementarity of financing. The form that the country platform takes in a given country is also shaped by the other mechanisms for coordination and partnership in the country, as the GFF approach is to build on these rather than duplicate them. This includes mechanisms related to sector-wide approaches or other government-led health sector coordination groups, A Promise Renewed, Gavi, and the Global Fund. The frequency of meetings and other operating procedures are determined in each country and typically vary over time (e.g., by stage of the process, with more frequent meetings during the preparation of the Investment Case and health financing strategy).

In terms of the principles of inclusiveness and transparency, the GFF expects country platforms to afford

each of the constituencies in the RMNCAH response the opportunity to contribute fully to the development and implementation of RMNCAH programming based on their specific skills and areas of focus. This includes involvement in the process of preparing Investment Cases and health financing strategies, such as by ensuring that the full set of stakeholders is invited to consultations on the preparation of the Investment Case and health financing strategy, supplied with all of the relevant documentation needed to be able to contribute technically, and involved in finalizing the documents.

To support countries to operationalize these principles, the GFF has established minimum standards that countries are expected to adhere to, which are contained in [Annex 6](#).

This approach means that the particular set-up used varies considerably between countries, as seen in the experience in the frontrunner countries (see the box in [Section 3.A](#)). By taking a principle-based approach and not insisting upon a one-size-fits-all model, the GFF accommodates this diversity of contexts in a manner that supports national ownership while promoting inclusiveness and transparency.

C. Functions

The country platform is intended to improve coordination related to four major areas:

- Development of Investment Cases and health financing strategies (following the steps outlined in [Section 3.A](#) and [3.C](#));
- Mobilization of resources, including determination of which elements of the Investment Case each financier supports (as covered in [Section 3.B](#));
- Coordination of technical assistance, in both the development and implementation of Investment Cases and health financing strategies;
- Coordination of monitoring and evaluation.

With regard to the first of these, the partners involved in the country platform jointly develop both the Investment Case and the health financing strategy. This covers all aspects of the steps outlined earlier

in [Sections 3.A](#) and [3.C](#), including preparation and review of the core analytics and health financing assessment, determination of the long-term results to be focused on, identification of key obstacles, selection of the focus areas for interventions, and development of the theory of change and results framework. Additionally, the partners involved in the country platform are responsible for ensuring the quality assurance of the Investment Case and health financing strategy (e.g., through a Joint Assessment of National Health Strategies process).

In terms of the second function, the partners in the country platform work on mobilizing the resources necessary to implement both the Investment Case and the health financing strategy. This includes domestic resource mobilization (from both public and private sources) and ensuring that external financing is aligned to the Investment Case and health financing strategy. The financiers (including the government) involved in the country platform are responsible for agreeing on the repartition of support for the implementation of the Investment Case and health financing strategy, as discussed in [Section 3.B](#).

These partners also assess the most effective and efficient ways to channel resources to the Investment Case and health financing strategy. There is considerable scope for increasing efficiency in this area given duplicative management and reporting structures, so the GFF works to improve efficiency by increasing the pooling of resources and the use of shared management structures. The GFF Trust Fund is an important vehicle for pooling RMNCAH resources at the global level. Pooling with the GFF Trust Fund has a number of significant advantages, including efficiencies in terms of low management costs, and the ability to allocate resources in a manner that maximizes impact globally.

In terms of shared management, several options are possible. For the GFF Trust Fund and IDA/IBRD, national governments assume responsibility for managing these resources, typically alongside the government's own financing. Other financiers can

also pool resources with the government. Another approach is the use of a multi-donor trust fund at country-level. This brings the resources of several financiers together into a single management mechanism outside of government, typically at the World Bank (although other organizations can also manage multi-donor trust funds), which then assumes fiduciary responsibility for the funds. A single group of staff manages these resources, using a common set of procedures.

A single-donor trust fund involves the establishment of a management mechanism for the resources of a single financier. This does not generate the same efficiencies as a multi-donor trust fund, but when established at the World Bank it does support coordination with the GFF Trust Fund and IDA/IBRD resources. Parallel financing involves resources that remain within the management systems of the donor but that are harmonized with the resources of other financiers. Regardless of the mechanism, the financing of all GFF partners is intended to be complementary and in line with the Investment Case.

With regard to technical assistance, the partners use the country platform as a mechanism for coordination to ensure that critical areas are covered and that no duplication is occurring. This can involve the development of a technical assistance plan or strategy to ensure cohesion and synergies in the approach of the various partners (which are discussed in detail in [Annex 5](#)).

To monitor implementation, the partners involved in the country platform track progress on the targets contained in the results framework of the Investment Case. Partners regularly review performance and use the country platform as a mechanism to coordinate implementation support in areas that are encountering challenges. The platform is also used to agree on approaches to evaluation and to share lessons learned. In addition to following up on Investment Cases, the partners involved in the country platform also examine the progress toward sustainable financing, including targets on domestic resource mobilization.



5. The GFF Trust Fund

A. Eligibility and Resource Allocation

Among the 75 “Countdown to 2015” countries, 63 countries are classified as low- or lower-middle-income countries. All but one of these are eligible to receive GFF Trust Fund financing (full list in [Annex 7](#)).¹⁶

Since sustainability is a foundational element of the GFF, a country wishing to access trust fund financing must be willing to commit to addressing the sustainability of its RMNCAH financing, including by demonstrating that it is committed to by increasing domestic resource mobilization for RMNCAH. The GFF is not prescriptive about the form of this commitment, and so simply requires governments to demonstrate that they have or will develop (e.g., through a health financing strategy) a clear approach to the issue. As described in [Section 3.B.i](#), the GFF supports the tracking of resource flows so as to be able to follow up on commitments around domestic resource mobilization.

Additionally, trust fund resources are only allocated to countries that have demonstrated their commitment to RMNCAH by indicating their interest in utilizing IDA or IBRD resources for RMNCAH.¹⁷ These resources must contribute concrete results toward

the overall goal of ending preventable maternal and child deaths. However, the IDA/IBRD funding does not need to focus solely on RMNCAH: if a project has a broader health systems focus or is even in another sector but can demonstrate that it will play a role in improving the health and quality of life of women, adolescents and children, then the country would satisfy this eligibility criterion.

The large majority of the trust fund resources are provided in grant funding to these eligible countries.¹⁸ (The remaining funding will be used for three areas: complementary support to countries, such as for the preparation of Investment Cases and health financing strategies; global public goods [which are not expected to exceed 5–10% of the total]; and the costs of the secretariat and the governance mechanisms.) In order to maximize impact globally, the trust fund has developed a methodology for allocating resources among the eligible countries that uses three criteria: need, population, and income. The specific indicators used and the methodology for combining them are described in [Annex 8](#).

These indicators are combined with the resources available for allocation to produce a broad range for each country (e.g., between US\$10 and US\$20 million per grant cycle—which is typically three to four years—for a country that has a low score on these criteria, or between US\$40 and US\$60 million for a country that scores highly). Having a range rather than a point estimate for each country is important in order to maximize the trust fund’s ability to be flexible, to incentivize domestic contributions, and to respond to changing external circumstances (e.g., a sudden increase or decrease in other external support). The final determination on the exact amount

¹⁶ The Democratic People’s Republic of Korea is not a member of the World Bank Group so cannot receive financing from a trust fund at the World Bank. Of the remaining 62 countries, 32 are low-income and 30 are lower-middle-income. Of the total, 46 are eligible for IDA-only financing, 9 are considered “blend” countries that receive both IDA and IBRD financing, and 7 are IBRD-only countries. To ensure predictability for these countries, all 62 countries will remain eligible for financing for the first three years of GFF operations. Thereafter, the list of eligible countries will be reassessed in light of changes in country classifications. Any countries that are no longer classified as low- or lower-middle-income would be ineligible to receive grant resources.

¹⁷ In the event that a country is ineligible for IDA/IBRD financing (e.g., because they are in arrears), an exception to this can be made.

¹⁸ The exact percentage is still being determined but will not be lower than 80%.

for each country is made in the course of negotiating financing with a government.

Given the constraints of the current trust fund commitments, limits on these ranges have been established. It is expected that the smallest allocation will be no less than US\$10 million per grant cycle¹⁹, while the largest allocation is expected to be no more than US\$60 million per grant cycle. These figures are directly related to the volume of financing currently available and represent a balance between, on the one hand, ensuring that the resources are significant enough to contribute meaningfully to a scaled response and to maximize the likelihood of leveraging financing and, on the other hand, safeguarding against all of the current commitments being allocated to only a handful of countries so that the GFF approach can be employed in a number of settings. Both of these figures will be reassessed based on ongoing resource mobilization and the initial experience of the trust fund.

CRVS is considered an integral element of the broader Investment Case. In addition, countries that explicitly include CRVS in their Investment Cases can qualify for additional resources from the GFF Trust Fund to scale up the CRVS components of their IDA/IBRD projects. These countries are then eligible for additional funding of up to US\$10 million specifically for CRVS, with the final amount based on the resource gap and the size of IDA/IBRD project component on CRVS. The grant funding is linked to IDA/IBRD and is part of the same project documentation and legal agreement.

The GFF Trust Fund does not make a proactive repartition of its resources between different objectives (e.g., maternal or child health), interventions (e.g., family planning, nutrition), or target populations (e.g., adolescents). Instead, in line with the broader principle that GFF is intended to build national ownership, national priority-setting with regard to objectives, interventions, and target populations (as manifested

through Investment Cases) determines the splits between these.

B. Roll-Out

The GFF Trust Fund has received pledges of US\$800 million from the governments of Norway and Canada. Based on strong country demand and the experience of HRITF, these bilateral contributions could be linked to up to an estimated \$3.2 billion from IDA. The design process for the GFF has started in four frontrunner countries. An additional 5–10 countries will be selected as a next step. These will be identified based on a combination of factors, including the three criteria used for resource allocation (need, population, and income) and an assessment of the opportunity to achieve impact in each country (including factors such as the interest in committing IDA/IBRD financing, the possibilities for domestic resource allocation, and historical progress on RMNCAH). The final decision about the additional countries will be made through the governance mechanisms described in [Section 6](#).

The current commitments enable results to be achieved in a core set of countries, but additional grant resources are required to reach the full set of eligible countries. Reaching all 62 eligible countries with one initial grant each would require US\$2.56 billion in contributions to the GFF Trust Fund (including the resources already pledged).²⁰

C. Operational Approach

The process for accessing grant resources from the GFF Trust Fund differs considerably from most global financing mechanisms: there is no stand-alone application process. To access GFF Trust Fund resources a country must have an Investment Case²¹, demonstrate that it is committed to increasing domestic resource mobilization through the development of a health financing strategy, and express an interest

¹⁹ The countries that receive the minimum amount are expected to be only those that have a low score. In these countries, the GFF Trust Fund investments are focused on technical assistance and capacity building (with a particular emphasis on ensuring that programs reach disadvantaged and vulnerable populations), rather than on financing service delivery. This is particularly the case for countries receiving IBRD financing.

²⁰ Details of the approach to costing are included in Annex 8.

²¹ However, if necessary the trust fund can provide financing to cover the costs of developing an Investment Case.

in utilizing IDA or IBRD resources for RMNCAH.²² The scope and areas of emphasis for the GFF Trust Fund and IDA/IBRD financing are determined as part of the Investment Case development, which has a number of benefits. Because a wide array of stakeholders is involved in the development of the Investment Case, the World Bank financing would be built on a foundation of broad-based agreement about RMNCAH priorities in a country. Additionally, the rigorous, evidence-based process for developing the Investment Case defines the technical content of the GFF Trust Fund and IDA/IBRD financing.

The GFF Trust Fund has the flexibility to use different World Bank Group financing instruments, including investment project financing and program-for-results (in which the disbursement of funds is directly tied to the delivery of defined results). Specific investment project financing modalities that are used include different forms of results-based financing (e.g., performance-based funding for facilities, conditional cash transfers and vouchers for target populations, and disbursement-linked indicators for higher-level [e.g., national] changes in policy or implementation progress) and input-based financing (e.g., for the

procurement of commodities).²³ The determination of which are used in a given country is based on the nature of the results to be achieved and on the preferences of the country.

The trust fund does not set up a parallel management structure in the design and implementation of grants to eligible countries, but rather integrates with the IDA/IBRD preparation and implementation processes managed by existing World Bank country teams, which in turn are supported by a broader set of GFF partners at country level. The GFF Trust Fund therefore leverages existing technical, financial management and procurement capacity, keeping the management costs for the trust fund low. HRITF has been managed by a small team at the World Bank, which will be enlarged slightly to reflect the new governance structure, the expansion of the country portfolio, and the wider partnerships. This secretariat manages the trust fund resources, provides overall quality control and technical assistance, and monitors results. Secondments from technical partners will be one approach to ensuring that the secretariat is staffed to address the increased scope of work.

²² In the event that a country is ineligible for IDA/IBRD financing (e.g., because they are in arrears), the GFF Trust Fund Committee can make an exception to this.

²³ See <http://www.worldbank.org/en/projects-operations/products-and-services> for further details.



6. Governance

The global GFF governance arrangements are focused exclusively on the GFF's core mandate of supporting smart, scaled, and sustainable financing to achieve RMNCAH results at country level, both through the broader facility and the GFF Trust Fund. They also support the GFF's role as a pathfinder around financing for development (including with regard to domestic resource mobilization) and so will evolve in light of developments with regard to the SDGs and the updated Global Strategy for Women's, Children's, and Adolescents' Health. GFF governance is a lean mechanism that is designed to strengthen coordination between key investors so as to facilitate complementary financing of Investment Cases at country-level. This provides global support to the discussions around complementary financing that occur through the country platform.

The GFF governance handles two discrete functions:

1. Ensuring that the GFF succeeds in mobilizing complementary financing for Investment Cases and health financing strategies;
2. Ensuring that the GFF Trust Fund uses its resources to provide financing in ways that achieve results while being catalytic and driving sustainability.

The first function is fulfilled by driving institutional commitments and agreements among partners on aligned financing and efficient resource allocation both within and across GFF countries. This entails building high-level support for the GFF and playing a leading role in mobilizing domestic and international resources (both public and private) for Investment Cases. Additionally, the governance mechanism is responsible for monitoring the performance of the GFF as a facility and ensuring accountability for results among the GFF partners. This includes ensuring that the GFF approach is well understood throughout the institutions involved and that country-based members

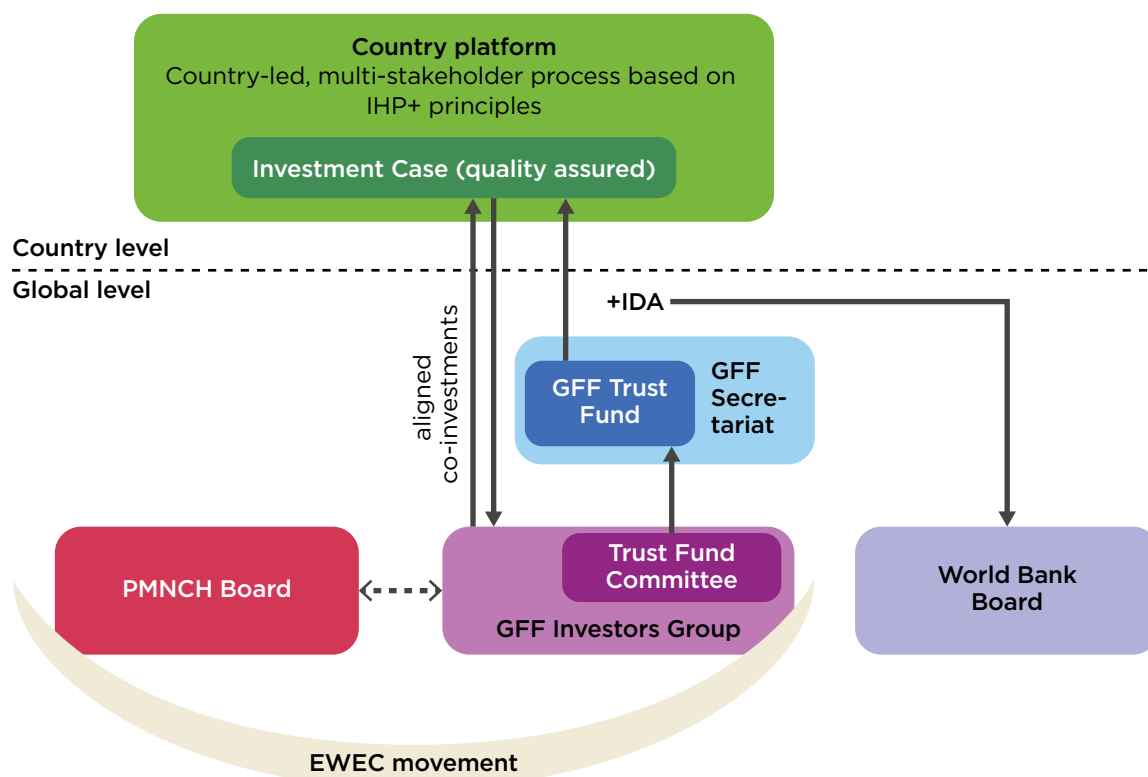
of these institutions adhere to commitments made and agreements reached at the international level in their engagement through country platforms (e.g., with regard to complementary financing of Investment Cases). This also covers ensuring that the commitments to the GFF are, to the extent possible, additional and do not divert resources from other important areas. The governance mechanism also supports learning and innovation around effective and efficient financing approaches.

The second function is addressed by setting the strategic funding approach and priorities for the GFF Trust Fund financing, including how the trust fund resources are used in a catalytic way to maximize mobilization of external and domestic financing. This includes approving trust fund financing allocations and agreeing on an annual work plan and budget for the secretariat. The governance mechanism is also responsible for overseeing the performance of the trust fund to ensure that investments deliver results.

The fiduciary arrangements for the GFF Trust Fund financing are integrated in IDA/IBRD projects that are approved by the World Bank Board, and so rely on existing World Bank Group policies and procedures. The World Bank also has managerial responsibility for the daily work of the secretariat.

To deliver on these two functions, an integrated model with two discrete but related governance elements has been developed. A broader GFF Investors Group addresses the first function, while a subset of the Group—the GFF Trust Fund Committee—focuses on the second function. The Investors Group addresses the financing for the updated Global Strategy and so considers all countries, not only the 62 countries eligible for support from the trust fund. Given that the 62 countries face particularly high burdens, the Investors Group focuses in the initial phase on these countries. This phased approach ensures the

FIGURE 6



development and financing of Investment Cases and health financing strategies in the highest priority countries while also putting in place a structure that serves the needs of all countries as the Global Strategy is implemented.

Figure 6 depicts the relationship between the different elements of the GFF architecture. The GFF is part of the Every Woman Every Child movement and has a role as a key financing mechanism for the updated UN Secretary-General's Global Strategy for Women's, Children's, and Adolescents' Health, which provides the broad policy framework for the GFF (in the context of the SDGs). A Secretary-General's High Level Champions Group as part of EWEC has been proposed as a way to strengthen political commitment for RMNCAH. Additionally, the Investors Group is highly complementary to PMNCH, which plays a leading role in addressing a number of elements that are critical to the GFF's success. These include global advocacy on RMNCAH and the updated Global Strategy, tracking and accountability relating to global resource flows for RMNCAH (including related

to the GFF), and monitoring of global progress on RMNCAH. Details on the interaction between the GFF governance mechanism and EWEC and PMNCH will be further discussed and agreed upon with the relevant stakeholders.

Membership in the Investors Group is based on active contribution to the success of the GFF. This co-investment requirement promotes the engagement of stakeholders that make substantial contributions financially or through in-kind assistance to Investment Cases and health financing strategies. Initially the Investors Group includes:

- 4-6 members from participating countries (including both ministries of health and of finance);
- 4-6 members from bilateral donors that contribute to the GFF²⁴;
- 1 member each from UNFPA, UNICEF, and WHO;

²⁴ There will be some flexibility to include new donors to the Investors Group; however, to remain nimble, a sharing of seat or rotation system may be introduced. If the number of donors increases, the number of participating countries will also increase.

- 1 member from the World Bank;
- 1 member each from Gavi and the Global Fund to Fight AIDS, Tuberculosis and Malaria;
- 1 member from the PMNCH board;
- 2 members from non-governmental organizations (one each from developing and developed countries); and
- 2 members from the private sector (including private foundations).

The members are senior representatives of governments and partners who bring the expertise required to ensure effective steering of a financing facility. Many of these are also members of the PMNCH Board, which promotes synergies between the two. For constituencies in which multiple institutions

could participate in the Investors Group (e.g., non-governmental organizations, the private sector) a transparent selection process will occur. The Group meets twice per year, one of which includes a high-level session. At its first meeting the Group will determine its rules of operations, including issues such as chairing, voting, policies related to the rotation of seats, how meetings are conducted, and whether working groups will be established.

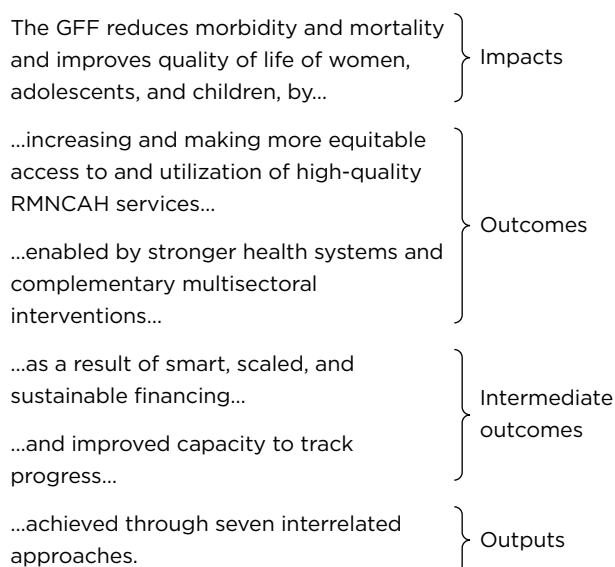
The members of the Trust Fund Committee are those donors that contribute to the GFF Trust Fund²⁵, plus the Chair of the Investors Group (or the Vice-Chair if the Chair is a donor to the trust fund). The Trust Fund Committee has decision-making authority for matters related to the operations of the GFF Trust Fund. It also meets twice per year and will also establish its rules of operation at its first meeting.

²⁵ Initially all donors to the trust fund have the option to join the Trust Fund Committee, but depending on the number of donors, a threshold for contributions or a system of rotating seats may eventually be introduced.



7. Theory of Change, Risk Analysis, Results Framework, and Accountability

The theory of change describes the pathways across each level of the results chain that lead to the achievement of the overall goal of the GFF:



This is a high-level summary of the theory of change, with further details contained in [Annex 10](#). The theory of change is useful for understanding the implicit assumptions about how change is brought about by the GFF, as well as the risks that threaten its success. These are particularly important to describe because of the innovative nature of the GFF and the extent to which its ability to deliver results is dependent on a broad set of partners collaborating closely, and so are covered at length in [Annex 10](#).

The theory of change is also important for the development of a robust results framework, since a results framework should be based on a clear analysis of proposed actions and desired changes at each level of the results chain. Therefore, the two documents are directly linked, with the results framework covering the same inputs, outputs, intermediate outcomes,

outcomes, and impacts. A preliminary set of indicators at each of these levels is included in [Annex 10](#), but these can only be finalized once the processes around indicators for the SDGs and updated Global Strategy for Women's, Children's, and Adolescents' Health are completed, as the GFF will use the indicators developed through these international processes to the maximum extent possible. For the same reason, it is not yet possible to include targets in the results framework. The finalized results framework will also include the data disaggregations that will be monitored. Determinations about disaggregation must be made individually for each indicator, but breakdowns will typically address age, sex, and income or wealth quintiles.

The results framework is a key component of the GFF's approach to accountability, as it provides a means to track progress globally. The GFF Investors Group will regularly review performance on the indicators in the results framework and use this to identify areas that are lagging and so require additional support.

Civil society will play an important role in accountability at both global and national levels, through the Investors Group, country platforms, and broader public dialogues. Different models for the social accountability function—which civil society is uniquely positioned to address—will be employed in different settings.

The results framework is a global document, but as mentioned in [Section 3](#) each Investment Case contains its own results framework that enables progress to be tracked at the country level. These results frameworks are tailored to the specific circumstances and approaches of each country and so inevitably differ. However, to ensure that GFF financing is results-focused, to strengthen global reporting,

and to enable comparability between countries so as to improve evidence-generation and the learning of lessons, a common set of indicators will be included in all Investment Case results frameworks. This set of indicators will be finalized upon completion of the SDGs and Global Strategy processes, as it will be drawn heavily from internationally agreed indicators.

ANNEX 1: List of Organizations Participating in the Oversight Group and/or Business Plan Team

African Health Budget Network
Bill and Melinda Gates Foundation
Government of Canada
Government of the Democratic Republic of the Congo
Government of Ethiopia
Family Planning 2020
Gavi, the Vaccine Alliance
Global Fund to Fight AIDS, Tuberculosis and Malaria
Government of Japan
J.P. Morgan
Government of Kenya
Government of Norway
Partnership for Maternal, Newborn, and Child Health (PMNCH)
Population Council
RESULTS
Save the Children
Government of Tanzania
United Nations Children's Fund (UNICEF)
United Nations Entity for Gender Equality and the Empowerment of Women (UN Women)
United Nations Population Fund (UNFPA)
United Nations Secretary-General's Office
United Nations Special Envoy's Office
Government of the United Kingdom
Government of the United States
World Bank
World Health Organization (WHO)

ANNEX 2: Methodology for the Resource Needs, Financing Flows, and Health Impacts

This annex describes the methodology for estimating resource needs and financing flows for RMNCAH, the effect of the GFF on both of these, and the health impacts related to the GFF. The bulk of the methodological approach was presented in the Concept Note that was released at the time of the announcement of the GFF in September 2014.²⁶ This annex covers both the original approach and the subsequent modifications to it.

A. Foundational Elements

The GFF approach to estimations is built on two recent modeling efforts that examine the impact of scaling up coverage for RMNCH: the Global Investment Framework (GIF)²⁷ for Women's and Children's Health led by the World Health Organization (WHO) and the Lancet Commission on Investing in Health (CIH)²⁸. Both these efforts were peer-reviewed and published their results and methodologies in *The Lancet*.

The GIF presented an “investment case” in 2014 that compared the health impacts and incremental costs of three scenarios for the period until 2035: (i) maintaining the present coverage but scaling up costs according to anticipated population growth (low scenario), (ii) gradually increasing coverage based on historical trends (medium scenario), and (iii) accelerating the scale-up to the pace achieved by top-performing low and middle-income countries (high scenario). This work was undertaken for 74 of the 75 countries highlighted in the Countdown to 2015 initiative; South Sudan was omitted from the analysis because of the absence of data.

The CIH built on this investment case and added some new approaches (e.g., factoring in the adoption of new tools and technologies over the course of the period) and some new diseases and populations (e.g., HIV and malaria in adults, tuberculosis, neglected tropical diseases) in the course of modeling the health impacts and incremental costs of two scenarios (current coverage and “convergence”, or accelerated scale-up). The CIH also examined the likely expansion of domestic financing for RMNCH in light of economic growth and increased

²⁶ World Bank, “Global Financing Facility in Support of Every Woman Every Child”, [Concept Note], 2014.

²⁷ Stenberg, K., et al., “Advancing social and economic development by investing in women's and children's health: a new Global Investment Framework”, *Lancet*, 2014, 383(9925): 1333-1354.

²⁸ Jamison, D., et al. 2013, “Global health 2035: a world converging within a generation”, *Lancet*, 2013, 382 (9908): 1898-955.

allocation of government budgets to health (which has typically been the case as countries experience economic growth).

B. Estimating Resource Needs

For the purpose of this Business Plan, the starting point for the estimates of the resource needs is the Global Investment Framework, which are based on country-by-country estimates derived from the OneHealth Tool. Needs are calculated for the incremental costs of scaling up coverage to the high scenarios starting from the current levels of coverage (low scenario). The implication of this is that the resource needs figures are not the total resources needed to address RMNCAH, but rather are the incremental needs. Costs related to health systems strengthening are frontloaded, which accounts for the drop in resource needs from 2024 to 2025.

Several changes are made to the GIF approach. Country-level data from GIF are adjusted from 2011 to 2013 constant US dollars using IMF country-level GDP deflators. A real inflation factor of 2 percent is applied to projected costs to account for expected increases in the cost of scaling up services and delivery. To reflect the impact of the rollout of anticipated future research and development, the methodology employed by CIH is used to factor in the costs of purchasing and scaling up new technologies. An incremental reduction of 2 percent is applied to the number of stillbirths, while declines in the maternal mortality ratio and under-5 mortality rates are accelerated by 2 percent.

The cost per death averted between the high- and low-coverage scenarios is then multiplied by the incremental number of lives saved from new technologies to estimate the cost of purchasing and scaling up new technologies. Costs of new technology scale-up are calculated at the income group level (low-income, lower-middle-income, and upper-middle and high income), with the per-country costs allocated based on countries' relative share of resource needs in their income group. The costs for basic investments in research and development are not included.

One of the key ways in which the GFF goes beyond existing initiatives is its focus on adolescents. GIF and CIH both include only limited estimates related to adolescents. For the GFF Concept Note, these partial estimates were used, although it was recognized that these are underestimates. For the Business Plan a more comprehensive approach was adopted to cover the health sector resource needs for the adolescent population (10–19 year old girls and boys). These are estimated in aggregate across all 74 countries for 2015 to 2019 and as a share of total RMNCH costs in 2015 and 2019. The additional percentage to be applied to RMNCH costs to account for adolescent health interventions is calculated for all years based on the 2015 and 2019 shares. The total RMNCAH resource needs is calculated by applying this percentage to the existing RMNCH estimates up to 2030 for the 63 countries on the GFF list. In the absence of a consensus about priority interventions for adolescent health and corresponding resource needs, estimates are limited to the available information about resource needs for sexual and reproductive adolescent health (SRH) as published by Deogan

et al. (2012)²⁹. These are likely a significant underestimate of the actual resource needs, as they do not include, for example, multisectoral interventions, which are particularly for adolescents. In addition, in order to avoid double counting of resource needs of 15–19 year-old women, which are already included in the original estimate of RMNCH resource needs and which would account for most of the SRH needs among all 10–19 year-olds, it is assumed that 20% of total adolescent costs reported by Deogan and colleagues are attributable to 10–14 year-olds, and 20% to 15–19 year-old boys.

This approach enables the calculation of resource needs in the absence of the GFF. However, a key element of the GFF approach is smart financing that improves the efficiency (both allocative and technical) of the RMNCAH response, particularly through the use of Investment Cases and health financing strategies. Therefore the resource needs are adjusted to account for efficiency gains as a result of the introduction of the GFF in those countries in which financing is made available. Efficiency gains are phased in with a five-year lag from the start of the GFF investments from the trust fund and IDA/IBRD, which reflects a conservative estimate of the amount of time it takes for system changes to start improving efficiency. The efficiency gains are assumed to increase by 1.25 percentage points per year (up to 20%, which is considered a conservative estimate³⁰). Efficiency gains are applied to an estimate of the total baseline need (taken from the GIF) and the incremental needs.

C. Estimating Financing Flows

The starting point for estimating financing flows is the work done by CIH on public financing. The first component of this captures the potential increase in public financing that relates to economic growth, since economic growth creates significant opportunities for increasing domestic financing for health. IMF projections of real GDP growth rates for each country are used through 2019, after which the simple average of projected growth rates for 2014–2019 is applied to 2020–2024. Between 2025 and 2027, all projected growth rates above 5 percent are dropped to 5 percent, while for 2028–2030, all growth rates above 3 percent are dropped to 3 percent. Should the recent trend of rapid economic growth in low—and middle-income countries begin to slow, the potential domestic financing flows could drop considerably.

In assessing the share of GDP directed toward general government expenditures on health (GGHE), it is assumed that countries would maintain existing (2012) proportions of GGHE (which are generally 2–3 percent of GDP), scaled each year by projected economic growth. This is a difference with the approach employed in the preparation of the Concept Note, which compared this base case with two scenarios related to increased prioritization of health. For the current exercise, this approach was replaced by the crowding-in effect of the GFF, as described below.

²⁹ Deogan, C., et al., “Resource Needs for Adolescent Friendly Health Services: Estimates for 74 Low- and Middle-Income Countries”, *PLoS ONE* 2012, 7(12): e51420.

³⁰ Chisholm, D. and Evans, DB, “Improving health system efficiency as a means of moving towards universal coverage”, World Health Report 2010 background paper #28.

It is also assumed, based on an estimate developed for the Countdown to 2015 process and employed by the Global Strategy for Women's and Children's Health, that countries allocate 25 percent of total GGHE to RMNCAH.

Incremental public financing estimates are then calculated relative to a 2015 baseline level (i.e., there is no incremental public financing in 2015).

Public financing estimates were unavailable for several of the Countdown countries: Comoros, Democratic People's Republic of Korea, Myanmar, Somalia, and Zimbabwe. Additionally, the exercise was limited to public financing because of data limitations related to private financing (both in terms of the share of private financing that is spent on RMNCAH and the evolution of private financing as a share of total health expenditure).

The second element is development assistance for health (DAH). This was not included in the Concept Note but has been introduced in the modeling for the Business Plan. Data for DAH are estimates of 2012 expenditure extracted from the OECD Creditor Reporting System using the Muskoka codes (and adjusted to 2013 US dollars).³¹ To avoid double counting, 70% of the estimate is included, based on research that has found that 30% of donor funding for health is on-budget (and so is included in the public financing estimates). Projecting DAH forward (particularly on a country-by-country basis) is a challenging exercise given the limited certainty about future estimates and the historical volatility of DAH. Therefore, in the base case scenario, DAH is kept constant up to 2015, with no incremental increase included in the model in absence of the GFF.

This approach enables the calculation of financing flows in the absence of the GFF. The introduction of the GFF has two effects on financing flows. The first is the direct effect: the introduction of financing from the GFF Trust Fund and from IDA/IBRD increases the resources available for RMNCAH.³² Financing from the GFF Trust Fund and IDA/IBRD is phased in over a four-year period from 2015 to 2018. The modeling is done for each individual country with the grant amount based on the resource allocation methodology described in [Section 5.A](#) and [Annex 8](#), with the maximum grant amount capped at US\$80 million (this estimate is slightly higher than the top end of the range of US\$10–60 million set out in [Section 5.A](#), but that is appropriate given the fact that resource modeling is done for the entire period over 2015 to 2030, and the figure of US\$10–60 million is explicitly considered an initial range that is tied to the availability of resources). Based on the historical track record of the HRITF, the ratio of grant financing to IDA/IBRD is 1:4.

The second effect—termed “crowding-in”—stems from the fact that the GFF provides scaled and sustainable financing: as a result of the introduction of GFF support in a country, domestic resources are mobilized and additional external assistance is attracted (and made more efficient through better planning and coordination). Historically, external assistance

³¹ Data on DAH are available for the five Countdown countries for which no public financing data are available, so these were included.

³² As noted earlier, allocations for RMNCAH from IDA/IBRD cannot be fixed at the global level but rather are determined by individual country governments. Therefore the estimated contributions from IDA/IBRD cannot be interpreted as commitments from the World Bank Group but rather are projections based on the historical track record of the HRITF. These estimates were checked against historical spending from the World Bank Group and found to be reasonable. Additionally, it is important to note that financing from IDA is dependent on future replenishments.

for health has resulted in a crowding-out effect, rather than a crowding-in one.³³ However, the GFF approach to external assistance differs considerably from previous efforts, including in the explicit bundling of support on health financing (including domestic resource mobilization) with grant funding. For the first five years of GFF support to a country, the crowding-out and crowding-in are assumed to be in balance, and there are no net effects. After five years of GFF support, crowding-in is calculated as a fraction of total domestic financing (general government expenditure on health taken from national health accounts, using the same assumptions discussed earlier that 25% is allocated to RMNCAH) and of total DAH for RMNCAH in a given country.³⁴ The fraction is initially set at 10% and increases by 1 percentage point per year thereafter.

In summary, this approach enables three discrete things to be calculated:

- The incremental domestic public financing flows for RMNCAH that stem from economic growth;
- The incremental domestic public financing that is generated by the presence of the GFF in a country generated by the presence of GFF in a country;
- The flows from the GFF Trust Fund and IDA/IBRD.

D. Estimating Overall Resource Gaps and GFF “Savings”

The basic calculation of the resource gap is simply the resource needs minus the financing flows calculated on the individual country level and aggregated.

The financing flows for RMNCAH are capped at a country’s total resource needs for that year, under the assumptions that countries would not rationally spend more than their total needs for RMNCAH. When financing flows reach the total resource needs cap, the sources of financing are assumed to be phased out in the following order: public financing, public crowding in, DAH, DAH crowding in, GFF Trust Fund and IDA/IBRD (i.e., public financing is the last to be capped).

This property also means that it is possible to project graduation from the GFF Trust Fund and IDA/IBRD. A number of countries that require GFF financing in the early years of the period eventually fully cover the resource needs and thus graduate from requiring support from the GFF.

These graduations and the accompanying shifts in resource needs reveal another important dimension to the modeling: the need for trust fund financing peaks in the early years and declines thereafter. In the base case scenario used in the modeling (which assumes that the

³³ Lu, C., et al., “Public financing of health in developing countries: a cross-national systematic analysis”, *Lancet*, 2010, 375 (9723): 1375–1387.

³⁴ Total rather than incremental flows are used for this because the GFF support influences the totality of RMNCAH financing in a country rather than simply the incremental amount.

size of grants from the trust fund remains constant over time), peak financing is attained by 2018 but is only maintained until 2022, after which the financing requirements decline steadily.

In addition, the total GFF “savings” can be determined by calculating the difference in the resource gaps between a scenario with and without the GFF. This provides an aggregate assessment of the impact of the GFF on both resource needs and financing flows (which because of the capping described above interact dynamically).

The timing of the introduction of financing from the GFF Trust Fund and IDA/IBRD emerges as a significant variable in these calculations. Frontloading of investments pays significant dividends: a rapid introduction scenario results in cumulative savings of nearly US\$12.5 billion when compared to a scenario of slow introduction, which comes from significantly greater efficiency gains as well as additional crowding-in. The base case scenario is a moderate scale-up, with the peak financing being reached after four years.

E. Estimating Health Impacts

The starting point for estimating the health impacts of the GFF is the projections done by the GIF. The GIF estimated the total number of deaths prevented using two approaches: lives saved from the scale-up of health interventions and deaths averted due to the scale-up of family planning. Deaths averted captures the fall in deaths attributable to a reduction in unwanted pregnancies and subsequent reduction in the number of births, while lives saved captures the fall in deaths that occurs as a result of health technology scale-up and subsequent decreases in mortality rates. Deaths prevented were then estimated as the sum of lives saved and deaths averted.

To reflect the anticipated health gains of adopting and scaling up future technological innovations, lives saved estimates from GIF were modified based on a similar method to the resource needs estimates. The annual reductions in under-five mortality rates and maternal mortality ratios were accelerated by a further 2 percent per year, while stillbirths were incrementally reduced by 2 percent per year. No other adjustments were made to the estimates of stillbirths prevented or under-five and maternal lives saved. Adjusted lives saved estimates were then added to GIF’s estimates of deaths averted due to scaling up of family planning to calculate the total number of deaths prevented from scaling up RMNCAH interventions.

This approach produces an estimate for the total deaths prevented from reaching high coverage. To calculate the share attributable to the GFF, two approaches were combined to provide a range of deaths prevented by the GFF. The first is based on CIH’s methodology: the incremental cost per death prevented (by income classification) is calculated and then applied to the incremental savings. The second is calculated based on the share of the total resource gap that the GFF is responsible for closing.

ANNEX 3: Methodology for the Investment Case

A. Scope

The Investment Case focuses on financing “best-buys”, particularly including the clinical and preventive interventions that have a strong evidence base demonstrating impact. A robust evidence base has developed around approaches such as family planning, iron and folic acid supplementation during pregnancy, and early initiation of breastfeeding and exclusive breastfeeding for six months.³⁵ The GFF also supports nutrition programming delivered through the health sector, given the important role that nutrition plays in improving health. In areas where the evidence base is less developed, such as around adolescent health, the GFF invests in the research needed to determine which approaches are most effective.

Clinical and preventive interventions can be grouped in a series of packages along a continuum that reflects the age of the clients and the setting for service delivery (as is depicted in Figure A as an example³⁶). As part of the development of the update of the UN Secretary-General’s Global Strategy for Women’s, Children’s, and Adolescents’ Health technical work is underway on packages of interventions. The approach used for the Investment Case will be updated accordingly based on this process.

However, the most efficient and effective ways to end preventable maternal and child deaths often involve approaches beyond direct RMNCAH interventions. Therefore, the GFF invests in broader health systems strengthening, such as around the health workforce, financing, or information systems. The GFF has the flexibility to make targeted investments in entirely different sectors, such as education, water and sanitation, social protection, or CRVS (which has both health and multisectoral elements) if these will have a significant impact on RMNCAH results.

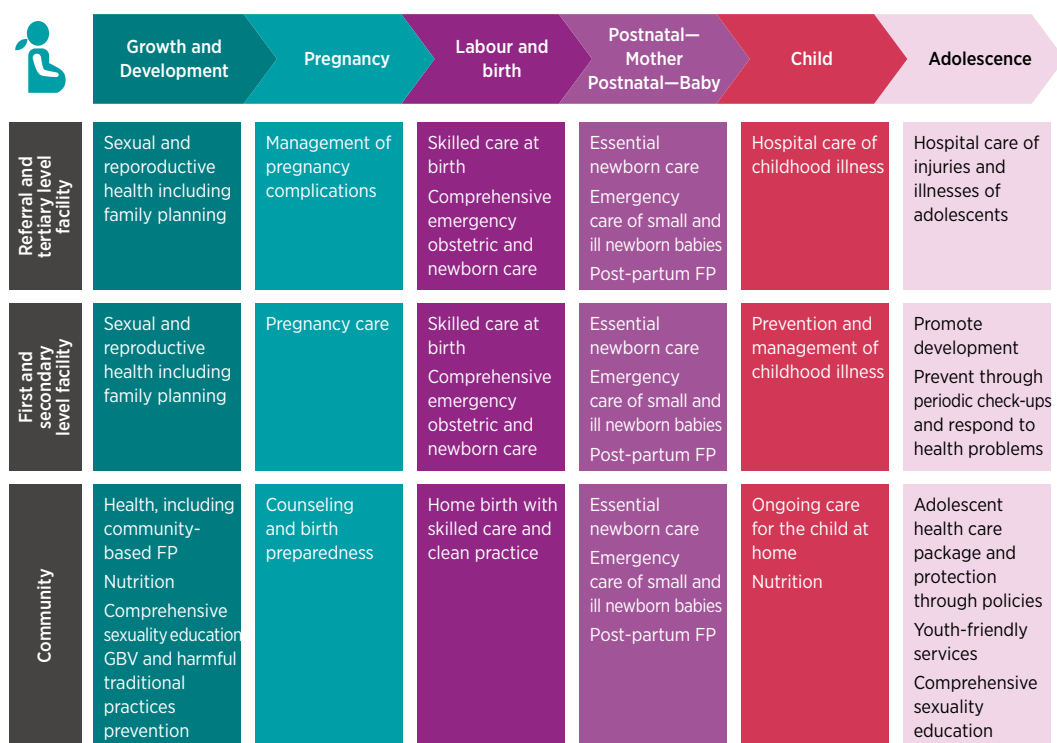
With regard to health systems strengthening, the World Health Organization describes six building blocks of a health system.³⁷ Investment Cases can address any of the six that play a key role in achieving progress on RMNCAH in a given country. For example, the procurement and supply chain for commodities for RMNCAH are often significant bottlenecks to achieving results, so Investment Cases include issues such as the procurement of commodities, capacity building in areas such as forecasting, procurement, and logistics, and monitoring of the availability and quality of commodities.

³⁵ See footnote 5.

³⁶ Adapted from Mason, E., et al., “From evidence to action to deliver a healthy start for the next generation”, Every Newborn paper 5, *Lancet*, 2014; 384: 455–67.

³⁷ World Health Organization, “Everybody’s Business: Strengthening Health Systems to Improve Health Outcomes”, 2007.

FIGURE A



On the health workforce, Investment Cases can include areas such as the quantity, skill, and distribution of human resources for RMNCAH, pre—and in-service training, and the provision of incentives to enhance retention and improve quality of care. Health information is another important area, such as around the collection and use of real-time data for planning, implementation, and performance management, including through strengthening health management information systems (e.g., DHIS2) and building links between these and national CRVS systems.

Health systems strengthening should also improve the resilience of health systems and build preparedness for emerging epidemics and pandemics as well as for other emergencies. The recent experience of Ebola in West Africa provided grim evidence of how women and children are particularly vulnerable and revealed the importance of building systems that are capable of coping with shocks such as the arrival of a new pathogen. This includes strengthening surveillance systems, building community health worker systems, and ensuring that mechanisms are developed to ensure continuity of care (particularly for vital, time-sensitive issues such as pregnancy) in the event of a catastrophe.

For multisectoral interventions, the emphasis is on those approaches that have a solid evidence base that show changes in health status as a result of the intervention. This includes interventions such as, in education, using conditional cash transfers to keep adolescent girls in school, comprehensive sexuality education, and deworming in schools, or in water, sanitation, and the environment, access to clean water and adequate sanitation, hand-washing, and reduction of indoor air pollution. With regard to nutrition, a significant proportion of

the child undernutrition burden can be addressed with a selected number of actions aimed at pregnant women and children under two years of age. A menu of evidence-based high-impact actions from which countries can choose based on their context has been identified through systematic evidence reviews.³⁸ In countries such as Madagascar, Peru, Senegal, and Thailand, these interventions have been financed, implemented, and scaled up and have achieved remarkable results. Furthermore, interventions aimed at reducing malnutrition are among the most cost-effective development actions.³⁹ Investments in nutrition have the potential to boost wage rates by 5–50%, make children 33% more likely to escape poverty in the future, and increase a country's GDP by 3–11% annually. Recent World Bank assessments of nutrition interventions in the Democratic Republic of the Congo, Nigeria, Togo, and Zambia showed that investing in evidence-based high-impact interventions has internal rates of return over 13% in each country.

CRVS is a key area that cuts across health systems strengthening and multisectoral interventions, and is fully integrated in the Investment Case.

Thus there is no minimum or maximum share of an Investment Case that a country can devote to health systems or to multisectoral interventions. As a general principle, though, the equity focus of the GFF means that it is important to ensure that a basic package of RMNCAH services is widely available, including to disadvantaged and vulnerable women, adolescents, and children.

All of the approaches are built on a foundation of equity, gender, and rights, which are mainstreamed throughout the GFF's work. The Investment Case must be built on a solid analysis of these issues that identifies which population groups experience differential vulnerability and access to services (whether as a result of place of residence, socio-economic status, race/ethnicity, occupation, gender/sex, religion, age, educational attainment, or disability status). The Investment Case should identify the barriers that prevent certain populations from getting and benefiting from the services they seek, and the gender norms and inequalities that exacerbate and sustain RMNCAH coverage gaps. The GFF also supports efforts by communities to mobilize themselves and advocate for their rights (including reproductive rights).

In addition to these technical elements, the Investment Case includes detailed costing of the interventions that have been prioritized. This is a critical element of the Investment Case, as it forms the basis for the subsequent process of determining how the government and key financiers can provide complementary financing. Finally, each Investment Case contains a results framework that sets targets for key indicators and so acts as a mechanism to promote accountability.

³⁸ Bhutta, op. cit.

³⁹ See, for example, World Bank. 2010. *Scaling Up Nutrition. What Will It Cost?* Washington, DC: World Bank; Hoddinott, J., et al., "The Economic Rationale for Investing in Stunting Reduction" *Maternal and Child Nutrition*, 2013, 9 (Suppl. 2): 69–82; and Horton S. and R. Steckel, "Global Economic Losses Attributable to Malnutrition 1900–2000 and Projections to 2050" in *The Economics of Human Challenges*, ed. B. Lomborg, Cambridge, UK: Cambridge University Press, 2013.

TYPICAL CONTENTS OF AN INVESTMENT CASE

1. Vision for 2030 results and the identification of the main obstacles to achieving them;
2. For the main obstacles, results to be achieved and key interventions over both the long- and short-term;
3. Costing;
4. Results framework based on a theory of change.

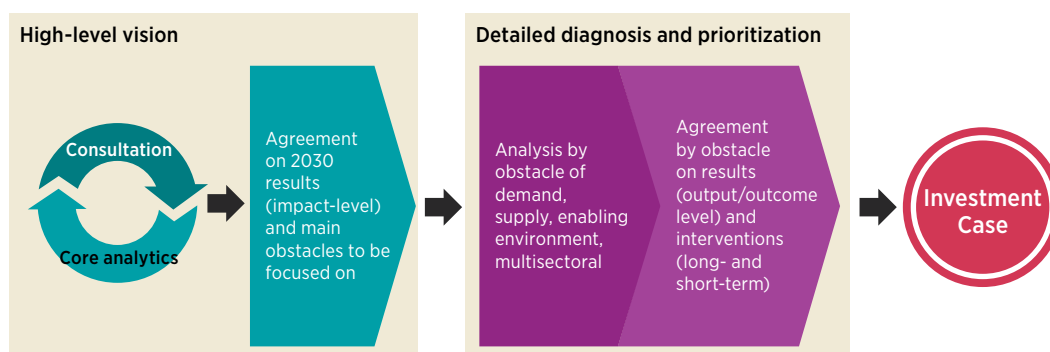
B. Key Steps

The development of an Investment Case typically involves several steps (see Figure B). However, in line with the principle of country ownership, the GFF approach is to be flexible and responsive to country contexts and ownership, and so not insist on rigid application of these steps. Instead, the GFF focus is on the objective—a rigorous analysis of data that enables an inclusive set of stakeholders to identify and prioritize the interventions that set a country on a course to achieving 2030 targets—not on a document.

In many countries, key elements of this are done in the context of IHP+ processes. Joint Assessments of National Health Strategies (JANS) in particular are valuable sources of information about national health strategies and systems.

The timing for the development of an Investment Case is determined by each country and varies considerably based on the availability of national strategic framework(s) and other in-country processes and planning cycles. In addition to promoting national ownership, another benefit of being flexible with regard to timing is that it enables countries to act opportunistically to take advantage of key events. Of particular importance here is the timing of the preparation of International Development Association (IDA) and International Bank of Reconstruction and Development (IBRD) projects. Since these are major sources of financing for Investment Cases, having Investment Cases prepared prior to the start of the preparations of IDA/IBRD projects is important to maximize the opportunities to use these as vehicles for financing the Investment Cases.

FIGURE B



Given the links to existing national processes, the duration of the preparatory process is variable, although it averages around four months.

STEP 1: AGREEMENT ON HIGH-LEVEL RESULTS TO BE ACHIEVED BY 2030 AND MAIN OBSTACLES TO BE ADDRESSED

The first step is agreeing on the 2030 vision of the RMNCAH results to be achieved. This is at the level of the goals that the country wants to achieve, typically in the form of changes in impact indicators (e.g., maternal mortality ratio, neonatal mortality rate, adolescent birth rate). Additionally, the process identifies the major obstacles in a country's health system—at sub-national as well as national level—that impede reaching these results. At a given time in any health system, there are many problems that can be addressed. The purpose of this exercise is to prioritize amongst these and select the focus areas that stakeholders, based on their assessment of the data, consider the most important.⁴⁰ Consideration of issues (e.g., family planning, nutrition) and target populations (e.g., adolescents) that have historically been neglected is particularly important at this stage.

The emphasis is on identifying the priority issues that must be addressed to get a country onto the trajectory needed to attain the relevant SDG targets and ensure universal coverage by 2030, rather than simply selecting among the existing areas of focus for RMNCAH programming in a given country. This approach shifts the conversation from simply being an assessment of what incremental progress is possible to a discussion of the trajectory required to attain the 2030 targets in a sustainable manner and what needs to be achieved in the medium-term to position a country to reach the longer-term targets. This means that the GFF process examines the possibility of prioritizing long-term transformational initiatives rather than solely concentrating on the incremental scaling-up of RMNCAH activities.

These long-term initiatives may focus on RMNCAH interventions, broader health systems changes (including around health financing and service delivery reforms) and/or multi-sectoral efforts that address key obstacles to end preventable deaths among women and children. As a result, in some countries Investment Cases include longer-term initiatives such as expanding financial risk pooling mechanisms that protect the poor and vulnerable, introducing a basic benefits package to be financed from public sources, or organizing private providers to ensure that they are formalized in the health sector, as over the longer-term these initiatives may play a more significant role in contributing to ending preventable deaths among women and children than incremental improvements in existing RMNCAH services. Experience from around the world has shown that these reforms are typically not completed in a single three to five year period, so the Investment Case covers the steps needed in the short—to medium-term to reach the long-term objectives (e.g., the initial policy reforms or investments in new technologies).

This emphasis on starting with the long-term results and working backward in a manner that is grounded in country realities means that the mix between RMNCAH results, health system reforms, and multisectoral interventions is shaped by where a country falls in the development

⁴⁰ It is important that stakeholders agree on the criteria for selecting results and obstacles prior to embarking on the process of identifying them, particularly since this decision often involves weighing competing normative principles (e.g., equity/solidarity vs. cost-efficiency).

continuum. In a country that is emerging from a conflict or that has experienced a recent catastrophe, the Investment Case might focus on frontline service delivery (particularly for disadvantaged and vulnerable women, adolescents, and children) and some of the basic building blocks of a health system. Conversely, in a rapidly growing lower-middle-income country, the Investment Case might instead concentrate on establishing a national health insurance scheme that shifts women and children away from a reliance on out-of-pocket expenditures toward a more equitable system.

The process for conducting step 1 varies from country to country but typically involves a multi-stakeholder consultative process that builds on strategic thinking in the sector (e.g., from existing health strategies) combined with a review of core analytics on health outcomes, service delivery, and the health system. Most countries already have a wealth of data available, including as a result of processes such as Joint Assessments of National Health Strategies, situation analyses for strategic planning, or joint annual health reviews. In a number of countries, it is not available in a form that facilitates decision-making across key areas and with adequate disaggregation to address issues of equity, which necessitates a specific exercise to bring together existing studies and evidence and to conduct additional analysis of existing data sets (including to ensure that issues of equity are fully explored). To the extent possible these analytics cover public, private, and non-profit providers, and include information that allows stakeholders to benchmark the performance of their country with other relevant reference countries. Additionally, particularly in contexts of decentralized health systems, sub-national data should be used.

The consultations should also be informed by key conclusions from the health financing assessment regarding current and expected (through 2030) budget envelopes for the health sector. A robust resource mapping is a critical input into the process of prioritization, since it determines the parameters for what is feasible. This should include both domestic and international resources.

The process of consulting and preparing core analytics is typically iterative. An initial set of core analytics usually informs the initial consultations but as issues emerge in the consultative process additional data analysis is required, which feeds into subsequent consultations, ultimately leading to national agreement on the key results to be attained by 2030 and the main obstacles to achieving them. Further details on the methodology are contained in the table below.

TABLE A: Examples of key sources of information, questions, and outputs

| | Process | Source of information | Results/questions to answer | Output |
|---|---|--|--|---|
| Step 1: Agreement on high-level results to be achieved by 2030 and main obstacles to be addressed | Core analytics This involves the production of user-friendly information in three areas: health outcomes, service delivery and the overall health system | Poverty assessments with health modules Population-based surveys (e.g., Demographic and Health Surveys, Multi-Indicator Cluster Surveys) Joint Assessment of National Health Strategies (JANS) Service Provision Assessments National Health Accounts Public expenditure reviews Public expenditure tracking surveys Private sector assessments | How have key health outcomes, including RMNCAH, changed over time (by geographical areas, socioeconomic groups)? How is the health system and service delivery organized? (supply [public, private and NGOs], demand, and operating environment) What are the major demand-side barriers? How does the country compare to other relevant reference countries? How does the organization of the country's health system and service delivery models compare to other functioning health systems? Where do we see the weakest links in the health system to address the 2030 vision? Which areas (e.g., family planning, nutrition) have historically been underinvested in but have significant potential to contribute to RMNCAH outcomes? | Provide user-friendly information to inform stakeholder consultations |
| | Stakeholder consultation Focus on reaching agreement on the 2030 vision and a few high level obstacles of focus to reach the vision | In-country facilitated consultations, data and user-friendly core analytics (including key elements of the health financing assessment) | What is the 2030 vision for RMNCAH results (impact level)? How will the poorest 40% benefit? To reach the 2030 vision, which are the main obstacles that need to be resolved? How will the resolution of the main obstacles contribute to the RMNCAH agenda? | 2030 vision including a selected number of high level obstacles of focus to reach the vision |
| Step 2: Detailed diagnostics and strategy formulation | Supply Analysis: This analysis studies the existing actors (public/ NGO/private) involved in the particular subsector of interest, their characteristics and challenges they face | Service Provision Assessments Private sector assessments Public expenditure tracking surveys | Who are the key public/private/non-profit actors addressing this (by subregion)? • Size, scope of subsector • Efficiency/quality in delivering health care services/products by providers/actors • Challenges/constraints | Specific solution sets as well as results (outcome and output levels) for the short term (3–5 years) and the long term (up to 2030) |

| | Process | Source of information | Results/questions to answer | Output |
|---|---|---|---|--------|
| Step 2: Detailed diagnostics and strategy formulation (continued) | Demand analysis: This analysis studies the poor/underserved/marginalized populations and describes their health needs, health seeking behavior, barriers to access and context in particular sub-market | Census data Socio-economic studies Poverty assessments with health modules Livelihood analysis with health modules Consumer research | Who are the poor/underserved/marginalized? • Size • Location What is their socio-economic profile? • Disposable income • Household composition, characteristics • Health decision-making • Financial decision-making, willingness and ability to pay What is their demand for health? • Demand for specific services and products • Unmet demand for specific services and products • Provider preference/perceived quality of providers What are the roles of gender, age, and other determinants of health in demand? | |
| | Enabling environment: This analysis examines the legal, policy, and regulatory frameworks | Reviews of laws, policies, and regulations Interviews with providers and consumers and those that regulate the subsector and define the rules of the game | What are the rules of the game for providers in the subsector? • Relevant formal/informal regulations and norms that shape the rules • Barriers to entry • Competition/crowding-out among providers • Asymmetry of information What's the subsector structure? • Number of providers (public, private, non-profit) • Concentration of providers • Range of services delivered • Prices of services | |
| | Factors outside the health sector: This analysis considers potential factors outside the health sector that affect health, such as social determinants | Analyses of gender, human rights, environmental factors and other social determinants of health (e.g., from sociological and anthropological research) Review of key documents from other sectors and interviews with stakeholders | How can expansion of civil registration and vital statistics (CRVS) contribute to resolving the obstacles? Are target populations and providers affected by issues outside of the health sector? How do issues related to women's empowerment come into play? What are the contributions of sectors such as education, water and sanitation, and agriculture to resolving the obstacles? How do security threats come into play? | |

STEP 2: DETAILED DIAGNOSIS AND PRIORITIZATION

The next step in the process is to conduct a detailed analysis of each of the main obstacles identified in the first step. This drilling-down considers four main components for each obstacle:

1. Supply factors (e.g., characteristics related to providers including the constraints that they face in their operating environment such as inadequate staffing, insufficient training, and lack of availability of key commodities);
2. Demand factors (e.g., characteristics of target populations, including the challenges they face with regard to health care, including inability to access services because of financial barriers and sociocultural norms that inhibit engagement with the health sector);
3. The enabling environment (e.g., policy or regulatory frameworks that impede progress; governance issues that result in wastage or inefficiencies);
4. Factors outside the health sector important to understanding the obstacle, including social determinants of health (e.g., gender norms, insufficient data for decision-making in health and other sectors due to poor CRVS systems, weak sanitation systems undermining the effectiveness of disease control measures).

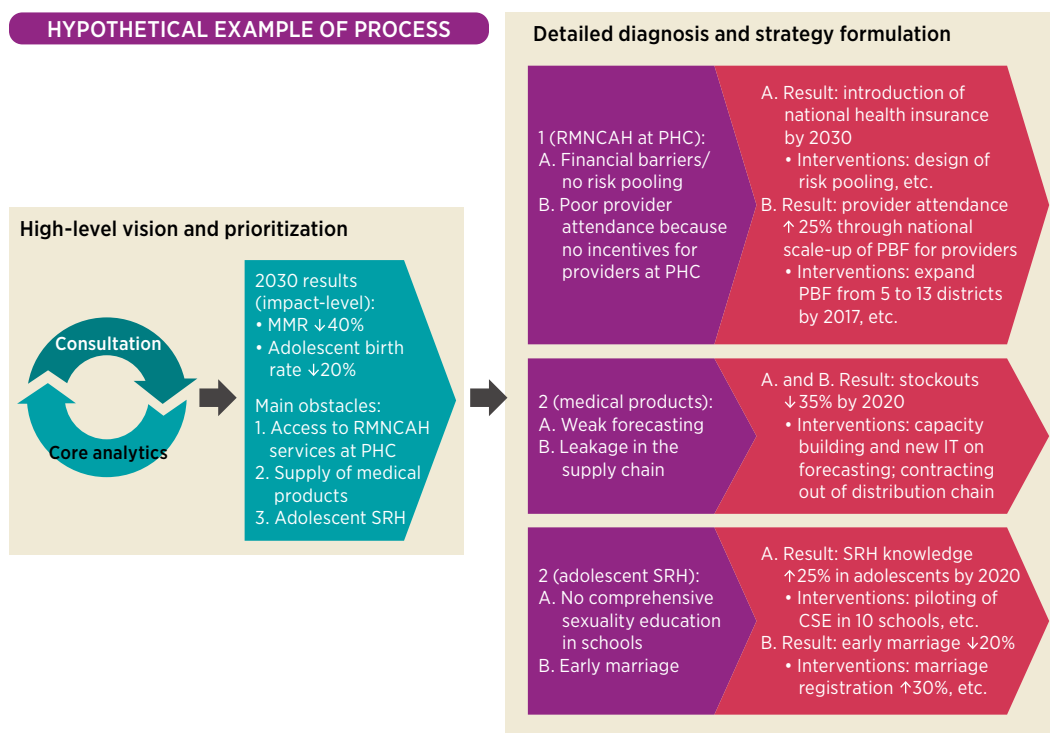
As with the first step, this is intended to be a data-driven exercise. A particular emphasis is on understanding the situation and trends with regard to issues (e.g., family planning, nutrition) and target populations (e.g., adolescents) that have historically been underinvested in. Equity considerations are also focused upon at this stage. In many countries, doing this rigorously requires sub-national analyses to be able to understand drivers of differences between provinces/states and even districts.

This process leads to a clear sense of what results the country wants to achieve with regard to each obstacle. These results are at a lower level than in step 1, and so are typically outcomes and outputs rather than impacts. In keeping with the GFF's equity focus, a particular emphasis is placed on ensuring that marginalized and underserved groups are proactively focused upon and so that coverage gaps are closed.

Clarity on the desired results enables the formulation of solution sets for each obstacle, which cover the package of interventions required both in the long—and short-terms required to overcome the obstacle. More detail is inevitably included on the short-term solutions than on the long-term ones, but the interplay between the two is important: the short-term interventions are intended to position a country on the trajectory to achieve long-term goals, so it is important that short-term steps are situated in a longer time horizon so as to ensure that they advance rather than set back the broader vision. These solutions should build on what has been demonstrated to work in a given country. The balance between RMNCAH service delivery, health systems strengthening, and multisectoral responses is dependent on the nature of the obstacle to be addressed.

In addition to comparing interventions, the prioritization process also addresses the shifts needed in service delivery to overcome the obstacle in question. This encompasses both the mode of delivery (e.g., public, private, or non-profit) and the location of delivery (e.g., facility, community, or household). In addition, it also highlights the changes in service delivery that must be introduced to achieve long-term results. This can include areas that are directly

FIGURE C



related to RMNCAH (e.g., task-shifting, introduction of a reimbursement mechanism that pay for RMNCAH results) but may also involve broader shifts that result in significant benefits to women and children (e.g., regulatory reforms that improve the private sector’s access to credit and therefore their ability to operate facilities in low-income areas). Figure C shows a hypothetical example of how the entirety of the process works in practice.

To tie these disparate elements together, an Investment Case typically also contains a clear theory of change that demonstrates how all of the parts contribute to setting a country on the path toward achieving the long-term vision. This is useful for ensuring that the package of solutions identified is truly sufficient to reaching the intended targets. A theory of change is also important for preparing another key element: the results framework. This includes indicators, targets, and data sources to enable regular assessments of the progress in following through on an Investment Case, which promotes mutual accountability for results.

The final element of the process is costing, although it is important that this is not treated as an afterthought, since it provides critical information that is factored into the decision-making around which solutions sets should feature in the Investment Case. The decision-making process weighs not only the technical effectiveness of different interventions but also the extent to which they represent value for money and are feasible within the projections emerging from the health financing assessment regarding projected health expenditure and fiscal space for health in the future. Therefore, in practice costing data are used as inputs into the prioritization decision-making, rather than simply applied to the results of the prioritization process.

There is not a specific GFF process for costing. Instead, countries use approaches that are tailored to their national contexts, as long as these are in line with international good practice. A number of tools have been developed in recent years (e.g., the OneHealth Tool, the Marginal Budgeting for Bottlenecks tool) that can facilitate this process, although these need to be complemented by additional analytic work in-country. Given the historical underinvestment in CRVS, ensuring accurate assessments of CRVS costs is an important element of the process.

As described in [Section 3.A](#), the Investment Case is subject to independent quality assurance that is intended to help improve its quality. The model for quality assurance is being developed based on the experience in the frontrunner countries but will have two elements: a process component that details the steps that are taken with regard to independent review and a set of guidelines that specify minimum standards for Investment Cases. The process element will address how the independent review will be conducted, including the entities involved and the assessment standards. The guidelines will set clear expectations for the contents of the Investment Case, including minimum standards for key areas, particularly those that have historically been underinvested in, such as family planning and nutrition. This will include expectations that are tied to a country's epidemiological context and the current coverage of interventions (e.g., a country that has a very low modern contraceptive prevalence rate will face higher expectations with regard to the prioritization of family planning in the Investment Case than a country that already has a high rate).

STEP 3: COORDINATED IMPLEMENTATION

Implementation proceeds using the normal operating procedures for each of the partners involved. Thus the government uses its standard rules, regulations, and approaches, while the World Bank Group, the Global Fund, and Gavi each follow their own guidelines, as do bilateral partners.

In addition to agreeing to a repartition of financing for the Investment Case, the major financiers also commit to ongoing coordination over the course of implementation. The form of this coordination varies between countries depending on the particular stakeholders involved but can range from informal discussions and sharing of information to joint missions and reviews to full-fledged coordination structures (e.g., akin to sector-wide approaches).

Another key element during implementation is the coordination of technical assistance and capacity building, which is discussed in [Annex 5](#).

ANNEX 4: Health Financing Strategies

A. Scope

Health financing strategies encompass the entire health sector rather than focusing solely on RMNCAH, as it would be inefficient or even impossible to address a number of key components (e.g., establishing or expanding a health insurance scheme, reforming public financial management, or strengthening revenue generation through improved tax systems) exclusively for RMNCAH. The approach also situates the health sector within broader social sector financing, which in turn is embedded within government financing, which itself is examined in the context of general macroeconomic trends.

The three major functions of health financing are all considered in the work on financial sustainability: domestic resource mobilization, risk pooling and purchasing. All major sources of financing are considered: public and private, domestic and external, on—and off-budget, and central and local.

B. Key Steps

As with the Investment Case, the work on sustainability is often associated with a tangible product—a health financing strategy (see box)—but the GFF approach is not concerned with

TYPICAL CONTENTS OF A HEALTH FINANCING STRATEGY

1. Vision, guiding principles, goals, and objectives;
2. Country context and main challenges;
3. Approach (e.g., concepts, evidence, framework, theory of change);
4. Specific strategies (by health financing function, including changes to overarching legislative and regulatory frameworks);
5. Implementation phases and sequencing;
6. Roles and responsibilities for implementation of specific strategies;
7. Monitoring, implementation research, and reviews.

the production of a particular document but rather with ensuring that a country embarks on a pathway to long-term sustainability in a manner that is based on rigorous analysis and a participatory process that results in agreement on reform priorities. Many countries already have some of this work completed. Therefore, the steps below are intended to be indications of an approach rather than rigid rules that must be followed.

Close collaboration between ministries of health and of finance is essential for the success of a health financing strategy, so this is a major area of emphasis for the GFF. Other actors that are important for financing, such as legislative bodies, are also engaged with in the process. These efforts ensure that the work is relevant to and feed into national planning processes.

STEP 1: HEALTH FINANCING ASSESSMENT

The first step in the process is typically a health financing assessment, which examines all aspects of health financing in a country: the sources of financing, the design of the financing system, the policies governing the various functions of health financing, the processes and capacities, and political economy considerations.

The availability of data about sources of financing has improved considerably in recent years. In many countries, national health accounts cover both public and private sectors, public expenditure reviews and public expenditure tracking surveys contain considerable detail about the public sector, and dedicated private sector assessments provide granularity on the private sector. Historical trends across these sources are analyzed, so as to understand, for example, if development assistance substitutes for domestic financing (as research has shown is often the case) or is additional to it. In addition to reviewing historical data, the assessment is also forward-looking, including projections of resource needs, health sector allocations, general government revenue, and economic growth.

The assessment reviews key aspects of the design of the financing system, including the institutional, legal, and regulatory setup, the structure of pooling, and the division of roles and responsibilities. This addresses matters such as whether purchasing and providing functions are integrated or split, and how different structures within health financing (e.g., a ministry of health and an independent national health insurance schemes) relate to each other and are governed. Similarly, the policies that cover health financing are included in the assessment. This covers areas such as government revenue, benefits packages, the structure of pooling, payments systems, and provider autonomy (in both public and private sectors).

With regard to processes and capacities, the assessment examines the basics of public financial management, including budget formulation, execution, accounting, reporting, and monitoring. Capacities in areas such as human resources and procurement are reviewed. In systems with purchaser-provider splits, the assessment looks at provider contracting and payment mechanisms and the system's ability to track outputs and outcomes. Decisions about health financing systems are often determined by political economy considerations, so the assessment looks at these as well.

Finally, the assessment examines two issues in a cross-cutting manner: efficiency and equity. With regard to efficiency, the assessment focuses on major potential drivers of inefficiency,

such as the mechanism of revenue collection (e.g., the extent to which tax and contributory systems are open to evasion), the design of the benefits package (e.g., the extent to which interventions are assessed for cost-effectiveness), fragmentation in pooling (which is often associated with duplication of responsibilities and suboptimal incentive structures), public financial management (e.g., around budget execution), the performance of disease-specific programs, and the financial incentives for efficient service delivery.

On equity, the assessment prioritizes two main issues: the extent to which government revenue policies and practices are progressive or regressive (including both general tax policy and specific health financing mechanisms such as point-of-service payments) and the expenditure patterns (e.g., by financing schemes, geography, and socio-economic groups).

Most countries already have key elements of the health financing assessment, so the GFF approach builds on what exists rather than duplicating efforts and focuses on addressing gaps in data and analysis. This requires the engagement not only of different parts of the national government but also of all major development partners.

This approach enables the development of a comprehensive picture of the state of health financing and the future prospects for it. Additionally, the use of a common approach based on the same parameters in each country means that a country can readily see how it compares with its neighbors or other countries in which an assessment has been carried out. This kind of informal benchmarking can be useful for identifying areas on which a country can learn from the experience of other countries and that may require particular attention in the health financing strategy.

STEP 2: DEVELOPMENT OF A HEALTH FINANCING STRATEGY

The next step is to use the health financing assessment to develop a roadmap for the sustainable financing of the 2030 targets for RMNCAH in the context of a broader push for universal health coverage. This strategy includes the health financing reforms set out in the Investment Case but covers a broader set of issues, as it addresses the three major functions of health financing (revenue mobilization, pooling, and purchasing).

With regard to the mobilization of resources, the GFF supports countries to prioritize between the range of possible approaches, such as strengthening general government revenue mobilization, increasing the share of general government expenditure devoted to health and other social sectors, attracting private capital to invest in healthcare, merging or coordinating different revenue streams, using innovative financing mechanisms, and employing development assistance for health in ways that lead to increased domestic resource mobilization.

Two key criteria for this process are efficiency and equity. Efficiency must be examined both from the perspectives of general public financial management and in the specific context of health financing. Addressing efficiency has the potential simultaneously to return significant resources to productive use in the health sector and to strengthen the arguments in favor of allocating more of general government revenue to health.

Equity is also an important criterion for comparing between different approaches to increasing domestic resource mobilization. Most importantly, poor women, adolescents, and children are often particularly disadvantaged by health systems that rely heavily on out-of-pocket expenditures to finance service delivery, as this tends to reduce access and increase the risk of incurring catastrophic health expenses as the result of an illness or injury.

One additional important element on domestic resource mobilization is that the strategy should cover not only how to increase resources but also how to respond in the event of an economic or financial crises. In particular, the imposition of uniform across-the-board budgetary cuts can have significant impacts on RMNCAH, so it is important to develop approaches to protect budgets for essential health services for women and children in the event of a crisis.

The second major function of a health financing system is risk pooling. The health financing strategy examines the role of risk pooling in reaching the relevant SDG targets and achieving universal health coverage, and sets a direction for the country. Significant changes to risk pooling (e.g., the introduction of a national health insurance scheme) typically take years to come to fruition, but their benefits can be very large: in a country that has historically relied heavily on out-of-pocket expenditures by individuals, the introduction of a national health insurance system can dramatically increase access to the formal health sector on the part of poor women and children, resulting in major improvements in health outcomes.

The process of prioritizing between different approaches to pooling also examines efficiency and equity. A key element of this is the size of the pool(s): larger pools are better from both equity and efficiency perspectives, as they spread risk more effectively while facilitating the use of subsidies to ensure equity (and also contribute to enabling strategic purchasing, as discussed below). However, in many countries, pools are highly fragmented, which means that an important component of the health financing strategy is the development of approaches to merge pools. Ensuring heterogeneity in the mix of risks across pools is also an important element for efficiency and sustainability.

The final major function of a health financing system is purchasing, or the process of contracting and paying providers for services. Purchasing arrangements can be significant sources of inefficiency within health systems and so improving purchasing can be an important means to finance the expansion of service delivery.

The key issues with regard to purchasing vary considerably depending on where a country falls on the development continuum. In many low-income countries, for example, the functions of purchasing and providing health services are both carried out by a single institution, such as a ministry of health. In such cases, the major issues with purchasing often relate to basic public financial management, such as budget execution, monitoring and accountability.

In countries that have split purchaser and provider functions, there is growing evidence on “strategic” purchasing. In contrast to “passive” purchasing (spending based on historical patterns or in response to bills presented or according to a predefined budget), strategic purchasing allocates resources based on health needs and the performance of service providers. In the process of developing a health financing strategy, the different approaches to purchasing across both public and private providers are compared and assessed (see the box on how to harness the private sector).

HARNESSING PRIVATE SECTOR PROVISION

The private sector is a major provider of health services in most countries, but strengthening it and improving its efficiency rarely features prominently in health financing strategies. The GFF approach is comprehensive, so health financing strategies address improvements in a range of mechanisms for harnessing private sector provision are considered, including:

1. Market entry regulation;
2. Infrastructure planning and certification;
3. Private sector investment/public-private partnerships;
4. Licensing and accreditation of providers and/or health facilities;
5. Provider contracting and payment methods;
6. Routine reporting from providers.

An important issue with regard to both equity and efficiency of purchasing is the definition of explicit benefits packages. For the purposes of improving RMNCAH outcomes, benefits packages should cover at least the essential set of services across the continuum of reproductive, maternal, newborn, child, and adolescent health that is contained in national RMNCAH frameworks. While explicit definitions of benefits packages empower beneficiaries, health financing strategies also include reforms to address demand-side barriers directly. These include mechanisms such as vouchers, conditional cash transfers, and other social protection schemes.

Finally, health financing strategies address the challenges of external financing, including the management of transaction costs (e.g., through promoting joint financial management platforms) or the smooth transition from external to domestic financing of priority disease programs, such as vaccine-preventable diseases, AIDS, tuberculosis, and malaria. In this latter effort, strategies also focus on building the capacity to integrate the delivery systems developed with external support, from managing supply chains to contracting private providers.

STEP 3: IMPLEMENTATION

The health financing strategy defines not only the strategic approaches to be employed, but also the legal, policy, and regulatory reforms needed to achieve progress. In many cases, health financing reforms also require the establishment of new institutions (or the revision of the mandates of existing ones), such as a purchasing agency or a regulator, and these plans are set out in the strategy.

A health financing strategy is not a document that can simply be implemented as drafted, as it is intended to take a high-level, long-term perspective. Therefore, the strategy is transformed into implementation plans, which often requires additional analyses to explore fully the complexities of the tradeoffs in designing specific activities. These plans cover a shorter time period (typically three to five years, in line with political or planning cycles such as

medium-term expenditure frameworks). Ideally, the first implementation plan focuses on the same period addressed by the Investment Case, to ensure that the two work in tandem.

Implementation plans delineate clearly the roles and responsibilities of different actors, and set realistic timetables for key steps. The approach to monitoring, evaluation, and implementation research is also included in the implementation plan. Importantly, these plans are costed, such that the financial implications of reforms are clear. As a result of containing these kinds of operational details, the plans also facilitate the coordination of support from partners, both financial and technical, as described in [Annex 5](#) on technical assistance.

ANNEX 5: Technical Assistance and Capacity Building

Technical assistance and capacity building are important for developing and implementing both Investment Cases and the health financing strategies.

Technical assistance covers areas such as providing technical guidelines and standards, sharing good practice, identifying and overcoming bottlenecks in the course of implementation, and supporting monitoring and evaluation. As a general principle, the GFF approach prioritizes the delivery of technical assistance in ways that build sustainable capacity and transfer skills. This includes activities such as:

- Training new staff and building the capacity of existing staff:
 - Learning programs in health financing (e.g., the World Bank flagship course, online courses);
 - Fellowships (e.g., the Overseas Development Institute fellows);
 - Professional networks and associations;
 - Accreditation programs;
- Supporting the strengthening of institutions:
 - Twinning programs and partnerships (North-South and South-South);
 - Local think tanks;
 - Training initiatives based in low—or lower-middle-income countries;
- Building an environment conducive to capacity development:
 - Research to provide local evidence;
 - The Joint Learning Network;
 - Development of appropriate incentives (e.g., technical career paths within and across ministries, establishment of strong links between academia and government, incentives to stop/reverse brain drain);
 - Mechanisms to place human resources where they can best be employed.

A number of partners and initiatives currently provide technical assistance for RMNCAH, and these play key roles in the context of the GFF. UN agencies such as UNFPA, UNICEF, and WHO, for example, provide support in line with their mandates and have mechanisms such as H4+ to help coordinate and improve technical assistance. South-South cooperation is another important ways for technical assistance to be provided. A growing number of local organizations—non-profit, academic, and for-profit—also play important roles in the

provision of technical assistance. With regard to CRVS, the Center of Excellence will make links between those seeking support to build capacity in CRVS and those able to provide this kind of capacity building.

Technical assistance is financed in a number of ways. In some cases implementers such as national governments use their own resources or external assistance to purchase technical assistance. In other instances, partners have core funding to provide technical assistance or receive dedicated resources from donors to deliver support. As the Investment Case process expands, resource needs for technical assistance will grow and so are likely to require specific additional commitments from financiers.

ANNEX 6: Minimum Standards for Country Platforms

The GFF requires that all country platforms embody two key principles (in addition to respecting the overarching GFF principles described in [Section 1](#)): inclusiveness and transparency. To support countries to operationalize these principles, the GFF has established minimum standards that countries are expected to adhere to:

- Inclusiveness: full involvement of all key constituencies in the processes of:
 - Preparing the Investment Case and the health financing strategy, including attending meetings, receiving and contributing to the preparation of materials, determining the approach to quality assurance for the documents, and endorsing the final version;
 - Agreeing to changes to the Investment Case and/or health financing strategy in the course of implementation;
 - Determining the approach to technical assistance and capacity building to support implementation of the Investment Case and health financing strategy;
 - Receiving and reviewing data about performance in the course of implementation.
- Transparency: making public the following documents:
 - Minutes of meetings at which Investment Cases and health financing strategies were developed (including documentation explaining decisions around the prioritization of particular interventions/approaches);
 - The final Investment Case and health financing strategy;
 - Agreements between financiers about which elements each will cover;
 - Disbursement data from each financier;
 - Progress reports on the achievement of targets in the results framework;
 - Evaluation reports.

ANNEX 7: List of Countries Eligible for GFF Financing

| Country | World Bank Income Classification | World Bank Lending Category |
|---------------------------------------|----------------------------------|--|
| Afghanistan | Low-income country | IDA |
| Bangladesh | Low-income country | IDA |
| Benin | Low-income country | IDA |
| Burkina Faso | Low-income country | IDA |
| Burundi | Low-income country | IDA |
| Cambodia | Low-income country | IDA |
| Central African Republic | Low-income country | IDA |
| Chad | Low-income country | IDA |
| Comoros | Low-income country | IDA |
| Democratic People's Republic of Korea | Low-income country | Not a member of the World Bank Group and so not eligible for financing from the GFF Trust Fund |
| Democratic Republic of the Congo | Low-income country | IDA |
| Eritrea | Low-income country | IDA |
| Ethiopia | Low-income country | IDA |
| Gambia | Low-income country | IDA |
| Guinea | Low-income country | IDA |
| Guinea-Bissau | Low-income country | IDA |
| Haiti | Low-income country | IDA |
| Kenya | Low-income country | IDA |
| Liberia | Low-income country | IDA |
| Madagascar | Low-income country | IDA |
| Malawi | Low-income country | IDA |
| Mali | Low-income country | IDA |
| Mozambique | Low-income country | IDA |
| Myanmar | Low-income country | IDA |
| Nepal | Low-income country | IDA |
| Niger | Low-income country | IDA |
| Rwanda | Low-income country | IDA |
| Sierra Leone | Low-income country | IDA |
| Somalia | Low-income country | IDA |
| Tajikistan | Low-income country | IDA |
| Togo | Low-income country | IDA |

| Country | World Bank Income Classification | World Bank Lending Category |
|-----------------------------|----------------------------------|-----------------------------|
| Uganda | Low-income country | IDA |
| United Republic of Tanzania | Low-income country | IDA |
| Zimbabwe | Low-income country | Blend |
| Bolivia | Lower-middle-income country | Blend |
| Cameroon | Lower-middle-income country | Blend |
| Congo | Lower-middle-income country | Blend |
| Côte d'Ivoire | Lower-middle-income country | IDA |
| Djibouti | Lower-middle-income country | IDA |
| Egypt | Lower-middle-income country | IBRD |
| Ghana | Lower-middle-income country | IDA |
| Guatemala | Lower-middle-income country | IBRD |
| India | Lower-middle-income country | IBRD |
| Indonesia | Lower-middle-income country | IBRD |
| Kyrgyzstan | Lower-middle-income country | IDA |
| Laos | Lower-middle-income country | IDA |
| Lesotho | Lower-middle-income country | IDA |
| Mauritania | Lower-middle-income country | IDA |
| Morocco | Lower-middle-income country | IBRD |
| Nigeria | Lower-middle-income country | Blend |
| Pakistan | Lower-middle-income country | Blend |
| Papua New Guinea | Lower-middle-income country | Blend |
| Philippines | Lower-middle-income country | IBRD |
| Sao Tome and Principe | Lower-middle-income country | IDA |
| Senegal | Lower-middle-income country | IDA |
| Solomon Islands | Lower-middle-income country | IDA |
| South Sudan | Lower-middle-income country | IDA |
| Sudan | Lower-middle-income country | IDA |
| Swaziland | Lower-middle-income country | IBRD |
| Uzbekistan | Lower-middle-income country | Blend |
| Vietnam | Lower-middle-income country | Blend |
| Yemen | Lower-middle-income country | IDA |
| Zambia | Lower-middle-income country | IDA |

ANNEX 8: Resource Allocation Methodology and Roll-Out Costing

In order to maximize impact globally, the trust fund has developed a resource allocation methodology for allocating resources among the 62 eligible countries. This uses three criteria to allocate resources among countries: need, population, and Income.⁴¹

(In contrast to the approach to dividing resources between countries, the GFF Trust Fund does not make a proactive repartition of its resources between different objectives [e.g., maternal or child health], interventions [e.g., family planning], or target populations [e.g., adolescents]. Instead, in line with the broader principle that GFF is intended to build national ownership, national priority-setting with regard to objectives, interventions, and target populations [as manifested through Investment Cases] determines the splits between these. The only caveat to this is with regard to CRVS, as discussed in [Section 5](#).)

The metrics for population and income are straightforward: given the focus on the GFF, the indicator for population is females 0–19 years old while income is measured using the Atlas method for gross national income per capita. Need is more complicated as there is not a single metric for all of RMNCAH (including CRVS). Therefore a set of indicators has been combined to form a composite need index. The GFF aims to build on existing international agreements rather than duplicate efforts, so the indicators are taken from the 11 core indicators from the Commission on Information and Accountability (CoIA)⁴² as well as birth registration coverage, the indicator used to determine a country's CRVS status in the "Global Civil Registration and Vital Statistics Scaling Up Investment Plan 2015–2024".

It was not possible to use all 11 of the CoIA indicators because four of them have insufficient data availability. Therefore, the indicators included are:

- Maternal mortality ratio (deaths per 100,000 live births);
- Under-five child mortality (deaths per 1,000 live births);
- Percentage of children under five years of age whose height-for-age is below minus two standard deviations from the median of the WHO Child Growth Standards;

⁴¹ These criteria are not identical to the indicators that the GFF uses to track progress, either at the global or the country levels. These indicators are covered in Annex 10.

⁴² <http://everywomaneverychild.org/accountability/coia>. The CoIA indicators have several weaknesses, and so once the SDG process is completed and there is a new set of internationally agreed indicators, the indicator set will be modified. One specific concern is that they do not contain an indicator that focuses specifically on adolescents. Therefore consideration was given to including adolescent fertility rate, but this was ultimately not included both out of deference to the existing international consensus around the CoIA indicators and because the correlation between adolescent fertility rate and the composite index was quite high (>0.6), meaning that adding the indicator did not have a significant effect on the final outcome.

- Proportion of women aged 15–49 years who are married or in union and who have met their need for family planning;
- Percentage of HIV-positive pregnant women receiving antiretrovirals for prevention of mother-to-child transmission of HIV;
- Percentage of live births attended by skilled health personnel;
- Percentage of infants aged 12–23 months who received three doses of diphtheria/pertussis/tetanus vaccine).

These (and birth registration) were combined in an unweighted manner to form a composite need score for each country using the methodology from UNDP’s Human Development Index⁴³ (and subsequently widely copied). In all cases (including for population and income), data were taken from international sources (the World Bank, WHO, UNICEF, and UNDESA).

The next step is to combine need, population, and income. To do so, the approach used to allocate IDA resources⁴⁴ was built on and adapted to the GFF context, with need replacing the “Country Performance Rating” in IDA and the weighting of need and population adjusted. The resulting equation is: $(\text{Need})^2 * (\text{population})^{0.5} * (\text{income})^{-0.125}$.

These indicators are combined with the resources available for allocation to produce a broad range for each country (e.g., between US\$10 and US\$20 million over five years for a country that has a low score on these criteria, or between US\$40 and US\$60 million for a country that scores highly). Having a range rather than a point estimate for each country is important in order to maximize the trust fund’s ability to be flexible, to incentivize financing from external and domestic resources, and to respond to changing external circumstances (e.g., a sudden increase or decrease in other external support). The final determination on the exact amount for each country is made in the course of negotiating a grant with a government.

Given the constraints of the current trust fund commitments, limits on these ranges have been established. It is expected that the smallest allocation will be no less than US\$10 million over five years, while the largest allocation is expected to be no more than US\$60 million over five years. These figures are directly related to the volume of financing currently available and represent a balance between, on the one hand, ensuring that the resources are significant enough to contribute meaningfully to a scaled response and to maximize the likelihood of leveraging additional financing, and, on the other hand, safeguarding against all of the current commitments being allocated to only a handful of countries so that the GFF approach can be employed in a number of settings. Both of these figures will be reassessed based on ongoing resource mobilization and the initial experience of the trust fund.

These ranges enable the total volume of resources needed for the roll-out of GFF Trust Fund financing to be calculated. Using the resource allocation formula, each country is classified as high, medium, or low priority, with a different range for each:

- High: \$40–60 million;

⁴³ See, for example, United Nations Development Programme, “Human Development Report Technical Notes 2014.”

⁴⁴ See the International Development Association, “IDA’s Performance-Based Allocation System for IDA17” for further details of the IDA methodology.

- Medium: \$20–40 million;
- Low: \$10–20 million.

Based on these ranges, the calculation of the volume of resources needed to provide a single grant to each country is straightforward, totaling US\$2.59 billion. This approach should not be interpreted as suggesting that country will receive one and only one grant from the GFF Trust Fund. Rather, this calculation is intended solely to provide an indication of the resources required to reach all countries eligible for trust fund financing.

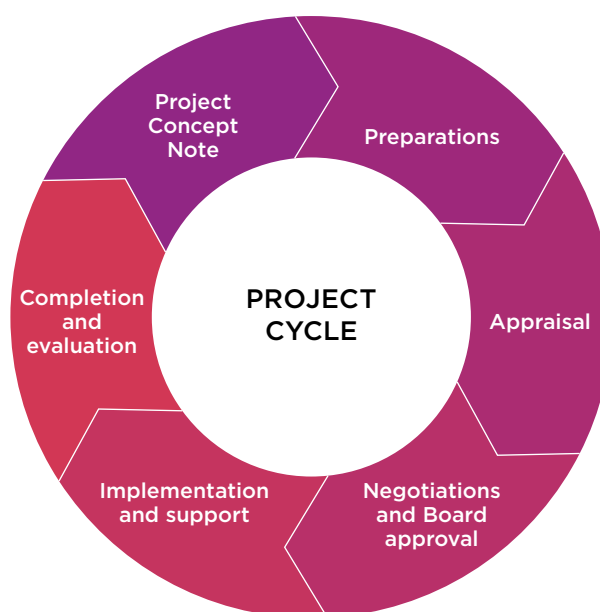
ANNEX 9: The GFF Trust Fund and World Bank Operations

The GFF Trust Fund has been established as a multi-donor trust fund at the World Bank. The implication of this structure—in contrast to an arrangement such as a Financial Intermediary Fund—is that the GFF Trust Fund is fully integrated in World Bank operations. This close link results in low management costs for the trust fund. This also means that many of the operational mechanics of the GFF Trust Fund (such as quality assurance, fiduciary management, procurement, and safeguards) are simply those of the World Bank Group more generally.

This link is typically established when a new IDA/IBRD project is being developed, although it can occur when an existing project is being restructured or when additional financing is being allocated to an existing project that is focused on RMNCAH.⁴⁵ The entry point for this is the part of the Investment Case process that defines what each financier covers. The scope and areas of emphasis for the GFF Trust Fund financing are determined at this stage. This agreement is used as the basis for the normal process of preparing a World Bank project (which, in the case of the GFF Trust Fund, is prepared in an integrated manner with the corresponding IDA/IBRD project), as shown in Figure D. Basing the process on the Investment Case has a number of benefits over and above the normal process of basing IDA/IBRD financing on national strategies. Because a wide array of stakeholders is involved in the development of the Investment Case, the World Bank financing is built on a foundation of broad-based agreement about RMNCAH priorities in a country. Additionally, the rigorous, evidence-based process for the Investment Case directly shapes the activities financed by the GFF Trust Fund and IDA/IBRD.

The first step in the process is the preparation of a Project Concept Note (PCN) that covers both the

FIGURE D



⁴⁵ The linking cannot occur at other points in time—even if an existing project already includes a focus on RMNCAH—because the trust fund resources are intended to incentivize the commitment of additional IDA/IBRD resources, which can only occur in the context of new project development, restructuring, or additional financing.

IDA/IBRD resources and the GFF Trust Fund financing. The PCN sets out the scope of the project, the challenges being addressed, and the approaches being employed. In the case of the GFF, the PCN is developed based on the agreement among financiers about the repartition of financing for the Investment Case. Although the PCN focuses on the specific elements of the Investment Case that the World Bank will finance, it also situates the IDA/IBRD and trust fund financing in the larger context of the Investment Case. The PCN is the basis for a quality control review leading to an endorsement to proceed with further preparations.

The next step is the detailed design, which results in the development of a Project Appraisal Document (PAD) that describes the project objectives, technical scope, implementation arrangements, financial management and procurement arrangements, monitoring and evaluation arrangements, risk analysis and mitigation measures, assessments for each of the World Bank safeguards (e.g., on environmental and social standards), and results framework. The PAD is the basis for the formal financing agreement and becomes a public document once approved by the World Bank board.

In the context of the GFF, the same steps are followed once a decision has been made about a country's allocation. A single PAD covers the entirety of IDA/IBRD resources and GFF Trust Fund financing. During the design process, the GFF Secretariat has a role in monitoring progress, providing technical assistance, and participating in formal quality reviews. The Investment Case is used as a key touchstone to ensure consistency between the PAD and the approach adopted by the broad set of GFF stakeholders. Additionally, country teams work closely with other financiers of the Investment Case and regularly engage with a broad set of key stakeholders throughout the remainder of the project preparation appraisal, and implementation, typically through the country platform. The specifics of this vary by setting but include things such as participating in peer reviews and conducting joint assessments in the course of implementation.

Because the financing from the trust fund is administered with IDA/IBRD resources, throughout the course of implementation the GFF Trust Fund benefits from the full set of fiduciary arrangements, procurement procedures, reporting, and safeguards that accompany every World Bank Group project.

Financing flows through government treasury systems (i.e., it is on-budget) and a government's general financial rules are followed. However, the government is generally not the sole implementer: it routinely contracts civil society organizations, the private sector, academia, or other partners to deliver key elements of a project.

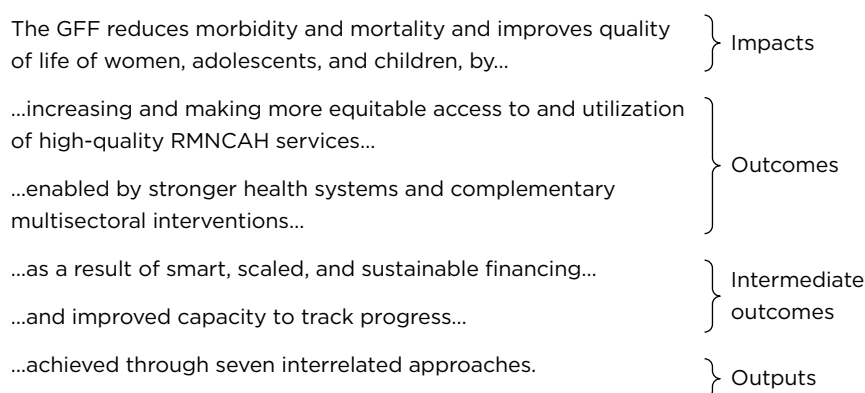
World Bank Group guidelines apply to procurement, with each project having a detailed procurement plan that is approved by the World Bank Group. National procurement procedures can be used when they are consistent with World Bank Group guidelines.

Implementation teams composed of representatives of the government oversee the resources and keep World Bank task team leaders and the trust fund informed on progress. In addition, the World Bank task team provides supplemental supervision, including regular reviews of progress against agreed objectives and targets, implementation of key components including safeguards, risk matrices and any course corrections that may be required.

ANNEX 10: Global Theory of Change and Results Framework

The theory of change describes the causal pathways through which the GFF contributes to ending preventable maternal, adolescent, and child deaths. In doing so, it ties together the different elements of the GFF, showing how they work synergistically to achieve impact globally.

The high-level summary of the theory of change is:



The organizing principle of this is the results chain, so it reveals how inputs lead to outputs, outputs to intermediate outcomes, and so on until the impact level. This does not capture the complexity of the causal pathways. These have not been depicted for reasons of simplicity, but detailed pathways have been developed for the key areas and used to inform the remaining aspects described herein (e.g., the assumptions, risks, and results framework).

The results chain logic is also critical for understanding the GFF's accountability, which lessens across each step of the results chain because the higher level results are more reliant on the contributions of multiple stakeholders. The GFF has full control over the inputs and so can be held fully accountable for these, but at the level of impact, the changes accomplished are the result of the contributions of many stakeholders, of which the GFF is just one.

The theory of change enables the development of a robust results framework, since a results framework should always be based on a clear analysis of proposed actions and desired changes at each level of the results chain. An initial draft of the results framework is included below. The indicators in this are preliminary, particularly at the higher levels of the results framework (impacts and outcomes), as progress at these levels is dependent on the actions of multiple stakeholders and so should reflect broad agreement about the appropriate ways to track performance. However, these agreements have not yet been reached globally. Extensive discussions on indicators are underway as part of the SDG process and materials developed for this have been drawn on for the preparation of the GFF results framework. Additionally,

the preparation of the updated Global Strategy for Women's, Children's, and Adolescents' Health should also provide valuable inputs for the finalization of the results framework.

For the same reason, the results framework does not yet include targets, as these can only be included once they have been agreed internationally.

These indicators are intended for use in tracking the global progress of the GFF. These are complemented by results framework that are contained in each Investment Case, which enable progress to be tracked at the country level (as described in [Section 3](#) and [Annex 3](#)).

To complement this, the risks to the transitions between each stage of the results chain have been identified. This is included as a table after the results framework.

Initial draft of global results framework (to be finalized based on further work on the Sustainable Development Goals and the updated Global Strategy for Women's, Children's, and Adolescents' Health)

IMPACT: Reduced morbidity and mortality and improved quality of life of women, children, and adolescents

| # | Indicator | Baseline | Means of verification | Source |
|---|--|----------|-----------------------|--------|
| 1 | Maternal deaths per 100,000 live births | | | |
| 2 | Under-five mortality per 1,000 live births | | | |
| 3 | Neonatal mortality per 1,000 live births | | | |
| 4 | Adolescent birth rate | | | |
| 5 | Other options for issues to be covered: HIV, malaria, violence against women, child marriage | | | |

OUTCOME 1: Increased and more equitable access to and use of high-quality RMNCAH services

| # | Indicator | Baseline | Means of verification | Source |
|---|---|----------|-----------------------|--------|
| 1 | Skilled birth attendance | | | |
| 2 | Antenatal care attendance (4 or more visits) | | | |
| 3 | Care seeking for suspected pneumonia in children under-5 | | | |
| 4 | ORS treatment and zinc treatment in children under-5 | | | |
| 5 | Demand satisfied with modern contraceptives | | | |
| 6 | Coverage of syphilis treatment in pregnant women | | | |
| 7 | Knowledge among young people about sexual and reproductive health | | | |
| 8 | Indicators for possible impact indicators on HIV and/or malaria | | | |

OUTCOME 2: Strengthened health systems and complementary multisectoral interventions

| # | Indicator | Baseline | Means of verification | Source |
|---|--|----------|-----------------------|--------|
| 1 | Fraction of the population protected against impoverishment by out-of-pocket health expenditures | | | |
| 2 | Fraction of households protected from incurring catastrophic out-of-pocket health expenditure | | | |
| 3 | Prevalence of stunting (low height-for-age) in children under 5 years of age | | | |
| 4 | Completion rate (disaggregated by sex and by primary, lower secondary, upper secondary) | | | |
| 5 | Percentage of schools with access to single-sex sanitation facilities | | | |
| 6 | Percentage of population using safely managed sanitation services | | | |
| 7 | Population with a hand washing facility with soap and water in the household | | | |
| 8 | Indicator(s) TBD on gender | | | |

INTERMEDIATE OUTCOME 1: Smarter financing that is more focused on evidence-based, high-impact “best buys” (RMNCAH, health systems, multisectoral)

| # | Indicator | Baseline | Means of verification | Source |
|---|--|----------|-----------------------|--------|
| 1 | Percentage of countries in which at least X% of total ODA is explicitly supporting the Investment Case | | | |
| 2 | Indicator(s) TBD on efficiency gains | | | |

INTERMEDIATE OUTCOME 2: Scaled up financing from domestic and external sources

| # | Indicator | Baseline | Means of verification | Source |
|---|--|----------|-----------------------|--------|
| 1 | Total volume of IDA/IBRD resources focusing on RMNCAH | | | |
| 2 | Percentage of IDA and IBRD spent on RMNCAH | | | |
| 3 | Percentage of World Bank Health, Nutrition, and Population commitments going to RMNCAH | | | |
| 4 | Percentage of development assistance for health going to RMNCAH | | | |
| 5 | Value of new private sector commitments to RMNCAH brokered by the GFF | | | |

INTERMEDIATE OUTCOME 3: More sustainable financing that enables countries to transition in equitable and efficient ways

| # | Indicator | Baseline | Means of verification | Source |
|---|--|----------|-----------------------|--------|
| 1 | Number of countries that increase the share of general government expenditure going to health from the previous year | | | |
| 2 | Number of countries that reduce the out-of-pocket share of health expenditure from the previous year | | | |
| 3 | Number of countries that decrease the median public sector procurement prices for essential medicines from the previous year | | | |

INTERMEDIATE OUTCOME 4: Improved capacity to track progress, particularly through civil registration and vital statistics systems

| # | Indicator | Baseline | Means of verification | Source |
|---|---|----------|-----------------------|--------|
| 1 | Percentage of births registered | | | |
| 2 | Percentage of maternal, newborn, and child deaths reported | | | |
| 3 | Percentage of cause of deaths in hospitals reliably determined and official certified | | | |

OUTPUT 1: Improved identification of “best buys” (RMNCAH, health systems strengthening, and multisectoral) through the use of Investment Cases

| # | Indicator | Baseline | Means of verification | Source |
|---|---|----------|-----------------------|--------|
| 1 | Number of Investment Cases completed | | | |
| 2 | Percentage of Investment Cases that: <ul style="list-style-type: none"> • Identify and prioritize historically neglected issues (e.g., family planning) and populations (e.g., adolescents) • Identify and prioritize disadvantaged and vulnerable populations • Present clear theories of change to articulate how the priorities identified set a trajectory toward reaching 2030 targets • Mechanisms to improve efficiency in the RMNCAH response | | | |

OUTPUT 2A: More complementary financing through systematic division of financing for Investment Cases

| # | Indicator | Baseline | Means of verification | Source |
|---|--|----------|-----------------------|--------|
| 1 | Number of countries in which key financiers agree on a repartition of financing for the Investment Cases | | | |
| 2 | Number of countries in which the government bases its financing on the Investment Case | | | |
| 3 | Number of countries in which at least three donors agree to finance the Investment Case | | | |

OUTPUT 2B: Increased domestic resource mobilization for RMNCAH

| # | Indicator | Baseline | Means of verification | Source |
|---|---|----------|-----------------------|--------|
| 1 | Number of countries that set targets for increasing the share of total financing for RMNCAH that is from general government revenue | | | |
| 2 | Number of countries that increase government commitments for RMNCAH in comparison to the previous year's budget | | | |

OUTPUT 2C: Increased IDA/IBRD financing for RMNCAH

| # | Indicator | Baseline | Means of verification | Source |
|---|--|----------|-----------------------|--------|
| 1 | Average ratio of GFF Trust Fund commitments to IDA/IBRD commitments for health, nutrition, and population | | | |
| 2 | Number of countries in which the ratio of GFF Trust Fund commitments to IDA/IBRD commitments for HNP is greater than 1:4 | | | |

OUTPUT 2D: Increased engagement of a range of private sector partners

| # | Indicator | Baseline | Means of verification | Source |
|---|--|----------|-----------------------|--------|
| 1 | Number of countries in which either the Investment Case or the health financing strategy addresses the role of the private sector in improving: <ul style="list-style-type: none"> • Coverage and quality of RMNCAH service delivery • Supply chains for key commodities • Adaptation and use of medical technologies • Access to capital for non-profit and for-profit healthcare providers | | | |

OUTPUT 3: Improved long-term planning for domestic resource mobilization, risk pooling, and purchasing through the use of health financing strategies

| # | Indicator | Baseline | Means of verification | Source |
|---|---|----------|-----------------------|--------|
| 1 | Number of health financing strategies completed | | | |
| 2 | Percentage of health financing strategies that: <ul style="list-style-type: none"> • Include indicators and targets for domestic resource mobilization • Include indicators and targets for efficiency gains • Explicitly identify strategies to address risk pooling or other forms of financial protection for disadvantaged and vulnerable populations • Take a mixed health systems approach to ensuring sustainability | | | |

OUTPUT 4: Increased provision of global public goods that address gaps identified at national level

| # | Indicator | Baseline | Means of verification | Source |
|---|--|----------|-----------------------|--------|
| 1 | Number of evaluations focused on identifying lessons learned for the global RMNCAH community completed | | | |
| 2 | Indicator TBD on knowledge platform/ South-South cooperation | | | |
| 3 | Indicator TBD on Center of Excellence | | | |

Initial risk analysis (to be completed based on final results framework)

| Transition | Risks | Mitigation measures |
|---|--|--------------------------|
| Inputs to outputs | <ul style="list-style-type: none"> Investment Case process is perceived as complicated and not adding significant value, and so countries do not use it (or treat it as a “paper requirement”) GFF Trust Fund does not receive additional donor contributions and so is only able to operate in a limited set of countries GFF financing is not additional but rather replaces existing donors investments National governments and/or World Bank board are not willing to increase IDA/IBRD allocations to RMNCAH Allocations from the GFF Trust Fund are too small to incentivize changes at the country level (either to encourage development of Investment Cases and health financing or to attract additional resources from domestic sources and from IDA/IBRD) Decision-making with regard to the GFF Trust Fund is too slow, resulting in delays in allocations and disbursements and frustrations from countries Insufficient technical resources can be sourced to support the development of health financing strategies, resulting in suboptimal quality documents In-country processes to develop Investment Cases and health financing strategies are insufficiently inclusive, resulting in suboptimal quality documents and a weakening of the partnership element of the GFF The drive to integrate CRVS within RMNCAH planning processes is unable to address historical separations between these communities, resulting in insufficient inclusion of CRVS in Investment Cases Stakeholders outside the health sector are not involved in the Investment Case process, resulting in insufficiently multisectoral approaches, leading to lower effectiveness and efficiency gains GFF partners do not provide technical and financial inputs to complement the resources from the GFF Trust Fund, leading to suboptimal quality of Investment Cases and health financing strategies Insufficient financing is available to support partners to provide technical assistance to the development and implementation of Investment Cases and health financing strategies | <i>To be added later</i> |
| Outputs to intermediate outcomes | <ul style="list-style-type: none"> Donors in-country are unwilling to base their funding decisions on Investment Cases, resulting in less willingness to prepare Investment Cases, fewer efficiency gains, and less financing The Investment Case process does not result in significant improvements in the identification of evidence-based interventions, resulting in few/no improvements in smart financing The historical neglect of key issues and target populations is not addressed by the Investment Case process, limiting the ability to deliver smarter financing Political economy considerations and/or political changes limit the ability of governments to deliver on the domestic resource mobilization commitments included in health financing strategies The private sector is insufficiently engaged in the development of Investment Cases and health financing strategies, resulting in approaches that are less inclusive and less sustainable Countries are unwilling to use considerable IDA/IBRD resources for CRVS, limiting the ability to improve capacity as the GFF Trust Fund financing is insufficient on its own given the size of current resource gaps | |

| Transition | Risks | Mitigation measures |
|--|---|---------------------|
| Intermediate outcomes to outcomes | <ul style="list-style-type: none"> • The other health systems elements needed to deliver services (e.g., trained human resources) are not adequately provided by governments and other key stakeholders • The political commitment to RMNCAH drops (globally and/or at national level) • The data generated through improved measurement capacity (e.g., from CRVS systems) are not used to improve programming • Corruption and/or governance weaknesses result in scaled-up financing being diverted into purposes other than intended • Scaled up international support ends up substituting for rather than being additional to domestic resources | |
| Outcomes to impact | <ul style="list-style-type: none"> • Morbidity and mortality do not respond as expected because the interventions chosen were partly based on insufficient evidence of what works at scale • Major humanitarian crises (e.g., pandemics, wars) overwhelm health systems and/or consume a significant share of resources | |