EURO HEALTH GROUP

WACI HEALTH

VOLUME III

Independent Evaluation of the Global Financing Facility for Women, Children and Adolescents (GFF)

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Abbreviations and acronyms

ACT	Antenatal care
ART	Antiretroviral therapy
ARTF	Afghanistan Reconstruction Trust Fund
BCHPF	Basic Health Care Provision Fund
BMGF	Bill & Melinda Gates Foundation
BPHS	Basic Package of Health Services
BSD	Bureau de Stratégie et Développement
CBHI	Community-based health insurance
CHAI	Clinton Health Access Initiative
CHW	Community health worker
CLP	Country Leadership Program
CMU	Universal health coverage
CP	Country platform
CRF	Consolidated Revenue Fund
CRVS	Civil registration and vital statistics
CSE	Comprehensive sexuality education
CSO	Civil society organization
DGS	Directeur Général de la Santé
DHFF	Direct Health Financing Facility
DIS	Direction de l'Information Sanitaire
DLI	Disbursement-linked indicators
DLR	Disbursement-linked results
DRM	Domestic resource mobilization
DRUM	Domestic resource utilization and mobilization
DTP	Diphtheria-tetanus-pertussis
EHS	Essential health services
EMR	Electronic medical record
EPHS	Essential Package of Health Services
FASTR	Frequent Assessments and System Tools for Resilience
FCV	Fragility, conflict, and violence
FCDO	Foreign, Commonwealth & Development Office
FP	Focal point
GBV	Gender-based violence
GFF	Global Financing Facility for Women, Children and Adolescents
GHI	Global Health Initiative
HBF	Health basket funding

HCP	Human Capital Operation
HER	Health Emergency Response
HIS	Health information system
HMIS	Health Management Information System
HQ	Headquarters
HRH	Human resources for health
HSS	Health system strengthening
HTSP	Health Sector Transformation Plan
HSWG	Health Sector Working Group
IBRD	International Bank for Reconstruction and Development
IC	Investment case
ICR	Implementation Completion and Results report
IDA	International Development Association
INEY	Investing in Early Years
IPF	Investment Project Financing
ITA	Interim Taliban Administration
JCCC	Joint Core Coordinating Committee
JCF	Joint Consultative Forum
JEE	Joint External Evaluation
KI	Key informant
M&E	Monitoring and evaluation
MERL	Monitoring, evaluation, and learning
MHR	Maternal health and rights
MMR	Maternal mortality rate
MOF	Ministry of Finance
MOH	Ministry of Health
MTR	Mid-term review
MNCH	Maternal, newborn, and child health
NHA	National Health Authority
NHIA	National Health Insurance Authority
NHIS	National Social Health Insurance Scheme
NGO	Non-governmental organization
OBF	Output-based financing
OOP	Out-of-pocket
P4R	Performance for Results
PAD	Program document
PBF	Performance-based financing
PDO	Project Development Objective

PFM	Public financial management
PFSA	Pharmaceuticals Fund and Supply Agency
PIU	Project Implementation Unit
PNCFS	Plateforme Nationale de Coordination du Financement de la Santé
PNDS	National Health Development Plan
QoC	Quality of care
RMCAH-N	Reproductive, maternal, child, and adolescent health & nutrition
RMET	Resource mapping and expenditure tracking
SBA	Skilled birth attendant
SCF	Save the Children Fund
SDG	Sustainable Development Goals
SLL	Saving Little Lives
SRHR	Sexual and reproductive health and rights
TA	Technical assistance
TATs	Technical Advisory Teams
ToC	Theory of change
TTL	Task team leader
TWG	Technical working group
UHC	Universal health coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WASH	Water, sanitation, and hygiene
WB	World Bank
WHO	World Health Organization

Côte d’Ivoire

Côte d'Ivoire Case Study

Brief outline of the GFF/ WB investment[1]

Component	GFF	World Bank IDA
SPARK (2019 – 2024)		
Extension of PBF in the context of Strat Planning		$92,864,934
Scale up of CMU		$17,422,808
Support to Health Reforms and Cap Building	$ 5,000,000	$ 1,100,000
Rehabilitation, Equipment and Sanitation		$33,142,800
Reproductive Health and Nutrition		$14,742,800
Strengthening HRH		$19,887,200
Governance and HMIS	$ 15,000,000	$ 8,810,298
Social Safety Net Strengthening (2022-2026)		
IPF component-Management, Coordination and M&E	$ 5,000,000	$ 7,500,000
Program Implementation		$187,500,000

- *What did the GFF invest in doing? (eg. TA / areas / CP etc.)* [2]

Details of the GFF investments:

Exec Type	Funding Cat	Budget Cat	Budgeted	Disbursed
RE	First Round Grants	First Round Grants	$20,000,000	$19,265,571
RE	Strategic Initiatives	Strategic Initiatives	$5,000,000	$401,586
BE	Core TA	Project Preparation	$399,642	$399,642
BE	Core TA	Supervision	$765,000	$760,884
BE	Core TA	Implementation	$70,000	$64,366
BE	Core TA	RMET	$160,000	$159,887
BE	Flexible TA	Demand Side Activities	$153,000	$119,670
BE	Flexible TA	DRUM	$250,000	$247,231
BE	Flexible TA	Quality RMNCAH-N	$195,997	$195,997
BE	Flexible TA	Results Monitoring	$100,000	$41,414.96

The investment case

- *Brief overview of the Investment case – Duration 2020 – 2023* (extended to end of June 2025)

The objectives of the Investment Case (IC) (*Dossier d'Investissement*) are to strengthen global efforts and support a systematized country-led process to address gender inequalities. The Investment Case Roadmap aims to make explicit how the Global Financing Facility for Women, Children and Adolescents (GFF) will expand and deepen its commitment to supporting the government in closing gender gaps. Six areas of action:

- ✓ **Action 1**: Prioritize analytical and technical support demonstrating the relationship between gender inequality and unsatisfactory health outcomes, and between gender equality and improved health and well-being.
- ✓ **Action 2**: Increase the country's investment in gender-sensitive monitoring and data systems.

[1] Cote d'Ivoire PAD (US$)

[2] GFF Evaluation - Case Study Countries - RE and BE Portfolio Summary July 2024

- ✓ **Action 3:** Support the foundations of reforms that enable the integration of sexual and reproductive health and rights into universal health coverage policies and programs.
- ✓ **Action 4**: Intensify engagement with local women's organizations, youth groups and other national gender equality actors to inform and support GFF's national platforms.
- ✓ **Action 5**: Create an enabling environment to empower women and adolescents as leaders in the GFF process at national and global levels.
- ✓ **Action 6**: Strengthen commitment at national level beyond the healthcare sector.[3]

The adaptation and evolution of the IC process responds to the following challenges: (i) low public spending on health despite strong economic growth, (ii) households bear 43% of total health expenditure, (iii) Côte d'Ivoire has one of the highest maternal mortality ratios in the world, (iv) one child in 10 does not reach the age of 5, and (v) fragmentation leading to inefficient health spending.

- *Are there clear RMNCAH-N priorities identified – if so, what?*

The main priorities of the GFF in Côte d'Ivoire are: (i) Primary health care and quality of care, (ii) Community health, (iii) Health information, (iv) Human resources, (v) Supply chain, (vi) Private sector, (vii) Health financing reforms. These priorities focus on mother-child, adolescent and youth health, as well as nutrition, with a component on health system strengthening. [4]

The Investment Case identifies health priorities but is perceived as duplicating the National Health Development Plan (PNDS).[5]

- *Funding gaps identified? Any evidence that it was able to leverage further funding from external partners?*

The Investment case estimated that the total amount necessary to fund the IC budget was 1,413 billion CFA francs**.** The analysis of the financing gap is based on the assumption that the State would continue to exercise its responsibilities in financing health, following current trends which estimate the annual growth of the public administration budget for health at 5%, and an allocation of 25% of this budget to the priorities of the Investment Case. Furthermore, the assumption is also based on the unpredictability of financing from technical and financial partners and therefore places this financing at a zero level.

This analysis of the financing gap shows that 1.059 billion FCFA (approximately US$ 1.787 million would need to be mobilized over four years to finance national priorities.[6] The World Bank SPARKS PAD budgeted for $382,970,840, or approximate 21% of the total funding gap.

The country platform

- *Brief overview of the platform*

The set up of the country platform is considered to be an **excellent initiative**, but its secretariat needs to be more operational and functional, with stronger human resources and funding for its operation from the government and donors. Stakeholders indicated that the platform's secretariat needs strengthening and transfer the initiative's lead from the GFF to the national side. Clearly, the national

[3] Improving SRMNEA-N results by advancing gender equality: GFF brief to operationalize the measure, November 2020
[4] GFF/WB, Government, Development partners and CSO KIs
[5] Government, Development partners and CSO KIs
[6] Investment Case 2020 -2023 analysis

side needs to take genuine ownership of the platform and provide it with sustainable funding and a more effective secretariat.[7]

- *Where is it based – who takes part?*

The country platform is based in the Prime Minister's office. "The GFF has facilitated the inclusion of diverse voices by supporting the creation and operation of the Plateforme Nationale de Coordination du Financement de la Santé (PNCFS), based at the Prime Minister's Office" [8]

- *Any evidence on how active it is?*

Due to its location in the Prime Minister's office, there were challenges when the GFF was first set up in Cote d'Ivoire with the consistency of convening platform meetings. According to the March 2024 CES review, good progress is being made towards improving the CP functionality. The CP is well positioned (at the level of the Prime Minister) to drive the big health systems strengthening reforms agenda, including those that are outside the scope of the MOH. The GFF team have made significant progress with buy-in of the Directeur Général de la Santé (DGS) to the GFF model and engagement in CIV.

> "*GFF's national commitment mobilizes wider stakeholders within government and the health sector quite strongly around national health priorities through the investment case, which is operationalized through high-impact interventions as part of the national health development plan" – Government KI*
>
> *"Thanks to the GFF, a coordination mechanism exists and works fairly well, but the alignment of partners in health is not yet perfect" – Development partner KI*

The World Bank TTL has strongly supported strengthening the CP and linking it with the PIU through performance contracting has been a transformational change. With the PIU now responsible for managing the CP contract, accountability for ensuring the CP functions effectively has increased. GFF provides technical support for planning and evidence-based decision-making, contributing to a significant improvement in the quality of CP meetings. Additionally, the GFF government Focal Point (FP) plays a key role in the new project as an advisor on the steering committee, further reinforcing collaboration and alignment with the World Bank project.

The World Bank project

- *What is the World Bank funded to do – what aspects of RMNCAH -N does it target?*

With GFF co-financing, the World Bank has funded the SPARK-Health project (2019-2024), which aimed to improve the utilization and quality of health services, particularly for maternal, neonatal, and child health (MNCH). The project included a US$200 million IDA credit and US$20 million GFF grant and focused on integrating strategic purchasing into the national health system through the scale-up of performance based financing (PBF) and deployment of CMUs.

The four key components of the SPARK project were:

1. Scaling up strategic purchasing and governance reforms to enhance financial sustainability.

[7] Government, Development partners and CSO KIs
[8] GFF/WB and Development partners KIs

2. Supporting key health system strengthening elements beyond strategic purchasing, such as rehabilitating and equipping health facilities, human resources for health, health information systems, and improving the quality of primary care—especially for RMNCAH.
3. Project management, knowledge-sharing, and learning to enhance implementation capacity.
4. A Contingent Emergency Response Component (CERC) (zero-dollar component).

- *What is the evidence that the GFF then led to a re-prioritisation of RMNCAH-N in the WB project?*

The SPARK PAD states that it is fully aligned with the Investment Case 'for the GFF Trust'. It goes on to state that "A National Platform is in the process of actualization and six priority areas have been identified under the overall priority reform of scaling up strategic financing." It appears that there was good linking between the World Bank and GFF team in the development of the 2020-2024 PAD, with strong collaboration carried on for the development of the new PAD that was being submitted for approval by the World Bank Board.

KEY FINDINGS BY AI

AI 1

- *Delivering health services – what is the model – how is this being achieved?*

GFF has contributed to high-quality healthcare services in Côte d'Ivoire, through its technical assistance in preparing the Investment Case, carrying out studies (resource mapping, mid-term review, etc.), supporting the office of the Minister of Health and central departments, developing a dashboard of healthcare indicators, etc. This technical assistance is targeted at and responds to the country's needs. It is requested according to the country's needs, with well-defined terms of reference. The focus continues to primary health care service delivery, with support to systems strengthening and increasing access through health financing reforms, including support for social health insurance.

- *Quality of care – what's the model – evidence of this being achieved?*

"Projet d'Achat Stratégique et d'Harmonisation des Financements et des Compétences de Santé" (SPARK- SANTE). Through this project, GFF has helped Côte d'Ivoire to improve the monitoring of the delivery, quality and outcomes of health services for women, children and adolescents by helping to set up a technical working group (TWG) to monitor and evaluate the national platform, as well as by strengthening performance-based financing, which makes it possible to monitor the quality of healthcare provision in general, and of RMNCAH-N in particular, through a quality score evaluation grid. In addition, GFF has helped Côte d'Ivoire to have better quality data and to use this data and evidence for decision-making through collaboration with the Countdown country team and support for the Direction de l'Information Sanitaire (DIS).[9]

The GFF has contributed to strengthening the RMNCAH-N health system by improving the supply chain, enhancing the health information system, regulating and supporting the private health sector, strengthening the health workforce, and reinforcing the quality of care.

The GFF has supported and contributed to high-quality health services, through technical and financial support for health financing initiatives such as Universal Health Coverage, performance-based financing, program budget reform, etc. **The mechanisms put in place to monitor and evaluate**

[9] Government and Development partners KIs

quality include: the technical working group (TWG) for monitoring and evaluation of the national platform, performance-based financing, which makes it possible to monitor the quality of healthcare provision in general, and of the RMNCAH-N in particular, through **a quality score evaluation grid.** The GFF-supported **Country Countdown team** also monitors the progress and performance of RMNCAH-N indicators.[10]

- *Added value to other RMNCAH-N actors? How? Evidence?*

GFF complements and enhances the work of other key players in RMNCAH-N, health system strengthening and health financing by mapping resources and tracking expenditure of the country's healthcare system. Among other things, these exercises revealed funding gaps and the over-funding of certain areas to the detriment of others that were underfunded. This enabled other key players to better allocate resources, and to advocate and seek funding to fill the gaps.[11]

AI 2

- *GFF/ WB leveraging each other's strengths*

The GFF and the World Bank collaborate strategically and jointly finance projects in Côte d'Ivoire. The different roles and responsibilities of GFF and the World Bank are clearly defined across the co-financed projects, and working methods are aligned and complementary. For example, the **"SPARK-santé" project** had a budget of US$ 220 million, including US$ 20 million from the GFF and US$ 200 million (IDA/credit) from the World Bank.

The new project, which is a 10-year program (2023-2033), has a budget of US$ 600 million, including US$ 235 million for the first phase, with US$ 200 million (IDA/World Bank credit) and US$ 20 million from the GFF. It should also be noted that the GFF is well integrated into the projects financed by the World Bank, so much so, that it is sometimes thought that the technical assistance provided by the GFF is rather provided by the World Bank. Opportunities to maximize this complementarity in Côte d'Ivoire include Universal Health Coverage (CMU) and "social safety net" projects.

The GFF's operational structure and working methods offer strong support, largely driven by national commitment at the highest level and ownership of GFF-supported tools. GFF has provided technical assistance in several key areas, including developing the investment case, conducting studies such as resource mapping and mid-term reviews, supporting the Minister of Health's office and central departments, and creating a health indicator dashboard.

- *Are the roles sufficiently clear/ separated?*

Not entirely - one of the areas of improvement cited by KIs was to increase the visibility of the GFF in terms of its overall contribution to the health sector.

- *Opportunities to maximize complementarity and Lessons Learned*

The lessons and opportunities for improvement concern the strengthening of the platform's activities, the intensification and efficiency of the Technical Secretariat's activities, the intensification of communication and the visibility of the GFF's activities, and the strengthening in human resources of the GFF's liaison team to 3 people instead of just one liaison officer. Indeed, the GFF does not have

[10] Monitoring & Evaluation TWG activity report, Resource mapping report, Mid-term review reports, Development Partner KI, GFF KIs

[11] Monitoring & Evaluation TWG activity report, Resource mapping report, Mid-term review reports, Development Partner KI, GFF KIs

sufficient dedicated human resources to fulfill its role and mandate. This sometimes affects the work to be done, which essentially relies on the single liaison officer.

AI 3

- *Where does GFF add value?*

The GFF adds value at strategic and operational levels through the establishment of the Plateforme Nationale de Coordination du Financement de la Santé (PNCFS), housed at the Prime Minister's office, and the funding of the IC. The GFF also adds value at the national level through:

- the mobilization of all stakeholders involved in health and nutrition in Côte d'Ivoire;
- the Government's commitment to mobilizing domestic resources for health;
- the involvement of the private sector and civil society;
- the creation and implementation of a permanent forum for dialogue between all stakeholders on health financing issues;
- the alignment of large and fragmented donor funding with national priorities.

Strengths include favorable contextual factors that have supported efforts to strengthen national leadership, along with the President's political commitment to providing affordable, high-quality healthcare in Côte d'Ivoire. The country's health situation and the opportunities presented by the GFF have also been key enablers.

However, **key obstacles** remain, including the excessive fragmentation of health coordination structures and the lack of an effective "One Administration, One Health" approach.

- *Extent ensured adequate funding for RMNCAH-N services?*

Adequate funding will be secured through the Multi-phase Programmatic Approach (MPA) to strengthen the RMNCAH-N healthcare system. This includes reinforcing the supply chain, supporting the Universal Health Coverage (CMU) policy, enhancing the health information system, regulating and strengthening the private healthcare sector, expanding the health workforce, improving the quality of care, and supporting the national nutrition program.

- *Data/ results – what aspects of the data system were strengthened/what benefits or outcomes?*

Key improvements to the data system include establishing mechanisms to monitor and evaluate healthcare quality, such as the TWG for monitoring and evaluation of the national platform, performance-based funding to assess healthcare provision (including RMNCAH-N), and the quality score evaluation grid. Additionally, the GFF-supported Country Countdown team tracks RMNCAH-N progress and performance. The implementation of CMU and PSNDPE 2023–2030 further enhances opportunities to improve data quality and evidence-based decision-making.

- *To what extent has there been demonstrable progress towards the Theory of Change (TOC) (in this country context)?*[12]

- 27% reduction in maternal mortality ratio per 100,000 live births between 2011 (MMR 614) and 2021 MMR (385)
- 16% increase between 2019 and 2023 of women who gave birth in a health facility
- 12% increase between 2019 and 2023 children receiving 3rd dose of DTP

[12] GFF Data Portal

- 8% increase between 2019 and 2023 in the number of antenatal clients who had a 4th ANC visit
- 93% increase between 2019 and 2021 of number of child cases taken care of by a community health worker (CHW) (malaria, diarrhea, pneumonia)
- 15% increase between 2019 and 2021 in numbers of women seen for ambulatory obstetric complications
- 13% increase between 2019 and 2021 in numbers of women receiving postnatal care within three days of delivery

COVID-19 clearly had an impact, which can be seen in Countdown Workshop data for 2021 and slowed down results achieved nationally.

Demonstrable progress has been made in strengthening health financing through technical and financial support for CMU, performance-based financing and program budget reform. GFF's support has also contributed to the government's commitment to increase national health funding by 15% each year. It has also catalyzed additional funding. The GFF has achieved demonstrable progress through its technical and financial support for CMU. Nearly 14 million members have been enrolled in the country, compared with 3 million at the start of the operation. Performance-based financing and program budget reform have improved RMNCAH-N indicators. For example, there has been a reduction in maternal and infant mortality. The country had one of the highest maternal mortality ratios in the world, and one child in 10 did not reach the age of 5, before the GFF interventions. However, these figures are clearly improving. The GFF has also enabled the deployment of the Electronic Patient Record (DPI).

GFF also supports the private sector through the Direction des Etablissements Privés et des Professions Sanitaires (DEPPS) in a process of census, administrative regularization, compliance with national standards and protocols, data reporting to the Direction de l'Information Sanitaire (DIS) and strong involvement in the provision of quality care. The process is underway, but we can already say without a doubt that there will be good results at the end of the process, with major lessons to be learned.

The resource mapping and expenditure tracking exercises revealed funding gaps, the overfunding of certain areas to the detriment of others that were underfunded. This enabled the government to better allocate resources, and to advocate and seek funding to fill the gaps.

- *What lessons in advancing gender, voice and equity?*

The lessons to be learned from GFF's experiences in supporting the advancement of Sexual and reproductive health and rights (SRHR), equity, voice and gender equality relate to the fact that equity is paramount in the Côte d'Ivoire investment case developed with a support of GFF. What's more, thanks to GFF, the issue of gender has been increasingly addressed at national level in recent years, with additional support provided by other development partners in Cote d'Ivoire, e.g. Canada.

Any reflections on key findings or implications for the model?

- The GFF is proving to be very useful for Côte d'Ivoire. Progress has been made under GFF and World Bank funding, but there are still many challenges and obstacles to improving the health of women, children and adolescents in the country. To overcome these, the GFF must stay the course and intensify its action in favor of women, children and adolescents. It has been also noted that the

GFF is leveraging the potential of multi-sectoral action to improve its results in terms of RMNCAH-N. This is achieved by aligning multi-sectoral actions.

- **In terms of adaptations to the model,** the GFF model in Côte d'Ivoire has supported and strengthened national leadership through the involvement of the national party at the highest level, with the commitment of the Prime Minister's Office, the Minister of Health, the Director General of Health and certain technical ministries. The sector is collaborative, but it can do better by improving coordination and genuine ownership from the national side.
- **In terms of lessons learned**, the evaluation data show that the collaboration between the GFF and the World Bank is essential and primordial for the country, but the IC must be more closely integrated with the National Health Development Plan (PNDS) and not compete with it. In addition, the GFF model in Côte d'Ivoire has supported and strengthened national leadership through the involvement of the national side at the highest level, with the commitment of the Prime Minister's office, the Minister of Health, the Director General of Health and certain technical ministries.

Annex 1: Documents reviewed and stakeholders interviewed

Documents reviewed	Year of issue
CIV RAPPORT FINAL Revue à mi parcours	2024
Cote d'Ivoire IC	2019
ARRETE 260 PM CAB DU 8 AVRIL 19 CREATION PNCFS	2019
2nd round grant CIS-CIV Jan 2023 draft V02 clean	2023
Background Note GFF Grant PforR fr	
Dialogue National sur le Financemnt de la Santé RAPPORT GENERAL	2019
Disclosable ISR June 2024 - Côte d Ivoire P179550	2024
Disclosable ISR June 2024 - Cte d Ivoire Social Safety Nets Program - P175594	2024
SPARK ISR June 2024 - P167959	2024
PAD Cote dIvoire Social Safety Nets System Strengthening Program P175594	2022
PAD Cote d'Ivoire P179550	2023
PAD SPARK ENG P167959	2019
Civil Society Engagement in Côte d'Ivoire's GFF Process FRENCH	2020
Rapport Final Enquête sur la percepetion de la CMU par les populations en CI	2023
FY23 Cote d'Ivoire CES review 2022.12.09	2022
FY24 Cote d'Ivoire CES review 2024.02.22-CPN	2024

Name	Position	Association
Dr. Ouattara Djeneba	Advisor / Government Focal Point	Prime Minister's Office
Dr. Fieny Ambroise Kobenan	Liaison Officer	GFF
Mme Charlotte Pram Nielsen	Country Focal Point	GFF
Mme Amal TUCKER-BROWN	Results Specialist	GFF
Dr. Opope Oyaka	TTL	World Bank TTL, Health
Mme Cathy Seya	TTL	World Bank TTL, SPJ
Dr. Kouakou Alphonse	Private Sector Advisor	GFF TA providers
Pr. Samba Mamadou	Director General of Health	Ministry of Health
Dr. Kouassy Edith Clarisse	Director General of Universal Health Coverage	Ministry of Health
M. Guebo Alexandre	Technical Advisor to the Minister	Ministry of Health
Dr. Bitty Marie Joseph	Director of Private Facilities and Health Professions	Ministry of Health
Dr. Koui Isabelle	Director of Foresight, Planning, and Strategies	Ministry of Health
Mme Lattroh Essoh Marie	Technical Advisor to the Minister	Ministry of Finance
Mme Akua Kwateng-Addo	Director of Health Office (USAID)	Donors
M. Serge Mayaka	Health Financing Officer (WHO)	Donors
Mme Kone Solange	Chairwoman of the Board of the National Federation of Health Organizations of Côte d'Ivoire	Civil Society/NGO
Mme Gnionsahe Hélène	Chairwoman of the Board of Alliance SUN Côte d'Ivoire	Civil Society/NGO
M. Kenneth Prudencio	Youth CSO Representative	Other donors and RMNCAH-N partners
Dr. Sery Jean Maurin	President of the Health Private Sector Platform of Côte d'Ivoire	Private Sector
Dr. Gaudet-Pitta Tania	Deputy Health Coordinator	Ministry of Health / UCP Health WB

Ethiopia

Ethiopia Case Study

Brief outline of the GFF/WB investment

Key WB and GFF funding includes:
The WB Additional Financing for Health Sustainable Development Goals Program for Results (US$ 150 million Credit), GFF (US$ 60 million grant) and Power of Nutrition Trust Fund (US$ 20 million grant) (building on support provided since 2013). The WB Program Development Objective was to improve the delivery and use of a comprehensive package of maternal and child health (MCH) services.

More specifically, at health system level, the project aimed at improving the Pharmaceuticals Fund and Supply Agency (PFSA) capacity through improved fiduciary and procurement reforms and on the health financing front to foster the functionality of community-based health insurance (CBHI) schemes; new DLIs and results areas including nutrition and health care financing were also introduced.

Specific changes made to the original PforR included the addition of new DLIs that will trigger disbursements upon attainment of results on:

(i) Contraceptive Prevalence Rate among rural women: DLI#4;
(ii) Fiduciary Management improvement: DLI#9 on timely financial audit reports; automation of the financial management system of the Pharmaceuticals agency;
(iii) Nutrition: DLI#10 on Vitamin A Supplementation; DLI# 11 on Iron and Folic Acid tables;
(iv) DLI#12 on Growth Monitoring and Promotion;
(v) Improving quality of health care as well as Adolescent and School Health: DLI#13 on adolescent health sector strategies development and roll out;
(vi) Financial protection through CBHI: DLI#14;
(vii) Enhanced Community Participation in Health Service Delivery: DLI#15 on increased use of the Grievance Redress Mechanism and use of Community Score Cards. Support was channeled through the SDG pooled fund in support of the HTSP-I. The project became effective in August 2016 and closed in June 2022.[13]

The WB and GFF are currently supporting implementation of the HSTP-II through the Program for Results (Hybrid) for Strengthening PHC services, with a US$400m IDA grant and a US$45m GFF grant (of which US$20m for essential health services) covering the period March 2023 to June 2025.[14]

WB Human Capital Operation (HCP) Program for Results with US$400m IDA and additional US$5m GFF co-financing covering the period November 2023 to June 2028.[15] The WB Program Development Objective is to improve learning outcomes and nutrition services for girls and boys, and to strengthen service delivery and accountability, in all regions including areas affected by conflict, droughts and high levels of refugees.

- *What did the GFF invest in doing? (e.g. TA/areas/CP etc.)*

The GFF's focus areas in Ethiopia are: addressing gender issues affecting health outcomes; fostering dialogue with the private sector; increasing the capacity of the pharmaceutical fund supply agency; improving the quality of adolescent health services; improving tracking and utilization of resources; increasing the volume of domestic resources for health and equity through community-based health

[13] GFF strategy note and PAD P160108, April 2017
[14] PAD P175167
[15] GFF FY23 Ethiopia CES review, September 2022 and PAD P172284, May 2023. Note that this is a WB education sector project

insurance as well as other collaborations with the WB (e.g. through the domestic resource utilization and mobilization (DRUM) grant); scaling up equitable access to quality health services; strengthening civil registration and vital statistics (CRVS); and strengthening the health information system.[16] According to the government KI, the GFF's investments focus on RMNCAH and align with Ethiopia's national priorities. Contributions include performance-based financing and technical support in monitoring and evaluation (M&E).[17]

Details of the GFF investments[18]:

Exec Type	Funding Cat	Budget Cat	Budgeted	Disbursed
RE	1St Round Grants	Grants	$59,259,658.85	$59,259,658.85
RE	EHS Grants	Grants	$20 million	$8,790,400
RE	2nd Round Grants	Grants	$25 million	$5,600,000
RE	2nd Round Grants	Grants	$5 million	$0
BE	Core TA	IC and country platform development	$724,892.09	$724,892.09
BE	Core TA	Supervision	$858,404.91	$858,404.91
BE	Core TA	Supervision	$100,000	$91,053.27
BE	Core TA	Supervision	$50,000	$3,687.84
BE	Core TA	Project Preparation	$99,204.19	$99,204.19
BE	Core TA	Project Preparation	$154,995.31	$154,995.31
BE	Core TA	IC Implementation	$120,000	$119,969.77
BE	Flexible TA	DRUM	$100,000	$4,364.10
BE	Flexible TA	Quality RMNCAH-N	$299,394.88	$299,394.88
BE	Flexible TA	Results monitoring	$100,000	$14,903.46

The investment case

- *Brief overview of the investment case*

Ethiopia was a GFF frontrunner country. The investment case (IC) has been based on existing national health sector plans – the Health Sector Transformation Plan I (2015-2019) and the current Health Sector Transformation Plan II (HSTP-II) 2020/21-2024/25. The development of the IC involved a top-down and bottom-up approach, incorporating inputs from various regions, situational analyses, and stakeholder consultations.[19] In the development of the HSTP-II, the GFF played an integral role in encouraging and supporting the government to work through a multi stakeholder platform. KIIs revealed that there was markedly more consultation with civil society in the design of the HSTP-II than HSTP-I.[20]

- *Are there clear RMNCAH-N priorities identified – if so, what?*

The GFF engaged with the government in the development of these plans. HSTP-I succeeded in expanding access to basic health services despite prioritization and financing challenges. HTSP-II also emphasizes the expansion of health services in order to achieve UHC and through the recently revised

[16] GFF data portal
[17] Government KII, GFF/WB KII
[18] GFF Case Study Countries - RE and BE Portfolio Summary July 2024
[19] GFF/WB KII
[20] SCF, 2023. The GFF's contribution to improving health financing and health outcomes in Ethiopia. Policy brief

essential health services package. RMNCAH-N and high-impact interventions are a central focus. HSTP-II serves as the first phase of a broader ten-year health sector plan and aims to enhance the initial transformation agendas implemented during HSTP-I, including initiatives on Woreda Transformation, Information Revolution, Quality & Equity, and fostering compassionate healthcare workers.

The findings of the MTR of the HSTP-II, which was supported by the GFF, informed the development of the Health Sector Medium-Term Development and Investment Plan (HSDIP) 2023/24-2025/6, and GFF TA is reported to have ensured that the RMNCAH-N was prioritized. (WHO was also closely involved in supporting the development of the HSDIP).[21] In addition, GFF efforts to engage stakeholders in / align donors around HSDIP development are reported to have improved communication between MOH and USAID and other partners and to have strengthened alignment of donor support for implementing partners with MOH/ RMNCAH-N priorities.

The GFF Ethiopia TOC 2024 notes the following IC and GFF priorities:

<u>Maternal and reproductive health</u>

- Strengthen expansion of post-partum FP at primary health care
- Expand and strengthen emergency obstetric and surgical care services
- Strengthen access to quality and equitable antenatal, labor, delivery, and postnatal care service

<u>Newborn and child health</u>

- Expand and strengthen KMC at health facilities
- Expand and strengthen sick newborn initiatives at hospitals
- Strengthen access to immunization services in low performing woredas

<u>Adolescent health</u>

- Strengthen and expand adolescent and youth friendly services

<u>Nutrition</u>

- Improve the quality and coverage of nutrition services for pregnant, lactating, and women of reproductive age.

<u>Improve community engagement and PHC</u>

- Redefine, standardize, and implement HEP service packages and restructure service delivery platforms
- Strengthen Woreda transformation coordination and monitoring mechanisms
- Support the implementation of climate resilient health interventions
- Enhance the implementation of clinical audit at PHC level

<u>HSS</u>

- Improve quality and supply of pharmaceuticals and medical devices
- Improve the HIS and digitalization for decision making
- Improve health financing and strengthen and expand health insurance
- Strengthen CRVS implementation

<u>Strengthen health service delivery in post-conflict areas</u>

- Restore essential health services to pre-conflict status
- Strengthen health system inputs in all health facilities affected by conflict
- Support establishment of mobile health and nutrition teams in conflict-affected areas

[21] Development partner KII

There is a need for the GFF to enhance monitoring of IC implementation to ensure that the allocated resources are used effectively and achieve the intended outcomes.[22] In addition, civil society representatives have been involved in IC development but not in IC monitoring.

- *Funding gaps identified? Any evidence that it was able to leverage further funding from external partners?*

The SDG pooled fund, consisting of both domestic and external resources, provides flexible funding for the implementation of the HSTP-II, with approximately 30-40% of pooled funds allocated to maternal, child, and adolescent health, according to an SCF report. [23] The GFF has played a critical role in aligning donor support with Ethiopia's health sector strategy, helping restore donor confidence in pooled funding mechanisms that had been weakened by internal conflict. This has contributed to continued external funding, such as the Dutch government's decision to maintain support for the SDG pooled fund through the World Bank despite challenges posed by the conflict in Tigray.

While the GFF has supported efforts to strengthen health financing mechanisms, DRM in Ethiopia is primarily led by other World Bank trust funds. The disbursement indicators linked to GFF funding focus more on service delivery and outcomes rather than directly incentivizing increased domestic health spending. [24]

The forecast financing gap between HSTP-I and HSTP-II fell from 21% to 14.6%[25] and while HSDIP is a broader health plan, it remains well-aligned with RMNCAH priorities, with a realistic financing gap of 11%.[26] However, Ethiopia remains highly donor-dependent, and financial constraints persist due to economic downturns, inflation, and shifting donor priorities. [27]

The country platform

The country platform comprises the Joint Consultative Forum (JCF) and the Joint Core Coordinating Committee (JCCC), both of which are part of existing governance structures. The JCF is the highest governance structure, and it provides oversight of the implementation of the IC. The government has provided strong leadership for donor coordination and alignment. Its Partnership and Cooperation Directorate has developed a strategy document to enhance stakeholder coordination. There is also a Health, Population and Nutrition development partners group which is also used for discussion of GFF-related issues.

- *Where is it based – who takes part?*

The JCF, which is chaired by the health minister, includes representatives from the federal government, including the MOF, the HPN development partners, CSOs, the private sector and health professional associations. GFF support to ensure MOF engagement in the JCF seen as a success as previously engagement between the MOF and MOH was challenging. JCF TWGs support the implementation of the HSTP-II, including the RMNCAH-N sub-sector strategy. The GFF has advocated for and supported CSO participation in the JCCC.

[22] Development partner KII
[23] SCF, 2023. The GFF's contribution to improving health financing and health outcomes in Ethiopia. Policy brief
[24] Development partner KII
[25] SCF, 2023. The GFF's contribution to improving health financing and health outcomes in Ethiopia. Policy brief
[26] GFF/WB KI
[27] Development partner KII

The GFF supports the inclusion of CSOs and the private sector in health decision-making through platforms like the JCCC. Engagement has improved, but further involvement from the private sector is needed.[28]

- *Any evidence on how active it is?*

The JCF meets at least once every six months. Attendance of high-level officials is not consistent. The JCF also meets with regional health bureaus.

The World Bank project

- *What is the World Bank funded to do – what aspects of RMNCAH -N does it target?*

Refer to the 'Brief Outline of the GFF/WB Investment' section for details.

- *What is the evidence that the GFF then led to a re-prioritization of RMNCAH-N in the WB project? Where is this evident?*

Some KIIs have observed an increase in WB engagement and support for health services, particularly in health system strengthening and addressing needs in conflict-affected areas, but how much this can be attributed to the GFF is difficult to say.[29]

KEY FINDINGS BY AI

AI 1

- *Delivering health services – what's the model – how is this being achieved?*

The GFF approach includes co-financing for infrastructure and service delivery; scaling up equitable access to quality health services including through support for expansion of community-based health insurance and targeted support (including use of DLIs) to under-performing areas; support for improving the quality of adolescent/ youth-friendly health services targeting adolescent girls. It also includes support for specific initiatives such as the development and scale-up of the Saving Little Lives (SLL) initiative, focusing on newborn care innovations. The GFF's role is not in creating innovations but in ensuring governments steward the innovation agenda and scale up successful interventions through WB financing.[30]

The previous WB and GFF co-financed project aimed to incentivize improvements in health service delivery and coverage especially in lower performing areas, and includes the following DLIs: 1) Deliveries attended by a skill birth attendant (SBA), 2) Deliveries attended by SBA for the bottom four performing regions, 3) Children 12-23 months immunized with Pentavalent 3 vaccine, 4) Pregnant women receiving at least four antenatal care visits, 5) CPR in rural areas, 6) Health centers reporting Health Management Information System (HMIS) data in time, 7) Develop and implement a postnatal care service directive to improve the quality of postnatal services , 8) Improve the quality of adolescent health services, 9) Proportion of woredas with established functional CBHI schemes. The new project is a progression and has an expanded focus on newborn health, CEmONC, post-partum family planning, and operationalising work on adolescent health.

- *Quality of care – what is the model – evidence of this being achieved?*

The WB-GFF co-financed project is tracking indicators relating to quality of care (QoC) but mostly focusing on quality of health infrastructure (e.g. functional health facilities, availability of essential

[28] Government KI, GFF/WB KI
[29] Development partner KI
[30] GFF/WB KII

commodities). It is acknowledged, including by the GFF, that there is a need for more investment in improving quality of care and its measurement. Current efforts focus on structural quality measures, such as CEmONC and health commodity availability, but there is recognition that more needs to be done to measure process and outcome quality, particularly regarding the experience of care and quality improvements over time.[31] It is anticipated that methods such as rapid cycle surveys will be used to help address this.

- *Added value to other RMNCAH-N actors? How? Evidence?*

A development partner reports that RMNCH is central to the HSTP, with significant efforts directed at reducing maternal and child mortality, and that this prioritization has influenced USAID's strategies, aligning them closely with the national plan.[32] Another development partner highlighted the alignment between UNICEF's work and GFF's objectives, particularly in supporting government initiatives.[33]

AI 2

- *GFF/ WB leveraging each other's strengths*

GFF reported to bring an international perspective, analytics and other TA to contribute to WB project preparation and the WB to bring strengths in health financing reform, HSS etc. within government systems. An example of effective collaboration is the redesign of the successor program to the MDG initiative, where GFF's technical expertise helped expand the program's scope to include comprehensive emergency obstetric care and other critical interventions.[34]

There is a need to improve the effectiveness of coordination mechanisms like the JCCC and HPN groups, and the WB could play a more influential role in these forums.[35] This suggests there might be an opportunity for the GFF to do more to advocate for WB engagement.

- *Are the roles sufficiently clear/ separated?*

GFF and WB are working as one team. Different roles and responsibilities are clear to 'insiders' but less so to some 'outsiders'. The GFF provides TA and co-financing, while the World Bank leads on health financing dialogue and program implementation.[36] GFF's role is more about providing analytical support to identify gaps and advocate for resource mobilization at the global level, rather than directly influencing stakeholder engagement at the country level.[37] GFF and the World Bank play distinct yet complementary roles, with the GFF focusing on technical and financial support for healthcare financing, monitoring, and evaluation, while the World Bank supports the broader essential service package.[38] According to a development partner KI, the roles and responsibilities between the GFF and the World Bank are not clearly articulated, leading to confusion and the WB often views GFF funds as an extension of its own resources, without a distinct separation of functions.[39]

- *Opportunities to maximize complementarity*

Some of the opportunities include:

[31] GFF/WB KII
[32] Development partner KII
[33] Development partner KII
[34] GFF/WB KI
[35] Development partner KI
[36] GFF/WB KI
[37] GFF/WB KI
[38] Government KI
[39] Development partner KI

- Strengthen joint monitoring of co-financed programs/projects.
- Strengthen GFF in-country presence.
- Maximize opportunities presented by WB financed projects in relevant non-health sectors, e.g. water and sanitation and transport. However, the extent to which the GFF can do this is limited by resource limitations.

- *Lessons learned*

The GFF and the World Bank have leveraged each other's strengths, with the GFF contributing technical expertise, analytics, and an international perspective to support World Bank project preparation, while the World Bank leads on health financing reform and health system strengthening within government systems. However, there is a need to improve coordination mechanisms, such as the JCCC and HPN groups, and for the GFF to play a stronger role in advocating for greater World Bank engagement in these forums. Additionally, while their roles are complementary, a clearer distinction between GFF and World Bank functions is needed to avoid confusion among stakeholders. Another key lesson is the importance of having dedicated senior personnel within the Ministry of Health to oversee GFF activities, ensuring sustained focus on RMNCH priorities. [40]

AI 3

- *Where does GFF add value?*

The GFF's flexibility and responsiveness to country needs have been key value additions. For example, the GFF supported governments in monitoring the provision of essential health services during the COVID-19 pandemic and conducting private sector assessments. The GFF's support for government-led processes and for alignment is reported to have helped restore donor confidence in pooled funding arrangements, which had been undermined by internal conflict in Ethiopia, although there are still concerns about accountability in relation to pooled financing.

The GFF has been instrumental in revitalizing harmonization efforts within Ethiopia's health sector. Despite challenges, including limited donor engagement in the "one plan, one report" initiative, the alignment assessment has helped improve donor coordination and support. This effort has also influenced partners like USAID to align their projects with government priorities, marking significant progress.[41] The GFF's government-centric approach, focusing on coordination and collective financing, positions it as a critical catalyst in achieving the objectives of Ethiopia's HSTP.[42]

The GFF has leveraged World Bank funding to strengthen health investments and has advocated with the Ministry of Finance (MOF) to highlight the importance of increasing domestic health financing. Both GFF and World Bank funds are included in the national budget, ensuring alignment with government priorities. According to a 2023 SCF report, since 2015, GFF support has helped mobilize US$ 1.09 billion for RMNCAH through IDA financing.

- *Extent ensured adequate funding for RMNCAH-N services?*

The GFF has supported resource mapping, but progress on resource and expenditure tracking has been limited. While a resource tracking tool is in development, its implementation has been inconsistent, making it difficult to maintain regular and effective health financing tracking for decision-making. [43]

[40] Development partner KI
[41] Government KII
[42] Development partner KII
[43] Development partner KII

Nevertheless, the GFF has helped the MOH take ownership of resource and expenditure tracking processes,[44] and the World Bank has supported integration of district health planning and budgeting into the DHIS-2 platform.

The Ethiopian government has invested in key interventions to improve RMNCAH-N outcomes, including training and deploying health workers, strengthening health facility infrastructure, expanding family planning services, and increasing investments in antenatal care, skilled birth attendance, child health services, and adolescent health services.

One area where the GFF has played a more direct role in domestic financing discussions is in brokering dialogue with the government on contraceptive financing. Following UK ODA cuts and inflation-driven funding shortfalls, Ethiopia faced a $41.1 million gap for contraceptive supplies in 2022-2023, with only $17.4 million available. In response, the GFF conducted a costing analysis and facilitated a co-financing arrangement between the government and donors, including USAID, the Bill & Melinda Gates Foundation (BMGF), and the Buffett and Packard Foundations. The agreement was structured to incentivize the government to progressively increase its domestic spending on family planning, starting at 25% in the first year, rising to 50% and 85% in subsequent years.[45]

The integration of GFF funds with the SDG pooled fund has been particularly valuable, as it directly supports the procurement of RMNCAH-N commodities while also contributing to broader health system strengthening efforts. However, Ethiopia's limited fiscal space for increased domestic resource allocation remains a challenge. Data from the GFF data portal (2016-2020) show little change in government health expenditure, although budget execution has improved. Meanwhile, the share of health expenditure allocated to frontline providers has decreased, and OOP health expenditures have increased.

The GFF has contributed to identifying program-based budgeting as a key public financial management reform, supporting pilot programs at the sub-national level and collaborating with the World Bank to align financing approaches, including community-based health insurance.[46] It has also supported health financing reforms aimed at improving revenue generation by health facilities, ensuring that they have the necessary resources to deliver quality services.

- *Data/ results – what aspects of the data system were strengthened/what benefits or outcomes?*

The GFF has provided TA to strengthen the routine HMIS, and support to strengthen CRVS has included health facility level training on recording and registration system requirements and support for the development of a national CRVS strategic plan. It is more difficult to identify specific support for strengthening the HMIS, but the co-financed project includes DLIs related to health centers reporting HMIS data on time; annual rapid facility assessments being developed and implemented; and development and implementation of a health service community scorecard.

- *To what extent has there been demonstrable progress towards the TOC (in this country context)*

There have been improvements in some, but not all impact indicators in Ethiopia (see below – source: GFF data portal). It is difficult to attribute improvements to GFF support as other donors are also investing in RMNCAH-N and the United Nations is also providing TA.

[44] GFF/WB KII
[45] SCF, 2023. The GFF's contribution to improving health financing and health outcomes in Ethiopia. Policy brief
[46] GFF/WB KI

Indicator		Year		Year	Progress
MMR	412	2016	-[47]	2019	
U5MR	67	2016	55	2019	Improved
NMR	29	2016	30	2019	Not improved
Stillbirths	17.3	2011	11	2016	Improved
Adolescent birth rate	80	2016	79	2019	Unchanged
% of births <24 months after preceding birth	21.7	2016	-	2019	
Stunting U5s	36.8	2019	39	2023	Not improved
Moderate and severe wasting U5s	7.2	2019	11	2023	Not improved

GFF-supported initiatives, such as those in Oromia and Somali regions, have led to substantial improvements in the number of skilled deliveries and the overall quality of care.[48]

Analysis of HMIS service utilization data suggests that there was a decrease in ANC1 coverage in the 4-year period 2020 and 2023 by 21.5% to 51%. During the same period institutional delivery coverage increased by 10.4% to 58%.[49]

The GFF's focus on civil registration and vital statistics has improved data availability and decision-making processes.[50] CRVS data (see data portal) show improvement in the percentage of births registered from 19.5% in 2019 to 40% in 2022; and in the percentage of deaths registered from 13% to 18.1% in the same period.

- *What lessons in advancing gender, voice and equity?*

GFF training and capacity building for CSOs has enabled these organizations to advocate more effectively, for example on resource allocation for RMNCAH-N for underserved populations. The GFF has provided grant funding to CSOs working on strengthening the voices of youth in addressing SRH challenges and increasing youth uptake of SRH services. However, financing CSOs has been challenging due to the WB's structural limitations in directly funding these organizations. The GFF set up a civil society host organization to manage grants, ensuring that CSOs like CORHA (Consortium of Reproductive Health Associations) remain actively engaged.[51]

It is difficult to attribute but GFF support for gender-related analysis and data disaggregation and capacity building for senior female leadership may have contributed to increased government focus on gender and health outcomes. However, gender inequalities in management at lower levels of the health sector persist.

Support to expand coverage/ enrolment in health insurance has the potential to address aspects of health inequities (e.g. access to services, OOPs). Likewise potential of targeted funding for service delivery in poorly performing areas and use of DLIs to increase access to quality services for under-served populations.

[47] UN 2022 report states that MMR has decreased to 219/100,000. The MOH GFF FP reports that significant progress has been made in reducing maternal mortality to 219 per 100,000 and under-five mortality to around 40 per 1,000 live births, though neonatal mortality remains a challenge.
[48] GFF/WB KI
[49] GFF FASTR Ethiopia presentation August 2023
[50] GFF/WB KI
[51] GFF/WB KI

Any reflections on key findings or implications for the model?

- Internal conflict and population displacement have had a significant impact on access to health services and health and nutrition outcomes. There may be scope for the GFF to apply lessons from its successes in working in other fragility, conflict, and violence (FCV) contexts.
- Nutrition is a priority for the GFF in Ethiopia, but its focus in this area has been limited to health sector actions and nutrition indicators have worsened.
- More focus may be required in supporting the government on the sub-national level to address regional inequalities and weak capacity. "Building capacity at the district level is very critical if we want to make a real impact on the system." [52]

[52] GFF/WB KI

Annex 1: Documents reviewed and stakeholders interviewed

Documents reviewed	Year of issue
Ethiopia Strategy Note .docx	2021
Ethiopia_IC.pdf	2021
GFF_TFC_ CIS Ethiopia_April 21 2020.pdf	2020
Ethiopia_Health-Sector-Transformation-Plan-I-2015-2020-Endline-Review_Dec2022.pdf	2022
Ethiopia AF_PAD_P160108.pdf	
Ethiopia-GFF Report Interior Pages 0717_42-43.pdf	
FASTR Ethiopia August 2023.pptx	2023
GFF-Country-Implementation-Workshop-Report-2018.pdf	2018
HSDIP_Ethiopia IC.pdf	
HSTP II MTR final report .pdf	2023
PAI GFF Workshop Proceeding. CORHA.pdf	2022
Policy Brief on GFF's contribution in Ethiopia.pdf	2023
FY23 Ethiopia CES review 2022.09.01.docx	2022
Summary-Note-RMET-COVID-ENGLISH.pdf	2020
Ethiopia_Health-Sector-Transformation-Plan-I-2015-2020-Endline-Review_Dec2022.pdf	2022

Name	Position	Association
Dinksera Debebe Mekuria	Liaison Officer	GFF
Tsedeke Mathewos Masebo	Result Specialist	GFF
Eshete Yilma Tefera	Consultant	GFF
Tseganeh Amsalu Guracha	TTL	WB
Roman Tesfaye	TTL	WB
Dr. Ruth Nigatu	Government Focal Point	MOH
Dr. Alemayehu Hunduma Higi	Acting MCH LEO	MOH
Naod Wendrad	Former Strategic Affairs LEO	MOH
Dr. Helina Worku	Deputy Director Health Office	USAID
Dr. Bejoy P. Nambiar	Health Policy and Planning Team Lead	WHO
Dr. Daniel Ngemera	Chief of Health	UNICEF
Susna De	Deputy Director for Health and Nutrition, Ethiopia	BMGF
Abebe Kebede	Executive Director Consortium of Reproductive Health Associations (CORHA)	CSO
Mr. Ermias Dessie	Health Economics Expert in Health Policy and Planning Team	WHO
Brendan Michaell Hayes	GFF Focal point for Ethiopia	GFF

Malawi

Malawi Case Study

Brief outline of the GFF/ WB investment

The GFF portfolio in Malawi currently stands at US$ 20 million, co-financing two major projects: the Investing in Early Years for Growth and Productivity Project (IEYP) - (P164771) and the COVID-19 and Emergency Preparedness Response Project, both implemented under the Ministry of Health. The IEYP is a multi-sectoral initiative led by the Ministry of Gender, Community Development and Social Welfare, in collaboration with the Ministry of Education, Ministry of Health, Ministry of Local Government, Unity and Culture, and the Department of Nutrition, HIV, and AIDS. This project focuses on adolescent health, child development, and nutrition. The COVID-19 and Emergency Preparedness Response Project, implemented by the Ministry of Health, aims to strengthen health systems and ensure quality service delivery, benefiting women and children.

Additionally, there is a new five-year project funded by the World Bank through IDA, the Malawi Health Emergency Preparedness, Response, and Resilience (HEPRR) Project (P505187), utilizing a Multiphase Programmatic Approach. The GFF is investing USD 10 million in this new project.[53] The new project will focus on climate change and health.

GFF and World Bank RMNCAH Investments in Malawi (2019 – 2024):

Component	GFF	World Bank IDA
Community-based nutrition and early stimulation interventions	US$ 8.9 million	US$ 26.2 million of which USD $17.3 million IDA
Center-based early learning, nutrition and health interventions	US$ 200,000	US$ 19.3 million of which US$ 19.1 million IDA
Multi-sectoral coordination, capacity and system strengthening	US$ 1 million	US$ 14.5 million of which USD$ 13.5 million IDA
Emergency COVID-19 Response		US$ 300,000
Supporting National and Sub-national Prevention and Preparedness		US$ 950,000
Implementation Management and M&E		USD 750,000
Essential Health Services	US$ 10 million	

Details of the GFF investments: [54]

Exec Type	Funding Cat	Budget Cat	Budgeted	Disbursed
RE	1st Round Grants - IEYD	Grants	$10 million	$9,741,168
RE	1st Round Grants	Grants	$10 million	$0
RE	EHS Grants	Grant	$10 million	$8,471,219
BE	CORE TA	Project Preparation	$99,974	$99,974
BE	Core TA	Supervision	$895,000	$887,771
BE	Core TA	IC Implementation	$70,000	$0
BE	Flexible TA	Quality RMNCAH-N Exploratory Grant	$199,988	$199,988

[53] WB PAD 2018; 2020

[54] GFF Case Study Countries - RE and BE Portfolio Summary 2024

BE	Flexible TA	Quality RMNCAH-N COVID-19 TA	$221,344	$221,344
BE	Flexible TA	SRHR (inc. Adolescents	$40,000	$0

Both the IEYP and the COVID-19 Emergency response projects are nearing the end, although there are other projects that are in the pipeline where the GFF will be a key co-financing partner with the World Bank.

The investment case

- *Brief overview of the Investment Case*

With GFF support, Malawi developed its first Investment Case (IC) in 2019 through a participatory process that aimed to prioritize RMNCAH-N interventions in alignment with the country's Health Sector Strategic Plan II (HSSP II). The IC was initially costed at approximately US$900 million, later revised to US$120 million, but its implementation faced significant challenges. A key issue was the lack of alignment between the IC and the existing World Bank projects that were co-financed by the GFF, which had been developed before the IC was finalized. Additionally, limited financial commitments from other partners further constrained implementation. As a result, enthusiasm around the IC's role in mobilizing and aligning resources for RMNCAH-N remained limited.

Despite these challenges, some elements of the first IC contributed to facility-based planning and budgeting, particularly through capacity-building efforts at the district and facility levels.[55] The GFF, alongside other partners, provided TA and training at the sub-national level, supporting districts in planning and budgeting processes that emphasized RMNCAH-N and health system strengthening.[56] This support helped strengthen local capacity for health service delivery and laid the groundwork for more effective integration of RMNCAH-N priorities into broader health sector planning efforts.

Recognizing the need for a more comprehensive and better-integrated approach, the GFF played a leading role in supporting the development of the Health Sector Strategic Plan III (HSSP III) (2022–2030), which was ultimately adopted as Malawi's new IC. This process involved extensive technical assistance from the GFF, alongside collaboration with key donors and the Ministry of Health, to ensure that various health initiatives were consolidated into a single, cohesive national plan. Unlike the initial IC, which operated as a standalone framework, HSSP III represents a more integrated and collaborative approach, embedding RMNCAH-N priorities within a broader health sector strategy.

The finalization of HSSP III has also led to a shift in how the IC is operationalized. The government, with GFF support, is focusing on translating national priorities into district-level operational plans, ensuring better resource alignment and evidence-based decision-making at the sub-national level. Guidelines have been developed to assist districts in preparing their own ICs, allowing for context-specific prioritization of interventions. This shift is intended to enhance the impact of RMNCAH-N efforts while aligning with available domestic and external financing.[57] Through this process, the GFF has helped facilitate stronger donor coordination and alignment, reinforcing the 'One Plan, One Budget, One Report' approach.

[55] Government KI
[56] Government KI
[57] Government KI

Are there clear RMNCAH-N priorities identified – if so, what?
The HSSP III prioritizes the RMNCAH-N issues in terms of a systems approach to the delivery of health services. The GFF role in the development of the HSSP III was consistently reported to be a main contribution by the GFF by all participants to the study.

> *"The one thing I would say about the engagement model that was very successful is that we were able to contribute, and I believe substantially, to the development of HSSP III, which is the one plan, one budget, one M&E approach that the government has launched. And you may be aware that previously there had been something like 56 different national level strategies in Malawi. And the HSSP III sought to integrate those into a single strategy."* – GFF/WB KI

A key advantage of adopting the HSSP III as the IC is that the scope for alignment increases as all partners have in principle, agreed to work in support of country priorities. Given the multiplicity of actors, each with different priorities, sometimes with possibility of duplication of support (to departments or districts), the adoption of the HSSP III as the IC increases the chances of alignment by the different actors. Nevertheless, some participants in the evaluation, including the World Health Organization and former TAs to the MOH consider RMNCAH-N issues not to have been sharply prioritized within the HSSP III, with the danger that some RMNCAH-N aspects may be deprioritized with regard to funding support and implementation.

These concerns were further corroborated through document review where HSSP III is seen as being broad and did not adequately allow for RMNCAH-N prioritization, as can be observed below:

> *"The HSSP III was finalized and serves as the new IC for Malawi. The GFF provided support for the development of the plan, however, the plan is very broad and did not provide an opportunity for a prioritized focus on RMNCAH-N. In view of the prioritization challenge, …. the government (and the GFF is) supporting this district level planning which further prioritizes the HSSP III, allows the opportunity to use data/evidence and to align the district plans to available resources." – Malawi CES Review, February 2024*

Nevertheless, while these concerns point to the need for a sharp focus of RMNCAH-N to ensure prioritization, there are specific RMNCAH-N results and indicators of progress in the HSSP III results framework.[58] Despite challenges with the first IC prepared with support from GFF, the current HSSP III is seen to be dynamic in responding to the current needs of the country as it approaches health from a health systems strengthening perspective.

> *"The HSSP III is a high-level policy document… it may not have the RMNCAH-N issues on the front page, but if you look closely in the details of the plan, you will find that RMNCAH issues are addressed… it talks of human resources for health and the RMNCAH-N indicators are tracked as part of the plan"* – GFF/WB KI

[58] Government of Malawi, 2023

Specifically, HSSP III includes critical indicators that track maternal and child health outcomes, such as reductions in under-five, infant, neonatal, and maternal mortality rates, as well as adolescent fertility and mother-to-child HIV transmission. It also emphasizes improving service delivery by monitoring access to and quality of essential interventions, including skilled birth attendance, antenatal and postpartum care, immunization coverage, family planning uptake, and ART coverage for HIV-infected pregnant women. While HSSP III may not present RMNCAH-N as a distinct priority, its integrated approach ensures that key maternal, newborn, and child health issues remain central to broader health system reforms, creating opportunities for targeted action.[59]

Country Platform

The Health Sector Working Group (HSWG) is Malawi's Country Platform as agreed between the government and partners following extensive reviews of the health sector stakeholder coordination platforms (Government of Malawi/GFF, 2018). Since the group represented the governance platform for coordinating health sector-wide reforms, it was deemed appropriate for the coordination of tasks requiring multi-sectoral engagement.

Where is it based – who takes part?

Country partners include the government of Malawi, led by the Ministry of Health and various MOH departments, with the Planning Department as the focal point. Other stakeholders include donor agencies such as the United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), World Health Organization (WHO), Clinton Health Access Initiative (CHAI), the United States Agency for International Development (USAID), and the Foreign, Commonwealth and Development Office (FCDO). They further include private sector, civil society and youth platforms. The HSWG is the country platform and consists of a mechanism where different actors interface around health sector support. It consists of a gathering of several constituencies, including donors, NGOs and youth. [64]

A number of subject specific sub-Technical Working Groups (TWGs) are in place and functioning, including the SRHR TWG, Community Health TWG, Human Resources and Services, Essential Health Package TWG, and others. The input from these TWGs is reported to the HSWG, which is at the pinnacle of health sector coordination in the country. With the launch of HSSP III, an HSSP III Technical Working Committee has been established and is now operational. This committee evaluates coherence across TWGs, finalizes the "One Plan," oversees the "One Budget," addresses risks and implementation challenges, reviews and guides implementation progress, and monitors performance targets.

> *"The GFF has not established real coordination structures, but uses the country existing structures, this is a key strength. Other global health agencies have set up standalone coordination platforms, but GFF uses existing country structures."*
> – Development Partner KI

- *Any evidence on how active it is?*

While the TWGs have been active, the HSWG has been less than fully functional in the recent past. The HSWG recently met in September 2024, having not met over the previous 1-2 years and there have been concerns about its effectiveness and provision of sector overall leadership.[60] The GFF reports there are

[59] Government of the Republic of Malawi Health Sector Strategic Plan III 2023-2030
[60] KIs, all non-state agencies consider this trend to be

resources available for the HSWG to meet, but its ability to convene appears to have been affected by competing time priorities in the wake of the need to attend to the COVID-19 pandemic and Cyclone Freddy. Another key factor cited for the lack of HSWG convening is the overextended human resource capacities in the MOH to coordinate the meetings. This challenge has been recognized by MOH and efforts are on-going to address it.

There are perceived limitations in the GFF effectiveness to fully engage partners in the country with a "light" staff presence against a transaction heavy engagement process.[61]

> *"To be effective in engaging stakeholders, really GFF has to increase its presence in the country… you know to follow up with donors and other partners. The Focal person needs to be based in Malawi"* – External Partner KI

KEY FINDINGS BY AI

AI 1

- *Delivering health services – what is the model – how is this being achieved?*

For Malawi, the GFF has supported the systems strengthening agenda by assisting the MOH policy and planning processes which tend to impact the whole health system. These come under the second additional financing for the COVID-19 Emergency Response and Health Systems Preparedness project (MOH) under IBRD/IDA-US$ 60.0 million, of which US$ 25.4 million is credit, US$ 24.5 million is IDA grant and US$ 10.0 million is GFF grant.

In addition, IEYP has a total funding of US$ 60 million, of which GFF contribution is US$ 10.0 million. Funding is channeled from WB TO project accounts retained by the Project Implementation Unit/ Project Facilitation Team with oversight from the Ministry of Finance and Economic Affairs. Both projects retain a USD account and a Malawi Kwacha operational account. Under the COVID-19 Emergency Response and Health Systems Preparedness project, the GFF refunds the government for the funds spent on service delivery, in government budget retro-financing arrangement.

Stakeholders viewed the inability of GFF to leverage significant amounts of funds to finance programs as weakness, although this could also be a result of limited information on actual funds leveraged by GFF for women, children and adolescent's health services. To date, GFF has co-financed two projects, investing US$ 20 million. A third project is in the pipeline where an additional US$ 10 million will be invested in a co-financing arrangement with the WB.

There is perceived limited direct engagement with the RMNCAH-N platforms, although working at a central planning level is designed to affect health systems to benefit women, children and adolescents. The following quote demonstrates this perception:

> *"I would say there is no direct engagement with the RMNCAH-N platforms... and I'm not sure why that is. But seriously, engagement with these platforms in Malawi really needs to improve."* – Development Partner KI

- *Quality of care – what is the model – evidence of this being achieved?*

[61] Development partners KIs and GFF/WB KIs

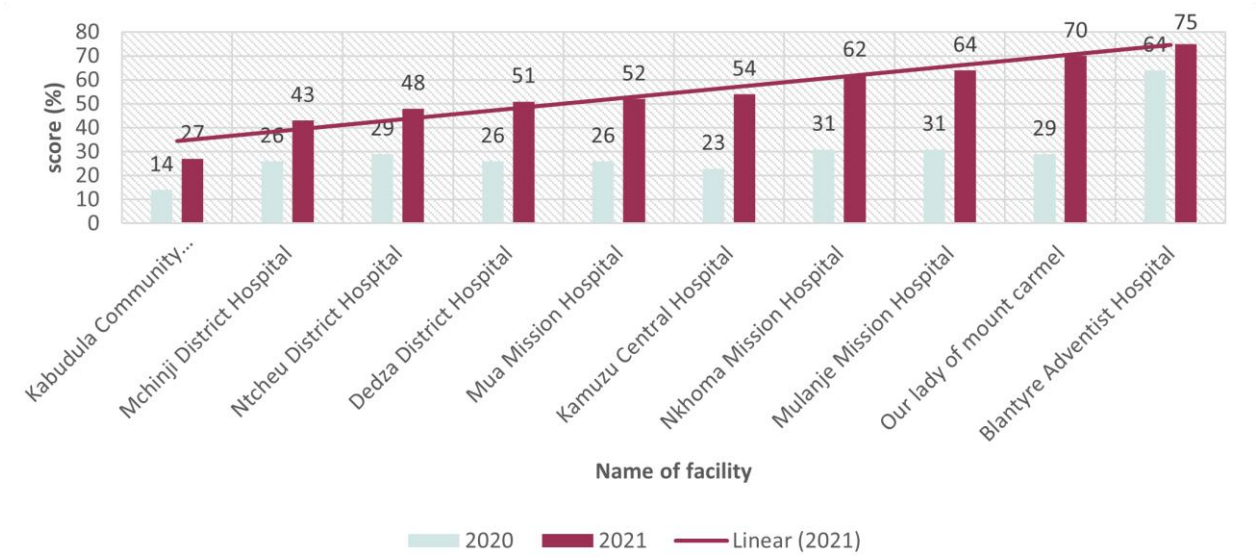
Under the COVID-19 Emergency project, sub-component 1.4, the following have been achieved:[62]

- Through GFF funding, skilled health workers have been trained in Basic Emergency Obstetric and Neonatal Care.
- Provision of 3000 motorbikes to enable mobility for Health Surveillance Assistants.
- Through the MOH, the GFF supported the Quality of Care Directorate in developing comprehensive service quality standards and monitoring the quality of health services.

As part of broader efforts to strengthen health systems, the step-wise quality improvement assessment was introduced to enhance service quality at health facilities. This structured assessment serves as the foundation for identifying gaps, planning improvements, and guiding interventions through mentoring, provision of supplies, and equipment.

Facilities progressively improve and can advance through five steps, with step 5 representing the highest quality of care rating. Assessments are conducted by external surveyors from the accreditation body, ensuring an objective evaluation of progress.

The following chart highlights the impact of this initiative, showcasing how it has identified quality issues and provided follow-up advice and mentoring to drive improvements.



The data suggest improvements in quality of care in health facilities when compared with baseline status. The recorded improvements are reported to be in part due to the quality of care assessments and the follow-up improvement efforts by the facilities based on the gaps identified. This suggests that the quality of care assessments tend to incentivize facilities to work on shortfalls to improve quality of care.

> *"Everything that we have talked about regarding quality of care program is funded under sub-component 1.4 by GFF. We see that after assessment and support, health facilities work hard to improve their rating and move to higher rated star status. In fact, after rating, some private health facilities implore the teams not to publish their ratings until they have worked on the shortfalls identified. This has now become a great*

[62] KIIs and document review

> *motivation for facilities, both public and private to improve the quality of care"* – Government KI

Target is to improve quality of care in 800 facilities by 2028. Results of the baseline assessment found only one facility (Blantyre Adventist) was a step 5 facility. A further 13 were rated to be 2nd step facilities, while 8 received a 3rd step rating. Results were used to support lower rated facilities to meet the expected quality standards in essential health services country-wide.[63]

- *Added value to other RMNCAH-N actors? How? Evidence?*

Participants indicated that the GFF and the World Bank, as part of the Health Donor Group, have the potential to leverage their position to mobilize additional resources for women's, children's, and adolescents' health in the country.[64, 65 66]

However, there was also a perception amongst stakeholders that GFF could do more to leverage more funding through the World Bank for health systems strengthening that is specifically targeted at women, children and adolescent's health. Greater collaboration with the Health Services Joint Fund is also highlighted as a key area to further focus on.[67]

The GFF is regarded as a strategic contributor in the health sector, complementing other initiatives such as RMNCAH-N Countdown 2030. However, stakeholders noted challenges related to GFF financing, as funds must be channeled through World Bank systems. Specifically, they highlighted that during the first Investment Case (IC) in Malawi, the World Bank did not directly co-finance Ministry of Health interventions due to the absence of a World Bank-funded health project at the time.

The Country Partnership Framework that included health support was completed in 2021 and covers the period 2021-2025, which should facilitate the financing of future health related investments by the WB and GFF.

> *"We are unable to channel resources, sometimes to the World Bank and sometimes to the country because the WB is not ready to receive the funds. We are also not able to channel funds to other partners such as UNICEF because our operational structure is tied to that of the World Bank"* – GFF/WB KI

AI 2

- *GFF/ WB leveraging each other's strengths*

There is a perception that before GFF and World Bank partnership in Malawi, the designs of health-related projects were disease specific. GFF/World Bank staff (former and present) indicate that this trend has changed, and greater attention is paid to RMNCAH-N issues.[68] Specific examples are the IEY and the COVID-19 Emergency response projects. On the other hand, the WB reputation has been used to influence other donors to align with the HSSP III by supporting the One plan, one budget, one report philosophy in HSSP III.

[63] Government KI
[64] CSO, GFF/WB, development/external partners KIs.
[65] The World Bank is currently the Chair of. the Health Donor Group, assisted by the GFF LO.
[66] Mentioned by all KIs
[67] External partner KI
[68] GFF/WB KIs

- *Are the roles sufficiently clear/ separated?*

All participants in the study that were non-GFF/World Bank declared they were not able to tell how the GFF and the World Bank worked, except that GFF is housed in the World Bank Offices. Government staff considered the arrangement to be "somewhat difficult" to apportion certain inputs between GFF and WB as seen through quote below:

> *"Because it was the WB using its strategic influence amongst other donors to say, okay, let's support ministry in a more coordinated way. …. But because GFF and World Bank are working together in the health sector, you can maybe give them 10% credit for that. But it's a difficult one, if we are to be honest."* – Government KI

Some participants indicated they knew of projects co-financed by the GFF and World Bank such as the Investing in Early Years Project. They cited the IEY Project and COVID-19 Emergency response project as examples, but beyond this, they did not seem to have further information.

- *Opportunities to maximize complementarity*

With the World Bank's funding capacity, participants pointed out the need to utilize this power to mobilize additional resources for RMNCAH-N. The following sentiments were illustrative of this expectation:

> *"Everyone listens to the World Bank because of its key role in development financing in the country. I think that power should be used more, to influence other donors, and perhaps the World Bank itself, to finance the HSSP III priorities"* – External Partner KI

Both GFF and World Bank are members of the Donor Health Group and should take the opportunity to advocate for greater alignment and prioritization of RMNCAH-N by health financiers.

> *"GFF and World Bank can do more, they should play more the convening role around alignment and advocate for RMNCAH-N. That role is currently played by FCDO as part of the Health Services Joint Fund"* – External Partner KI

Stakeholders agree that GFF and World Bank support to government through MOH has been effective. The technical assistance support, especially with respect to the preparation of the HSSP III and the two projects that GFF has co-financed with WB are said to be effective as it addresses RMNCAH-N issues. The caveat is that financial support for direct service delivery is viewed to be inadequate.[69]

Stakeholders agree that the GFF has made important contributions to the development of Malawi's third generation Health Sector Strategic Plan (HSSP III). Rather than an issue or project specific focus, the HSSP III has been adopted as the investment case for the country and is built around the alignment principles of one plan, one budget and one M&E.[70]

- *Lessons learned*

[69] Government KI
[70] Government, CSOs, GFF/WB and development partners KIs

Several key lessons emerged from the GFF-World Bank partnership in Malawi. One major challenge has been the perceived lack of flexibility in accessing small amounts of funding to support the MOH in unlocking collaboration and coordination benefits. Stakeholders expressed frustration over inconsistent responses to funding requests, making it difficult to secure support for critical needs.

> *"We have made requests for support, we submitted our request last year, … depending on who you meet, there is always a different story, about why the requests cannot be funded, because the system does not work like that"* – Government KI

Another key lesson is that while past tensions between the GFF and the World Bank previously hindered deeper engagement, these issues have largely been resolved. Stakeholders acknowledged that efforts to strengthen collaboration have improved coordination and clarified roles between the two entities.

> *"Well, I think it's [the relationship] become more effective, especially recently. There was a lot of tension between the World Bank and the GFF a few years ago, and I think that it hindered the ability of the GFF to engage as deeply as we could have. But those things have since been resolved, and the World Bank and GFF, I think, have been forging a path forward, working pretty well together and kind of understanding, you know, who has what roles, right."* – Government KI

The adoption of HSSP III as Malawi's Investment Case reflects GFF's role in promoting alignment, prioritization, and coordination in a crowded health financing landscape with over 200 players. The Government's leadership in owning and implementing HSSP III is seen as a key step forward in structuring partner engagement under a unified approach.

Existing country-owned platforms, such as the Health Sector Working Group and the Donor Health Group, provide opportunities for improved dialogue and action on alignment and prioritization of RMNCAH-N. While stakeholders recognize that the HSSP III is still in its early stages, there is strong momentum around the alignment agenda. The following sentiments reinforce this perception: *"… and I think we're kind of at relatively early stages, the HSSP III is new and is at the beginning of its strategic life. But I think, the alignment agenda is strong, and the desire of the development partners to align seems very strong."* – GFF/WB KI

AI 3

- *Where does GFF add value?*

Most participants indicated that GFF's value addition is reflected in its support for policy and planning processes in the health sector. However, others found it difficult to pinpoint GFF's specific contributions to the RMNCAH-N agenda in the country. Participants highlighted GFF's support for the development of HSSP III and efforts to operationalize facility-level planning as key contributions.

CSO and GFF/World Bank participants view GFF's engagement through the Ministry of Health's Planning Department—rather than through operational directorates—as a key strength. This approach, along with the use of existing country platforms for engagement, enables GFF to play a role in influencing national planning and budgeting processes.

> *"No, but the thing is, this goes back to the fragmentation within the ministry, because you could have instead established a relationship with the reproductive health department*

right but in that case then you wouldn't be part of something which is really critical which is the planning and budgeting process" – CSO KI

Consistent support and mobilization of different constituencies around RMNCAH-N is seen as an added strength.

"But in terms of the structure, the country platform, we have the structure in place. And the CSOs within this engagement framework, I think we have maintained and supported it. Because it also brings everyone to the table. It's not that the CSOs are operating outside that framework. There's a seat for every key stakeholder, donors, CSOs and others." – Development Partner KI

Barriers to GFF's effectiveness include having a minimal in-country presence, which limits its ability to engage extensively with stakeholders. Additionally, there is a perceived low capacity to directly finance or leverage sufficient funding for RMNCAH-N.

- *What factors have contributed to success/limited progress?*

Stakeholders agree that the success that has been achieved by GFF in Malawi arises from its use of country systems-Health Sector Working Group and its associated Technical Working Groups, as well as the Government Planning systems. Alignment with country priorities through adoption of the HSSP III as IC is in further evidence. GFF has always asked government partners, through the Ministry of Health, where they should provide support.

However, its limited capacity to finance and mobilize adequate funds so far is seen as a barrier towards the achievement of its mandates. It was reported that GFF should leverage its convening power to mobilize additional funding as well as promote alignment.

"I think GFF is strong when it comes to strengthening the health system as a whole which is the direction that the ministry is taking, when it comes to the specifics in RMANCH, perhaps I don't have much knowledge, but I'm still not convinced that they have done such a good job …." – Government KI

- *Extent ensured adequate funding for RMNCAH-N services?*

Stakeholders point to Resource Mapping and Expenditure tracking (RMET) supported by GFF to have the potential to prevent duplication in financing and support alignment and prioritization of RMCAH-N, as the following quote illustrates:

"It avoids pulling in different directions. It ensures that everyone is pulling in the same direction Using the one plan, one budget and one report principles of the HSSP III" – Development Partner KI

RMET will enhance co-creation of outcomes and mutual accountability for results, aligning with the "one plan, one budget, one report" principle of HSSP III. This approach will help identify funding gaps and areas for collaboration.

The GFF has supported RMET in partnership with CHAI. There are future prospects for GFF financing RMET efforts through CHAI, which has been assisting the government in conducting these assessments.

RMET has increased awareness of RMNCAH-N through expenditure tracking. However, the GFF's impact on Malawi's broader health financing landscape remains limited, as reflected in stakeholder feedback:

> "GFF *has not been very effective around health financing in Malawi. It has just started on work around efficiency and domestic resource mobilization."*
> – GFF/WB KI

The HSSP III and the Health Financing Strategy that articulate health financing reforms are only now being rolled out, hence, it is considered early to demonstrate their effect in Malawi. The HSSP III was prepared with the support of GFF, while health financing is core interest of the GFF.[71] However, participants further point to the fact that RMNCAH-N budgets are not protected, and facilities tend to just "scrap by", highlighting the need to actively protect RMNCAH-N budgets.[72]

- *Data/results – what aspects of the data system were strengthened/what benefits or outcomes?*

GFF is now considering support for the operationalization of the one report principle from the HSSP III. A mechanism for data collection for quality of care measurement and management has been rolled out with GFF support.[73] Through the Quality Department, there is periodic assessment of quality of care in health facilities that is reported periodically (see AI 1). A harmonized tool for service delivery quality assessment has been developed and used for monitoring quality.

Contribution to national level data generation and evidence use has been done collaboratively with other partners, although participants indicate this is an area where GFF can increase its efforts, especially data and evidence around RMNCAH-N.

- *To what extent has there been demonstrable progress towards the TOC?*

Participants agree that some RMNCAH-N indicators show improvement over 2015 status, but that it would be extremely audacious to link them to GFF despite the great effort exerted around planning and alignment promotion-*see Annex 2.1 and 2.2.*

Based on its theory of change, the GFF has made contributions towards support for the sustained government led multi-stakeholder platform, as well as health systems strengthening through the projects currently under implementation (*see Annex 2.1 and 2.2).* Hence, assuming the assumptions of the chain of causation in the ToC hold, it is plausible to indicate that GFF in Malawi has contributed to both the envisaged immediate and intermediate outcomes.

- *What lessons in advancing gender, voice and equity?*

Some development partners felt that the scope of RMNCAH-N priorities in Malawi was too broad, making it difficult to ensure adequate attention and funding for all components. As a result, certain areas—particularly sexual and reproductive health and rights (SRHR) and child health—were perceived to have received insufficient funding. [74] In addition, the following lessons learned were noted:

- Broad stakeholder engagement facilitates representation and voice for constituencies that can easily be excluded from the alignment and prioritization agenda for RMNCAH-N.

[71] Government KI and GFF/WB KI
[72] External partner KI
[73] Government KI
[74] Development partners KIs

- Support for community health service delivery via facility level planning is a good practice to achieve quality and equity in health service delivery.
- Involvement of CSOs in the country platform is beneficial but should extend to capacity building for CSOs to generate issues from the communities they represent.
- Clarity on funding expectations from the outset is essential in IC development. The absence of concrete funding for the first IC led to disappointment among stakeholders, which some felt weakened the perception of GFF as a strong financial partner.

Any reflections on key findings or implications for the model?

- The findings show that the GFF engagement model is effective, facilitating collaboration between the GFF, the Government, and stakeholders through support to country platforms.
- GFF has worked through government-led platforms to promote alignment and prioritization of RMNCAH-N, mainly via the Ministry of Health's Planning Directorate. The operational structure includes a focal person, Results Expert, and Liaison Officer who work closely with the World Bank and partners.
- The investment case has evolved from a separate RMNCAH-N effort to adopting the national health strategic plan (HSSP III), reflecting negotiation and learning, particularly after the limited success in mobilizing funding for RMNCAH-N initially.
- Some adaptations are needed, such as: a) basing focal persons in-country for more efficient engagement, and b) better use of GFF-World Bank convening power to align donor support with HSSP III.
- The GFF model assumes the government will adopt and implement reforms to improve RMNCAH-N outcomes, and that donors will align their support. For Malawi, this is a critical assumption reflected in how the GFF engages and supports the government of Malawi-via policy and planning systems, that are expected to further influence service delivery. However, donor financing models may not always allow easy alignment.
- Evaluation results highlight the need for active funding for RMNCAH-N and direct engagement with RMNCAH-N platforms, as well as for GFF and the World Bank to show alignment with HSSP III to influence additional donor funding.

- *Considerations for the future*

Some considerations for the future include the following:

- Place additional focus on the protection of RMNCAH-N budgets in the health systems.
- Besides the central planning level, consider direct engagement with the RMNCAH-N platforms to facilitate aligning and program funding support.
- Invest in data and evidence generation to facilitate RMNCAH-N alignment and learning in the country.
- To leverage its strengths, use the combined convening power of the WB and GFF, especially among donor agencies to mobilize more funding and promote greater alignment and prioritization of RMNCAH-N in Malawi.
- Review the GFF focus scope and consider streamlining aspects that are core to increase impact and avoid overextending GFF reach. This is in view of perceptions that the GFF appears to be spreading itself too thin as it takes on more and more interventions beyond a focus on the RMNCAH-N.
- Consider arrangements that afford greater flexibility for GFF to be dynamic in the provision of financial assistance to effectively respond to government and partner needs. This would include

permitting GFF to have a country budget, as well scope to co-finance initiatives with other partners other than the World Bank.

- Improve communication between global level partners and country level partners to remove confusion among country level players in RMNCAH-N. This is in view of perceptions that while there is good dialogue among global level partners through the investors group, the dialogue at the country level is less coherent.

Annex 1: Documents reviewed and stakeholders interviewed

Documents reviewed	Year of issue
Connolly, E., Mohan, S., Twea, P., Msuku, T., Kees, A., Sharma, L., Manthalu, G. Revision of Malawi's Health Benefits Package: A Critical Analysis of Policy Formulation and Implementation. Value Health REG Issues, 84-94.	2024
Ganchimeg, T., Ota, E., Morisaki, N., Laopaiboon, M., Lumbiganon, P., Zhan, J., . . . Mori, R. Pregnancy and Child Births among adolescent mothers: a World Health Organization multi-country study. International Journal of Obstetrics & Gynaecology, 40-48.	2014
The Government of Malawi's Investment Case for Reproductive Health, Maternal, Newborn, Child and Adolescent Health and Nutrition	2020
Government of Malawi - The National Health Financing Strategy: 2023-2030	2023
Government of Malawi/GFF/World Bank - MALAWI: COVID-19 Emergency Response and Health Systems Preparedness Project (P173806) Implementation Support Mission	2024
Global Financing Facility 2021-2025 Strategy: Protecting, promoting and Accelerating Health Gains for Women, Children and Adolescents	2020
Main Discussion and Decision Points – Malawi CES Review	2022
Malawi CES Review	2024
World Bank. International Development Association Project Paper for the Second Additional Financing for Malawi COVID-19 Emergency Response AND Health Systems Preparedness Project	2021
World Health organization (2007). Global Fund Strategic Approach to Health Systems Strengthening: Report from WHO to The Global Fund Secretariat	2007

Name	Position	Association
Jean Nyondo	Former GFF TA Provider	GFF
Matthew Kagoli	Director, Public Health Institute of Malawi (PHIM)	Ministry of Health
Kenasi Kasinje	Liaison Officer	GFF
Gerald Manthalu	Director of Planning and Policy Development (DPPD)	Ministry of Health
Maziko Matemba	HREP Malawi / GFF CSO Global Ambassador	
Prof. Adamson Muula	Team Leader, Countdown to 2030	KUHeS
Atamandike Chingwanda	Former GFF TA Provider	GFF
John Borrazzo	Former GFF Focal Point	GFF
John Paul Clark	Lead Health Specialist (Former GFF Focal Point)	GFF/World Bank
Pius Nakoma	Former GFF Liaison Officer	Health Sector Joint Fund
Regina Mankhamba	Former GFF TA Provider	GFF TA Providers
Stella Tambala	Community Health Services Projects Office	Ministry of Health
Selemani Kondowe	Quality Management Director	Ministry of Health
Bernadette Chibwana	Principal Pharmacist	Ministry of Health
Dr. Clara Sambani	Project officer	Ministry of Health
Christina Chiilimba	Civil Society Orgs-Youth Platform	Youth Lead Organization
Stephanie Heung	Program Manager, CHAI	RMNCAH-N donors and partners
Solome Nampewo	Health System Specialist, WHO Malawi	UN technical agencies
Emilia Connolly	Partners in Health	Other Partners (technical agencies
Isidore Sieleunou	Malawi Focal Person	GFF/WB
Kirsten Gagnaire	Results Specialist	GFF/WB

Annex 2: Additional evidence

Annex 2.1: IEYP Progress towards key indicator results

Indicator Level	Indicator	Baseline[75]	Midline (2022)	Annual Survey (2024)	End of Project Target (2024)	Progress towards end target at 2024 Annual
Project Development Indicator	Children aged 6 – 23 months receiving a minimum acceptable diet (Percentage)	13	20.1	**23.3**	20	116.5%
	Children aged 0 – 6 months who were exclusively breastfed (Percentage)	60	66.2	**70.4**	68	103%
	Children aged 36-59 months who completed at least one year of early learning in CBCCs (Percentage).	0	82.3	**87.1**	50	174.2%
	Project beneficiaries who are children 0-59 months, adolescent girls 11-19 years and pregnant women (Number)	0	879,901	**2,003,631**	2,600,000	71.1%
Intermediate Result Indicators	Children aged 48 – 59 months achieved at least 50% score on literacy and numeracy components of the MDAT (Percentage)	17	26.4	**31.5**	30	105%
	Households practicing integrated homestead farming (Percentage)	28	37.3	**45.2**	38	118.8%
	Children aged 6 – 24 months who received micronutrient powder supplementation (Percentage)	5	16.1	**14.4**	25	56.7%
	Households where children 0 – 36 months play with toys made from locally available materials (Percentage)	43	59.5	**55.5**	58	95.7%
	Adolescent girls aged 10-19 years who received iron-folate supplementation (Number)	0	57,468	**936, 199**	1,700,000	50.1%
	Care group cluster leaders and promoters who received an integrated training package (Percentage)	0	36.9	**93.9**	80	117.4%
	Model CBCCs upgraded and equipped (Number)	0	0	**76**	150	51%

[75] Sources: MDAT Study (2021) and MCBN Survey (2019).

Indicator Level	Indicator	Baseline[75]	Midline (2022)	Annual Survey (2024)	End of Project Target (2024)	Progress towards end target at 2024 Annual
	Model CBCCs in target communities engaged in VSL activities (Number)	0	150	**150**	150	100%
	CBCC caregivers and mentors that received an integrated training package (Percentage)	0	44	**83.6**	80	104.5%
	Councils that receive a satisfactory rating from women and caregivers whose children received nutrition interventions and early learning and stimulation services (Number)	0	7	**8**	13	62%
	Percentage of districts budget allocated for nutrition and early learning in the project districts (Percentage)	0	1.87	**2.1**	10	21%
	Councils that submitted a monthly report into the nutrition database on time (Percentage)	0	62	**90**	90	100%
	Staff completed short- and long-term courses including diploma and master programs (Number)	0	0	**70**	100	70%
	Councils incorporated and implemented DIPs with ECD and nutrition (Number)	0	13	**13**	13	100%

Annex 2.2: COVID-19 Emergency Response Project Progress Towards Indicators

Indicator	Baseline	Actual	End Target	Comment
Project Development Objective (PDO) Level Indicators				
Percentage of designated laboratories with staff trained to conduct COVID-19 diagnosis. (Percentage)	0.00	110%	80.00	Target reached
Percentage of designated health facilities ready to treat COVID19 (Percentage)	0.00	100%	80.00	Target reached
Percentage of targeted population fully vaccinated based on the targets defined in national plan (Percentage) (Percentage)	0.00	39.5%	30.00	Target reached
Percentage of females fully vaccinated (Percentage)	0.00	53%	50.00	Target reached
Number of OPD visits per 1000 population (Number)	930.00	1061	1100.00	
Intermediate Results Indicators by Components				
Number of health staff trained in infection prevention and control per MOH-approved protocols (Number)	0.00	1141	1,448.00	Training of Trainers =260, Mobile Diagnostic Units = 68, Health Facility staff = 620, The 620 were oriented by the ToTs. 75 new staff have been trained. 118 managers trained in IPC WASH March 2024.
Oxygen plant installed and functional (Yes/No)	No	No	Yes	Specifications submitted for procurement. The project has had challenges in the procurement of the life and fire safety specialist. Bank informed of the challenge and advised to continue with procurement with BOQs containing the need of the supplier to provide the Life and fire safety considerations in their bid.
Number of health surveillance assistants (HSAs) oriented in contact tracing, by gender. (Number) (Number)	0.00	4598	4,500.00	Completed
Number of female health surveillance assistants (HSAs) oriented in contact tracing (Number) (Number)	0.00	2340	2,025.00	Completed
Percentage of health worker COVID-19 related trainings for which the training materials were assessed to identify the extent to which Gender Based Violence (GBV) is addressed (Percentage)	0.00	46%	70.00	6 out of 13 training materials of the planned trainings were reviewed for GBV.

				i.e. Case management, AEFI, Nursing, QMD, POE
Number of healthcare professionals (HCPs) and district investigation officers trained on detection and reporting, or investigation of AEFIs, by gender (Number)	0.00	1475	1,475.00	Completed
Number of female healthcare professionals (HCPs) and district investigation officers trained on detection and reporting, or investigation of AEFIs. (Number)	0.00	603	516.00	Completed
Number of districts conducting monthly community dialogues on COVID-19 vaccination and prevention measures (Number)	0.00	28	29.00	Blantyre, Nsanje, Rumphi Ntchisi, Mangochi, Nkhatabay, Chitipa, Kasungu, Mchinji, Dedza, Dowa, Nkhotakota, Salima, Machinga, Neno, Likoma, Mzimba North Chikwawa, Chiladzulu, Karonga, Mulanje, Lilongwe, Mwanza, Ntcheu, Thyolo, and Zomba.
Number of districts with the required climate sensitive/energy-efficient ultra-low temperature freezer to store COVID-19 vaccines (Number)	0.00	29	29.00	Procurement completed. Fridges distributed to districts
Number of central hospitals rehabilitated for COVID-19 case management (Number)	0.00	0	4.00	EOI from prospective consultants were evaluated by 9th April 2024. Contracts are expected to be signed by 10th May, 2024
Number of incinerators that are functional (Number)	0.00	27	15.00	Karonga has 4 functional incinerators
Contraceptive utilization rate (Percentage)	62.00	65	70.00	
Percentage of pregnant women who made their first ANC visit within the first three months of pregnancy (Percentage)	24.00	15.3%	30.00	
Percentage of surviving infants receiving the last (i.e., third) recommended dose of Pentavalent vaccine at the national level (Percentage)	93.00	85%	97.00	
People who have received essential health, nutrition, and population (HNP) services (CRI, Number)	0.00	1362316	1,250,867.00	Target surpassed
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement) (CRI, Number)	0.00	581985	560,000.00	=Number of deliveries attended by skilled health personnel (CRI, Number)

				146,088 recorded Jan-March 2024. Target surpassed
Number of children immunized (CRI, Number)	0.00	780 331	690,867.00	171,205 recorded Jan-March 2024 Target surpassed
Number of health staff trained in emerging infectious diseases (Number)	0.00	250 (173M; 77F)	180.00	completed
Number of district where Event- Based Surveillance system is functional (Number)	0.00	12	10.00	EBS trainings conducted in Nsanje, Chikwawa, mwanza, Phalombe, Mulanje, Mangochi, Nkhotakota, Dowa, Kasungu, Nsanje, Mchinji and Mzimba. Target surpassed
Percentage of grievances addressed within 4 weeks of initial complaint being recorded (Percentage)	0.00	72.6%	80.00	This reflects all grievances received in the health system as recorded in the DHIS2. 946 complaints were resolved out of 1,302 complaints
Percentage of health care facilities supported by the project that are adhering to health care waste management as per the national IPC minimum standards (Percentage)	0.00	30	100.00	
Case Fatality Rate (CPR) (Percentage)	3.27	1.1	3.00	Had 3 deaths cumulatively since 1st November 2023.
Number of districts reporting zero cholera cases for the past 14 days (Number)	3.00	28	29.00	As of 19 May 2024, Karonga district was still reporting Cholera cases
Number of Vibrio Cholera genomic sequencing tests conducted during active outbreak (Number)	0.00	125	100.00	Using test kits supported by Africa CDC. Test kits procured by the project are undergoing procurement processes
Percentage of CTC/CTUs at the district level adhering to cholera case management guidelines during active outbreak (Percentage)	0.00	0	100.00	CTU supervision not done. Changing terrain for cholera
Percentage of CTC/CTUs at the district level adhering to waste management protocols during active outbreak (Percentage)	0.00	0	100.00	CTU Supervision not done. Changing terrain for cholera

Pakistan

Pakistan Case Study

Brief outline of the GFF/WB investment

Pakistan joined the GFF partnership in May 2019. GFF engagement in Pakistan focuses on strengthening health financing and advancing Universal Health Coverage (UHC). This includes supporting the National Health Support Program (NHSP) through performance-based financing and technical assistance. The GFF has aligned with the World Bank to co-finance the NHSP, which includes support for the development and implementation of the Essential Package of Health Services (EPHS), originally prioritized through the Disease Control Priorities (DCP-3) process at the federal level. However, the EPHS has faced challenges in gaining traction.

The World Bank and the GFF have co-financed the National Health Support Program (NHSP):

- GFF contribution: US$ 82 million, which has been tied to the achievement of specific results agreed by the WB and the Government of Pakistan (Federal and Provincial).
- WB contribution: US$ 258 million through IDA credit.

Both the IDA credit of US$ 258 million and the GFF grant provide financing for the DLIs, as well as the additional monies under the Investment Project Financing (IPF) component. The GFF provides catalytic financing to leverage and increase domestic resources for health alongside the WB financing, aligned external financing, and private sector resources. The GFF model multiplies the impact of relatively small grants by leveraging countries' own financial commitments, generating a high return on investment and contributing to improved health outcomes and human capital development.[76]

Details of the GFF Investments:

Exec Type	Funding Cat	Budget Cat	Budgeted	Disbursed
RE	1St Round Grants	Grants	$42 million	$17,539,500
RE	EHS Grants	Grant	$40 million	$33,200,000
BE	CORE TA	Project Preparation	$49,909.79	$49,909.79
BE	Core TA	Supervision	$100,000	$74,249.77
BE	Core TA	IC Implementation	$120,000	$101,094.91
BE	Core TA	RMET	$175,000	$152,573.71
BE	Core TA	RMET	$ 75,000	$ 74,249.77
BE	Flexible TA	DRUM	$250,000	$213,467.94
BE	Flexible TA	Quality RMNCAH-N COVID-19	$131,384.42	$131,384.42
BE	Flexible TA	Quality RMNCAH-N TA activities	$49,931.05	$49,931.05
BE	Flexible TA	Results monitoring	$312,500	$196,112.08
BE	Flexible TA	CRVS	$130,891.43	$130,891.43

Additional support:

[76] Implementation Status and Results Report, WB April 2024

- Senior Health Specialist and the GFF Liaison officer as key technical support team in the World Bank Office.
- Three technical resource personnel available as part of the Monitoring, Evaluation, Results and Learning team.
- A digital health and HMIS specialist, based in Karachi, regularly engages with the Director General (DG) of Health in Sindh.
- Technical DHIS2 support, which includes an HMIS specialist embedded in the Sindh DG Health Office.
- Project management staff that are physically embedded in the KP HMIS cell to provide ongoing support. Additional resources for gender mainstreaming work.
- Technical resources are based out of the World Bank Islamabad office and they conduct engagement visits to provinces for the support that is needed.

The investment case

- *Brief overview of the Investment Case*

The investment case (IC) was based on the UHC agenda and was developed by the FMOH with support from UNICEF.[77] This was not well received by the GFF and World Bank teams in the country as well as other donor partners. The IC was critiqued for its lack of inclusivity, lack of in-depth consultative process and the lack of strong provincial consultation. Being led by the federal government, it was seen as a federal initiative and not owned by the provinces. In the face of a poorly executed IC without a robust inclusive process, the GFF opted to align with the World Bank's program on supporting Primary Health Care – the NHSP that was designed to utilize a "Performance for Results" (P4R) mechanism for health financing. A large counterpart funding requirement was expected to encourage increases in host government financing for PHC including RMNCAH-N.

The GFF has aligned itself strongly with the NHSP as its IC. Financing is based on achievement of performance against Disbursement Linked Indicators (DLIs) which will be measured through household surveys, health facility assessments, and facility-based routine monitoring systems by the provincial health departments.[78] With the exception of a few, most DLIs are scale-able and evidence of completion/achievement of results is verified by the WB/GFF team. Additional condition of the NHSP is the targeting of poor performing or 'lagging' districts –defined by using 1) Burden of Zero Dose children for Punjab; and 2) UHC coverage index for KP and Sindh.

The NHSP areas of work include: (1) Provincial and district governance strengthening to skills, accountability and use of quality data; (2) Progressive increase and improved financing and fund flow; (3) Performance monitoring of HR; (4) Uninterrupted availability of essential commodities; (5) Equitable access to health services including timely referral of obstetric, neonatal, and other emergencies; and (6) Quality improvement through oversight, standards, and accountability. The strong results focus of the GFF approach aligns well with the PforR instrument proposed for the NHSP.

The National Health Support Program was declared effective on 24 October 2022. The NHSP PforR component covers Punjab, KP and Sindh; while all three provinces and the Federal have Investment Project Financing (IPF) components.

[77] Pakistan IC for 2021-2026
[78] WB 2022 Project appraisal document - National Health Support Program

For implementation of the NHSP, each provincial government needs an approved PC-1 (project document) which authorizes the setup of a project management unit that oversees implementation of the NHSP in their respective province. To provide technical support to the NHSP, the following structures are to be established:

i. Provincial steering committee at each province, comprised of health, planning and finance departments and NHSP technical partners
ii. Technical Working Groups (TWGs) for each DLI, comprised of government and technical partners to monitor and advise on Disbursement Linked Results (DLR) achievement
iii. Monitoring and evaluation teams including embedded technical assistance in the provinces
iv. Technical Advisory Teams (TATs) comprised of technical partners and WB/GFF teams to coordinate among the technical partners (Gates, GAVI, GFF, WB, WHO, UNICEF)

A total of 10 DLIs were agreed upon, with varying milestones and results across provinces. However, not all DLIs are effective in each province, and overall implementation has been slower than anticipated. As of April 2024, a review of Year 1 DLR achievement indicated delays in key areas, including service delivery norms, the development of a National Health Financing Framework, and Provincial Health Financing Strategies, largely due to the absence of a fully operational PMU.[79]

At the government level, the implementation of the NHSP has faced considerable delays due to several factors. A key challenge has been the protracted approval process for Planning Commission PC-1s, which has slowed project rollout. Additionally, broader systemic issues—including a lack of understanding of the PforR+IPF hybrid instrument, limited accountability at the provincial level, and resistance to shifting traditional ways of working—have further hindered progress. While some DLRs have been met, these were primarily process-oriented milestones, and measurable impacts on service delivery quality and quantity are expected only in later years. Delays in setting up coordination committees and inactive TWGs in some provinces have further slowed implementation. Similarly, delays in establishing project bank accounts at federal and provincial levels have also contributed to these challenges.

The country platform

The UHC country platform, notified in 2019, is a 20-member body of senior-level government representatives. [80] Since its establishment, the platform has met three times; however, meetings were paused during the COVID-19 pandemic, creating a hiatus in the schedule. A meeting was initially planned for August 2024 but did not take place, and the next meeting is now expected in February 2025.

Coordination among provinces and between federal and provincial levels remains weak, particularly given the devolved nature of health financing and service delivery. Capacity constraints at the federal level further limit effective stewardship, providing little assurance to provincial counterparts, who largely see themselves as independent of federal requirements.

[79] Implementation Status and Results Report, WB April 2024
[80] Country platform notification 2019

KEY FINDINGS BY AI

AI 1

- *Contribution to the country-led alignment and prioritization, in support of women, children and adolescents' health*

The GFF country engagement model has aligned with existing donor priorities on RMNCAH-N. Major development partners, including the World Bank, FCDO, and USAID, have consistently focused investme in RMNCAH-N due to its high burden of disease. While RMNCAH-N services are formally included in the EHSP at the primary care level, EHSP has not gained traction at the provincial level.

Given the absence of a country-led alignment or prioritization process, the GFF has opted to align with t NHSP, which has also attracted funding from three other partners. This approach ensured that GFF resources are integrated into a broader, coordinated effort rather than operating independently.

The initial IC developed by the federal government was not well received by the GFF and WB as it was considered non-inclusive and untargeted. As a result, GFF aligned with the NHSP to focus on RMNCAH-N services and health system improvements.[81] This approach allows GFF funding to support targeted technical assistance within a UHC framework, helping to strengthen health systems in a resource-constrained environment.

Engagement with civil society has been limited due to the absence of a dedicated civil society platform, well as a lack of an organized CSO institution in Pakistan, which has presented challenges for direct collaboration with youth and marginalized communities.[82]

Coordination between the ministries of finance and health around the NHSP is structured through sever mechanisms, including DLIs 8 and 9, which focus on health financing and involve close collaboration wit finance departments. Additionally, the NHSP steering committees, chaired and convened by Planning ar Development Ministries, include representation from finance departments, ensuring engagement with t Ministry of Health. In theory, the design is appropriate and lays out a clear pathway for implementatior There are several governance bodies i.e. Steering committees, TWGs, TATs and smaller working groups. practical terms most stakeholders feel that there are too many coordination structures to juggle with, several people overlap among the varied platforms within and across provinces and may lead to lack of coherence.

Some key informants suggested that these structures could have been better integrated into existing government mechanisms rather than established as stand-alone platforms. However, the UHC coordination platform—led jointly by federal and subnational governments—was created in response to donor demands for a mechanism that supports alignment, coordination of work plans, and optimization government and external resources. No similar coordination structure previously existed, meaning this i not a duplication but rather an effort to fill a critical gap in the governance framework.

- *Delivering health services – what is the model – how is this being achieved?*

The GFF is fully aligned with the World Bank's NHSP, which is driving health system reforms at the provincial level—the primary areas for service delivery. Under a EPHS umbrella, service improvements i

[81] GFF/WB KI
[82] GFF/WB KI

RMNCH services have been identified such as the improvements in basic and comprehensive emergency obstetric care, quality standards for delivery and RH services, availability of commodities and supplies a defining and rolling out effective referral pathways. The design of the program is sound, however implementation is considerably delayed, for reasons highlighted in the above sections, as is the anticipa increases in financing envelope.[83] While Pakistan joined GFF in 2019, the WB agreement on NHSP only occurred in October 2022 and the project management units are still to be set up in any of the province Hence despite some earlier process markers, little in terms of quality and coverage of services has changed. GFF and WB KIs state that *"it is too early to talk about results at this stage*".[84]

There has been some documentation of a marginal increase in PHC budgets in two provinces in 2024 compared to 2023. However, it is difficult to gauge the GFF or WB contribution to this finding given that the project is still not operational on the ground and the funding disbursed by the WB has yet to trickle down to the health departments.

- *Added value to other RMNCAH-N actors? How? Evidence?*

The GFF has coordinated well with other donors, however most of them indicate that their engagement limited to their specific areas rather than a wider alignment of approach.[85]

Since implementation of the program is considerably delayed, the program approach sounds appropriat in theory. Reflections from other partners indicate that the mechanism is patchy, cumbersome, disorganized and may need to be radically changed.

Several key Informants were of the view that the proposed P4R approach is not appropriate for the Pakistani context and has failed to catalyze or generate health prioritization beyond policy statements a design documents. However, the early-year DLRs were intentionally designed to focus on policy formulation and system strengthening, laying the groundwork for future reforms. The later-year DLRs, y to roll out in Year 3, are focused on the implementation of these strategies at the service delivery level. such, the full impact of the NHSP will only become evident as the program progresses.

Some additional success has been seen in terms of agreement to strengthen the health MIS for measurement of quality of care i.e. Sindh and KP agree on adopting the DHIS-2, whereas Punjab will roll out its electronic medical record EMR system that was developed in-house.

AI 2

- *GFF/ WB leveraging each other's strengths*

The WB and GFF teams are very well coordinated and there is a considerable amount of collaboration a a joined-up approach in term so engagement with the Pakistan government and delivery units at both federal and provincial units. Roles and responsibilities between the WB and GFF teams are clear and we understood.

There is some feedback that at times, the GFF prioritization may be overshadowed by the larger IDA cre negotiations and program in the eyes of the government staff who fail to see the catalytic nature of GFF At times, they only see this as a loan agreement that brings additional, and in their view unnecessary, paperwork for them.

[83] Implementation Status and Results (ISR) report dated April 2024
[84] GFF/WB KI
[85] Development partners KIs

- *Are the roles sufficiently clear/ separated?*

The GFF Liaison Officer serves as the key technical support within the World Bank Office. Additionally, there are three technical resource personnel available as part of the Monitoring, Evaluation, Results and Learning team, national HMIS and digital support and additional resources for gender mainstreaming w The technical resources conduct engagement visits to provinces for the support that is needed. There is one embedded technical resource in Punjab and one in Sindh for all the support related to NHSP and GF funding. At the operational level, the World Bank and GFF teams are well-coordinated, routinely sharing information and technical resources to support implementation.

However, roles and responsibilities between the WB and GFF are less well understood at government le as is the difference in funding. Both donors and partners feel that the WB engagement with both could improved further. They also feel that the mechanisms, numerous TWGs and TATs, are hugely complex a are leading to loss in focus as well as fatigue among government and counterpart representative as eac part of many TWGs and there are other pressing issues to deal with.[86]

There is an observation that since the GFF technical resources sit within the WB offices, they are not adequately embedded within government and as such are not readily available for support to the provinces, specifically the technical units. As such the existing TA is seen external to the NHSP at the government's end and more meant for WB's use rather than government capacity strengthening. [87] One the reasons cited by the GFF team for not situating themselves in government is the lack of seating spac in government offices – something that could be easily addressed if pursued with the government.

AI 3

- *Where does GFF add value?*

Findings from the interviews did not consistently reflect a strong value-add of GFF at the country level. E aligning closely with the NHSP, its visibility appears to be diluted. There is also a general consensus that DLRs agreed under the NHSP for the initial years were neither compelling nor challenging and could hav been achieved even without GFF or WB support in an environment where the FCDO, Gates, GAVI, GF an USAID all have their independently run programs and are able to provide more flexible TA support to government.[88] In reality, the NHSP has also relied on additional TA support from these independently funded projects to progress their interventions.

However, many key informants may not be fully aware that the early-year DLRs were not intended to dr immediate transformation but rather to lay the foundation for the reform process—including improvements in quality of care, governance, and PFM. The full impact of these reforms can only be meaningfully assessed in the later-stage DLRs, once implementation has progressed.

Federal and provincial health department strongly felt that they were unable to see added value of the NHSP, which was not owned by the government and seen as "additional work" that needed more proce management for government entities.[89] However, this perspective highlights an inherent tension: the P mechanism is designed to finance the government's own program, meaning that doubts about NHSP's value may also reflect a broader lack of ownership of their own reform agenda. Specifically, the Punjab

[86] GFF/WB, Government, and Development partners KIs
[87] GFF/WB and Government KIs
[88] Government and Development partners KIs
[89] Government KIs

Health Department has been actively pursuing its own reform efforts and has structured its DLRs to alig with its priorities. While Punjab is willing to collaborate where NHSP priorities align with its own, it is unlikely to adjust its approach significantly unless NHSP adds clear value to its existing strategy.

Partners, meanwhile, raised concerns that the P4R approach with fungible monies is not working. A recommendation was to redesign completely with monies ring-fenced solely for the use of the health sector. Note: the loan agreement did not ring-fence the budget for health – thus there are delays in the project money being disbursed to the health budget. This is confirmed by WB PPTs showing a low level project money disbursement.

- *What factors have contributed to success/limited progress?*

Success has been reported where dedicated technical resources have been strongly embedded or has partnered strongly with the government in improving their existing systems as opposed to external, periodic mission-based TA or setting up newer systems.[90]

A learning by the WB has been to shift its MERL strategy towards using government monitoring and dat reporting mechanisms rather than setting up a new TPV mechanism.

Government counterparts continue to emphasize that the TA is external and is not embedded with ther hence external and the resource only makes periodic visits to the field. This decreases their utility and effectiveness. One informant stated, "*the only time we actually are more active is when a WB Mission is expected and then we see some movement, otherwise they come once is a while, we have meetings whi don't really result in much"; "I need the consultant to sit in my office and working day to day in helping r improve these systems."*

- *Extent ensured adequate funding for RMNCAH-N services?*

There is limited information available to assess whether RMNCAH-N services have received adequate funding, as the NHSP is still in its early stages and significant delays in execution persist. [91] [92] While there has been some documented marginal increases in PHC budgets in two provinces in 2024 compared to 2023, it remains unclear how much of this can be attributed to the GFF or World Bank's efforts, as fundi disbursed by the World Bank has yet to fully reach health departments.

The broader challenge lies in the lack of sufficient domestic resources for PHC, including RMNCAH-N. Th NHSP's PforR mechanism was designed to encourage increased domestic financing through a large counterpart funding requirement, but it remains uncertain whether this has led to significant additional investment in PHC. Systemic issues such as limited fiscal space, competing budget priorities, and delays disbursement have further constrained funding flows to RMNCAH-N services.

Efforts to mobilize more domestic resources for RMNCAH-N require stronger high-level advocacy, particularly at the Prime Minister and Finance Ministry levels, but stakeholders note that such engagem has been limited so far.

- *Data/ results – what aspects of the data system were strengthened/what benefits or outcomes?*

[90] Government KIs
[91] WB ISR report
[92] GFF/WB KIs

This is difficult to assess at this time as the PMUs for the program are still not operational, the MERL approach has still not been finalized. There are no solid results to report at this time.[93]
Note: GFF staff have provided a bit more of the specific DLIs so we should be able to see more on the data/results side.

- *To what extent has there been demonstrable progress towards the TOC (in this country context)*

The NHSP, which is the IC for the GFF, was formally agreed in October 2022.[94] The PMUs for the prograr are not operational, progress has only been noted on very basic process activities. Impact on outcomes cannot be measured or reported at this stage.

There is a consensus from KIs on the following aspects:

- The P4R model is not working in Pakistan, specifically as financial incentive is not directed towa the health sector. Financial support is disbursed as general budget support. The current mechanism may not be salvageable.
- Coordination among federal and provinces is poor, there needs to be stronger presence in provinces which is not the case for either the WB or GFF (nor for Gates or GAVI).
- There is a need to redesign and ringfence the funding so that it can be directed towards health a RMNCH if results are to be achieved.
- Technical resource needs to be embedded within countries for it to be catalytical and useful.

- *What lessons in advancing gender, voice and equity?*

Reportable improvements have also been noted in the gender equity and prioritization agenda, specific in Punjab province due to continued and dedicated technical resources from the GFF. Discussions on mainstreaming gender in development programs, managerial HR recruitments, prioritization of gender considerations in workplace practices and in health services delivery at primary healthcare level have be held with positive acceptance by the government. It is still early to consider whether there have been measurable outputs or results, given that this only began in the last six months.

Limitations

- The case study analysis was limited by the challenges in accessing appropriate evidence on implementation of the program and the progress against indicators. Implementation review information was not readily available beyond anecdotal information.

Any reflections on key findings or implications for the model?

- Firstly, the GFF's close alignment with the World Bank's NHSP has led to an undervaluation of the GFF's unique contributions, making it difficult to distinguish the added value of GFF in the broader health landscape. The Program-for-Results (P4R) model, which is central to GFF's strategy in Pakistan, has not resonated well within the local context. Financial incentives under this model are not directly benefiting the health sector, as funds are often disbursed as general budget support rather than being earmarked for specific health interventions. This has resulted in limited progress in areas such as RMNCAH, where the GFF's impact was expected to be most pronounced.

- Coordination between federal and provincial health departments has also been problematic, further complicating the implementation of GFF-supported initiatives. The GFF's technical

[93] HFAs are still to be initiated
[94] WB ISR report April 2022

resources, though available, are not sufficiently embedded within government structures, reducing their effectiveness. Instead of being integrated into the day-to-day operations of the health departments, technical assistance is perceived as external and intermittent, leading to inefficiencies and a lack of sustained progress. Stakeholders have expressed the need for more consistent and integrated support, with technical experts embedded within provincial health offices to ensure continuous and meaningful engagement.

- Monitoring, evaluation, research and learning (MERL) processes, crucial for tracking the effectiveness of health interventions, are also not fully operational, making it difficult to measure the impact of the GFF's investments. Although some steps have been taken to align monitoring frameworks with existing government systems, progress has been slow, and there is little evidence to suggest that these mechanisms are effectively driving improvements in health outcomes.

- Moreover, the GFF's engagement with CSOs, youth, and marginalized communities has been limited, partly due to the absence of a robust civil society platform in Pakistan. This lack of inclusivity undermines the GFF's potential to foster a more participatory and community-driven approach to health system strengthening.

- In summary, while the GFF's strategic objectives in Pakistan are clear and well-intentioned, the practical challenges of implementation have significantly hindered its impact. The current model may need to be reevaluated and redesigned to better fit the local context, with a stronger emphasis on direct health sector support, more robust and integrated technical assistance, and improved coordination between national and provincial levels. Without these changes, the GFF's ability to deliver meaningful health improvements in Pakistan remains constrained.

Annex 1: Documents reviewed and stakeholders interviewed

Documents reviewed	Year of issue
World Bank. Program Appraisal Document – National Health Support program. Islamic Republic of Pakistan	2022
Implementation Status Results Report	2024
Budget execution analysis	2024
GFF annual report 2021-2022	2022
CRVS Strategy	2021
Final UHC IC report Pakistan	2021
MERL assessment of data sources	
Country Platform notification	2019
UHC Country Platform notification	2022
Pakistan RMNCAH Investment Case	2020

Name	Position	Association
Ghazna Khalid Siddiqui	Liaison Officer	GFF
Supriya Madhavan	Country Focal Point	GFF
Karin Gichuhi	Results Specialist	GFF
Manav Bhattarai	NHSP TTL	WB TTL
Farooq Azam	MERL Coordinator (Senior Consultant)	GFF TA Provider
Dr Sabeen Afzal	Deputy Executive Director	Ministry of National Health Services, Regulation and Coordination
Dr Farhana Memon	Project Director, Reproductive Maternal and Neonatal Child Health	Sindh (Gov)
Dr Khizer Hayat	Provincial Coordinator for Maternal, Newborn, and Child Health	KPK (Gov) (Khyber Pakhtunkhwa?)
David Wilson	Senior Program Officer	Bill & Melinda Gates Foundation
Zehra Riaz	Engagement Manager	Impetus Advisory Group
Zahra Ansari	Public Health Expert	Acasus
Taimur Adil	Chief Commercial Officer (CEO?)	Impetus Advisory Group
Sara Shahzad	Senior Health Adviser	FCDO
Jahanzaib Sohail	Health Economist / Finance Specialist	WB
Anju Malhotra	Senior Advisor, Gender and M&E	GFF/WB
Sadia	Gender Adviser	WB
Ather Saeed	Digital Health	WB
Pamela Sequeira	Monitoring, Evaluation & Learning Specialist	Integrity
Adil Akbar Khan	Secretary	Government of Pakistan

Afghanistan

Afghanistan Country Brief

Brief outline of the GFF/WB investment

GFF has co-financed two recipient-executed projects in Afghanistan, before and after the Taliban takeover:

- Sehatmandi; 2017-2021: GFF US$ 35 million, Afghanistan Reconstruction Trust Fund (ARTF) US$ 450 million, IDA US$ 140 million
- Health Emergency Response (HER) Project; 2022-2025: GFF US$ 19 million, ARTF US$ 314 million

The World Bank and UNICEF Afghanistan signed an agreement for the Health Emergency Response (HER) Project on 26 May 2022 to support health and nutrition services in Afghanistan through December 2023. An Additional Financing was signed with UNICEF and WFP on 15 December 2023, which extended support for the health system through March 2025.[95]

The HER project is funded by the Afghanistan Reconstruction Trust Fund – since Afghanistan was not eligible for an IDA loan after the Taliban takeover (they have recently become eligible). Currently, US$ 600 million is allocated to the ARTF for spending from 2022 onwards.[96] [97] The ARTF is funded by various donors – the WB hosts the ARTF to pool donor funds e.g. from USAID, FCDO and others. The ADB has recently come on-board to also finance health services in 10 provinces that HER does not reach,[98] providing an estimated additional US$ 200 million.

Details of the GFF investments:

Exec Type	Funding Cat	Budget Cat	Budgeted	Disbursed
RE	1St Round Grants	Grants	$34,973,527.63	$34,973,527.63
RE	EHS Grants	Grants	$19 million	$19 million
RE	2nd Round Grants	Grants	$20 million	$0
BE	CORE TA	Project Preparation	$148,087.56	$148,087.56
BE	Core TA	Supervision	$100,000	$98,668.41
BE	Core TA	Supervision	$479,386.93	$479,386.93
BE	Core TA	IC Design	$196,679.39	$196,679.39
BE	Core TA	IC Implementation	$120,000	$119,816.48
BE	Flexible TA	Quality RMNCAH-N PASA	$198,250.72	$198,250.72
BE	Flexible TA	Quality RMNCAH-N HFCS Data Collection Support	$120,172.56	$120,172.56
BE	Flexible TA	Supply Chain and Commodity	$10,851.44	$10,851.44

[95] HER PAD
[96] GFF round 2 proposal
[97] Sehatmandi project closure report
[98] HER additional financing

In addition, the GFF has funded bank-executed core TA for:[99]

Previously (pre-Taliban takeover):

- WB TA on health financing options, including how to address very high rates of OOP.
- WB TA on options to fund innovations to increase demand for FP, addressing maternal health and reducing MMR, and addressing high rates of malnutrition.
- COVID-19 survey work.
- The CP was supported by the GFF but was led by the government (the Deputy Minister of health was chair).

Since 2021 (post-Taliban takeover):

- Development of the investment case.
- The country platform, which is mainly a forum for donors and implementation agencies. This is co-chaired by the WB which is one of the few agencies that can directly engage with the MOH. GFF has supported and conducted several rounds of the RMET.
- 2023 – supply chains options analysis and paper to feed into HER2.
- Specific technical inputs into quality of care and other domains.

The Investment Case (IC)

- *Brief overview of the Investment Case*

The original IC was developed in 2021 and was about to be signed when the Taliban took over. Since then, it has been used as the basis for the HER project. After the Taliban takeover, international donors ceased aid to the government and wanted to have a framework for future engagement in Afghanistan. GFF was one of the penholders for the development of that framework, the 'Health Sector Transition Strategy' (HSTS), which then become the IC. The HSTS costed the running of the Afghani health service (since the Taliban ceased funding it and many development partners paused funding). The total budget needed to sustain the health sector after the Interim Taliban Administration (ITA) came to power was costed at roughly US$ 2.4 billion over three years (2023 to 2025).

The HSTS has a focus on stabilizing the health system, with strong elements of RMNCAH. It is organized around four strategic directions: (1) strengthen and expand essential service coverage/ utilization and quality of care, and improve financial risk protection for the most vulnerable groups; (2) sustain and strengthen the essential foundations of the health system necessary for meeting basic human health needs; (3) strengthen capacities to prevent, detect, and respond to disease outbreaks and other health emergencies; and (4) strengthen the harmonization and alignment of financing for national health priorities to increase the predictability, adaptability, and efficiency of funding.

The 2023 RMET found that the World Bank was one of the major IC funders – with the largest being USAID (27.8 percent), followed by the World Bank (16.6 percent), the Asian Development Bank (12.7 percent), Gavi (7.7 percent), and the Global Fund (4.2 percent).[100] The GFF second-round financing proposal states that HER funding was 11% below what was needed[101] and GFF funding helped to address this funding gap. The IC also has strong commitment, having met 89.9 percent of total funding needs in

[99] GFF Evaluation - Case Study Countries - RE and BE Portfolio Summary July 2024
[100] Afghanistan RMET 2023
[101] GFF second-round financing proposal: Afghanistan. June 2023.

2023. 2023 RMET also revealed an outstanding funding gap of $302.2 million (89.9 percent of total funding needed).

The Country Platform

Before the Taliban takeover, the Country Platform was led by the government with GFF support.[102] [103] After the Taliban takeover, the new Country Platform – known as the Health Strategic Transition Working Group (HSTWG) – convened donors to review progress, assess critical issues, and have a joint voice in advocating to the Interim Taliban Administration (ITA). For example, the HSTWG discusses health sector issues such as the ITA's ban of a list of commodities that they argued could be locally sourced, putting supply at-risk.

The HSTWG meets virtually every month and biannually in-person. The GFF is one of three co-chairs, and has been critical to convening the in-person meetings, ensuring that inputs and outputs are delivered, etc. The Liaison Officer is a Secretariat for HSTWF meetings. KIs asserted that there is "*a lot of in-kind support"* to keep the focus on RMNCAH-N and on "*high impact practices".* While INGOs are engaged in HSTWG meetings to some extent, engagement with local CSOs is limited beyond those that are commissioned to implement the HER project due to the current situation.

While GFF and World Bank informants assert that the platform is being used to increase efficiencies and improve alignment, some KIs asserted that the HSTWG is primarily used to share information and advocacy tactics. For example, a development partner stated: *"I feel like it's an information sharing platform primarily, but that's really helpful too, because we all have different degrees of presence and access in the country."*

Country Platform meeting notes confirm that there is joint work and collaboration on advocacy to the government including on issues such as: social sector/health spend (as the ITA currently does not want to spend in social sectors), regulations (e.g., of commodities), and control over verification and presence of NGOs. There is also additional work in commissioning a Mid-Term Review (MTR) of the HER project.

The World Bank project

The HER project, primarily implemented through UNICEF and a smaller contract to WFP for cash transfers and nutrition, is currently delivered at PHC and effectively covers all aspects of UHC. HER finances the Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) in 24 provinces (ADB finances an additional 10 provinces) – all 34 provinces in Afghanistan are thus covered.[104] It does not cover hospital-based care in urban areas (these are under-funded).[105]

There are notable differences between the previous project (Sehatmandi) and the current project (HER), especially in the use of PforR attached to a district-level quality score.[106] However, in terms of RMNCAH-N areas covered, HER continues its focus on RMNCAH-N from the previous project.

KEY FINDINGS BY AI

AI 1

[102] Country KIIs with different donors and participants in the country platform
[103] Detailed review of the CP notes
[104] GFF Round 2 proposal
[105] HSTS 2023-2025
[106] Sehatmandi project closure report & HER additional financing

- *Delivering health services – what is the model – how is this being achieved?* [107]

Afghanistan has had a long history of using PforR. In addition, health services have been funded by UN agencies, donors, and NGOs, and many implemented by NGOs, for several decades.[108] The previous project, Sehatmandi, represented a shift from contract management to performance management. Payments were based on a fixed fee for service delivered, and performance was monitored against 11 key indicators: couple-years of protection (family planning), antenatal visits, postnatal visits, institutional deliveries, tuberculosis cases treated, caesarian sections, tetanus 2+ vaccinations, outpatient visits (children under five years of age), pentavalent 3+ vaccinations, major surgeries, and growth monitoring.

For the ongoing HER project, UNICEF is contracted to 'run' the service. HER has a PforR model where health funds are distributed to districts.[109] The UNICEF TPM monitors facility-level performance against quality-of-care indicators, and if they are achieved, a 10% top-up is released. The results framework also includes measures of health systems functionality, e.g., timely release of health staff salaries.

> *"[The HER project] contributed to the restoration of services at over 2,300 health facilities to deliver health and nutritional interventions nationwide. In February 2022, the World Bank successfully paid US$30.73 million to service providers for services delivered before 15 August 2021. It covered salaries for over 26,000 healthcare workers, including more than 9,600 women. By maintaining health workers in place, it helped ensure that the health sector did not collapse."*[110]

There is clear evidence that the HER project and GFF managed to stabilize the health system in Afghanistan. However, further work on building the health system is hampered by the current fragility of the situation with the ITA.

The HER project also uses the health system to deliver other development initiatives, e.g., cash transfers to vulnerable households. There is also a strong element in HER which measures how many female staff are present, and this has enabled women health staff to keep working even in the context of the ITA's efforts to stop them doing so.

The second-round GFF funding proposal notes that the reduction in active fighting presents an opportunity to reach under-served areas particularly for nutrition services. Previously, these relied on outreach nutrition teams which have high costs. GFF identifies this as an area 'where innovation is needed' – but we did not find any evidence of this innovation being funded or happening.

- *Quality of care – what is the model – evidence of this being achieved?*

There is a clear shift in focus to more comprehensive quality of care, which is included in the GFF strategy for Afghanistan and is visible in the way that quality of care is measured and included into the payment indicators for the HER project. Sehatmandi mostly focused on fixed fees for the delivery of specific services and an uplift for meeting those targets. Those did not do much to shift quality of care[111] – which HER now focuses on. However, while the Quality of Care (QoC) measures are facility-based, and

[107] GFF Round 2 proposal
[108] HSTS 2023-2025
[109] HER PAD
[110] Extract from the GFF proposal round 2
[111] Country KIs

implemented by the TPM, the actual payment goes to the districts, and so it is not clear whether this extra payment is then shifted down to the facility level.

The QoC approach uses a combination of measurement approaches collected by UNICEF TPM, including (1) clinical vignettes; (2) a quality checklist; and (3) client exit interviews.[112] Clinical vignettes cover areas such as managing more complex maternity cases, e.g., post-partum hemorrhage, as well as management of childhood illnesses. There is also now a quality checklist which includes several RMNCAH-N domains, as well as other areas such as health records management, waste and infection control, general management, and commodities. Client exit interviews also capture the client experience dimension, however, are often missing or poorly done.

The QoC measurement results show rapid improvement, e.g., from 27% in 2023 to 41% in June 2024.[113] However, there is a mixed view on the use of QoC measurement approaches from KIs, who had concerns about the approach due to the lack of investment in *'structural quality'* (meaning the buildings, sanitation facilities and hardware (e.g., beds) of a health service) which can strongly affect service delivery. In this context, they expressed, for instance, concerns of potential overreliance on a reward approach versus a training approach and of the fitness for purpose of financial incentives when the project is under-funded and facing significant resourcing gaps, potentially risking that staff may be taking from other critical areas to fund things that may improve the quality score.

Despite this, the QoC scores are comprehensive and the QoC checklist tracks areas such as staff salaries, protecting against those funds being reallocated to meet quality criteria. QoC measurement embedded in PforR has shown dramatic effects even in countries which have strong issues around structural quality (e.g., Yemen), and there is no evidence to back up this claim that more training and infrastructural investments are needed at this time.

One area where QoC may be less effective is that the payments are linked to performance at the district level, and in this setting, it is difficult to see how this tracks down to the facility level. This is how the PforR is currently designed due to security constraints, but this could be improved by having a design more focused on the facility level. In addition, while the QoC measurement is comprehensive and it is plausible that they could extract a measure of basic & comprehensive emergency obstetric and newborn care (BEMONC/CEMONC) from a combination of the scores, it's not clear that this is being tracked. This is important because MMR will not be reduced without adequate access to BEMONCs and good referral networks to CEMONCS. There are missed opportunities to strengthen this area of work, e.g., by recording maternal deaths in medical records and reviewing maternal deaths as a routine part of service delivery, and it is not clear if this is being done. Furthermore, QoC measurement is outsourced, making it expensive, and at the current time cannot be built into existing institutions that would better ensure sustainability.

- *Added value to other RMNCAH-N actors? How? Evidence?*

There is strong evidence of GFF working with partners in Afghanistan, e.g., Gavi as part of reaching zero-dose. However, several development partners wanted to see better alignment and partnership in areas of implementation, e.g., around quality-of-care improvement, through providing inputs such as training to staff who were deficient in meeting quality scores, or in addressing supply chains blockages. There

[112] Afghanistan – Quality Enhancement, Status Update HER2, May 2024.
[113] Afghanistan – Quality Enhancement, Status Update HER2, May 2024.

also appears to be strong alignment of the ADB project to the HER project, in part due to the IC clarity as well as coordination meetings.[114]

Capacity to bring on other partners appears limited at this stage. It is expected that donor funding will decrease in the next few years, and there is a critical need to increase the government of Afghanistan's revenue and budget for health. This is an area that the World Bank can work on, with the promise of further IDA credits if the government agrees to co-finance. The HSTWG platform notes that the ITA is unwilling to increase the health budget because donors are funding it, so further off-budget approaches are unlikely to solve this problem.

AI 2

- *GFF / WB leveraging each other's strengths*

The World Bank played a critical role in this emergency situation as the main development partner who could both convene other donors and partners, re-establish dialogue with the ITA, and act as a 'single voice' for donors in advocating on specific issues. The World Bank also:

- used the ARTF to pool funding from donors to fund HER and pulled in other donors (e.g., the ADB) to address financing gaps;
- put special conditions on funding which were essential criteria that had to be respected at all levels, e.g., the presence of female health staff in all facilities (currently reported that 95% of facilities have female health staff);[115]
- multi-sectoral linkages in the HER service delivery model, e.g., with education (also funded by WB in a broad move to secure social sector funding), nutrition, cash transfers, and livelihoods;
- continued work on coordination, alignment, analytical work and financing.

The GFF team are all remote and rely on World Bank staff to be the boots on the ground, as only recently have limited World Bank staff been able to return to Afghanistan. However, KI feedback is that the GFF is *"well-embedded"* in the Afghanistan country team – and provides *"funding at the margin"* and important technical inputs.

In addition, the World Bank is uniquely positioned to advocate for greater domestic financing for health. The World Bank is aware of the critical lack of medium-term solutions for the critical economic situation that Afghanistan is in. The World Bank's ability to dialogue with the government on addressing these macro-economic issues is hampered due to the context – in health specifically, *'they do not know how the [national] health budgets now work'.* Thus, addressing health financing is difficult and currently all donor-funding is off-budget. The World Bank, however, continues to advocate for the ITA to pick up a greater proportion of the health budget. Note that even pre-Taliban – the health sector was funded almost 100% by donors (and donors funded about half of the economy in general).[116] Thus, in domestic resource utilization and mobilization, the GFF is not well-positioned to add value.

In this context, the GFF's value is additive to the functions that the World Bank does – adding technical and supportive assistance to back-up the dominant role that the World Bank plays in convening partners, for instance. Country KIs highly value this role, saying that the technical assistance has been valuable: particularly the GFF role in being *"a pen holder"* for the IC, acting as the Secretariat for the CP, and doing specific tasks such as the RMET which helps to align funding and donors. Additionally, Afghanistan is one

[114] Country KIs
[115] HER additional financing
[116] HSTS 2023-2025

of the few countries where the RMET is now being extended to the sub-provincial level, enabling activity and budget mapping at the district level. This allows for micro-planning of resources, reduces duplication, and improves equity in funding allocation.

The HSTWG includes a broad range of committed health sector actors who actively engage in strategic discussions. Rather than being solely focused on negotiating with the ITA development partners rely on the HSTWG as a key forum for coordinating joint advocacy efforts and ensuring a unified approach to sector-wide priorities.

The GFF has also taken up some specific pieces of work that are certainly a step towards making the health service more efficient, e.g., looking at options for increasing efficiencies in supply chains, as commodities are a key cost driver. However, it's notable that the USAID project LAFIAT is also bringing in a new mSupply component which will digitalize the supply chains, and there is potential space for alignment.[117]

- *Are the roles sufficiently clear/ separated?*

A range of country KIIs perceive the GFF and World Bank team as one team. Realistically in this setting, the GFF's means of operation is to leverage the dominant convening role that the World Bank plays. While there was little awareness of the GFF, what they do, or how they further the work of the World Bank amongst non-World Bank and GFF stakeholders, components like the IC, CP, and RMET were recognized and are working well.

- *Opportunities to maximize complementarity*

There is good evidence that the GFF is maximizing the influence and convening power that the World Bank provides in this context, and that they are working effectively with each other. Despite the situation in Afghanistan, the picture is of donors working well and in alignment.

On the technical side, the contribution of the GFF's input is less clear due to the integration of the GFF and the World Bank into one task team. GFF's technical efforts are often carried out in close partnership with the World Bank, for example, with GFF staff leading or co-leading aspects of the co-financed HER project. They are generally perceived as one team by external stakeholders.

However, KIs assert that the GFF has provided a lot of technical expertise, for instance, in designing the health financing component, integrating quality of care into HER (where it is a strong focus), and in focusing on data utilization. The World Bank experts are also deeply involved in the work on quality of care and data utilization and have experts in nutrition who have inputted into program design. Due to the integration of the teams, the specific evidence on the GFF's technical inputs is scant apart from in specific areas, e.g. the IC and the CP, likely due in part to the high integration of the GFF and World Bank teams.

- *Lessons learned*

In this setting, GFF relied heavily on the World Bank strengths in alignment, convening, coordination, making the model more efficient. The HER project was deliberately designed to fill essential needs identified in the IC. Other areas – e.g., DRUM – almost impossible for the GFF to work on in this setting, so more of a focus on either a) improving efficiencies in the health system or b) bringing in other funders.

[117] Country KI

AI 3

- *Where does GFF add value?*

The GFF adds value in several key areas, particularly in partner alignment, IC development, technical expertise in quality of care, and targeted technical assistance in key areas such as supply chains.

A critical contribution of the GFF has been its role in resource mobilization and alignment of donor investments around the IC. Through extensive engagement with donors during the IC drafting process, the GFF ensured that funding commitments were closely aligned with national health priorities. This has resulted in significant financial commitments from key partners, covering approximately 90% of the total funding needs identified in the IC.[118]

Additionally, the RMET process has been instrumental in tracking financial commitments, identifying funding gaps, and facilitating alignment between donors and country priorities. The GFF's technical assistance in this area has strengthened transparency in funding flows and helped optimize resource allocation.

- *Extent ensured adequate funding for RMNCAH-N services?*

RMNCAH - and especially nutrition – are well-embedded in the main projects, which are HER and the ADB-funded sister project. The main mechanism for pooling funding is the ARTF, which is managed by the World Bank. There is limited scope to work on DRUM in this context.

- *Data / results – what aspects of the data system were strengthened/what benefits or outcomes?*

Currently the GFF and the World Bank have a wealth of data being gathered through the HMIS, TPM & verification, specific tools to measure aspects of the health system (e.g. mSupply to monitor supply chains/expenditures/stock-outs) as well as specific tools to measure patient satisfaction (e.g. grievance mechanisms). There are also a variety of survey tools including the Multiple Indicator Cluster Survey (UNICEF) and the Afghanistan Health Survey which is scheduled for 2024 (last done in 2019). There is a national M&E plan which is supported by partners, including Gavi and the Global Fund.

The GFF is also supporting the use of data for decision-making through Frequent Assessments and System Tools for Resilience (FASTR) initiatives in Afghanistan. They have used mEHS at multiple points to produce rapid analytics about data completion (as low as 40% in some districts), service coverage, and disruptions by district. This began during COVID-19 and after the ITA came into power, and reports continue into 2023.[119] This was also used to estimate the number of zero dose children, pinpointing areas with low DTP1 coverage to inform interventions.[120] Additionally, there are plans to conduct mobile phone client exit interviews to fill gaps in the understanding of the effectiveness of nutrition counselling and behavior change interventions, which will commence in late 2024/2025.[121]

The World Bank led a data and innovations concept note (dated mid-2024) that looked at how this wealth of data could be used more effectively. It notes that much of the data (especially qualitative data) is under-utilized beyond the monitoring of the specific indicators that are being tracked. The CP is not being used to use the data to address systems blockages, for instance. There is a need to consolidate the

[118] GFF/WB KI
[119] Monitoring EHS in times of COVID-19, July 2022 & HMIS QUIC Analytics Afghanistan, March 2023.
[120] Afghanistan Zero Dose Estimation from HMIS, September 2023
[121] Concept Note- measurement approaches for nutrition

data being used across different platforms, improve the inter-operability of the data systems, and the use of AI/machine learning to improve the use of rapid analytics. There are different levels of use: e.g., the QoC data is well-used in the sense that it is linked to the payment indicators and is thus routinely used. In itself, it includes domains (in the QoC check-list) then monitors the completeness of medical records. However, there appears to be less use of the QoC data to do a blockages analysis, so in that sense, data utilization could be improved.

- *To what extent has there been demonstrable progress towards the TOC (in this country context)*

On the GFF data portal, Afghanistan shows good progress with all output level indicators in place apart from a comprehensive health systems assessment. Medium-term indicators show good progress in meeting their core RMNCAH-N indicators. This includes, for instance, having data on quality of care and systematic use of data, which has not been implemented fully in Afghanistan (see previous sections). In terms of longer-term indicators, Afghanistan does well in service delivery indicators for RMNCAH-N but not in terms of health systems. This, partly because there is currently no route mapped towards sustainable financing for health, and this is not possible at this stage. At the impact level – the reduction in MMR in Afghanistan is notable (701 in 2015 to 638 in 2018),[122] but this data pre-dates the ITA and it is likely that we will see some increases in MMR once the results from the AHS come through in 2025.

These provide some current updates on results achieved:

Indicator	Baseline to current value
Facility-based deliveries	Baseline was set to 0 – 1062671 by May 2024
Quality scores (using the checklist)	41% in June 2023 (but see above)
Timely payment	47% (22) to 86% (24)
CYPS	Baseline set to 0 – 659770 by May 2024.

- *What lessons in advocacy, gender, voice and equity?*

While the IC and the HER project (and sister ADB project) cover the Essential Package of Health Services (EPHS) and the Basic Package of Health Services (BPHS), they also included training on gender-based violence treatment, case management and referrals within the support provided to the health facilities. However, this reports on training given and not on any related results. There is a strong focus on gender equity which is visible in the KPIs being monitored on female staff, the inclusion of cash transfers to reach vulnerable households, and in links to the funding of livelihoods and agricultural support which intend to reach female households.

However, there is limited inclusion of the CSOs into the CP at this time due to the adverse environment in which donors, including the World Bank and the GFF are currently operating.

Any reflections on key findings or implications for the model?

- This case study shows the importance of the adaptability of the GFF, sliding into support where the World Bank is gaining good traction in terms of alignment, coordination, and convening, but particularly in terms of normalizing and liaising with the ITA even as sanctions are imposed on them (preventing others from being able to interact with them). There are also demonstrated GFF focus areas where the World Bank has a stronger strategic advantage, for example, in advocating for DRUM.
- This is a 'short route' case – the IC directly fed into the project design of HER.

[122] GFF Data Portal, accessed 15 October 2024: https://data.gffportal.org/country/afghanistan.

- There is a need for data innovations in Afghanistan – there is a bit of evidence that this work is starting, but this underlines the importance of more being done on quality of care.
- The QoC approach is robust, but it's too early to say how this will impact service utilization rates and improvements in outcomes – but there is some evidence that the other development partners could align more effectively around this agenda. Alignment by the GFF is approached as a financing/ expenditure issue, rather than a joint solution to improving quality of care.

Annex 1: Documents reviewed and stakeholders interviewed

Documents reviewed	Year of issue
Investment Case.pdf	2020
1st Round of RMET_Report.pdf	
2nd Round of RMET-Report.pdf	2022
GFF TFC_Second Round Grant Proposal_0723.pdf	2023
AFG HSTS Mission Report_Nov 2022.pdf	2022
H-STWG meeting 13 May 2024.pdf	2024
H-STWG meeting 10th June 2024.pdf	2024
ToR Country Platform.docx	

Name	Position	Association
Husnia Sadat	Liaison Officer	GFF
Marwa Ramadan	Result Specialist	GFF
Supriya Madhavan	Country Focal Point	GFF
Meredith Dyson	Health Specialist	UNICEF
Debbie Gueye	Health Officer	USAID
Dr Jamshed Tanoli	Coordinator I WHO Representative	WHO
Gyuri Fritsche	Senior Health Specialist	WB
Hadia Samaha	Practice Leader	WB

Guinea

Guinea Case Study

Brief outline of the GFF/ WB investment[123]

Component	GFF	World Bank IDA
Strengthen supply of basic RMNCH services in target regions	US$ 5 million	US$ 12 million
Strengthen district level capacity to recruit and improve competencies of health workers		US$ 4 million
Strengthen the District Health Directorates capacity to supervise and monitor RMNCH service delivery	US$ 3 million	US$ 4 million
Implementing an innovative district level fee financing scheme to mitigate OOP expenses for the indigent poor		US$ 8 million
Support District health directorates recruitment, training etc. of CHWS for outreach and basic RMNCH services	US$ 2 million	US$ 3 million
Enhance the quality and quantity of RMNCH services for recipients in selected districts		$17 million
Strengthen the capacity of the MOH in health financing and development of long-term health financing reform strategies	US$ 2 million	US$ 3 million
Strengthen project management, implementation and donor coordination	US$ 1 million	US$ 2 million

- *What did the GFF invest in doing? (eg. TA / areas / CP etc*)[124]

Details of the GFF investments:

Exec Type	Funding Cat	Budget Cat	Budgeted	Disbursed
RE	1St Round Grants	Grants	$10 million	$9,857,663.59
BE	CORE TA	Project Preparation	$100,000	$19,387.70
BE	Core TA	Project Preparation	$215,098.45	$215,098.45
BE	Core TA	Supervision	$510,000	$509,241.8
BE	Core TA	IC Implementation	$70,000	$68,978.18
BE	Core TA	IC Implementation	$150,000	$9,987.80
BE	Core TA	RMET	$200,000	$115,332.97
BE	Core TA	RMET	$75,062.06	$75,062.06
BE	Flexible TA	Quality RMNCAH-N	$178,850.81	$178,850.81
BE	Flexible TA	Quality RMNCAH-N	$61,088.6	$61,088.6
BE	Flexible TA	Results monitoring	$100,000	$97,666.35

The Investment Case

[123] Guinea PAD (US$)

[124] GFF Evaluation - Case Study Countries - RE and BE Portfolio Summary July 2024

- *Brief overview of the Investment case – Duration 2020 – 2024*

The Investment Case (IC) priorities improved health outcomes for women, children and adolescents with a focus on 'lagging' regions, both in terms of resources and outcomes. The IC just finished (as of December 2024) focused on five regions and provided resources for training frontline staff, especially community health workers (CHWs) and equipping them with medical commodities. The IC also prioritized a number of health systems and health financing reforms, including strengthening results-based financing and improve spending efficiency; rolling out a streamlined health management information system, and modernizing the civil registration and vital statistics systems.[125] To align resources and ensure accountability, the GFF supports the government to coordinate partners, engage civil society organizations in the implementation and monitoring of the IC and promote better health management information systems.

The evolution of the World Bank investments in Guinea is outlined in the following table:

Investment Case	**Investment Case geographical coverage**	**WB project**	**WB project priority regions**
Prior to GFF engagement	---	2015 WB project	Faranah and Labé
2017-2020 Investment Case	Covers (in priority order): Kankan, Kindia, Faranah, Labé	2018 WB project (developed in parallel)	Kankan and Kindia
2020-2024 Investment Case	Whole country, with special focus on: Kankan, Kindia, Faranah, Labé and Boké	2024 WB project 2024 WB project	Whole country except Conakry

The 2020–2024 IC served as a key reference document during the development of two new World Bank-financed health projects, which were recently validated by the World Bank Board and will cover the entire country over the next five years:

1. The Health Security Project in Central and West Africa (PreSes-AOC) – USD 106 million (approved by the National Transitional Council and promulgated by the President of the Republic).
2. The Health System Transformation Project (GUEST) – USD 95 million (approval scheduled for March 31, 2025).

- *Are there clear RMNCAH-N priorities identified – if so, what?*

The IC was based on an evaluation of the previous RMNCAH strategy. Having identified bottlenecks in improving RMNCAH-N outcomes, the Ministry of Health decided to prioritize interventions at three levels that included availability of medicines, human resources for health (HRH) availability and effective health care coverage.

- A community health package that prioritized health promotion interventions:
- A prevention package comprising interventions provided by both fixed facility and mobile health staff
- A curative package offered across the different levels of the health care system

[125] Guinea IC

An additional bottleneck at community level included social-cultural challenges, such as stigma and discrimination and various environmental health determinants (e.g. open defecation).[126]

Other systems bottlenecks were identified, in particular weaknesses in the HMIS. Health sector reforms that were prioritized included:[127]

- Implementing the community health strategy
- Extending performance-based financing
- Implementing integrated communication plan and initiatives
- Strengthening the quality of health data
- Improving the supply chain
- Strengthening governance and multisectoral coordination
- Promoting civil registration efforts

- *Funding gaps identified? Any evidence that it was able to leverage further funding from external partners?*

The IC estimated budget was between US$ 509 and 638 million depending on which scenario was used. It provides a thorough mapping of resources available for its implementation across all DPs, which came to a total of approximately US$ 479 million for the IC time period. The funding gap, based on the three scenarios, was between US$ 30 and US$ 158 million over the four-year period.

A key informant shared that the IC allowed them to prioritize and address areas that were previously underserved by interventions and projects. For example, new projects, such as one on adolescent and youth sexual and reproductive health rights, were directed to regions like Bokeh, where there had been limited interventions. This project, financed by AFD (French Cooperation), was based on the IC's prioritization and also included aspects like gender-based violence. Additionally, a new project funded by Enabel (Belgian Cooperation) similarly built on the groundwork established in the IC.[128]

The country platform

- *Brief overview of the platform*

The country platform has been in operation since 2019, but it did not function very well for its first few years.[129] Since 2021 the country platform has been highly functional, as described below.

- *Where is it based – who takes part?*

In 2019, the GFF has supported the Ministry of Health to set up a multisectoral country platform (Comité Technique Multisectorial), which is the main body, whose quarterly meetings attract some 80-90 participants from health programs, regional and district teams, other ministries, civil society, and development partners. However, it actively monitors the activities of the RMNCAH-N through four thematic groups that exist within it (maternal and child health, family planning, adolescent and youth health and nutrition) and helps to align them around IC priorities – not only across health ministry programs and directorates but also among other key ministries and sectors. The IC has been so successful as a coordination and prioritization mechanism that the Ministry of Health has initiated discussions with its stakeholders to explore the possibility of not renewing its RMNCAH-N

[126] Guinea IC
[127] Guinea IC
[128] Country KI
[129] Country KI

strategy and instead use the upcoming 2025–2029 IC as the cross-sectoral plan for the country's RMNCAH-N activities.[130]

- *Any evidence on how active it is?*

Very active – the CTM meets quarterly to discuss progress monitoring data and to agree work plans for the following quarter. It also comprises four main task teams: a) MNCH, b) Family Planning c) Adolescent and Youth reproductive health and d) Nutrition, which according to interviewees meet monthly.[131]

- *Are there clear RMNCAH-N priorities identified – if so, what?*

The IC was based on an evaluation of the previous RMNCAH strategy. Having identified bottlenecks in improving RMNCAH-N outcomes, the Ministry of Health decided to prioritize interventions at three levels that included availability of medicines, HRH availability and effective health care coverage.

- A community health package that prioritized health promotion interventions:
- A prevention package comprising interventions provided by both fixed facility and mobile health staff
- A curative package offered across the different levels of the health care system

An additional bottleneck at community level included social-cultural challenges, such as stigma and discrimination and various environmental health determinants (e.g. open defecation).[132]

Other systems bottlenecks were identified, in particular weaknesses in the HMIS. Health sector reforms that were prioritized included: [133]

- Implementing the community health strategy
- Extending performance-based financing
- Implementing integrated communication plan and initiatives
- Strengthening the quality of health data
- Improving the supply chain
- Strengthening governance and multisectoral coordination
- Promoting civil registration efforts

- *Funding gaps identified? Any evidence that it was able to leverage further funding from external partners?*

The IC estimated budget was between US$ 509 and 638 million depending on which scenario was used. It provides a thorough mapping of resources available for its implementation across all DPs, which came to a total of approximately US$ 479 million for the IC time period. The funding gap, based on the three scenarios, was between US$ 30 and US$ 158 million over the four-year period.

A key informant shared that the IC allowed them to prioritize and address areas that were previously underserved by interventions and projects. For example, new projects, such as one on adolescent and youth sexual and reproductive health rights, were directed to regions like Bokeh, where there had been limited interventions. This project, financed by AFD (French Cooperation), was based on the IC's

[130] GFF TFC Guinea second round proposal 2024
[131] Rapport Syhnthese De La Reunion CTM SRMNIA-N, 01.06.23 and KIIs
[132] Guinea IC
[133] Guinea IC

prioritization and also included aspects like gender-based violence. Additionally, a new project funded by Enabel (Belgian Cooperation) similarly built on the groundwork established in the IC.[134]

The World Bank project

- *What is the World Bank funding – what aspects of RMNCAH-N does it target?*

The WB PAD is fully aligned with the RMCNAH-N investment case. Areas that it finances are indicated in the table above.

- *What is the evidence that the GFF then led to a re-prioritization of RMNCAH-N in the WB project?*

The 2018 WB PAD was developed at the time that the IC was being developed. The WB had been financing a previous PBF pilot in Guinea. However, it appears that a previous PAD, provided in 2015 (before GFF started in Guinea) was already targeting the same two priority regions in Guinea with funding for improving "utilization of primary health care services by strengthening the supply, demand, and management capacity for maternal and child health services delivered at health post and health centers to meet immediate needs of mothers and children".[135] The main difference between the 2015 and the 2018 PAD is the value. The 2015 PAD had a total value of US$ 13 million while the 2018 PAD had a total value of US$ 55 million (US$ 45 million WB and US$ 10 million GFF).

Two health financing modalities are highlighted in the PAD. One is extending the PBR pilot from one district in a different region to four districts in the two focus regions for this project, using 'output-based financing' (OBF).

"This project will cover all health centers and their catchment areas in two districts, strengthening district and public sector capacity for implementation and monitoring. For such an output-based financing (OBF) model to realize its potential as a driver of long-term systematic change, the Bureau de Strategie et Developpement (BSD), which is in charge of health financing at the central level, will be heavily involved in the design, monitoring, and evaluation of the schemes. A simple process evaluation (before- and-after study) will also be funded to generate lessons to help drive the policy dialogue toward more systemic change. ….. The PCU will pay invoices, paying for the resources that the health establishments obtained and other structures on performance contracts."[136]

The other measure is a fund to pay the health care fees for 'indigent' families. "The program which builds on the lessons from the World Bank's Productive Social Safety Net Project, focuses on a local, community-driven process to identify indigents, verify such indigents through independent local NGOs, develop an electronic database on these people administered by the district health authorities, and provide all selected indigents with a corresponding indigent health card, which will allow the poorest people to access RMNCH services free of charge at primary level facilities. The facilities providing services to the indigent population will bill the central government (the project) for services rendered (after NGO verification). The activities to be financed under this component will focus on financing the community selection of indigents and the NGO verification process, administrative expenses related to management of the database, issuing cards, training and communication activities, and reimbursement to health facilities for services rendered to indigents."[137]

[134] Country KI
[135] Guinea PAD 2018
[136] Guinea PAD 2018, p.48-50
[137] Guinea PAD 2018, p. 14

KEY FINDINGS BY AI

AI 1

- *Delivering health services – what's the model – how is this being achieved?*

The following quotes highlight how the GFF has contributed to strengthening the delivery of health services, focusing on capacity building and addressing key health issues:

> *"The GFF also contributed a lot to (health services). The strengthening, so to speak, sums up really all the pillars of the health system have been affected. The availability of products, the strengthening of the capacities of human resources with a lot of training on different themes."* – Country KI

> *"So, this project takes into account everything that is capacity building at the level of the state structure, but also at the level of civil society because each child has training. There is a certain quota which gave a high number of civil society groups for training, for capacity building, but also for the implementation of honors. And what remains clear with this strengthening package, with this package of activities and implications, is a modification because where civil society exists, where there is civil society, the health problems of young people and women are currently being taken into account at a good level and nothing is being left behind. So, at the core structural level, obstetric care, care for children, vaccinations and everything that follows is taken into account."* – Country KI

- *Quality of care – what's the model – evidence of this being achieved?*

The quality of PHC services continues to be a challenge. While the GFF-supported IC and the World Bank-funded HSCSP have significantly boosted service volumes over the past five years and improved service readiness in project regions, maintaining high-quality care remains an ongoing issue. Although RBF facility scores have improved, these mainly reflect infrastructure and readiness, not clinical performance. Both SARA quality-of-care assessments and World Bank supervision visits have identified gaps in clinical quality and respectful treatment of patients.[138]

- *Added value to other RMNCAH-N actors? How? Evidence?*

The most substantial added value, based on reading and interviews, appears to be the support given to convening the technical multi-sectoral committee and the technical task teams, which bring together a large number of RMNCAH-N actors in the country on a regular basis and, where they can, together with the government of Guinea, to analyze performance data and agree joint actions.

> *"The GFF supports the government to operationalize the alignment of partners. The partners involved in the sector are involved in the development of the Investment Case, they are involved in the implementation of the Investment Case. And they also participate in the platform, in the dynamism of the platform. We have UNICEF, we have UNFPA, we have USAID, we have national and international NGOs, we have the national coalition of civil society organizations, etc., etc. So, this means that the alignment is respected."* – Country KI

[138] GFF-TFC Guinea second round proposal 2024

AI 2

- *GFF/ WB leveraging each other's strengths*

According to the documents reviewed, the GFF and World Bank have effectively leveraged each other's strengths to enhance project sustainability and expand health interventions in Guinea.

"The support that the GFF provides is an invaluable contribution to project sustainability. The GFF-financed investment case complements Bank-executed and GFF-financed technical assistance to strengthen health financing capacity in Guinea, further refining community and primary-level service delivery strategy in Guinea and identifying optimal yet realistic service delivery models to enable long-term reform in the sector."[139]

"The Trust Fund Committee (TFC) is invited to acknowledge the progress made in Guinea to date and to provide its non-objection for a second-round grant envelope totaling US$ 10 million, in line with the objectives of the GFF 2021–2025 strategy. Subject to TFC approval, the requested funds will be used to co-finance an allocation from the World Bank's International Development Association (IDA) amounting to US$ 85 million, which will extend the current World Bank project interventions to other regions prioritized in Guinea's investment case (IC), strengthen the quality of Reproductive, Maternal, Newborn, Child and Adolescent and Nutrition (RMNCAH-N) services, scale up results-based financing (RBF), address supply chain weaknesses, and better respond to gender inequalities in the health system."[140]

"Earlier this year, Guinea received an essential health services (EHS) grant of US$ 16 million through the World Bank Health Security Program in West and Central Africa, which the GFF has cofinanced. The GFF support was critical to ensuring the inclusion of 1) a key indicator across the region and in Guinea related to routine monitoring of PHC services to detect and mitigate potential disruptions in essential services; as well as 2) regional training on a basic package of sexual and reproductive health services in the context of public health emergencies."[141]

- *Are the roles sufficiently clear/ separated?*

Yes, as can be seen in the first section above, the GFF has primarily provided TA in support of the development of joint project aims, coordination, and results monitoring to feed into coordination mechanisms.

- *Opportunities to maximize complementarity*

It would be hard to see how the GFF and WB could do more than they are already doing to maximize complementarities. The GFF coordination role, relationships with the MOH and support for the TMC, and especially the strong drive on practical data use on different platforms has clearly helped boost the performance of both sets of funding. According to KIs, the WB could do more to facilitate the inclusion of the Ministry of Finance (MOF) in the RMNCAH platforms, which could, in the long run, boost opportunities for sustaining the gains in the project. GFF could potentially do more to strengthen QoC efforts, as it is not clear why this has continued to be such a challenge. GFF TA could be used to do a deep dive into the bottlenecks to QoC efforts.

[139] Guinea PAD 2018,
[140] GFF TFC Guinea second round proposal 2024
[141] GFF TFC Guinea second round proposal 2024

AI 3

- *Where does GFF add value?*

In addition to what has already been mentioned above, the GFF's engagement and co-financing significantly boosted progress in areas where the country would have faced challenges in allocating sufficient resources or securing quality technical assistance. These areas included: 1) data systems and utilization, 2) CRVS policy and systems, and 3) resource mapping and expenditure tracking to ensure alignment with priority regions and populations. The partnership on data systems facilitated a successful use of the FASTR analysis of DHIS2 data to identify service disruptions during the COVID-19 pandemic. The RMET is now recognized by the government as a key tool for alignment.[142]

> *"There has been a lot of setbacks in the implementation of the investment case. In fact, it is the first that we are really implementing, but we have noticed that it greatly facilitates coordination and therefore capacity building. It might still help. And also, continue support for health promotion around maternal, newborn, child health and adolescent health and nutrition, through programs. We realize that the funds, the resources mobilized by GFF really help to catalyze, to bring other financing towards our target for which indicators are still low. So, it is a tool that is targeted in our, not only in our strategic documents, but also in relation to our commitments at the international, regional and international level."* – Country KI

- *Extent ensured adequate funding for RMNCAH-N services?*

Budget allocated to health: After two years of increase, the proportion of the state budget allocated to health decreased in 2022, from 8.4% to 6.6%.
Donor financing for RMNCAH-N: The number of donors financing RMNCAH-N continued to grow between 2020 and 2022.[143]

Despite the funding gap noted earlier for the implementation of the investment case, there were sufficient funds to make some impact on Guinea's outcome indicators, though these are variable (see progress against TOC below). Guinea benefited from the following results between 2020 and 2024.

- *Data/ results – what aspects of the data system were strengthened/what benefits or outcomes?*

The government of Guinea, together with its partners, including GFF, has made considerable progress in strengthening its data system.

> *"Through the GFF, through the investment case has helped improve the capacity for data analysis and the dissemination of information across stakeholders at all the levels, At the time of the coordination meetings, we will look. We have now become accustomed to going beyond what management itself does. We are also going to take information relating to RMNCAH-N from other programs and all the partners, all those who work on RMNCAH-N."* – Country KI

GFF has supported two consultants, one Guinean HMIS specialist based in the MOH and an international HMIS specialist who covers multiple countries. In the words of the international

[142] GFF TFC Guinea second round proposal 2024
[143] Presentation sur le dossier d'investissement

specialist there was a complete 'overhaul of the HMIS' in Guinea. While data use has been improved at the national level through discussions at CTM meetings, there is still work that needs to be done to get health facility staff to have access to and use their own data. There is an initiative ongoing in Guinea to develop dashboards and information products tailored for facility-level use.[144]

- *To what extent has there been demonstrable progress towards the TOC?*

Progress towards the ToC includes:

- A slight rise in facility based CPN4 and deliveries
- A slight increase in vaccination rates (2% increase) between 2020 and 2023.
- Variable performance in ACT provision to <5s between different regions, though nationally <A5 ACT treatment reached almost 200,000 more children in 2023 than in 2020.
- Sustained relatively high levels of recovery after treatment for malnutrition (except in one region)
- Variable family planning (CYP) performance, though adolescents accessing contraception rose from just under 50,000 in 2020 to just under 200,000 in 2023, a four-fold increase.
- Steady increase in numbers of women receiving postnatal care
- Slight increase nationally, but in some cases a decline, in availability of RMNCAH-N commodities between 2020 and 2023.

COVID-19 clearly had an impact and slowed down results being achieved. With regards to adolescent health one key informant suggested:

> *"(GFF) takes the health of the mother, the health of the adolescents. Today it allows adolescents to access health facilities whereas before, they were hesitant to join the structures because they were frowned upon. But the capacity building of agents at all levels has allowed everyone to know that these adolescents have rights. They have rights and we must help them solve their problems. And today, it was during the time of the GFF that we made pleas. Very strong plans to prove to the State or to explain to the State that we must facilitate free care, facilitate free care for adolescents. In terms of free care, perceptual contracts for planning."* – Country KI

- *What lessons in advancing gender, voice and equity?*

The GFF/World Bank joint project focused its attention on the two poorest performing and remote regions in Guinea in an effort to ensure improved RMNCAH -N services reached an underserved population.

One KI acknowledged that *"…equity and gender integration have historically been gaps in the GFF's work, with the first few years focused more on the basics. However, in the last couple of years there has been a big push to make these priorities, including through the design of new World Bank projects. However, it is still an area that needs more focus and integration across all the GFF's work."*

Any reflections on key findings or implications for the model?

- The Guinea GFF experience would suggest that a combination of strong country leadership (in this case from the Director FH&N), with additional TA support for planning, coordination and

[144] Country KI

performance monitoring provide a strong basis for improving the outcomes and impact of the mutual investments.

- Despite these efforts RMNCAH-N service outcomes have been variable across the country, including in the GFF/WB two focus regions. The program was restructured in early 2023 at the request of the government, with a view to making up for the fallout from COVID-19.
- The strength of the Guinea program lies particularly in the fact that key decision makers, both in the Government of Guinea and in the World Bank and GFF are open to learning lessons and have apparently been working to apply these to the next WB/GFF project that will be presented to the WB Board (and presumably GFF IG) in September. This new program has increased funding and will support a larger number of regions.

Annex 1: Documents reviewed and stakeholders interviewed

Documents reviewed	Year of issue
GFF TFC Guinea second round proposal	2024
Rapport SMART Guinée2022 DNSFN VF	2022
Bulletin SRMNIA-N N°01	2023
Bulletin SRMNIA-N N°2	2024
Disclosable Restructuring Paper - Guinea Health Service and Capacity Strengthening Project - P163140_1.pdf	2018
Disclosable Version of the ISR - Guinea Health Service and Capacity Strengthening 1-12	2018-2024
PAD Guinea Health Service and Capacity Strengthening Project (P163140)	2018
Rapport Syhnthese De La Reunion CTM SRMNIA-N	2023
Présentation sur le Dossier d'Investissement (3)	2022
Suivi du DI (présentation au CTM de mai 2024) VF	2024
Guinea IC Final Version Signed	2019
PSNSRMNIA 2020-2024 DNSFN VF	2022
Rapport Final Réunion Coordinat SRMNIA-N	2021
Rapport Réunion GT SMNI 31 Mai 2023.	2023
FY23 Guinea CIS Review 2022.12.13	2022
FY24 Guinea CES Review 2024.02.21	2024

Name	Position	Association
Freddy Essimbi Onana Essomba	Liaison Officer	GFF
Dr Ndiouga Diallo	FP/RHCS Advisor	UNFPA
Dr Hadja Bintou Bamba	President of the Coalition of CSOs	CSO
Dr Dieney Fadima Kaba	DNSFN	Min of Health

Indonesia

Indonesia Case Study

Brief outline of the GFF/WB investment

There have been 2 Indonesian WB projects co-financed by the GFF:

- **Investing in Early Years (INEY) I (2018-2022):** World Bank funding was US$ 400 million, GFF co-financing was US$ 20 million with additional US$ 3 million from a GFF EHS grant, and Government of Indonesia co-financing was US$ 6,185 million.[145] This means that the GFF financing was less than 1%.

- **INEY II (2023-2028):** has a combined financing of funding from the World Bank (US$ 600 million, and GFF of US$ 17 million and Gavi funding of US$13 million. Government of Indonesia financing is US $568 million.[146]

INEY I / GFF inputs:

- Supervision and capacity building for sub national implementation
- Country platform convening/ self-assessment and included the RMET
- DRUM TA support including looking at policy options to increase revenue, and work on chart accounts to be able to track budgets
- COVID response support
- E-HDW app development (a digital tool for use by the health development workers to measure budgets/ services used/ vulnerable populations)

INEY II / GFF inputs:

- Project preparation
- Supervision and capacity building
- Support to the investment case, including a lot of work under M&E, completion of the ICR and identification of 'lessons learned' from INEY I, improvements on the inter-operability of the tools to develop data dashboards at the national/ sub-national levels
- Private sector TA (policy options, including sugar tax, market systems assessment)
- Work on quality of care and how to integrate these measures into national and sub-national financing systems
- Contributions to policy work, e.g. the policy brief on the sugar tax.

Details of the GFF investments: [147]

Exec Type	Funding Cat	Budget Cat	Budgeted	Disbursed
RE	1St Round Grants	Grants	$20 million	$19,851,431.24
RE	EHS Grants	Grants	$3 million	$2,585,147.41
RE	EHS Grants	Grants	$17 million	$2,107,000
BE	CORE TA	Project Preparation	$43,995.54	$43,995.54
BE	Core TA	Supervision	$50,000	$43,746.59
BE	Core TA	Supervision	$500,260.72	$500,260.72

[145] INEY I PAD, May 2018
[146] INEY II PAD, June 2023
[147] GFF Evaluation - Case Study Countries - RE and BE Portfolio Summary July 2024

BE	Core TA	Supervision	$344,579.94	$344,579.94
BE	Core TA	IC Implementation	$119,960.75	$119,960.75
BE	Core TA	RMET	$229,.986.14	$229,986.14
BE	Flexible TA	DRUM	$500,000	$190,981.66
BE	Flexible TA	DRUM	$149,992.97	$149,992.97
BE	Flexible TA	Private Sector	$108,033.47	$108,033.47
BE	Flexible TA	Quality RMNCAH-N Analytics and Innovation	$343,271.72	$343,271.72
BE	Flexible TA	Quality RMNCAH-N COVID response	$291,111.31	$291,111.31
BE	Flexible TA	Quality RMNCAH-N Data Collection Support	$69,706.87	$69,706.87
BE	Flexible TA	Quality RMNCAH-N HSS Reforms and RMNCAHN	$68,910.83	$68,910.83

Note that the World Bank project closure report says that some of the GFF grant money was cancelled and re-programmed into INEY II.[148] While no rationale for this was provided in the report, it was attributed to changes in the institutional implementation of the IC, with the appointment of BKKBN as the chief executive of IC implementation (Presidential Decree 72/2021).

The investment case[149] [150] [151]

- *Brief overview of the Investment Case*

The Indonesia IC, the National Strategy on the Reduction of Stunting, was developed through a rapid, cross-country learning-focused approach. Government health leads were taken on a visit to Latin America (Peru) to dialogue on potential solutions to stunting.[152] They also drew down on examples from other countries, which was fed into the design. The IC was endorsed by the government in 2018 and ratified as a law (Presidential Decree 72/2021) in 2021. While the primary impetus was focused on stunting, pregnant women are also a focus due to the influence of protracted malnutrition over time. The strategy details a number of nutrition specific and nutrition sensitive interventions, broadly targeted at pregnant and/or breastfeeding women, but also children 0-59 months. The World Bank projects with GFF co-financing, INEY I and INEY II, support the national strategy.

The IC is based on five inter-locking pillars, namely: 1) leadership commitment and vision; 2) national campaign and behavior-change communication; 3) national, regional and village program convergence; 4) food and nutrition security; and 5) monitoring and evaluation. The strategy identifies that international learning on stunting reduction has found that there is multisectoral approach is needed, including, e.g., access to primary health services, immunization, water/ sanitation, nutrition including practices such as breast-feeding, education, agriculture and social

[148] INEY I ICR, June 2024
[149] Country KIs
[150] Addressing malnutrition multisectorally-FINAL-submitted.pdf (mdgfund.org)
[151] INEY I PAD, May 2018
[152] Country KIs

protection. It identifies things such as getting a birth certificate as being important to addressing stunting. It also has a focus on how effective planning and budgeting can be done in stunting programs. The approach in Indonesia was thus strongly multi-sectoral from the beginning, as it called on different line ministries to align around realizing the strategy (including health, local community and development, education, and others).

The IC includes a strong focus on developing the linkages between different levels of the governance system, down to the village level, to mobilize leadership, funding and support for pregnant women and children at risk of stunting. The multi-sectoral approach also applies at all levels – the strategy refers to a 'multi-sector convergence approach' which operates at different levels from the village up to districts and states.

- *Are there clear RMNCAH-N priorities identified – if so, what?*

As the Indonesian IC is the National Strategy to Reduce Stunting, it has specifically prioritized nutrition and is not a broader sexual, reproductive, and maternal health-focused national strategy (although the country also has RMNCAH strategies). The IC also describes the target groups which will be included in the strategy: pregnant women, breastfeeding women, children aged 0-23 months, children aged 24-59 months, women of reproductive age, and adolescent girls. It also makes linkages to wider agendas, e.g. adolescent health, maternal health, and universal health care coverage.

There is limited coverage of some components of RMNCAH in the IC. For instance, the only nutrition-specific intervention for adolescents is iron supplementation. However, nutrition-sensitive interventions are more focused on RMNCAH – including improving access to family planning, provision of health and reproductive health education to adolescents, and *'women's empowerment and child protection'.* There are also several interventions with wider benefits, e.g., water and sanitation.

Multiple KIs have stated that this intersection of nutrition and adolescent sexual and reproductive health was due to the GFF's technical inputs and steer, with some external KIs saying that such an intervention had *"never occurred to them"*.

- *Funding gaps identified? Any evidence that it was able to leverage further funding from external partners?*

INEY is national in scale and fully invests in the financial needs identified to comprehensively address stunting. The government's budget contribution is the largest and is significant, and the IC is fully covered. The need for technical assistance for the implementation of the IC exists and partners, including the GFF, are currently supporting the government. Funding gaps may become a more critical issue in future years as donors, including the GFF, transition out.

The country platform[153]

- *Brief overview of the platform*

The **Stunting Reduction Acceleration Team** is a strongly government-led national platform with inter-ministry coordination, as well as sub-national platforms (varying in strength). This platform is connected to CSO, private sector, donor and development partner, and academia networks, which support implementation of the Stranas (IC), the national stunting reduction strategy.

The GFF supports the Office of the Vice President in coordinating the country platform (CP): "*it is clear that the GFF is very instrumental in implementing the Stranas [IC] and Stunting Reduction Coordination Team at all levels."*[154] They initially provided TA to assist with central government coordination, but now that political commitment has increased, this has shifted to include local government coordination.[155]

The CP was formalized (alongside the IC) with Presidential Regulation 72/2021. It is focused on tracking progress, as well as providing a political forum to motivate local governments to align with the national strategy on stunting.

- *Where is it based – who takes part?*

The CP has high-level ownership; it's led directly by the Office of the Vice President, with membership of 11 ministers and coordinating ministers. As the SUN Focal Point, Bappenas (the Ministry of National Development Planning) coordinates SUN Networks, including CSOs, Donors and Development Partners, Private Sector, Academia and Government, which meet regularly to align agendas.

Evidence suggests that coordination between CSO representatives and the government is strong at the national level. However, progress at the subnational level has been more advanced in some districts than others (e.g., with more local NGO activity in Central Java and East Java). While GFF's model in Indonesia promotes strong government ownership of the CP, as a result, some KIs report that CSOs have limited visibility of GFF's engagement and analytical work.[156]

- *Any evidence on how active it is?*

The national CP meets biannually. There is good evidence of strong political leadership and mobilization of actors at the national level (e.g., evidence of national level meetings to mobilize political support). KIs stated that the CPs have been formulated at the sub-national level (e.g. at the regional/ district levels), but that some are more active than others.

There is some evidence that there has been effective advocacy on specific issues, e.g., action on micro-nutrients (e.g., fortification of rice), and support for a tax on tobacco products that would facilitate generating revenues for health budgets. GFF also supported a policy brief on sugar tax,[157] but there is evidence that this has not progressed very far due to political sensitivities.[158]

[153] CP – notes of meetings / various dissemination activities
[154] Country KI
[155] Country KI
[156] Country KI
[157] The World Bank Group, Global Financing Facility, the Global Fund, and Bill and Melinda Gates Foundation. A Dual Edged Fiscal Policy Tool for Double Burden of Malnutrition, n.d.
[158] Country KI

There is weaker evidence that the CP led to the GFF-supported mandate of increased alignment. Many other development partners are working across nutrition, focused on early child nutrition, however, there is little evidence that GFF supported greater alignment in this area. However, a key role of the GFF was providing TA for the coordination of the many government ministries that needed to come on-board for project preparation under INEY I: "*GFF played a key role. Without them, they don't think they could have done the coordination for consultation of different levels of the government."* – Country KI

The World Bank project

- *What is the world bank funded to do – what aspects of RMNCAH-N does it target?* [159]

INEY I was designed as a multi-sectoral project that would address the deficiencies to address stunting across many different sectors. The project is national in scope. INEY I covered four years, with 33 priority nutrition interventions and 48 million beneficiaries over 514 districts.

INEY I commits 22 ministers and an estimated US$ 3.9 billion per year to converge priority nutrition interventions across health, water and sanitation, early childhood education, social protection, and food security. The intention was to develop a truly multi-sectoral approach that would reduce inefficiencies in spending while also serving as a roadmap for other development objectives that could benefit from inter-ministerial collaboration. The World Bank PforR project thus also focused on incentives to improve the performance management of different ministries, as well as inter-sectoral collaboration and coordination. Specifically, it aimed to improve the capacities of Bappenas (National Planning and Development Ministry) and the Ministry of Finance to manage PforR.

Key target beneficiaries: INEY I prioritized pregnant women and children aged 0-24 months ("1,000-day households") by ensuring the convergence of 21 nutrition-specific and 12 nutrition-sensitive interventions. This approach aimed to deliver all 33 interventions within each district, ensuring that all populations at risk or suffering from stunting had simultaneous access to a comprehensive package of nutrition services. To support convergence, supply-side actions focus on strengthening the delivery of health services, early childhood education, water and sanitation, and food assistance. On the demand side, it promotes nutrition and early childhood services through the Government's conditional cash transfer program (PKH), awareness campaigns, and outreach activities by Human Development Workers.

The operation was designed to start with 100 priority districts and then to scale up to hit a total of 514 districts. There were a number of ways in which INEY I was going to achieve this, including using: a) a 'programmatic approach' to incentivize local governments to align with the stunting strategy (in terms of budgets and approaches); b) mobilizing a cadre of 'multi-sectoral development workers' who would report to their local village heads, but would monitor "first 1,000 days of life" households to ensure access to height/weight measurement and other nutrition interventions (including cash transfers to vulnerable households); c) data innovations to monitor, learn and adapt; and d) an empowerment approach which uses a 'village convergence score-card' to monitor implementation. Notably, there is a deep commitment to monitoring budgets in line with program delivery and PforR incentives.

[159] Extract from the WB PAD for INEY I

"By incentivizing districts to monitor stunting and intervention coverage more regularly and accurately, adjusting budgeting to align with what is working, and creating the conditions for villages to do their part, the program will stimulate more active involvement of district leaders and officials in solving the persistent service delivery challenges that contribute to stunting."[160]

Results areas and indicators were as follows:

Table 1: INEY I DLIs

Results Area 1: Strengthening national leadership
DLI 1 – Public commitments of Priority District leaders to accelerate stunting prevention
DLI 2 –Tracking and performance evaluation of national spending on priority nutrition interventions
DLI 3 – Timely publication of annual national and district stunting rates
Results Area 2: Strengthening delivery of national sector programs
DLI 4 – Priority Districts delivery of nutrition-sensitive professional development program for ECED Teachers
DLI 5 – Beneficiaries receiving food assistance program (BNPT) in DLI 5 Priority Districts
DLI 6 – Priority Districts implementation of locally adapted interpersonal communication (IPC) activities
Results Area 3: Strengthening convergence of district activities
DLI 8 – Performance of districts in targeting priority nutrition interventions
DLI 9 – Predictability and results-orientation of fiscal transfers that support convergence
Results Area 4: Converging village service delivery
DLI 10 – Village-level convergence of nutrition interventions on 1,000-day households

Table 2: INEY I PDOs and indicators

PDO 1: To enhance delivery of services
Number of active Posyandu delivering essential health and nutrition services according to agreed standards
Number of identified under-performing districts increasing coverage of complete immunization in under-five children
PDO 2: To accelerate the reduction of stunting
Number of villages achieving good performance in the acceleration of stunting reduction
Percentage of under-five children monitored for growth and development

INEY II (2023-2028) continued with the same focus on improving *'convergence'* through greater alignment and coordination among different line ministries and in delivery through strengthened local leadership to address stunting. INEY II has four pillars: 1) leadership, delivery and quality of nutrition specific and sensitive indicators; 2) service delivery and convergence for stunting reduction; 3) convergence at village and household levels; and 4) a greater focus on strengthened service delivery incentives (strengthened role for the MOH), use of budget statements and tracking, and a greater emphasis on quality of care which is integrated into the DLIs.

There is a notable shift in the content of DLIs between INEY I and INEY II, and in the program's

[160] INEY I-PAD

focus on key ministries (with only eight line ministries included in INEY II). INEY I focused on supporting systems while there is a greater focus in INEY II in the delivery of 'essential public health services'.

The focus of the INEY II program development objectives is on the strengthening of 'Posyandu centers,' health posts which should be staffed with five health development workers who are focused on maternal and child health and carry out a variety of activities including: monitoring of children's growth (height/weight), nutrition counselling, breastfeeding advice, counselling on hygiene/WASH, encouraging use of family planning, and pre- and post-partum vitamin supplementation for pregnant women (e.g., iron, folic acid) and for children (Vitamin A).

Table 3: INEY II DLIs

Results Area 1: Leadership
DLI 1 – Commitment, performance and accountability of district and regional leaders to address stunting
DLI 2 – Results-based and climate responsive nutrition planning and budgeting systems
DLI 3 – Integrated climate responsive M&E for acceleration of stunting reduction
Results Area 2: Delivery and quality of nutrition specific and sensitive indicators
DLI 4 – Delivery of nutrition interventions through the education sector
DLI 5 – Evidence-based and climate-responsive nutrition-specific interventions
Results Area 3: Service delivery and convergence for stunting reduction
DLI 6 – Improving the quality of essential health and nutrition services at *puskesmas* (community health centers)
DLI 7 – Improving the coverage of essential health and nutrition services at the district level
DLI 8 – Districts and cities achieve good performance in the acceleration of stunting reduction
Results Area 4: Convergence at village and household levels
DLI 9 – Village Kaders (health workers) are skilled and support their villagers to achieve good performance in the acceleration of stunting reduction
DLI 10 – Strengthen the provision of essential health and nutrition services at the village level

- *What is the evidence that the GFF then led to a re-prioritisation of RMNCAH-N in the World Bank project? Where is this evident?*

KIs reported that while developing the first and second INEY projects, the World Bank and GFF staff worked closely together as one team. It's thus quite difficult to determine how the GFF influenced the World Bank. However, this project is an example of excellent joint working between nutrition specialists in the World Bank and in the GFF, who had similar skills-sets but were able to share the intense design workload for the set-up of this project.

Broadly, the INEY programmes were designed to address a critical area within the GFF and the World Bank's remits: nutrition. Some aspects of the project can be tentatively attributed to GFF, e.g., the inclusion of adolescents, especially through school-based counselling and supplementation programmes which are linked to reproductive health goals of delaying pregnancy and marriage (and thus, fertility).

INEY I was designed to reach approximately 16,200,000 pregnant women with iron supplementation and nutritional counselling over five years of operation. The INEY I PAD notes a number of areas where maternal health was neglected (particularly prenatal maternal health), where gender-based barriers affected women's access to education and resources, and where there are links between adolescent pregnancy, child marriage and nutrition indicators. These linkages between agendas were cited as a value add of GFF-supported inputs to INEY. Other areas of work are also gender-sensitive, e.g., nutrition counselling for men to improve maternal and child health, and adolescent-focused education on sexual and reproductive health and nutrition in schools, but it is more challenging to attribute inclusion of these aspects to the GFF.

INEY II: There is not that much documented evidence that the GFF itself led to the re-prioritization of RMNCAH-N but GFF was actively involved in the project coordination and design meetings. The project was co-designed between the World Bank and the government and realized the commitments that the government had publicly made at nutrition summits. However, there is some evidence of linking agendas (e.g., DLI 4 is focused on nutrition through schools and targets adolescents), and this is an area where the GFF was said to have provided good steers. The GFF supported the greater focus on quality of care, the linkage of nutrition interventions to health, and monitoring and evaluation.

While the GFF's support is linked to a large-scale, national project that has achieved impact, the links to the wider RMNCAH agenda (aside from nutrition) are indirect – e.g., the economic benefits of iron supplementation for pregnant women. The benefits for other areas of RMNCAH are underdeveloped and are not well-reported in World Bank documents. For example, the project aims to expand the coverage of health posts and health centers, many of which have a wider remit in reproductive and maternal health (e.g., provision of family planning, referrals for risky pregnancies, antenatal and postnatal care). These are tracked by the project but are not reported against.

KEY FINDINGS BY AI

AI 1

- *Delivering health services – what's the model – how is this being achieved?*

INEY I & II are comprehensive programs addressing determinants of stunting at scale in Indonesia through a multi-sectoral approach. In INEY II especially, there is a clearer focus on improving quality of health care and coverage through essential frontline services e.g., through health posts, health centers, and in working with the 'kadres' – community health workers. There is robust evidence that the project has delivered a rapid reduction in stunting, despite disruptions to service delivery during COVID-19. The prevalence of stunting declined from 30.8% (2018-baseline), to 26.9% (2020), and the latest available figure is 21.6% (2022).

The GFF data portal also shows that there is strong progress in a number of areas related to strengthened governance, alignment with the IC, and mobilization of resources, e.g., rapid increases in the number of villages that prioritize IC interventions in their annual village expenditure reports (from 9,351 in 2019 up to 70,129 in 2021)[161] or the percentage of priority districts that started implementing the District Convergence Action Plan (98% in 2022).[162]

[161] GFF Data Portal, accessed 15 October 2024: https://data.gffportal.org/country/indonesia.
[162] Ibid

Additionally, there is good progress in some of RMNCAH indicators – e.g., an increase in skilled birth attendance (85% in 2019 to 96% in 2022),[163] and ANC visits appear to have increased (74.1% of pregnant women receiving all four prenatal checkups in 2018 to 86.2% in 2023)[164] and an increase in women receiving iron supplements during pregnancy (80% in 2023)[165]. However, only 44.2% of women were reported as actually consuming IFAs in 2023.[166]

Specific areas of RMNCAH – e.g., work with adolescents – were reported as 'not happening' by KIs, and the World Bank ICR notes that the area of early childhood development education had 'modest' progress with poor uptake of the professional development of teachers (who were meant to deliver counselling/ education to adolescents). The PforR for this program was reported as largely successful – DLIs were structured to promote 'convergence' of a multi-sectoral approach at the national, district, and village levels, and this broadly worked. There were issues with the DLIs, however, which were restructured five times during INEY I due to learnings from implementation and COVID-19 pandemic-related setbacks.[167]

- *Quality of care – what's the model – evidence of this being achieved?*

There is a noticeable shift between INEY I and II in terms of quality of care; INEY II has greater inclusion of service delivery quality in DLIs. While both projects mobilized a massive health workforce to address stunting, under INEY II there is a greater focus on supporting health care workers to do a better job. There is a sharpened focus on training and building up basic skills of 'kadres' (frontline health workers), with CSOs involved as implementers of capacity-building initiatives.

While there is evidence of BETF being used to conduct a number of activities related to more comprehensive measurement of quality of care, there is no evidence that this has been put into practice (e.g., use of vignettes, etc.) as of this time. This may be because of the difficulties being faced in general by the M&E component, which resulted in five re-designs of the DLIs for INEY I.[168] There have, however, been huge investments in the nutrition data collection system that is used by the Kaders to monitor services provided and outcomes (the EPPBGM).

Objectives for INEY II demonstrate an increased focus on improving maternal health. Under the quality of care rubric, tracer indicators are tracked which include provision of iron supplementation, detection of HIV-positive pregnant women, Hepatitis B screening, skilled birth attendance, use of partographs, and postnatal care. While the reasons for this increased focus are not documented, the ICR for INEY I showed that maternal health indicators were lagging despite investments.[169]

Some aspects of care were reported as trailing by KIs – specifically the work on adolescents in schools (such as iron supplementation and counselling on preventing early marriage and childbearing) – with little evidence of progress.

[163] Ibid
[164] INEY I ICR, June 2024
[165] Ibid
[166] Ibid
[167] Ibid
[168] INEY I ICR, June 2024
[169] INEY I ICR, June 2024

- *Added value to other RMNCAH-N actors? How? Evidence?*

INEY II presents an example of successful leveraging of other RMNCAH-N actors in GFF-co-financed World Bank projects. Gavi co-financed INEY II (US$ 13 million) because the project provided an effective vehicle for them to reach remote areas and zero-dose children. However, KIs confirmed that this partnership and funding was negotiated through the World Bank, not via the GFF. In addition, some BETF-funded specific policy actions, such as the joint policy brief on the sugar tax, were done in partnership with other nutrition funders (e.g. BMGF).

In general, some KIs have attributed the GFF to bringing together diverse actors (e.g., UNICEF, the World Bank, private sectors, and CSOs) on the issue of stunting. In particular, KIs emphasized the contribution of the INEY program and GFF to strengthened governance and data systems at all levels, increasing capacity of national, district, and local governments to align actors. Despite this, there is some evidence that the coordination and alignment of partners is patchy in some districts. This may be a challenge to the GFF model to achieve scale, or a result of strong national leadership.

The CP is government-owned and attended, with the planning department (Bappenas) coordinating connected networks of partners. CSOs are involved in multiple ways: they are directly engaged by the GFF through IC development and indirectly engaged SUN CSO networks at the national and local levels. A challenge in this area is accessibility of the data for CSOs, as KIs have indicated that only the government can access certain internal health services and quality of care data. GFF's efforts to include the CSO networks in implementation appeared to be limited and ineffective. KIs pointed to a need for: a) ongoing advocacy to keep stunting on the national agenda, and b) a multi-sectoral coordination so that efforts to raise the quality of training and care are well coordinated at the sub-national level.

AI 2

- *GFF / World Bank leveraging each other's strengths / Are the roles sufficiently clear / separated?*

GFF and World Bank teams are highly integrated in this setting. Both GFF and the World Bank teams have expertise in nutrition, monitoring and evaluation and health financing to leverage better nutritional outcomes. Rather than the GFF providing necessary sectoral and thematic expertise, both GFF and World Bank staff can maximize their inputs.

Most of the BETF-funded TA, policy, and design work reviewed in this case study has a clear connection to the World Bank project. For instance, with digital work, there was a direct route from concept to design (GFF) to piloting, evaluation, and scaling (World Bank). KIs stated that GFF inputs at the design stage were very valued and needed for INEY I and II. There was also a clear line of sight between the work done to develop the health financial systems, e.g., chart of accounts, and the considerable work done on budget tracking. This work was also directly built by the World Bank project and fed through into the DLIs, PforR mechanisms, and the management of the project. The results BETF supported the monitoring and evaluation (M&E) plan of the StraNas (IC) and complements the GFF grant supporting government M&E through the WB project.

While the World Bank provided the bulk of financial resources, the GFF played a critical role in shaping key technical and policy aspects of the project. Its contributions in design, monitoring, and coordination were instrumental in advancing a complex, multi-sectoral agenda. This collaborative

approach ensured that GFF's targeted support complemented the broader World Bank-led investments.[170]

- *Opportunities to maximize complementarity*

KIs described a high degree of complementarity between the GFF and the World Bank, and the GFF was seen as vital partners by the World Bank team. There were some policy successes which were jointly owned by the World Bank and the GFF – e.g., the tax on tobacco, which has been successful in raising revenues which go directly to micro-nutrient supplementation. However, other policy actions such as the sugar tax were less successful due to their political nature and possible reluctance of the Government to push this agenda further forwards at this stage.[171]

- *Lessons learned*

This case study presents a 'short route' from government prioritization to the national strategy/IC, and to the World Bank project. In this model, GFF inputs appear to be much more tied to the World Bank needs for support at the design stage, and for selected technical areas (e.g. in health financing). These were small inputs, which the World Bank project could then rapidly scale. In this context, GFF was over-shadowed and taking a 'back-seat' role, with little visibility.

Strong government leadership was evident at all levels and was a primary contributor to project success. However, this also meant that the GFF was not yet able to take on a primary alignment role. As a result, GFF has not yet fully facilitated CSO participation in government dialogues and data-sharing, though this remains a possibility under INEY II, where greater CSO engagement could add value. Despite this, the GFF provided important inputs to coordination during the project design stage and continues to support the SUN network, which is a DLI under INEY II.

AI 3

- *Where does GFF add value?*

The GFF played a pivotal role in shaping the design and implementation of a complex, multi-level, and multi-sectoral strategy to combat stunting and malnutrition. The INEY program introduced the concept of convergence, which aimed to deliver all essential, evidence-based interventions to each child and mother at risk of stunting and malnutrition. Unlike traditional top-down nutrition programs that distribute services broadly with the hope that many will receive what they need, Indonesia's approach is bottom-up—ensuring that every at-risk child receives the full spectrum of necessary interventions.

A key innovation in this strategy is the coordination across sectors and actors, from the national level down to the community level, to ensure that interventions are aligned and effectively implemented. The e-HDW system and human development workers are central to this approach, tracking priority households, coordinating service delivery, and ensuring that all relevant interventions reach those who need them most. The GFF's catalytic contributions strengthened these mechanisms, ensuring greater alignment, monitoring, and accountability.

[170] INEY I PAD, May 2018; INEY II PAD, June 2023
[171] Country KIs

The GFF also made multiple, specific contributions which were deemed 'catalytic' by KIIs, particularly:

Coordination and alignment

GFF was meant to lead on the coordination and alignment of other global health actors/ donors around the agenda on stunting, as well as to leverage in the private sector. GFF was strongly credited with inputs and support to TA and coordination for the project design stages of INEY I, and thus the achievement of a strong multi-sectoral and multi-level approach. This was well-established under INEY I but strengthened under INEY II through more focused leadership, i.e., by the MOH, working with Bappenas (planning).

Digital – EHDW apps

The E-HDW Digital Citizen Engagement and Service Delivery Tool has been piloted and rolled out nationwide with the support of the GFF. Initial funding for the design and scoping phases was provided by the GFF, but it was rapidly scaled up in the World Bank project and is currently being used by the community health development workers (CHDWs). The app can track a variety of project activities, populations at risk, and budget allocation to activities (participatory budgeting). The app brings together several types of data (household, activity, budget tracking, and referrals), generating 'big data' for the government to use to compare service outcomes. It also identifies priority households at risk of stunting in each area. While this is an achievement, more evidence is needed on how this data changed service delivery.

TA

Broadly speaking, TA provided for project design, discrete pieces of TA (e.g. policy brief on sugar tax), and development of EHDW were said to be strategic and useful by external KIs. Some KIs said that the support of the GFF meant that they were able to do 'deeper' design work that would not have been possible otherwise.

- *Extent ensured adequate funding for RMNCAH-N services?*

Resource mobilization[172]

The GFF's support to implementing **budget tracking** was seen as particularly catalytic. At all levels, the budget for nutrition is tagged and expenditures can be monitored. Financial monitoring of the budget is then analyzed and budgets for nutrition are re-programmed for the following year. KIs credited the work on budget tagging for maintaining the commitment to nutrition budgets during COVID-19, when governments were often reallocating health budgets to fund the response. However, there was a decline in budget expenditure during this time due to the reduction in activity (e.g., use of travel funds) and service utilization. Despite this, a KI argued that the nutrition budget had been maintained *"in real terms."*

There is good evidence that the use of the multi-sectoral approach was able to leverage financing and resources to address stunting from a number of different *"pots"*. E.g., the Ministry of Social Protection provided cash transfers but there was little evidence that this was being used by vulnerable households to buy better food – this budget could be tagged and tracked with INEY's work. In the next phase, they plan to move this budget to school feeding programmes which they believe will be more effective.

[172] World Bank Document – on budget tracking

The GFF also supported other analytical pieces to mobilize and track resources. For example, through the BETF-funded private sector strategy, the GFF mobilized and worked with private sector national agents, such as foundations, to leverage further financing for local initiatives on addressing stunting. The GFF also supported the RMET, and this was actively used by the national and district levels to track and monitor progress. However, this currently cannot go below the district level, which is an area to be further developed.

As illustrated above, there is strong evidence that the focus on financial systems and participatory budget tracking resulted in local health budgets being more effectively used to support services to address stunting.

- *Data / results – what aspects of the data system were strengthened/what benefits or outcomes?*

Results can be identified in three main areas: 1) the use of budget tracking; 2) innovations in the use of data systems to report on project progress; and 3) outcomes achieved.

Budget tracking and financial management systems

In INEY I, there were a lot of reforms which were needed to be able to enact the use of DLIs, for instance, strengthening the financial monitoring system and budget tagging. As stated above, there is strong evidence that the inputs into budget tagging and tracking resulted in better use of data.

In addition, a lot of GFF TA went into strengthening the financial management systems, particularly related to the management of the national health insurance scheme, e.g., management of fraud, improving capitation and payments to hospitals (health insurance), and improvements in the use of chart accounts (financial management).

Innovations in data systems

As described above, use of the EHDW app and tool, as well as data system strengthening, enabled tracking of the DLIs.

Outcomes

There is strong evidence that the initiative has been successful, with a reduction in stunting prevalence from 30.8% in 2018 to 21.5% in 2023.[173] The government is on track to meet their targeted 14.5% prevalence.

However, the ICR for INEY I also stated that there were many challenges in the M&E due to the very short timelines for the project preparation and thus design being done on *"a moving target"*.[174] Several of the indicators were not achieved partly due to measurement issues.[175] The ICR further notes that there were design issues particularly at the lower levels and that measurement design was over-ambitious.

[173] INEY I ICR, June 2024
[174] Ibid
[175] Noting that this is within the World Bank's control rather than GFF.

- *To what extent has there been demonstrable progress towards the TOC (in this country context)*

As above, the GFF data portal also shows that there is good progress across a number of indicators in health financing, child health, health systems strengthening, and RMNCAH. For example, the percentage of districts using their convergence action data to inform their fiscal transfer proposals is high (100% in 2022),[176] which means that each district is using their dashboard. The data also confirms that there is high achievement on the plan of 'convergence' (districts or villages achieving the key stunting actions).

- *What lessons in advancing gender, voice and equity?*

There is a strong focus on geographic equity in the project, as it has a very strong poverty reduction agenda. The World Bank project targets the poorest 40% of households, which are those with children at highest risk of stunting in priority districts.[177] It also strengthens the provision of an integrated package of health and other services at these households (i.e., cash transfers, but also a range of other interventions in WASH, education, referral support, etc.).

There are strong aspects of gender which have been included in the project, for instance, a focus on women's empowerment (at the village level), nutrition and health counselling for men, and behavioral change communication targeted at addressing gender-based issues such as early child marriage and prevention of early child-bearing. The World Bank INEY I PAD recognized that there are important gender dimensions in stunting, particularly related to maternal health and the health of mother during their pregnancy.[178]

"The operation had identified that there were gaps in the: (i) delivery of nutrition-specific interventions targeting maternal health; (ii) government's list of priority nutrition-sensitive interventions particularly in relation to women's empowerment programs; (iii) delivery of nutrition counseling interventions to men; and (iv) targeting of early marriage and adolescent pregnancy."

- INEY I PAD

However, arguably the efforts to address these gender dimensions were one of the least successful areas of the program. There were good results for the inclusion of male partners in community nutrition counselling (40% of men were reached),[179] but some initiatives had to be re-programmed and scaled up to reach their targets, specifically the iron and folic acid supplementation of adolescent girls in school. Anemia is still pervasive and appears to be lagging in some districts.

The World Bank ICR also noted that the efforts on interpersonal communication for adolescent girls on prevention of early adolescent marriage and pregnancy far exceeded its target (the target was 130 districts, but 390 districts reported conducting these activities),[180] but there is no data to demonstrate the effectiveness of the implementation.

Transition:

[176] GFF Data Portal, accessed 15 October 2024: https://data.gffportal.org/country/indonesia.
[177] INEY I ICR, June 2024
[178] INEY I PAD, May 2018
[179] INEY I ICR, June 2024
[180] Ibid

KIs expressed some concerns about the transition of GFF funding in 2028 and what it means for the INEY project and TA. Domestic funding comprises the vast majority of INEY, but KIs were concerned about maintaining the flexible and additional GFF funding for TA and support (including analytics), which has primarily been from external (not local) consultants, for advocacy, DRUM, and coordination when the GFF pulls out. There has not been preparation for this thus far.

KIs expressed the need to increase local capacity-building to carry out analytical work (including universities, local organizations, etc.),[181] increased decentralization and local planning/ownership of the stunting programs,[182] evaluations of ongoing programs in preparation,[183] and heightened guidance from GFF HQ.[184]

Any reflections on key findings or implications for the model?

- This case study demonstrates a model where the GFF is highly embedded within a very much larger program but is able to provide focused inputs into a number of areas that were then rapidly scaled through the World Bank program.
- The GFF and World Bank team appear to work very well together, leveraging necessary resources for TA when needed for project design, development of specific technical areas, and progression of some agendas (e.g., the focus on adolescents). There are opportunities to link further to plan for transition.
- The government-led agenda prioritized adolescent health as part of the broader nutrition strategy, and the GFF played a key role in supporting implementation and ensuring the availability of financing to advance this commitment. The alignment of nutrition and adolescent health remains a critical focus, with continued efforts to strengthen programmatic linkages and delivery mechanisms.
- The case study shows a highly effective project, built on harnessing government leadership in complex, multi-stakeholder management, and at all levels. When this was linked with data and innovation, the project achievements in the reduction in stunting are impressive.
- The case of Indonesia underlines the importance of using more stable settings as laboratories for innovation that can then potentially be applied to other country contexts.
- There is still a need to focus on maternal health. The project only addresses a very small (but important) part of the drivers of poor maternal health outcomes in Indonesia
- There are gaps in transition planning and how to handle transition in the GFF model. As Indonesia is transitioning out of GFF, it's an opportunity for them to explore how and whether to support HICs with domestic resources but that still have gaps. KIs expressed wanting more visibility on the transition.

[181] Country KIs
[182] Country KIs
[183] Country KI
[184] Country KIs

Annex 1: Documents reviewed and stakeholders interviewed

Documents reviewed	Year of issue
FY23 Indonesia CES review 2022.10.31.docx	2022
Indonesia - Investing in nutrition and early years, Phase 2 PforR.pdf	2023
Indonesia - Investing in nutrition and early years - Implementation status and results report (last ISR).pdf	2023
Laporan Akhir INEY I_V4.6_210624 (signed) (1) en.pdf	2024
Laporan Kemajuan INEY Tahun 2019 en.pdf	2019
Indonesia - Investing in nutrition and early years.pdf	2018

Name	Position	Association
Ali Subandoro	Senior Nutrition Specialist	World Bank
Suprayoga Hadi	Deputy Minister I GFF Govt Focal Point	Office of the Vice President (SoVP)
Genesis Samonte	Country Focal Point	GFF
Minarto Noto Sudarjo	Liaison Officer	GFF
Somil Nagpal	INEY I & II Task Team Leader	WB

Niger

Niger Case Study

Brief outline of the GFF/ WB investment

Timeline of GFF / WB loans:[185]

- First contact was in 2017 – with a grant as part of 'exploratory TA'
- Investment case was started in 2019 but started in earnest in 2020
- WB project was approved Aug 2021
- IC was finally approved in 2022 (but we assume that the delay was the official sign-off and that the IC did feed into the WB project)

The current WB project 'Lafiya Iyali' was for US$ 125 million – IDA loan (US$ 50 million), IDA grant (US$ 50 million) and the GFF grant (US$ 25 million). Note that some of this was re-programmed when the new military government demanded that the WB project financed more health infrastructure (rehabilitation and construction). E.g. more from GFF was put into the institutional strengthening component. See below for further details on the project.

The WB/ GFF approach in Niger is built on a long-term commitment for 15 years and a 'multi-phase approach'. For instance, the first phase will address demand and supply sides, as well as developing institutional capacity of the government to project manage the loan. To do this, it will also work with the INAM (the national health insurance agency) in two provinces. The plan is to scale up to more regions in later phases of the project.

- *What did the GFF invest in doing? (e.g. TA / areas / CP etc.)*

Details of the GFF investments: [186]

Exec Type	Funding Cat	Budget Cat	Budgeted	Disbursed
RE	1St Round Grants	Grants	$25 million	$491,827.47
BE	Core TA	Supervision	$270,000	$248,883.1
BE	Core TA	IC Design	$149,632.95	$149,632.95
BE	Core TA	IC Implementation	$120,000	$48,824.47
BE	Core TA	RMET	$110,000	$31,650
BE	Core TA	RMET	$49,842.97	$49,842.97
BE	Flexible TA	DRUM	$780,000	$725,480.74
BE	Flexible TA	Quality RMNCAH-N	$100,000	$2,632.74
BE	Flexible TA	Quality RMNCAH-N	$199,409.36	$199,409.36
BE	Flexible TA	Results monitoring	$100,000	$0

The investment case (IC)

- *Brief overview of the Investment Case*

[185] Note that there is a strong focus on addressing adolescent SRH in Niger – this was already identified by the World Bank in 2016 and reflected in the previous project. WB Addressing Sexual and Reproductive Rights in Niger. https://documents1.worldbank.org/curated/es/920521468196758750/pdf/104964-WP-PUBLIC-AddressingASRHNiger.pdf

[186] GFF Evaluation - Case Study Countries - RE and BE Portfolio Summary July 2024

The IC was conducted in 2021 and projected needs/investment for 2022-23-24. It aligns with the 'National Health and Social Development Plan' (2022-2026).[187] The first RMET was done during COVID-19. A second RMET was done in March 2023 to 2024, nearly 2 years into the current national health plan. However, in practice, the IC had its own costing and was used as the basis for the development of the WB project before the final government approval of the IC.

Development of the IC

- The IC was developed during COVID-19 and was done in partnership with UNICEF, who used the EQUIST tool to identify areas where higher investment was needed.
- The lack of data availability from a more recent DHS hampered the development of the IC, especially for the EQUIST analysis, even though everyone agreed that this was a useful tool.
- The IC used thorough analysis, using GFF TA, to identify systems blockages and priority interventions in a number of areas, including by levels (e.g. community level, health facility levels), and by thematic area (e.g. maternal health, neo-natal health, adolescent health).
- The IC thoroughly prioritized RMNCAH-N and looked at current investments against these. The analysis found that there was poor coverage in highly prioritized areas, particularly in community health / demand side.
- The IC developed 3 scenarios: highest priority (60% population coverage), next highest priority (90%) and national coverage.
- The cost for the HSDP for 2023/2025 was estimated at 1.1 billion USD. This includes 492 million USD from government financing, and 668 million USD from international partners.
- This leaves the following financing deficit: 2023 – US$ 53 million; 2024 – US$ 79 million and 2025 – US$ 237 million which totals US$ 369 million. This is mostly due to the lack of visibility (i.e. long-term planning) of the donor budgets for 2025.
- Currently the WB is focused on the highest mortality burden priority areas and focused in two provinces (Zinder and Maradi) which was costed at US$ 136 million (and the WB project nearly covers this).

Note that the development of this IC was much more in line with the updated IC development guidelines, in that it used the national health development plan (PDSS) as the basis for the IC. Despite the long timelines, the IC is recognized as being a thorough document which helps to guide decision-making.[188]

> *"The second round they're not asking for investment cases anywhere anymore because it's just adding another document on top of the government strategy, so it makes more sense to just use the government's health strategy and try to align and make sure it's a good strategy, well-costed, and everything rather than doing a separate document which I think it's maybe not helpful."* – Country KI

The IC is based on a clear prioritization of 'high impact' RMNCAH-N interventions. There is a theory of change for the IC in key areas of RMNCAH-N which cut across a broad range of interventions including maternal, neo-natal and child health, schools-based education, GBV, WASH and

[187] Dossier d'investissement du Niger pour la santé reproductive, maternelle, néonatale, infantile, adolescent et la nutrition (srmnia-nut)
2022-2026. https://www.globalfinancingfacility.org/sites/default/files/Niger-GFF-Investment-Case-FR.pdf
[188] Country KI

sanitation. The IC ToC recommends a multi-sectoral approach (for education, WASH and community empowerment components). There is also a focus on strengthening institutional capacities to deliver the IC, and M&E to follow it up.

The IC was designed to have different levels of investment. The WB project covered the highest level of funding. Due to the events in Niger, there was minimal investment in the IC since all donor funds were halted. However, the IC was used in advocacy towards the Ministry of Finance to increase the investments in the health sector budget (see below). The Dutch development agency also used the IC to re-invest in RMNCAH-N when they were allowed to come back into Niger. (note that the Dutch had already set up a health pooled fund, which was noted as working quite well before the French had to pull out after the coup).

The country platform

Before the coup, there was good evidence that the Country Platform (CP) was working well and was being well utilized to mobilize participation in the IC, endorse, track and monitor the implementation of the IC.[189] [190] There is good evidence that the CP was working as a technical working group and had even been attended by the Ministry of Finance. A review of the development of the IC found that the CP was well involved in the development of the IC, though they noted that the participation of youth-led CSOs was minimal (only one member input).[191]

> *"The Minister of Finance was there on behalf of the government and domestic resources. He made his commitments, he facilitated the exercise, he contributed on behalf of the government of Niger, they were on our side, they were very active."* – Country KI

However – after the coup, the country platform has not been functioning well due to disruptions brought about by the coup. Some of the KIs (see below) also said that the CP had been difficult to manage, with often fractious CSOs with low capacity undermining its functionality (see below). There is a need currently to re-start the CP, but in the new context, it is difficult to push this ahead.

> *"The civil societies, they're not working at all. Apart from that, they are, because you know, civil societies are difficult organizations to manage. Very, very difficult."* – Country KI

The World Bank project

As above – the WB is noted as having long recognized the need for a focus on RMNCAH-N in Niger. It has also been working alongside the government to move from inputs-based financing in health and move towards results-based financing.

The WB project works across 3 components, and the GFF grants money is allocated within some of these components:

- **Component 1:** Coverage, utilization and quality of RMNCAH-N services
- **Component 2:** Demand for health/ nutrition

[189] Rapport Cartographie 2020_Niger
[190] PPT Mise à jour_Processus GFF Niger
[191] IPPF GFF case studies report WEB

- **Component 3:** Strengthen project management and institutional capacity

These components cover vital services in RMNCAH-N including FP, skilled birth attendance, and nutrition (in schools and through health services including counselling and supplementation). For component 3 – note that the project was able to start to work in two provinces only to build the capacity of the INAM to monitor the delivery of free health services in maternal and newborn/child health. This built on previous projects funded by the WB to strengthen the moves towards strong health financing but does this in a stepped approach.[192]

There is strong evidence that while the WB project built on existing priorities for adolescent health in Niger, the current WB project design drew directly from the IC. The IC involved a very thorough prioritization process. The focus on the 2 highest priority provinces (Zinder and Maradi) clearly came from the IC. There is an integration of gender empowerment into the different project components which again relied on GFF TA. Some linkages e.g. adolescent health and nutrition came from GFF support. Secondly, when the new government came in, the GFF was able to protect the budgets for school-based SRH. It seems the new government wanted to cut these activities in order for those funds to go towards capital investments in health, rather than any ideological objections.[193]

GFF TA and inputs were also directly visible in the work on health financing. The WB and GFF worked in highly complementary ways in this area. E.g. the GFF-supported IC and RMET were used to identify where greater prioritization could improve the efficiency of investments. This then led to a health financing strategy developed by the MOH with the support of the WB and GFF. The WB also developed an options paper analyzing the needs for health financing support, and how the current project could build on this area of work.[194]

Both the government and the MOH health financing paper note a number of areas where improvements in health financing could build greater trust in both the MOF and with wider health actors to increase health budgets. Current low capacities in health financing are one of the key barriers to progress identified. This is linked to delivering on UHC and strengthening the government's capacity to do this. The MOH paper in particular then develops an action plan and roadmap to strengthen health financing levers, but it is not known how far along this activity is.

KEY FINDINGS BY AI

AI 1

- *Delivering health services – what's the model – how is this being achieved?*

School Health Clubs/ CSE

- Signed into effect in Nov 2021 – the Ministry of Education / Ministry of Health signed into policy a mandate to establish schools-based comprehensive sexuality education (CSE) – 'les clubs de sante scolaires'.

[192] AideMemoire - MTR Aide memoire Niger-June24 EN.
[193] Country KIs
[194] Technical Report Niger Health Financing System Assessment Accelerating Informed Decision-Making For Universal Health Coverage Financing.
https://documents1.worldbank.org/curated/en/099121423052543374/pdf/P17571207c00e10700b6450408231c3941e.pdf

- The manual (Nov 2023) specifies that the school clubs were established with co-financing from the GFF (US$ 2 million from IDA and US$ 5 million from the GFF).[195]

In Niger, GFF supported the use of an additional financing instrument – WB Development Policy Operation – which required policy development on improving girls' access to schools-based life and sexual health / reproductive counselling. This policy was adopted in 2021 but implementation which is planned through the Lafia-Iyali has been delayed to the Niger events. WB was put under pressure to remove this activity and redirect the funds towards infrastructure by the new Nigerien government, but GFF was able to push back since the funding from this came directly from the GFF grant.

Some of the IDA money was then re-allocated to infrastructure, and GFF grant money used for schools-based SRH education.[196] [197]

- The school health clubs in each school have 6 boys/ 6 girls and are set up to support pupils to get access to information and refer students to services if they need them, as well as reinforce messaging on SRH. Provision of menstrual hygiene kits. This is complemented by training teachers (at least 2 per school), raising awareness of parents and other investments in increasing accessibility of services.[198]
- Note that this is part of a comprehensive schools approach that provides interventions in nutrition, WASH, SRH as well as supplements and parasite control (de-worming).

*"*The calendar 2021 DPO created school health clubs for comprehensive sexual/reproductive health education which will be supported by Lafia-Iyali. This built upon the calendar 2019 DPO trigger that sought to (i) reduce child marriage through village committees (continued in the calendar 2020 DPO to operationalize the committees), (ii) facilitate access to family planning for married adolescent girls, and (iii) maintain access to school for married adolescent girls. These programs support the continuation of girls' schooling, the most important factor in delaying pregnancy.*"*[199]

The ICR for this project states credit a rise in the use of contraception among adolescents as resulting from the project's support for school health clubs – from 7.6 percent in 2021 (97,263 girls) to 18.7 percent in 2023 (260,644). This was credited to improved access due to the establishment of 145 integrated health centers, outpatient clinics, community distribution sites, and NGO-led awareness efforts. But data on the establishment of the school health clubs (at this time) was not provided by the Ministry of Education, who instead referred to a circular which was issued after the end of the DPO.[200]

However, it is too early for any assessment of wider results. The latest project updates note that the project is now up and running again after a period of inaction. But it's too early to demonstrate any results and there is a lack of data across the board to report on the project PDOs.

[195] Arrete Club Sante DPO Nov 2021
[196] GFF supported DPO-P175256
[197] Country KIs
[198] Manuel Operationnel De Mise En Oeuvre Composante 2B 31 octobre 2023
[199] GirlsEducation Niger GFF
[200] GFF supported DPO-P175256

- *Quality of care – what's the model – evidence of this being achieved?*

The quality of care (QoC) component is built into the project's RBF. Namely – the health centers will be provided with an inputs-based budget and will be re-imbursed 80% on a fixed fee basis for the services delivered. An additional 20% of the budget will be disbursed based on achievement of the quality of services, which will be verified by a third-party monitor. Due to project delays, there is not a lot of information on the QoC approach.

The PAD also notes that there will be investments in structural quality of care (infrastructure through building health centers/ hospitals). While this was a re-design based at the request of the new government, Niger still has a very low health service coverage and therefore this is a needed investment.[201]

The selection of the third-party verification agency was also contested by the new government, which did not want to involve NGOs. A workaround was found by using INAM to conduct the verification in one province, and contracting NGOs to do it in another, as a comparative pilot, with the aim of fully building INAM's capacities to do verification in the future. This is a good investment in strengthening the health governance system as it moves towards better health financing capacities.

- *Added value to other RMNCAH-N actors? How? Evidence?*

The recent RMET highlighted that most of the funding which Niger is receiving is highly concentrated in a few global health players (e.g. UNICEF, UNFPA and the Global Fund). The RMET in particular was very much valued by the government in supporting alignment between partners. In practice, this means encouraging greater focus among partners in areas identified in the IC, but there is limited evidence that this has been taken on by partners, or that they have invested in line with the IC. The RMET also notes that partners are increasingly calling their investments 'health systems strengthening' rather than aligning with a national HSS plan.[202]

There is good evidence that the IC was developed in a participatory way, and that partners were well engaged in this process:

> *"Now, what gets funded is, seems to be donor-led. But at least when it comes to identifying the needs, that seems to be very, very evidence-based and also government-led. And that has been interesting. Because in other countries, other organizations, I have developed, drafted in the most participatory, interactive way possible, national plans that just get put in the cupboard. And this one, and really, it seems to be much more interesting."* – Country KI

There does appear to be some joint work e.g. with Gavi, in reaching under-immunized children in the two focus regions and tracking key indicators on immunization. The IC also involved high quality equity analysis with partners, such as UNICEF in using EQUIST, and the development of policy briefs on specific areas in RMNCAH-N (for instance, on maternal mortality). The government would like to see the capacity to use these tools built, and less reliance on 'external consultants' in the future.[203]

[201] PAD Lafia Iyali-final
[202] Rapport Cartographie 2020; 2023
[203] Country KI

The Dutch Ministry of Foreign Affairs are currently discussing the use of the GFF Joint Financing Framework (JFF) to come back into Niger and re-invest in needed areas aligned with the IC priorities.

AI 2

- *GFF/ WB leveraging each other's strengths*

There is strong evidence that the WB/ GFF leveraging each other's strengths in Niger, but a mixed picture in terms of how effective that relationship is when it comes to tracking implementation.

A country KI showed that the WB really values the GFF inputs in a number of different areas:[204]

- Technical inputs into the design, particularly because the GFF FP has a background in SRH and in gender, and this then led to a better program design which really emphasized the linkages between these agendas. Also, in the area of nutrition, some technical linkages were made to the adolescent health agenda. However, there is strong evidence that SRH and high fertility among adolescents was already a high priority for the WB before the GFF began.
- WB use of TA was quite flexible and allowed for a lot of analysis to be done that could feed into both the IC and the project design. The work done on the health financing assessment was particularly strong and led to the MOH's own health financing policy and action plan. This allows further discussion with the MOF to address their concerns about MOH management capacity. It allows the WB and the GFF to trial ways of building capacity in two provinces to have a stepped approach.
- There is some evidence that the focus on maternal health was due to the GFF influence:

  "The World Bank has never really had the opportunity to formulate a project focused on women's health. It was only the arrival of the GFF with its US$ 25 million grant, which of course was to be injected into mother and child health, that led the World Bank to come in to support and co-finance this vital project. So, if it's not that the GFF came in, I can't see the World Bank getting into the idea on its own of financing the country's maternal health. I think that the GFF has served as a trigger and really facilitated the World Bank, really to go into this focus of health which is the RMNCH."

- The WB also really valued the GFF's work to convene wider partners as part of the IC (even though with the change of government and the current situation, the IC is now out of date)

There are consistent reports from the KIs that the GFF was well placed in the MOH and that because of this placement was able to leverage the MOH's convening power, and to work to influence actors and advance certain agendas. They also said that the link with the WB had been tenuous and difficult to get much information in terms of project progress from the WB. Regular calls were set up to remedy this, but it still appears that the reports on implementation are quite weak.

- *Are the roles sufficiently clear/ separated?*

[204] Country KI

From our limited sample, it seems that there is some clarity about the separation of the roles. For example, the government informants are clear about this and know how to call on the GFF for support, as well as donors. However, wider partners are unclear and appear to view the GFF as part of the WB. This may undermine their capacity to drum up further investment in line with the IC.

- *Opportunities to maximize complementarity*

There is good evidence that the GFF/WB teams are working effectively together. Technical areas where further work was needed included in data and results. It was noted that the GFF has planned work with Blue square to improve the tracking of results using data dashboards. This work was halted after the coup and is now re-starting.

However, the data system was noted as being weak, with poor data quality continuing to undermine how data can be used. There was also weak data utilization, e.g. government partners were not adequately using the data to question performance, and there are still significant lags in when results are being reported. This is an area that needs strengthening between the GFF and WB – with the WB strengthening investment in data systems, and the GFF perhaps taking a stronger lead in data utilization.

There is good evidence that both the GFF and the WB are working effectively to develop and strengthen national leadership. The government counterparts interviewed felt that both the GFF and the WB were putting data in their hands which were necessary for better government leadership. The RMET was highly praised by the MoH. The WB project is strongly focused on developing the financial system and improving government institutional strength. The health financing design work is very strong. Work with INAM provides a model to continue to strengthen institutional capacity. This is really important, since the MOF's reluctance to improve health budgets was partly due to the MOH's low capacity to implement and manage finances.

However, while many of the MOH staff stayed in place, much of the work done by the GFF to cultivate 'national leadership' was effectively undone by the changeover to the new government leadership. Government ownership among the new cadres was said to be weak, with low understanding of the approaches and tools that had been put in place. One KI wanted to see more flexible ways of strengthening their capacity e.g. workshop-based, as these government staff were unlikely to use resources on the portal.[205]

- *Lessons learned*

There is clearly a longer-term strategy in Niger embedded within the WB's 'multi-phase approach' planned over a 15-year period. In Niger, there has been a strong need for a multi-sectoral approach, working on both demand/ supply side e.g. working with education, WASH, community empowerment, and health service provision. This is hampered by the low capacity of the respective Ministries, which makes it difficult to make this work into practice. The GFF notes that working with the government takes longer but is more impactful once it starts to work. The GFF/ WB also had a strong emphasis on building government capacity. This was especially important once the new government came in who had lower tolerance for working with CSOs:

[205] Country KI

> *"We've chosen to do that with the Ministry of Education, and that has been a key point also in keeping the component, because it hadn't been an NGO or specifically an international NGO, then that component would not have gotten off the ground. I'm quite sure of that. So, there's a little bit of the going through the national systems and all of that, even if it takes longer, but retrospectively I think that has also been a good choice of where Niger is currently."*
> – Country KI

The GFF LO has been very effective but is based at MOH. This has trade-offs since it enables his convening role but then appears to make monitoring implementation of the WB project a bit harder. Moreover, there has been limited progress in advocacy with the MOF and this is where the MOH staff want to have more support from the WB, in advocating for health budgets. There is good evidence that the GFF/WB are taking the right approach in having a long-term approach to developing institutional capacity, but there have been repeated pressures on the health budgets, and there is some evidence of displacement effects (e.g. increasing capital investments through the WB loan, offsetting the cuts to capital expenditures when the government's budget was under pressure). Given these bigger macro-fiscal pressures, that GFF approach of tagging and monitoring budgets as a means of securing budgets for RMNCAH-N has been less effective.

AI 3

- *Where does GFF add value?*

The sample of government counterparts in this case study is small, but broader evidence suggests that tools like the RMET have been highly valuable for prioritizing and costing health needs and aligning World Bank investments accordingly. However, with the withdrawal of donors such as the French, the IC and RMET are now outdated, though a new RMET is planned.

The development of the IC was evidence-based, incorporating high-quality analyses funded by GFF TA, and was widely regarded as inclusive and well-received. There is strong evidence that the collaboration between the GFF and the World Bank has led to a strategic, long-term investment in strengthening government capacity and decision-making. While this case study primarily reviews the project's design—since implementation is still in its early stages—it demonstrates effective use of GFF resources, which played a key role in shaping the project.

Additionally, there is some evidence that the IC helped mobilize other donors, such as the Dutch, to fund high-priority RMNCAH-N areas. The IC also proved particularly valuable for the World Bank during the project design phase, streamlining the process and ensuring the project closely reflected the highest-priority areas identified in the IC.

The government also saw great value in using tools to track expenditures against the areas prioritized in the IC (RMET). It was notable that the GFF/WB project focused on two areas selected because of their low rates of progress in RMCAH-N, but these areas are also very crowded with many other NGOs/ CSOs – in other words, alignment is also needed at the sub-national level.

> *"RMET has really helped to get everybody on board with, with, with, with where the funding gaps are, who's funding what, and, and to, to, to get the people excited about, about it all, and seeing how their funding is contributing to a bigger picture."*
> – Country KI

> *"Frankly, this review was one of the presentations that was most appreciated, OK, because I can really see where we've put what the gaps are, it's visible, it's very clear. There's an action behind it, it means there's an action behind yours that we really want to implement the Investment Case."* – Country KI

While the GFF team was recognized for its embedded gender specialist and the gender analysis it conducted, CSOs criticized the lack of a truly gender-transformative approach. They argued that the World Bank project did not go far enough in addressing gender-based barriers faced by adolescent girls and women.

- *Extent ensured adequate funding for RMNCAH-N services?*

While the IC helped mobilize some additional funding, the primary investment came from the World Bank and GFF, with a strong focus on the two highest-priority regions.

Government counterparts provided positive feedback, emphasizing that the GFF has played a crucial role in aligning the Ministry of Health's RMNCAH-N priorities with funded projects, ensuring that key interventions receive financial support.

> *"(The IC) is an extremely important tool for (demonstrating) their vision, because the vision is that we have health, it's a priority, we have to do something. Nutrition is a priority; something must be done. So, I think it's important."* – Country KI

However, the recent RMET also revealed that the majority of health sector funding comes from the major Global Health Initiatives (GHIs) (since government budget allocations are quite low). There is very little evidence that these GHIs have shifted much in terms of alignment with the IC. However, since the IC is based on the PDSS, it is possible that the GHIs are aligned with wider national policy. Key informants did not perceive this as a challenge, as long as partners remained aligned with national policy. With the GFF's support in tracking expenditures by area, the government is better equipped to use data for informed decision-making.

The government's health financing has been inconsistent during this period, with mixed data on overall trends. While the health budget increased by 15% from 2018 to 2022 (according to GFF data), it has not kept pace with the broader government budget, which grew by 33% over the same period. A significant contraction occurred in 2021 when the health budget was reduced by 20%. Government health expenditure has remained between 5% and 6% of total spending—well below the recommended minimum of 10%. In per capita terms, Niger spends only $14.5 on health, far short of the $86 per capita required to achieve UHC. These budget constraints existed even before the new government came into power, highlighting ongoing challenges in domestic health financing.

- *Data / results – what aspects of the data system were strengthened/what benefits or outcomes?*

Significant efforts are underway to strengthen data systems for RMNCAH-N, including work with Countdown 2030 on data analysis and investments in health information systems. Additionally, Bluesquare has been commissioned to develop a data dashboard to track key indicators for the WB/GFF project.

However, country KIIs highlighted ongoing challenges. Data quality remains low, suggesting that investments should prioritize improving accuracy and reliability before expanding dashboard functionalities. Data utilization is also limited, with government partners not fully leveraging available data for decision-making. Furthermore, a stakeholder mapping exercise has not been conducted, which could help better align investments in data system strengthening and maximize the impact of the WB/GFF project.

- *To what extent has there been demonstrable progress towards the TOC (in this country context)*

It is too early to assess significant progress in Niger. The GFF data portal tracks various indicators related to HSS, health financing, and broader impact measures, but most show limited progress to date. Given the relatively recent implementation of key initiatives and the broader political and economic challenges, it will take time for measurable improvements to materialize.

- *What lessons in advancing gender, voice and equity?*

The GFF/World Bank project in Niger has integrated an equitable approach by leveraging tools such as EQUIST to prioritize interventions and RMET to track how health budgets are distributed. However, challenges remain in ensuring resources reach high-impact interventions at the subnational level. The project has made efforts to address gender disparities, particularly through investments in community-based interventions to improve access to services for adolescent girls and women.

While the GFF engaged CSOs in developing the IC through an inclusive, evidence-based process, youth-led CSOs were underrepresented, highlighting the need for stronger youth engagement. Gender-focused initiatives, such as school-based CSE, are included in the project but have faced delays in implementation.

A key lesson from the World Bank project is the importance of closely monitoring policy-based lending mechanisms like DPOs. In a context where reliance on World Bank loans is growing, there is a risk that governments may deprioritize certain programmatic commitments—such as implementing CSE in schools—without strong oversight. The World Bank must ensure that policy commitments are actively followed through, rather than assuming government compliance.

Any reflections on key findings or implications for the model?

Niger presents several valuable insights:

- Aligning the IC with the national health plan has proven to be an effective approach, ensuring government ownership and strategic prioritization of RMNCAH-N investments.
- The government has strongly endorsed GFF-supported tools such as RMET and expenditure tracking. These tools not only help the MOH coordinate partners but also enhance its credibility with the MOF, potentially improving budget allocations for health.
- Strengthening institutions capable of managing RBF mechanisms remains a long-term priority. The establishment of INAM as an independent body to oversee health insurance and verification processes marks an important step toward sustainable health financing under UHC.
- Despite the IC providing a clear roadmap for RMNCAH-N priorities, many GHIs remain misaligned, with over 65% of external funding following separate channels. The RMET highlights the

inefficiencies and high transaction costs of fragmented funding, reinforcing the need for pooled financing and stronger alignment with national priorities.

- There is some indication that PBF and quality of care mechanisms helped sustain health services during the coup. However, further evidence is needed to verify this impact and assess the adaptability of PBF in fragile contexts.

Annex 1: Documents reviewed and stakeholders interviewed

Documents reviewed	Year of issue
GFF supported DPO-P175256.pdf	2024
GirlsEducation-Niger-GFF.docx	
MANUEL OPERATIONNEL DE MISE EN OEUVRE COMPOSANTE 2B 31 octobre 2023 FINAL.pdf	2023
Niger country report_adolescent financial levers-10.12.21.docx	2021
Referentiel De Sante Nutrition Et Deparasitage Scolaires 31 octobre 2023 FINAL.pdf	2023
Cartographie des ressources Niger-2023-24- Rapport provisoire.docx	2023
L'équité En Matière De Santé Au Niger.pdf	
Rapport Cartographie 2020_Niger.pdf	2020
EtudeSPSNiger-Analyse Plateforme-Rapport Final22mars2022 EN.pdf	2022
EtudeSPSNiger-Cartographie-Rapport Final22mars2022 EN.pdf	2022
GFF_Compte rendu_Réunion d'échanges GFF-OSC.pdf	2020
IPPF_GFF-case-studies-report_WEB.pdf	2024
RAPPORT ATELIER OSC_GFF_BRAVIA.pdf	2020
Dossier Investissement_Niger.pdf	2022
Mise à jour_Processus GFF Niger_20032024.pdf	2024

Name	Position	Association
Aboubacar Chaibou Begou	Liaison Officer	GFF
Amal Tucker Brown	Results Specialist	GFF
Charlotte Pram Nielsen	Country Focal Point	GFF
Mohamed Vadel Taleb El Hassen	Senior Health Economist	WB TTL
Laurence Lannes	Senior Health Economist	WB TTL
Dr Issoufa Harou	Director General of Reproductive Health	Min of Public Health

Nigeria

Nigeria Case Study

Brief outline of the GFF investment

GFF has co-financed three recipient-executed projects in Nigeria, including:

- Accelerating Nutrition Results in Nigeria (ANRiN); 2018-2024: GFF US$ 7 million, IDA US$ 225 million
- Basic Health Care Provision Fund (BCHPF); 2019-2021: GFF US$ 20 million
- Nigeria State Health Investment Project Additional Financing (NSHIP); 2017-2020: GFF US$ 20 million, IDA US$ 125 million

GFF has also funded bank-executed TA for:

- Project preparation (US$ 383 384; 7.7% of BETF)
- Supervision, including of the Country Platform and ongoing projects (US$ 755,534; 15.2%)
- Implementation research of adolescent health interventions (US$ 400 000; 8.1%)
- IC mid-term evaluation and revision (US$ 210 000; 4.2%)
- Support to ANRiN, including workshops on performance-based contracting for Federal and State MOH project implementers, deployment of min. one technical/operational consultant in each ANRiN participating state) (US$ 3 million; 60.5%)
- Development of RMNCAH response guidelines & protocols during COVID-19 (US$ 82 763; 1.7%)

Details of the GFF investments: [206]

Exec Type	Funding Cat	Budget Cat	Budgeted	Disbursed
RE	1St Round Grants	Grants	$7 million	$5.590.000,00
RE	1St Round Grants	Grants	$20 million	$6.172.069,31
RE	1St Round Grants	Grants	$11.330.397,31	$11.330.397,31
BE	Core TA	Project Preparation	$100.000	$0
BE	Core TA	Project Preparation	$233.436,17	$233.436,17
BE	Core TA	Project Preparation	$49.948,31	$49.948,31
BE	Core TA	Supervision	$219.952,29	$219.952,29
BE	Core TA	Supervision	$535.581,88	$535.581,88
BE	Flexible TA	Country platform	$130.000	$0
BE	Flexible TA	Implementation Research - Adolescent	$400.000	$11.990,63
BE	Flexible TA	Implementation Research and Evaluation	$210.000	$124.184,95
BE	Flexible TA	Quality RMNCAH-N Accelerating Nutrition Results in Nigeria Project	$3 million	$2.737.600,21
BE	Flexible TA	Quality RMNCAH-N COVID-19	$82.763,66	$82.763,66

[206] GFF Evaluation - Case Study Countries - RE and BE Portfolio Summary July 2024

The investment case

- *Brief overview of the Investment Case*

The first RMNCAH Investment Case (IC) (2017-2030) was developed through a series of prioritization processes led by the FMOH and with extensive consultation with Country Platform members, development partners, CSO representatives, and subnational governments. Despite initial buy-in, the MTR conducted in 2023 revealed limited implementation of the IC beyond GFF interventions.

The initial IC was not seen as a platform for partner alignment around RMNCAH, but rather a guide for GFF resourcing: "*the IC mostly guided GFF resources and provided strategic inputs or guidance on how the projects should be designed and delivered,"*[207] and *"many stakeholders, particularly those from civil society and private sector partners, perceived the IC as synonymous with the GFF grant and the interventions it funded"*.[208] The MTR also noted that while RMNCAH-N activities were carried out in Nigeria during the lifespan of the plan, there was "*no evidence to suggest a direct link between RMNCAH-N implementation and the IC, apart from activities supported by the GFF projects"*.[209]

Investment of other partners in the IC was highly limited. While the World Bank, FCDO, and BMGF provided project-based support on the BHCPF pilot and TA provision under the ANRiN project, partners such as PHSAN, PharmAccess, SOLINA, the Global Fund, Global Affairs Canada, USAID, WHO, UNICEF, and UNFPA were involved in RMNCAH-N implementation but not linked to the IC. The IC MTR noted that there was limited data to inform how well the IC and prioritized interventions were funded from 2017-2023, although the recent RMET, supported by the GFF in partnership with CHAI, was anticipated to provide more information about this.

Barriers to effective implementation of the original IC included:

- Partners expected that money would go to them rather than to the government: *"Once the GFF grant… was allocated to BHCPF, ANRIN, and NSHIP, many stakeholders lost interest in the development and finalization of the RMNCAH-N strategy. Secondly, some UN organizations were disappointed that they were not going to manage the fund*."[210]
- There were numerous changes in the MOH, and it was difficult to maintain continuity and ensure implementation.[211] Country leaders were accustomed to a five-year strategy, and the IC spanned 13 years and multiple federal government turnovers.[212]

During the recent mid-term review of the IC in 2023, they realized that the Ministry had begun developing a parallel RMNCAH strategy that fit into the government's Strategic Vision of the Health Sector (2023-2026) and SWAP agenda.[213] Therefore, GFF pivoted towards helping them prioritize and cost their strategy, rather than revising the IC. The GFF also supported the alignment of consultants working on the IC MTR and the new RMNCAH strategy. The new strategy is expected to be launched in November 2024 at the National Council of Health meeting, where all lead health sector stakeholders from the 36 states and the FCT will be in attendance.[214]

[207] Country KIs
[208] Nigeria Mid-Term Review Investment Case Report. March 2024.
[209] Nigeria-Mid-Term-Review-Investment-Case-Report-March-2024
[210] Nigeria-Mid-Term-Review-Investment-Case-Report-March-2024
[211] Nigeria-Mid-Term-Review-Investment-Case-Report-March-2024 and GFF LO, FP, and RS KII
[212] Country KIs
[213] Country KI and FY24 Nigeria CES review 2023.10.04
[214] GFF/WB KI

The country platform

The GFF supported the Department of Family Health at the FMOH in establishing the government-run Reproductive, Maternal, Neonatal, Child, Adolescent, and Elderly Health and Nutrition (RMNCAEH-N) Multi-Stakeholder Partnership Coordination Platform in 2020. Sub-committees include: (1) leadership, partnership, and coordination, (2) advocacy, resource mobilization, and communication, (3) quality technical delivery, and (4) accountability, data & knowledge management. The GFF provided training for platform members on leadership for health system change and embedded technical support to facilitate implementation of the platform's workplan, including the development of an implementation guide at the state level. GFF staff also provide direct technical support to the sub-committees, with the LO serving as a member of the RM sub-committee and the FP as a member of the leadership, partnership, and coordination sub-committee.

The coordination platform was expected to meet bi-annually and subcommittees were expected to meet quarterly, although the IC MTR implicated that this was not happening as intended. GFF is currently providing BETF to strengthen CP functioning with an embedded consultant, which provides support in organizing a minimum of 4 platform meetings yearly, reports of platform and sub-committee meetings, and facilitation of RMET, FASTR, HIS, and other data sources review.[215]

While the coordination platform is functional at the national level, there are limited mechanisms for RMNCAEH-N at the subnational level – the IC MTR noted that only 4 out of 36 states had similar subnational coordination bodies.[216] However, supported by GFF's advocacy, National Council of Health consisting of all the States Commissioners of Health and chaired by the Minister of Health passed a memo to set up coordination platform at sub-national level.[217]

Nigeria is now shifting to a Sector-Wide Approach with a SWAp coordination office, and country KIs have acknowledged the need for GFF to strengthen engagement during this time.[218] As part of their TA, they are currently supporting the SWAP coordination office on the alignment agenda, including collecting data on the state of alignment of development partners and stakeholders in-country and are also supporting the M&E TWG and One Report agenda of the SWAp via the GFF's Results and Learning support to countries.

KEY FINDINGS BY AI

AI 1

- *Delivering health services – what's the model – how is this being achieved?*

The NSHIP, BHCPF, and ANRiN projects operate through performance-based financing levers.

GFF's investment in NSHIP allowed the expansion of a results-based financing system to the six conflict-affected states comprising North East Nigeria. DFF and PBF were used to increase the delivery, use, and quality of high-impact maternal and child health interventions at select health facilities in the project states.

[215] GFF Evaluation RE and BE Portfolio Summary
[216] Nigeria Mid-Term Review Investment Case Report. March 2024.
[217] FY24 Nigeria CES review 2023.10.04
[218] Country KIs

BHCPF piloted a health financing reform in three states, operationalizing DFF and PBF components through two 'gateways': NPHCDA, which increased supply-side readiness of facilities in exchange for regular and timely operational expenditures, and NHIS, which expanded health insurance to the poor with public financing. This fiscally decentralized approach brought operating funds directly into the bank accounts of facilities, disbursing funds contingent upon accreditation criteria (including QoC criteria) and appropriate documentation of the use of funds and targeting resources to the most vulnerable. World Bank funding was channeled through the Central Bank of Nigeria's account, which allowed donor funds to comingle with domestic funds.

ANRiN operates through performance-based contracts with non-state actors who deliver an integrated package of nutrition-specific and nutrition-sensitive interventions in hard-to-reach areas for women, children, and adolescents. The project has also piloted mainstreaming of provision of family planning and ASRH in one of the states implementing ANRiN, Kaduna State.

- *Quality of care – what is the model – evidence of this being achieved?*

The NSHIP AF[219] introduced a *"more robust way of measuring QoC"*.[220] The NSHIP project piloted DFF and PBF to increase the quantity and quality of care provided in public facilities. Increased quality of care was one of the project development objectives. The NSHIP impact evaluation conducted in December 2018,[221] which was carried out by the World Bank with GFF support, found that PBF and DFF both had a sizeable impact on QoC – 20 out of 26 indicators of quality (77%) showed statistically significant estimates of program impact, including availability of essential drugs, contraceptive supplies, basic equipment, hand-washing stations, and proper waste management.[222] Process measures of QoC, such as health worker knowledge and the extent to which national protocols were followed, did not improve as consistently. There was little difference between QoC in PBF and DFF facilities.

BHCPF included a project development objective on quality of care. The project was implemented through both a DFF component through the National Primary Health Care Development Agency (NPHCDA) gateway, in which public PHCs meeting accreditation criteria received quarterly grants to complement their operating budget, and a performance-based payment component through the National Social Health Insurance Scheme (NHIS) gateway, in which public and private facilities meeting more rigorous accreditation criteria (including quality) received reimbursement for services.[223] State-level implementing agencies supervised and mentored NHIS and NPHCDA-accredited facilities to meet quality standards.

Throughout NSHIP, quality of care was measured with a QoC survey, measuring (i) Content of Care Quality (30%); (ii) Drug availability (20%); (iii) Readiness to deliver services (iv) Quality of supervision

[219] Structural QoC indicators were added in the additional financing phase of NSHIP, when GFF began co-financing.
[220] Country KI
[221] The study team conducted a three-armed trial with experimental and quasi-experimental components, comparing LGAs randomly allocated to DFF, PBF, and control.
[222] Impact Evaluation of Nigeria State Investment Project, December 2018
[223] While it was envisioned that private providers would be accredited and paid under the NHIS gateway in the BHCPF project, this did not happen for multiple reasons: public PHCs were prioritized for accreditation, private providers were disincentivized to participate as providers were receiving higher payments from State Social Health Insurance Agencies for other health insurance enrollees (N750 per enrollee per year, compared to N500 through BHCPF to cover the poor), and some remote and rural LGAs did not have private facilities.

(20%); and (v) Financial management (15%).[224] To inform PBF, health facility quality scores provided by local government area PHC departments and hospital management boards were verified by TPMs on a quarterly basis[225]. A country KI said that this rigorous measurement of quality of care was not prioritized in BHCPF nor expected to be maintained as this PBF was scaled up.

In BHCPF, quality-of-care scorecards were used as a prerequisite for receiving funds[226] and for continuous receipt of funds. Baseline and follow-up assessments were designed and conducted to monitor adherence to QoC criteria during supervision visits and regular reporting. The accreditation process and accountability culture were attributed to an increase in QoC, with the average QoC score in project states increasing by 155.7% from the baseline in 2018 to the final score in 2021.[227] These scorecards are now part of the nationwide BHCPF reform.

- *Added value to other RMNCAH-N actors? How? Evidence?*

While there is limited evidence of the added value to RMNCAH-N actors beyond the government, there is evidence of GFF's contribution to increased partner collaboration on BHCPF. GFF funding and TA facilitated the development of a single account at the central level and fiduciary and fund flow arrangements, as well as a Public Financial Management (PFM) system that allowed for pooling.[228] Other donors, such as BMGF, were mobilized to finance BHCPF using the central mechanism.

Building on a partnership with the GFF on the EHS work, Exemplars subsequently carried out new work with the FMOH to develop new guidelines on continuity of essential health services following the Joint External Evaluation (JEE) of Nigeria's health security system.[229]

AI 2

- *GFF/ WB leveraging each other's strengths*

GFF leverages IDA credits, i.e., through the NSHIP and ANRiN projects for a greater impact: e.g., *"GFF money is very small in a country like Nigeria – drop in the ocean. But when utilizing IDA credits, it's a lot of money."*[230]

In turn, GFF's contribution is primarily described as their ability to *"use resources to make sure IDA credits work well"*[231] and *"ensure implementation capacity"*[232]. They are enabled by their relative ease in procuring technical support.[233] RETF resources were accompanied by significant funding for TA and analytics, including capacity-building to ensure effective implementation of projects and a focus on results. US$ 3 million of GFF's US$ 10 million investment in ANRiN was reserved for TA to build capacity of government in the management of performance-based contracts with non-state actors, to pilot adolescent health interventions, and to conduct implementation research.[234] It also

[224] NSHIP PAD
[225] Ibid
[226] Facilities could receive provisional initial accreditation with the agreement that they would reach full accreditation after one year by following a quality improvement plan, allowing access to funds while promoting quality improvement.
[227] BHCPF ICR
[228] BHCPF ICR
[229] GFF/WB KIs
[230] Country KIs
[231] Country KIs
[232] Country KI
[233] Country KIs
[234] GFF_TFC_CEF_November 30 2023

enabled the World Bank to place a consultant in each project state supporting the PIU with technical and operational expertise to guide implementation,[235] which was seen as a helpful resource.[236] GFF's support to analytical work, including through BETF and through GFF technical staff such as the Results Specialist, was also seen as an asset to inform project design.[237] The GFF grants were also described as being helpful to *"sweeten the bitter taste of having to take finite credits to do development."*

- *Are the roles sufficiently clear/ separated?*

Multiple KIs reported that their roles were clear/separated, although WB TTLs work in close partnership with the GFF in the provision of TA for project implementation. KIs also noted that external partners (e.g., the government) conflate their identities, at times posing a barrier to the GFF's coordination efforts.

- *Opportunities to maximize complementarity*

Country KIs described having limited coordination and visibility over GFF's activities at times. They cited resource mapping as an example of where the World Bank was not fully involved and where there was scope for greater integration for more success and visibility. They said that *"most of the work for resource mapping was not led by the in-country team, and World Bank staff had other competing priorities. [They] did not see the value of this output or use it to engage with other stakeholders."*[238] However, the government reportedly found the RMET useful,[239] as demonstrated by its application in key processes. Notably, the first RMET report was used by the current health leadership for the first portfolio review, the SWAp Coordination Office requested GFF support to institutionalize RMET, and RMET was included as an indicator to monitor donor alignment and commitment in the joint annual health sector review.

- *Lessons learned*

Working with the World Bank has given the GFF access to a larger pool of resources. Meanwhile, GFF grant funding has been key to financing catalytic RMNCAH-N and PHC interventions. GFF grants enhance co-financed projects by providing implementation support, for example, through TA for adolescent health intervention implementation research and project supervision. ANRiN's model of 70% funding to RETF and 30% to BETF was appreciated by implementers, e.g., an ANRiN PIU KI.

There are opportunities for further collaboration and joint advocacy between the World Bank and the GFF, e.g., for data use (RMET).

AI 3

- *Where does GFF add value?*

As previously described, GFF primarily adds value through its ability to work closely with the government and catalyze projects for RMNCAH-N and broader PHC reforms.

GFF supported piloting of innovative financing mechanisms such as PBF and DFF to increase service delivery and quality, which are now being used routinely. Through the catalytic financing of the

[235] ANRIN PAD
[236] Country KIs
[237] Country KIs
[238] Country KI
[239] Country KIs

BHCPF pilot project, GFF operationalized the National Health Act 2014 and mobilized domestic resources to provide a basic minimum package of services nationwide. GFF has also accelerated equity: in Nigeria, GFF has supported an agenda focusing on underserved and fragile geographies as well as underserved populations, including adolescents.

GFF's flexible TA has allowed them to fill data gaps, e.g., through EHS monitoring support during COVID-19 and resource mobilization and expenditure tracking. They have also focused on the use of results for data and results for advocacy, e.g., by using the impact evaluation of NSHIP to influence the health financing reform dialogue, or by supporting policy dialogue around adolescent nutrition.[240]

GFF also adds value through its partnerships with CSOs and the private sector to enhance service delivery.[241] For example, GFF supported the contracting of non-state actors to deliver services in conflict-affected areas with diminished public sector capacity through NSHIP and the use of non-state actors to deliver nutrition services through the ANRiN project.[242]

- *Extent ensured adequate funding for RMNCAH-N services?*

In Nigeria, GFF has focused on stimulating health financing and health systems reforms to improve the sustainability and effectiveness of PHC and RMNCAH-N financing from domestic resources.

GFF's first investment, co-financing the scale-up of NSHIP into six conflict-affected states, provided proof of concept for DFF and PBF[243]. The subsequent World Bank and GFF-supported impact evaluation and cost-effectiveness analyses of DFF and PBF in NSHIP demonstrated that they were cost-effective interventions for strengthening MCH services in Nigeria, and it was then applied to the subsequent BHCPF project.[244][245]

The BHCPF, which was co-financed by the GFF through a US$ 20 million grant, is widely acknowledged as a catalyst for the Government of Nigeria to enact a law passed in 2014. As a result, the government committed 1% of their Consolidated Revenue Fund (CRF) to the BHCPF. The "small" investment from GFF was attributed to leveraging more than US$ 200 million in domestic financing since the start of the project.[246] BHCPF has now been scaled up across the country. Since the BHCPF pilot, there has been formation of State Health Insurance Agencies in 34 states, and the National Health Insurance Authority (NHIA) Act, with provisions for mandatory health insurance coverage for citizens, was passed into law in 2022.[247]

- *Data/ results – what aspects of the data system were strengthened/what benefits or outcomes?*

In partnership with Exemplar Global Health, the GFF also supported the monitoring of essential health services (EHS) during COVID-19 through analysis of administrative data and mobile phone

[240] Country KIs
[241] Country KIs
[242] The GFF in Nigeria – August 2019 & NSHIP, BHCPF, and ANRiN PADs
[243] Impact Evaluation of Nigeria State Investment Project, December 2018
[244] Zeng, W., Pradhan, E., Khanna, M., ... Odutolu, O. (2022) 'Cost effectiveness analysis of the decentralized facility financing and performance-based financing program in Nigeria', *Journal of Hospital Management and Health Policy,* 6, 13.
[245] Impact Evaluation of Nigeria State Investment Project, December 2018
[246] BHCPF ICR
[247] Nigeria Mid-Term Review Investment Case Report, March 2024

data collection, which was highly appreciated by government.[248] This was acknowledged as one of the largest value adds of the GFF: "*this was the only data on EHS available during COVID-19. Otherwise, we would have been making decisions without any evidence."* The rapid availability of data on service volume (e.g., family planning, ANC, delivery, immunizations, outpatient) compared to pre-pandemic predictions, disaggregated by local government area,[249] was seen as key in presenting low-performing areas as well as in identifying factors promoting resilience in high-performing areas.

EHS data subsequently informed policy dialogue on the provision of essential services and commodities during COVID. This generated FMOH interest in additional use of FASTR for rapid, evidence-informed decision-making, which is being supported by the GFF (particularly the Results Specialist). Additionally, the mEHS (transformed into FASTR) was integrated as a mechanism to support the monitoring of results from the health reform initiative implemented through SWAp.

- *To what extent has there been demonstrable progress towards the TOC (in this country context)*

GFF's country portal reports some national gains in RMNCAH-N. From 2013 to 2018, maternal mortality declined from 576 to 512 per 100,000 live births, under-five mortality from 132 to 102 per 1,000 live births, and neonatal mortality from 39 to 32 per 1,000 live births. However, some impact indicators were unchanged or worsened: stillbirths increased from 12.3 to 17.5 per 1,000 total births, percent of births <24 months after the preceding birth increased from 23.2% to 24.9% and stunting among children under 5 years of age was 36.8% in 2013 and 2018.

The share of the government budget allocated to health has fluctuated in recent years but declined overall from 4.1% in 2016 to 3.9% in 2020. The sum of domestic general government health expenditure as share of general government expenditure declined from 5.3% in 2015 to 4.2% in 2020. However, the sum of out-of-pocket spending on health per capita declined from US$ 69.2 in 2015 to US$ 52.1 in 2020.

NSHIP results demonstrated substantial gains in service coverage and quality in the six project states in North East Nigeria.

	Baseline (January 2016)	**Target**	**Final (September 2020)**
Proportion of children sick in the last month who used a government hospital or clinic (average of project states)	61.70	72.00	69.10
Number of outpatient visits per year, children and adults (sum of project states)	169,666.00	500,000.00	20,936,639.00
Average Health Facility Score – Structural Quality of Care (average of project states)	41.00	72.00	61.60

[248] Country KIs
[249] Nigeria EHS States Profiles

Proportion of skilled births attended by skilled health personnel (average of project states)	22.20	75.00	68.60
Percentage of 12–23-month-old children vaccinated with Penta3	27.40	49.00	68.60
Births (deliveries) attended by skilled health personnel	26,960.00	700,000.00	2,083,502.00
Average Health Facility Quality of Care Score	41.90	61.00	67.00
Direct project beneficiaries	0.00	12,000,000.00	22,390,040.00

BHCPF results also demonstrate increased service delivery and quality in pilot states. This has received commitment from the government and is now scaled up to all 36 states in Nigeria, and the GFF grant-funded pilot was largely attributed to catalyzing the operationalization of NHA.[250]

	Baseline	**Target**	**Final (June 2021)**	**Achievement in project states (%)**
Number of public primary health centers receiving operational expenses via DFF mechanism	0.00	800.00	898.00	112% (Surpassed)
Number of accredited facilities receiving payments for services financed through the Fee-for-Services (FFS) mechanism	0.00	1,000.00	645.00	65% (Partially achieved)
Number of beneficiaries receiving services financed through the FFS mechanism[251]	0.00	600,000.00	74,930.00	12% (Not achieved)

[250] BHCPF ICR

[251] GFF previously included this indicator in its Theory of Change to track its investments. However, it has since adopted the indicator "Number of BHCPF enrollees accessing or utilizing the BMPHS", which focuses on access to a basic minimum package of health services. In 2021, the total number of enrollees accessing the basic minimum package of health services was 940,000, increasing to 1,620,000 by 2023.

Quality average of care in project states in June 2021	28	43	71.6	291% (Surpassed)
Percentage of births attended by skilled health personnel (average of project states)	70.00	75.00	79.47	189% (Surpassed)
People who have received essential health, nutrition, and population (HNP) services	0.00	850,000.00	945,420.00	111% (Surpassed)
Number of outpatient visits per year, children and adults (sum of project states)	294,915.00	1,000,000.00	1,181,776.00	126% (Surpassed)
Percentage of children (12-23 months) with Pentavalent 3 vaccination (average of project states)	57.00	67.00	68.70	117% (Surpassed)
Percentage of public health facilities in the project area with functioning management committees having community representation	-	75	100	133% (Surpassed)
Percentage of health facilities enrolled in the DFF payment system that received supervision in the last quarter	-	75	90	120% (Surpassed)
Number of project facilities receiving payments on time	0.00	950.00	898.00	95% (Achieved substantially)

ANRiN results demonstrate increased utilization of quality, cost-effective nutrition services. A total of 7,989,342 children, 3,614,210 pregnant women, and 362,751 adolescents had been reached at the time of the most recent implementation status and results report published in June 2024.[252] Below are the results of ANRiN as of 15 March 2023, with over 1.5 years left of implementation. For each of the below indicators, they also monitor disaggregated results for adolescent women and children of adolescent mothers.

	Baseline (Dec 2018)	**Target**	**Actual (15 March 2023)[253]**
Infants 0-6 months exclusively breastfed (%)	27.20	38.00	34.40
Children 6-24 months who receive micronutrient powers as part of complementary feeding	0.00	955,090.00	194,685.00
Children 6-59 months who receive zinc and ORS as treatment for diarrhea	0.00	2,332,335.00	1,408,198.00
Children 12-59 months dewormed twice a year	0.00	2,040,463.00	1,920,477.00
Pregnant women who received a minimum of 90 iron-folic acid tablets	0.00	493,814.00	329,391.00
Pregnant women who receive intermittent presumptive treatment for malaria (at least 3 doses)	25,855.00	493,814.00	220,206.00

- *What lessons in advancing gender, voice and equity?*

GFF has consistently been focused on underserved populations in Nigeria, both in conflict-affected regions (NSHIP) and in underserved population groups (e.g., adolescents).

For example, GFF's support to NSHIP allowed the project to expand to all six North Eastern states, targeting a conflict-affected region with significantly worse health outcomes. BHCPF also included a

[252] ANRiN Implementation Status and Results Report, 10 June 2024.
[253] ANRiN Implementation Status and Results Report, 10 June 2024.

focus on geographic equity; while public PHCs were targeted in general, the allocation methodology enabled a focus on the rural poor during the first five years of implementation.[254]

GFF's support to ANRiN has catalyzed policy dialogue around adolescent nutrition, with a specific focus on service delivery to adolescents alongside the broader focus of the project on child and maternal nutrition services. This has catalyzed an expansion in the scope of service delivery contracts in Kaduna state, where they have integrated services such as family planning.[255] A country KI stated that they have also trained non-state actors to recognize GBV and refer to services, and that they hope to leverage their adolescent health delivery model to provide services such as life skills training and to target adolescents with additional inequities (e.g., disabilities).

There is also evidence that GFF has contributed to creating an enabling environment for CSO engagement.[256] Engagement of civil society in GFF has been strong since its inception – e.g., through the Nigeria Civil Society Working Group, equipping and mentoring Nigerian GFF youth coalitions to develop an RMNCAH-N scorecard to measure governance and monitor IC implementation.[257] They have also been engaged in advocacy to increase health financing for UHC, contributing to the release of the 1% CRF.[258] CSO and youth representatives are also members of the RMNCAEH-N coordination platform.

Any reflections on key findings or implications for the model?

- Nigeria is an example of the GFF's ability to catalyze broader gains in RMNCAH-N, PHC, and health financing reforms by filling essential gaps and strategically using results for advocacy. The GFF has played an active role in advancing partner coordination and alignment in Nigeria, particularly as an engaged member of the partner alignment TWG under the SWAp. Additionally, the GFF has served as a catalyst for the RMET process, supporting data-driven decision-making and alignment of resources.
- There remains further scope for the GFF to strengthen coordination and alignment of RMNCAH-N stakeholders through SWAp, a key concern for the government moving forward. The GFF-supported costed RMNCAH-N strategy and recent RMET findings should guide engagement with partners such as BMGF, USAID, FCDO, Gavi, the Global Fund, CIFF, UN agencies, and bilateral funders.
- The GFF's recent MTR and their decision to pivot from using their own IC to aligning with the government's RMNCAH-N strategy is positive and has the potential to increase the utility of the IC as a tool for donor alignment and fund mobilization. The previous IC was not widely recognized or utilized beyond GFF, and it was eventually a parallel document to the government's RMNCAH-N strategy.
- The collection and use of high-quality data for decision-making is a priority for the government, and there is scope to increase the CP's use of data under SWAP. There is a demand for continued TA for FASTR and Countdown to 2030, as well as support for HIS improvements such as CRVS.

[254] BHCPF ICR
[255] Trust Fund Committee Second Round GFF Grant Financing Proposal, May 2024.
[256] Country KI
[257] Country KI, GFF_TFC_CEF_November 30 2023 & brochure - GFF – NGR
[258] Country KI, GFF_TFC_CEF_November 30 2023 & brochure - GFF – NGR

    - There is also interest in generating more disaggregated data, including gender and equity analyses.[259]
- Despite the closure of GFF's support to the BHCPF project, there is interest in the GFF's continued support to monitoring BHCPF health outcomes after the nationwide scale-up.[260]
- There are additional opportunities for the GFF and World Bank to align in Nigeria for increased advocacy and strategic use of data. There is also potential for further linkages between GFF's adolescent health implementation research and the World Bank's ongoing Adolescent Girls Initiative for Learning and Empowerment (AGILE) program.

[259] FY24 Nigeria CES review 2023.10.04; IC MTR
[260] FY24 Nigeria CES review 2023.10.04

Annex 1: Documents reviewed and stakeholders interviewed

Documents reviewed	Year of issue
TFC_Second Round Financing_Nigeria_May 2024	2024
4Gs alignment summary (1)	
ANRIN PAD	2018
ANRIN restructuring paper	2018
BHCPF ICR	2022
brochure - GFF - NGR	
CHARTBOOK NIGERIA 2024	2024
Nigeria-Mid-Term-Review-Investment-Case-Report-March-2024	2024
Nigeria-Investment-Case	
FY23 Nigeria CES review_2023.02.23.docx	2023
FY24 Nigeria CES review 2023.10.04.docx	2023
GFF_TFC_CEF_November 30 2023.pdf	2023
Progress on the RMNCAEH+N platform	
NSHIP_LSC_Management_Lessons_Learned_Assessment_Report_June2022	2022
The GFF in Nigeria - August 2019.pdf	2019

Name	Position	Association
Dr Aminu Magashi	Coordinator & Founder	CSO AHBN
Dr Opeyemi Fadeyibi	SCO M&E Lead	Min of Health
Zainab Muhammed Idris	Project Manager -ANRIN	Sub-national-Kaduna
Munirat Iyabode Ayoka Ogunlayi	Country Focal Point	GFF
Saudatu Umma Yaradua	Liaison Officer	GFF
Rachel Vernee Neill	Results Specialist	GFF
Ritgak Tilley Gyado	Senior Health Specialist	WB TTL
Fatimah Mustapha	Senior Health Specialist	WB TTL
Raveena Chowdhury	Director - SRHR	CIFF

Tanzania

Tanzania Case Study

Brief outline of the GFF/ WB investment

GFF co-financed three recipient-executed operations in Tanzania, including:

- Strengthening Primary Health Care for Results Program (P4R); 2016-2021: GFF US$ 40 million, IDA US$ 200 million, Achieving Nutrition Impact at Scale MDTF US$ 20 million, and USAID US$ 14.5 million. Other development partners expected to contribute US$ 290 million through parallel financing, and the government financed the remaining balance (expected 77.5% of the program cost).[261]
- Tanzania Maternal and Child Health Investment Program (TMCHIP); 2023-2027: GFF US$ 25 million and IDA US$ 250 million. The total cost of the government program is expected to be US$ 2.347 billion; health basket funding (HBF) development partners were anticipated to contribute US$ 163 million (7 percent) through parallel financing, and the government/other donors will fund the remainder.[262]
- TMCHIP Additional Financing for Innovation to Scale – Safer Births Bundle of Care (SBBC); 2024-2027: GFF US$ 8.54 million

GFF has also used Bank-executed funding to provide technical assistance in key areas:

- Project preparation (US$ 374,204.70, 17.2% of BETF)
- Supervisory missions, World Bank participation in the CP and CP assessment process, and completion of the World Bank MTR and ICR (US$ 968,938.18, 44.6% of BETF)
- Investment case implementation support – CP meetings, data use review meetings, implementation progress reviews, and CP assessment (US$ 120,000.00, 5.5% of BETF)
- Support to drafting RMNCAH IC (US$ 41,253.45, 1.9% of BETF)
- RMET reports and presentations, National Health Authority (NHA) public health expenditures analysis report, and donor database assessment report (US$ 168,201.00, 7.8% of BETF)
- Support to domestic resource use and mobilization, including a draft financing plan for UHI and designing and implementing other health financing policies (US$ 217,548.84, 10.0% of BETF)
- Analytical report of the impact of COVID-19 on continuity of RMNCAH-N services, dashboard to facilitate data use for decision-making, stakeholder engagement, and a report on clinical learning implementation (US$ 231,498.55, 10.7% of BETF)
- Results monitoring TA, including quarterly RMNCAH-N scorecard, IC implementation data, capacity building, and GFF Data Portal (US$ 50,000.00, 2.3% of BETF)

Details of the GFF investments: [263]

Exec Type	Funding Cat	Budget Cat	Budgeted	Disbursed
RE	1St Round Grants	Grants	$40 million	$34.043.509
RE	EHS Grants	Grants	$25 million	$5 million
RE	EHS Grants	Grants	$8.5 million	$0
BE	Core TA	Project Preparation	$226.400,72	$226.400,72

[261] Strengthening Primary Health Care for Results PAD
[262] TMCHIP PAD
[263] GFF Evaluation - Case Study Countries - RE and BE Portfolio Summary July 2024

BE	Core TA	Project Preparation	$147.803,98	$147.803,98
BE	Core TA	Supervision	$74.000	$2.112,29
BE	Core TA	Supervision	$894.938,18	$894.938,18
BE	Core TA	IC Impl. Support	$120.000	$69.603,58
BE	Core TA	IC Impl. Support	$41.253,45	$41.253,45
BE	Core TA	RMET	$13.132,79	$13.132,79
BE	Core TA	RMET	$155.068,21	$155.068,21
BE	Flexible TA	DRUM	$50.000	$49.871,78
BE	Flexible TA	DRUM	$167.548,84	$167.548,84
BE	Flexible TA	Quality RMNCAH-N Covid-19	$231.498,55	$231.498,55
BE	Flexible TA	Results monitoring	$50.000	$48.135,18

The investment case

- *Brief overview of the IC*

Tanzania was among the four front-runner countries to join the GFF in 2015 and is now on its second round of engagement. GFF has provided TA to support development and monitoring of the implementation of the IC. The process of developing the ICs was described as highly consultative, involving the government, development partners, and civil society.[264]

When Tanzania joined the GFF, the government was already in the process of developing a new national RMNCAH-N strategy (OnePlan II), which was aligned to the fourth Health Sector Strategic Plan, 2016-2020 (HSSP IV) and other country strategies, such as the CRVS Strategy.[265] The government adapted this strategy as the RMNCAH-N IC. It prioritized:

- Access to quality RMNCAH-N services which were affordable, equitable, and sustainable, focusing on strengthening RMNCAH
- Scaling up the child health program
- Strengthening response to cross-cutting issues

The second, and current, IC is OnePlan III, which is aligned with the fifth Health Sector Strategic Plan, 2021-2025 (HSSP V), has the following objectives:[266]

- Create an enabling environment for provision and utilization of quality, equitable, and accessible RMNCAH-N services
- Strengthen the capacity of health systems for planning, management, and service delivery of RMNCAH services
- Increase access and utilization of quality RMNCAH services
- Improve quality of care for RMNCAH services

Results	Objectives	Strategies
Reduced maternal mortality ratio	1. To create enabling environment for provision and utilization of	1.1: Policy leverage
		1.2: Leadership, governance, and accountability

[264] Country KIs
[265] One Plan II (2016-2020), June 2016
[266] One Plan III (2021/2022 – 2025/2026), November 2021

Reduced neonatal mortality rate Reduced underfive mortality rate Reduced teenage pregnancy (15-19 years) Reduce MTCT of HIV and syphilis	quality, equitable and accessible RMNCAH and nutrition services	1.3: Financing for RMNCAH and nutrition
	2. To strengthen the capacity of health systems for planning, management and service delivery of RMNCAH services	2.1: Improve Services delivery
		2.2: Improve Human resources for health
		2.3: Improve RMNCAH&N commodity security
		2.4: Improve Health management information system
		2.5: Improve Community systems for RMNCAH
		2.6: Improve Research for RMNCAH Services
	3. To increase access and utilization of quality RMNCAH services.	3.1: Prioritized packages of RMNCAH interventions
	4. To improve Quality of Care (QoC) for RMNCAH services	4.1: Improved package for QoC

- *Funding gaps identified? Any evidence that it was able to leverage further funding from external partners?*

The 2021/2022 RMET revealed that there was a large financing gap for Year 1 of One Plan III – at the time of the report publication, only 38% of the required funding had been committed.[267] Maternal and newborn health had the highest allocation of committed funding, whereas the highest financial gap was observed in child health.

There is evidence that the GFF partnership played a role in *"mobilizing financiers to increase funding in support of Tanzania's IC,"* despite the aforementioned gaps in partnerships with major GHIs such as Gavi and the Global Fund. They have invested in increasing alignment through projects such as an assessment of donor alignment to public financial management systems and RMET (supported by GFF through CHAI), as well as through projects. GFF mobilized partner resources for the first PforR operation, resulting in co-financing from the Achieving Nutrition Impact at Scale MDTF and USAID. Through the TMCHIP project, they have supported alignment of donors to a basket fund to finance Direct Health Facility Financing (DHFF). Regardless, the CES review in 2023 noted a persistent *"high financing gap"* which impacts service delivery and quality.

The country platform

The government adapted an existing RMNCAH technical working group, under the SWAP mechanism, as the RMNCAH Country Platform. The GFF provides support for the availability and use of data for the CP, as well as resources for convening meetings, in collaboration with other partners.

- *Where is it based – who takes part?*

The CP is coordinated by the government, primarily chaired by the Department of Reproductive, Maternal, and Child Health, but also involves:[268]

[267] RMET 2021/2022
[268] List of Country Platform Members, n.d.

- Development partners and donors (CHAI, UNFPA, UNICEF, USAID, Jhpiego)
- Private sector (Association of Private Health Facilities in Tanzania)
- Health research organizations (Ifakara Health Institute)
- Professional associations (Association of Obstetricians and Gynecologists in Tanzania, Pediatric Association of Tanzania, and Tanzania Midwives Association)
- CSOs (Health Promotion Tanzania, AMREF, and Jakaya Mrisho Kikwete Foundation)

While stakeholders broadly acknowledged the broad representation in the RMNCAH TWG, lack of youth representation and private sector participation were criticized as particularly weak points.[269] Country KIs noted that they recently did stakeholder mapping and are engaging with the government to promote more diverse CP membership of CSOs and the private sector. In addition, some influential partners such as Gavi and Global Fund are outside of the CP. In the most recent CES review in June 2024, KIs requested assistance in coordinating their support at the global level.[270]

There are mixed views about GFF's convening power through the CP. There is strong membership in the CP and the government appreciates the GFF's ability to work with external partners (which was seen as a value add over and above the World Bank). On the other hand, a KI felt that some key external partners had to engage GFF (rather than GFF engaging them), and that others were not aware of the GFF.[271]

- *Any evidence on how active it is?*

The CP is intended to meet quarterly, but it currently meets bi-annually. Interviews with KIs and CES reviews from 2022-2024 describe barriers to regular convening of the CP including conflicting in-country activities, such as conferences.

Despite this, the RMNCAH TWG is described as the best-performing working group under SWAP due to its use of data. This is a strong focus of GFF's engagement in Tanzania and has improved over time, with evidence of the GFF presenting RMNCAH Scorecard results and sub-national performance tracking in partnership with Countdown 2030 at CP meetings.[272,273] Country KIs stated that *"utilizing data was a challenge… now they are seeing higher quality data and presentation in the CP for decision-making*."

However, some KIs noted outstanding barriers, with one of them noting that visibility of some data initiatives is limited, and that they have to "*push the committee to talk about the GFF and performance indicators"*. The June 2024 CES review asserted that *"the CP, through GFF support uses data to monitor progress of the IC, however, more support is needed to strengthen data analysis and use for decision making."*[274]

The World Bank project

- *What is the World Bank funded to do – what aspects of RMNCAH -N does it target?*

With GFF co-financing, the World Bank has funded two program for results (PforR) operations: Strengthening Primary Health Care for Results (2016-2021) and Tanzania Maternal and Child Health

[269] Country KIs
[270] FY24 Tanzania CES Review 2024.06.04
[271] Country KI
[272] Country KIs
[273] Tanzania Country Platform Meeting Minutes, 7 December 2023
[274] FY24 Tanzania CES Review, 4 June 2024

Investment Program (TMCHIP, 2023-2027). The program development objective of the Strengthening Primary Health Care for Results operation was to improve the quality of PHC, with a focus on maternal, neonatal and child health (MNCH) services. While the program supported all 26 regions in Tanzania, the RBF covered nine regions by 2020. The program development objective of the TMCHIP is to scale up the provision and improve the quality of essential health care services, with a focus on maternal and child health. This has been supported through implementation of the Direct Health Financing Facility (DHFF) and the use of scorecards to promote accountability.

Additionally, in 2024 TMCHIP received an additional financing of US$8.54 million from the GFF to expand maternal and newborn care and referral services. The additional financing specifically supports capacity building for health staff to provide quality Comprehensive Emergency Obstetric and Newborn Care (CEmONC) through the Safer Births Bundle of Care (SBBC Plus) approach. It also strengthens innovations to address high maternal and newborn mortality rates and stillbirths, as part of Disbursement-Linked Indicator (DLI) 7.1 on ensuring PHC facilities are fully equipped and functional for emergency obstetric and newborn care.[275]

- *What is the evidence that the GFF then led to a re-prioritisation of RMNCAH-N in the WB project? Where is this evident?*

Country KIs emphasized that while they bring a relatively small amount of funding, GFF brings a specific focus on RMNCAH as a priority area, emphasizing it through provision of technical support and advocacy. They said that *"while financing is through the World Bank, they provide support through some indicators."*

While it is not possible to determine that GFF exclusively led to a re-prioritization of RMNCAH-N in the World Bank operations, the original PforR project was broadly focused on PHC strengthening with a specific focus on MNCH, with the PAD asserting: *"this PforR aligns closely with the main objectives of the GFF to: (i) finance national RMNCAH scale-up plans for results; (ii) support countries in the transition toward sustainable domestic financing of RMNCAH; and (iii) contribute to a better-coordinated and streamlined RMNCAH financing architecture"*[276] and *"this program supports the operationalization of this investment case as a critical step towards the realization of the GFF vision to end preventable maternal, newborn, child and adolescent deaths in Tanzania."*

GFF's ongoing support to the second PforR operation (TMCHIP) specifically increased the value of (i) DLI 1 – associated with delivery of MCH services to LGAs, focusing on high-priority areas such as newborn care, delivery in health facilities, family planning services, and extension of MCH services in communities using CHWs, and (ii) DLI 5 – associated with the management of emergencies and referrals.[277] The GFF provided an additional grant to integrate, scale, and sustain the SBBC innovation within the TMCHIP program.

KEY FINDINGS BY AI

AI 1

- *Delivering health services – what's the model – how is this being achieved?*

The first PforR operation supported health service delivery through results-based financing (RBF). The second PforR operation, TMCHIP, is using DHFF to support health service delivery.

[275] PAD5533 - Tanzania Maternal and Child Health Investment Program Additional Financing (P180798) 2024
[276] Strengthening Primary Health Care for Results PAD
[277] TMCHIP PAD

- *Quality of care – what is the model – evidence of this being achieved?*

Quality of care has been recognized by multiple key informants, including GFF staff, the MOH, and CSO KIs, and CES reviews as a persisting issue in Tanzania. While service delivery increased markedly with the assistance of GFF, they struggled to increase QoC. While this has been a focus throughout GFF's engagement, the second IC, OnePlan III, has a sharper focus on improved quality of care, with QoC as one of the four primary objectives.

Strengthening Primary Health Care for Results

The Program Development Objective of the first operation was to *"improve the PHC services nationwide with a focus on MNCH services,"* measured through five PDO indicators:[278]

- PDOI 1: Percentage of PHC facilities with a 3-star rating and above
- PDOI 2: Percentage of expected pregnant women attending four or more ANC visits
- PDOI 3: Percentage of ANC attendees receiving at least two doses of intermittent preventative treatment for malaria
- PDOI 4: Percentage of institutional deliveries
- PDOI 5: Percentage of children 12-59 months of age receiving VitA supplementation

While these were largely reached, the PDOI for PHC facilities with 3-star ratings and above had to be adjusted from 50% to 30% (see below) and was still not achieved – it was 19% at the end of the operation.[279] The baseline Star Rating assessment, which rated almost one third of all PHC facilities at 0-star, was used to prepare quality improvement plans for individual facilities. The second assessment showed a marked improvement, but the third and final assessment was never completed due to delays with releasing funds, transfer of key staff overseeing the initiative, and delays with the revision of the Star Rating tool (as the initial version was manual and resource-intensive). [280]

Table 3. Changes to the Program Results Framework under the 2020 Restructuring

Program Development Objective Indicators (PDOIs)	Unit	Baseline 2014/15	Revised Baseline	Original Target	Revised Target
PDOI 1. PHC facilities with 3-star ratings and above	%	0	No Change	50	30
PDOI 2. Pregnant women attending four or more ante-natal care (ANC) visits	%	41.2	No Change	60	68
PDOI 3. Institutional Deliveries	%	44.72	No Change	60	70
PDOI 4. ANC attendees receiving at least 2 doses of intermittent preventive treatment (IPT2) for Malaria	%	42.52	No Change	60	80
PDOI 5. Proportion of children 12-59 months receiving at least one dose of Vitamin A supplementation during the previous year	%	51	No Change	65	90

Two DLIs were related to quality of care:

- DLI 3: PHC facilities have improved maternal, neonatal and child health service delivery and quality as per verified results and received payments on that basis each quarter

[278] The Star Rating Assessment is a quality improvement approach designed to assess performance of health facilities in a stepwise manner. Performance scores assessing quality of RMNCH at the facility level included four domains: (i) facility management and staff performance; (ii) service charters and accountability; (iii) safe and conducive facilities; and (iv) quality of care and services, including interviews with patients and spot checks of medical records to verify the quality of content of care and recording. The "Star Rating" assessment scale is from 1 to 5 stars, with 5 being the best quality and 3 being minimally acceptable.
[279] The World Bank. Strengthening Primary Health Care for Results Program-for-Results: Implementation Completion and Results Report. 29 March 2022.
[280] Ibid.

Substantially achieved – 83% disbursed

- DLI 4: LGAs have improved annual maternal, neonatal and child health service delivery and quality as measured by the LGA Balance Score Card
  11 of 12 DLRs were achieved – 94% disbursed

The ICR Review notes that while program outcomes primarily reflected increased service utilization rather than direct measures of quality, it is reasonable to expect that greater utilization contributed to quality improvements.

However, persistent gaps in staffing, medical equipment, supplies, and infrastructure continue to undermine QoC in Tanzania. The health sector remains underfunded, with 59% of health spending in 2019 reliant on development partners. [281] Despite the development of quality improvement plans at the facility level, implementation has been fragmented and poorly coordinated. The subsequent World Bank and GFF co-financed operation aims to address these barriers by strengthening human resources for health, improving emergency referral systems, and refurbishing PHC facilities.

TMCHIP

Quality of care is a central focus of the second PforR operation, the TMCHIP operation. The PDO is to scale up the provision and improve the quality of essential health care services, with a focus on maternal and child health, and the PDO-level results indicators include:

- PDOI 1: Percentage of dispensaries with at least two qualified/skilled health providers
- PDOI 2: Percentage of PHC facilities achieving 3 stars and above[282]
- PDOI 3: Percentage of newborns receiving postnatal care within 48 hours after delivery
- PDOI 4: Percentage of pregnant women attending first ANC visit in the first trimester
- PDOI 5: Percentage of patients referred (through the dispatch center – new system) that are managed at receiving health facility
- PDOI 6: Percentage of funds received through DHFF utilized in the financial year

The Star Rating assessment was updated and digitized for TMCHIP, and they are currently in the process of doing the first round of assessments. Otherwise, TMCHIP is currently making good progress on PDOI targets (see AI3).

The GFF is supporting the first DLI, which is focused on quality of care:

- DLI1: Improved annual delivery of maternal and child health services by the LGAs as measured by average LGA scorecard.

The LGA score card contains 10 criteria comprising 6 RMNCAH-N services delivery criteria and 4 health systems strengthening criteria targeted toward improving the quality of care. Funds for LGAs are channeled through the health basket fund and disbursed to LGAs and PHC facilities based on an allocation formula which includes both performance and equity elements.[283]

[281] World Bank, 2019. Health Sector Public Expenditure Review.
[282] The Star rating was updated under TMCHIP to include the following domains: (a) health facility management and staff performance; (b) service charters and social accountability; (c) safe and conducive facilities; and (d) quality of care and services, which are further subdivided into 12 service areas: legal status, facility management, HMIS, staff performance, organization of services, emergency and referral system, client focus, social accountability, facility infrastructure, infection prevention and control, clinical services and clinical support services. The service areas are rated on a scale of 1 to 5 stars.
[283] TMCHIP PAD

Tanzania has already scaled up delivery of maternal and child health services by the LGAs, improving the average scorecard rating by 27.3% (55 to 70) from May to December 2023.[284]

- *Added value to other RMNCAH-N actors? How? Evidence?*

There is no direct evidence that the GFF's involvement added value to the work of other development partners. However, country KIs highlighted that the introduction of PforR played a key role in improving health indicators, particularly maternal mortality, by incentivizing performance-based results. As one KI noted, the approach *"built the morale of people in getting paid to achieve results."* [285]

The scaling of RBF to nine underperforming regions under the first operation was seen as a significant achievement. Additionally, a country KI emphasized that renovation and construction of health facilities using GFF co-funding or catalyzed funding contributed to improving service delivery and overall health system performance.

AI 2

- *GFF / WB leveraging each other's strengths*

GFF primarily supports the World Bank's work through strategic TA with an RMNCAH-N lens, e.g., support for National Health Insurance, RMET and National Health Accounts analyses, and data quality improvements. GFF-supported data is used not only by the government, but also to inform World Bank investments: *"the World Bank was able to give a soft loan to the government based on the GFF's [support to availability, quality, and use of] data."*[286]

A KI also noted that the GFF is uniquely positioned to work with different partners and contribute to the alignment agenda. While the World Bank works with different partners in Tanzania, including through the Development Partner's Group on Health,[287] the GFF was perceived by KIs as being better positioned to work with the government than with external partners.

- *Are the roles sufficiently clear / separated?*

Country KIs did not identify any issues with ways of working and role divisions, stating that the World Bank and the GFF both liaise through the GFF government focal point, and that the World Bank generally manages other government communications. A KI, however, described this as a *"difficult relationship to manage."* He experienced confusion between the entities (*"it's difficult to tell who is GFF and who is the World Bank"),* as the GFF uses World Bank structures and supports their stances, and GFF funding comes to the country from the World Bank.

AI 3

- *Where does GFF add value?*

Aside from value added mentioned before, GFF was primarily identified as a *"key player"* contributing to increasing **access to service**s in Tanzania. Their contribution to increasing provider autonomy and scaling up key indicators such as institutional deliveries and ANC has been attributed to the impressive maternal and child mortality reductions from 2015 to date.

[284] TMCHIP ISR3, 9 April 2024
[285] Country KI
[286] Country KI
[287] Minutes of DPG Health Meeting 3rd April 2024

The GFF has also contributed to **innovation** through the initial piloting and scale-up of the Safer Births Bundle of Care Approach to end preventable maternal and neonatal deaths through clinical innovations (electronic fetal heart rate monitor, newborn heart monitor, and resuscitator), continuous quality improvement through a data management platform, simulation training, and local ownership. SBBC was initially piloted in 30 hospitals in five regions with a US$ 4.5 million grant from the GFF Innovations to Scale Initiative and support from UNICEF.[288] It was a success – the halfway evaluation of the SBBC pilot in 30 hospitals in Tanzania demonstrated a trend towards 50 percent reduction in 24-hour newborn mortality, and 10-20 percent reduction in maternal mortality in four of five regions.[289]

The additional financing for TMCHIP to scale up this innovation will allow the government to institutionalize the innovation within government systems and focus on building capacity of health staff to provide quality Comprehensive Emergency Obstetric and Newborn Care (CEmONC) services. It was described as an *"eye-opener in addressing issues of neonatal care"* and that they have *"seen more survival in units where it has been implemented*." Prior to the operation, GFF invested in the assessment of public sector demand and scale-up of RMNCAH-N innovations in Tanzania, focusing on policy, regulatory, and institutional contexts.[290]

GFF has also added value in increasing **data quality and use**, including through strengthening the utilization of RMNCAH-N scorecards (both at the national and LGA levels). This data has informed decision-making and was reportedly appreciated by KIs. Analytics such as RMET have also been described as a useful resource in providing the government with timely insights about where to put their resources, e.g., *"the first resource tracking, we noted the area of child deaths was under-funded and were able to fund under-fives. Currently, we know that more resources are required to ensure availability of neonatal care services."*[291]

- *Extent ensured adequate funding for RMNCAH-N services?*

GFF has been engaged on domestic resource mobilization, but this was noted by KIs and in documentation as a persistent weak point. Domestic General Government Expenditure as a share of General Government Expenditure has stagnated in the past years,[292] at 9.5% in 2016 and 9.4% in 2020. The 2021/2022 RMET revealed that the government budget allocation (including the health basket fund) represents 44% of total mapped RMNCAH resources, while donor allocations account for 56%, presenting a threat to sustainability.[293] Incorporating an indicator for increasing the share of health in the overall budget under DLI 2 in the first PforR operation was unsuccessful (reached 7% against the target of 9.75%).

> *"Last year, the government passed a bill on health financing, but it's still not clear how funding for health would be ringfenced. It's still a threat if GFF was to pull out; there's no concrete mechanism to maintain the project."* – Country KI

While gains in domestic resources for health have been minimal, GFF has supported multiple analytical pieces to increase efficiency:

[288] Safer Births Bundle of Care to be scaled up with $ 13m in funding from the World Bank – Safer Births
[289] TMCHIP AF PAD
[290] TZ Enhancing Public Sector Demand and Scaling & Supply side RMNCAH-N Innovation Analysis
[291] Country KI
[292] FY24 Tanzania CES Review 2024.06.04
[293] RMET 2021/2022

- **RMET –** Two RMET reports were produced in partnership with CHAI and are used by the government for annual operational planning and budgeting.[294] Includes information about IC funding gaps (as discussed in AI1).[295]
- **NHA public expenditure analysis and review –** Financed a consultant to undertake a public expenditure review to assess how funds are allocated and explore opportunities for increased fiscal space and efficiency gains in the health sector.[296] Also used to inform the design of the second PforR.
- **Assessment of donor alignment to public financial management systems –** Undertook an assessment to understand the current degree of alignment of donors to government PFM systems, identify challenges in alignment, and propose ways forward.[297]

GFF also contributed to health systems reform in Tanzania, introducing and scaling up RBF in the first PforR operation and leading to the government prioritizing DHFF in all HFs in the second PforR operation, enhancing efficiency and budget execution. The government provided the vast majority of funding for both operations, contributing an estimated 77.5% in the first PforR operation and 81.3% for the second PforR operation.[298] However, a country KI noted that the complete government co-financing of TMCHIP is still unclear, making it challenging to ascertain whether this had resulted in more resources being mobilized.

While GFF has been engaged in supporting the government in developing a financing and implementation plan for UHI with a focus on the poor and informal sector, this is still in progress and results are not yet available. In the most recent CES review, there was a request to have a *"follow-on discussion clarifying the storyline on why this is a priority for the GFF, how it links to the overall RMNCAH-N agenda, and if not, how it can be strengthened through engagement with MAGE on strengthening gender dimensions*." [299]

- *Data/ results – what aspects of the data system were strengthened/what benefits or outcomes?*

Strengthening data quality has been a strong focus of GFF's engagement in Tanzania. In general, DLIs were attributed to holding stakeholders accountable and building a results-oriented culture, including strengthened M&E at the LGA level.[300]

BETF has also focused on enhancing data quality, including both the development and improved utilization of national and LGA RMNCAH-N scorecards.[301] These are reviewed in the CP quarterly and are attributed to *"helping a lot to address various issues in the health sector, from pre-pregnancy to post-pregnancy, vaccinations, etc., to address where they are not doing well."*[302] Indicators are now being revised due to country achievements in reducing maternal and under-five mortality.

[294] GFF Evaluation - Case Study Countries - RE and BE Portfolio Summary July 2024
[295] RMET 2021/2022
[296] GFF Briefing note for Tanzania for JPU & GFF Evaluation - Case Study Countries - RE and BE Portfolio Summary 2024.07.23
[297] GFF Briefing note for Tanzania for JPU & GFF Evaluation - Case Study Countries - RE and BE Portfolio Summary 2024.07.23
[298] PADs
[299] FY24 Tanzania CES Review 2024.06.04
[300] TZ-SCD-Final-Approved-by-AFRVP-03012017, CSO and Govt FP KIIs
[301] RMNCAH in Tanzania: GFF Investors Group Meeting, 2016.
[302] Country KI

		LGA Scorecard
6 quantity indicators	1	4+ antenatal care visits (ANC4)
	2	Mothers receiving 2 doses of IPT during pregnancy
	3	Institutional deliveries
	4	Modern family planning use
	5	Pregnant women receiving Iron and Folate tablets
	6	Vitamin A supplementation (children aged 12-59 months)
6 quality indicators	7	PHC facilities with "3 stars" rating or higher
	8	PHC facilities with at least one skilled staff
	9	Availability of 10 tracer medicines
	10	LGAs with functional Council Health Service Boards
	11	Completeness of quarterly DHIS 2 entry by LGA
	12	Percentage of LGAs with unqualified opinion in the external audit report

While there are persisting issues with data, including discrepancies between survey and facility data and inaccurate denominators,[303] the GFF seeks to improve this through collaborations with Countdown 2030. Notably, the GFF has also provided BETF resources for an embedded M&E consultant to support the World Bank and the Reproductive & Child Health department of the MOH since FY 2023.[304] Further support for CRVS strengthening and for capacity building for M&E staff was approved in the recent CES review.[305] Stakeholders reported GFF's support to increasing availability, quality, and use of data as a major value added.

- *To what extent has there been demonstrable progress towards the TOC (in this country context)*

Maternal mortality has declined tremendously since GFF's engagement, from 556 in 2015 to 104 in 2022. While impossible to attribute results to GFF, multiple KIs tied the results to the PforR operations. Under-5 mortality has also decreased markedly, from 67 to 43 per 1,000 live births, and moderate and severe wasting among children under 5 years of age has declined from 4.4% to 3.3%. Despite this, several indicators are still lagging – neonatal mortality was 25 in 2015 and 24 in 2022, stillbirths only declined marginally, from 18.4 to 18 per 1,000 live births, and stunting is still high, declining from 34 in 2015 to 30 in 2022. Adolescent birth rate declined from 132 to 112 per 1,000 women, percent of births <24 months after the preceding birth declined from 18.8% to 17%.[306]

Strengthening PHC for Results

The first PforR operation, Strengthening PHC for Results, notably improved service delivery, with ANC, institutional deliveries, and proportion of children 12-59 months receiving at least one dose of Vit A achieved above targets. However, PHC facilities with a 3-star rating or above were lower

[303] FY24 Tanzania CES Review 2024.06.04
[304] FY23 Tanzania CES review 2022.10.03
[305] FY24 Tanzania CES Review 2024.06.04
[306] GFF Data Portal

	Baseline (August 2015)	Revised Target (January 2020)	Achieved at Completion (December 2020)
PDOI 1: PHC facilities with 3- Star Ratings and Above	0.00	30.00	19.00 (Dec 2018)
PDOI 2: Pregnant women attending 4 or more ante-natal care (ANC) visits	41.20	68.00	90.00
PDO 3: ANC attendees receiving at least 2 doses of intermittent preventive treatment (IPT2) for malaria	42.52	80.00	79.00
PDOI 4: Institutional deliveries	44.72	70.00	83.00
PDOI 5: Proportion of children 12-59 months receiving at least one dose of Vitamin A during the previous year	51.00	90.00	100.00

TMCHIP

Less than a year into implementation (February 2023 to December 2023), TMCHIP has made progress on some key indicators – there is an increased percentage of dispensaries with at least two qualified/skilled health providers, and a higher percentage of newborns receiving postnatal care within 48 hours after delivery. 94.0% of patients referred through the new dispatch system are managed at the receiving health facility, and 81.0% of funds received by health facilities through DHFF are utilized in the fiscal year. Some indicators are still pending data collection and review, including the PHC facility star rating and the LGA scorecards.

	Baseline (December 2021)	End Target (2027)	Actual (December 2023)
DLI 1: Improved annual delivery of maternal and child health services by the LGAs as measured by average LGA scorecard	55.00	70.00	55.00
PDOI 1: Percentage of dispensaries with at least two qualified/skilled health providers (nurse/midwife and clinician)	60.00	100.00	73.00
PDOI 2: Percentage of PHC facilities achieved 3 stars and above	19.00 (2018)	50.00	18.00 (June 2023)
PDOI 3: Percentage of newborns receiving postnatal care within 48 hours after delivery	86.00	96.00	91.60
PDOI 4: Percentage of pregnant women attending first ANC visit in the first trimester	27.00	60.00	42.90

PDOI 5: Percentage of patients referred (through the dispatch center - new system) that are managed at receiving health facility	0.00	100.00	94.00
PDOI 6: Percentage of funds received through DHFF by the health facilities that is utilized in the financial year	60.00	100.00	81.00

- *What lessons in advancing gender, voice and equity?*

Geographic equity is a focus of the GFF in Tanzania, with the first nine regions piloting RBF selected based on their *"critical shortages."*[307] GFF has supported disaggregated data by LGA, which has contributed to decision-making and RBF.

Gender-sensitive interventions are a weak point in GFF's engagement thus far as indicated in KIIs: (*"we've had limited engagement on gender"*). While the PAD for the MCHIP program stated that the program has the *"potential to address some of the gender inequities within the health sector that contribute to poor quality care,"* although stated that it needs to be explored further through a health sector gender analysis and support to ensuring that policy development pays adequate attention to gender. BETF TA to support the gender analysis was requested in the October 2022 CES review, but it was declined, stating that they could find support within the MAGE operation.[308] In 2024, it was suggested in the CES review that GFF country staff could engage with MAGE on strengthening gender dimensions of the GFF-supported NHI development.[309] There is no evidence on this progressing.

CSO involvement was also identified as a relatively weak point in the model. While the IC process was described as being highly participatory, a country KI said that there was a *"disconnect"* between this and the *"prioritization of priorities"* co-financed by the GFF under the World Bank operation, during which only the World Bank and the government are sitting in the room.[310] As a result, certain CSO priorities such as demand creation, access barriers, and nutrition services are underfunded. They also felt that they had to engage the GFF, rather than the GFF engaging them.

In addition, despite the GFF's focus on adolescents at the global level, a country KI noted that there were no youth representatives on the CP, potentially limiting integration of adolescent health priorities into the IC and resulting operations. Notably, there have been recent efforts to change this. Following a stakeholder mapping at the end of 2023, a youth representative was invited to sit on the CP.[311]

Any reflections on key findings or implications for the model?

- GFF has primarily succeeded in contributing towards increasing access to care, whereas quality is still lagging. In light of issues with monitoring and achieving results in QoC in the former operation, they have heightened the focus in the current IC and PforR operation.

[307] Strengthening Primary Health Care for Results PAD
[308] FY23 Tanzania CES review 2022.10.03
[309] FY24 Tanzania CES Review 2024.06.04
[310] Country KI
[311] Tanzania Stakeholder Mapping & Engagement Plan, 2023 & RMNCAH TWG membership.

- While the government has an active CP with a platform for data review, engagement of private sector, CSOs, and key donors such as Gavi and the Global Fund is still lacking. Further engagement of the government and development partners is needed due to persistent funding gaps.
- Despite significant gains in MCH, indicators such as stunting, stillbirths, neonatal mortality, and adolescent birth rates are still lagging.
- Continued and heightened investment into advocating for domestic resources for health and promoting efficiency are needed.
- Data quality and use has increased as a result of GFF support, and planned efforts to continue capacity-building and HMIS strengthening are promising.
- Gender is an area of limited GFF engagement and visibility. The potential involvement of MAGE in assisting with gender analyses and strengthening gender dimensions of NHI is promising, but there is no evidence that this has progressed thus far.

Annex 1: Documents reviewed and stakeholders interviewed

Documents reviewed		Year of issue
82.	PAD P152736.pdf	2015
83.	Tanzania-Strengthening-Primary-Health-Care-for-Results-Project.pdf	2022
84.	TZ-SCD-Final-Approved-by-AFRVP-03012017.pdf	2017
85.	P170435 ISR 1.pdf	2023
86.	P170435 ISR 2.pdf	2023
87.	P170435 ISR 3.pdf	2024
88.	Program Paper Document (Additional Financing).pdf	2024
89.	Tanzania Maternal and Child Health Investment Program_PAD_P170435.pdf	2022
90.	2021_2022 Resource Mapping Final report.pdf	2021
91.	Donor Alignment Final Report .pdf	
92.	Phase One Executive Summary (FINAL).pdf	2022
93.	Phase One GFF Recommendations.pdf	2022
94.	Supply side RMNCAH-N Innovation Analysis (FINAL).pdf	2022
95.	TZ inception report Final.pdf	
96.	TANZANIA COUNTRY PLATFORM MEETING.docx	2023
97.	Tanzania_One_Plan_II.pdf	2016
98.	Tanzania-One-Plan-III.pdf	2021
99.	CEF_Tanzania 2023.07.14.docx	2023
100.	CHARTBOOK TANZANIA 2024.pdf	2024
101.	GFF Briefing note for Tanzania for JPU.docx	2023
102.	GFF implementation in Tanzania.pptx	2024
103.	FY24 Tanzania CES Review 2024.06.04.docx	2024
104.	FY23 Tanzania CES review 2022.10.03.docx	2022

Name	Position	Association
Georgina Msemo	Liaison Officer, 1st GFF Government Focal Point	GFF
Maletela Tuoane	Country Focal Point	GFF
Kirsten Gagnaire	Results Specialist	GFF
Dr. Peter Bujari	CEO, Health Promotion Tanzania	CSO
Dr. Ahmad Makuwani	Government Focal Point	Min of Health

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