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**Critical review of the Global Financing Facility  
in two front-runner countries: Kenya & Tanzania**

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Presentation for the Ministry of Foreign Affairs

5 July 2018

# Background

## Wemos

- An independent civil society organization that aims to improve health worldwide

## Methodology of assessment on GFF

- In-depth interviews with national CSOs, international NGOs, professional associations, bilateral donors, and the World Bank in Kenya and Tanzania (May/June 2018)
- Desk review of investment cases, program appraisal documents and NGO reports



# Global Financing Facility (GFF)

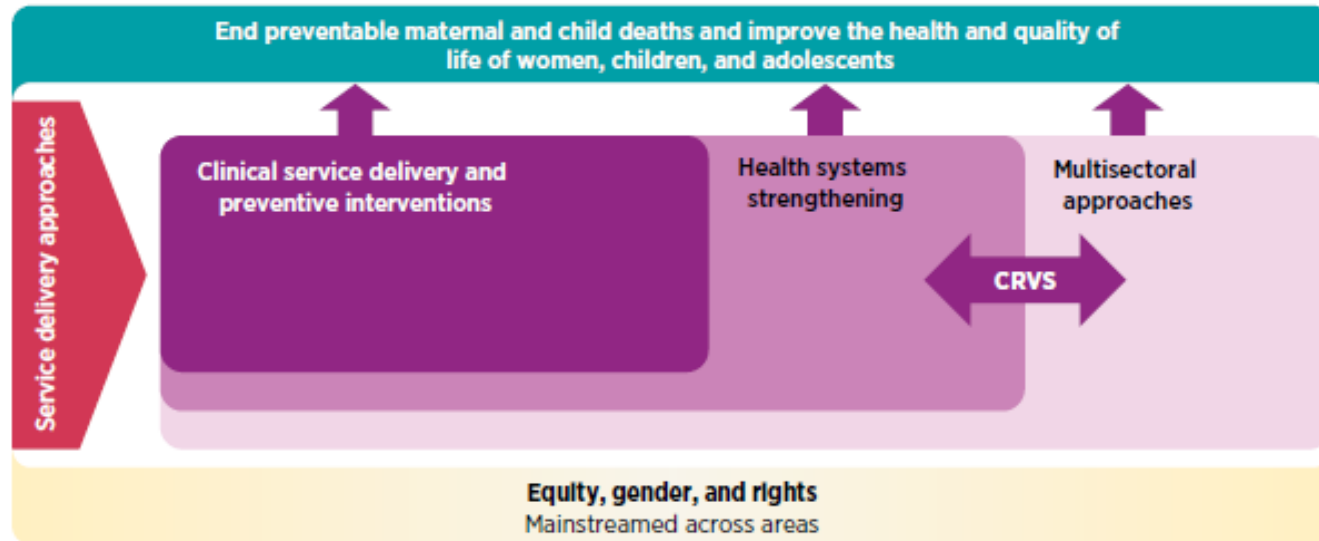
Brief overview



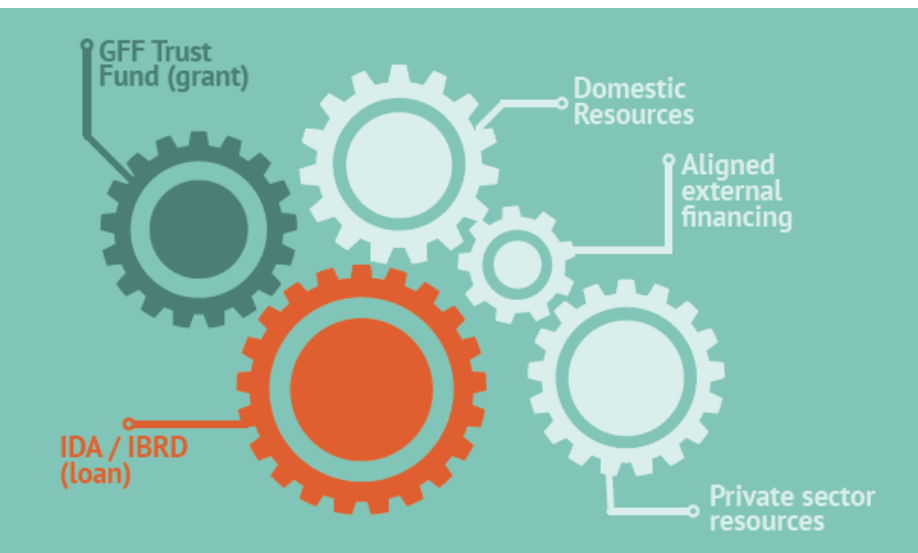
# Global Financing Facility

## Purpose

- Innovative funding model for EWEC
- Close global funding gap in RMNCAH-N (annual \$ 33.3 billion)



## How the GFF works (1/4)



### GFF Trust Fund

- LMIC eligible for financing from GFF-TF (63 countries)
- Condition: IDA-eligible
- between \$ 10 – 60 million for 3-4 years
- Trust Fund capital: \$ 800 million
- Replenishment aim \$2 billion

### IDA Loan

- GFF-TF grants only allocated if countries spend IDA resources on RMNCAH

Source: Mama Ye! Evidence for action

Ratio Grant to Loan: 1:4

## How the GFF works (2/4)

### Domestic resources

- Applying country must show willingness to increase domestic resources for RMNCAH e.g. development of health financing strategy
- IDA loan = domestic resource contribution:  
*GFF Business Plan: “.....increasing IDA/IBRD allocations for RMNCAH represents an important step forward greater domestic financing for RMNCAH.”*

### Aligned external financing

- Contribution of other development partners to Country Investment Case

### Leveraging of private sector capital

- PPPs, private service provision and insurances

## How the GFF works (3/4)

### Investment case

- Nationwide, evidence-based, prioritised plan for RMNCAH-N (3-5 years)
- Developed by Country Platform

### Program Appraisal Document (PAD)

- World Bank develops a PAD for IDA & GFF-TF
- Results-based Financing of high impact interventions

# How the GFF works (4/4)

## Investors Group

- government, ministries (including sub-national government structures), CSOs, private sector, technical agencies providing TA, multilateral & bilateral agencies, foundations



SEVENTH INVESTORS GROUP MEETING  
23 April 2018

[INVESTORS GROUP MEETING REPORT](#)

## Country Platforms

- Country-led and-managed multi-stakeholder platform to coordinate:
  - Development of Investment Case and Health Financing Strategy
  - Resource mobilisation for IC
  - Technical assistance
  - Monitoring and Evaluation



# GFF in Kenya

## Key findings



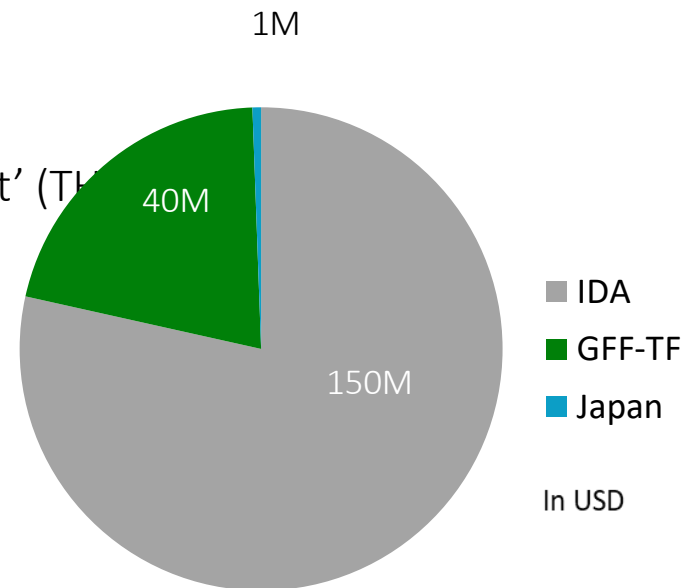
# Kenya: Investment case & Project Appraisal Document

## Program Appraisal Document

- 'Transforming health systems for universal care project' (THS) (UHC)
- June 2016 – June 2021
- Total project cost: \$191 million

## Investment Case

- National RMNCAH Investment Framework
- Counties Annual Health Work Plans = County ICs
- Counties must  $\geq 20\%$  of total budget to health
- GFF initially for RMNCAH-N needs in 20 high burden counties, now all 47 counties



# Setup of GFF in Kenya

## Financing Model

- Counties receive GFF funds in “Special Purpose Accounts” (established for the GFF)
- GFF funds are ‘non-conditional’
- Disbursement is based on performance indicators
- Health Financing Strategy still under development

## Technical Assistance

- Additional World Bank Executed RMNCAH Multi-Donor Trust Fund (USAID, DANIDA, DFID)
  - Hands on operational support

# Coordination and engagement in Kenya

## Country platform

- New Inter-Agency Coordination Committee (ICC) for RMNCAH-N
- GFF progress – standard agenda item

## CSO representation

- Initially GFF handpicked US NGO as representative
- Criticism resulted in development of Minimum Standards for CSO Engagement
- Official CSO focal point: HENNET (Health NGO Network)
- MoH values CSOs but there is very limited engagement with MoF

# Kenya: Progress

## Disbursements

- Late disbursement to county level
- Low absorption capacity at county level
- All counties received seed funding from GFF-TF (Dec 2017)

## Monitoring

- 2nd Scorecard to monitor GFF progress under development
- CSO engagement at national level, but not at county level

# GFF in Tanzania

## Key findings



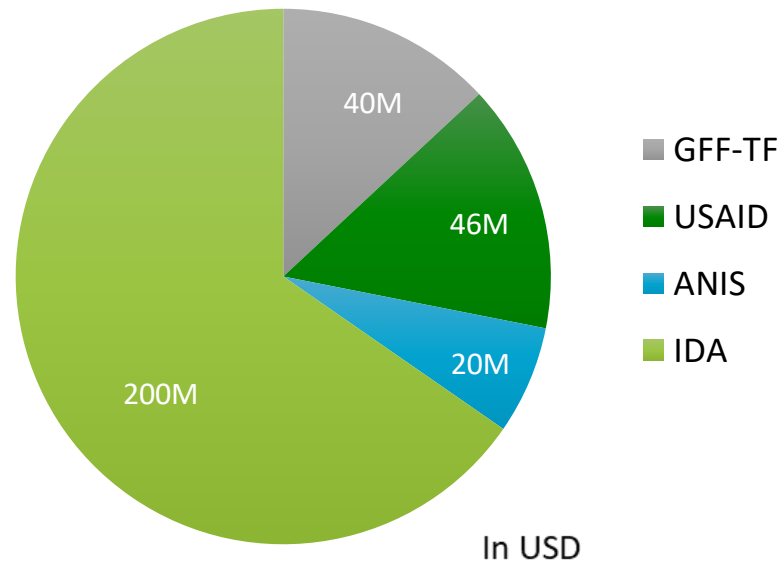
# Tanzania: Investment case & PAD

## Program Appraisal Document

- 'Strengthening Primary Health Care for Results Program' (PHC4R)
- May 2015 – June 2021
- The PAD preceded the Investment Case

## Investment case: ONE PLAN II (2016-2020)

- The pre-existing *National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child and Adolescent Health in Tanzania (2016-2020)*



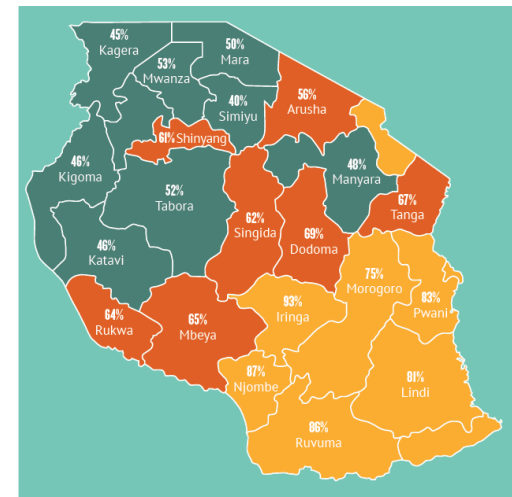
# Setup of GFF in Tanzania

## Financing model

- GFF funds are disbursed at different levels (nation, regional, district, facility)
  - Most is for service delivery sent directly to facility-based accounts
- Disbursement is based on performance indicators
- GFF is not earmarked in the budget as separate budget line
- Draft Health Financing Strategy under review

## Roll out

- GFF implemented in 9 regions (will be rolled out to the other 14 regions)





# Coordination and CSO engagement in Tanzania

## Country platform

- Existing MNCH Technical Working Group (TWG)
- TWGs (total of 11) fall under the SWAP Technical Committee

## CSO representation

- Official CSO focal point: Health Promotion Tanzania
- CSOs represented at TWGs at MoH but limited direct interaction
- Initial engagement on GFF process slow
- Several national CSOs monitor separate components of RMNCAH-N
- CSO engagement at national level, but not at district level

# Tanzania: Progress

## Disbursements

- Only 32% disbursed of PHC4R in 3rd year of implementation (mainly from IDA)

## Preliminary results from World Bank Mid Term Review

- Limited knowledge at facilities of Result Based Financing
- Payment is often disbursed very late
- Data for calculating the disbursements is unstable

## Comparison Kenya – Tanzania

	KENYA	TANZANIA
<b>PAD</b>	No comprehensive RMNCAH plan in place	Based on pre-existing national plans
<b>Financing model</b>	New accounts created for GFF Earmarked GFF funds	Uses existing financial structure GFF Funds not earmarked
<b>MoH engagement</b>	Approachable	Fragmented & unavailable
<b>CSO engagement</b>	Proactive	Passive and reactive
<b>National decision-making processes</b>	WB and MoF (financial) WB and MoH (technical)	
<b>Transparency</b>	Lack of willingness to share information	
<b>Barriers to success</b>	HRH crisis	

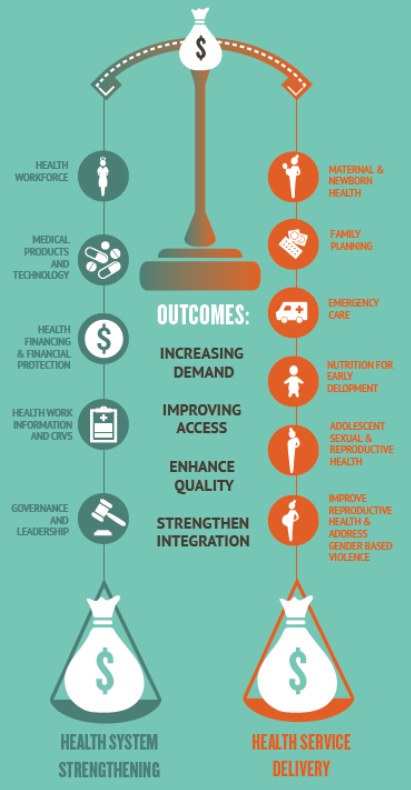
# Key findings

GFF in two front-runner countries: Kenya & Tanzania



## Where is the money going?

High impact interventions across the continuum of care and per level of service delivery.



## Key findings (1/5)

### CSO Engagement needs work

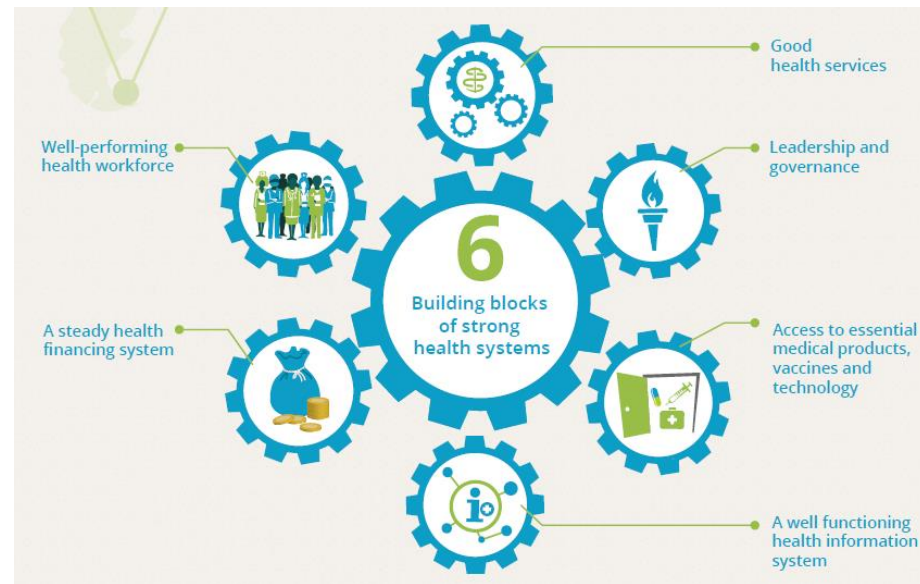
- CSOs that pro-actively demand engagement & accountability are more successful (see Kenya case)
- More funding and technical assistance needed for CSOs to engage, especially at local level
  - GFF small grants mechanism is good start but needs more funding
- GFF is 'learning by doing' and needs critical watchdogs to steer GFF reforms

*Invest the funds necessary for true CSO engagement at all levels*

## Key findings (2/5)

### GFF not fully aligned with Health Systems

- IDA/ grants are issued before plans and structures are ready, e.g.
  - Health financing strategy
  - Country accountability structures
  - Financial risk mitigating measures
- Parallel financial system created (Kenya)
- HRH crisis insufficiently addressed!
  - GFF cannot be used for salaries



*Make health systems strengthening the foundation of RMNCAH-N, not an add-on*

## Key findings (3/5)

### Continuum of Care (CoC) approach is lagging behind

- Insufficient coordination on RMNCAH-N components
- GFF not linked enough to broader UHC movement particularly on the discussion on equity and leaving no one behind
- Indicator selection for RBF is biased



Source: Mama Ye! Evidence for action

*Apply 'integrated health care' indicators to measure and steer CoC results*

## Key findings (4/5)

### Insufficient attention to risks of GFF financial model

- Recipient governments use loan to increase domestic resources from RMNCAH-N
- Broader development partner group do not sufficiently address issue of impact of loan on fiscal space
- 'Economic literacy' of CSOs to be able to engage with MoF is poor

In the **short term**, IDA loan increases fiscal space for health but:

- Can take away incentives to increase domestic resources from other sources
- could lead to reallocation domestic health funds to other sectors

In the **long run** it **decreases** fiscal space because of debt servicing

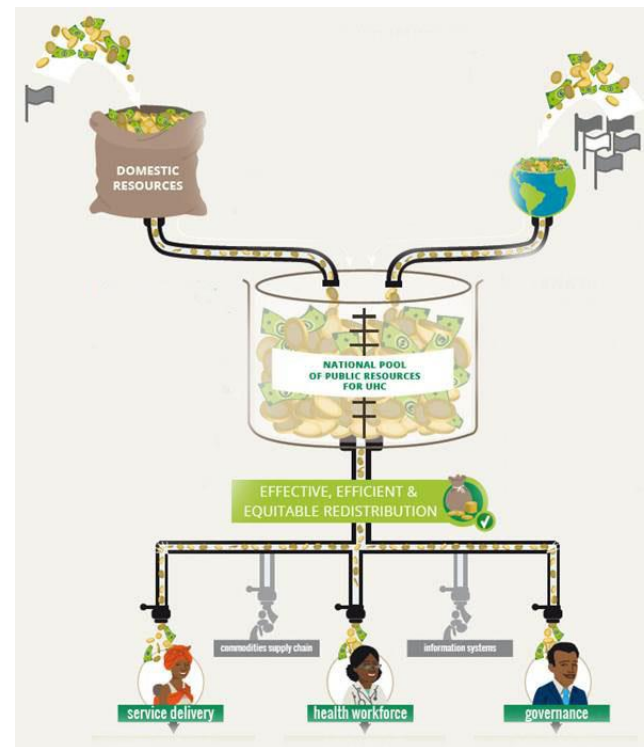
*Critically address short and long term risks of loan on fiscal space*



## Key findings (5/5)

There is limited coordination between other bi- & multilateral donors

- Lessons of GAVI & GFATM not applied
- Limited information sharing outside immediate GFF network
- Ideally, health financing from all sources (including GFF) should be pooled and pushed through government systems



*Integrate the GFF in the Sector Wide Approach (SWAp) for Health*

## Concluding remarks:

*“The GFF is a big animal that needs to be tamed”*

### Gap between GFF design and implementation

- Objectives and principles of GFF are sound
- Implementation is rushed, without enough consideration for risks and lessons-learned

### Future funding for the Continuum of Care

- Increased funding (domestic and external) for a true CoC approach is crucial, but must:
  - Be more driven by relevant recipient government ministries, beyond MoF
  - Be embedded in strong government policy and structures
  - Have active involvement of development partners/ investors in necessary GFF reforms
  - Foster true CSO engagement in technical and financial discussions