CONCEPT NOTE

# A Global Financing Facility in Support of Every Woman Every Child

■ September 25, 2014

# TABLE OF CONTENTS

# ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| AIDS | acquired immunodeficiency syndrome |
| CRVS | civil registration and vital statistics |
| CSO | civil society organization |
| DFID | Department for International Development |
| DRC | Democratic Republic of Congo |
| EPMCD | ending preventable maternal and child deaths |
| EWEC | Every Woman Every Child |
| GFATM | The Global Fund to Fight AIDS, Tuberculosis and Malaria |
| GFF | Global Financing Facility |
| HIV | human immunodeficiency virus |
| HRITF | Health Results Innovation Trust Fund |
| IBRD | Int'l. Bank for Reconstruction and Development |
| IDA | International Development Association |
| iERG | Independent Expert Review Group |
| IHP+ | International Health Partnership |
| IMCI | integrated management of childhood illness |
| LIC | low-income country |
| LMIC | lower-middle-income country |
| MDG | Millennium Development Goals |
| MDSR | maternal death surveillance and response |
| MIC | middle-income country |
| MNCH | maternal, newborn and child health |
| NGO | non-governmental organization |
| P4H | Providing for Health - Social Health Protection Network |
| PMNCH | Partnership on Maternal, Newborn and Child Health |
| PMNCH | Partnership for Maternal, Newborn and Child Health |
| RBF | results-based financing |
| RMNCAH | reproductive, maternal, newborn, child and adolescent health |
| SDG | Sustainable Development Goals |
| TB | tuberculosis |
| UMIC | upper-middle-income country |
| UN | United Nations |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| USAID | U.S. Agency for International Development |
| WBG | World Bank Group |
| WHO | World Health Organization |

# EXECUTIVE SUMMARY

As the world approaches the 2015 deadline for the Millennium Development Goals (MDGs), the enormous progress that has been made in improving maternal and child health is becoming evident. However, despite the progress, it is equally clear that more remains to be done: far too many newborns, children, adolescents and women die of preventable conditions every year, and far too few have reliable access to quality health services.

There is now an unprecedented global momentum to further accelerate improvements in Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH). Through key global partnerships such as the Partnership on Maternal, Newborn and Child Health (PMNCH), the G8 Muskoka Initiative, Committing to Child Survival: A Promise Renewed and the United Nations Secretary-General's Every Woman Every Child (EWEC) movement, the importance of women's and children's health have been put at the center of global development efforts. Building on this momentum, there is now strong support for the concept of "convergence": accelerating progress in improving the health and quality of life of women, children, and adolescents so that all countries achieve the levels reached by the best-performing middle-income countries. The global interest in RMNCAH is an opportunity to make a final push on the MDGs and ensure a solid foundation for the post-2015 work. To take advantage of this opportunity and ensure more rapid acceleration toward the 2030 convergence targets, these following challenges will need to be addressed:

- Significant additional investments are needed from both domestic and international resources to close the funding gap of US$5.24 per capita in 74 high-burden countries in 2015;
- Financing arrangements undermine equitable and sustained progress as countries transition from low- to middle-income status;
- The state of civil registration and vital statistics systems remains poor;
- Global public goods are inadequately financed;
- Fragmented financing and governance cause high transaction costs, hindering progress at the country level.

This Concept Note argues that a Global Financing Facility (GFF) in support of Every Woman Every Child can help drive the transformative change needed to prepare the

road to convergence on RMNCAH. The overall goal of the GFF will be to contribute to the global efforts to end preventable maternal, newborn, child and adolescent deaths and improve the health and quality of life of women, adolescents and children. It is estimated that compared with current trends, an accelerated investment scenario would help prevent a total of 4 million maternal deaths, 107 million child deaths, and 22 million stillbirths between 2015 and 2030 in 74 high-burden countries.[1]

The GFF will mobilize and channel additional international and domestic resources required to scale up and sustain efficient and equitable delivery of quality RMNCAH services. Additionally, the GFF will support the transition to long-term sustainable domestic financing for RMNCAH. A special focus area for the GFF will be to support the scale up of civil registration and vital statistics (CRVS) systems to contribute to universal registration by 2030.

The GFF has five objectives:

1. Finance national RMNCAH scale-up plans and measure results;

2. Support countries in the transition toward sustainable domestic financing of RMNCAH;

3. Finance the strengthening of civil registration and vital statistics systems;

4. Finance the development and deployment of global public goods essential to scale up;

5. Contribute to a better-coordinated and streamlined RMNCAH financing architecture.

The GFF will facilitate a clear strategy for fully-scaled and smart financing of RMNCAH services in different countries. This strategy will be articulated in a financing roadmap informed by a rights-based, results-focused, fully costed RMNCAH national plan linked to national strategies for health and other sectors. The roadmap will provide a comprehensive picture of a country's immediate and longer-term RMNCAH resource needs and will outline strategies to mobilize the requisite domestic (public and private) and international (bilateral and multilateral) funding over time. The aim is to harmonize funding for RMNCAH plans through a common country financing framework which is linked to clear results and backed by common accountability and reporting mechanisms. The financing roadmaps will be linked to longer-term planning that strengthens domestic resource mobilization and diversifies modalities of development assistance in line with a country's rate of economic growth.

1 South Sudan was excluded from the analysis due to lack of data.

The GFF will also position itself as a major investor in the financial roadmap through mobilization of development assistance. Specifically, it will build on the existing Health Results Innovation Trust Fund (HRITF) at the World Bank that offers excellent leverage of International Development Association (IDA) and International Bank for Reconstruction and Development (IBRD) resources, good value-for-money in terms of achieving RMNCAH results and low administrative costs. In addition, through a dedicated financing window, the GFF will support the strengthening and scaling-up of CRVS plans contributing to the universal registration of every pregnancy, every birth and every death by 2030. Other financing windows are also envisaged for "multi-sectoral", "multi-lateral" and "market-shaping" investments.

Three discrete governance capabilities need to be put in place for the further development of the GFF. One relates to the need for effective convening around the development and implementation of the country financing roadmaps. A second relates to the operations and further development of the GFF windows. And a third relates to the need for an umbrella stewardship that convenes stakeholders, forges consensus amongst domestic and international financiers, reviews progress, and recommends actions to accelerate the achievement of results. With an agreement on the objectives and functions of the GFF, a collaborative business planning process is anticipated in the coming months. The World Bank will play a convening role for the GFF, working with partners to further design and operationalize the GFF in the lead-up to a formal launch in mid-2015.

# INTRODUCTION

This Concept Note lays out the high-level **rationale for and objectives of a proposed Global Financing Facility (GFF) for reproductive, maternal, newborn, child and adolescent health (RMNCAH) in support of Every Woman Every Child**. It describes suggested financing priorities of the facility, proposed country groupings to benefit from support, and how the facility will collaborate with partners to simplify RMNCAH financing at the country level. Finally, it provides key principles to guide GFF governance, a sequenced approach for defining GFF governance and institutional arrangements and outlines how these will interact with and help streamline the existing RMNCAH financing architecture.

The Concept Note was developed under the guidance of the GFF Working Group, which included a broad range of partners and was chaired by the Government of Norway, the United States Agency for International Development (USAID) and the World Bank (see Annex 1 for membership). It marks the beginning of and provides the foundation for a consultative process over the coming months to develop in more detail the strategic approach, operational design and governance for the GFF. These will be summarized in a GFF business plan, with the aim of launching a fully operational GFF by September 2015.

## Background

As the world approaches the 2015 deadline for the Millennium Development Goals (MDGs), the enormous progress that has been made in improving reproductive, maternal and child health is becoming evident. The under-five mortality rate and maternal mortality ratio – key indicators for MDGs 4 and 5 – have both dropped dramatically, from 90 deaths per 1,000 live births in 1990 to 46 in 2013 and from 380 deaths per 100,000 live births in 1990 to 210 in 2013.[2] This success makes it conceivable that preventable deaths can be averted and the health and quality of life of women and children improved within a generation.

However, despite this progress, it is equally clear that more remains to be done. Far too few women, newborns, children, and adolescents have reliable access to quality health services and too many die of preventable causes every year. Annually, 6.6 million children still die before the age of 5, of which 2.9 million are newborn babies in the first month of life. Many children still die from easily preventable diseases, such as malnutrition (the underlying cause of 45 percent of all under-five deaths), pneumonia and diarrhea. For those children who survive, malnutrition can jeopardize their

2 WHO, UNICEF, UNFPA, UNPOP and the World Bank (joint publication). (2014). Trends in Maternal Mortality: 1990 to 2013.

potential for optimal growth and development, with significant consequences later in life. Malaria, HIV and AIDS further cause significant deaths in high-burden countries.

The leading causes of maternal mortality—heavy bleeding, high blood pressure, infections and unsafe abortion—are, to a large extent, preventable. Ensuring the availability of certain services—such as family planning, prenatal care, skilled care at birth, reproductive health care after delivery and a range of services for adolescents—is key to preventing maternal deaths and improving the quality of life for woman and children. Some 11 percent of all births worldwide are to girls aged 15 to 19 years, and the vast majority of these births are in low- and middle-income countries. Complications linked to pregnancy and childbirth are the second most common cause of death for 15-19-year-old girls globally. Access to services for contraception, prevention and management of sexually transmitted diseases and care in pregnancy are key to better health and quality of life for adolescents. However, coverage for many of these interventions remains low in many countries. Further, coverage for many high-impact essential health services is unevenly distributed across the world, with sub-Saharan Africa and South Asia lagging in particular.

Within-country distribution also remains uneven, with insufficient progress on equity dimensions such as wealth, gender, age, maternal education, ethnicity, and urban/rural residence. Achieving meaningful progress in reproductive, maternal, newborn, child and adolescent health requires delivering essential health services to all population groups. Further, as more mothers choose to come to health facilities to give birth, they need to be treated with respect and dignity, and given high quality care. Otherwise, even advances in coverage may not translate into good health outcomes.

The growing global interest in RMNCAH is an opportunity to make a final push on the MDGs and ensure a solid foundation for post-2015 work. In order to take advantage of this opportunity, a number of challenges will need to be addressed to ensure more rapid acceleration toward the 2030 convergence targets.

## Significant additional investments are needed from both domestic and international resources to close the funding gap

International donor financing for RMNCAH has increased significantly over the past decade. Bilateral and multilateral disbursements to the 75 highest-burden countries (Annex 2) reached an estimated US$9-9.5 billion in 2011, an increase of more than 70 percent compared with 2006. Between 2009 and 2012 an estimated total of US$38 billion was disbursed to these countries. Of this amount, 66 percent was channeled via bilateral programs and 34 percent via multilateral instruments. In addition, the Bill & Melinda Gates Foundation provided US$3 billion in private grants for RMNCAH to the 75 highest-burden countries.

Data on domestic financing for RMNCAH are much poorer than those for international

financing, but it is estimated that nearly US$60 billion of domestic government resources was spent on RMNCAH in 2012 in the Countdown to 2015 countries.[3] Despite these increases in both international and domestic financing, a significant financing gap remains for the financing of the Global Strategy.

The **Global Investment Framework for Women's and Children's Health**[4] and the **Lancet Commission on Investing in Health**[5] have both shown that financing will need to increase significantly over the coming 15 years to achieve the levels of coverage and improvements in the health status of women and children reflective of levels currently reached by the best-performing countries. Both reports argue that investments in the so-called **"grand convergence"** will yield high economic returns and societal gains such as enhanced political and social capital.

By building on and combining key elements of these two efforts, further modeling was undertaken for this Concept Note. The aim was to estimate the resources needed to scale up to a high-coverage scenario, the potential contributions from domestic financing, and the remaining resource gap for the 75 high-burden countries currently being tracked under the Countdown to 2015 initiative.[6] Resource needs estimates from the Global Investment Framework were adjusted for a number of additional factors including inflation and the purchase and scale-up of new technologies, based on methods used by the Commission on Investing in Health. Domestic financing flows were estimated using a similar approach to that taken by the Commission on Investing in Health. All estimates were projected through 2030. The methodology is described in Annex 3.

The projected resource gaps peak early in the period, when an estimated US$28-30 billion of additional financing is needed, in large part due to up-front health systems strengthening investments (particularly in low-income countries) that are the necessary foundation for convergence. By 2030, the total additional financing gap is projected to fall considerably to about US$8 billion, or US$1.23 per person (down from US$5.24 per person in 2015), due to a combination of increased domestic financing and reduced health systems strengthening costs, as shown in Figure 1.

Nearly the entire resource gap occurs in the 63 Countdown countries classified as low-income (LIC) and lower-middle-income (LMIC). In 2015, the projected resource gap for these countries is US$27.2 billion, falling to US$7.2 billion by 2030. In per-capita terms, this translates into a resource gap of US$7.68 per person in 2015 and US$1.69 in 2030. Resource gaps remain particularly large in LICs, where only about half of the US$11 billion needed in 2030 is projected to be met by domestic government expenditures, leaving a gap of US$5.4 billion, or US$4.60 per person.

---

3 Partnership for Maternal, Newborn, and Child Health. (2014). PMNCH Accountability Report 2014.

4 Stenberg, K. et al. (2014). Advancing social and economic development by investing in women's and children's health: a new Global Investment Framework. *The Lancet*, 383: 1333-54.

5 Jamison, D.T. et al. (2013). Global health 2035: a world converging within a generation. *The Lancet*, 382: 1898-955.

6 http://countdown2015mnch.org/. South Sudan is a Countdown country but has not been included because of insufficient data.

## All Coundown Countries

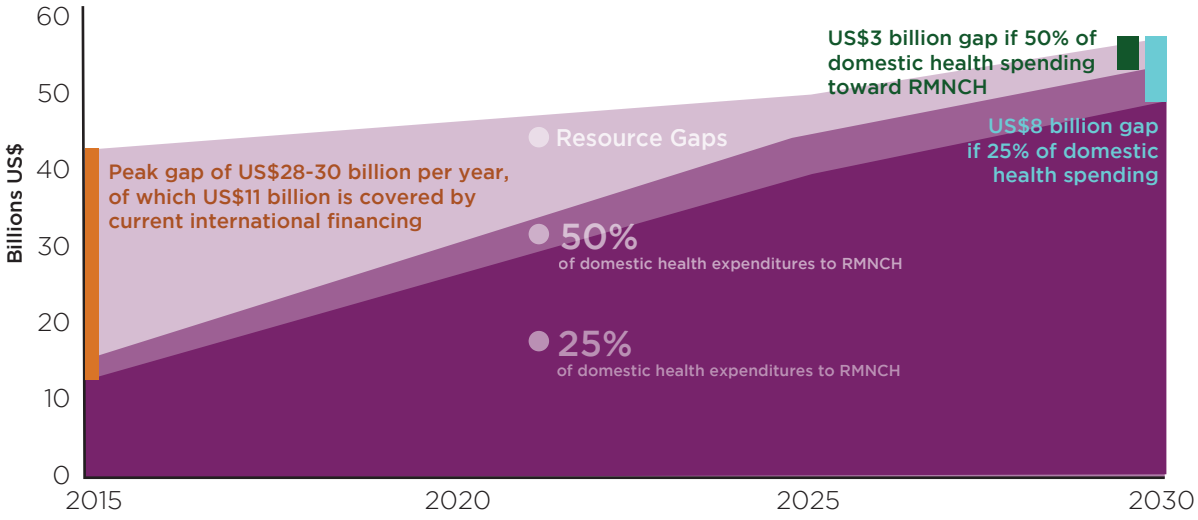
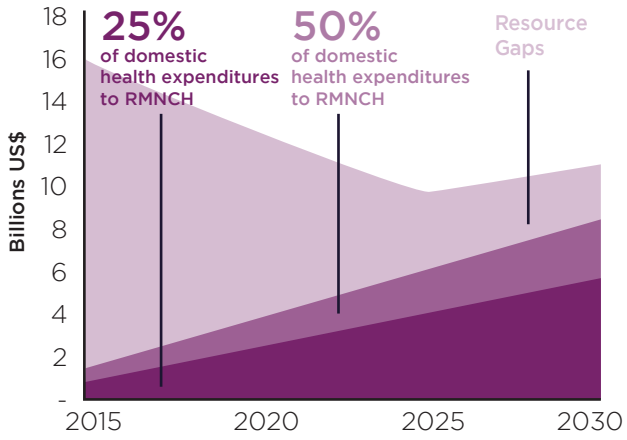



**Figure 1:** Resource needs to reach convergence and the role of domestic financing in the closing gap

Figure 1 highlights an important consideration in interpreting these numbers: the domestic financing estimates are sensitive to the share of domestic health financing allocated to RMNCAH. In the base case, this share is taken as 25 percent, which is an estimate developed from the Countdown to 2015 process and used by the Global Strategy. If this increases to 50 percent – a share that may be more appropriate for many countries given the high burden of disease related to RMNCAH – the financing gap drops to under US$3.5 billion in 2030.

## Low-Income Countries




## Lower-Middle-Income Countries

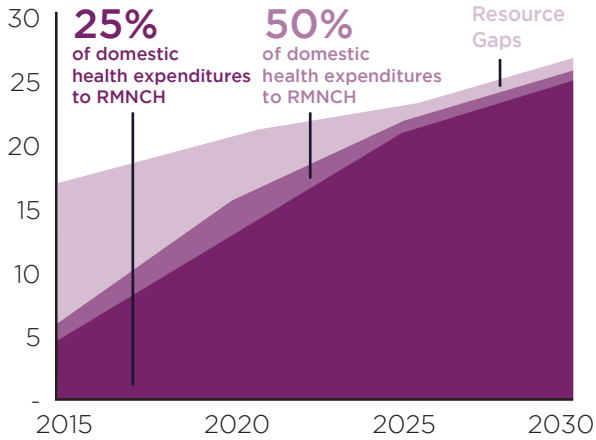



**Figure 2:** Resource needs to reach convergence and the role of domestic financing in the closing gap

Figure 2 shows that the financing gap varies considerably by income level, with middle-income countries (MICs) better positioned to assume progressively larger shares of RMNCAH financing. For the 63 low- and lower-middle-income countries overall, the resource gap is estimated at just over US$7 billion by 2030 (down from US$27 billion in 2015). Should a higher proportion (50 percent) of government health expenditures be allocated to RMNCAH, the resource gap will close further, to US$2.6 billion for LICs and US$0.8 billion for LMICs.

It should be noted that these estimates are highly sensitive to economic growth. Domestic financing estimates are based on projections of continued high growth in most LICs and MICs. Should the recent trend of rapid economic growth in low- and middle-income countries begin to slow, domestic financing flows could drop considerably.

These projections highlight the fact that without a significant increase in financing from both international *and* domestic sources, the goal of convergence will remain out of reach. The scale of the challenge suggests that new approaches are needed, as incremental increases in existing mechanisms will be insufficient to close the gap.

## Financing arrangements undermine equitable and sustained progress as countries transition from low- to middle-income status

Most countries in the world are experiencing a transition in health financing characterized by an increase in health expenditures and a rising share of government spending due to a combination of economic growth and changing political priorities. The health financing transition, however, is often not a steady process but rather an uneven one with particular challenges for economies undergoing the transition from low-income to middle-income status. As RMNCAH constitutes a large share of health expenditures in low- and lower-middle-income countries, these general health financing challenges impede progress and jeopardize early gains made toward the 2030 goals.

At the onset of this transition – when still classified as low-income – countries tend to rely heavily on international support. This assistance, however, often reduces domestic funding for health—on average, each additional dollar of development assistance for health diminishes domestic financing by approximately 50 cents.[7] This pattern leaves countries unprepared for the challenges they face as economic growth propels them into lower-middle-income status. Most importantly, during this transition, the link between income growth and increases in total and government expenditure on health is weakest when the countries attain lower-middle-income status. For example, while every percentage point increase in economic growth

7 Lu, C., Schneider, MT., Gubbins, P et al. (2010). Public financing of health in developing countries: a cross-sectional systematic analysis. *The Lancet*, 375 (9723): 1375-1387.
-Farag, M., Nandakumar, A. K., Wallack, S. S., Gaumer, G., Hodgkin, D. (2009). Does funding from donors displace government spending for health in developing countries? *Health Affairs*, 28: 1045–1055.

translates into a 1.18 percentage point increase in government expenditure on health in LICs and 0.54 percentage points in upper middle-income countries (UMIC), it is only 0.37 percentage points in LMICs. It is therefore likely that governments of LMICs fail to effectively compensate for potential decreases in development assistance. As a consequence, out-of-pocket spending increases and households bear a large share of the financing burden. In both lower- and upper-middle-income countries, unprecedented levels of total and government expenditures on health mask drastic differences in spending across population groups. These inequalities in spending imply significant differences in access to services and financial protection, to the detriment of the poor.

## The efficiency of RMNCAH investments is suboptimal

Much attention in recent years has focused on making RMNCAH resources go further and maximizing value for money.[8] Significant progress has been made in developing a consensus on the essential RMNCAH intervention packages that should be prioritized in country planning, and technical partners are working with countries to ensure this is reflected in national plans. Despite this progress, many RMNCAH plans have suboptimal targeting and insufficient prioritization of evidence-based, high-impact interventions.[9] Further, some aspects of the continuum of care and some populations have received inadequate investment. Reproductive, newborn and adolescent health have been notably under-prioritized compared to their relative burden and potential for impact. RMNCAH interventions are frequently hampered by bottlenecks in the health system, such as insufficient human resources for health.[10] The implementation of RMNCAH programs can be enhanced by improving efficiency in the delivery of services through innovative mechanisms including results-based financing.[11] Finally, inequity between rich and poor populations is more pronounced with regard to RMNCAH services than with any other health area. Although increases in health services coverage have been in general pro-poor[12], this has not always translated into better health outcomes for poor people, possibly pointing to a poor/ rich divide in the quality of health services provided. Efforts to improve RMNCAH will need to address this, and measurement of progress by socioeconomic status will be essential. Improving the health impact of existing resources is an important measure to be considered alongside further increases in financing for RMNCAH.

8 The World Bank. (2013). Using Results-Based Financing to Achieve Maternal and Child Health: Progress Report 2013. Available from http://rbfhealth.org/progressreport2013

9 Bhutta, Z.A. et al. (2014). Can available interventions end preventable deaths in mothers, newborn babies, and stillbirths, and at what cost? *The Lancet*, 384(9940): 347-370.

10 Dickson, K.E., et al. (2014). Every newborn: health-systems bottlenecks and strategies to accelerate scale-up in countries. *The Lancet*, 384(9941): 438-454.

11 Basinga, P. et al. (2011). Effect on maternal and child health services in Rwanda of payment to primary health-care providers for performance: an impact evaluation. *The Lancet*, 377(9775): 1421-1428.
–Gertler, P., Giovagnoli, P., & Martinez, S. (2014). Rewarding provider performance to enable a healthy start to live: Evidence from Argentina's Plan Nacer. The World Bank, Policy Research Working Paper 6884.

12 Wagstaff, A., Bredenkamp, C., & Buisman, L.R. (August 2014). Progress on Global Health Goals: are the Poor Being Left Behind? *World Bank Research Observer.*

## Poor state of civil registration and vital statistics (CRVS) systems

Civil registration and vital statistics (CRVS) systems are acknowledged as a critical platform for promoting women and children's health.[13] Strong CRVS systems are critical for safeguarding people's rights and those of their children. They are crucial for development and accountability, particularly in health, as well as for generating information on vital events (births, deaths and cause of death), population trends and the overall well-being of the population, especially maternal and child health. CRVS systems are also important for effective policymaking and long-term national planning, efficient resource allocation and accurate evaluation and monitoring. These systems will be an important support to accelerating RMNCAH improvements and investments.

Yet over 100 developing countries lack well-functioning CRVS systems. Around the world, almost 230 million children under the age of five are not registered.[14] Despite the critical need for information about mortality, progress with death registration has been slow globally, with up to 80 percent of deaths that occur outside of health facilities and two-thirds of all deaths globally not counted.[15] Both demand-side and supply-side challenges explain the current poor state of CRVS systems. These challenges include poor coordination among various ministries and development partners responsible for CRVS and development partners, lack of needed infrastructure and capacity at the country level, absence of necessary legal frameworks and limited awareness among people on the importance of registration.

Yet the transformative potential of effective CRVS systems has been recognized by many partners and fora, such as the UN Commission on Information and Accountability for Women's and Children's Health. The multi-stakeholder workplan to implement the Commission's recommendations has identified strengthening CRVS and maternal death surveillance and response (MDSR) as priority areas in 75 countries. Recent global momentum has been achieved through regional and global partnerships, as well as critical country partnerships. The health sector is acknowledged as a good entry point for the development and strengthening of CRVS systems, with RMNCAH systems acknowledged as both a beneficiary of and contributor to strengthening.[16] Health provides a major entry point for scaling up birth and death registration through innovative approaches (e.g. linking birth registration and MNCH tracking and immunization, mortality reporting through community health

13 Commission on Information and Accountability for Women and Children's Health (2011) Keeping Promises, Measuring Results. http://www.everywomaneverychild.org/images/content/files/accountability_commission/final_report/Final_EN_Web.pdf

14 UNICEF. (2013). United Nations Children's Fund. A Passport to Protection: A guide to birth registration programming.

15 World Bank-WHO (2014) Global Civil Registration and Vital Statistics Scaling up Investment Plan 2015–2024. http://www.worldbank.org/en/topic/health/publication/global-civil-registration-vital-statistics-scaling-up-investment

16 WHO 2013 Strengthening CRVS through Innovative Practice sin the Health Sector: Guiding Principles and Good Practices, http://www.who.int/healthinfo/civil_registration/crvs_meeting_dec2013_report.pdf?ua=1

workers). It can be the sector responsible for birth notification and cause of death information and it is one of the main investors in and users of vital statistics.

## Inadequate provision of global public goods

Global public goods such as research and development, market shaping, disease surveillance, and international norms and standard setting are components critical to making health systems work, but, in the words of the Commission on Investing in Health, "the serious underfunding of global public goods… has now reached a crisis point." [17] Two examples are measurement and access to commodities. The Commission on Information and Accountability for Women's and Children's Health and the UN Commission on Life-Saving Commodities for Women's and Children's Health developed a set of recommendations in these areas. Most of these recommendations still need to be implemented.

## Fragmented financing and governance cause high transaction costs, hindering progress at the country level

Since the launch of the UN Secretary-General's "Global Strategy for Women's and Children's Health" and the G8 Muskoka Initiative on Maternal, Newborn and Child Health, both in 2010, more than 300 stakeholders have made a broad range of financial and non-financial commitments to support the Global Strategy. Some bring an in-depth focus to specific elements of the RMNCAH Continuum of Care (such as the Child Survival Call to Action – A Promise Renewed; the Global Action Plan for Newborns; the Global Action Plan for Pneumonia and Diarrhoea). Others address key elements of the underlying RMNCAH architecture in cross-cutting ways, such as the UN Commission on Information and Accountability and the RMNCH Steering Committee. The Partnership for Maternal, Newborn and Child Health (PMNCH), established in 2005, brings together more than 600 members to catalyze collective action for RMNCAH.

The recent review of the Every Woman Every Child (EWEC) accountability work (August 2014) listed a multitude of different financing mechanisms for RMNCAH, including Family Planning 2020, the H4+ Partnership, the Health Results Innovation Trust Fund, the Thematic Trust Fund for Maternal Health, the Global Program to Enhance Reproductive Health Commodity Security, the US Fund for UNICEF, the Bridge Fund, the Pledge Guarantee for Health and the RMNCH Trust Fund.

Recent years have seen an increased focus on better coordination of the multitude of initiatives in the RMNCAH ecosystem and increased transparency, especially relating to financing flows to countries. In 2011 and 2012, PMNCH proposed options

17 Jamison, D.T. et al. (2013). Global health 2035: a world converging within a generation. *The Lancet*, 382: 1910.

for strengthening the global financing architecture and then led a multi-stakeholder process that included in-depth thinking around a pooled financing facility for RMNCAH. In 2013, the RMNCH Steering Committee, supported by the RMNCH Strategy and Coordination Team, was created as a platform to better harmonize and coordinate international financing and reporting, and strengthen alignment with country plans, working closely with the H4+.

However, despite the recent efforts to strengthen coordination, the multitude of financing initiatives still causes fragmentation in financing streams at the country level. National governments routinely devote considerable resources to managing multiple parallel initiatives and the associated planning and reporting needs of the multiple partners supporting RMNCAH services. Additionally, it remains hard to track donor financing to RMNCAH and to drive accountability for commitments made. Fragmentation also leads to suboptimal distribution of resources globally. Some countries receive disproportionately high levels of support while others are "donor orphans".

# GOALS, PRINCIPLES AND OBJECTIVES FOR A GLOBAL FINANCING FACILITY

The unprecedented level of global support for RMNCAH provides an opportunity to step up efforts and achieve the ambitious but realizable goal of "convergence" by 2030. If this goal is to be attained, decisive action is needed now to overcome the challenges outlined above. Simply strengthening, expanding or coordinating current initiatives is unlikely to bring the transformative impact required to reach the convergence goal.

This Concept Note outlines a proposal for a Global Financing Facility for RMNCAH to help drive the transformative change needed to prepare the road to convergence. The overall goal of the GFF will be to contribute to the global efforts to end preventable maternal, newborn, child and adolescent deaths and improve the health and quality of life of women, adolescents and children. It is estimated that compared with current trends, an accelerated investment scenario would help prevent a total of 4 million maternal deaths, 107 million child deaths, and 22 million stillbirths between 2015 and 2030 in the Countdown to 2015 countries (excluding South Sudan). In terms of economic benefits, the Global Investment Framework estimates that scaling up intervention coverage would yield high rates of return, producing up to nine times the economic and social benefit by 2035.[18] It also emphasizes that health gains can lead to wider societal gains in areas such as education, environment, gender equality and human rights, and that these can, in turn, lead to health benefits.

18 Stenberg, K. et al. (2014). Advancing social and economic development by investing in women's and children's health: a new Global Investment Framework. *The Lancet*, 383: 1333-54..

To reach the targets set, investments are needed in key interventions as well as in key enablers such as laws and policies, improved health systems performance, community engagement and innovations. In addition, investments are required in cross-sectoral issues such as gender, equity and human rights. The conceptual framework developed for the Global Investment Framework outlines the key enablers and interventions leading to lives saved and healthy lives[19] and is attached in Annex 4.

Consistent with the recommendations of the Global Investment Framework and the Commission on Investing in Health, the GFF will mobilize and channel additional international and domestic resources required to scale-up and sustain efficient and equitable delivery of quality RMNCAH services. Additionally, the GFF will support the transition to long-term sustainable domestic financing for RMNCAH. A special focus area for the GFF will be to support the scale-up of CRVS to contribute to the universal registration of every birth, death and cause of death as a platform for accelerating improvements in RMNCAH by 2030.

The principles of the GFF are based on existing agreements on principles of cooperation among key RMNCAH stakeholders (such as those adopted by the PMNCH Board[20]):

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

The GFF will concentrate on five objectives:

1. Finance national RMNCAH scale-up plans and measure results;

19 Stenberg, K. et al. (2014). Advancing social and economic development by investing in women's and children's health: a new Global Investment Framework. *The Lancet*, 383: 1333-54.

20 http://www.who.int/pmnch/about/governance/board/members/en/

2. Support countries in the transition toward sustainable domestic financing of RMNCAH;
3. Finance the strengthening of civil registration and vital statistics systems;
4. Finance the development and deployment of global public goods essential to scale up;
5. Contribute to a better coordinated and streamlined RMNCAH financing architecture.

There are many other needs related to the scale-up of RMNCAH services that the GFF will not attempt to address. Instead, the GFF will work closely with existing stakeholders who are actively working on these issues. For example, the GFF will not play a normative role with regard to technical matters associated with the delivery of RMNCAH services. The technical assistance needed to develop and implement high quality RMNCAH plans will mostly be provided through partners with in-country presence and existing capacity in this area.

The facility will be time-limited and focused on achieving convergence targets by 2030; this reinforces a sense of urgency to achieve results and the prospect of an exit strategy for development partners.

## Objective 1: Finance national RMNCAH scale-up plans and measure results

The first objective of the GFF is to facilitate a clear strategy for fully-scaled and smart financing of RMNCAH services in each country. This strategy will be articulated in a "financing roadmap" informed by a rights-based, results-focused, fully-costed RMNCAH national plan linked to strategies for health and other sectors[21] and aligned with country planning cycles. The process of articulating these roadmaps will be fully inclusive – comprising the government, private sector[22], civil society, and development partners – with a strong focus on the needs of vulnerable populations. The roadmaps will be guided by a robust financing framework that includes core financing functions related to resource mobilization, allocation, purchasing, payment and accountability with the aim of achieving universal and equitable access to quality services without financial barriers or compromise to users.

The financing roadmaps will place a priority on domestic resource mobilization from public and private sources and explicitly look at new or innovative approaches.

21 Given the already significant mobilization of the RMNCAH and health partners at the country level, the GFF will align with these efforts and provide support where appropriate to strengthen national planning efforts around RMNCAH.

22 For more information on the role of the private sector refer to Annex 5.

Development assistance that contributes to the full financing of RMNCAH strategies[23] will also be accounted for in these roadmaps, irrespective of whether it is directed through direct contributions in countries by bilateral aid agencies (USAID, DFID etc.) or multilateral channels (GFATM, Gavi, World Bank). The total resources to be mobilized will be based on costed, evidence-based, "best-buy" intervention packages covering the full continuum of health services, and will be inclusive of the costs of the necessary health system inputs such as infrastructure and human resources. Recognizing that sectors beyond health such as education and social protection are critical areas for investment to achieve RMNCAH goals, the GFF will advocate for and facilitate "multi-sectoral" financing opportunities. Insofar as there are sub-national distributions, these will reflect differential RMNCAH needs. Purchasing arrangements of services will draw on growing evidence of the better value-for-money that is being achieved through results-based financing, paying for results, vouchers, cash transfers and other mechanisms. Strengthened institutional mechanisms and country platforms related to procurement, financial management, reporting and accountability will figure centrally in the plans.

## Objective 2: Support countries in the transition toward sustainable domestic financing of RMNCAH

A second objective of the GFF is to support countries in anticipating and preparing for the transition toward sustainable domestic financing of RMNCAH. In the 15-year time frame (2015-2030) of the Sustainable Development Goals (SDG), many countries will move from low- to lower-middle-income status and perhaps even to upper-middle-income status. Building on the financing roadmaps described in Objective 1, the work under this objective will extend these roadmaps forward to project financing needs, costs (accounting for factors such as population growth) and revenue sources over the 15-year SDG period. Guided by these projections, an explicit strategy to strengthen domestic resource mobilization for RMNCAH will be articulated. This will involve analyses of fiscal space, public expenditure reviews, and institutional capacity assessments that inform the opportunities and constraints of public finance as well as identification and development of innovative private financing arrangements. External funding from development partners will seek to contribute to strengthening and accelerating the transition by linking external financing to domestic resource mobilization targets and transitioning development assistance from the current predominance of grants toward IDA credits and IBRD loans. Grants will be re-structured to create incentives for borrowing (e.g. buy-downs). The transitional financing strategies will also include other international financing opportunities such as social impact bonds, advanced market commitments and pooled procurement arrangements (see Objective 4). This transitional financing agenda will be explicitly linked with the broader "financing for development" agenda for the SDGs for which the World Bank Group (WBG) is taking a leadership role.

23 The alignment of external funding from key partners, including Gavi, the Global Fund, other multilaterals (UNICEF, UNFPA), and bilaterals, can learn from the positive experiences in for example Ethiopia, Rwanda, Benin and Burundi where development partners have jointly financed country strategies with common indicators and accountability mechanisms.

## Objective 3: Finance the strengthening of civil registration and vital statistics systems

Availability of accurate, timely, and consistent cause of death and vital statistics data generated by CRVS systems at the national and sub-national levels is crucial for countries to be able to effectively manage their health systems, allocate resources according to need and, importantly, ensure accountability for delivering on RMNCAH commitments. There is growing recognition that these CRVS systems require deliberate and dedicated strategies and investments to be strengthened. The work of both the Independent Expert Review Group (iERG) and the UN Commission on Information and Accountability highlighted the critical need to improve coverage and quality of information systems. Alongside this consensus, the "leap-frog" opportunities inherent in e- and m- health applications to strengthen CRVS systems and information for both providers and users of RMNCAH services have been recognized.[24] The GFF will finance coordinated investments in strengthening the capacities required at all levels of the health system to register births and deaths and causes of death, and generate and use these vital statistics.

CRVS systems are an especially important information platform for counting the lives and deaths of every woman and every child. The poor state of CRVS systems in many countries, coupled with the opportunities emerging from innovative application of information and communications technologies (ICTs) and acknowledged political commitment at the country and regional levels, has led the RMNCAH community, through the iERG, to advocate for stronger and scaled-up CRVS in all countries. A strong CRVS that covers an entire country offers an unprecedented opportunity for a real-time scorecard that can track progress toward the 2030 targets of ending preventable maternal and child deaths. This opportunity is also recognized in a strategy and investment plan to strengthen and scale-up CRVS recently published by the World Health Organization (WHO) and the World Bank.

Building on the work of the Government of Canada, the World Bank and WHO, and using a dedicated window, the GFF will support this CRVS scale-up such that by 2030 there will be universal registration of every birth and death (including cause of death).[25] Achieving this objective entails working with a broader set of stakeholders and sectors than would normally be identified as part of the RMNCAH community to articulate multi-sectoral CRVS investment plans. The GFF will facilitate the production of these plans with inputs from all partners, and will focus on mobilizing the right mix of domestic and international resources required to accelerate improvements and sustain CRVS systems by 2030 (as per Objective 2 above). It will also support a Center of Excellence for CRVS that articulates best practices and shares lessons on implementation.

24 World Health Organization. (2013). Strengthening CRVS through Innovative Practices in the Health Sector: Guiding Principles and Good Practices, http://www.who.int/healthinfo/civil_registration/crvs_meeting_dec2013_report.pdf?ua=1

25 World Bank-WHO (2014) Global Civil Registration and Vital Statistics Scaling up Investment Plan 2015–2024. http://www.worldbank.org/en/topic/health/publication/global-civil-registration-vital-statistics-scaling-up-investment

## Objective 4:
## Finance the development and deployment of global public goods essential to scale up

Global public goods can help to accelerate the affordability and accessibility of RMNCAH services by breaking through knowledge, know-how, price and technology barriers and bottlenecks. The GFF will work with partners to identify promising areas for the development and deployment of global public goods. Investment areas may include market shaping to ensure sustainable access to key commodities, technological developments that simplify delivery, innovations in the delivery of services such as task-shifting and impact assessments that inform ways of overcoming bottlenecks to implementation. A good example of a promising investment is to translate global interagency efforts to align supply chain management into appropriate and effective country-level responses for delivering commodities to "last mile" facilities. The GFF financing can supplement available financing from other sources where needed. This will mostly be done through implementing partners who will be selected based on the nature of the specific activity.

## Objective 5:
## Contribute to a better-coordinated and streamlined RMNCAH financing architecture

Beyond its specific financing objectives, the GFF aims to contribute to a better-coordinated and streamlined RMNCAH financing architecture at the country and global level by providing a platform for coordination around financing of RMNCAH and by facilitating the convergence and consolidation of fragmented RMNCAH financing streams. While a central aim of these efforts is to reduce unreasonably high transaction costs for countries as well as other partners, greater alignment around the roadmaps will improve leverage prospects for individual investors as well as greater efficiency and effectiveness of those investments. Evidence on the leverage ratios and value-for-money of investments are increasingly important criteria for sustaining the resource commitments of development partners.

As part of the planning process for the long term financial roadmaps, the GFF will facilitate more efficient and complete financing of RMNCAH plans at the country level by developing long-term strategies for financing and working with partners to better align, and where possible pool, funding for efficient implementation of the plans. More detail on the coordination and consolidation objective of the GFF is included in the governance section of this Concept Note.

# COUNTRY SELECTION

In order to maximize its impact toward achieving the convergence goals of ending preventable maternal and child deaths (EPMCD), the GFF will focus on the countries with the greatest RMNCAH burden and needs. The 75 high-burden countries currently being tracked under the *Countdown to 2015* initiative[26] represent over 95 percent of all maternal and child deaths. By targeting those countries with the largest financing gaps (as shown in Figure 2) i.e. LICs and LMICs in the "Countdown", the GFF will focus on 63 countries that account for the vast majority of maternal and child deaths (92 percent and 87 percent, respectively[27]).

An important objective of the GFF is to help support countries as they transition to higher levels of financial self-sufficiency in their RMNCAH programs, particularly for those that are graduating into higher income levels and, possibly, lower levels of development assistance eligibility. Thus, to abruptly discontinue GFF support to countries upon their graduation from LMIC- to UMIC classification might represent a missed strategic opportunity to help see these countries through to RMNCAH program sustainability. For this reason, the GFF will also make support available to LMICs as they graduate into UMIC classification. This support will be both time-limited and discrete. Possible assistance options to this category of countries are discussed further in the GFF Country Financing Scenarios section.

Annex 2 provides relevant data on all 75 Countdown countries to help the reader contextualize the factors considered for determining the scope of countries to be supported through the GFF, as well for determining financing scenarios.

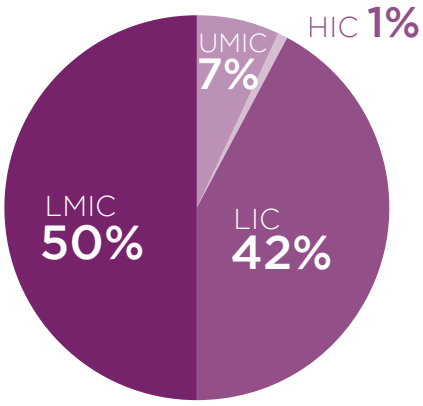



**Figure 3:** % of maternal deaths in 2013 by income group (N=183)

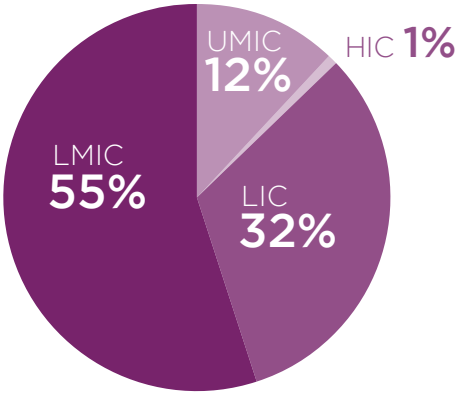



**Figure 4:** % of under-five deaths in 2012 by income group (N=195)

26 http://countdown2015mnch.org/

27 WHO, UNICEF, UNFPA, UNPOP and the World Bank (joint publication). (2014). Trends in Maternal Mortality: 1990 to 2013 [Report]. -United Nations Inter-Agency Group for Child Mortality Estimation. (2013). Levels and Trends in Child Mortality [Report].

# COUNTRY ACCESS TO FINANCING

A pre-requisite for reaching the post-2015 targets of ending preventable maternal and child deaths will be the implementation of country-specific plans with clear targets, priority setting of key interventions and articulation of their delivery strategies. Furthermore, the plans need to link to the national health plans and other sectoral plans that bear on the health of women and children, and to national development plans. In addition, they must respond to the country specific context and be based on the best available evidence. Country ownership will be a key operating principle in all aspects of the work, with governments, ministries of health and other relevant actors playing a central leadership role in planning, coordination and oversight, and ensuring coherence in the implementation, monitoring and reporting of strong national RMNCAH plans. The process of articulating these plans will build upon existing coordinating mechanisms such as IHP+. Recognizing the critical role of the H4+ in the articulation and implementation of these plans, the GFF will advocate for full financing of H4+ and other technical partners in carrying out these essential functions.

The strengthened and costed RMNCAH plans constitute the basis for developing financial roadmaps, which will provide a comprehensive picture of a country's immediate and longer-term RMNCAH resource needs and will outline strategies to mobilize the requisite domestic (public/private) and international (bilateral/

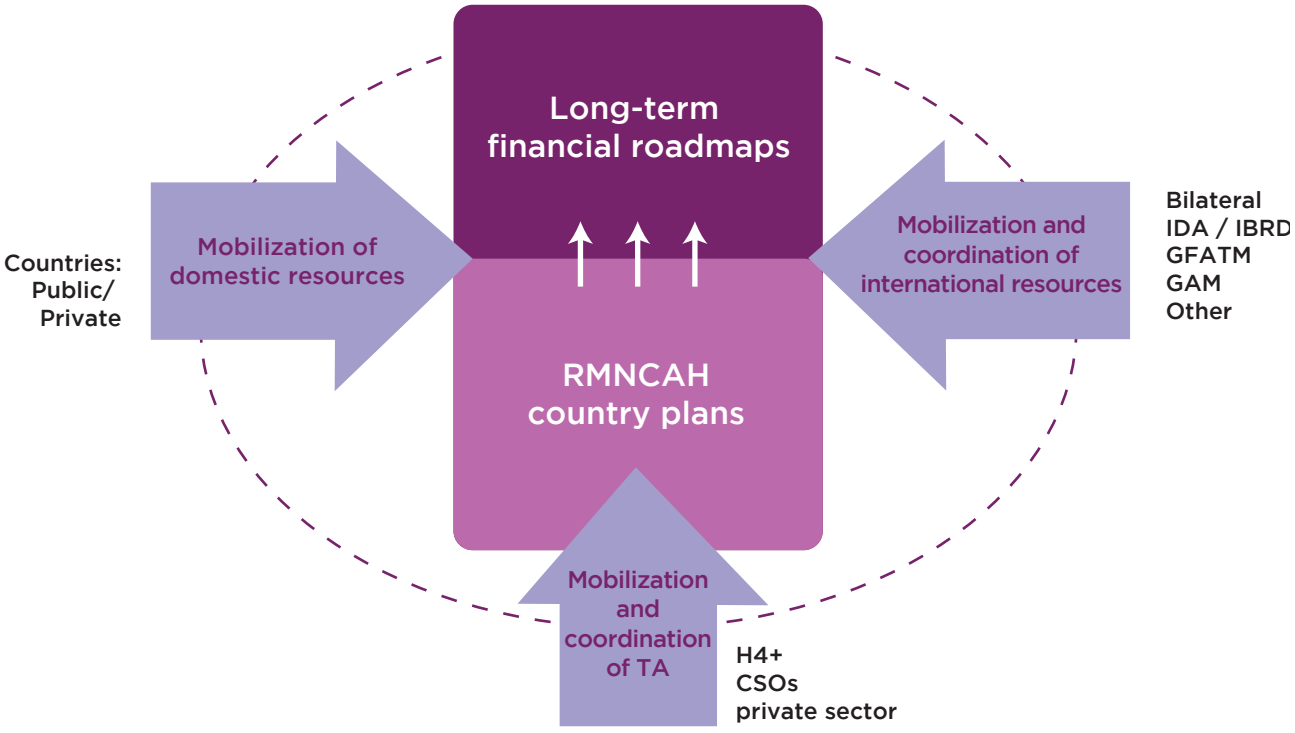



**Figure 5:** Harmonizing financing around quality RMNCAH plans and financial roadmaps

multilateral/private) funding over time. The roadmap will reflect the broader picture of economic growth, national health priorities, and the overall budget- and fiscal space for the health sector. The process for developing financial roadmaps will involve strong country-based analytical work that links with national planning as well as budgeting mechanisms, cycles and processes.

Together, the RMNCAH plans and financial roadmaps will be the basis for the harmonization of the various streams of financing – both domestic (public/private) and international (bilateral/multilateral/private) – around the overall plan, thereby maximizing the impact and programmatic coherence of all partners' in-country RMNCAH support. The aim is to harmonize funding for RMNCAH plans through pooling resources around a common country financing framework linked to clear results and backed-up by common accountability and reporting mechanisms. The GFF will have the flexibility to adapt based on country specific and donor financing requirements. An example of an innovative partnership to improve RMNCAH outcomes from the Democratic Republic of Congo (DRC) can be found in Annex 6.

## GFF COUNTRY FINANCING SCENARIOS

The GFF financing roadmaps will be designed to catalyze and sustain progress toward national RMNCAH objectives. More specifically, they aim to: (i) mobilize domestic resources across the public and private sectors; ii) scale international financing to complement domestic resources and provide a strong leverage rationale for individual investors; (iii) improve the efficiency of investments with respect to achieving results; and (iv) make the longer-term sustainability of financing for RMNCAH an explicit and feasible strategy. To fulfill these aims, the GFF and its partners will draw upon a menu of available financing options ranging from more traditional instruments such as taxes, grants, credits, loans and guarantees, to more innovative approaches such as impact bonds, buy-downs and health transformation funds. Leveraging partner financing tools and resources will provide the opportunity for more harmonized financing for RMNCAH across domestic and international partners. Driven by the specific context of each country, the GFF roadmaps, for example, will lead to a variety of tangible financing results such as: ensuring that all international financing for RMNCAH is on budget and additional, earmarking specific budget allocation targets for RMNCAH under reduced debt service obligations, linking finance to attainment of RMNCAH results across the system through Pay for Results approaches, and accelerating policy and institutional reforms to scale up and make domestic RMNCAH financing more sustainable (e.g. through Development Policy Credits/Loans).

GFF financing of roadmaps and instruments will be tailored to specific country needs. While final eligibility criteria have yet to be agreed upon, four country groups can be

envisaged, all facing high RMNCAH burdens[28] but different financing challenges due to their eligibility for external funding and income levels. These include: (1) LICs not expected to transition to LMIC status in the foreseeable future; (2) LICs transitioning to LMIC status; (3) LMICs; and (4) LMICs transitioning to UMIC status.[29]

The GFF will support a country's transitional financing through multiple sets of instruments and approaches. More details on the financial roadmaps for RMNCAH can be found in Annex 7.

**Low-income countries:** This group will include the poorest countries with high RMNCAH burdens, none of which are expected to transition to lower middle-income status in the foreseeable future. Country examples include Burundi and the Democratic Republic of Congo. GFF grants will focus on complementing existing resources to reduce out-of-pocket expenditures and achieve higher coverage of key RMNCAH interventions. With disbursements linked to RMNCAH results, such grants will also encourage countries to seek additional grant funding and/or concessional loans (for example IDA grants and credits) as well as commit local resources to accelerate progress. GFF grant-financed technical assistance will focus on laying the foundations of good public financial management to ensure that funds actually benefit mothers and children. In LICs experiencing political instability and conflict, such as the Central African Republic, public financing and delivery systems may prove unfit for this purpose and GFF grants will use alternative financing routes to ensure access to basic RMNCAH services, including direct financing of non-governmental organizations (e.g. civil society and international organizations) or even humanitarian interventions.

**Low-income countries in the transition to lower-middle-income status:** This group will include high-burden LICs transitioning into LMIC status such as Uganda and Kenya. GFF grants will aim to increase coverage of key RMNCAH interventions, but would adopt designs that facilitate domestic resource mobilization to sustain the growth in RMNCAH financing when overall external assistance declines. GFF grants will finance buy-downs of interest, principle of credits or loans, or any combination of these items (e.g. WB IDA credits and IBRD loans), encouraging countries not only to borrow for RMNCAH, but also to commit to specific budget allocation targets for RMNCAH. Such grants, credits and loans will be disbursed against the attainment of RMNCAH results (e.g. through Pay for Results approaches) as well as the implementation of policy and institutional actions that scale-up and make domestic RMNCAH financing more sustainable (e.g. through Development Policy Credits/Loans). GFF grants will also finance technical assistance to support such policy and institutional actions. This includes, for example, steps that build on earlier public financial management reforms to improve procurement, financial and human

28 "High burden" refers to a country's designation as one of the high-burden, priority RMNCAH countries under the Countdown initiative, as described earlier in this note.

29 The instruments and tools described in the following paragraphs are indicative and not necessarily available to all within each grouping, nor unavailable to other groupings. Eligibility for each instrument or tool is based on a number of factors, and not strictly on income classification.

resource management as well as the introduction of more advanced provider payments mechanisms (particularly pay for performance arrangements) with the potential to enhance the quality and efficiency of RMNCAH services. Moreover, technical assistance will support innovations to broaden the domestic revenue base for RMNCAH by, for example, emulating reforms proven successful in upper-middle and high-income countries such as sin taxes. In countries with rapid economic growth, support will focus on innovations to strengthen the often weak link between economic growth and spending on RMNCAH by, for example, capturing revenues from extractive industries and investing them in RMNCAH.

**Lower-middle-income countries:** This group will include some large countries with the highest numbers of maternal- and child deaths, such as India, Nigeria and Pakistan. In these countries, marked improvements in the coverage and quality of RMNCAH interventions would have a significant impact on the global RMNCAH burden. Similar to financing modalities in countries transitioning to LMIC status, GFF grants will leverage loans with disbursements linked to RMNCAH results and policy and institutional reforms of financing arrangements for RMNCAH. Such grants and loans, however, will be contingent upon significant increases in RMNCAH financing from general tax revenue. GFF grants will also finance technical assistance to deepen reforms of public financial management, payment and revenue systems. In addition, they will help countries tackle the growing inequalities in RMNCAH financing and service delivery typical for this stage of the economic transition by targeting public resources to the poor and equalizing geographical and fiscal imbalances. Often this is done in the context of decentralizing power and functions to lower levels of government.

**Lower-middle-income countries in the transition to upper-middle-income country status:** This group will include countries that received GFF support as LMICs, which – upon their graduation to UMIC status – would benefit from continued support to expand RMNCAH gains while achieving financial sustainability. The support will be limited in time (e.g. 3 years after graduation to UMIC status) and scope (e.g. grants financing technical assistance to deepen, complete and assess reforms and develop consecutive phases of financing roadmaps). At the same time, this group of countries will remain eligible for IBRD lending and the World Bank Group will encourage them to draw upon these loans to deepen coverage and improve the quality of RMNCAH services.

# GOVERNANCE AND INSTITUTIONAL ARRANGEMENTS

This section of the Concept Note outlines the institutional and governance arrangements for the GFF. It describes the guiding governance principles, the rationale for the World Bank hosting the GFF and three governance capabilities the GFF needs to secure.

## Governance principles

The role of GFF governance is to provide the oversight, strategic guidance and well-coordinated decision-making required for delivering on the core functions of the GFF. In order to do so, GFF governance arrangements will be guided by the following key principles:

- **Country-driven:** Forge viable financing roadmaps, align itself and work effectively with the policy and planning cycles and development partner coordination mechanisms related to RMNCAH, health and other sectors that are specific to each country.

- **Inclusive and streamlined:** Engage all major financial partners – domestic/international, public/private – supporting RMNCAH, with the aim of streamlining the financial architecture for RMNCAH.

- **Responsive and accountable:** Deliver financial services that are tailored to country needs in a timely and cost-efficient way.

- **Scale and leverage:** Influence significant flows of international development assistance for RMNCAH that offer leverage incentives to RMNCAH investors.

- **Aligned and synergistic:** Work with and promote the consensus strategies, public goods and technical assistance services offered by diverse partners – multilateral, bilateral, private sector and CSOs – under the EWEC umbrella.

## Institutional arrangements

While there are, in principle, a number of institutional and hosting options for the GFF, it is proposed that the GFF be located at the World Bank for the following reasons:

- **Credibility and mandate:** The World Bank Group is playing a leading role in articulating the financing needs and architecture for the post-2015 development goals and will play an important role in financing for the new goals.

- **Proven leverage:** As has been seen over the last five years of the HRITF, channelling grant financing through the World Bank creates an opportunity to unlock far larger investments in the form of credits and loans from IDA and IBRD that are anchored in the fiscal accounts of countries.

- **Multi-sectorality:** Many of the critical interventions necessary to achieve accelerated RMNCAH results lie outside the health sector.

The World Bank, by virtue of its overarching development focus, can mobilize co-investments in sectors such as education, social protection, water and sanitation and macro-fiscal policy, among others. In addition, the private sector arm of the World Bank – the International Finance Corporation – can be tapped to engage private sector partners more systematically.

- **Hit the ground running:** Given that the HRITF and its secretariat housed at the World Bank are already up and running, the GFF will be able to move forward swiftly and efficiently with the work on the ground.

- **Expertise on financing:** The World Bank has the depth and breadth of expertise related to the full range of financing challenges that will figure prominently in the financing roadmaps of the GFF. These challenges include purchasing and procurement and financial management and accountability. Further, the Bank's close working relationship with ministries of finance will help to forge necessary linkages with the broader and longer-term financing policies for health.

## Core GFF capabilities

The GFF requires at least three different governance capabilities in order to achieve its objectives. The **first capability** relates to supporting country-based mechanisms that will permit the articulation and implementation of the financing roadmaps through effective convening and building alliances among all major stakeholders, which GFF governance should facilitate. Developing high-quality financing roadmaps involves both content and process dimensions. The content relates to the costing of RMNCAH plans, identifying domestic and international sources of financing, specifying procurement and purchasing arrangements as well as financial management and projections related to sustainability. The process relates to the alignment with planning cycles, the engagement of key stakeholders in the RMNCAH community – both domestic (public/private) and international (bilateral/multilateral/private) – and generating consensus on, or buy-in, to plans. Achieving this will require effective convening and building alliances among all major stakeholders, which GFF governance should facilitate.

**A second governance capability** of the GFF relates to its ability to be recognized as a major source of international financing for the RMNCAH agenda through dedicated financing windows. In this regard, the GFF governance structure will build on the existing HRITF at the World Bank in order to allow for a rapid acceleration of investments in RMNCAH that offer good leverage, high value-for-money and low administrative costs. More information on the HRITF is in Annex 8. The scope of the existing HRITF will be expanded from its current focus on service delivery to the financing of comprehensive RMNCAH plans with the possibility of also funding across sectors. As such, the country platform developed through the HRITF will facilitate the convening and development of financing roadmaps. The GFF platform will also facilitate the development of a dedicated multi-sectoral window for the financing

of CRVS and another window will finance global public goods and normative and technical assistance functions critical for RMNCAH scale up. This can include financing for UN technical agencies, NGOs and the private sector. The operational details for these financing windows, criteria for country eligibility, financing and decision-making will be specified in the development of the business plan.

**A third governance capability** for the GFF relates to global convening, coordination and communication amongst key stakeholders. The GFF needs to convene a full range of partners including client countries, the public, private and nongovernmental sectors, and bilateral and multilateral agencies. Together the GFF partners must promote effective and efficient convergence on the strategies and opportunities to achieve the objectives of fully scaled, smart and sustainable financing of the RMNCAH agenda.

Further, there must be a capacity to monitor and review progress against an agreed set of financing targets that reflect the overall aims and objectives of the GFF. Finally, the GFF must be able to issue, advocate and act on recommendations to improve performance. It is recognized that this governance capability of the GFF needs to align with, or be part of a consolidation of, existing steering and coordinating mechanisms that currently populate the RMNCAH global landscape.

# NEXT STEPS AND TIMELINE

Following the development of the Concept Note and the initial commitments at the UN General Assembly 2014, the focus will be on keeping the momentum for implementation and scale up of successful programs under the current portfolio. There will be a strong emphasis on expanding existing packages of services to incorporate agreed-upon priority areas including newborn care and adolescent health, as well as increases in geographical scope and equity focus to achieve maximum impact, particularly for poor and vulnerable groups.

The second phase of the planning process will focus on the development of the Business Plan for the GFF. During business planning the full operating model including the financing window for CRVS will be developed. The business plan will also be informed by the current mobilization of partners around regions (in the case of CRVS) and specific countries, such as the DRC. By building on existing in-country momentum there is an opportunity to accelerate the achievement of results under the GFF.

More in-depth analysis will take place on the structure and content of the financing roadmap, including the development of country examples. The work on the business plan will be informed by in-depth consultations with countries, donors and other partners.

Upon completion of the business plan by May 2015 the full operationalization of the GFF will begin. The goal is for the GFF to be fully operational around the time of the UN General Assembly in 2015.

# ANNEX 1: GFF WORKING GROUP MEMBERSHIP

| NAME | TITLE |
|---|---|
| Minister Kesetebirhan Admasu | Minister of Health, Ethiopia |
| Michael Anderson | CEO, Children's Investment Fund Foundation |
| Suprotik Basu | CEO, UN Secretary General's Special Envoy for Financing the Health MDGs and for Malaria |
| Pascal Bijleveld | RMNCH Strategy and Coordination Team, UNICEF |
| Dr. Flavia Bustreo | Assistant Director-General, Family, Women's and Children's Health, World Health Organization |
| Kathy Calvin | President & CEO, United Nations Foundation |
| Joanne Carter | Executive Director, Results |
| Dr. Mickey Chopra | Chief of Health, UNICEF |
| Dr. Mariam Claeson | Director, Maternal Newborn and Child Health, The Gates Foundation |
| Kate Dodson | VP of Global Health, United Nations Foundation |
| Dr. Jane Edmondson | Group Head, Human Development, DFID |
| Dr. Tim Evans | Senior Director of Health, Nutrition, Population, The World Bank Group |
| Dr. Tore Godal | Special Advisor on Global Health, Office of the Prime Minister of Norway |
| Diane Jacovella | Assistant Deputy Minister, Foreign Affairs, Trade and Development, Canada |
| Josiane Kamikazi | Technical Adviser, Minister of Finance, Burundi |
| Hind Khatib-Othman | Managing Director, Gavi, the Vaccine Alliance |
| Michael Klosson | Vice President, Policy & Humanitarian Response, Save the Children |

| | |
|---|---|
| Alexia Latortue | Deputy Assistant Secretary for International Development & Debt, US Department of the Treasury |
| Dr. Christopher MacLennan | Director General, Department of Foreign Affairs, Trade & Development, Canada |
| Jacqueline Mahon | Senior Policy Adviser, Global Health & Health Systems, UNFPA |
| Joanne Manrique | President, Center for Global Health and Diplomacy |
| Dr. Anders Nordstrom | Ambassador for Global Health, Ministry for Foreign Affairs, Sweden |
| Dr. Ariel Pablos Mendez | Assistant Administrator for Global Health, USAID |
| Dr. Carole Presern | Executive Director, Partnership for Maternal, Newborn & Child Health |
| Ann Starrs | President & CEO, Guttmacher Institute |
| Nana Taona Kuo | Sr. Manager, Every Woman Every Child, United Nations |
| Dr. Albert Welo Kalema | Délégué, Democratic Republic of the Congo |
| Marijke Wijnroks | Chief of Staff, GFATM |

# ANNEX 2: THE 75 COUNTDOWN COUNTRIES

Relevant data on WB instruments, income classifications and RMNCH burden

| COUNTRY | WB INCOME CLASSIFI-CATION | LENDING CATEGORY | HRTIF GRANTS | WB FRAGILE SITUATIONS LIST | MATERNAL DEATHS (MMR) | UNDER-5 DEATHS (U5MR) |
|---|---|---|---|---|---|---|
| Afghanistan | LIC | IDA | Yes | Yes | 4,200 (400) | 103,171 (98.5) |
| Bangladesh | LIC | IDA | Yes | No | 5,200 (170) | 126,835 (40.9) |
| Benin | LIC | IDA | Yes | No | 1,300 (340) | 31,690 (89.5) |
| Burkina Faso | LIC | IDA | Yes | No | 2,800 (400) | 66,279 (102.4) |
| Burundi | LIC | IDA | Yes | Yes | 3,400 (740) | 43,227 (104.3) |
| Cambodia | LIC | IDA | No | No | 670 (170) | 14,230 (39.7) |
| Central African Republic | LIC | IDA | No | Yes | 1,400 (880) | 19,192 (128.6) |
| Chad | LIC | IDA | Yes | Yes | 5,800 (990) | 82,114 (149.8) |
| Comoros | LIC | IDA | No | Yes | 90 (350) | 1,921 (77.6) |
| Congo, Dem. | LIC | IDA | Yes | Yes | 21,000 (730) | 391,229 (145.7) |
| Democratic People's Rep. of Korea | LIC | | No | No | 310 (87) | 1,913 (28.8) |
| Eritrea | LIC | IDA | No | Yes | 880 (380) | 11,365 (51.8) |
| Ethiopia | LIC | IDA | Yes | No | 13,000 (420) | 204,926 (68.3) |
| Gambia | LIC | IDA | Yes | No | 340 (430) | 5,278 (72.9) |
| Guinea | LIC | IDA | No | No | 2,800 (650) | 41,288 (101.2) |
| Guinea-Bissau | LIC | IDA | No | Yes | 360 (560) | 7,669 (129.1) |
| Haiti | LIC | IDA | Yes | Yes | 1,000 (380) | 20,083 (75.6) |
| Kenya | LIC | IDA | Yes | No | 6,300 (400) | 108,097 (72.9) |
| Liberia | LIC | IDA | Yes | Yes | 980 (640) | 10,918 (74.8) |
| Madagascar | LIC | IDA | Yes | Yes | 3,500 (440) | 44,058 (58.2) |
| Malawi | LIC | IDA | No | No | 3,400 (510) | 43,375 (71) |
| Mali | LIC | IDA | Yes | Yes | 4,000 (550) | 83,449 (128) |
| Mozambique | LIC | IDA | Yes | No | 4,800 (480) | 83,787 (89.7) |
| Myanmar | LIC | IDA | No | Yes | 1,900 (200) | 48,485 (52.3) |
| Nepal | LIC | IDA | Yes | No | 1,100 (190) | 24,265 (41.6) |
| Niger | LIC | IDA | No | No | 5,600 (630) | 90,558 (113.5) |
| Rwanda | LIC | IDA | Yes | No | 1,300 (320) | 23,603 (55) |
| Sierra Leone | LIC | IDA | Yes | Yes | 2,400 (1100) | 38,809 (181.6) |
| Tajikistan | LIC | IDA | Yes | No | 120 (44) | 15,388 (58.3) |
| Togo | LIC | IDA | Yes | Yes | 1,100 (450) | 22,415 (95.5) |
| Uganda | LIC | IDA | No | No | 5,900 (360) | 103,428 (68.9) |
| United Republic of Tanzania | LIC | IDA | Yes | No | 7,900 (410) | 97,989 (54) |

| | | | | | | |
|---|---|---|---|---|---|---|
| Zimbabwe | LIC | Blend | Yes | Yes | 2,100 (470) | 38,874 (89.8) |
| Somalia | LIC | IDA | No | Yes | 3,900 (850) | 64,584 (147.4) |
| Bolivia | LMIC | Blend | No | No | 550 (200) | 10,874 (41.4) |
| Cameroon | LMIC | Blend | Yes | No | 4,900 (590) | 73,961 (94.9) |
| Congo | LMIC | Blend | No | No | 690 (410) | 15,286 (96) |
| Cote d'Ivoire | LMIC | IDA | Yes | Yes | 5,300 (720) | 75,148 (107.6) |
| Djibouti | LMIC | IDA | Yes | No | 55 (230) | 1,896 (80.9) |
| Egypt | LMIC | IBRD | No | No | 860 (45) | 40,360 (21) |
| Ghana | LMIC | IDA | Yes | No | 3,100 (380) | 55,907 (72) |
| Guatemala | LMIC | IBRD | No | No | 660 (140) | 14,878 (32) |
| India | LMIC | IBRD | Yes | No | 50,000 (190) | 1,414,227 (56.3) |
| Indonesia | LMIC | IBRD | No | No | 8,800 (190) | 151,605 (31) |
| Kyrgyzstan | LMIC | IDA | Yes | No | 110 (75) | 3,952 (26.6) |
| Laos | LMIC | IDA | Yes | No | 400 (220) | 13,771 (71.8) |
| Lesotho | LMIC | IDA | Yes | No | 280 (490) | 5,693 (99.6) |
| Mauritania | LMIC | IDA | No | No | 430 (320) | 10,563 (84) |
| Morocco | LMIC | IBRD | No | No | 880 (120) | 22,717 (31.1) |
| Nigeria | LMIC | Blend | Yes | No | 40,000 (560) | 826,604 (123.7) |
| Pakistan | LMIC | Blend | Yes | No | 79,000 (170) | 408,805 (85.9) |
| Papua New Guinea | LMIC | Blend | Yes | No | 460 (220) | 13,105 (63) |
| Philippines | LMIC | IBRD | No | No | 3,000 (120) | 68,712 (29.8) |
| Sao Tome and Principe | LMIC | IDA | No | No | 14 (210) | 340 (53.2) |
| Senegal | LMIC | IDA | Yes | No | 1,700 (320) | 29,975 (59.6) |
| Solomon Islands | LMIC | IDA | Yes | Yes | 23 (130) | 529 (31.1) |
| South Sudan | LMIC | IDA | No | Yes | 3,000 (730) | 39,515 (104) |
| Swaziland | LMIC | IBRD | No | No | 120 (310) | 2,907 (79.7) |
| Uzbekistan | LMIC | Blend | Yes | No | 220 (36) | 25,091 (39.6) |
| Vietnam | LMIC | Blend | Yes | No | 690 (49) | 32,765 (23) |
| Yemen | LMIC | IDA | Yes | Yes | 2,100 (270) | 43,276 (60) |
| Zambia | LMIC | IDA | Yes | No | 1,800 (280) | 50,167 (88.5) |
| Sudan | LMIC | IDA | No | Yes | 4,600 (360) | 88,524 (73.1) |
| Angola | UMIC | IBRD | No | No | 4,400 (460) | 148,006 (163.5) |
| Azerbaijan | UMIC | IBRD | No | No | 43 (26) | 5,943 (35.2) |
| Botswana | UMIC | IBRD | No | No | 83 (170) | 2,577 (53.3) |
| Brazil | UMIC | IBRD | No | No | 2,100 (69) | 41,839 (14.4) |
| China | UMIC | IBRD | No | No | 5,900 (32) | 258,250 (14) |
| Gabon | UMIC | IBRD | No | No | 130 (240) | 3,171 (62) |
| Iraq | UMIC | IBRD | No | No | 710 (67) | 34,757 (34.4) |
| Mexico | UMIC | IBRD | No | No | 1,100 (49) | 37,056 (16.2) |
| Peru | UMIC | IBRD | No | No | 530 (89) | 10,831 (18.2) |
| South Africa | UMIC | IBRD | No | No | 1,500 (140) | 49,815 (44.6) |
| Turkmenistan | UMIC | IBRD | No | No | 68 (61) | 5,538 (52.8) |
| Equatorial Guinea | HIC | IBRD | No | No | 79 (290) | 2,521 (100.3) |

# ANNEX 3: METHODOLOGY FOR ESTIMATING HEALTH IMPACTS AND RESOURCE GAPS

The approach to modeling health impacts, resource needs estimates, the financing flows from domestic sources and the resulting financing gap for this Concept Note is based heavily on using existing estimates and methodologies. Two recent modeling efforts have assessed key elements of the resource needs, financing flows and projected health outcomes of scaling-up coverage for RMNCH (both of which built on earlier efforts, including those of the Global Strategy, the Commission on Macroeconomics and Health, and the Commodities Commission).

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

The Lancet Commission on Investing in Health (CIH) built on this investment case and added some new approaches (e.g., factoring in the adoption of new tools and technologies over the course of the period) and some new diseases and populations (e.g., HIV and malaria in adults, tuberculosis, neglected tropical diseases) in the course of modeling the health impacts and incremental costs of two scenarios (current coverage and "convergence", or accelerated scale-up). The CIH also examined the likely expansion of domestic financing for RMNCH in light of economic growth and increased allocation of government budgets to health (which has typically been the case as countries experience economic growth).

Both these efforts were peer-reviewed and published their results and methodologies in The Lancet.

## Estimating resource needs

For the purpose of this Concept Note, the starting point for the estimates of the resource needs was the Global Investment Framework. In particular, needs were calculated for the incremental costs of scaling up coverage to both the high and the medium scenarios. Country-level data from the Global Investment Framework was adjusted from 2011 to 2013 constant US dollars using IMF country-level GDP deflators. A real inflation factor of 2 percent was applied to projected costs to account for expected increases in the cost of scaling up services and delivery.

To reflect the impact of the rollout of anticipated future research and development, the methodology employed by the Commission on Investing in Health was used to factor in the costs of purchasing and scaling up new technologies. An incremental

reduction of 2 percent was applied to the number of stillbirths, while declines in the maternal mortality ratio and under-5 mortality rates were accelerated by 2 percent.

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

## Estimating domestic financing flows

To estimate domestic financing, the approach employed by the Commission on Investing in Health was used. The first component of this is capture the potential increase in domestic financing that relates to economic growth. IMF projections of real GDP growth rates for each country were used through 2019, after which the simple average of projected growth rates for 2014-2019 was applied to 2020-2024.

Between 2025 and 2027, all projected growth rates above 5 percent were dropped to 5 percent, while for 2028-2030, all growth rates above 3 percent were dropped to 3 percent. Should the recent trend of rapid economic growth in low- and middle-income countries begin to slow, the potential domestic financing flows could drop considerably.

The share of GDP directed toward general government expenditures on health (GGHE) was then assessed under three scenarios:

- Countries maintain existing (2012) proportions of GGHE, which are generally 2-3 percent of GDP;
- GGHE steadily climbs to 3 percent of GDP by 2030 for low- and lower-middle-income countries, while remaining stable at the historical average of 3.24 percent for upper-middle and high-income countries;
- GGHE steadily climbs to 4 percent of GDP for all income groups by 2030.

Countries allocate less than 100 percent of total GGHE to RMNCAH, so a range of proportions for the share going to RMNCAH was then assessed.

Incremental domestic financing estimates were then calculated relative to a 2013 baseline level. The maximum financing available for RMNCAH was capped at a country's total resource needs for that year, under the assumptions that countries would not rationally spend more than their total needs for RMNCAH, and that domestic financing is non-transferable between countries. Several of the Countdown countries could not be included because of data unavailability: Comoros, Democratic People's Republic of Korea, Myanmar, Somalia, and Zimbabwe.

## Estimating overall resource gaps

To estimate the gap between overall domestic financing flows and resource needs, the following parameters were used for the base case:

- Resource needs compared the incremental amounts between the low and high coverage scenarios;
- The middle scenario of countries allocating 3 percent of GDP to health was used (based on the historical experience that GGHE increases as countries experience economic growth);
- The share of total domestic financing allocated to RMNCAH was 25 percent, an estimate that was developed in the Countdown to 2015 process and employed by the Global Strategy for Women's and Children's Health.

An additional scenario in which the share of domestic financing for RMNCAH increases to 50 percent was also included in the Concept Note.

## Estimating health impacts

As with estimating the resource needs, projections from the Global Investment Framework for Women's and Children's Health were adapted to calculate the projected health impact of scaling-up to a high coverage scenario.

The Global Investment Framework estimated the total number of deaths prevented using two approaches: Lives saved from the scale-up of health interventions, and deaths averted due to the scale-up of family planning.

Deaths averted captures the fall in deaths attributable to a reduction in unwanted pregnancies and subsequent reduction in the number of births, while lives saved captures the fall in deaths that occurs as a result of health technology scale-up and subsequent decreases in mortality rates. Deaths prevented were then estimated as the sum of lives saved and deaths averted.

To reflect the anticipated health gains of adopting and scaling up future technological innovations, lives saved estimates from the Global Investment Framework were modified based on a similar method to the resource needs estimates.

The annual reductions in under-5 mortality rates and maternal mortality ratios were accelerated by a further 2 percent per year. Stillbirths were incrementally reduced by 2 percent per year. No other adjustments were made to the estimates of stillbirths prevented or under-five and maternal lives saved.

Adjusted lives saved estimates were then added to the Global Investment Framework's estimates of deaths averted due to scaling up of family planning to calculate the total number of deaths prevented from scaling up RMNCAH interventions.

# ANNEX 4: CONCEPTUAL FRAMEWORK

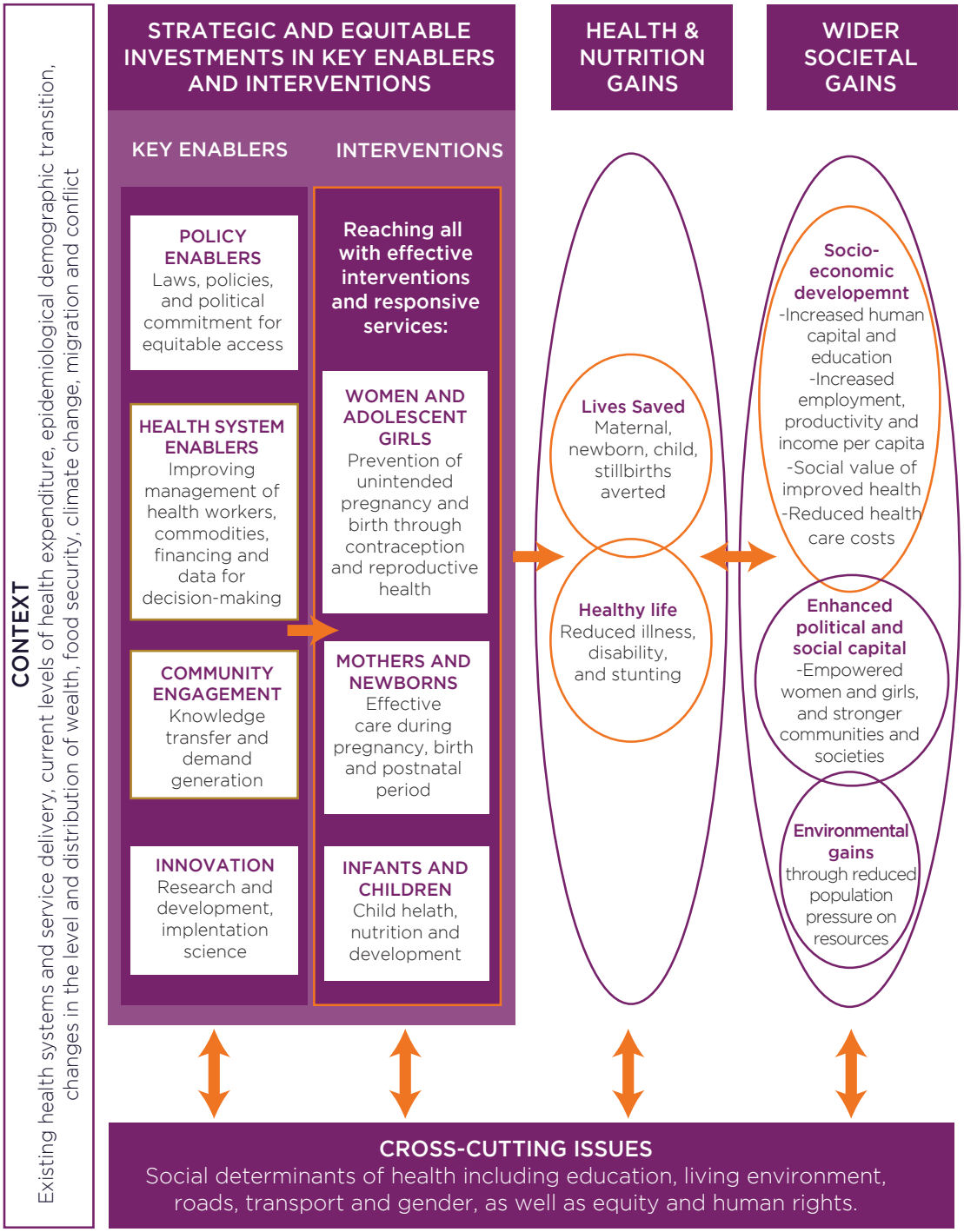



**Figure 6:** Stenberg, K. et al. (2014). Advancing social and economic development by investing in women's and children's health: a new Global Investment Framework. *The Lancet*, 383: 1333-54.

# ANNEX 5: ROLE OF THE PRIVATE SECTOR

To improve RMNCAH outcomes, we need an integrated health system approach that looks for the best solutions, regardless of whether they are provided by the public, private sectors or both in meaningful collaboration with each other. According to DHS data, in Africa, South Asia and East Asia Pacific, where 92 percent of the poor live, 50-80 percent of general outpatient pediatric care visits by the poorest quintile were to private providers (see figure); maternal deliveries in private clinics increased from 8 percent in 1990 to approximately 22 percent in 2008. Therefore, there is a clear opportunity for governments to expand effective coverage of RMNCAH services to the poor by leveraging private sector capacity.

Health systems need to be better regulated, less fragmented, and more efficient to offer basic and essential healthcare to mothers and children at affordable prices. This can be done for example by strengthening the role of the government as a strategic purchaser of RMNCAH services from the best provider regardless of public/private ownership. In order to achieve this, countries and donors need support to identify and develop financing mechanisms that are sustainable and appropriate to the local context.

The GFF can support scaling up efforts of mainstreaming mixed health systems approaches in RMNCAH at the country, regional and global levels by:

- Analysis and strategic thinking to match the right instrument (performance-based contracts, vouchers, insurance, etc.) to the specific objective;
- Experimentation with different approaches to costing and pricing of services that provide incentives for high quality services;
- Reform of licensing and registration regimes that push private providers to operate informally or seek work outside the health sector;
- Strengthening of the government's capacity to supervise and improve patient safety and quality of care;
- Private sector engagement through private provider associations and the creation of public private dialogue platforms;
- Advice on addressing inefficiencies in supply chains of essential medicines and commodities, improved price regulations and procurement practices;
- Facilitation of regulatory harmonization between countries to reduce unnecessary barriers to market entry for essential medicines and technology.

# ANNEX 6: PARTNERSHIP FOR BETTER MATERNAL AND CHILD HEALTH RESULTS IN DRC

In DRC an innovative partnership will finance and support the scale up of the results-based financing (RBF) program. The Global Fund, UNICEF, World Bank and the RMNCH Trust Fund are coming together to work with the government to design a program that aims to rapidly increase access to essential maternal and child health services. It is expected that by the end of 2015, all the health zones in two provinces (Equateur and Bandundu) will be covered by a comprehensive package of services implemented through an RBF program. The GFATM and UNICEF have committed financial, technical and human resources and will work with the WB to scale-up RBF in DRC.

Synergistic support from the three agencies will complement each other, utilize comparative advantages to maximize effectiveness, avoid duplication of efforts and improve efficient use of resources. The GFATM is expected to provide essential malaria test kits and drugs as well as HIV/TB commodities to health facilities participating in the program. In addition, the GFATM will finance key services pertaining to Malaria, TB, and HIV in 96 out of 110 targeted health zones in the Bandundu and Equateur. It will also finance the entire RBF package of services and performance framework in the remaining 14 health zones in Bandundu.

UNICEF will support health facilities by supplying the Kit Familiaux both at the health facility and community level, finance community mobilization, decentralize monitoring and management for results and provide technical assistance. UNICEF will also contribute funding toward the RBF package of services focusing its funding on integrated management of childhood illness (IMCI) indicators. The UNICEF DRC office has reassigned its own human and financial resources and is mobilizing additional resources to support further expansion of this joint initiative beyond 2015. The objective of this partnership is to support the Government's Acceleration Program to Achieve MDGs 4 and 5. It is expected that more than 200 health zones will be covered by 2017/2018.

The WB, in addition to contributing significant financing as part of its new Health System Strengthening Project, will support the setting up, management of the RBF program as well as the verification of results. Scaling up RBF costs an estimated US$3.5 per capita per

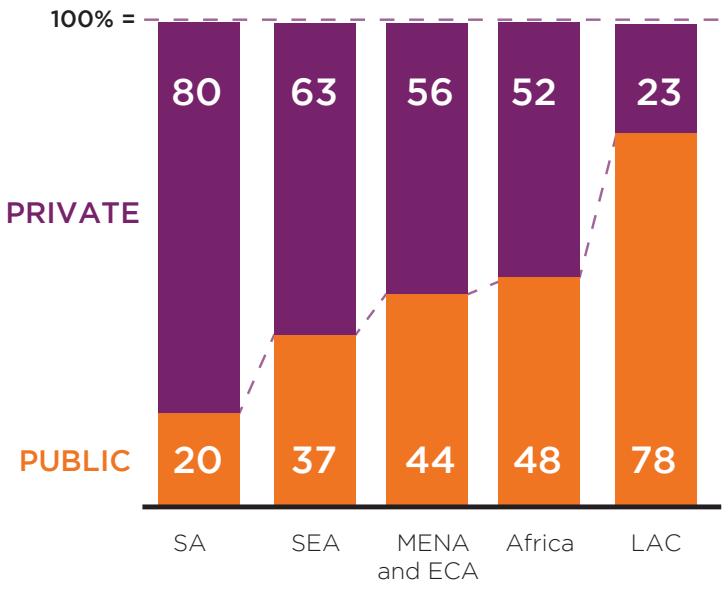



**Figure 7:** Source of outpatient pediatric care, poorest quintile, averages of latest available DHS Survey Montagu, Dominic. 2010. Analysis of Demographic and Health Surveys (DHS). Available at www.ps4h.org/globalhealthdata.htm

year which includes the output budget and the overhead costs of RBF, but excludes the drugs, donated kits and management costs of the various agencies.

This collaborative approach will contribute toward the provision of an integrated package of services, offered to a larger portion of the population. It is expected that such alignment of development partners will contribute to not only strengthening the health system (efficient, effective and better governed) both from a service delivery and stewardship aspect but will also achieve the intended results in terms of improving utilization and quality of care as well as achieving the intended maternal and child health results. Finally, this alignment is very much in line with the Ministry of Public Health objectives to reduce partners' fragmentation and ensure harmonization. Discussions for future alignment with GAVI, USAID, UNFPA and the Gates Foundation are ongoing.

# ANNEX 7: RMNCAH FINANCIAL ROADMAPS

The GFF aims to support countries in their health financing transition, especially as they move from low- to lower-middle-income status. The health financing transition is characterized by an increase in health expenditures and a rising share of government spending due to a combination of economic and political trends. However, this transition is often not a steady but rather a bumpy process with particular challenges for economies when they advance from low-income to middle-income status. At the onset of this transition, countries tend to rely heavily on development assistance. This assistance decreases domestic financing and commonly flows through mechanisms developed outside weak public financial management systems. As countries attain lower-middle-income country status, the link between economic growth and increases in government health expenditure often weakens. Governments then fail to compensate for shortfalls in development assistance, with people facing increasing pressures to meet their health care needs by paying out-of-pocket and making them vulnerable to catastrophic expenditures and impoverishment. During the transition from low to middle-income country status, countries increasingly face the challenge of distributing the growing levels of government expenditure equitably, with often rapidly growing differences in health spending across population groups.

The GFF will support countries in developing financial roadmaps that will help them make the health financing transition more equitable and sustainable and lead them toward universal access to quality RMNCAH services by 2030. The RMNCAH financial roadmaps are integrated financing strategies that help countries meet their RMNCAH goals. They provide estimates of medium and long-term RMNCAH resource needs in line with national RMNCAH objectives. They translate these estimates and objectives into medium-term budgetary and performance frameworks, taking into account other national health priorities, fiscal policy frameworks and economic trends. The RMNCAH financial roadmaps also set forth fully-funded, medium-term action frameworks to strengthen local RMNCAH and health financing systems.

Medium-term budgetary and performance frameworks set forth the financial commitments of a government and its development partners for RMNCAH over a period of 3 to 5 years. They harmonize the various streams of financing around national RMNCAH plans, thereby reducing the administrative burden for countries and maximizing the impact of all partners' RMNCAH support. Moreover, they combine financing instruments across sources to facilitate the transition toward domestic financing and encourage progress toward RMNCAH goals.

For example, grants may be combined with credits and loans to finance buy-downs of interest and principle to encourage not only borrowing for RMNCAH, but also country commitments to specific budget allocation targets for RMNCAH under reduced debt service obligations. Grants, credits and loans may also be disbursed against the implementation of policies and institutional actions that scale-up and sustain domestic RMNCAH financing (e.g. through Development Policy Credits/Loans) as well as against RMNCAH results (e.g. through Pay for Results approaches). The frameworks guide the annual health sector budgeting processes for RMNCAH.

Medium-term RMNCAH and health financing action frameworks establish activities - including the responsibilities for financing and implementation – that are critical to support a country's transition to greater self-sufficiency in financing both RMNCAH and health more generally. The action frameworks ensure the programmatic coherence and impact of technical assistance. They aim to strengthen public financial management, including the introduction of more advanced provider payment systems, to allow for greater use of country systems and enhance the returns to investments in RMNCAH. They also aim to enhance domestic resource mobilization and allocation to make RMNCAH gains more sustainable and equitable. Frameworks support urgently needed innovations to strengthen the often weak link between economic growth and spending on RMNCAH, for example, by capturing revenues from extractive industries and earmarking shares of them for investments in RMNCAH in countries with rapid, natural resource driven growth.

The development of financial roadmaps builds on IHP+, P4H and other well-established coordination mechanisms at the country level. The process provides the platform to engage with ministries of finance to plan for increased levels of spending on RMNCAH. It starts with an in-depth assessment of the RMNCAH and national health financing system, the public financing architecture, and the fiscal and macro context. The in-depth assessment of the RMNCAH and national health financing system combines various instruments, such as public expenditure reviews, fiscal space analysis, and capacity and institutional assessments. The roadmaps are reviewed annually and, as needed, adjusted. Lessons are captured and shared across countries. Reviews may trigger updates of the in-depth assessment of the RMNCAH and national health financing systems.


39

# ANNEX 8: LEVERAGING IDA THROUGH THE HEALTH RESULTS INNOVATION TRUST FUND

Since 2007, the Health Results Innovation Trust Fund (HRITF) has supported results-based financing (RBF) approaches to help resource-constrained countries accelerate progress toward the health-related Millennium Development Goals (MDGs), focusing particularly on MDGs 1c (nutrition), 4 (child mortality), and 5 (maternal health).

HRITF is supported by the governments of Norway and the United Kingdom, with a total commitment of US$537 million, and managed by the World Bank as a multi-donor trust fund. Country implementation grants from the trust fund are linked to project financing from IDA.[30]

The combined IDA and HRITF financing jointly finances the in-country program, significantly increasing the overall resource envelope for RMNCAH. Each dollar from the trust fund generates on average five dollars from IDA. The overall portfolio currently consists of 32 country programs with US$420 million in grant funding leveraging US$2.4 billion in IDA funding. By linking the grant funding to World Bank operations, the trust fund has a very low overhead of less than 2 percent.

Country programs finance the implementation of comprehensive maternal and child health services with an aim to improve the volume and quality of RMNCAH services. Many programs support additional community and demand-side interventions to increase the utilization of essential services. Across the portfolio there are many different ways in which RBF programs improve equity. An independently verifiable information system for real-time tracking of service delivery performance provides accountability and ensures careful monitoring of implementation progress.

As a result, the projects funded achieve an average five-fold return on investment, with a 4 percent additional investment in RMNCAH services yielding a 20 percent gain in performance. The impact evaluations accompanying the programs are measuring the impact on service coverage, quality and health outcomes. In Argentina, the program resulted in a 74 percent decrease in neonatal mortality[31] in Nigeria, the modern contraceptive prevalence rate doubled in comparison to non-RBF areas, from 10 to 21.5 percent; and in Zimbabwe institutional deliveries increased from 33 percent to 67 percent in intervention districts.

There are an increasing number of countries where development partners jointly support the financing and implementation of RBF programs at the country level. For example, in DRC, GAVI, the Global Fund, UNICEF and USAID are working together to scale up services

30 IDA- International Development Association, the World Bank's fund for the poorest countries.

31 Gertler, P., Giovagnoli, P., & Martinez, S. (2014). Rewarding provider performance to enable a healthy start to live: Evidence from Argentina's Plan Nacer. The World Bank, Policy Research Working Paper 6884.

and harmonizing financing around a comprehensive package of services. In Benin, the Global Fund, GAVI and the World Bank are covering the cost of a comprehensive package of maternal and child health services in different geographical areas, contracting the same implementing agency.[32]

32 Vergeer, P., & McCune S. (2013). How Governments and Development Partners Work Together to Scale Up Successful Results-Based Financing Programs. Available from: http://www.rbfhealth.org/resource/how-governments-and-development-partners-work-together-scale-successful-results-based#sthash.f2zmYs53.dpuf.