

COMPARATIVE ANALYSIS OF THE  
**GLOBAL  
FINANCING  
FACILITY**

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*Enhancing inclusivity, transparency,  
and accountability*

PREPARED BY



## Abbreviations

CBCC	Community Based Childcare Centre
CSO	Civil Society Organization
DANIDA	Danish International Development Agency
DFID	Department for International Development
DRM	Domestic Resource Mobilization
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GFF	Global Financing Facility
GGE	General Government Expenditure
GGHE	General Government Health Expenditure
HENNET	Health NGOs Network
HERFON	Health Reform Foundation of Nigeria
HFQCAP	Healthy Facility Quality of Care Assessment Program
IBRD	International Bank for Reconstruction and Development
IC	Investment Case
IDA	International Development Association
JICA	Japan International Cooperation Agency
MOH	Ministry of Health
NGO	Non-Governmental Organization
NHIF	National Health Insurance Fund
OSF	Open Society Foundations
PMNCH	Partnership for Maternal, newborn and Child Health
RMNCAH	Reproductive, maternal, newborn, child and adolescent health
RMNCAH-N	Reproductive, maternal, newborn, child and adolescent health and nutrition
SGM	Small Grants Mechanism
SMART	Standardized, Monitoring and Assessment of Relief and Transition methods
UNPF	United Nations Population Fund
USAID	United States Agency for International Development
WBG	World Bank Group
WHO	World Health Organization

# EXECUTIVE SUMMARY

The Global Financing Facility (GFF) created in 2015 in support of “Every woman, every child” aims to contribute to ending preventable maternal, newborn, child, and adolescent deaths by 2030. The facility is underpinned by a financing model that ought to leverage on comparatively small amounts of grant resources to catalytically unlock more funding from domestic government resources, World Bank International Development Association (IDA) and International Bank for Reconstruction and Development (IBRD) financing, aligned external financing, and resources from the private sector in order to bring reproductive, maternal, newborn, child and adolescent health and nutrition (RMNCAH-N) programs to scale. Key to the GFF mechanism is country ownership that should be reflected in the inclusive, transparent, and accountable multi-stakeholder country platform. In many GFF participating countries, the mechanism has been opaque and has failed to meet requisite transparency thresholds. This has precluded meaningful engagement in the mechanism by key stakeholders including civil society organizations (CSOs).

An in-depth comparative analysis of the GFF across seven GFF participating countries demonstrates that while the mechanism is expected to unlock domestic resources for reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N), there is little, if any, evidence that this is achieved. Opacity around the mechanism’s decision-making approaches and processes, lack of optimal inclusion of key stakeholders

including CSOs, misunderstanding of what the mechanism is by stakeholders, and the absence of sustainable financing mechanisms for CSOs constitute other key challenges facing the mechanism. The resolution of these challenges will require concerted efforts to enhance domestic resource mobilization, implement the minimum standards for inclusion, transparency, and accountability for the multistakeholder country platforms, align off-budget financing with country investment cases (ICs), and leverage on lessons learned in other financing mechanisms such as the Global Fund to improve on the GFF. Further, there is merit in enhancing the technical capacity of CSOs to advocate for the improvement of the GFF especially with regards to unlocking domestic resources for RMNCAH-N. The perennial challenge of the financing of CSOs calls for greater consideration by the GFF Secretariat, members of the GFF Investors Group (GFF-IG), and other bilateral and philanthropic donors. Meeting this challenge will require provision of sustainable, meaningful, dedicated funding for civil society engagement in GFF processes, if the hope of multi-stakeholder decision making is to be realized. The implementation of these recommendations will not only enhance civil society advocacy but also enable the GFF to live up to its mission of being a catalytic funding mechanism. The GFF still has much potential to use modest amounts of grant resources to realize far greater sums of domestic government resources, IDA and IBRD financing, aligned external financing, and resources from the private sector to improve RMNCAH-N programming and health outcomes.

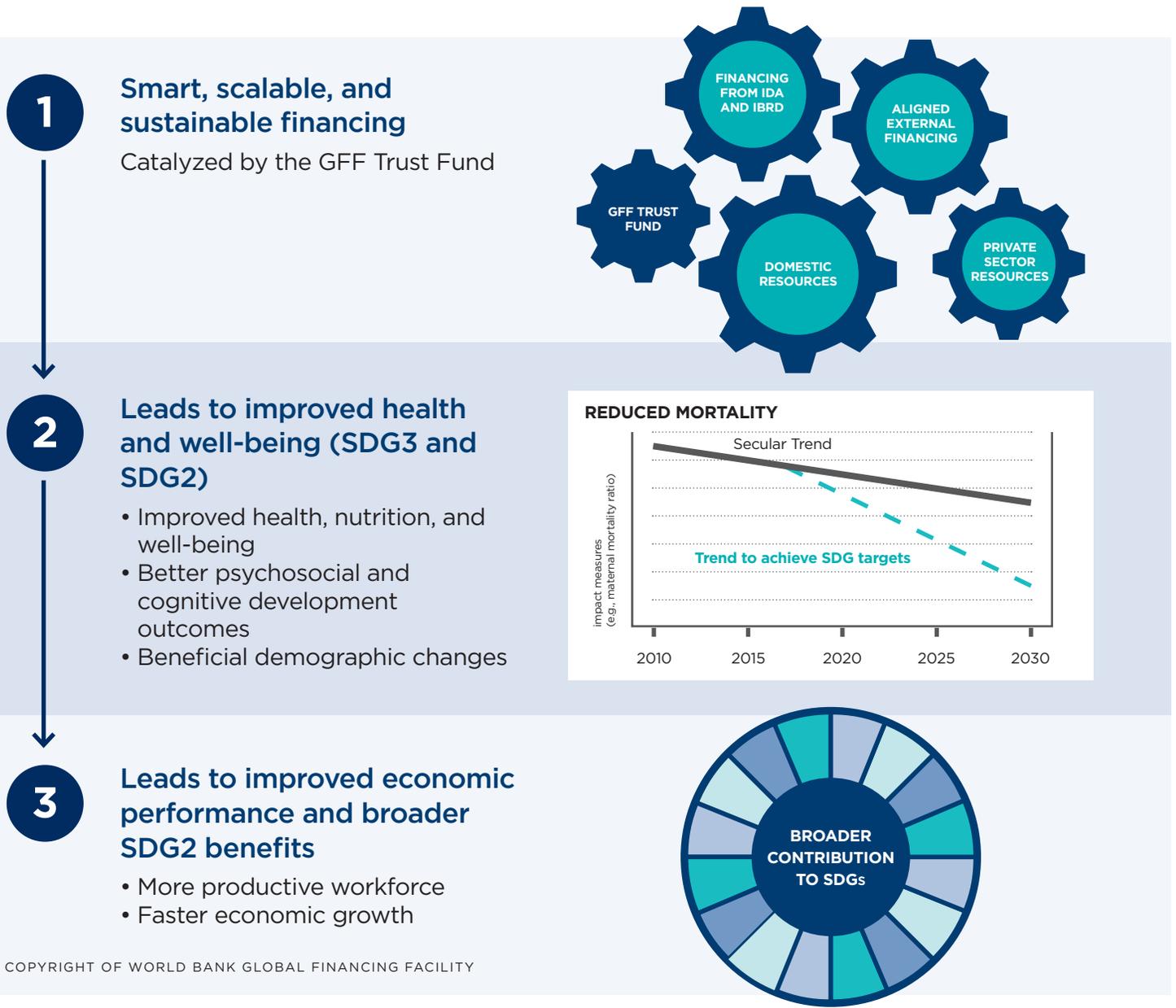
Recently, there have been significant policy-level changes in the global health architecture including the re-affirmation of the global prioritization of Universal Health Coverage (UHC) at the 74th Session of the UN General Assembly (UNGA) and the World Health Organization's renewed commitment to double health coverage in the world between 2019 and 2030. In light of these global policy changes, the change in leadership at the GFF, and the expansion of the facility to cover an additional nine countries, the time to implement the recommendations put forward here is now!

# INTRODUCTION TO THE GFF

The Global Financing Facility (GFF)<sup>1</sup> is a multi-stakeholder country-led financing mechanism for reproductive, maternal, newborn, child and adolescent health and nutrition (RMNCAH-N). The mechanism, established in 2015, aims to harmonize the hitherto

fragmented RMNCAH-N financing initiatives, under the leadership of the governments of participating countries, to close the annual financing gap of U.S.\$33 billion needed to eliminate preventable maternal, child, and adolescent deaths, achieving the Sustainable Development

**FIGURE 1: GFF AIMS AND FINANCING MODEL**



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1 [https://www.globalfinancingfacility.org/sites/gff\\_new/files/FAQs\\_EN\\_Web.pdf](https://www.globalfinancingfacility.org/sites/gff_new/files/FAQs_EN_Web.pdf)

Goals (SDGs) by 2030. The GFF is a catalytic funding mechanism that uses modest amounts of grant resources to realize far greater sums of domestic government resources and IDA, and IBRD financing that will align with external financing, and resources from the private sector to improve reproductive, maternal, newborn, child, and adolescent health RMNCAH-N programming and health outcomes (Figure 1). While the GFF portends huge potential to revolutionize the financing of RMNCAH-N, its success is contingent on the inclusivity, accountability, and transparency of its mechanisms.<sup>2</sup> The mechanism has been criticized as being inconsistent, exclusive, and opaque<sup>3</sup> in most GFF countries, which has limited the

meaningful engagement of key stakeholders including civil society organizations (CSOs). On this premise, the Open Society Foundations (OSF) commissioned a comparative analysis of the GFF mechanism to:

1. Identify key trends in the health financing landscape of the GFF
2. Identify key opportunities for civil society organizations (CSOs), both at global and country level, to advocate for increased transparency, accountability and participation of GFF operations
3. Inform OSF's own work in the area.

## TECHNICAL APPROACH

### COUNTRY SELECTION

A sample of seven countries was selected: namely, Cote d'Ivoire, Guatemala, Kenya, Malawi, Nigeria, Sierra Leone and Uganda. This selection was based on pragmatic and purposeful criteria that considered: regional representation; country income level; eligibility for World Bank (WB) funding; country performance against key RMNCAH indicators; strategic opportunity for advocacy work by OSF-supported CSOs; and the time point at which countries started participating in the GFF; with countries joining before and after November 2017 being referred to as Phase 1 and Phase 2 countries respectively.

### METHODOLOGY

In order to address the broad objectives of the study a mixed methods approach was adopted that involved: (1) desk review of GFF-related literature including investment cases (ICs), health financing strategies, project appraisal documents, case studies and reviews on innovative financing mechanisms; (2) comparative analysis of financing trends in the seven countries; and (3) expert interviews with local and global CSOs, GFF liaison officers, private sector representatives, and academics to inform context mapping, assess political economy, and identify advocacy opportunities.

<sup>2</sup> Salisbury, Nicole A., et al. "Operationalizing the Global Financing Facility (GFF) Model: The Devil Is in the Detail." *BMJ Glob Health*, vol. 4, no. 2018-001369 BMJ, 2019, pp. 2018-20, doi:10.1136/bmjgh-2018-001369.

<sup>3</sup> [https://www.ippf.org/sites/default/files/2018-09/GFF\\_Recommendations\\_IPPF\\_Feb2018.pdf](https://www.ippf.org/sites/default/files/2018-09/GFF_Recommendations_IPPF_Feb2018.pdf)

# RESULTS/FINDINGS

## FINANCING TRENDS

### Matching ratio of GFF grants to IDA/IBRD credit

The total GFF Trust Fund commitment amounts to U.S.\$532 million with co-financing of U.S.\$3.3 billion from IDA and U.S.\$500 million from IBRD. The GFF portfolio matching ratio is, on average, U.S.\$1 for every U.S.\$7.1 of IDA/IBRD co-financing (Figure 2). This implies that for every dollar granted by the GFF to the portfolio countries, U.S.\$7.1 of IDA/IBRD loans are unlocked.

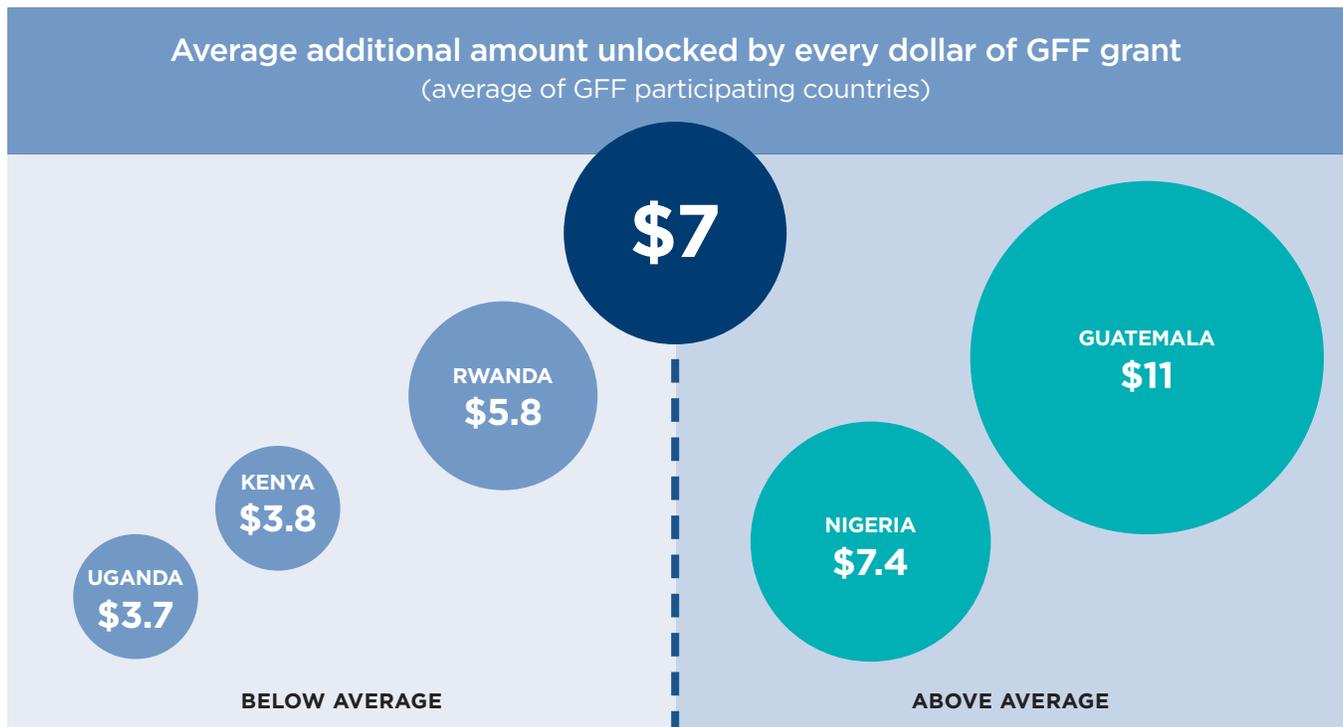
### Additionality of the GFF

The GFF is underpinned by a financing model that should ideally leverage on comparatively

small amounts of grant resources that act as a catalyst to unlock more funding from domestic government resources and IDA and IBRD financing that is aligned with external financing, and the private sector in order to bring RMNCAH programs to scale.<sup>4</sup> In this light, the GFF mechanism enhances the process on four levels:

1. Ring-fencing funds for RMNCAH rather than being left open and at risk of being re-appropriated to other country needs—a level evident in all the seven countries
2. Unlocking more funds from IDA/IBRD—at a level evident in all countries apart from Sierra Leone where there are no financial commitments yet

**FIGURE 2: MATCHING RATIOS OF GFF GRANTS TO LOANS**



<sup>4</sup> <https://www.globalfinancingfacility.org/financing-model>

Country	GFF	Additional Donor Fund	IDA Loans	Effect of GFF Additionally
Nigeria	47	—	350	✓ Funds ring-fenced
Kenya	40	17	150	✓ IDA/IBRD unlocked
Uganda	30	35	110	✓ Additional donor investments enabled
Rwanda	18	35	105	✗ Domestic resource allocation increased
Malawi	10	—	—	
Nigeria	9	—	—	
Sierra Leone	0	—	—	

Note: Add'l means additional donor investments

**FIGURE 3: ADDITIONALITY EFFECT OF GFF MECHANISM**

3. Additional donor investments realized as a result of initial GFF investments—evident in Kenya, Uganda, Rwanda, and Nigeria
4. commitment of domestic resources towards RMNCAH by governments, which is generally non-existent in many countries under study (Figure 3). Most governments have opted for additional credit from the IDA/IBRD, which may be unsustainable, rather than mobilizing domestic resources that are more sustainable. This lowers the overall financial sustainability of RMNCAH-N financing mechanisms in GFF participating countries, which is tangential to the attainment of UHC. Rwanda and Nigeria are the only countries (out of the seven studied) that have mobilized some domestic resources albeit in rather small scale in light of the overall funding requirement. The Independent GFF Observer, the African Health Budget Network has recently released the most up to date analysis

of domestic resource mobilization efforts, demonstrating the vast gaps that remain.<sup>5</sup>

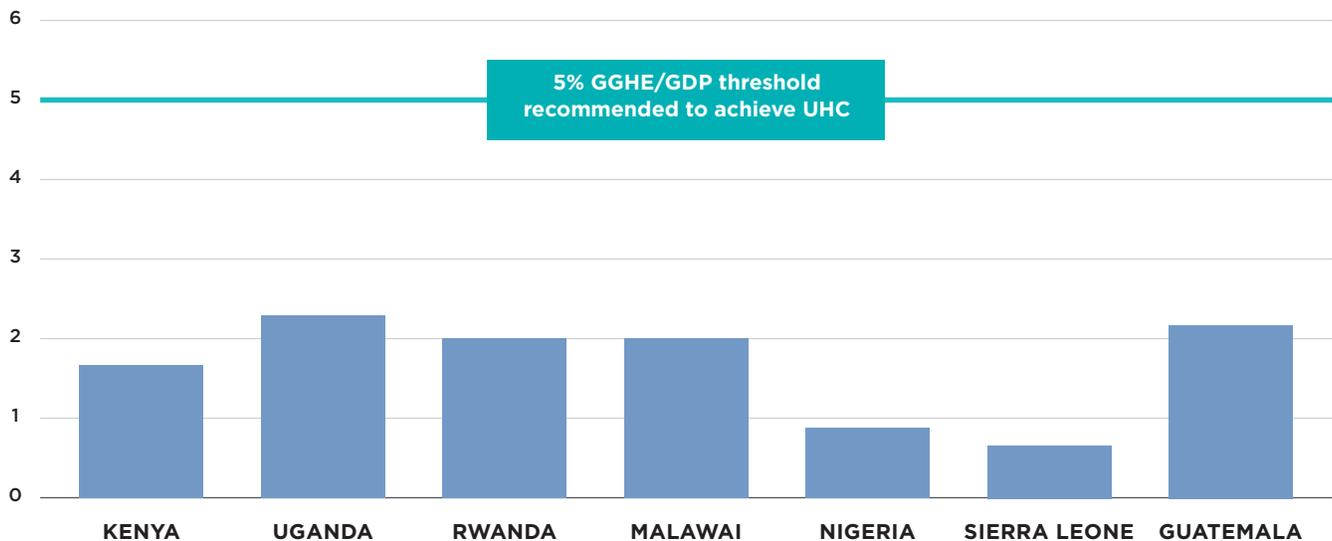
A key premise of the GFF is that it will generate additional resources for RMNCAH-N spending. This ‘Additionality’ as it is known, is critical for the sustainable attainment of UHC as well as RMNCAH-N health outcome targets in the GFF participating countries. Most, if not all, countries are yet to attain key health financing thresholds e.g., general government health expenditure as a percent of GDP is below 5 percent, which is considered requisite for the attainment of UHC.<sup>6</sup> (Figure 4).

#### The GFF and country indebtedness

The contribution of GFF-catalyzed loans to overall increase in country debt is low in all the countries studied apart from Rwanda where the GFF-catalyzed IDA loan makes up 22.5 percent of the increase in country debt between 2017 and 2018 (Figure 5). The low contribution to total country debt is because the countries

<sup>5</sup> [http://africahbn.info/sites/default/files/resources/ahbn\\_2019\\_health\\_expenditure\\_domestic\\_spending\\_scorecard.pdf](http://africahbn.info/sites/default/files/resources/ahbn_2019_health_expenditure_domestic_spending_scorecard.pdf)

<sup>6</sup> Chatham House Report. *Shared Responsibilities for Health A Coherent Global Framework for Health Financing*. 2014.

**FIGURE 4: GENERAL GOVERNMENT HEALTH EXPENDITURE AS A % OF GROSS DOMESTIC PRODUCT**

studied have acquired significant debt independent of the GFF mechanism. The percentage of overall debt to GDP ranges from 21 percent to 71.4 percent with Sierra Leone, Kenya, and Malawi having the highest percentages as of 2018. Sierra Leone is above the World Bank's (2010) recommended debt/GDP threshold of 64 percent for emerging markets,<sup>7</sup> while other countries were below it. The proportion of GFF catalysed IDA (IBRD) loans to health sector debt is seemingly below 50 percent with Nigeria's loan<sup>8</sup> contributing 21 percent of the overall health sector between 2016 and 2017. This shows that the GFF is not the only mechanism driving debt in the health sector, but it is the case that countries have taken on more loans for the sector.

#### Complementary innovative financing mechanisms

The UN estimates that SDG implementation costs U.S.\$3.9 trillion a year in developing

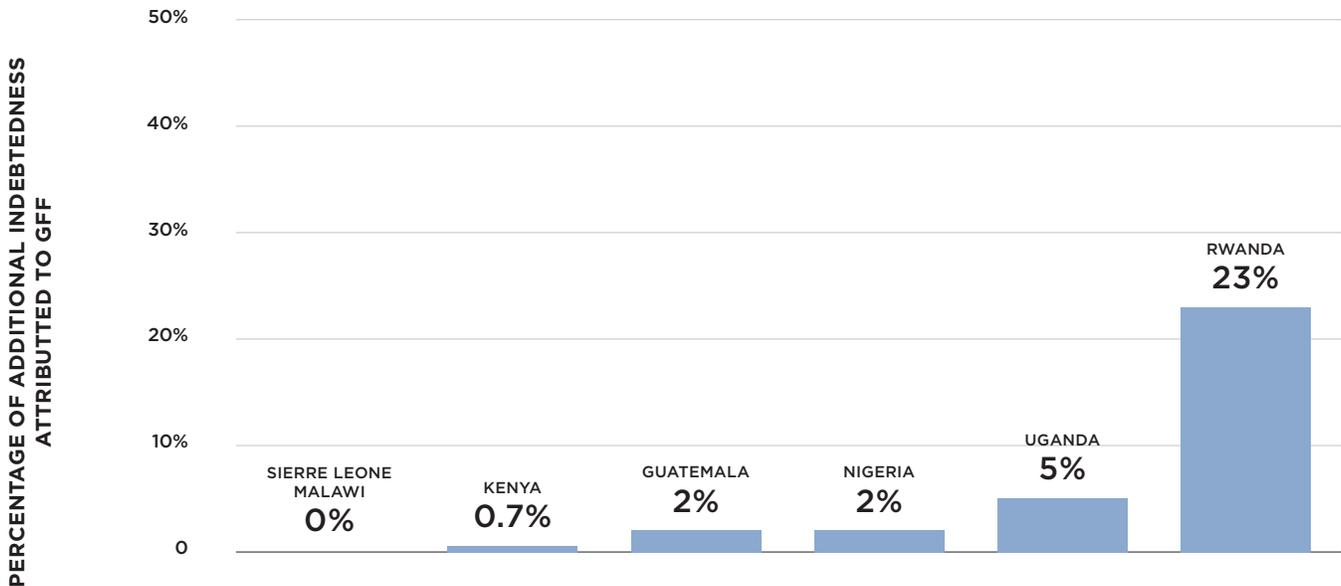
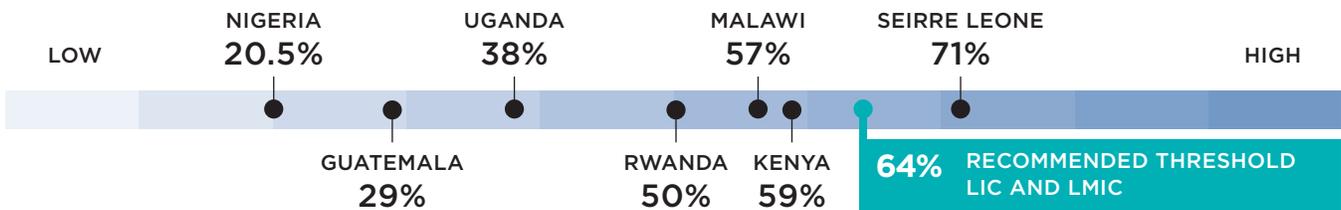
countries and the current financing levels can only cover U.S.\$1.4 trillion leaving a projected annual gap of U.S.\$2.5 trillion that necessitates innovative financing. This is congruent with the GFF's intent of catalyzing additional financing using innovative financing mechanisms. The Multi-Donor Trust Fund (MDTF) in Kenya, the Scaling Up Nutrition MDTF in Rwanda, the Basic Healthcare Provision Fund in Nigeria, and IBRD Interest-buy down in Guatemala exemplify innovative financing mechanisms that complement the GFF grant funding.

#### ADVOCACY TRENDS

In terms of CSO advocacy specialties, monitoring, accountability and involvement in the implementation in the GFF mechanism appears weak in most of the countries studied. In countries like Malawi and Uganda, holding the government to account is poorly done because

7 Grennes, T., Caner, M., & Koehler-Geib, F. (2010). "Finding the Tipping Point -- When Sovereign Debt Turns Bad". *Policy Research Working Papers*. <https://elibrary.worldbank.org/doi/abs/10.1596/1813-9450-5391>

8 <https://www.dmo.gov.ng/publications/reports/dmo-annual-report-statement-of-accounts/1021-dmo-2015-annual-report/file>

**FIGURE 5: ADDITIONAL INDEBTEDNESS DUE TO THE GFF AND PERCENTAGE OF DEBT TO GDP****PERCENTAGE OF DEBT/GDP**

of fear of victimization by government. Private sector involvement in Malawi and Uganda is also weak. Globally and at country levels, there is movement towards coordinated advocacy through CSO coalitions that currently exist in Kenya (HENNET), Nigeria (HERFON), and Sierra Leone (Health Alert). The main challenge facing the CSO coalitions is poor governance structures. CSOs have increasingly succeeded in key advocacy initiatives for example, the enactment of National Health Act in 2014 and the establishment of the BHCPF and the allocation of 1 percent of Consolidated Revenue Fund to the BHCPF in Nigeria. In Malawi, CSOs have

continuously advocated on lifting the recruitment ban and employ health care workers indirectly on a locum basis. Globally, “The GFF We Want” Campaign<sup>9</sup> has been successful in raising awareness on the importance of a participatory and country-led GFF mechanism.

**TRANSPARENCY TRENDS**

When compared against the GFF minimum guidelines on transparency, there has been little transparency in the GFF mechanism. The lack of transparency is largely due to three factors: (1) ad-hoc involvement of CSOs; (2) lack

9 <https://wacihealth.org/gff-campaign/>

of open flow of information (full disclosure); and (3) unnecessary government influence on the activities of CSOs. With regards to (1) ad-hoc involvement, key stakeholders including CSOs in Kenya, Malawi, Sierra Leone, and Guatemala were poorly involved in critical GFF processes. In Kenya, for instance, CSOs were only invited to review (and endorse) the IC case yet they were not invited to participate in its development. In Guatemala, CSOs were requested to submit their organizational logos to be incorporated in the GFF documents despite the CSOs not participating in the development of these documents. On (2) lack of full disclosure of information, there is little flow of information from the Nigerian Federal Government and WB on the Nigeria States Health Investment Project (NSHIP); the Nigeria Health Sector Reform Coalition does not release timely information to CSOs, a situation that also prevails in Uganda; minimal openness on budget allocations to health in Sierra Leone; and opacity in the disbursement of funds to county governments in Kenya. In relation to (3) government influence, the three CSOs that participate in the national CSO platform in Malawi have been handpicked by the Government and are not willing to engage with other CSOs in the country.

## KEY CHALLENGES

While the GFF has yielded some success as explained in the preceding chapters, the mechanism has been faced with several challenges elaborated below:

- A. **Opacity in the GFF mechanism:** First, this is evident in the dysfunctional country platforms that have limited the participation of key stakeholders, for example CSOs complain that governments and WB claims that GFF conversations are internal and are not open to the public. Secondly, country selection, development of ICs and Project Appraisal Documents (PADs) and allocation of funding contingent on the negotiations between the government and WB compounds opacity further. In some countries (e.g., Malawi), IDA loans have been approved before finalizing the IC which contravenes the approved GFF process.
- B. **Lack of evidence-based financing:** The fact that there are countries that have received WB funding without developing an IC (e.g., Rwanda) or instances where ICs are developed yet PADs already exist (e.g., Malawi) suggests that the linkage (or necessity for) evidence-based ICs in informing the design of PADs is non-existent or not appreciated.
- C. **Lack of clear linkage between GFF funding and impact:** There is no consensus on a framework against which improvements in RMNCAH-N indicators can be tracked and attributed to the GFF mechanism. Further, there is redundancy in financing mechanisms (e.g., with funds from off-budget mechanisms such as USAID's funding to NGOs that is parallel to the GFF). This redundancy precludes any scientific way of demonstrating a causal link between GFF funding and any changes in RMNCAH-N indicators.
- D. **Multi-stakeholder country platform:** The multi-stakeholder country platforms are not inclusive, transparent and have weak accountability mechanisms in most GFF countries studied and this negates the effective development principles of the GFF.
- E. **CSO organization and representation:** In some countries, the CSOs do not have an organized system for being represented in the GFF mechanism. The result is that the

more resourced (often global organizations) end up being the representatives of other CSOs in the GFF mechanism crowding out indigenous CSOs. For instance, in Uganda the absence of a system for the nomination of a CSO to represent other CSOs in the mechanism resulted in World Vision having a seat at the country platform albeit without the knowledge or consent of other CSOs in the country. Government influence in appointing CSOs to the platform, for example in Malawi, and competition among CSOs have led to redundancy of the local CSOs as they are outwitted by highly resourced global CSOs. The CSO coalitions that elect or nominate representatives to the country platform are being embraced in different countries to reduce competition and redundancy among CSOs.

**F. Misunderstanding about the GFF:** CSOs seem to look at the GFF as a “global funding opportunity” that they can apply for funding from to meet their operating expenditure needs and therefore the concept that the GFF catalyzes financing for RMNCAH is lost. Many CSOs in Nigeria, Malawi, and Uganda submitted funding proposals only to be turned down. Other stakeholders think that GFF funds or IDA loans unlocked as a result of the GFF should take an equity approach and benefit all citizens equally and not focus on marginalized populations and RMNCAH-N indicators. This was evident by county governors in Kenya.

**G. Limited capacity of GFF-eligible countries to make the GFF “country-led”:** By design, GFF eligible countries are low-income, fragile states or countries in conflict and many of them are heavily donor-dependent e.g., Malawi where 75 percent of health expenditure is financed by donors. These

countries are at risk of losing leadership and priority-setting to donors.

- H. Lack of funding for CSOs:** Currently, the provision of the Small Grants Mechanism (SGM) has a funding ceiling of U.S.\$70,000 per CSO and only 9 countries out of 36 secured the funding and for the GFF resource hub grants around 11 countries receive financing from it. This demonstrates the dire financing constraints that CSOs face and many end up applying for grants and therefore struggle and cannot carry out their core governance roles well.
- I. Poor inter-CSO collaboration/coordination:** While many CSOs claim to be open to collaboration while in public forums, most do not engage in collaborative work due to fear of loss of budget or relevance to donor-driven priorities.
- J. Inclusion and participation of key stakeholders in the GFF mechanism:** The GFF mechanism has often failed to be optimally inclusive and to consistently allow for CSO participation. This is evident at three levels: at in-country level key ministries are left out, CSOs representation on country platforms is inconsistent apart from Rwanda and Nigeria, and key stakeholders like the private sector and academia are left out, e.g., in Uganda.

# POLICY RECOMMENDATIONS

Based on insights gathered in this comparative analysis, there is merit for consideration of the following policy recommendations as part of future work on the GFF by different stakeholders:

## A. Implementation of the minimum standards for inclusion, transparency, and accountability for the multi-stakeholder country platform:

Since many of the country platforms are lacking in inclusivity, transparency, and accountability mechanisms, there is need to revamp the platforms to live up to the minimum guidelines proposed by the GFF.<sup>10</sup> The Governments and Ministries of Health of GFF participating countries, in their capacity as conveners and leaders of the GFF multi-stakeholder country platforms, ought to take charge of the restructuring of the country platforms. The development of the IC should follow a four-step process: developing roadmaps with key roles, timelines and milestones; consultative engagement to develop the IC in line with SDGs and country priorities; commission detailed assessment and diagnostics and reviewing that the IC ensuring quality is upheld. The multi-stakeholder country platform should bolster inclusion, transparency, and accountability by allowing the participation of key stakeholders in country, making timely public disclosure of GFF documentation, and aligning the monitoring and accountability mechanism with the national processes strengthening them in the long run.

**B. Peer-to-peer learning:** The GFF secretariat, GFF-IG, and individual CSOs should strive to ensure that future work in countries

that have recently joined the GFF leverages on learnings from Phase 1 and 2 countries, e.g., with regards to the formation of country platforms and ICs. Countries like Rwanda and Ethiopia are good models of strong government leadership. Further, the GFF secretariat and the GFF-IG and Trust Fund should ensure that key learnings from the financing models and governance structures of other mechanisms such as GAVI and the Global Fund are leveraged on to improve the GFF. CSO coalitions should draw lessons from each other, especially from those that have been comparatively more successful in engaging with the GFF, for example HERFON in Nigeria.

## C. Awareness creation to correct existing misconceptions:

The GFF Secretariat and the Civil Society Coordinating Group should initiate and support health finance and budget-focused advocacy both globally and locally to create the correct understanding that GFF is pro-equity and should enhance equity by prioritizing those who are currently least covered by RMNCAH-N services. Similarly, the Civil Society Coordinating Group and the CSO coalitions should focus on creating awareness among CSOs on what the GFF is.

## D. Strengthening of monitoring and accountability in project implementation:

The multi-stakeholder country platforms should ensure that the GFF minimum guidelines on accountability are instituted. Since monitoring and accountability were reported to be weak in most countries like Uganda; the platforms should create monitoring and accountability frameworks

<sup>10</sup> [https://www.globalfinancingfacility.org/sites/gff\\_new/files/documents/GFF%20Country%20Platform%20guidance%20note.pdf](https://www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF%20Country%20Platform%20guidance%20note.pdf)

that leverage on data quality and integrate health information systems to monitor facilities at sub-national levels.

- E. Use of key opinion leaders as advocacy champions:** CSOs should consider incorporating key opinion leaders as key contributors to their advocacy mandate, especially in light of the influence these leaders have over the CSOs key audiences and stakeholders. For example, faith-based organizations in Uganda own more than 50 percent of health facilities and the parliamentary committee on health in Malawi participates in district councils. These are influential advocacy champions whose influence should be harnessed by CSOs.
- F. Making funding calls pro-collaboration:** Donors and other funders, including Open Society Foundations may consider using funding calls to promote collaboration among CSOs by making these calls more advantageous to CSO consortiums (as opposed to individual CSOs) whose work is best aligned with the respective county priorities and ICs. This will reduce competition and redundancy among CSOs.
- G. Addressing CSO funding challenge:** The GFF Secretariat, GFF-IG, and the GFF Trust Fund Committee should institute sustainable, dedicated, and adequate streams of funding for CSOs to engage adequately with the GFF mechanism in the country. Beyond the GFF, since CSO funding for advocacy and accountability is critical to achieving global health priorities, multilateral institutions and bilateral and private donors should confront this challenge by drawing lessons from sectors like the Global Partnership for Education and
- its new Advocacy and Social Accountability funding stream<sup>11</sup> or new proposals on Global Public Investments.<sup>12</sup>
- H. Building capacities of GFF stakeholders for optimal engagement in the GFF mechanism:** CSO coalitions and individual CSOs should build the capacity of governments (in countries that have recently joined the GFF) to lead and set priorities for the GFF mechanism in their respective countries. Further, CSOs ought to create awareness on the existence and scope of government support to the GFF in Phase 1 and 2 in GFF participating countries. A case in point is Rwanda, where the government's strong leadership has been reported to contribute significantly to Rwanda's GFF mechanism being country-led. CSOs can leverage on this example to advocate for stronger engagement in the GFF by governments. Donors and other funders who fund CSOs to carry out advocacy work in relation to the GFF, should consider identifying capacity gaps in the CSOs they fund and supporting these CSOs to bridge these gaps in order to effectively engage with the GFF. This support could be in providing access to information and enhancing the grant writing skills of CSOs.
- I. Advocacy to align off-budget funding with country ICs:** Currently, GFF funding is considered "on-budget" since it flows through the government. There are significant pockets of funding that are "off-budget" and are channelled directly to NGOs and other implementing entities. Since it difficult to ascertain that these off-budget funds are used to advance the country priorities, there is merit in aligning these

<sup>11</sup> <https://www.globalpartnership.org/focus-areas/advocacy-and-social-accountability>

<sup>12</sup> Jonathan Glennie, *Global Public Investment: Five Paradigm Shifts for the Future of Aid*. 2019

funds to respective country ICs priorities. The GFF-IG that is mandated to mobilize resources for ICs and whose membership includes donors and other funders who in some cases provide off-budget support to CSOs, NGOs, and other entities, is best placed to take up this recommendation.

- J. Advocacy to enhance participation in the GFF mechanism:** The GFF-IG and the GFF Trust Fund Committee should drive the implementation of the private sector engagement strategy<sup>13</sup> in order to enhance private sector participation in the GFF and enhance domestic resource mobilization. The GFF-IG and the multi-stakeholder country platforms, at the global and country levels

respectively, should involve academia in the GFF mechanism, especially in the generation of research evidence to power the investment cases and financing strategies of the GFF. This can draw on the experience of the John Hopkins School of Public Health that has pioneered the countdown to 2030 initiative that provides technical analysis and support to countries on effectively prioritizing areas and activities for their participation in the GFF. Individual CSOs at the country level should ensure increased participation of the devolved units of government since devolution exists in many countries, e.g. Kenya, Malawi, Rwanda, and Nigeria.

## CALL TO ACTION

The GFF, hinged on a financing model that leverages on modest grant funding to unlock additional resources to scale up RMNCAH interventions, is far from achieving its noble mission. The facility has not only failed to mobilize sustainable domestic resources from the governments of participating countries but has also been plagued by transparency, accountability, and inclusivity deficits. These challenges stand out against the backdrop of recent and significant policy-level changes in the global health architecture including the re-affirmation of the global prioritization of Universal Health Coverage at the 74th Session of the UN General Assembly, and the World Health Organization's renewed commitment to double health coverage in the world between 2019 and 2030. In light of these global policy dynamics, the change in leadership at the GFF, and the increase in the number of GFF participating countries from 27 to 36, now is the time for concerted multi-stakeholder efforts to implement the policy recommendations put forward here.

<sup>13</sup> <https://www.globalfinancingfacility.org/gff-private-sector-engagement-strategy-0>

## About E&K Consulting

E&K Consulting is an advisory and investment firm that provides turnkey solutions in the health care, finance, and technology sectors in Africa and beyond. The firm has advised on transactions (mergers and acquisitions) in the global health care industry worth over U.S.\$20 billion, conducted transactional advisory work valued at over U.S.\$100 million, developed strategies for health care businesses worth over U.S.\$160 million and advised several development programs in over 20 countries in Africa and Europe. The firm is an advisor to over 100 unique clients globally. Beyond being an advisor, E&K Consulting is an implementer and investor in health care, finance, and technology sectors across the public, private, and development sectors globally. E&K Consulting is driven by its mission to support its clients to not only achieve competitive commercial advantage but also drive positive societal change in the geographies where we operate.



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