# Comparative Analysis of Selected Global Financing Facility-related Investments

## Report

May 2020

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## Abbreviations

| | |
|---|---|
| CBCC | Community Based Childcare Centre |
| CSO | Civil Society Organization |
| DANIDA | Danish International Development Agency |
| DFID | Department for International Development |
| 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 |
| HFQCAP | Healthy Facility Quality of Care Assessment Program |
| IBRD | International Bank for Reconstruction and Development |
| 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 |
| RMNCAH | Reproductive, maternal, new-born, child and adolescent health |
| RMNCAH-N | Reproductive, maternal, new-born, child and adolescent health and nutrition |
| SMART | Standardized, Monitoring and Assessment of Relief and Transition methods |
| USAID | United States Agency for International Development |
| WBG | World Bank Group |
| WHO | World Health Organization |
| UNPF | United Nations Population Fund |
| DRM | Domestic Resource Mobilization |
| PMNCH | Partnership for Maternal, New-born and Child Health |
| SGM | Small Grants Mechanism |
| HERFON | Health Reform Foundation of Nigeria |

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## About the Open Society Foundations

The Open Society Foundations, founded by George Soros, are the world's largest private funder of independent groups working for justice, democratic governance, and human rights. George Soros opened his first international foundation in Hungary in 1984. Today, the Open Society Foundations support a vast array of projects in more than 120 countries, providing thousands of grants every year through a network of national and regional foundations and offices.

Website: https://www.opensocietyfoundations.org/

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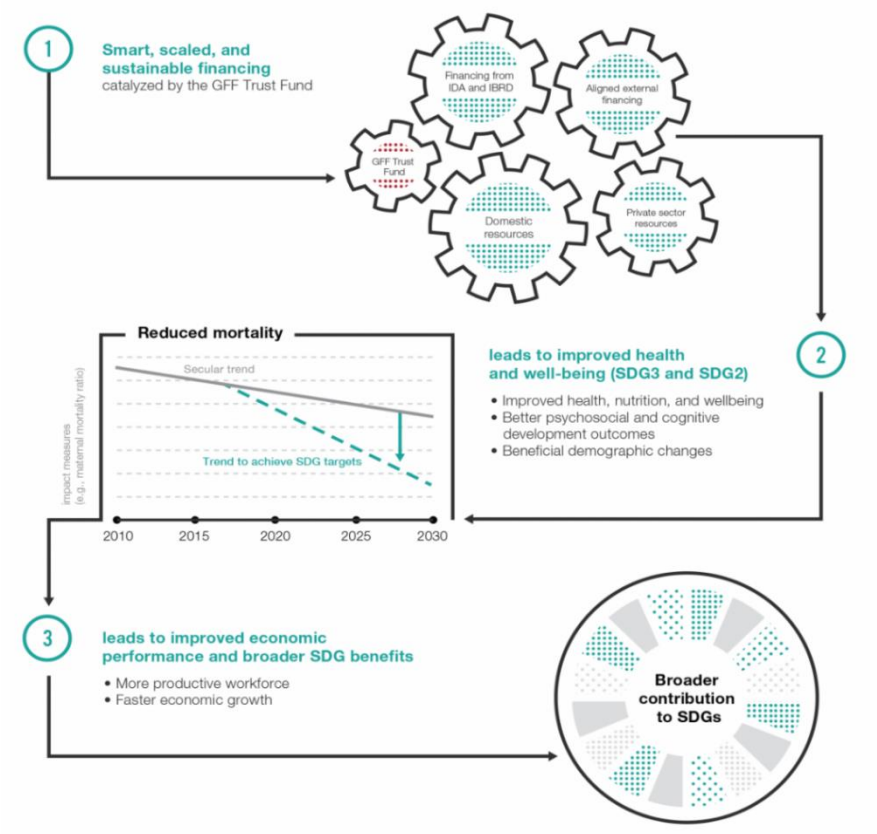
## 1. Introduction

The Global Financing Facility (GFF)[1] is a multi-stakeholder country-led financing mechanism for reproductive, maternal, new-born, 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 US$33 billion needed to eliminate preventable maternal, child, and adolescent deaths, achieving the Sustainable Development Goals (SDGs) by 2030. Beyond bridging the financing gap, the GFF was envisioned to support participating country governments to coordinate stakeholders and lead an evidence-based process to identify, prioritize and jointly invest in cost-effective interventions (such as family planning) and eliminate health-system bottlenecks (Figure 1). The GFF is therefore a partnership that brings together stakeholders through a government-led country platform that typically includes the national government, civil society organizations, the private sector, multilateral and bilateral institutions, and foundations[1]. Currently, out of the 67 countries that are eligible for GFF support, the mechanism works in 36 countries that are referred to as GFF participating countries.[2]

**Figure 1: Financing model and aims of the GFF**




Data source: GFF website

[1] https://www.globalfinancingfacility.org/sites/gff_new/files/FAQs_EN_Web.pdf
[2] https://www.globalfinancingfacility.org/where-we-work

While GFF portends huge potential to revolutionize the financing of health priorities and indeed the development landscape, its success is contingent on several factors.[3] Key among them being the extent to which the financing choices and decision-making processes are transparent. The GFF has indeed been criticized in the past on account that these critical processes remain largely inconsistent, exclusive and opaque.[4] There have been efforts by several stakeholders, including civil society groups to advocate for enhanced transparency in the GFF mechanism.[5]

As part of work to advance transparency, accountability and participation in health decision-making, the Open Society Foundations (OSF)[6] has supported civil society organizations (CSOs) to engage with the GFF mechanism including convening other stakeholders, engaging in country GFF processes directly, interrogating the programmatic and financing choices made as part of GFF roll-out, and monitoring early implementation of GFF programs. To further optimize its support to CSOs and contribute to the broader understanding of this development financing mechanism, OSF commissioned a comparative analysis of GFF-related investments in select countries. The study sought to analyze a cross-section of GFF countries to identify trends in the health financing choices of the GFF mechanism, to increase the transparency of the decisions by and funding facilitated through the GFF and contribute to civil society advocacy at a global and country level.

## 2. Objectives

The objectives of the comparative analysis of GFF-related investments presented here were to:

1. Analyze a cross-section of GFF countries to identify trends in the health financing choices of the GFF mechanism;
2. Identify opportunities and make recommendations on how civil society advocacy at country and global level can be enhanced to increase transparency of the GFF mechanism;
3. Identify opportunities and make recommendations on how OSF's operational work on GFF, including advocacy with the GFF Secretariat and donors as well as the foundation's influence on future grant making choices can be improved.

## 3. Technical Approach

### Country selection

The comparative analysis of GFF-related investments presented here made an intentional focus on country-specific rather than general perspectives of the facility. In light of this, the analysis prioritized country processes and country stakeholders. A sample of nine countries was selected out of the 27 GFF participating countries using pragmatic and purposeful criteria that considered:

1. Regional representation
2. Country income level
3. Eligibility for World Bank lending/funding

[3] 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.
[4] https://www.ippf.org/sites/default/files/2018-09/GFF_Recommendations_IPPF_Feb2018.pdf
[5] https://www.wemos.nl/wp-content/uploads/2018/11/Joint-Open-Letter-to-the-GFF-by-Wemos-and-CSOs-05112018.pdf
[6] https://www.opensocietyfoundations.org/

4. Performance of individual countries in terms of health outcomes against key RMNCAH-N indicators
5. 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
6. Opportunity for advocacy work by OSF-supported mechanisms and CSOs

Based on these criteria the selected countries are (Figure 2):

1. Cameroon
2. Guatemala
3. Kenya
4. Malawi
5. Nigeria
6. Rwanda
7. Senegal
8. Sierra Leone
9. Uganda

**Figure 2: The nine countries selected for the Global Financing Facility comparative analysis study**


The selected countries were deemed representative and relevant for the comparative analysis because they:

1. Represent all geographical regions save for South Asia and East Asia and Pacific which are not represented because of the lack of immediate strategic opportunity for advocacy work by OSF-supported mechanisms and CSOs
2. Represent all income groups with a higher representation of low-income countries which is reflective of the higher representation of low-income countries among the GFF participating countries

3. Represent all categories of eligibility for World Bank lending i.e. eligibility for International Development Association (IDA), International Bank for Reconstruction and Development (IBRD) and blend financing
4. Span the entire spectrum of country performance in terms of health outcomes against key RMNCAH-N indicators
5. Represent both Phase 1 and Phase 2 countries

### Methodology

In order to address the broad objectives of the study, a mixed-methods approach was adopted. This methodology primarily involved:

1. Desk review of relevant GFF-related literature including investment cases, health financing strategies, Project Appraisal Documents (PADs), policy and financing strategy documents, case study publications on GFF implementation and data/information on health financing and results-based financing (RBF) mechanisms such as the GFF from major repositories such as PubMed; Cochrane Database; Blackwell Publishers; and Google Scholar
2. Empirical information gathering through expert interviews. This involved consultations with international and national civil society groups and other GFF stakeholders in the country and at a global level to understand their GFF engagement, to inform context mapping, political economy analysis and advocacy opportunities

Data and information that were gathered through the desk review and empirical methodology were analyzed to generate insights that addressed the objectives of the study i.e.:

1. Composition and scope of financing, e.g. the level of GFF Trust Fund grants, IBRD funding, IDA grants, IDA loans, ratio of loans to grants, ratio of Trust Fund resources to IDA and IBRD funding
2. Level of additional indebtedness incurred as part of GFF programming
3. Additional donor investments
4. Scope of Project Appraisal Documents and
5. Use of innovative financing mechanisms or release of funding linked to domestic resource mobilization (DRM) targets

The research presented here was conducted between June 2019 and January 2020. The analysis reported here reflects insights on the GFF as of January 2020.

## 4. Results

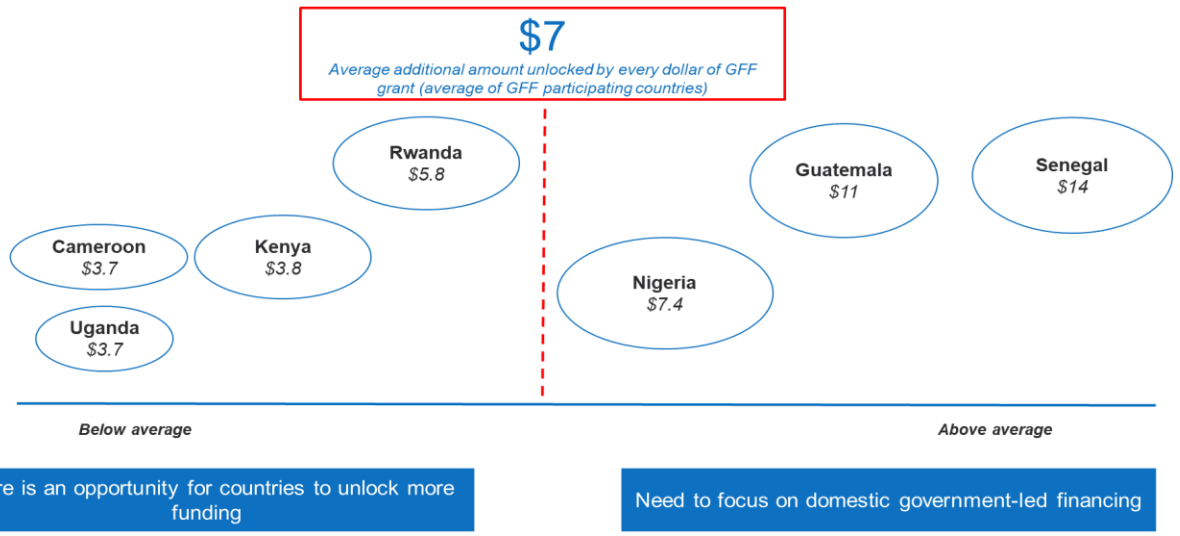
### 4.1. Trends in financing choices of the GFF

In May 2019, nine countries joined the GFF bringing the total number of GFF supported countries to 36.[7] The total GFF Trust Fund commitment amounts to US$532 million with co-financing of US$3.3 billion from IDA and US$500 million from IBRD. The GFF portfolio matching ratio is averagely US$1 for every

[7] https://www.globalfinancingfacility.org/nine-countries-join-global-financing-facility-now-reaching-36-countries-greatest-health-and?

US$7.1 of IDA/IBRD co-financing (Figure 3). This implies that for every dollar grant from GFF to the portfolio countries, the IDA/IBRD loans are unlocked 7.1 times more.

**Figure 3: Matching ratios of GFF grants to IDA/IBRD Loans**




Note: Malawi and Sierra Leone are not featured in this illustration. Malawi received an IDA grant rather than a loan. In the case of Sierra Leone, data on loans and grants were not available since the financial commitments from different financiers had not been finalized by the time of publishing this report. The investment case for Sierra Leone contemplates a funding requirement of US$545 Million and estimates the resource gap to be US$228 million.
Analysis: E&K Consulting Firm

From the desktop review of literature, Nigeria seems to be in line with the overall GFF portfolio matching criteria with a loans-to-grant ratio of 7.4 while Senegal has a higher matching ratio of 14. On the other hand, Uganda and Cameroon have the same matching ratio of 3.7 when the additional donor investments and Multi-Donor Trust Fund (MDTF) are not considered in the GFF grants sum. Rwanda has an average matching ratio of 5.8. Inferentially, there is still an opportunity to unlock more funding from IDA/IBRD for countries like Cameroon, Uganda, Kenya and Rwanda while more emphasis on DRM is merited in Nigeria, Guatemala and Senegal.

The absolute composition of the GFF funds and funds unlocked from IDA/IBRD are depicted in Table 1. Additional investments complementary to GFF have been identified in different countries as per Table 1. For example, in Kenya, US$1.1 million is committed by JICA and US$16 million from the MDTF financed by DFID, USAID and DANIDA. For the Rwandan case, the Scaling Nutrition Grant for the MTDF funds US$35 million aimed at reducing stunting rate in children under five years of age in targeted districts.[8] Data on the loans and grants for Sierra Leone is not available yet as the financial commitments from different financiers have not been finalized but the investment case requires US$545 million and the resource gap is estimated to be US$228 million.[9] For Malawi, the country did not receive a loan from IDA but was granted US$10 million from GFF Trust Fund and US$50 million grant from IDA for the "Investing in early years

[8] http://projects.worldbank.org/P164845/?lang=en&tab=overview
[9]https://www.afro.who.int/sites/default/files/2017[11]/Sierra%20Leone%20National%20Reproductive,%20Maternal,%20Newborn,%20Child%20and%20Adolescent%20Health%20Strategy%202017-2021.pdf

for growth and productivity in Malawi project". Insights gathered from the expert interviews conducted as part of this comparative analysis indicate that there are more than 50 proposals to be included in the investment case to capture RMNCAH-N though negotiations between stakeholders are still happening.

Taken together, the decision to either advance a grant or loan from IDA is pegged on IDA's lending terms with reference to a country's risk of debt distress and level of Gross National Income (GNI) per capita. With regard to IBRD, the aforementioned factors in addition to the country's creditworthiness are considered. Recipient countries with high risk of debt distress are financed fully through grants. This possibly explains the case of Malawi that received grant financing from both GFF and IDA. Further, the GFF resource allocation methodology is based on country's need and population. Countries that score low on these criteria qualify for between US$10 million and US$20 million over a four-year period. Rwanda, Senegal and Malawi fall in this category. Countries that score highly on these criteria are eligible for between US$40 million and US$60 million over a similar period. Kenya and Nigeria fall in this category. The funding is also influenced by a country's negotiation with the World Bank Group (WBG).

**Table 1: Composition and scope of financing**

Composition and scope of financing ($, Mn)

| | GFF | Add'l donor fund | IDA Loans | IDA Grants | IBRD |
|---|---|---|---|---|---|
| Nigeria | 47 | | 350 | | |
| Kenya | 40 | 17 | 150 | | |
| Uganda | 30 | 35 | 110 | | |
| Cameroon | 27 | | 100 | | |
| Rwanda | 18 | 35 | 105 | | |
| Senegal | 10 | | 140 | | |
| Malawi | 10 | | | 50 | |
| Guatemala | 9 | | | | 100 |
| Sierra Leone | 0 | | | | |

GFF seen to unlock high levels of additional donor funds and IDA loans **with minimal domestic government-led financing**

**IDA grants** seem to be advanced based on country's risk of debt distress and GNI per capita
**IBRD** advanced to lower and upper middle income countries on basis of credit worthiness

Note: Add'l means additional donor investments complementary to GFF
Analysis: E&K Consulting Firm

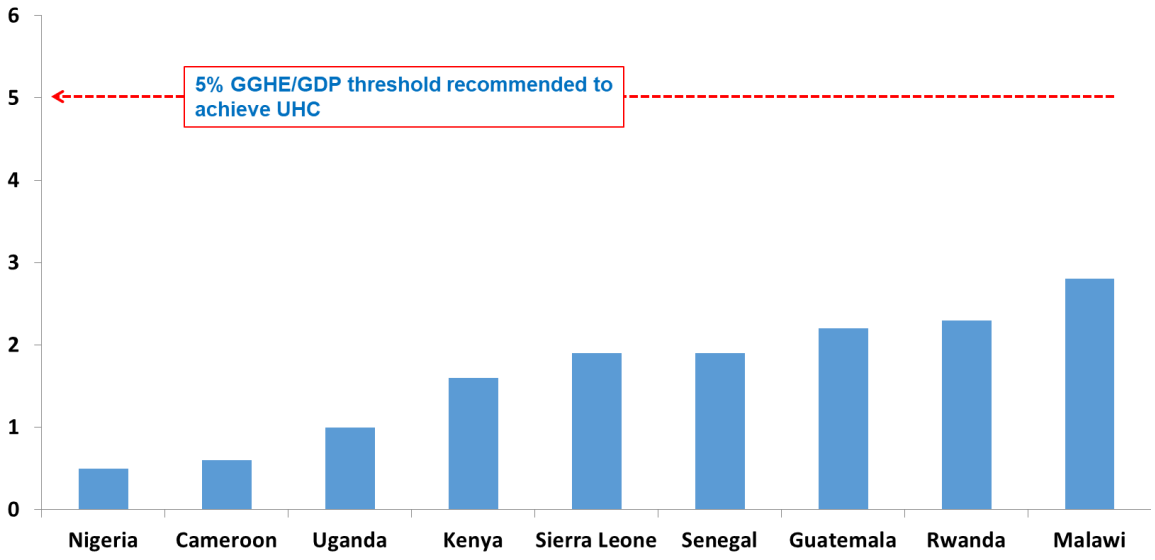
### 4.1.1. Additionality of the Global Financing Facility

The GFF is underpinned by a financing model that should leverage on comparatively small amounts of grant resources to catalytically unlock more funding from domestic government resources, IDA and IBRD financing, aligned external financing, and resources from the private sector in order to bring RMNCAH-N

programs to scale.[10] In this light, the GFF mechanism is envisaged to have an additionality aspect. This additionality is demonstrable on four levels. The first is the demonstration that the GFF mechanism provides funds that are ring-fenced for RMNCAH-N rather than being left open and at risk of being re-appropriated to other country needs. This is evident in all the nine countries studied here. The second is the ability of GFF grants to unlock more funds from IDA/IBRD mechanisms which is evident in all the nine countries apart from Sierra Leone where there are no financial commitments yet. The third is the commitment of domestic resources towards RMNAH by governments. Rwanda has attained this level of additionality where the government has committed US$6 million towards the strengthening of social protection projects, with US$80 million co-financing from IDA loans. Similarly, the Nigeria Federal Government has committed 1% of the Consolidated Revenue Fund (CRF) for the implementation of Basic Health Care Provision Fund (BHCPF). The fourth level is where additional donor investments are realized as a result of initial GFF investments. This is evident in Kenya, Uganda, Rwanda and Nigeria.

The additionality aspect of the GFF mechanisms is important since the sustainable attainment of universal health coverage (UHC) as well as RMNCAH-N health outcome targets is contingent on sustainable domestic financing of health. In the context of GFF-participating countries, additionality is acutely critical since many, if not all, countries are yet to attain key health financing thresholds. One such threshold is the proportion of general government health expenditure (GGHE) to a country's gross domestic product (GDP). The World Health Organization (WHO) declared 5% as the threshold needed to be met, for a country to progress towards UHC. Despite this, of the nine countries examined in this study, none met the threshold to exhibit progress towards UHC achievement. Malawi recorded the highest allocation of GGHE to GDP of 3%, but this allocation was still below WHO's recommendation (Figure 4).

**Figure 4: The percentage of General Government Health Expenditure (GGHE) to Gross Domestic Product (GDP) for the 9 countries in 2016**




Analysis: E&K Consulting Firm

[10] https://www.globalfinancingfacility.org/financing-model

### 4.1.2. Global Financing Facility – attributable additional indebtedness

The contribution of GFF-catalyzed loans to overall increase in country debt is low in all the countries studied here (Figure 5). The only exception to this is Rwanda where the GFF-catalyzed loans (US$ 105 Million IDA loans) make up 22.5% of the US$ 466 Million increase in country debt between 2017 (pre-GFF year) and 2018 after the country joined the GFF. The GFF-attributable additional indebtedness is considered insignificant because the countries studied here have acquired significant debt independent of the GFF mechanism. The percentage of overall debt to GDP ranges from 21% to 71.4% with Sierra Leone, Kenya and Malawi having the highest percentages as of 2018 (Figure 5). It is worth noting that, other than Sierra Leone which is above the World Bank (2010) recommended debt/GDP threshold of 64% for emerging markets,[11] all the other countries have indebted levels below this threshold (Figure 5).

In depth analysis of the contribution of GFF-catalyzed loans to health sector specific debt is largely precluded by the lack of data on health sector specific debt. Nonetheless, insights based on data from countries where this data is available, suggest that the proportion of GFF-catalyzed IDA and IBRD loans out of total health sector debt is low and GFF-catalyzed loans make up the minority of health sector specific debt. In Nigeria, for instance, while health sector specific debt increased from US$ 1.3 billion in 2015 (considered as pre-GFF period) to US$ 1.6 billion in 2017, GFF-catalyzed IDA loans represented only 21% of overall health debt as of 2017.[12] This observation implied that the bulk of health sector-specific debt is incurred independently of the GFF mechanism. Further, this observation implies that the GFF mechanism is not unique in terms of catalyzing debt acquisition since other health programs have also been funded through debt. This assertion is supported by observations made in Kenya and Uganda. In Kenya, apart from the GFF-catalyzed loan for the Transforming Health Systems for Universal Care project, the country has financed other programs through debt. A case in point is the acquisition of a US$ 250 million loan from IDA for the Social and Inclusion Project within which 9% of the financing is allocated to health-related interventions. Similarly, in Uganda, the Uganda Intergovernmental Fiscal Transfers Program is financed through a debt of US$ 200 million that is independent of the GFF mechanism. In summary, GFF is not the only mechanism driving debt acquisition in the health sector and countries have taken on more loans for the sector through mechanisms that are independent of the GFF mechanisms.

Insights gathered from the expert interviews conducted as part of this comparative analysis indicate that GFF has not pushed the countries into indebtedness. Rather, the interviewed stakeholders opine that it is corruption and misuse of public funds that have driven increased debt in some, if not most, of the GFF-participating countries.

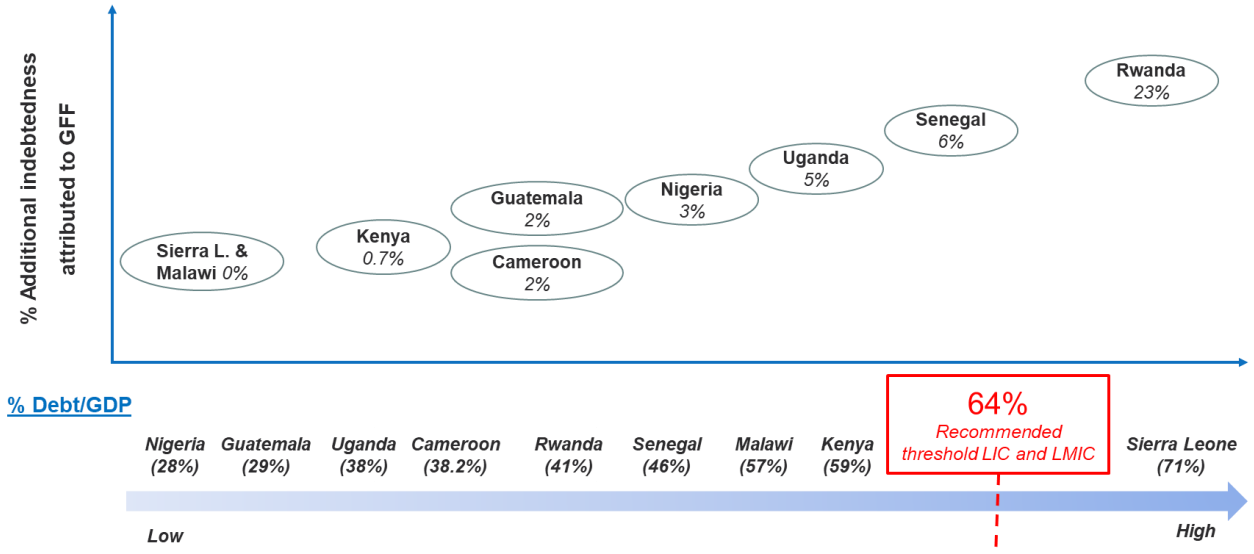
> When GFF came, debt was one of the pushbacks, but later on we have realized that insincerity and corruption is the one driving the countries into indebtedness, not the GFF
>
> –Health Finance Expert working in Nigeria

Taken together, there is little if any increase in total country indebtedness that can be attributable to the GFF mechanism. In this light, it is reassuring that GFF seems to be playing a catalytic role of increasing or ring-fencing funds for RMNCAH-N than it is increasing overall country indebtedness.

[11] 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)

[12] https://www.dmo.gov.ng/publications/reports/dmo-annual-report-statement-of-accounts/1021-dmo-2015-annual-report/file

**Figure 5: GFF attributable additional indebtedness compared to set benchmarks**




Note: LIC means lower income countries, LMIC means lower middle-income countries
Analysis: E&K Consulting Firm

### 4.1.3. The Scope of Project Appraisal Documents

In 2007, WHO proposed a framework to guide the design and evaluation of an efficient and equitable health system that consists of six building blocks, namely: financing, leadership and governance, human resources for health, service delivery, health information systems, and access to essential medicines.[13] This framework has been used to assess the scope of the project appraisal documents (PADs) related to the GFF mechanism in the nine countries studied here. The comprehensiveness of the PADs is summarized in Table 2 below.

[13] Geneva: World Health Organization (2007) "Everybody's business: Strengthening health systems to improve health outcomes. WHO's framework for action". (http://www.who.int/healthsystems/strategy/everybodys_business.pdf)

**Table 2. The Scope of Project Appraisal Documents**

| | Health Financing | Leadership & Governance | Human Resources for Health | Service delivery | Health Information Systems | Access to essential medicines |
|---|---|---|---|---|---|---|
| Kenya | + | ++ | ++ | + | + | ++ |
| Uganda | + | + | + | + | + | + |
| Rwanda | + | ++ | ++ | + | + | ++ |
| Nigeria | + | + | + | + | + | + |
| Sierra Leone | | | | | | |
| Cameroon | + | + | + | + | + | + |
| Senegal | + | ++ | + | + | + | + |
| Malawi | + | + | + | + | + | + |
| Guatemala | + | + | + | + | + | + |

Note: + poor, ++ average, +++ above average and ++++ excellent coverage of health systems building blocks

Analysis: E&K Consulting Firm

In Kenya, the leadership and governance block of the health system is weak in the areas of coordination and evidence-based decision making in the Public Financial Management (PFM). The PAD seeks to address this by fostering the training of counties (devolved units of governance in Kenya) in annual work plans (AWP) formulation that promotes efficiency, introducing performance-based evaluation, cross county coordination and capacity building. Health Information Systems (HIS) is also poor as there is low data quality and incomplete reporting, unlinked data platforms and incomplete birth and deaths registration. The PAD's scope covers HIS and the project intends to incentivize timely and complete reporting through a continuous update of HIS, data quality audits, facility scorecards, integrating birth registration and digitization of birth and death registrations. Like HIS, there is a shortage of skilled health workers in underserved areas coupled with low competency and productivity. The PAD seeks to address the human resources building block by contracting of health workers, introducing performance-based incentives, in-service training on RMNCAH-N and midwifery bonding.

On the health financing block, there is low budget allocation to health and fragmented financing initiatives and the project addressees this by proposing to increase advocacy around county budget allocations, strategy development for the financial protection of vulnerable groups and UHC capacity building. The PAD's scope also addresses the service delivery block which is plagued by unsystematic inspection of health facilities and service providers, incomplete Kenya Quality Model for Health (KQMH) tool, long distance and costly transport to health facilities. The PAD proposed to address these challenges by providing for inspection of public/private facilities using the Joint Health Inspection Checklist (JHIC) framework, revision of the KQMH framework, and provision of transport vouchers and outreach services to the underserved groups. Access to essential medicines in Kenya is hampered by insufficient budget allocation

and the PAD proposes procurement of EMMS strategic commodities, capitalization of Kenya Medical Supplies Authority (KEMSA) and increased advocacy for allocation of budget to strategic commodities.[14]

In Uganda, the ratio of 0.87 health workers per 1000 population is among the lowest in the world, there is also a high absenteeism rate of 52% as unearthed by World Banks service delivery indicators (SDI) survey, hence health personnel are in short supply. The PAD addresses the health workers challenge by training RMNCAH-N cadres in short supply, in-service training and mentorships and filling all wage allocated vacancies. There is lack of appropriate infrastructure and medicines in most health facilities in Uganda and the Project intends to construct maternity units, procure RMNCAH-N equipment, redistribute unused equipment and procure and distribute drugs. In Uganda, the quality of care of RMNCAH-N services seems low and the PADs scope is to establish service standards, incentivize facilities through results-based financing (RBF), and implementation of HFQCAP through star rating of healthcare facilities. The referral system in Uganda is poor and the project shall develop protocols for operations of ambulance system and referral services. The PAD seeks to address the HIS block by strengthening institutional capacities for CRVS registration.

Rwanda's project targets to reduce stunting among children under five years of age. It faces supply side barriers in the Community Health Workers (CHW) program where CHWs have variable workloads, are not well remunerated nor regularly trained and whose performance is often hindered by stock-outs of essential medicines.[15] The project intends to incentivize CHWs, improve the accountability of health personnel, provide grant funds to support convergence agenda, strengthen capacity for multi-sectoral response and incorporate nutrition indicators for the *Imihigo* contracts between the president and the mayors. The PAD proposes to address key gaps in service delivery by incentivizing facilities within target districts for increased coverage of high impact interventions that include height monitoring promotion and tracking of faltering children, critical nutrition and healthcare interventions for women. On the HIS block, the PAD proposes to support health facilities by introducing an information technology that uses a two-way messaging system on phones and tablets and an interactive system that tracks pregnant women ensuring fast identification of faltering growth and response at the facility.

In Nigeria, the Accelerating Nutrition Results project addresses bedeviled supply constraints namely: low health system worker motivation and weak capacity to deliver, insufficient nutrition commodities, insufficient financing and insufficient data for decision making. The project addresses them by establishing performance-based contracts, training of existing workers and developing tools; enactment of special procurement provisions; advocating for domestic financing using MTDF and harmonized financing; development of national surveillance system and financing SMART technology respectively.

Investing in early years for growth and productivity in the Malawi project intends to develop capacities of the CHWs, prioritizing early stimulation and responsive parenting through nutrition specific activities, early stimulation and nutrition, and gender sensitive activities. Component 2 of the PAD seeks to improve the quality and coverage of preschool education and RMNCAH-N services. This will address the gender inequalities against women and girls by promoting nutrition for adolescent ages and lactating women. The key activities, financed through disbursement linked indicators, will be developing capacities of caregivers in 25 model CBCCs and the establishment of a communal garden. On the financing block there is a restricted fiscal space in Malawi and competing priorities for health. The PAD addresses this by investing in analytical

[14] http://projects.worldbank.org/P152394?lang=en
[15] Liverpool School of Tropical Medicine (2016) "Comprehensive Evaluation of the Community Health Program in Rwanda" (https://www.unicef.org/evaldatabase/files/Annex_5_Survey_Report.pdf )

work that supports multi-sectoral strategic investments aligned with the National Strategy on Adolescent Girls and Young Women. Component 3 intends to strengthen multi-sectoral management and implementation of learning interventions and enhance service delivery and citizen engagement.

In Guatemala, the key constraints to health care are chronic malnutrition, deteriorating quality of care, budget constraints and funding flow bottlenecks. The PAD intervenes by providing inter-sectoral services targeted at addressing chronic malnutrition by supporting nutrition services to mothers, promoting behavior change, improving access to safe drinking water and enhanced coordination across sectors. The PAD addresses budget constraints by utilizing the IBRD loan to provide results-based financing of health facilities, breastfeeding programs and strengthening of the government Conditional Cash Transfer (CCT) program and finance consulting services that will evaluate the achievement of disbursement linked indicators (DLIs).

In Cameroon, national health expenditure is low, it is allocated inefficiently and budget execution is poor. Financial governance is a major issue with informal payments and corruption. Cameroon has insufficient numbers of health workers, high absenteeism and uneven distribution of health workers across the country with most of them in the cities and major towns. This is due to a harsh environment, lower salaries, poor working conditions and fewer opportunities for professional growth in the rural areas.[16] There are major challenges in the pharmaceutical sector affecting the availability of quality-assured medicines in Cameroon. The PAD in Cameroon proposes to address these key challenges in the healthcare system in Cameroon, for example public expenditure, human resources for health and pharmaceutical supply management.

Senegal does not have enough health workers and their distribution is uneven. Moreover, increasing their level of competence has been identified as necessary so as to improve quality of care. Budgetary prioritization of health is low and most people access healthcare through out-of-pocket (OOP) payments. OOP payments accounted for 44 % of the total health expenditure in 2014 and 2015.[17] This represents a low level of financial protection against financial risks that are related to health and this could lead to impoverishment. The PAD in Senegal proposes to address these key challenges in the healthcare system in Senegal, for example, human resources for health and reduction in OOP expenditure.

Generally, there is a positive correlation (alignment) between the contents of the investment case and PAD. In Kenya, the key priorities as per the investment case are: to address disparities and increase equitable coverage through prioritized investments in underserved counties and accelerating action for underserved and marginalized populations; addressing demand-side barriers and increasing utilization, coverage and affordability of RMNCAH-N services; and addressing supply side bottlenecks in the health systems, improving access to high impact interventions that ensures financial protection of the poor. The PAD is aligned to these priorities and its core components address these priorities directly. For instance, component 1 of the PAD aims at improving public healthcare delivery, utilization and quality at the county levels with key focus on RMNCAH-N and addresses the first priority outlined in the investment case. Component (1) was allocated US$150 million consisting of US$115 million equivalent credit from IDA and US$35 million grant from the GFF trust fund. Component 2 aims at strengthening institutional capacities to deliver on component 1 through improving quality of care, strengthening M&E and CRVS and supporting health financing reforms towards universal healthcare. Component 2 was allocated US$15.1 million consisting of US$9 million credit from IDA, US$5 million grant from the GFF TF, and US$1.1 million grant from JICA.

[16] Cameroon Health Country Status Report, 2013
[17] National Health Accounts (NHA) for Senegal

The correlation between the investment case and PAD is weak in countries where the PAD was approved before the finalization of the IC. For instance, in Malawi the PAD was developed in the absence of an investment case and the correlation between the two documents is weak.

### 4.1.4. Innovative financing that is complementary to the Global Financing Facility

GFF from the onset was meant to catalyze additional financing ring-fenced for RMNCAH-N or general health. In some countries, GFF has been the driving force in raising additional financing using innovative financing solutions. Innovative Financing is an approach to funding enterprises, interventions, and value chains that creates positive environmental or social impact by using financial tools in catalyzing and scaling solutions[18]. It relies on forging partnerships, pooling resources from public and private sources and solving problems effectively at a larger scale than would be possible otherwise. The UN estimates that SDG implementation costs US$3.9 trillion a year in developing countries and the current financing levels can only cover US$1.4 trillion leaving a projected annual gap of US$2.5 trillion that necessitates innovative financing. The World Bank views innovative financing as a non-traditional approach to official development assistance (ODA) that catapults fundraising by engaging investors as development partners and co-creators of financial solutions.[18]

In Kenya, the MDTF, financed by USAID, DANIDA and DFID, established by World Bank and with current financial commitment of US$16 million, enhances effectiveness of national and county governments thereby strengthening health system components and support UHC operating alongside the GFF co-financed 'Transforming Health Systems for Universal Care Project' (Table 3). In Rwanda, the Scaling Up Nutrition (SUN) MDTF is co-financed by GFF and IDA credit and funds the Stunting Prevention and Reduction project to the tune of US$20 million (Table 3). In Nigeria, the Basic Health Care Provision Fund is financed by the Federal Government's allocation of at least 1% of the government consolidated revenue and by development partners. The National Health Accounts (NHA) enacted in 2014 the paved way for establishment of BHCPF and the GFF facility co-financed it with US$20 million in 2018 and Bill and Melinda Gates contributed US$2 million. Nigeria`s parliament approved the first full 1% of revenue in May 2018 and President Buhari rolled out BHCPF in January 2019[19] (Table 3).

The buy-down of interest has also been leveraged as an alternative innovative financing approach. For the case of Guatemala, the GFF granted US$9 million to buy down interest that would have accrued from the nutrition and health project. The buy-down made the loan concessionary and the Guatemalan government matched the buy-down by using the freed-up resources to finance a conditional cash transfer program.

A newly launched Development Impact Bond (DIB) is funding a health practice that will save and improve hundreds of newborn lives in Cameroon through Kangaroo Mother Care (KMC). This ground-breaking US$ 2.8 million DIB is the first DIB globally to focus on newborns, the first DIB to focus on maternal and child health in Africa, and whose design has been led by the government of Cameroon. The DIB is largely funded by the GFF.

[18] https://www.bsr.org/reports/BSR_Healthcare_Innovative_Finance_F18inal_September_2017.pdf
[19] https://www.premiumtimesng.com/health/health-news/304833-buhari-rolls-out-basic-health-care-provision-fund.html

**Table 3: Innovative financing mechanism identified across the GFF countries surveyed**

| | Kenya | Rwanda | Nigeria | Guatemala | Cameroon |
|---|---|---|---|---|---|
| Mechanism | Multi-Donor Trust Fund | Scaling Up Nutrition (SUN) MDTF | Basic Healthcare Provision Fund | IBRD Interest buy down | Impact Bond |
| Project | Transforming Health Systems for Universal Care | Stunting Prevention and Reduction Project<br>Strengthening Social Protection | Basic Healthcare Provision Fund | Guatemala Nutrition and Health Project | Kangaroo Mother Care |
| Amount ($,Mn) | 16 | 20<br>15 | 20 (GFF)<br>2 (BMGF-NG) | 9 | 2.8 |
| Partners | USAID, DFID, DANIDA | SUN, Rwanda, IDA credit | BMGF, Nigeria Gov't, GFF | IBRD, GFF | Grand Challenges Canada |

Analysis: E&K Consulting Firm

## 4.2. Trends in advocacy work on the GFF

Advocacy has been recognized as a key cog in the GFF mechanism. The GFF Financiers (e.g. Bill and Melinda Gates Foundation, JICA, Governments of Japan and Norway and USAID), UN agencies (e.g. Global Health Alliance, UNICEF, WHO and UNPF) and CSOs (e.g. PATH, PAI) appreciate the role of advocacy and some have prioritized part of their financing to be dedicated to advocacy.[20] Advocacy is not only done by CSOs but other GFF partners like UNICEF though CSOs have been poised as the main actors in the advocacy space as they carry out social mobilization, campaigning, accountability and service delivery. The recognition of CSOs role in advocacy is not reflected in how they are financed to engage as there is no specific allocation ring-fenced for advocacy. The GFF investors group and PMNCH in 2018 supported CSOs at the country-level to advocate at the national and subnational level.[21] The funding inadequacy has strained CSOs that opt to fundraise independently.

The spectrum of avenues through which CSOs can engage with the GFF mechanism are broad and include advocacy (to mobilize resources and drive policy change), monitoring and evaluation (M&E), elevating voices of affected populations, and implementation (improving health outcomes by introducing and scaling up innovative solutions and reaching the most vulnerable). Additional avenues are research and data analysis and technical assistance (supporting decision-makers to implement policies and programs based on the best available evidence. The participation of CSOs across this spectrum varies across the GFF-participating countries (Table 4).

[20] https://www.globalfinancingfacility.org/about/partners
[21] https://www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF-CreativeBrief_CSO_EN.pdf

**Table 4: CSO Advocacy spectrum/specialties in the GFF mechanism**

| Spectrum of CSO engagement | Commentary | Example |
|---|---|---|
| **Advocacy** | In many countries, CSOs' engagement with governments and GFF has contributed to the mobilization of new resources for important health areas e.g. BHCPF and 1% of CRF in Nigeria | *PATH (Kenya), CEGSS, Health Alert, Evidence for Action-MamaYe (E4A-MamaYe), Action HERFON* |
| **Monitoring and Accountability** | Holding government accountable has been poorly done in Uganda and Malawi while Guatemala has performed well overtime. This is done through periodical reviews | *CEGSS, Health Alert, E4A-MamaYe, Action, HERFON* |
| **Elevating voices of affected populations** | CSOs In Malawi, Rwanda, Nigeria, Uganda and Guatemala have amplified the voices of local communities & involved them in decisions that affect them. E.g. in crisis & humanitarian settings where maternal deaths occur | *Journalist Association against AIDS (Malawi), HERFON (Nigeria)* |
| **Implementation** | East African country CSOs are engaged in GFF implementation to a comparatively lesser extent. Generally implementation is weak across the 7 countries | *Health Alert (Sierra Leone)* |
| **Research and Data analysis** | Maternal deaths reviews in counties, budget and expenditure reviews for counties etc. in Kenya, Nigeria, Rwanda, Malawi & development of state level scorecards in Nigeria, Kenya & Malawi | *E4A-MamaYe (Kenya, Nigeria)* |
| **Technical Assistance** | CSOs have provided technical support that complements government, donors, private sector, academia etc. in planning and implementation of national health strategies | *E4A-MamaYe (Kenya, Nigeria)* |

Analysis: E&K Consulting Firm

In Kenya, the CSOs interviewed as part of this study indicate that they are involved in health budget allocation advocacy, review of health expenditure, review of RMNCAH-N indicators, advocacy for increased DRM, GFF budget optimization and advocacy to increase transparency in use of funds by county governments. In Kenya, CSOs are engaged in GFF implementation to a comparatively lesser extent.

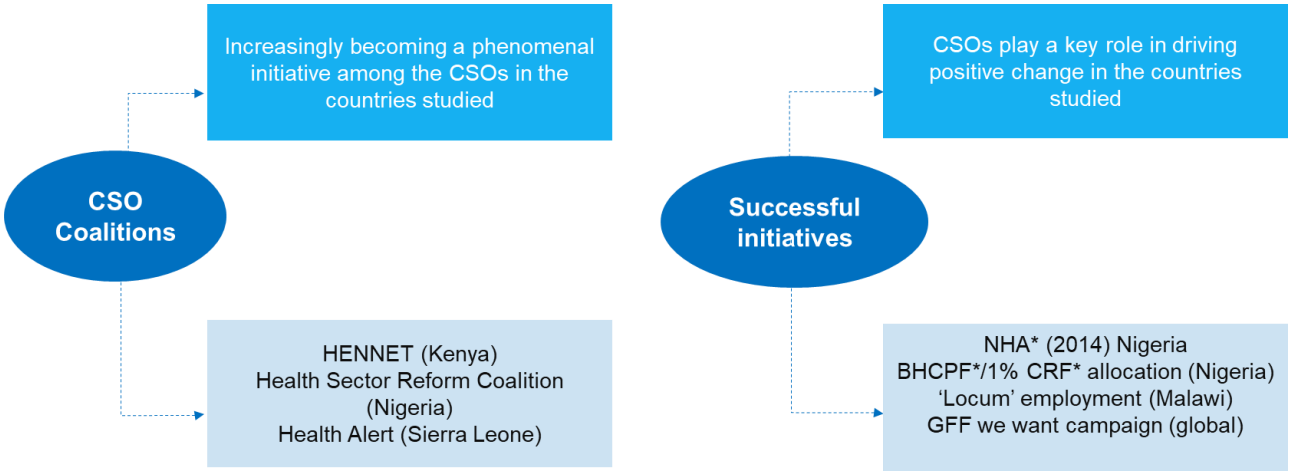
In Uganda, CSOs have done poorly in monitoring and accountability especially in holding government accountable, but performed well in community engagement and technical assistance. In Malawi, CSOs are greatly involved in human resource development for health, service provision, elevating voices of affected populations, technical assistance and research, and data analysis. In Nigeria, CSOs are engaged in monitoring, private sector involvement and diagnostics, communication and health budget advocacy. In Sierra Leone, M&E, advocacy, media engagement, project implementation, budget advocacy for nutrition, community engagement and training are the main activities that the interviewed CSOs engage in. The CSOs in the governance and political space are not well coordinated and current collaboration with the private sector in Nigeria is poor. In Guatemala, the CSOs are mainly involved in monitoring and evaluation and implementation with relatively little focus on governance.

The development of CSO coalitions is increasingly becoming a phenomenal trend among the CSOs in the countries studied here (Figure 6). The CSO coalition in Kenya (HENNET) is, to a large extent, functional. Formed in 2005 and managed by an 11-member team, it is widely accepted as the umbrella body for health CSOs in the country. The Health Sector Reform Coalition (HERFON) and Health Alert are the CSO coalitions in Nigeria and Sierra Leone respectively. HERFON was started in 2015 and has so far systematically nominated a representative to the country platform. Hearth Alert has been quite successful in coordinating health CSOs even to the extent of the CSOs developing joint proposals for funding. The coalition has recently won a grant to implement a nutrition program in Sierra Leone. In Senegal, the coalition of civil society organizations for GFF (COSC/GFF) is an active member of the country platform

and has been involved in the GFF process from the onset including in the development of the investment case. The main factor precluding the successful development of CSO coalitions in other GFF participating countries is the apparent inability of CSOs in these countries to develop good governance structures to underpin the coalitions they have created so far.

There are several advocacy initiatives that have seen CSOs play a key role in driving positive change in the countries studied here. The successful initiatives include the development and enactment of the Nigerian National Health Act in 2014, the establishment of the BHCPF and the allocation of 1% of CRF to the BHCPF in 2018 and 2019 budgets in Nigeria. In Malawi, similar success that is in part attributable to CSO advocacy in the work leading to the lifting of the recruitment ban in Malawi and the adoption of "locum" employment that the government is slowly responding to. At the global level, the "GFF We Want" campaign[22] has been successful in raising awareness on the importance of a participatory and country led GFF mechanism (Figure 6).

**Figure 6: Trends in advocacy identified**




Analysis: E&K Consulting Firm
Note: BHCPF means Basic Healthcare Provision Fund, CRF means Consolidated Revenue Fund

Overall, there is recognition of advocacy both at the global level and national levels, but the lack of financing has contributed to CSOs involvement in some spectrum but not all. The weak areas like accountability and implementation are partly attributed to the CSO under funding. Therefore, GFF and partners need to make provisions for fund advocacy, as this will enable CSOs to implement advocacy across all aspects of the GFF completely..

## 4.3. Trends in transparency in the GFF mechanism

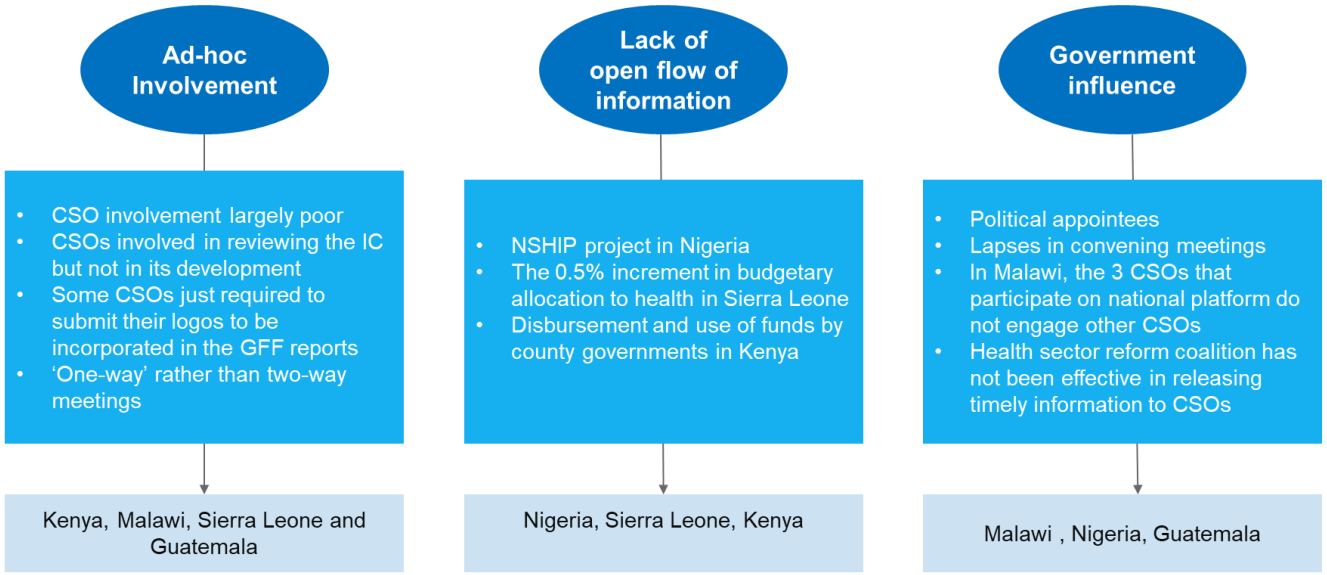
The interviews done as part of this research indicate that there has been little (if any) transparency in the GFF mechanism. In the formative phase of the GFF in Kenya, Malawi, Sierra Leone and Guatemala, transparency of the GFF and thus optimal CSO involvement was largely poor. This is exemplified by the ad hoc involvement of CSOs in Kenya where they (the CSOs) were only involved in reviewing the investment case that they did not participate in developing; the submission of logos to be incorporated in GFF reports

[22] https://wacihealth.org/gff-campaign/

whose development the CSOs in Guatemala were not part of, and the political appointment of selected CSOs by the MoH to participate in GFF processes in Uganda (Figure 7).

The transparency challenge has been compounded by the lack of open flow of information. In Nigeria, there has been little open flow of information from the Federal Government on the Nigeria States Health Investment Project (NSHIP) project. Similarly, there has been minimal openness with regards to the 0.5% budgetary allocation to health and the disbursement and use of funds by County Governments in Sierra Leone and Kenya respectively. In some countries, CSOs participation in the GFF mechanism has become a "just a matter of formality". There seems to be secrecy both on the inter-CSO collaboration and government. For instance, in Malawi, the three CSOs that participate in the national platform have been selected by the government, are not willing to engage with other CSOs, the government does not tolerate criticism, there has been no audit on the loans taken by government and CSOs have not been active in holding the government accountable. In Nigeria, the Health Sector Reform Coalition that houses the CSO working group has not been effective and does not release timely information to CSOs and there are lapses in convening meetings – a situation that also prevails in Uganda (Figure 7).

**Figure 7: Summary of trends in transparency across the 7 countries**




Analysis: E&K Consulting Firm

## 4.4. Key challenges to the Global Financing Facility

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

A. **Opacity in the GFF mechanism:** This comparative analysis of the GFF mechanism confirms that the GFF mechanism is to a large extent opaque. In most GFF countries studied, the country platforms are dysfunctional, and this in part compounds opacity in the GFF mechanism. This has limited the key stakeholders, for example, CSOs to participate in the GFF since in some countries the CSOs claim that governments and WB do not allow CSO participation claiming that they are internal conversations not open to the public. This poses a challenge of transparency. Opacity is also evident in the process of GFF country selection, development of investment cases and PADs and negotiations of the funding

amounts between the WBG and governments. In some countries, IDA loans have been approved before finalizing the investment cases, for example, Malawi and Rwanda, this is in contravention of the approved GFF process. Previous efforts by in-country partners to advocate for governments to open the conversations and allow for greater participation have appeared to be fruitless unless these efforts are made in parallel with advocacy at the global level.

> While there are gaps in country selection, it is unlikely that CSOs will be able to influence the GFF mechanism at this point because the WBG and governments of countries that are interested in joining the GFF often claim that these negotiations are "internal conversations" that cannot be opened up the public. This problem seems to be the major bottleneck to the participation of CSOs in the GFF mechanisms.
>
> –CSO Advocacy Specialist in Kenya

> Selection of flag bearer countries and development of investment cases has been opaque. While Ministries of Health would ask for data from CSOs, whenever CSOs would ask what the data is for, MOH would say that the data is for 'high level conversations' that CSOs were locked out of.
>
> –Advocacy Specialist at a CSO working in Africa

**B. Lack of evidence-based financing:** The fact that there are countries that have received WB funding without developing an investment case (e.g. Rwanda) or instances where investment cases are developed yet PADs already exist (e.g. Malawi) suggests that the linkage (or necessity for) evidence based investment cases in informing the design of PADs is non-existent or not appreciated. This together with the fact that there is little evidence on whether GFF trust funds unlocks IDA funding makes it difficult to demonstrate the value of GFF in unlocking additional funding for RMNCAH-N.

> The initial process was working well with the working groups focused on key priority areas: Nutrition; RMNCAH, CRVS and early child stimulation until the Investing in Early Years for Growth and Productivity (IEYGP) was allocated US$10 million from GFF and a US$50 million IDA grant. Though the project is focused on one of the priority areas, it didn't get owned by the taskforce and the Ministry of Health and Planning leadership and was approved even before the investment case was finalized. This made people abandon the process though from March 2019 it is slowly improving.
>
> –Health Financing Expert, Malawi

**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 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 there are weak accountability mechanisms in most GFF countries studied and this negates the effective development principles that GFF subscribes to. In the countries studied, the MoH have been at the forefront of the GFF but there has not been meaningful participation, engagement and decision making has not been anchored on inclusivity. Most of the country platforms have not met the

transparency thresholds and therefore engaging key stakeholders like CSOs, private sector and academia has not been optimal. For instance, in Guatemala CSOs have been engaged on an ad-hoc basis, in Kenya CSOs were only engaged in reviewing the investment case they did not develop and in Nigeria the Multi-stakeholder country platform for GFF has not been active for almost a year since most of its roles were taken over by the MoH technical working group.

> [Our group] was invited to the GFF national platform in Guatemala, however……was only requested to submit our logo and was not to be involved in discussions of GFF priorities in Guatemala because this was 'not a role' of civil society. …. turned down the terms of engagement and because we were critical of what was being done, we were not invited again to the platform.
>
> –CSO Advocacy Specialist working in Guatemala

**E. CSO organization and representation:** In some countries, the CSOs do not have an organized mechanism of nominating representatives to the GFF multi-stakeholder country platform. The result is that the more resourced (often global organizations) end up being the representatives of other CSOs in the GFF mechanism. As a result, there is limited representation by indigenous in-country CSOs. For instance, in Uganda the absence of a mechanism for the nomination of a CSO to represent other CSOs in the mechanism resulted in World Vision having a sit at the country platform albeit without the knowledge or consent of other CSOs in the country. Also, government influence sets in and political appointees become CSO representatives like for the case of Malawi where the three CSOs that participated in the GFF process were picked by government. These have resulted to competition among the CSOs which mostly favors 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.

> The GFF secretariat is not entirely sure there is consensus among in-country CSOs on how CSOs get represented at the GFF secretariat. In some countries, the CSOs do not have organized mechanisms of nominating a representative among themselves.
>
> –GFF Focal Point, for two countries in Africa

> In those early years, there was little if any CSO involvement and the GFF process e.g. development of the investment case was done predominantly by MoH and WB … the CSO I work with only participated in the review of the RMNCAH investment case through an invitation sent to HENNET. The invitation to CSOs and criteria for selection of CSOs to join the meetings seemed ad hoc.
>
> –Advocacy Specialist at a CSO working in Kenya

**F. Misunderstanding about the GFF:** There seems to be significant differences among CSOs and other stakeholders on what the GFF is. CSOs seem to look at the GFF as a 'global funding opportunity' that they can apply for funding from to meet their operational needs or pursue their advocacy and/or lobbying initiatives. The concept that GFF should be a fund that catalyzes increased prioritization of financing for RMNCAH-N is therefore lost. For the case of Nigeria, Malawi and Uganda, many CSOs

initially submitted proposals for funding only to be turned down. This has resulted in CSOs eyeing the small grants as opposed to aligning their already funded advocacy mandate to improve accountability and oversight on the GFF.

Other stakeholders think that GFF funds or IDA loans unlocked as a result of GFF should take an equity approach and benefit all citizens equally since repayment of these loans will be made from the taxes raised from all citizens. In this light, the idea that GFF should promote equity and prioritize most vulnerable populations is often not realized. As per Kenya's experience, the County Governors demanded that all the counties be considered for the funds irrespective of the prevailing RMNCAH-N indicators or any other equity considerations.

> In Kenya, GFF is not (or poorly) understood even by CSOs and County Governments outside of Nairobi City. The CSOs think that GFF is a loan that must be equitably distributed to everyone and even County governments governors opine that GFF funds be distributed to all counties equitably.
>
> –CSO Advocacy Specialist in Kenya

> CSOs view GFF as a source of funds for the CSOs rather than it being a catalytic fund.
>
> –GFF Liaison Officer working in Africa

> Many CSOs do not understand what GFF is about, initially CSOs thought that GFF was a funding agency and therefore submitted many proposals for funding before realizing that it was a catalytic fund and not a CSO funding agency.
>
> –GFF Liaison Officer working in Africa

G. **Limited capacity of GFF-eligible countries to make GFF "country-led":** By design, GFF eligible countries are low-income, fragile states or countries in conflict. These countries tend to be heavily donor-dependent e.g. Malawi where 75% of health expenditure is financed by donors. Due to the heavy donor-dependence, these countries are at risk of losing the leadership and priority-setting mandate to the donors. Thus, these countries are at high risk of not having country led GFF mechanisms.

H. **Lack of funding for CSOs:** While CSOs are expected to play an advocacy role it is not clear how they ought to be funded to do this. Currently, the provision of the Small Grants Mechanism (SGM), that was initiated and financed by PMNCH and GFF secretariat to the tune of US$500,000 and US$300,000 respectively and managed by Management Sciences for Health, has a funding ceiling of US$70,000 per CSO which is inadequate for optimal CSO engagement. In addition, the GFF CSO Resource Hub grants by PAI that averages US$3,000 to US$30,000 for few CSOs to engage complements the SGM. For the SGM 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. This is because of fear of loss of budget or relevance to donor – driven priorities. Driving GFF advocacy as a coalition has been a

challenge as some CSOs dislike the participation of others and prefer leading advocacy alone and local CSOs (in the case of Nigeria) think that international CSOs are taking away their space and mandate.

**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:

(i) The GFF mechanism in-country seems to be mainly inclusive of the ministries of health and finance leaving out other key ministries such as the Ministry of Agriculture. This is contrary to what is envisaged by the GFF as outlined in the GFF Country Platform Guidelines.
(ii) CSOs representation on the country platforms has not been consistent apart from Nigeria and Rwanda where the CSO coalition was strong before the advent of the GFF for the former and there is a strong government support for the latter. In Kenya, Uganda, Malawi and Guatemala CSOs have been engaged on an ad hoc basis and have not been the mainstream drivers of the GFF as envisaged in the GFF Country Platform Guidelines.
(iii) Representation of the private sector and academia in the GFF mechanisms is lacking in some countries. For instance, in Uganda, Kenya and Malawi the private sector and academia have not played a lead role and have not been active on the country platform.

## 5. Recommendations and opportunities for future work

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

**A) Implementation of the minimum standards for inclusion, transparency and accountability for the multi-stakeholder country platform**

The GFF mechanism envisages the multi-stakeholder country platform to be an inclusive forum under the stewardship of the national ministry of health that leads and coordinates GFF activities at the level of individual GFF participating countries. Insights gathered from the interviews conducted as part of this study indicate that many of the country platforms are lacking in inclusivity, transparency and accountability mechanisms. Considering this, there is need to revamp the platforms so that they live up to the provisions of the guideline's issues by the GFF on how country platforms ought to be constituted and function.[23]

According to these guidelines,[23] the involvement of the multi-stakeholder country platform in the development of the investment case should take a four-step process. First, there is development of the road map with agreement on key roles and responsibilities on the RMNCAH investment case that includes milestones and timelines on the specific elements. Secondly, the multi-stakeholder country platform then organizes for a transparent, inclusive and multi-stakeholder consultative process to develop the national RMNCAH-N strategy/ investment case ensuring that there is alignment between the health financing strategy (HFS), RMNCAH-N and the investment case. This should be done in line with SDGs and the global strategy that necessitates country platforms to prioritize objectives with a five-year horizon that can be realized by 2030. Thirdly, the multi-stakeholder country platform should commission detailed

[23]https://www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF%20Country%20Platform%20guidance%20note.pdf

assessments and diagnostics that surface the key obstacles that should inform the platform on what actions to focus on and what results need to be achieved in five years. In implementing this task, the multi-stakeholder country platform can create new technical working groups (TWGs) or co-opt existing ones to work on specific tasks under the guidance of the country platform. Fourthly, the multi-stakeholder country platform reviews the detailed assessment and diagnostics and uses it to develop the investment case /RMNCAH-N strategy. The level of adoption and compliance with this four-step process in GFF participating countries such as Malawi has been low.

Further, according to the GFF guidelines,[23] the constitution and operationalization of the multi-stakeholder country platform should embody three key principles: inclusiveness, transparency and mutual accountability which aligns with globally agreed development effectiveness principles.[24] Inclusiveness should be instituted by allowing the participation of key constituents on the multi-stakeholder country platform. Examples of stakeholders to be included in the country platform include academia, private sector, government, CSOs, technical agencies, bilateral and multilateral agencies and foundations, global financing mechanisms, parliamentarians (for example in Malawi), adolescents and youths, affected populations and healthcare professional associations. The stakeholders should be involved in preparing the investment case and HFS, making significant changes to the investment case as required, determining the right approach to capacity building and technical assistance and support implementation of the investment case and receive, review and respond to data made available regularly. There ought to be meaningful engagement in a transparent manner between members of the country platform and those external stakeholders who are not part of the platform. Therefore, the implementation of the GFF guidelines on the inclusiveness of the country platform will contribute to reducing opacity in the GFF process, which has largely been attributed to dysfunctional country platforms that lacks in inclusivity of key stakeholders like CSOs, private sector and academia.

To enhance transparency around the GFF mechanism, the multi-stakeholder country platform should make public all relevant documents. These include notice of multi-stakeholder country platform meetings including review documents in a timely manner; posting in a timely manner the minutes of meetings at which the investment cases and HFS were developed; the final investment case and HFS with results framework and costing measures. Additional documents include financial agreements and commitments; annual disbursement data from financiers; memorandum of understanding governing the platform; evaluation reports of the investment case; list of members of the platform; and a focal point who liaises all stakeholders.

Enhancing mutual accountability bolsters efficiency and effectiveness in the functioning of the multi-stakeholder country platform. Accountability enhanced by leveraging on community-based accountability interventions like using scorecards and engaging citizens in budget analysis should be instituted.

Lastly, fidelity to the adoption of these key principles should be monitored through annual reviews of the multi-stakeholder country platform operations. These reviews should aim to identify opportunities for improvements that can be made to optimize the country platform in terms of inclusivity, transparency and accountability.

Insights gathered in this research suggest that fidelity to these key principles at the country level is low. In these regards, there is merit in focusing future efforts on the GFF towards building the capacity of in-

[24] These are elucidated in a number of key international documents including: Paris Declaration on Aid Effectiveness (2005); Accra Agenda for Action (2008); and the Busan Partnership for Effective Development Cooperation (2011) and underpin the 'Minimum GFF Standards' for a multi-stakeholder country platform

country stakeholders to build country platforms that live up to these principles to unlock the value of these platforms to the GFF mechanism.

**Responsibility**: This recommendation is addressed to the Governments and Ministries of Health of GFF participating countries in their capacity as conveners and leaders of the GFF multi-stakeholder country platforms.

**B) Peer-to-peer learning:** Future work on GFF can leverage on peer-to-peer learning on three fronts:

(i) Future advocacy in the newly co-opted GFF countries should consider borrowing lessons from the phase 1 and 2 countries. This can be centered on avoiding the mistakes made by phase 1 and 2 countries in relation to formation of country platforms, investment case development, multi-stakeholder engagement especially in terms of involvement of the private sector and academia. This concept of peer-to-peer learning across countries has been shown to work in other advocacy work done by CSOs like ACTION in Kenya.

**Responsibility**: This recommendation is addressed to the GFF Secretariat, GFF Investors Group and individual CSOs that can spearhead peer-to-peer learning at the global and country levels respectively.

(ii) Borrow lessons from advocacy initiatives that have worked with other mechanisms such as GAVI. These may include borrowing lessons from the governance structures of GAVI applicable to GFF. For instance, the agreements between GAVI and its participating countries has a clear endpoint, i.e. a point in time where the governments of participating countries ought to take up 100% of the vaccine financing costs. GFF on the other hand is quite open ended and it is unclear how RMNCAH-N will be financed by governments once the immediate GFF grant or IDA loans run out.

**Responsibility**: This recommendation is addressed to the GFF Secretariat, Investors Group and the GFF Trust Fund Committee in light of their mandate to develop, review and direct financing approaches of the GFF.

(iii) CSOs and CSO coalitions should learn from actively engaged CSOs in the GFF mechanism in different spectrums of specialization and CSO coalitions that have meaningfully engaged in the GFF. For example, Evidence for Action (MamaYe) was involved in the development of the health financing strategy for Nigeria and scorecards for monitoring GFF in the different states in Nigeria and Malawi. Strong CSO coalitions like HERFON of Nigeria could also be a learning point for struggling CSO coalitions and for new GFF countries where the CSO coalitions are non-existent.

**Responsibility**: This recommendation is addressed to individual CSOs, CSO coalitions and the Civil Society Coordinating Group.

**C) Awareness creation among GFF stakeholders to correct existing misconceptions**

(i) Health finance and budget-focused advocacy, at both global and in-country levels, to correct the misconception that "GFF is a loan to be repaid from tax revenues and thus should be available equally to everyone" and create the correct understanding that GFF should enhance equity by being available to those who are currently least covered by RMNCAH-N services.

**Responsibility**: This recommendation is addressed to the GFF Secretariat and the Civil Society Coordinating Group at the global level and individual CSOs at the country level.

(ii) Awareness creation among CSOs on what GFF is and what it is not, that is, it being a catalytic fund and not a funding agency for CSOs to meet their operational costs.

**Responsibility**: This recommendation is addressed to the Civil Society Coordinating Group and CSO coalitions that have a direct reach and influence over individual CSOs.

**D) Strengthening of monitoring and accountability in project implementation:** The GFF minimum guidelines on accountability should be instituted. Since monitoring and accountability was reported to be weak in most countries like Uganda, the country platforms stakeholders, inclusive of CSOs, should build monitoring capacity at all levels of the health systems through developing data systems and mechanisms that can track performance up to the facility level. This can be done through enhanced data quality and M&E frameworks; building on existing systems and leveraging partners focused on data systems; and integrating health information systems and data architecture to increase subnational demand for the use of quality data for decision making.

**Responsibility**: This recommendation is addressed to the multi-stakeholder country platforms that are mandated to implement the GFF minimum standards on accountability.

**E) Use of key opinion leaders as advocacy champions:** Various organizations and entities are key opinion leaders in different GFF participating countries and ought to be leveraged as advocacy champions. For instance, faith-based organizations in Uganda own more than 50% of health facilities and a third of schools and have a strong influence on the healthcare ecosystem. In Malawi, the Parliamentary Committee on health participates in district councils and is a potential advocacy champion.

**Responsibility**: This recommendation is addressed to CSO coalitions and individual CSOs.

**F) Making funding calls pro-collaboration:** Donors and other funders, including OSF can use funding calls to promote collaboration among CSOs by making the calls more advantageous to consortiums of CSOs that can provide more comprehensive advocacy solutions rather than individual CSOs. Further, donors and other funders can enhance the emphasis placed on applicants to demonstrate that their grant applications are aligned with the country/government priorities, work plans and RMNCAH-N investment cases. This has the potential to reduce the competition and redundancy among CSOs and contribute to solving the challenge around the lack of linkage between GFF and impact (e.g. RMNCAH-N health outcomes)

**Responsibility**: This recommendation is addressed to donors and other funders who fund CSOs to carry out advocacy work in relation to the GFF.

**G) Addressing CSO Funding Challenge:** Considering that CSOs in all the countries studied here reported that lack of funding is a critical challenge, there is merit in CSOs, partners and the GFF Secretariat to consider instituting sustainable financing of CSOs to engage in the GFF. This should take several approaches:

(i) The GFF and the partners should institute sustainable, dedicated and adequate streams of funding for optimal CSO engagement since CSOs play a critical role in the strengthening of health systems. This should involve learning from other international financing mechanisms that provide greater quotas of financing in all the countries participating in the mechanism unlike the SGM under GFF that allocates less per CSO coalition in few GFF participating countries. For example, GAVI strongly supports CSOs through prototyped two-tiered financing levels: type A support that grants between US$10,000 to US$100,000 in all the 72 GAVI countries CSOs and type B that selects CSOs in 10 countries that participate in health systems strengthening. GAVI finally recommends CSOs funding to be incorporated in the country's Health Systems Financing Platform. This can as well be applied to GFF where the country platforms are strengthened and financing for CSOs to engage in the GFF multi-stakeholder are guaranteed and sustainable and are part of the GFF financing requests in the country platform. This will see CSOs actively engage in the GFF and widen their scopes of engagement.

**Responsibility**: This recommendation is addressed to the GFF Secretariat, Investors Group and the GFF Trust Fund Committee. Since they oversee the fundraising and resource allocation processes within the GFF, they are best positioned to make funding provisions for CSOs within GFF's budget.

(ii) CSOs should explore opportunities to offer technical assistance to governments and generating revenue in return. CSOs can use existing donor funds to strengthen their

internal capacities to offer these services competitively such that they can continue to generate revenue even beyond the tenure of their existing grants.

**Responsibility**: This recommendation is addressed to the Civil Society Coordinating Group, CSO coalitions and individual CSOs.

(iii) Beyond the specific example of the GFF, the question of funding for civil society advocacy and accountability is a critical one in global health. Multilateral institutions, bilateral and private donors must confront this challenge, given the importance placed on civil society as a key stakeholder to deliver domestic and global health priorities. Discussions may draw on lessons from other sectors like the Global Partnership for Education and its new Advocacy and Social Accountability funding stream[25], or new proposals on Global Public Investments.[26]

**Responsibility**: This recommendation is addressed to the multilateral, bilateral and private donors.

**H) Building capacities of GFF stakeholders to optimally engage in the GFF mechanism:**

(i) Governments: Future advocacy work should focus on building capacity of governments to lead and set priorities for their respective country GFF mechanisms in the newly incorporated countries and creating awareness on the existence of government support to the GFF in Phase 1 and 2 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.

Further, there is merit in building the capacity of governments to comply with the financial management standards stipulated by the World Bank. The case of weak accounting and reporting practices in Cameroon—that have resulted in the lack of proper financial audits of how disbursed funds have been spent and subsequently low disbursement rates and delayed implementation of RMNCAH-N interventions—demonstrates the relevance of this recommendation.

**Responsibility**: This recommendation is addressed to CSO coalitions and individual CSOs.

(ii) CSOs: Identifying capacity gaps and positioning CSOs to engage locally and globally with evidence by providing access to information; equipping the CSOs with key skills in grant writing, alternative revenue generation, M&E and governance structure development; developing strong scorecards that can track GFF indicators and training CSOs on financial management. Also, capacity building should focus on building capacity to meaningfully

[25] https://www.globalpartnership.org/focus-areas/advocacy-and-social-accountability
[26] Jonathan Glennie (2019) " Global Public Investment: Five paradigm shifts for the future of aid"

engage in the GFF mechanism for example in the development of the investment case and enhancing DRM in the respective countries.

> There is a general appreciation and recognition at the GFF secretariat and investment group that there is need to strengthen civil societies in GFF participating countries so as to strengthen their oversight role on the GFF country platform.
>
> –GFF Focal Point for a country in Africa

**Responsibility**: This recommendation is addressed to donors and other funders who fund CSOs to carry out advocacy work in relation to the GFF.

**I) Advocacy to align off-budget funding with country investment cases:** As is now, most of the GFF funding has gone to unlock IDA/IBRD loans, government commitments for RMNCAH-N and grants from the WBG. These funds flow through the government budget and are considered "on-budget". Beyond these, there are significant pockets of funding that come from donors that are "off-budget" in the sense that they are channeled outside of government budget directly to CSOs, NGOs and other entities. As is now, it is difficult to ascertain that these off-budget pockets of funds are used to meet objectives set out in the country IC. Future work on the GFF ought to focus on aligning these funds with country priorities and the IC.

> Moving forward, one of the greatest opportunities for CSOs is to engage with these donors and advocate that they align their funding to country investment cases. This will potentially generate more funding for RMNCAH-N or re-direct the off-budget funds towards RMNCAH-N and country priorities.
>
> GFF Focal Point for a country in Africa

**Responsibility**: This recommendation is addressed to the GFF Investors Group that is mandated to mobilize resources for investment cases and whose membership includes donors and other funders who in some cases provide off-budget support to CSOs, NGOs and other entities.

**J) Advocacy to enhance participation in the GFF mechanism:**

(i) **Private sector and governments to enhance domestic resource mobilization:** Since official development assistance for health has plateaued between 1990 and 2017, there is urgent need for enhanced DRM to ensure sustainable financing.[27] Countries can raise more resources domestically through government tax revenues, efficiency gains, health insurance schemes and from the private sector. The private sector broadly includes health service providers, investors, philanthropists, pharmaceutical producers and wholesalers and

[27] http://www.healthdata.org/sites/default/files/files/policy_report/FGH/2018/FGH_2017_full-report.pdf

private firms. The private sector has been envisioned as a key player in the GFF since its inception, with a specific private sector engagement strategy proposed.[28] The role of the private sector is one which attracts great debate in global health discourse, with many views on how to balance the potential added value of the sector with ensuring that the health financing and health care interventions prioritized are those that advance sustainability, equity, and access.

> **Responsibility**: This recommendation is addressed to the GFF Investors Group and to individual CSOs at the global and country levels respectively.

(ii) **Academia:** Drawing on the experience of successful initiatives by universities e.g. John Hopkins and London School of Hygiene and Tropical Medicine(LSHTM), academia ought to be greatly involved in the GFF process to reverse the current practice where most involvement is "individualistic" rather than university-wide participation. For example, the John Hopkins School of Public Health has pioneered the Countdown to 2030(CD 2030) initiative that provides technical analysis and support to countries on effectively prioritizing areas and activities for their participation in the GFF. Academia can generate evidence around the investment case by developing financial models and simulation testing of the different financing strategies to be embraced. These can be powered to the CSOs and the multi-stakeholder country platform.

> **Responsibility**: This recommendation is addressed to the GFF Investors Group at the global level and to the multi-stakeholder country platforms at the country level. The latter ought to include academia in its membership and leverage on research evidence and analysis generated by academia to inform GFF processes such as the development of investment cases.

(iii) **Devolved units of government:** There needs to be increased participation of the devolved units of government in countries where devolved systems of governments operate and where the devolved units have a role to play in healthcare delivery as is the case in Kenya, Rwanda, Malawi and Nigeria. In line with this, there is merit in increased CSO participation in M&E and oversight of the use of funds at the health facility level (state level) since the facility/ward/constituency committees can be compromised.

> **Responsibility**: This recommendation is addressed to individual CSOs at the country level that can advocate for increased participation of county governments.

**K) Systematic evaluation of the GFF in-country:** There is need for GFF participating countries to carry out systematic evaluations that bring out the "true" state of the GFF process in-country in an objective manner. The evaluations should be all-inclusive with the participation of all GFF stakeholders. The

[28] https://www.globalfinancingfacility.org/gff-private-sector-engagement-strategy-0

results obtained from such evaluations should inform the way forward in terms of implementation of the investment case. For instance, Cameroon carried out a midterm review in 2019 so as to evaluate the progress in implementation of the investment case during the first two years (2017 and 2018). Data was collected from health facilities, relevant ministries, civil society, partners, private companies, academia, and beneficiaries of the investment case interventions. Results from the review demonstrated key achievements, challenges, what was working and what was not working. This allowed for formulation of recommendations in a bid to ensure achievement of the investment case objectives.

**Responsibility**: This recommendation is addressed to the Governments and Ministries of Health of GFF participating countries in their capacity as conveners and leaders of the GFF multi-stakeholder country platforms.

## 6. Conclusion

The comparative analysis of GFF-related investments to enhance civil society advocacy demonstrates that the GFF mechanism has had mixed outcomes in different countries. On one hand, the mechanism has resulted in not only the ring-fencing of funds for RMNCAH-N, but also the allocation of more domestic government expenditure towards RMNCAH-N as in the case of Nigeria. On the other hand, there is little evidence of the ability of the GFF grant to unlock more domestic financing since most of the governments such as the Government of Kenya have not allocated domestic resources to RMNCAH-N, rather have borrowed loans from IDA to provide matching funds to the GFF grants. From an advocacy perspective, the GFF's main challenges include: little transparency; poor access to data on the mechanism; misconceptions among GFF stakeholders on what the GFF is and what it is not; and poor monitoring and evaluation of the mechanism that has resulted in little empirical evidence on the impact of the GFF or RMNCAH-N outcomes. These challenges seem to be evident in most, if not all, GFF participating countries.

Moving forward, there are several opportunities for OSF and CSO advocacy to enhance the GFF mechanism. Key among them being the opportunity for peer-to-peer learning to borrow lessons from other funding mechanisms to enhance the GFF; awareness creation among GFF stakeholders to correct misconceptions about what GFF is and what it is not; capacity building of CSOs to enable them to optimally engage with the mechanism, especially with regards to offering technical assistance in M&E, governance and accountability. Other opportunities include widening the inclusivity of the GFF to include devolved units of governments within countries, the private sector and academia; and advocacy to providers of off-budget funding to align it with county investment cases. The implementation of the recommendations put forward in this report will enhance the civil society advocacy and the GFF to enable the latter to live up to its mission of being a catalytic funding mechanism. It has the 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.

# 7. Annex - Country Case Studies

## 7.1. Cameroon

### 7.1.1. Fiscal space for health in Cameroon

Cameroon is a lower-middle-income country with a population of 25 million (2018) that is projected to increase to 28 Million by 2023.[29] Located along the Atlantic Ocean, it shares its borders with Chad, the Central African Republic (CAR), Equatorial Guinea, Gabon, and Nigeria. Two of its border regions with Nigeria (northwest and southwest) are Anglophone, while the rest of the country is Francophone.[30] Cameroon's average Gross Domestic Product growth in real terms has stood between 3.5% in 2008 and 3.9% in 2018. The economy improved between 2009 (at 2.1%) to 5.8% in 2014 and experienced a downtrend between 2014 (5.8%) to 2017(3.5%) and improved slightly in 2018 (3.8%) (Figure A1). Cameroon is classified as a lower middle-income income country, but poverty levels are high and score lowly on the social indicators.[31] Cameroon is richly endowed with oil, high-value timber and agricultural products mainly cocoa, cotton and coffee though the poor infrastructure, unfavorable business environment and weak governance dampen economic activities. The GGHE/GGE increased between 2008 (3.4%) and 2011 (6%) before slumping to 3.7% in 2012 and then decreased to 2.9% in 2016. This has fallen below the agreed upon threshold by African Heads of states to allocate at least 15% of the government expenditure in health (Abuja declaration). The GGHE/GDP has averaged 0.5% between 2008 and 2018, also falling below the suggested threshold of 5% for countries that have made progress towards UHC. The combination of the GGHE/GGE and GGHE/GDP implies that Cameroon has made less progress in investing in healthcare, which puts in disarray calls for UHC and increased investments in healthcare by governments.

Ministry of Health budget execution is poor with a 36% execution rate of the investment budget in 2013 and an average execution rate of 53 percent between 2007 and 2013. Additionally, interventions that have the highest impact among the neediest groups are not prioritized during budgetary allocation. For instance, preventive services got only 2.9 % of the budget in 2011.[32]

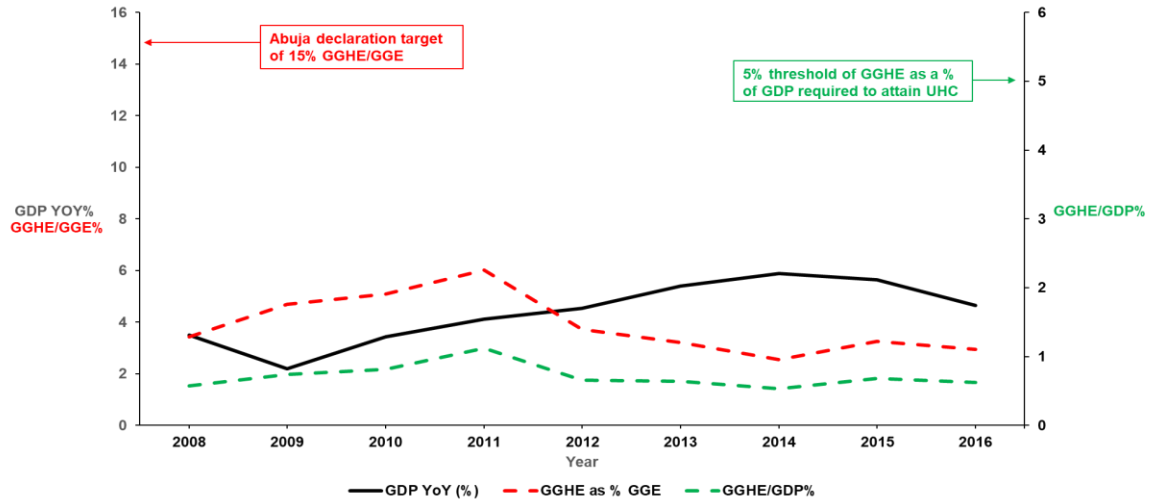
[29] https://www.imf.org/external/pubs/ft/weo/2019/01/weodata/weorept.aspx?sy=2017&ey=2024&scsm=1&ssd=1&sort=country&ds=.&br=1&pr1.x=51&pr1.y=14&c=622%2C722&s=NGDP_RPCH%2CNGDPD%2CLP&grp=0&a=

[30] https://www.worldbank.org/en/country/cameroon/overview

[31] Cameroon Global Financing Facility co-financing Project Appraisal Document PAD1666

[32] National Health Accounts 2011

**Figure A1: Fiscal Space for health in Cameroon**




Note: GDP YoY% means GDP growth year-on-year; GGHE/GGE% means General Government Health Expenditure as a percentage of General Government Expenditure, GGHE/GDP% means General Government Health Expenditure as a percentage of GDP

Analysis: E&K Consulting Firm

### 7.1.2. RMNCAH-N outcomes

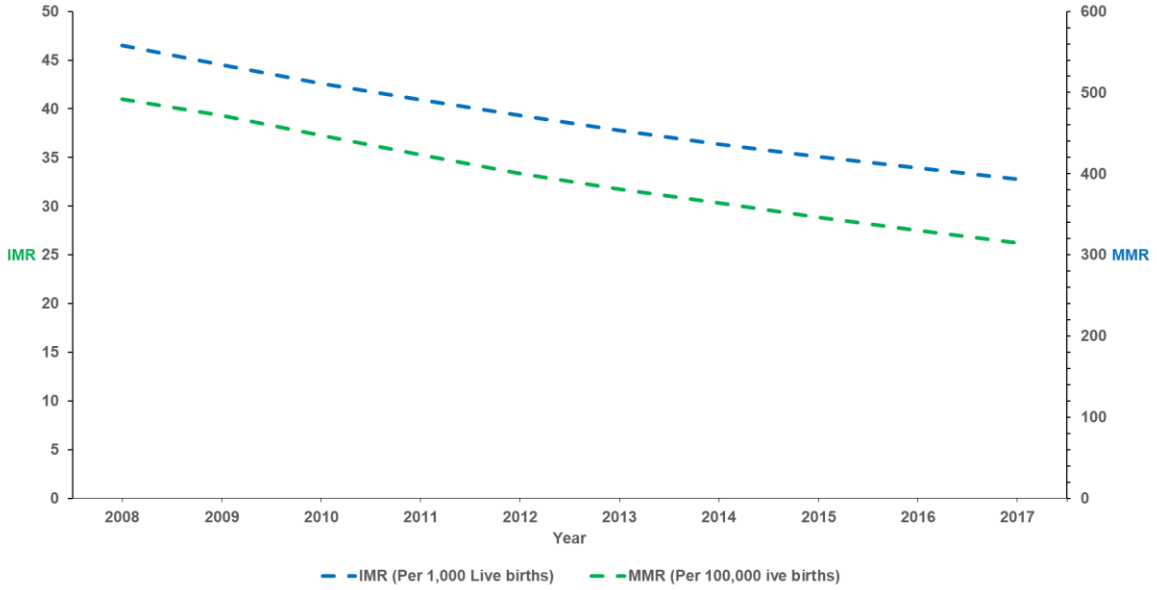
According to World Bank modelled estimates for Cameroon, the infant mortality rate per 1,000 live births has decreased steadily from 72 in 2008 to 51 in 2018 (Figure A2). This falls above the global target for the achievement of the Sustainable Development Goals targets for infant and neonatal mortality at 25 and 12 respectively by 2030.[33] On maternal mortality ratio per 100,000 live births, Cameroon ranks 18th among the top countries with the highest maternal mortality[34] rates which stood at 529 in 2017 falling below the SDGs target of 70 and the global average of 216. Though the maternal mortality showed slight improvement, dropping from 618 in 2008 to 529 in 2017, it remains a worrying statistic. According to WHO, hemorrhage is the most prevalent cause of high maternal mortality compounded by lack of emergency drugs, donor blood, unsafe abortions and infections. Maternal mortality annual rate of change between 2000 and 2015 is, on average, 2.6% and lifetime risk of maternal death is at 35%. This compounds the need for a collaborative approach to reverse these trends implying that maternal mortality remains a big threat to Cameroon.[35] One in every four young girls have given birth by the time they are 18years old, newborns with less educated mothers are 1.5 times more likely to die during the first month than those born to highly educated mothers.

[33] https://uni.cf/sdgfullreport

[34] https://www.globalcitizen.org/en/content/cameroon-maternal-mortality-rates-gff/

[35]https://data.unicef.org/wpcontent/uploads/country_profiles/Cameroon/Maternal%20and%20newborn%20health%20country%20profiles/country%20profile_CMR.pdf

**Figure A2: RMNCAH-N outcomes for Cameroon**




Note: IMR means infant mortality rate per 1,000 live births, MMR means the maternal mortality ratio per 100,000 live births

Analysis: E&K Consulting Firm

### 7.1.3. The GFF mechanism so far

In Cameroon, the RMNCAH-N investment case was prepared in 2016 and it received commitments from IDA (US$100 million) and GFF (US$27 million) and did not have a financing gap as indicated in the PAD. The project implementation period was from 2017 to 2020. The health sector strategy committee serves as the GFF country platform.[36] The GFF country platform meets infrequently which has a negative impact on coordination of the GFF process.

CSOs that participated in the development of the investment case did so as individual organizations with individual interests and not as a coalition as envisaged in the GFF's minimum standards for inclusion, transparency and accountability for the multi-stakeholder country platform guidelines. These CSOs were selected based on their historical engagement with the government which means that some CSOs were left out in the process. This was mainly due to the absence of a mapping of CSOs in the country and lack of CSO self-organization. CSOs are involved in increasing demand for health services but they tend to operate mainly in specific health districts and they work without necessarily aligning themselves with national or strategic priorities.[37]

The private sector was not involved in the development of the investment case. Private companies, despite their low level of involvement in the development and implementation of the investment case, provide maternity equipment as part of their Corporate Social Responsibility. However, they complain about poor collaboration, monitoring and use of their contributions. They would like to be invited to participate in the investment case implementation and to receive recognition for their actions.[37]

[36] https://www.globalfinancingfacility.org/cameroon

[37] Report of the midterm review of the GFF mechanism in Cameroon

Partners attend meetings of the technical group whenever possible and indicate that there is little follow-up and impact of the decisions that are made. They complain about irregular progress reports, low ownership levels, slowness of the disbursement process and the dependence on funding from partners. They would like to see free maternal and child healthcare and an increase in budgetary allocation to health in the national budget.[37]

Academia participates in the GFF process through capacity building of RMNCAH-N care providers. However, academics suggest that inadequate communication has led to low awareness levels of the investment case.[37]

Cameroon launched a Development Impact Bond for Kangaroo Mother Care (KMC) to reduce Low Birth Weight (LBW) related risks in February 2019 and it should run until March 2021. KMC involves continuous skin-to-skin contact between caregivers and LBW infants and exclusive or near-exclusive breastfeeding. KMC allows infants to spend less time in incubators which is a more efficient use of limited resources. The Development Impact Bond is funded by the Ministry of Public Health, Cameroon drawing on funds from GFF (US$ 2 million) and Grand Challenges Canada (US$ 800,000).[38] Facilities provide upfront working capital thereby taking on the financial risk, demonstrating how GFF can bring in new financing partners to improve health outcomes. Funders only pay for agreed target outcomes that have been achieved thus ensuring effective use of limited financial resources. Target outcomes include increased access to quality KMC for LBW infants, weight gain and reduced LBW infant mortality.

A midterm review was done in 2019 to evaluate implementation of the investment case during the first two years (2017 and 2018). A qualitative approach was used with semi-structured interviews, guided discussion groups of key informants, secondary analysis and documentary analysis of the health information system (DHIS2) and Demographic and Health Surveys (DHS 2011 and 2018). Data was collected from players at all levels of the health pyramid of Cameroon, relevant ministries, civil society, United Nations organizations and bilateral partners, private companies, academia, and beneficiaries of the investment case interventions. Results from the review formed the basis of recommendations that were made in order to ensure achievement of the investment case objectives. One of the recommendations was a no-cost extension of the project to 2022.[37]

### 7.1.4. Trends in advocacy

In Cameroon, the CSOs engage in advocacy activities under their individual mandates and according to their organizational priorities. GFF and the Global Fund extended an invitation to the CSOs in the health space to form a coalition for better coordination of their activities. The CSOs came up with "Alliance" as their umbrella body but, unfortunately, this body has not been operational mainly due to lack of funds according to the interviews conducted. Alliance members have not been able to regularly hold their own meetings but rather take advantage of when some members meet during conferences and workshops to discuss their issues. This is not an ideal scenario since not every member will have attended the conference or workshop.

> Lack of funds has rendered the coalition inactive with members meeting on the sidelines of other meetings meaning no adequate quorum.
>
> –Alliance Chairperson

[38] https://www.globalfinancingfacility.org/first-its-kind-development-impact-bond-launched-cameroon-save-newborn-babies

Most CSOs carry out advocacy activities at the community level and also target community and religious leaders while some CSOs also engage the government at different levels. Advocacy areas include: family planning, prenatal care, delivery at a health facility, postnatal care, discouraging early marriage and promoting keeping girls in school. However, most CSOs are not engaged in advocacy activities within the GFF framework as envisaged in the GFF process.

Communication and outreach activities for the investment case launch were not carried out as initially planned which may explain the low involvement of certain key players.[37].

The GFF country platform is actively engaging the decision-makers in government to increase the annual budget spent on health which in 2016 was at 5.6% of the total national budget[39] representing a third of the Abuja Declaration target of 15%. While the advocacy activities seem to be successful at the technical level, there has been little or no success at the higher decision-making and budget allocation level. This is attributable to the country platform being composed mainly of technocrats who do not have the final word on the budgeting process, which is determined by the decision-makers.

As part of the investment case, the government has also increased advocacy activities on the need for civil registration. It has also introduced Performance Based Financing (PBF) for the secondary civil registration centers in a bid to increase civil registration rates.

### 7.1.5. Trends in transparency

Most of the CSOs interviewed as part of this research indicated that there have been low levels of transparency in the GFF mechanism in Cameroon. The fact that only a few selected CSOs were invited to participate in the investment case development was not well received by CSOs that were left out. Infrequent meetings of the GFF country platform also imply some level of opacity and also reduce the flow of information to the relevant stakeholders. A clear example cited in lack of transparency is a draft health bill that is being discussed in parliament yet the CSOs do not even know its contents let alone contribute to its drafting under public participation.

> We are aware that currently there is a health bill that is being discussed in parliament but we do not know the contents of this bill.
>
> –Alliance Chairperson)

Omission of the private sector in the development of the investment case and their level of engagement in the GFF process has also raised transparency questions as they are part of the stakeholders who are expected to play a key role in the GFF process. The private sector is particularly important in Cameroon because according to a survey, private sector health facilities accounted for 49 % of total hospital visits[40].

[39] Extrait des lois de finances du Cameroun de 2016
[40] 2014 assessment by USAID's Strengthening Health Outcomes through Private Sector (SHOPS) project

### 7.1.6. Key challenges

The key challenges in Cameroon include:

A. **Lack of CSO self-organization:** The CSOs in Cameroon do not have an operational coalition, which makes it virtually impossible for them to coordinate GFF related activities. The interviews revealed that the main reason for this is lack of funding to run Alliance, which is the coalition for CSOs in health. The interviews conducted demonstrated that most CSOs thought that GFF was going to directly finance their operations. This misunderstanding seems to arise from inadequate CSO engagement at the level of the GFF country platform as well as CSOs not taking time to read available GFF resources such as the GFF website.

B. **Lack of CSO Activity Mapping:** The different activities carried out by the CSOs are not well mapped in the country. This makes CSO engagement in the GFF process difficult as the GFF country platform, and indeed the Ministry of Health and government being the conveners of the platform, may not be aware of some stakeholders.

C. **Financing and Governance:** Cameroon is confronted by several challenges related to financial governance including limited financial and human resources, insufficient coordination, supervision, audit, control, monitoring and reporting of expenditure[37]. This has had a negative impact on the implementation of Performance Based Financing (PBF) and Chèque Santé – the latter being a facility that covers healthcare costs for the poor during pregnancy, delivery and six weeks after delivery including for the newborn. PBF and Chèque Santé were envisaged in the investment case to increase both the demand and supply of healthcare services. However, due to poor accounting and reporting there has been a low disbursement rate resulting in delayed payments to the health facilities—a fact that has discouraged health facilities from offering healthcare services to the intended beneficiaries of PBF and Chèque Santé. Beneficiaries of Chèque Santé also complain that health facilities prioritize cash paying patients over Chèque Santé beneficiaries when it comes to service delivery thereby reducing the demand and update of the facility.

D. **Insecurity and challenging context of the northern regions:** Three out of the four GFF priority areas are in the North (Far North, North and Adamawa). However, the northern regions face high levels of chronic poverty, have the poorest health outcomes (including RMNCAH-N outcomes) in the country and face an acute shortage of health personnel to deliver health services. At the same time, instability and displacement of populations has increased in recent years due to violent attacks by Boko Haram. This has impeded the implementation phase of the GFF mechanism and also has resulted in a reduction in the availability of health services due to staff of health facilities in affected areas fleeing to safer areas. At the same time, there is an increase in the need for health services for these displaced populations affected by instability.

### 7.1.7. Key opportunities for future work

The following opportunities merit consideration in future work on the GFF mechanism in Cameroon:

A. **Activity Mapping:** The different activities carried out by CSOs in health need to be clearly mapped. This will help in identifying the relevant stakeholders for the different investment case priorities. CSOs cannot be invited to engage in the GFF mechanism if what they do is not known.

B. **Self-Organization:** The CSOs need to operate under a coalition as envisaged in the GFF process. Even though Alliance exists as the umbrella body for CSOs in health, it is not operational. There is therefore need for operationalization of Alliance for meaningful GFF engagement.

C. **Training and Capacity Building**: Training workshops should be carried out at the national, regional, and local levels for all relevant GFF actors. For example, training on World Bank accounting and audit requirements for involved government officials as well as partners participating in the PBF scheme. This is necessary for the effective operationalization of the PBF approach.

D. **Country Platform:** The Cameroon GFF country platform is not fully constituted as envisaged by the GFF's minimum standards for inclusion, transparency and accountability for the multi-stakeholder country platform guidelines and meets infrequently. Support could be rendered so as to improve the effectiveness of the country platform and thereby increase realization of the investment case objectives. This may take the form of ensuring that all relevant stakeholders are part of the platform and that each member of the platform understands and is well equipped to carry out their roles.

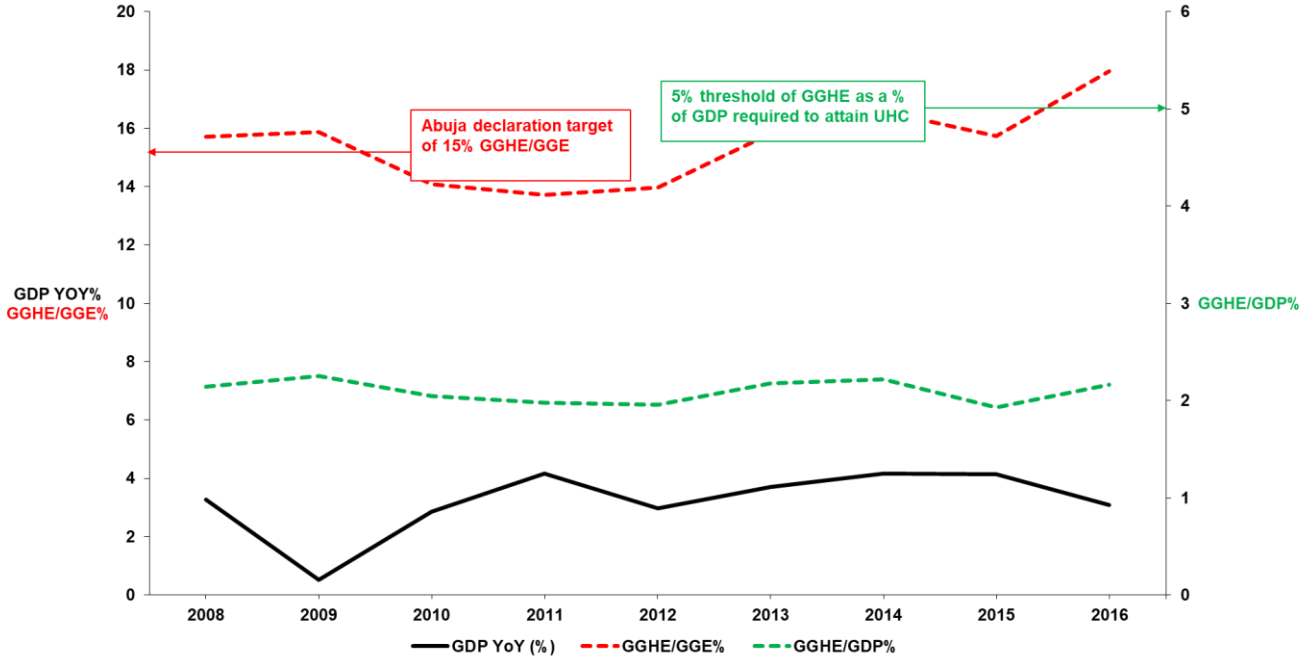
## 7.2. Guatemala

### 7.2.1. Fiscal space for health

Guatemala is a Latin American country bordered by Mexico, Belize, Caribbean, Honduras and El Salvador with a population of 17.2 million and GDP of US$78.5 billion that has grown intermittently between 2008 and 2018. From GDP growth rate of 3.3% in 2008, it dropped to 0.5% in 2009 then experienced an uptrend up to 2011 at 4.2% then grew sluggishly up to 2018 at 3.1% (Figure A3). World Economic Outlook (2019) projects that Guatemala's GDP will grow at an average of 3.6% between 2019 and 2023. Prudent macroeconomic management has positioned Guatemala as one of the strongest performing economies in Latin America though with the highest inequalities rates occasioned by malnutrition, maternal and infant mortality rates and predominant rural poverty[41]. The fiscal space in health is the ability to mobilize additional budgetary space for the health sector in a fiscally and economically sustainable and consistent manner[42]. GGHE/GDP has relatively levelled at around 2% from 2008 to 2016 and the CHE/GDP decreased between 2009 and 2015 from 6.2% in 2009 to 5.5% in 2015 and increased in 2015/2016 to 5.8% (Figure A4). Analysis of the fiscal space for health in Guatemala indicates that its current level of funding falls short of the amount required to meet the population's needs. The Ministry of Public Health and Social Assistance (MSPAS, Ministry of Public Finance and the Congressional Health Commission, have resorted to resolve this with the 5-10-year targets to increase the MSPAS budgets to address the underfunding. The current health financing in Guatemala is mainly out of pocket expenditure that represents 53% of current health expenditure[43]. The 2015 Guatemala Health System Assessment highlighted the urgency of "overall increment in government revenue" and "reprioritization of health within the government budget" as the lead sources of additional fiscal space[44]. Interestingly, Guatemala is unique from other GFF countries as only 0.93% of its health expenditure is externally funded and was also upgraded to an upper middle-income country status by World Bank. Therefore, GFF ought to revolve around catalyzing internal coordination and less focus on external partners.[45] Based on the Abuja declaration, Guatemala has achieved the required threshold though lagging in the Chatham report recommended target for GGHE/GDP.

[41] https://www.worldbank.org/en/country/guatemala/overview
[42] Heller PS. (2006) The prospects of creating "fiscal space" for the health sector. Health Policy Plan.;21(2):75-79. doi:10.1093/heapol/czj013.
[43] https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?end=2018&locations=GT&start=2008
[44] Avila, C., R. Bright, J. Gutierrez, K. Hoadley, C. Manuel, et al. 2015. Guatemala Health System Assessment. Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc.
[45] 2017-2018 Annual Report, The Global Financing Facility

**Figure A3: Fiscal Space for Health in Guatemala**




Note: GDP YoY% means GDP growth year-on-year; GGHE/GGE% means General Government Health Expenditure as a percentage of General Government Expenditure, GGHE/GDP% means General Government Health Expenditure as a percentage of GDP

Analysis: E&K Consulting Firm

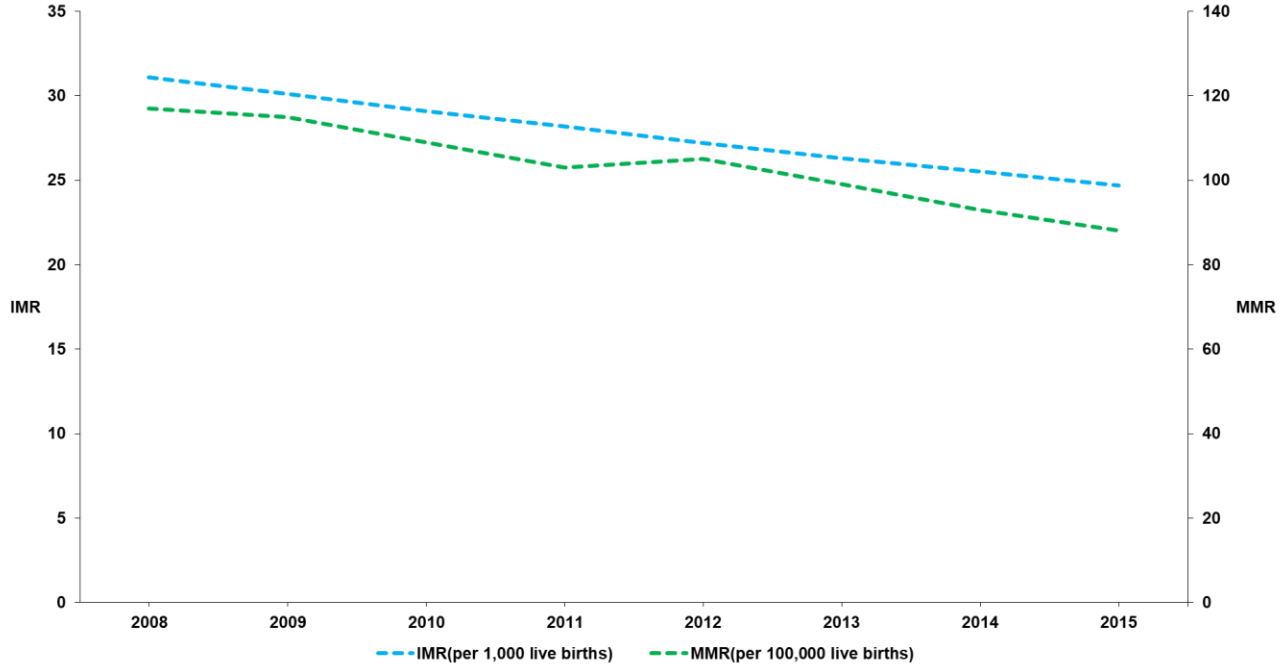
### 7.2.2. RMNCAH-N outcomes

Guatemala`s IMR reduced from 31.1 deaths per 1,000 live births in 2008 to 23.1 in 2017 while the MMR has had a downtrend since 2008 reducing from 117 deaths per 10,000 live births in 2008 to 88 in 2015 which is below the world average MMR at 216 deaths per 10,000 live births. The main causes of the mortality in the early 2000s were chronic stunting, lower respiratory infections and digestive diseases.[46] Through the coverage program by the Guatemalan Government in 2005, there was an increase in the access of healthcare services to over 100 rural municipalities through a two-phase approach. The intervention saw the reduction in infant and maternal mortality rates between 2008 and 2015[47] (Figure A4).

[46] http://www.healthdata.org/guatemala

[47] https://www.worldbank.org/en/results/2014/08/07/guatemala-improves-maternal-infant-health-nutrition

**Figure A4: RMNCAH-N Indicators for Guatemala**




Note: IMR means infant mortality rate per 1,000 live births, MMR means the maternal mortality ratio per 100,000 live births
Analysis: E&K Consulting Firm

### 7.2.3. The GFF mechanism so far

In Guatemala, the National Health Sector Strategy for prevention of chronic malnutrition has been opted in as the investment case though it took long to get congressional approval. The insights gathered from the interviews carried out with CSOs and the WB focal person indicate that the CSOs have not been involved in the process and it has been shrouded in secrecy both from the WB, GFF and the few CSOs that engage on the platform. The country platform in Guatemala is a high-level platform that is not inclusive at all: chaired by the secretariat of food security under the prime minister and the national council for food security. Being an upper middle-income country, Guatemala has been earmarked for a GFF grant of **US$9 million** and **US$100 million** IBRD loan for the "Grecer Sano: Guatemala Nutrition and Health Project". The GFF grant will be utilized in buying-down the interest on the IBRD loan making the interest more concessionary.

> The project was approved by World Bank Board in 2017 and it took one and half years to be approved the Guatemalan Congress and the funds have not been released yet, the WB requirement is that if the Board approves a project and the funds are not released within twelve months, the project should be cancelled. Guatemala had to apply for an extension of the period by one year and funds are supposed to be released by September 2019."
>
> –GFF Focal Point for two countries in Latin America

### 7.2.4. Trends in advocacy

In Guatemala there is a broader engagement of CSOs on issues of transparency and accountability for public government funds. CSOs have harnessed this strength and use it for the GFF. On the power interest matrix, the private sector (because of corruption) is likely to have the most influence on the GFF mechanism. Most CSOs and the Attorney General's office have power to demand accountability of public funds but no specific interest in RMNCAH-N as stipulated by the GFF.

CSOs are engaged in advocacy centered on health systems public policy, which monitors different government investment plans, indigenous populations, capacity building of indigenous populations, budget monitoring, public funding and strategic advocacy on issues affecting indigenous and marginalized populations. On the GFF mechanism, CSOs are involved in monitoring and evaluation from the users of services and monitoring of governance arrangements. The key priorities for the CSOs are set at the annual assembly of CSOs.

Insights gathered from interviews carried out with CSOs and the GFF focal person indicate that involvement of the CSOs in the GFF process is one-way. For greater involvement in the process, CSOs ought to be given a chance to alter the agenda items and voice their opinions during the meetings. This does not happen as the CSOs invited to meetings are only allowed to listen to presentations already prepared rather than it being a two-way engagement.

### 7.2.5. Trends in transparency

CSOs have started engaging in the GFF mechanism because of the alignment of their objectives with those of the GFF. The CSOs get invitations to the country platform in Guatemala but some of them end up only submitting their logos but are not privy to the GFF discussions as the government claimed that GFF negotiations are not within the auspices of the CSOs. This casts doubts on the level of transparency and participation as a "matter of formality" by the CSOs in the GFF mechanism in Guatemala. Many CSOs are not aware of the details of the investment case and PAD and they are not in a position to determine with certainty any improvements since Guatemala joined the GFF mechanism.

> [a CSO] was invited to the GFF national platform in Guatemala, however……[it] was only requested to submit their logo and was not to be involved in discussions of GFF priorities in Guatemala because this was 'not a role' of civil society. …. [we] turned down the terms of engagement and because we were critical of what was being done, we were not invited again to the platform.
>
> –CSO Advocacy Specialist in Guatemala

The CSO interviews carried out as part of this research indicate that there has been an increasing trend in transparency in Guatemala though not directly attributed to the GFF but to the activity of the CSOs in demanding in country accountability. For example, CSOs have raised concerns about GFF collaboration with some private sector players who are already being tried for corruption charges. The GFF has been secretive about their meetings and engagements with the private sector. This casts doubt on GFF openness and their engagement with the corrupt private sector.

> One private sector entity had partnered with GFF in the development of stock cards aimed at improving supply chain management. The firm was heavily implicated in a corruption scandal and the GFF ended up avoiding any dealings with the firm.
>
> –GFF Focal Point for two countries in Latin America

### 7.2.6. Challenges

While the GFF has yielded some success, the mechanism has been faced with several challenges. The key challenges in Guatemala are elaborated below:

A. **Lack of innovativeness**: There are concerns that most of the interventions that the GFF seeks to implement such as private sector involvement are being done and have been done over a very long time. This challenges the originality of the GFF interventions since most of them seem to be a "reinvention of the wheel".

B. **Decision making:** Decision making within the GFF process is challenging since individuals are charged with small elements of the whole process.

> The major challenge anticipated with the GFF is having many people charged with many small parts, therefore missing the big picture. Not even the official overseeing Guatemala have the power to make decisions, rather they are just 'part of the portfolio.
>
> –CSO Advocacy Specialist in Guatemala

C. **Misalignment of service delivery and governance:** The CSOs involved in service delivery in Guatemala are willing to be part of the GFF mechanism. In contrast to that, the CSOs involved in governance do not want to be involved in the GFF mechanism claiming that they are not service providers.

D. **Politics and corruption**: Insights gathered from the interviews carried out with CSOs indicate that Guatemala is a highly politically charged country and this directly affects the GFF mechanism. For instance, Guatemala just came out of an election and the new leadership is set to be operational from 2020. Therefore, the GFF actors have been hesitant to liaise with the current leadership since they will soon exit their positions. Also, the selection of the CSOs to participate in the GFF process has been marred with political appointments.

E. **Country selection**: Insights gathered from the interviews carried out with the GFF focal person indicate that the country selection process for participating in the GFF has not been transparent enough. In Guatemala, it has been more than two years since the country was selected to join the GFF yet there has not been much progress since.

> The GFF process has not been transparent for the last two rounds of selection. The process has been unclear even to the countries and at the secretariat. The first 27 countries selection was not transparent.
>
> –GFF Focal Point for two countries in Latin America

### 7.2.7. Opportunities for future work

The following opportunities merit consideration in future work on the GFF mechanism in Guatemala:

A. **CSOs onboarding and capacity building**: The CSOs need to be onboarded early enough into the GFF mechanism once the announcement of the country has been made and insights are shared on the GFF operations and possible avenues of advocacy for the CSOs. A developed CSO could assume a caretaker role on the country platform and develop the capacities of the CSOs.

B. **Increasing the number of CSOs involved in governance:**

> An effort should be made to attract more CSO to join advocacy in the area of GFF governance. Health is not only important for service providers but is also important for organizations that work on governance, budget monitoring, public transparency and accountability.
>
> –Health Advocacy Specialist in Guatemala

> CSOs ought to be helped ask the 'Big question' regarding governance of the GFF and due diligence in the IC. Since CSOs come late into the national GFF mechanism they also need to be helped get on board earlier before they are invited to be part.
>
> –Health Advocacy Specialist in Guatemala

C. **Addressing CSOs underfunding**: Broader level support should be channeled to CSOs, for example, financial support to engage in governance and monitoring and accountability of the GFF mechanism since as currently constituted there are only a few donors that support these. Therefore, more donors ought to be onboarded to offer a broader level of support to CSOs in Guatemala.

> Donors have limited support for engagement of CSOs; which is restrictive and limiting. So far, the only donor interested in this broader level support is OSF. Having support (for travel, etc.) from donors will enable CSOs to engage more broadly on the GFF mechanism.
>
> –CSO Advocacy Specialist in Guatemala

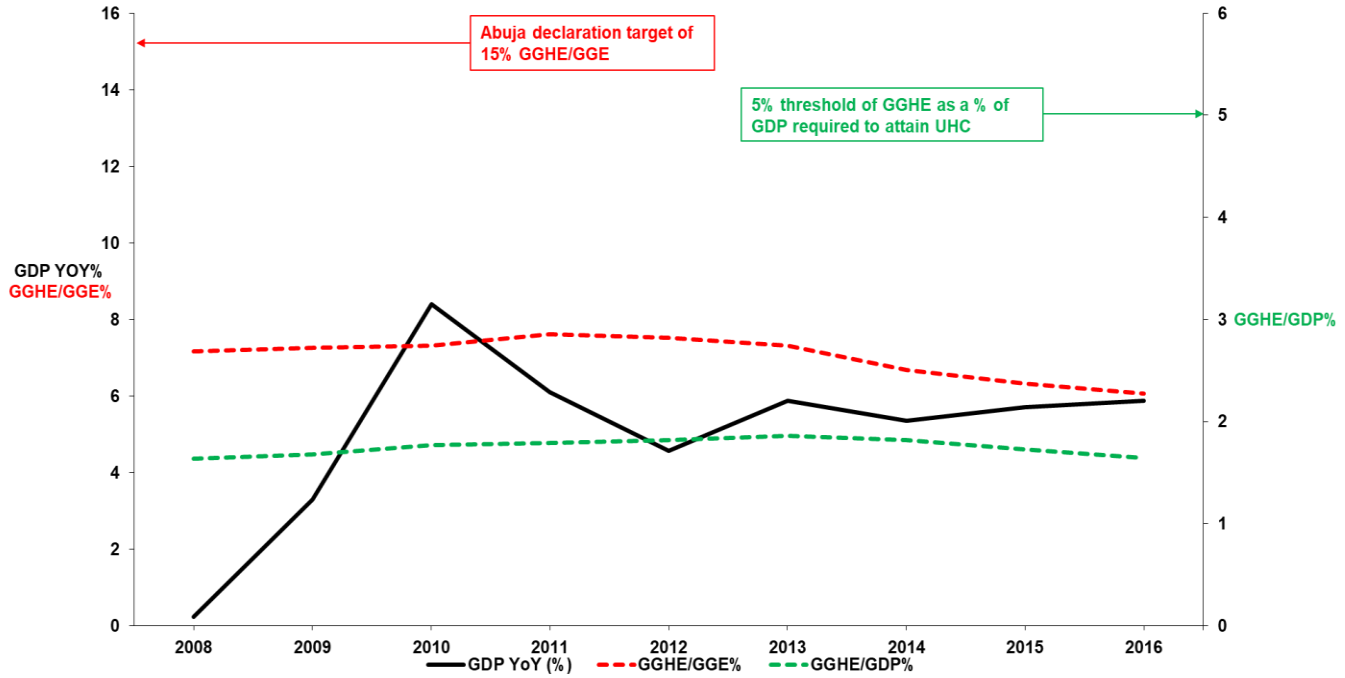
## 7.3. Kenya

### 7.3.1. Fiscal space for health

Kenya, with a population of 51.4 million and a gross domestic product (GDP) of US$87.908 billion, is considered a lower middle-income country.[48] Whereas Kenya's economy has grown steadily in recent years – with the gross domestic product (GDP) growing by 3.3%, 4.6%, 5.9%, 5.3%, 5.6%, 5.9%, 4.86% and 6.32% in 2009 (pre-devolution), 2012, 2013, 2014, 2015, 2016 , 2017 and 2018 respectively[49] and is projected to be 5.5% in 2019 and average 6.1% between 2019 and 2023.[50] The government's current healthcare spending as a percent of GDP (CHE/GDP) has decreased steadily from 6.0% in 2008 to 4.5% in 2016.[51] The domestic government health expenditure to total government expenditure (GGHE/GGE) has also been declining, from 7.2% in 2008 to 6.29% in 2017,[52] and is projected to decrease further to 4.4% by 2019.[53] Relative to its total revenue, the government's health-care expenditure falls far below the 15% target set by the Abuja Declaration[54] as well as the global average of 9.9%.[55] Kenya`s General Government Health Expenditure to GDP (GGHE/GDP) has averaged around 1.7% between 2008 and 2016 falling below the 5% threshold that is requisite for the achievement of UHC[56] (Figure A5). The limited government-funded fiscal space for health has, at least in part, created an increasing demand for innovative financing mechanisms including the GFF Trust Fund and the MDTF.

[48] http://data.worldbank.org/country/kenya
[49] http://data.worldbank.org/country/kenya#wbboxes-source-gep_chart2
[50]https://www.imf.org/external/pubs/ft/weo/2019/01/weodata/weorept.aspx?sy=2017&ey=2024&scsm=1&ssd=1&sort=country&ds=.&br=1&pr1.x=85&pr1.y=5&c=676%2C694%2C714%2C724%2C746%2C664&s=NGDP_RPCH&grp=0&a=
[51] http://www.who.int/countries/ken/en/
[52] https://www.globalfinancingfacility.org/sites/gff_new/GFF-Annual-report/pdf/Kenya-GFF%20Report%20Interior%20Pages%200717_48-49.pdf
[53] Kenya: Vaccines and Immunization Financing Review towards Predictable and Sustainable Immunization Programme Financing. September 2014.
[54] A pledge made by African Union countries in April 2001 to dedicate at least 15 percent of their annual budgets to the health sector.
[55] http://www.who.int/gho/health_financing/en/
[56] Chatham House Report. Shared Responsibilities for Health A Coherent Global Framework for Health Financing. 2014.

**Figure A5. The fiscal space for health in Kenya**




Note: GDP YoY% means GDP growth year-on-year; GGHE/GGE% means General Government Health Expenditure as a percentage of General Government Expenditure, GGHE/GDP% means General Government Health Expenditure as a percentage of GDP

Analysis: E&K Consulting Firm

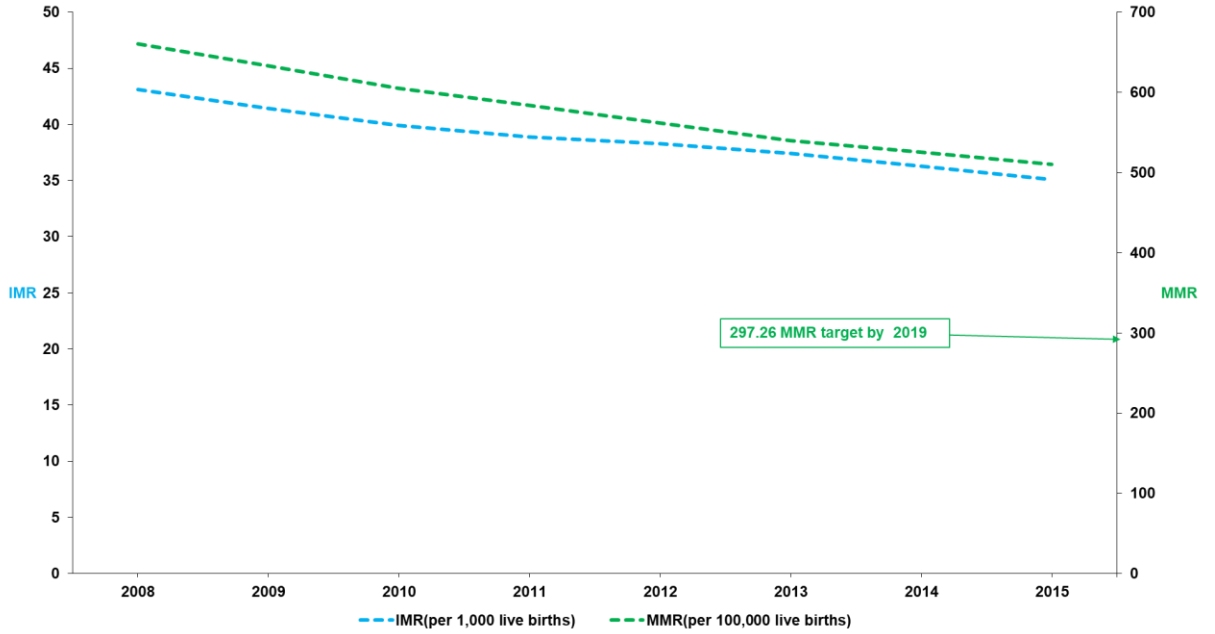
### 7.3.2. RMNCAH-N outcomes

The Kenya RMNCAH-N Investment Framework (2016)[57] identifies maternal mortality ratio, infant mortality rate and under age of five mortality as key RMNCAH-N indicators. The infant mortality rate has decreased from 43.1 deaths per 1,000 live in 2008 to 33.6 in 2017. After Kenya joined the GFF, the infant mortality rate reduced modestly from 35.1 in 2015 to 33.6 in 2017. Maternal mortality ratio on the other hand has decreased from 660 deaths per 100,000 births in 2008 to 510 in 2015 (Pre-GFF period) and reduced significantly after Kenya joined the GFF to 362 in 2017. Importantly, while Kenya has recorded reductions in maternal mortality, the country is yet to achieve the maternal mortality targets (i.e. 321.38, 309.14 and 297.26 deaths per 100,000 live births in 2017, 2018 and 2019 respectively) set out in the RMNCAH-N Investment Framework (Figure A6)[58].

[57] https://www.globalfinancingfacility.org/sites/gff_new/files/documents/Kenya%20RMNCAH%20Investment%20Framework_March%202016.pdf

[58] Kenya Reproductive, Maternal, New-born, Child and Adolescent Health (RMNCAH) Investment Framework (March 2016)

**Figure A6: The RMNCAH-N Indicators for Kenya**




Note: IMR means infant mortality rate per 1,000 live births, MMR means the maternal mortality ratio per 100,000 live births
Analysis: E&K Consulting Firm

### 7.3.3. The GFF mechanism so far

In Kenya, the investment case for RMNCAH-N was ready by January 2016 and it got commitments from IDA (US$150 million), GFF (US$40 million) and additional financing of US$1.1 million from JICA and did not have a financing gap as indicated in the PAD. It is worth noting that the CSOs interviewed as part of this research indicated that the development of the investment case was not participatory and was largely developed by the World Bank Group.

> In those early years, there was little if any CSO involvement and the GFF process e.g. development of the investment case, was done predominantly by MoH and WB … the CSO I work with only participated in the review of the RMNCAH investment case through an invitation sent to HENNET. The invitation to CSOs and criteria for selection of CSOs to join the meetings seemed ad hoc.
>
> –Advocacy Specialist at a CSO working in Africa

The funds have so far been allocated, disbursed and released and set to end by September 2021. Also in support of the Transforming Health Systems for Universal Care Project the MDTF was established with commitments from USAID (US$10 million), DANIDA (US$2 million) and DFID (US$4 million) for the next five years though USAID, being the biggest contributor to the fund, has pulled out of the project effectively for the next two years[59]. While the GFF Annual Report 2017/2018 indicates that the country platform for Kenya is established and working, insights from CSOs interviewed as part of this research indicate that there is no country platform in Kenya and what is referred to as the country platform are the

[59] Interview with the Ministry Official who chairs the MDTF

RMNCAH-N and MoH working groups that discuss GFF-related work. These working groups are not constituted as envisaged in the country guideline documents of the GFF.[60] The civil registration and vital statistics (CRVS) and management of medicines has been prioritized and being funded.

> In Kenya there is no 'GFF Country Platform' as envisaged in the 'Country Guideline Document' and the GFF Country Implementation Guidelines.
>
> –Advocacy Specialist at a CSO working in Africa

### 7.3.4. Trends in advocacy

In Kenya, the umbrella body for the Health NGOs, HENNET formed in 2005, has been doing advocacy on general health issues and has an 11-member governance structure. When the GFF came, the CSOs were involved on an ad hoc basis and HENNET participated on an individual basis but other sectors like the private sector were left out. The CSO interviews carried out as part of this research found that some CSOs only participated in the review of the RMNCAH investment case through an invitation sent to HENNET. The CSOs have been largely involved in health budget allocation advocacy, expenditure reviews for counties, maternal deaths review, sensitization on DRM, optimization of budgets of GFF funds, increasing transparency in flow of funds between county and national governments and transparency in the use of funds by county governments. But there has not been much focus on the implementation engagement in the GFF mechanism in Kenya.

### 7.3.5. Trends in transparency

The interviews done as part of this research suggest that there has been less transparency in the GFF mechanism in Kenya. The CSOs were not aware when the four countries launched GFF and the selection of flag bearer countries and development of investment cases has been opaque. There seems to be mistrust between CSOs and the MoH in Kenya and the level of information access has been low. For example, while information on how much has been disbursed to counties is available, information on how funds were used or how they were incorporated into county budgets has not been forthcoming.

> While MoH would ask for data from CSOs, whenever CSOs would ask what the data is for, MoH would say that the data is for 'high level conversations' that CSOS were locked out of.
>
> –Advocacy Specialist working for a CSO in Kenya

### 7.3.6. Key challenges

While the GFF has yielded some success, the mechanism has been faced with several challenges. The key challenges in Kenya are elaborated below.

A. **Misconception about GFF:** In Kenya, as per some CSOs' experience, GFF is not (or poorly) understood even by CSOs and county governments outside of Nairobi City. The CSOs think that GFF is a loan that must be equitably distributed to everyone and even county government governors opine that GFF funds be distributed to all counties equitably.

[60] https://www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF_Business_Plan.pdf

> Major misconceptions are that GFF is a World Bank grant or project; that GFF, being a loan, must be used equally by each Kenyan i.e. the concept of equity and the need to start with those with the least coverage is not well understood. Based on this misconception, governors have demanded that RMNCAH-N services be provided equally to all counties rather than targeting these services to counties that are most in need.
>
> –Advocacy Specialist working for a CSO in Kenya

B. **Inter-CSO collaboration:** While many CSOs claim to be open to collaboration while in public forums, most do not engage in collaborative work. This is because of fear of loss of budget, relevance and donor-driven priorities.

C. **Underfunding of CSOs:** While CSOs are expected to play an advocacy role, it is not clear how they ought to be funded to do this. Currently, the provision of the "Small Grants" which averages at **US$90,000** per annum per CSO is inadequate for optimal CSO engagement.

### 7.3.7. Key opportunities for future work

The following opportunities merit consideration in future work on the GFF mechanism in Kenya:

A. **Enhance inclusiveness:** Currently, the private sector is largely left out. There is need to see how the private sector can contribute to public health. For instance, there is merit in exploring how resources in the mining and oil sector (which are largely exploited by organizations in the private sector) can be used to enhance public health.

B. **Improve prioritization:** There is need for research on most impactful investments or funding interventions that are known to be impactful. For instance, the investment in a medical equipment scheme rather than in primary healthcare (PHC) in Kenya demonstrates poor prioritization of investments in health.

C. **Technical assistance to in-country CSOs**: The capacities of the CSOs ought to be developed so that they can build strong investment cases to motivate DRM. Most investment cases only demonstrate value in investing in RMNCAH-N at the level of health outcomes and do not demonstrate the value (in dollar terms). The absence of demonstration of value in dollar terms makes most investment cases not appealing to stakeholders who control resource allocation such as the Ministry of Finance.

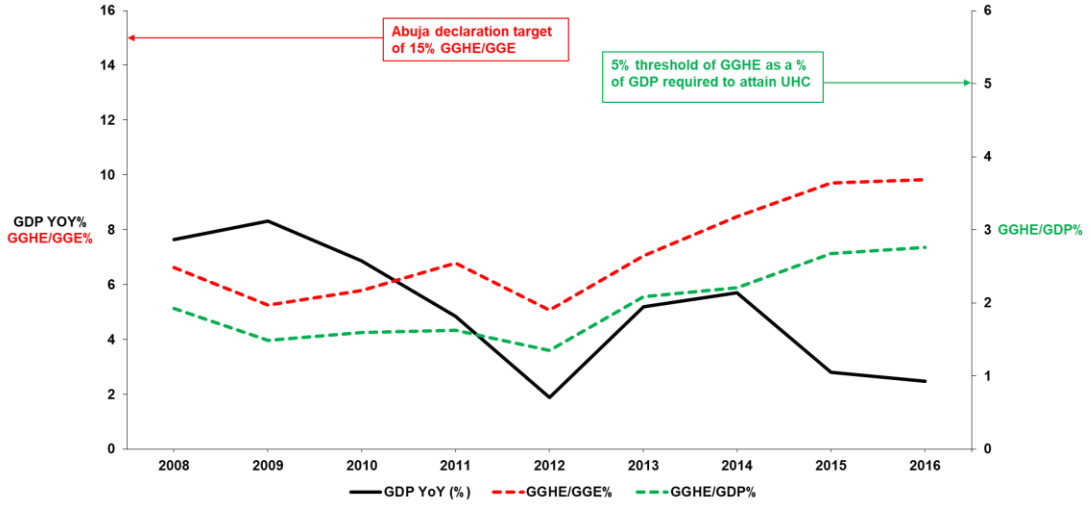
## 7.4. Malawi

### 7.4.1. Fiscal space for health

The Republic of Malawi is a landlocked country that borders Zambia, Tanzania and Mozambique with a population of 18.1 million in 2018 which is projected to exceed 29 million by 2030 and reach 45 million in 2050.[61] It is considered one of the most densely populated countries in the world. It has a GDP of US$7.1 billion which has experienced an intermittent trend between 2008 and 2018. The GDP (YoY) annual rate grew from 7.6% to 8.3% between 2008 and 2009 declining to 1.9% in 2012 and rebounding to 5.2% and 5.7% in 2013 and 2014 respectively before decreasing back in 2015 and 2016 at 2.8% and 2.4% respectively. GDP grew by 3.5% in 2018 and is projected to average 5.4% between 2019 and 2023.[62] The intermittency is caused by the predominance of agriculture that accounts for more than one third of GDP and 90% of exports. Tobacco is the key crop and therefore long dry spells, floods[63] and fall armyworms infestation curtails GDP growth.[64] Malawi`s GGHE/GGE increased from 6.7% in 2008 to 9.8% in 2016[65] though the uptrend streak was between 2012 and 2016 where it increased from 5.1% in 2012 to 9.8% in 2016. The GGHE/GDP reduced between 2008 and 2012 lagging at around 1.5% and then increased meagerly from 1.3% to 2.8% from 2013 to 2016 (Figure A7). CHE/GDP follows a similar trend to GGHE/GGE decreasing between 2008 and 2010 from 8.5% to 7.2% respectively and then increasing significantly from 7.2% to 11.6% in 2013. Malawi's CHE/GDP falls from 11.5% in 2013 to 9.3% in 2015 and showed a slight improvement between 2015 and 2016 increasing from 9.3% to 9.8%. Therefore, health care financing in Malawi remains unsustainable and unpredictable.[66]

[61] https://mw.one.un.org/country-profile/
[62] https://data.worldbank.org/country/malawi
[63] http://documents.worldbank.org/curated/en/723781545072859945/pdf/malawi-scd-final-board-12-7-2018-12122018-636804216425880639.pdf
[64] http://taxsummaries.pwc.com/ID/Malawi-Overview
[65] https://data.worldbank.org/indicator/SH.XPD.GHED.GE.ZS?end=2016&locations=MW&start=2008
[66] http://www.nationalplanningcycles.org/sites/default/files/planning_cycle_repository/malawi/health_sector_strategic_plan_ii_030417_smt_dps.pdf

**Figure A7: Fiscal Space for Health in Malawi**

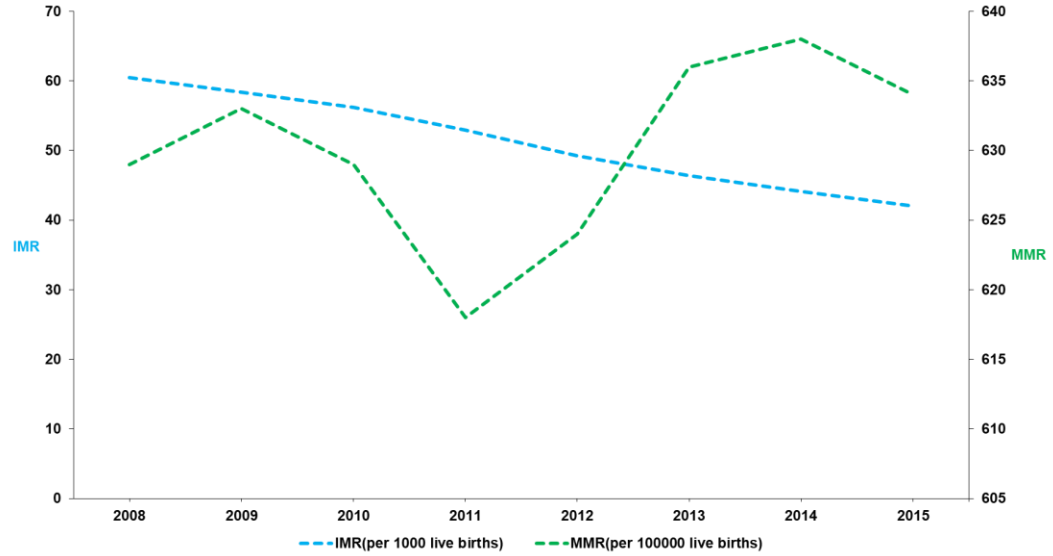



Note: GDP YoY% means GDP growth year-on-year; GGHE/GGE% means General Government Health Expenditure as a percentage of General Government Expenditure, GGHE/GDP% means General Government Health Expenditure as a percentage of GDP
Analysis: E&K Consulting Firm

### 7.4.2. RMNCAH-N outcomes

Malawi`s infant mortality rate has reduced from 60.5 deaths per 1,000 live births in 2008 to 38.5 in 2017. The maternal mortality ratio increased from 629 to 633 deaths per 100,000 live births between 2008 and 2009 and then decreasing to 618 in 2011 then increasing to 638 in 2014. In 2015, 634 deaths per 100,000 live births were recorded.[67] Despite the efforts, Malawi`s MMR and IMR remain among the highest in sub-Saharan Africa (Figure A8)

**Figure A9: RMNCAH-N Indicators for Malawi**




Note: IMR means infant mortality rate per 1,000 live births, MMR means the maternal mortality ratio per 100,000 live births
Analysis: E&K Consulting Firm

[67] https://data.worldbank.org/indicator/SH.STA.MMRT?end=2017&locations=MW&start=2008

### 7.4.3. The GFF mechanism so far

The investment case is still being developed with the Health Sector Strategic Plan (HSSP) being the basis.

> In Malawi, the investment case is just an operational plan operationalizing the HSSP.
>
> –CSO Health Financing Expert, Malawi

The donor space is already crowded and therefore the GFF coming onboard ought to be targeted to generate impact. The Ministry of Health and Population embraced the GFF model and formed a multi-stakeholder GFF taskforce composed of donors, CSOs and the government. The taskforce was just a reinvention of the Malawi Health Sector Working Group. The GFF taskforce is currently doing analytic work: situational analysis, resource mapping, financial gap analysis and health systems bottleneck analysis. Insights gathered from interviews carried out with CSOs indicate that the GFF process, in Malawi, was working well until the IEYGP project got approved for funding even before the finalization of the IC. This cast doubts on the level of transparency in the GFF mechanism in Malawi. This negated stakeholders' participation in the process and efforts have been initiated to bring back the partners.

> The initial process was working well with the working groups focused on key priority areas: Nutrition; RMNCAH-N, CRVS and early child stimulation until the Investing in Early Years for Growth and Productivity (IEYGP) was allocated **US$10 million** from GFF and **US$50 million** IDA grant. Though the project is focused on one of the priority areas, it didn't get owned by the taskforce and the MoH leadership and was approved even before the investment case was finalized. This made people to abandon the process.
>
> –Health Financing Expert, Malawi

### 7.4.4. Trends in advocacy

The CSOs are involved in a broad spectrum of advocacy specialties; development of human resources for health, service provision, human rights, elevating voices of affected populations, technical assistance and research and data analysis. Involvement in the development of the investment case has been averaging well from the onset though only three CSOs were picked by the government to participate in the process. The three CSOs are : Maikanda, Health Rights Education Program and Malawi Health Equity Network. There is a joint annual review and usually all CSOs participate by advocating during the meet up that happens after every six months. There is a recruitment ban in Malawi as per the IMF's advice,[68] this coupled with vacancy rate of more than 50% in the health facilities has necessitated CSOs to continuously advocate on the issue by proposing for locum employment of healthcare workers. Some CSOs are even employing healthcare workers indirectly and the government is slowly responding.

### 7.4.5. Trends in transparency

The three CSOs participating on the national platform have been "selected" by the government and are not willing to engage with other CSOs. This raises transparency concerns and the independence on the three CSOs to hold the government accountable. Insights gathered from the interviews carried out with CSOs indicate that the level of transparency has been weak.

[68] https://www.imf.org/~/media/Files/Publications/CR/2018/cr18336.ashx

> On a scale of 0-10, transparency gets a score of 6/10 as not much has been done in this space.
>
> –CSO Advocacy Specialist working for a CSO in Malawi

There is secrecy on the side of government as the government does not respond to criticism from CSOs on how loan monies are utilized as there has been no audit on the loans taken by the government. Also, CSOs have not been active in holding the government accountable and therefore most often public funds are diverted for the benefit of the few in Malawi.

> Loan money is often diverted for private benefit of politicians; e.g. The Malawi Social Action Fund from the World Bank.
>
> –CSO Advocacy Specialist working for a Journalist's Association in Africa

> CSOs have some collaboration with other CSOs in the country but their work is poorly coordinated, inconsistent and therefore does not achieve concrete deliverables.
>
> –CSO Advocacy Specialist working for a Journalist's Association in Africa

### 7.4.6. Key challenges

While the GFF has yielded some success, the mechanism has been faced with several challenges. The key challenges in Malawi are elaborated below:

A. **Financial commitments uncertainty**: In Malawi, the investment case is still being developed and the partners have already committed to financing the priority areas. Insights gathered from interviews carried out with CSOs indicate that there is lingering uncertainty on whether partners will be ready to redirect funds in line with IC. For example, technical assistance is oversubscribed and therefore funds should be channeled to purchase medical equipment and fund community mobilization strategies aimed at enabling people in remote areas access care. It is uncertain as to whether partners will be willing to invest in community mobilization.

> In Malawi, some financiers have already made their financial commitments for the next three years. They know that in the next three years they will fund these specific projects. We are not sure after the finalization of the investment case whether they will be willing to channel funds to more priority areas. For example, some are providing technical assistance and it is oversubscribed and we are unsure whether they will be ready to channel funds to medical equipment. Also, one of the biggest challenges is mobilizing the community to access care and the organizations are not open to interventions aimed at mobilizing the community to access vaccination through traditional community initiatives preferred by the community.
>
> –Health Advocacy Specialist in Malawi

B. **Misunderstanding of GFF**: Many CSOs in Malawi do not understand what GFF is about. Initially, CSOs thought that GFF was a funding agency and therefore submitted many proposals for funding before realizing that it was a catalytic fund targeted towards improving RMNCAH-N outcomes.

C. **Conflicts of interest:** The CSOs seem to have a conflict of interest in the GFF engagement process as some participate in the project development and implementation gives them an unfair competitive advantage over others.

D. **Misalignment of the HSSP**: In Malawi, the partners rarely apply the HSSP in guiding their investments.

> The Malawi Health budgets is 75% funded by donors and even with overarching strategies e.g. the Malawi HSSP plan that should guide partners investments, it's never used.
>
> –Health Advocacy Specialist in Malawi

E. **Financing of CSOs**: The CSOs are underfunded and this has precluded their ability to consistently engage with their constituents as well as convene advocacy meetings.

F. **Portfolio under concentration**: IDA's portfolio in Malawi is less in healthcare and mostly concentrated in infrastructure.

### 7.4.7. Key opportunities for future work

The following opportunities merit consideration in future work on the GFF mechanism in Malawi:

A. **Parliamentary committee engagement**: The parliamentary committee on health participates in district councils and is a strong body of influence and therefore CSOs ought to find a strategy of engaging politicians since they interact with the people more directly.

B. **Addressing underfunding of CSOs**: Issuing grants to the CSOs or developing a revenue generation strategy for them would help solve the underfunding problem and spur CSO competitiveness.

C. **Peer-to-peer learning**: Peer-to-peer learning for local CSOs in recently co-opted countries like Malawi in order to forge and maintain working relationships with CSOs in earlier phase GFF countries.

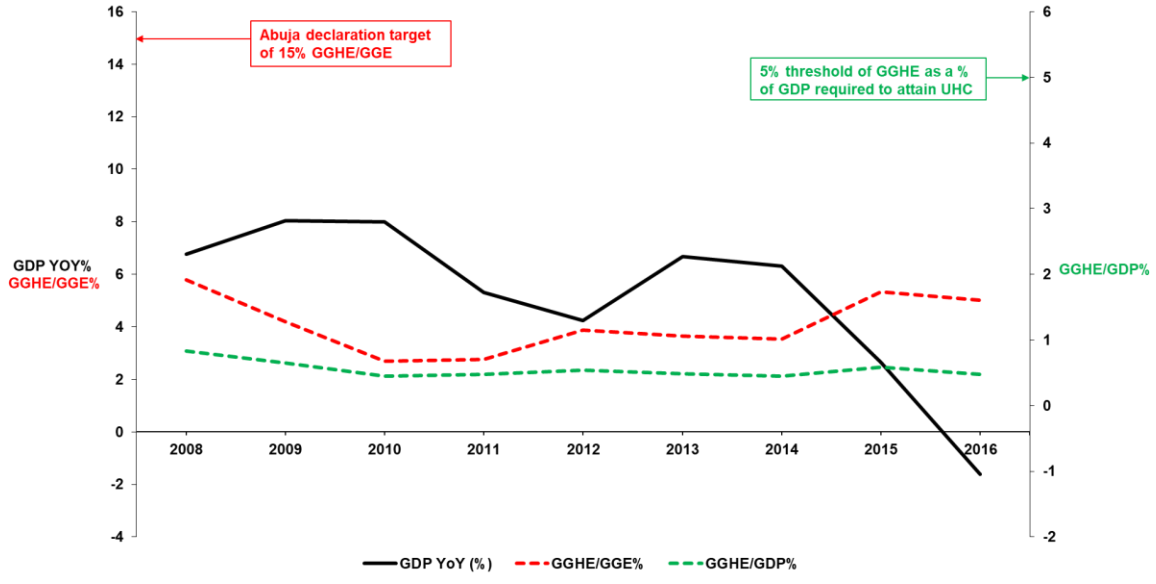
D. **UHC inclusion in IC**: Advocacy for inclusion of UHC in the investment case should be initiated.

## 7.5. Nigeria

### 7.5.1. Fiscal space for health

Nigeria has an approximate population of 197 million projected to be 222 Million by 2023. It plays a key role in West Africa with the largest youth population in the world. The abundance of oil makes it the biggest oil exporter on the continent and has the largest gas reserves. In 2018, it had a GDP of US$397.3 billion projected to almost double by 2023. GDP (YoY) growth rate grew between 2008 and 2010 from 6.8% to 8% in 2010 and then dropped from 8% in 2010 to 4.2% in 2012 increasing to 6.3% in 2013. Nigeria then experienced a sluggish economy between 2013 and 2016 and the GDP growth rate dropped from 6.6% in 2013 to -1.5% in 2016 that plunged it into a recession. This was caused by the fall in oil prices. Nigeria came out of the recession in 2017 recording 0.8% GDP growth, 1.9% in 2019 and is projected to average 2.5% between 2019 and 2023. This recovery is attributed to the focus on macro-economic and structural reforms as per the Economic Recovery and Growth Plan for 2017-2020[69] though softening in oil prices remains a threat.[70] Nigeria`s GGHE/GGE dropped from 5.8% in 2008 to 2.6% in 2010 then experienced a lackluster sluggish growth between 2010 and 2014 increasing from 2.7% to 3.5% then grew to 5.3% in 2015 and then dropped to 5% in 2016. Nigeria's GGHE/GDP has been insignificantly low: decreasing from 0.8% in 2008 to 0.5% in 2016.[71] A similar trend is experienced in the CHE/ GDP indicator that declined from 3.7% in 2008 to 3.3% in 2010 before gradually increasing to 3.7% in 2016. With GGHE/GDP at about 0.5%, Nigeria spends less on health as compared to nearly all the countries in the world (Figure A9).

**Figure A9: Fiscal Space for Health in Nigeria**



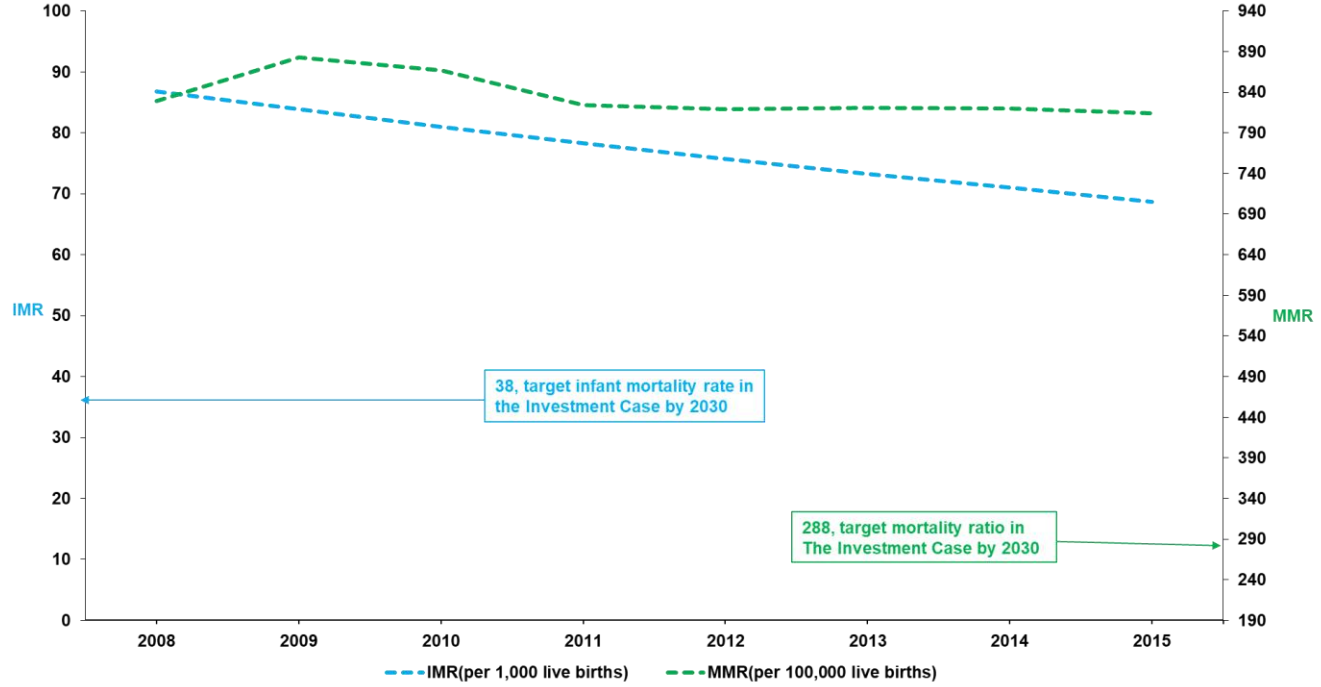

Note: GDP YoY% means GDP growth year-on-year; GGHE/GGE% means General Government Health Expenditure as a percentage of General Government Expenditure, GGHE/GDP% means General Government Health Expenditure as a percentage of GDP
Analysis: E&K Consulting Firm

[69] https://www.worldbank.org/en/country/nigeria/overview#1
[70] https://www.imf.org/en/Publications/WEO/Issues/2019/01/11/weo-update-january-2019
[71] https://apps.who.int/nha/database/ViewData/Indicators/en

### 7.5.2. RMNCAH-N outcomes

The under prioritization of health by the government makes Nigeria underperform in key RMNCAH-N indicators[72] (Figure A10). Nigeria's infant mortality rate has declined from 86.8 deaths per 1,000 live births in 2008 to 64.6 in 2017. Maternal mortality increased from 830 deaths per 100,000 live births in 2008 to 883 in 2009 then dropped to 814 in 2015. Maternal mortality rates have decreased slightly between 2008 and 2018[73] though the pace has been slower compared to the rest of the world. The country is the fourth largest contributor to MMR after Sierra Leone, Central African Republic and Chad. Nigeria recorded the highest number of maternal deaths in the world at 58,000 in 2015. Nigerian maternal deaths are mostly caused by hemorrhage upon delivery, sepsis at childbirth and unsafe abortions.[74] Nigeria's investment case prioritizes reducing MMR by 50% to 288 by 2030 and IMR by 50% to 38 in the same period, which is still far from being achieved (Figure A10).

**Figure A10: RMNCAH-N Indicators for Nigeria**




Note: IMR means infant mortality rate per 1,000 live births, MMR means the maternal mortality ratio per 100,000 live births
Analysis: E&K Consulting Firm

### 7.5.3. The GFF mechanism so far

In Nigeria, the phased type RMNCAH investment case has been prepared and approved by the Federal Minister of Health in 2018 and is being implemented with commitments from GFF, IDA, Scaling Nutrition and the Federal Government of Nigeria. The World Bank is co-financing with GFF two projects: Accelerating Nutrition results in Nigeria (US$225 million) and Nigeria State Health Investment Project (US$125 million). The GFF is also co-financing the BHCPF program by US$20 million that was utilized in

[72] Hafez, Reem. (2018). Nigeria Health Financing System Assessment. 10.1596/30174.
[73] https://dhsprogram.com/pubs/pdf/PR118/PR118.pdf
[74] http://aphrc.org/wp-content/uploads/2017/06/APHRC-2017-fact-sheet-Maternal-Health-in-Nigeria-Facts-and-Figures.pdf

prototyping the program in three states, and the government has committed 1% of the CRF in the 2018/2019 budget operationalizing the National Health Act enacted in 2014. In the 2019/2020 budget the government has committed approximately US$102 million.[75] After prototyping of BHCPF in three states, 28 states have so far expressed interest, nine states have received funding and five states are already implementing it as per the CSO interviews.

> The country platform has been established which initially was the Health Financing Committee that participated in the development of the Health Financing Strategy and the investment case which was disbanded in 2016 by the new minister.
>
> –Health Financing Specialist working for a CSO in Nigeria

Insights gathered from the interviews carried out with CSOs indicate that there is a representative functional platform. For instance, the Health Sector Reform Coalition for CSOs, government, partners and the private sector are involved and the GFF focal point and liaison persons have all been recruited.

The views of the CSOs contradict the insights from the interviews carried out with representatives from the Nigeria Federal Ministry of Health who opine that the GFF country platform has been dysfunctional since 2016 when the BHCPF technical working group overshadowed the country platform. This implies that the BHCPF performs most of the roles that the country platform ought to play. This, in part, has been fueled by the change of leadership at the Federal Ministry of Health that has affected the reconvening of the country platform as the leadership argues that the GFF platform cannot be used to coordinate BHCPF since the bulk of the money is contributed by the government.

The priority interventions have been identified through a consultative process with the stakeholders and disbursements from WB are on-going. The private sector has been supportive through the private sector innovation strategy in place that allows for testing and scaling of the private sector ideas.

> The Nigerian investment case has 5 phases. The first phase has been implemented for 18 months and the second one started being implemented 2 or 3 months ago. The third will be implemented from September 2019 and there is a midterm review for the first phase.
>
> –CSO Advocacy Officer in Nigeria

### 7.5.4. Trends in advocacy

With the introduction of the GFF in 2015, the CSOs coalesced under the Health Sector Reform Coalition and elected one representative to the country platform. Before then, the NHA (2014) provided an opportunity for CSOs like E4A-MamaYe to become part of the Health Financing Sub-committee in the MoH and then participate in the development of the Health Financing Strategy and later the IC. CSOs have participated in successful advocacy initiatives like pushing the NHA (2014) to be approved by parliament and budget allocation to the BHCPF in 2018/2019 and 2019/2020 budgets. The health sector reform coalition after the disbandment of the Health Financing Committee in 2016 remained active and formed the CSO working group on GFF, spearheaded by then a CSO representative at the IG that continued advocacy on GFF. This stimulated many CSOs to participate and appreciate the role of GFF. Key advocacy specialties have been monitoring the following: analytics, private sector involvement and diagnostics, and

[75] Interview with GFF Liaison Officer

communication focused on giving the right information to journalists about GFF. Initially M&E was not very strong, and this applied to many GFF countries. The advocacy has been made possible by key tools like the scorecard that tracks funds from the central bank to the local facilities.

> We endeavor to provide communication that drives public knowledge by strengthening the capacity of journalists to report the right information on the GFF mechanism in Nigeria. The media picks up all the evidence generated from the facilities.
>
> –Health Financing Specialist working for a CSO in Nigeria

> "……[we] have mainly done national level advocacy and produced documents to guide CSOs understand GFF and the roles that CSO could play to support the national level."
>
> –Health Financing Specialist working for a CSO in Nigeria

> We piloted a quick action plan to push for the passage of a law that would enable us to access state BHCPF funding. The law was passed and in 2019 our CSO is strengthening capacities at the community level to track the funds that come in at the ward level.
>
> –Health Financing Specialist working for a CSO in Nigeria

> CSOs had a contribution in the development of the IC, HERFON had a representative and youths were not represented initially but thanks to continued advocacy there is a youth representative now.
>
> –Health Financing Specialist working for a CSO in Nigeria

### 7.5.5. Trends in transparency

There is openness with the BHCPF though information release has been too slow and not in line with international standards on timing as a component of transparency. There is no information from the World Bank about the funds allocated to different states in the NSHIP project and therefore the WB ought to open this process and avail information. The health sector reform coalition that houses the CSO working group has not been effective and does not release timely information to the CSOs and there are lapses in convening meetings. At the state level, the WB is not transparent enough as it fails to avail information to the CSOs claiming they are not beneficiaries. Comparatively, GFF money is less than what the government commits and therefore CSOs indicate that the WB and GFF ought to allow Nigeria to drive their investments and not dictate to the country on what is to be invested in.

> The NSHIP project was co-financed by US$20 million from GFF, the WB country managers do not understand that GFF is part of NSHIP and do not want to release information to some CSOs for they are not beneficiaries.
>
> –Health Financing Expert working for a CSO)

> We have not been as transparent as we should be.
>
> –Ministry of Health Official working in Africa

### 7.5.6. Challenges

While the GFF has yielded some success, the mechanism has been faced with several challenges. The key challenges in Nigeria are elaborated below:

A. **Donor influence**: Insights gathered from the interviews carried out with CSOs indicates that some donors do not carry out thorough due diligence on how to address issues and use untrue reports about Nigeria that are commingled with wrong information. They then initiate projects based on this.

B. **Attribution and competition**: Driving GFF advocacy as a coalition is challenging since some CSOs dislike working with others and prefer leading advocacy alone. Also, local CSOs attribute their problems to the financially endowed international CSOs that seem to be crowding them out of their advocacy space because of their global presence and wide capacity base.

C. **Decentralization and fragmentation:** The decentralized nature of Nigeria poses a monitoring and implementation challenge at the state and facility level where funds are channeled directly from the central bank. The management of the funds is vested upon the ward development committees which might be compromised if the M&E systems are weak. Also, donors and CSOs are working on different projects that tend to achieve the same outcome therefore, posing duplication challenges.

D. **Funding for CSOs:** The CSOs have constantly written to the GFF liaison officer for Nigeria requesting the GFF mechanism to have a funding arrangement for them. Some CSOs are financially constrained to the extent of not being able to meet operational expenses like meeting venues and travelling to the different states to perform their core roles.

E. **Duplication:** There are several projects such as the Saving One Million Lives Project that can potentially impact the same indicators (such as maternal mortality) that the GFF is envisioned to impact. This duplication of initiatives precludes scientific attribution of impact to the GFF mechanisms.

F. **Monumental corruption by some CSOs:** Insights gathered from interviews carried out with officials from the Federal Ministry of Health indicate that some CSOs are monumentally corrupt and use advocacy to advance their interests and seek employment. This puts to disarray their genuineness in participating in the GFF mechanism in Nigeria.

G. **Technical capacity** is lacking among the CSOs to do end-to-end advocacy engagement.

### 7.5.7. Opportunities for future work

The following opportunities merit consideration in future work on the GFF mechanism in Nigeria:

A. **Capacity strengthening**: Strengthening CSOs' capacities around alternative financing and equipping them with key skills in grant writing, alternative revenue generation, M&E and governance will bolster their engagement capability in the GFF. Independent financial strengthening and a mentorship scheme should also be instituted for CSOs in engaging in the BHCPF gateways (National Health Insurance and PHC) at the ward development committees.

B. **Multi-sectoral approach for GFF**: In the onset of the GFF process in Nigeria, some key sectors, for example, agriculture, were left out. This is against the GFF guidelines on taking on a multi-sectoral approach. Therefore, engaging other key sectors and ministries that have a synergistic connection with RMNCAH-N and nutrition should be prioritized going forward.

C. **Funds defragmentation**: There should be an initiation of defragmentation of the major funds focused on maternal health, polio, TB, malaria, vaccine etc. into a single integrated fund. This should take into consideration the non-communicable disease pandemic warnings from the international community and research.

D. **Providing access to information**: Efforts should be geared towards identifying capacity gaps of CSOs and positioning them to engage locally and globally with evidence by providing access to information.

E. **Peer-to-peer learning**: GFF should borrow lessons from the GAVI's accountability framework that enables GAVI to follow up on the whole process. For example, GAVI funding for vaccines to countries reduces with time as the government increasingly commits more funding to the vaccines.

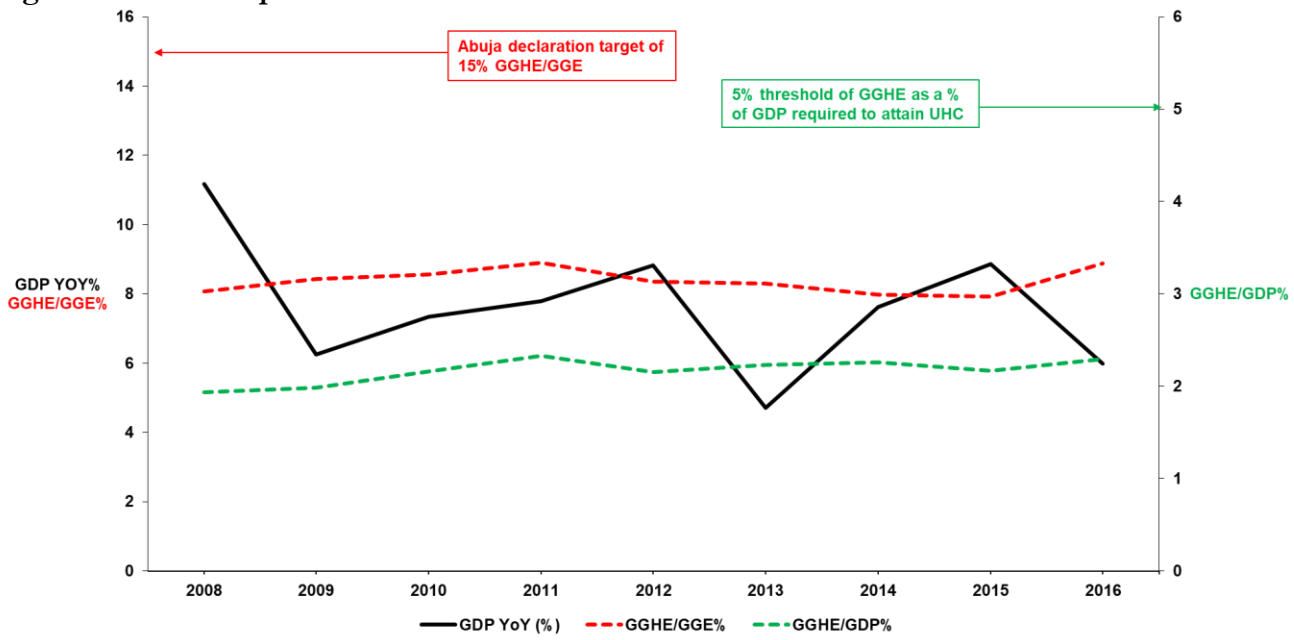
F. **Tackling CSOs underfunding**: donors and partners ought to prioritize supporting CSOs through seed grants using the Action Health Nigeria model.

## 7.6. Rwanda

### 7.6.1. Fiscal space for health

Rwanda is a landlocked country with rich fertile soils and the population has grown from 9.5 million in 2008 to 12.3 million[76] in 2018 and is projected to be 13.5 million by 2023. The current GDP is US$9.5 billion and the GDP (YoY) growth rate reduced from 11.2% in 2008 to 4.7% in 2013, the lowest in the 10-year period. It rebounded in 2015 to 8.9% and stagnated in 2016 at 6% rebounding in 2018 at 8.7% and is projected to average 7.9% between 2019 and 2023.[77] This is attributed to growth in exports due to the "Made in Rwanda policy," continued public investments e.g. Bugesera airport and the strong record of reform implementation in the achievement of long-term goals.[78] The GGHE/GGE has averaged around 8.3% between 2008 and 2016[79] though increased slightly between 2015 and 2016 from 7.9% to 8.8%. GGHE/GDP has increased slightly between 2008 and 2016 from 1.9% in 2008 to 2.3% in 2016 while CHE/GDP has dropped significantly in the same period from 9.0% in 2008 to 6.5% in 2015 and changed to an upward trend between 2015 and 2016 from 6.5% to 6.7%. This has fallen below the Rwanda Health Sector Strategic Plan 3 health financing ratios and the Abuja declaration[80] (Figure A11). The execution rate of the health budget increased between 2015/16 at 86% for the national level and 99.6% at the district level attributed to the stronger planning at the districts due to the decentralization policies.[81]

**Figure A11: Fiscal Space for Health in Rwanda**




Note: GDP YoY% means GDP growth year-on-year; GGHE/GGE% means General Government Health Expenditure as a percentage of General Government Expenditure, GGHE/GDP% means General Government Health Expenditure as a percentage of GDP

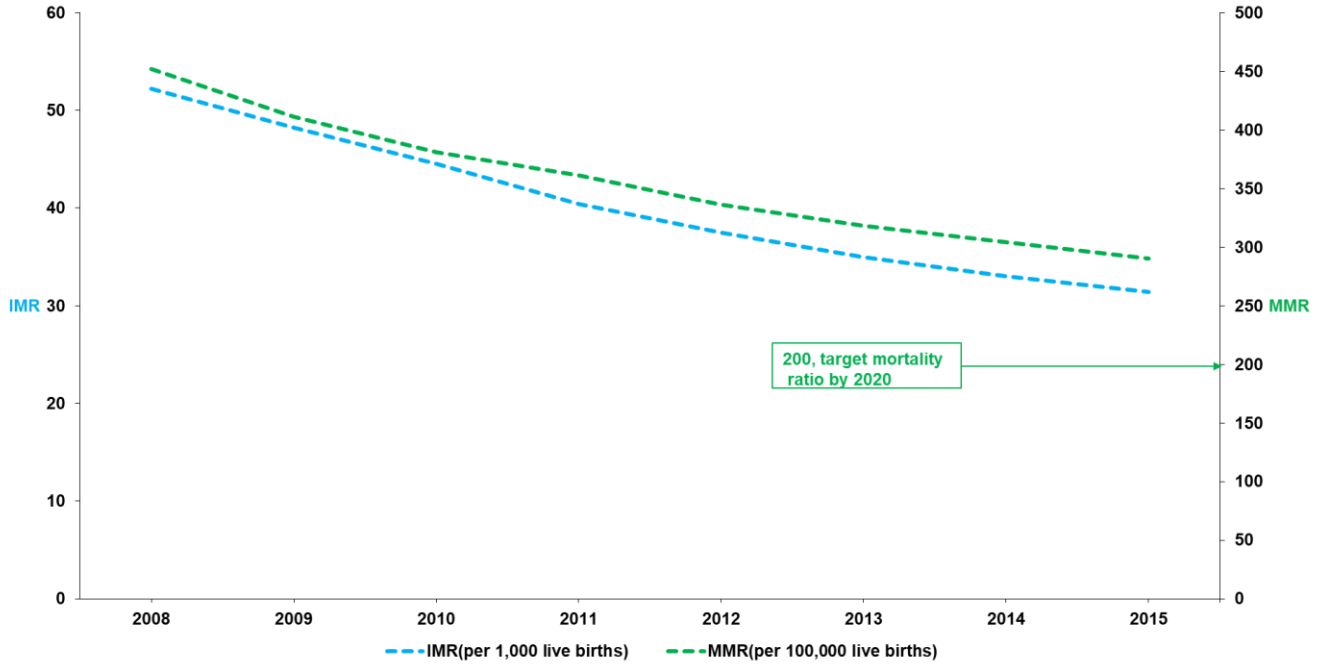
Analysis: E&K Consulting Firm

[76] https://data.worldbank.org/country/rwanda
[77] World Economic Outlook (April,2019)
[78] https://www.afdb.org/en/countries/east-africa/rwanda/rwanda-economic-outlook
[79] https://data.worldbank.org/indicator/SH.XPD.GHED.GE.ZS?locations=RW
[80] http://www.moh.gov.rw/fileadmin/templates/Docs/HSSP_III_FINAL_VERSION.pdf
[81] https://www.unicef.org/esaro/UNICEF_Rwanda_--_2017_--_Health_Budget_Brief.pdf

### 7.6.2. RMNCAH-N Outcomes

Infant mortality has decreased almost twofold between 2008 and 2017 from 52.2 deaths per 1,000 live births in 2008 to 28.9 in 2017. The maternal mortality ratio has also been on a downward trend between 2008 and 2015 reducing from 452 per 100,000 live births in 2008 to 290 in 2014/15. Rwanda Vision 2020 RMNCAH-N targets on infant mortality have been achieved as it targeted to reduce it from 107 to 50 which is currently at 28.9. The maternal mortality ratio is in line to being achieved as it aimed at reducing it from 1070 to 200 by 2020 which is in line with the "Rwanda Economic Development and Poverty Reduction Strategy Second Generation 2013-2018" aimed at reducing maternal mortality to 220 by 2018 (Figure A12).

**Figure A12: RMNCAH-N Indicators for Rwanda**




Note: IMR means infant mortality rate per 1,000 live births, MMR means the maternal mortality ratio per 100,000 live births
Analysis: E&K Consulting Firm

### 7.6.3. The GFF mechanism so far

GFF is supporting the development of the new National Early Childhood Development Program Strategic Plan (NECDP SP) 2019-2024 that will serve as the IC. NECDP SP is under development but is expected to be finalized by August 2019. NECDP SP is inclusive and multisectoral as it brings on board government, development partners, faith-based organizations (FBOs), CSOs, academia and the private sector. GFF TF co-finances two World Bank-financed projects: (1) Stunting Prevention and Reduction Project (SPRP) (total project amount of US$55 million, including GFF TF US$10 million), which supports community-based approaches to improve the delivery of high-impact nutrition and health interventions, incentivize frontline community health workers (CHWs) and health personnel, strengthen accountability mechanisms, and promote a learning-by-doing approach; and (2) Strengthening Social Protection Project (SSPP) (total project amount of US$103 million, including US$8 million from GFF) which scales up the main components of the flagship Social Protection Program called Vision 2020 Umurenge Program (VUP). It includes innovations such as a gender and child-sensitive public works schemes, a co-responsibility cash transfer support

targeting poorest households with pregnant women and/or children under two years of age and strengthening of civil registration and vital statistics (CRVS) and service delivery systems.

### 7.6.4. Trends in transparency

The level of transparency in Rwanda is very clear: There was a launch workshop that was led by government and GFF co-financing is clear and straightforward with all the information available online. Also, the WB releases information bi-annually and the country platform has CSO representation. CSOs are part of the process because of a strong government and the CSOs are participating fully and even the head of the CSO attended the Norway GFF replenishment meeting.

### 7.6.5. Opportunities for future work

The following opportunities merit consideration in future work on the GFF mechanism in Rwanda:

A. **Peer-to-peer learning:** This course should be developed and financed so that countries and CSOs can learn from one another, for example on obstacles and copying mechanisms.

B. **Strengthening of the "Imihigo" contracts:** The "imihigo" contracts between the president and the district mayors are a sign of strong government leadership and the GFF has advocated for inclusion of 35% of the indicators in the contract to be health related. There need to be efforts to strengthen the contracts and probably continued engagement to increase the percentage.

C. **Shifting to performance-based financing**: Rwanda's nutrition project should be factored in the PBF and shift from inputs-based financing.

D. **Fiscal space sustainability**: There is need to have an improvement in the fiscal sustainability space for healthcare by harmonizing the work of Ministry of Finance and Health to leverage on domestic financing rather than development partners.

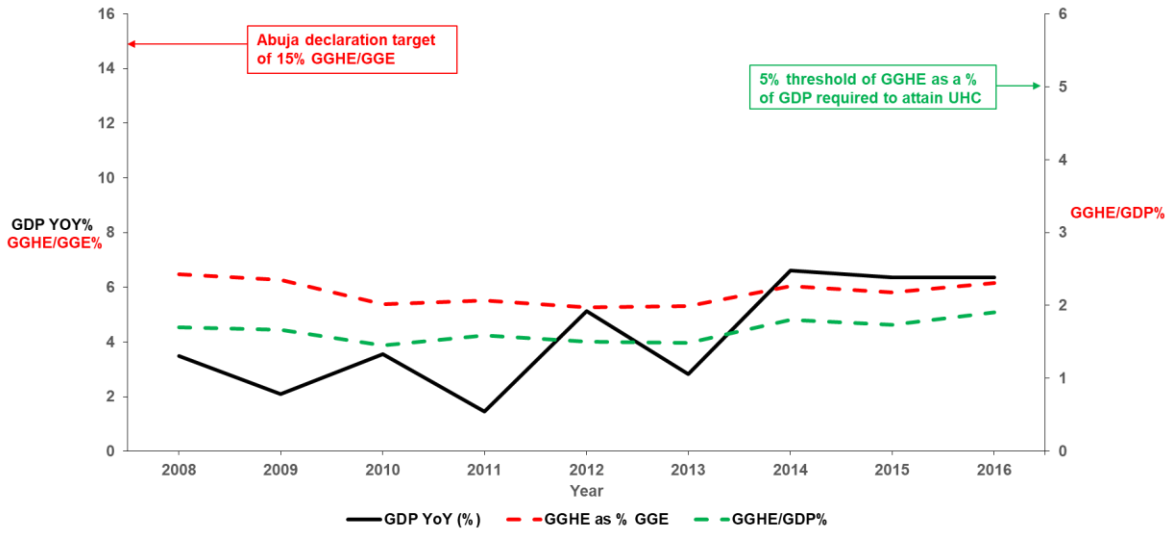
> CSOS at the country level are very useful; they are the go between people and donors. They need to be supported to have capacity to participate in the country platform.
>
> –GFF Focal Point for two countries in Africa

## 7.7. Senegal

### 7.7.1. Fiscal space for health in Senegal

Senegal, located in Western Africa, is bordered by Mauritania to the north, Mali to the east, Guinea and Guinea-Bissau to the south, and the Atlantic Ocean to the west. Senegal is divided into 14 regions, each administered by a regional council, with Dakar as its capital.[82] Senegal had a population of 15.8 million in 2018 and is projected to grow to 18.76 million by 2023. Senegal's GDP grew from $16.94 billion to $24 billion in 2018, and the GDP YoY growth rate stagnated between 2008 (at 3.5%) to 1.5% in 2011 before rebounding to 6.8% in 2018 from 1.5% in 2011. The GDP YoY is projected to average 8.7% in the next four years. Senegal's GGHE/GGE has been intermittent from 6.8% in 2008 to 6.1% in 2016 falling below the agreed upon Abuja declaration[83] that obliges the government to allocate at least 15% of its budgets to health (Figure A13). The same trend is seen in the GGHE/GDP that has averaged around 1.6% between 2008 and 2016 also falling below the recommended level of 5% GGHE/GDP for low income countries.[84] This confirms the limited fiscal space for health in Senegal.

**Figure A13: Fiscal space for health in Senegal**




Note: GDP YoY% means GDP growth year-on-year; GGHE/GGE% means General Government Health Expenditure as a percentage of General Government Expenditure, GGHE/GDP% means General Government Health Expenditure as a percentage of GDP

Analysis: E&K Consulting Firm

[82] http://taxsummaries.pwc.com/ID/SenegalOverview#targetText=Senegal%2C%20located%20in%20Western%20Africa,with%20Dakar%20as%20its%20capital.

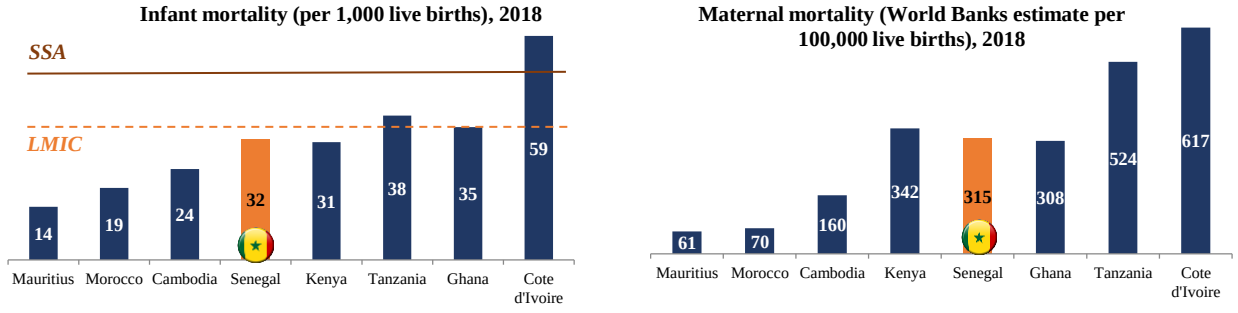
[83] https://www.who.int/healthsystems/publications/abuja_declaration/en/

[84] https://www.chathamhouse.org/sites/default/files/home/chatham/public_html/sites/default/files/20140300DomesticFundingHealthMcIntyreMeheus.pdf

### 7.7.2. RMNCAH-N outcomes for Senegal

Senegal has made substantial progress in reduction of infant mortality from 2008 to 2018 (Figure A14). It decreased from 46.5 deaths per 1,000 live births in 2008 to 32 in 2018,[85] performing better than sub-Africa and LMICs, and this is attributed to better access to malaria treatment and prevention and enhanced vaccine coverage.[86] The maternal mortality ratio has improved slightly between 2008 and 2017, reducing from 492 deaths per 10,0000 live births in 2008 to 315 deaths in 2017. The high-performing national family planning program, though, faces malnutrition as the major risk factor with over a fifth of maternal deaths associated with undernutrition particularly anemia.

**Figure A15: Infant and maternal mortality rates for Senegal and comparator countries**




Source: World Bank
Analysis: E&K Consulting Firm

### 7.7.3. The GFF mechanism so far

The GFF multi-stakeholder country platform has representation from government, partners, civil society organizations, private sector, youth, women and religious organizations. The investment case was developed through a participatory process led by the GFF multi-stakeholder country platform. The investment case focuses on five prioritized regions. The World Health Organization (WHO) funded a mapping exercise to determine the different needs and the interventions that were already in place. This was useful as it enabled an evidence-based approach to be used in development of the investment case.

The investment case has received commitments from IDA (US$140 million) and GFF (US$10 million). In this light, Senegal has one of the highest amounts additional of IDA funding that has been unlocked by GFF grant which stands at US$14 of IDA funding for US$1 of GFF grant. This was possible because the minister of finance in Senegal was proactive in the negotiation of GFF-related financed. The minister enhanced the scope of the RMNCAH-N investment case to cover interventions (such as WASH and electrification of health facilities) that may not be directly related to RMNCAH-N but facilitate the provision of RMNCAH-N services. Approval was given for the IDA facility and disbursement was due to commence in early 2020. However, there exists a financing gap with the available financing not completely covering

[85] https://data.worldbank.org/indicator/SP.DYN.IMRT.IN?end=2017&locations=SN&start=2008
[86] http://documents.worldbank.org/curated/en/863591527771122001/Concept-Project-Information-Document-Integrated-Safeguards-Data-Sheet-Investing-in-Maternal-and-Child-Health-P162042.docx

implementation of the first scenario. More financial resource mobilization is required to be able to cover scenario one completely and also cover scenario two and three.

The GFF implementation phase is scheduled to be launched in February 2020.

### 7.7.4. Trends in advocacy

The CSOs have an operational coalition with a proper governance structure and five working groups namely:

i) Supply Chain Management of RMNCAH-N commodities;
ii) Demand Creation for RMNCAH-N services and Access to these services;
iii) Social Accountability to ensure proper implementation of the investment case;
iv) Advocacy on any pertinent issues that may arise during implementation of the investment case;
v) Resource Mobilization so that the coalition has funding for its operations.

The working groups were created after a national CSO mapping exercise that was commissioned by the CSOs for proper GFF engagement. Each working group is expected to actively engage in the GFF process in such a way that ensures realization of the investment case priorities in their respective domain. The coalition intends to set up a secretariat whose mandate will be coordination of CSO activities within the GFF mechanism. The coalition has already developed an action plan which it hopes to implement upon the availability of funds.

> The CSOs are well organized and have a robust action plan already in place.
> –GFF Liaison Officer

> As CSOs in Senegal we have organized ourselves into a coalition with elected officials and five working groups.
> –CSO Coalition Member

### 7.7.5. Trends in transparency

So far, the government has demonstrated a strong willingness to engage all the relevant stakeholders in the GFF process. This might be an indication of high levels of transparency on the government's part.

> As CSOs we have been involved in the GFF process from the beginning including in the development of the investment case.
> –CSO Coalition Chairperson

> The government has invited different stakeholders to be part of the GFF process.
> –GFF Liaison Officer

However, the GFF process is still in its early stages in Senegal and so more time is needed to ascertain transparency levels especially on utilization of funds. Some of the interviewees suggested that another review of the GFF process be carried out after two years.

### 7.7.6. Key Challenges

Some of the challenges include:

A. **Country Platform Coordination:** It has been difficult to convene the four planned meetings a year due to the busy schedules of the platform members. This was then reduced to two meetings per year but that has also been difficult. However, part of the reason for the lethargy may be because the financing from the World Bank had not yet been approved and the implementation had not started. The delay in approval was caused in part by the presidential elections, personnel changes at the World Bank and extended negotiations after expansion of the investment case. Now that approval has been given the projected is scheduled to be launched in February 2020, which might lead to improved engagement of the platform members.

B. **Financing of the Investment Case:** The investment case has three scenarios depending on availability of financing with priority being given to implementing scenario one first and if enough financial resources are mobilized implementing all the three scenarios. However, the currently available financing only covers scenario one and does not actually completely cover it. Financing is expected from other partners like JICA so the expectation is that scenario one will be fully covered. This will mean looking for additional funding for scenario two and three.

C. **Lack of CSO Understanding of World Bank Requirements:** The CSOs expected to receive financing directly as the coalition and were therefore disappointed that they have to go through competitive bidding. However, this forms part of the WB requirements for accountability and to ensure that the most qualified service provider is contracted.

D. **Domestic Resource Mobilization:** The proposed innovative financing mechanisms that the government has proposed to increase DRM are generally not under direct control of the government and therefore may not yield the intended finances. For example, tax on incoming international calls has been proposed but nowadays most international calls are done over the internet using applications like Skype or WhatsApp and so very little tax will be collected through this. Other proposals revolve around introducing or increasing sin taxes and levies on airfares. Importantly, the proposed revenue generating avenues (such as introduction of sin taxes and levies on airfares) proposed by the governments do not seem to be supported by rigorous analysis of their long-term sustainability. For instance, there is a risk that the new taxes and levies will have a negative effect on the overall growth of the airline industry and other industries affected by the sin taxes and thus result in a net reduction, rather than increase, in tax revenues generated by the government. This research did not find any evidence that this risk has been taken into account by the government.

### 7.7.7. Key opportunities for future work

The following opportunities should be considered in future work on the GFF mechanism in Senegal:

A. **CSO Capacity Building:** The CSOs require training to allow them to better carry out their role within the GFF framework. This may include building the competencies within CSOs to conduct analytical

work and develop evidence-based cases to justify and motivate the commitment of more domestic resources towards RMNCAH-N interventions. This would be done practically through the already existing working groups within the coalition. Part of the capacity building can be done through peer-to-peer learning where within the working groups the CSOs could learn from each other.

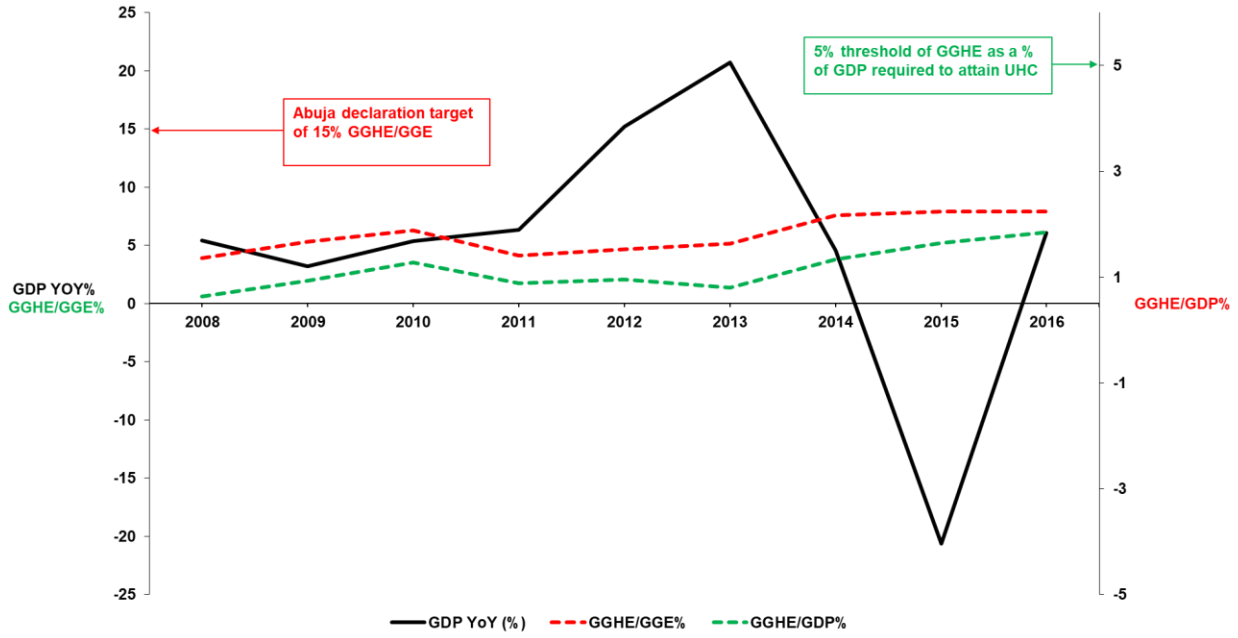
**B. Resource Mobilization:** The existing financing gap requires further mobilization of financial resources so as to be able to cover all the three scenarios that are stipulated in the investment case. There is merit in stakeholders exploring and designing financing mechanisms that can unlock more domestic resources to complement the resources already unlocked by the GFF mechanism.

## 7.8. Sierra Leone

### 7.8.1. Fiscal space for health

Sierra Leone is located on the West Coast of Africa, and borders Guinea and Liberia with a total population of 7.6 million in 2018 that grew from 6.1 million in 2008. With a GDP of US$4 billion, the economy grew at an average rate of 8% between 2008 and 2014. It then slumped by -20.5% in 2015 precipitated by the Ebola outbreak and the fall in iron prices which is the main export.[87] The GDP growth rate rebounded in 2016 to 6.1% and decreased in 2017 to 4.2% and decreased further in 2018 at 3.7%. The recovery efforts were subdued in 2017 by a massive landslide that hit Freetown disrupting economic activities. The GDP is projected to grow by 5.2% annually between 2019 and 2023. GGHE/GGE increased between 2008 and 2010 from 3.9% to 6.3% and then dropped to 4.3% in 2011. The rate has been on an uptrend since 2012 to 2015 and leveled between 2015 and 2016[88] at 7.9%. Sierra Leone's GGHE/GDP has remained low increasing from 0.6% in 2008 to 1.3% in 2010. It then decreased to 0.8% between 2010 and 2013 then had an uptrend of up to 1.8% in 2016 (Figure A15). The CHE/GDP has been moderately higher compared to other countries under study, rising from 9.8% in 2008 and averaging around 11% between 2008 and 2013 then significantly rose in 2014 and 2015 at 19.7% and 20% respectively. The increment is attributed to the Ebola outbreak where the funds were mostly used in the payrolls of the health workforce.[89]

**Figure A15: Fiscal Space for Health in Sierra Leone**



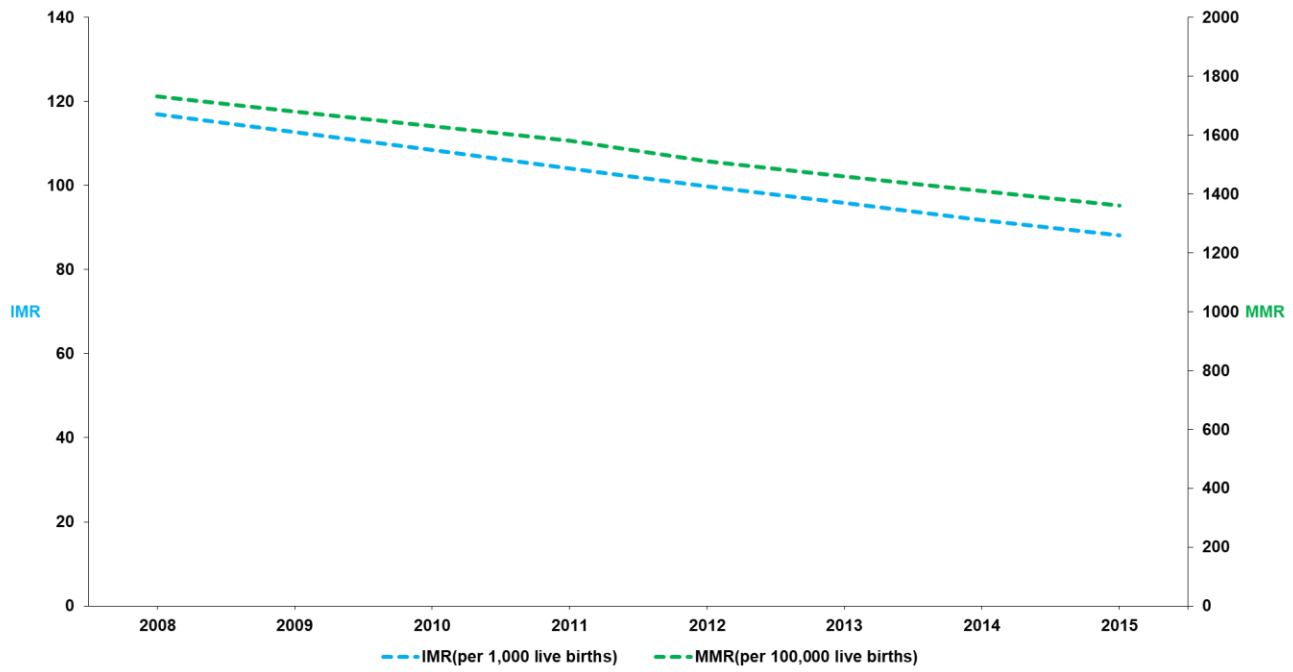

Note: GDP YoY% means GDP growth year-on-year; GGHE/GGE% means General Government Health Expenditure as a percentage of General Government Expenditure, GGHE/GDP% means General Government Health Expenditure as a percentage of GDP
Analysis: E&K Consulting Firm

[87] https://www.worldbank.org/en/country/sierraleone/overview
[88] https://data.worldbank.org/indicator/SH.XPD.GHED.GE.ZS?end=2016&locations=SL&start=2008
[89] https://www.giz.de/de/downloads/Factsheet%20Health%20Financing%20Final%20May%202018.pdf

### 7.8.2. RMNCAH-N outcomes

Sierra Leone has made strides in improving RMNCAH-N indicators: infant and maternal mortality. Mortality level and pattern informs the health status of a country`s population.[90] Sierra Leone was massively affected by Ebola virus epidemic that spread from Guinea to Sierra Leone between February and May 2014 that saw 8,000 people infected and 3,000 succumb. Apart from killing people, it had a toll on the health sector as doctors and nurses died and all the focus was on Ebola at the neglect of other health problems that even caused more death. The IMR declined steadily between 2008 and 2017 from 116.9 deaths per 1,000 live births to 81.7 in 2017 making Sierra Leone the second country after the Central African Republic with the highest infant mortality rate in the world. As of 2017, it was almost triple the world average IMR that is at 29.4. Sierra Leone has the highest MMR in the world at 1360 in 2015 though declined from 1730 in 2008 (Figure A16). The Sierra Leone`s Ministry of Health is constrained, as per the ministry's Health Sector Recovery Plan (2015– 2020), because of poor health infrastructure. This includes lack of key drugs and medical equipment, health financing inadequacy as most are done out of pocket, low water provision and shortage of health care personnel.

**Figure A16: RMNCAH-N Indicators for Sierra Leone**




Note: IMR means infant mortality rate per 1,000 live births, MMR means the maternal mortality ratio per 100,000 live births
Analysis: E&K Consulting Firm

### 7.8.3. The GFF mechanism so far

The Ministry of Health and Directorate of RMNCAH-N are not happy with the GFF process so far as there are no financial commitments yet from WB and the GFF and the WB process has been very slow. The investment case is not ready, but it has been agreed that the RMNCAH-N strategy, which is a 5-year

[90] https://sierraleone.unfpa.org/sites/default/files/pub-pdf/Mortality%20report.pdf

strategy, be used as the IC. The country platform is not functional in terms of pressing for GFF work. There is currently no funding and training from WB and GFF. There is no inclusive country platform yet but the MoH Health Sector Steering Committee co-chaired by the Chief Medical officer and director of health representatives' functions as the country platform in the interim. Currently, there are no GFF matters discussed in this platform as the GFF talks have been postponed and are expected to resume in 2020.

### 7.8.4. Trends in advocacy

The CSOs have expertise in M&E, advocacy, media engagement and project implementation. Some CSOs are engaged in budget advocacy for nutrition, advocacy centered on community engagement by training CSOs to monitor health service delivery and promote RMNCAH-N interventions. Health Alert and Health CSO are considered role models for CSOs working in other sectors due to a well-organized RMNCAH-N coalition. They have designed joint proposals for funding, for example, the nutrition grant received this year. CSOs in governance and political space are not well coordinated and current collaboration with the private sector is poor since the private sector is mostly concerned about service delivery.

### 7.8.5. Trends in transparency

The level of transparency on the government side in Sierra Leone has deteriorated over time as the government is secretive on information centered on health allocation to the total national budget. The government has currently allocated 5.5% of tax funds to health up from 5% and it has not released information to the CSOs about the 0.5% increase in allocation.

> In Sierra Leone, transparency has not changed as the process was postponed to 2020 since they could not agree on IDA project and negotiations are still ongoing.
>
> –Healthy Advocacy Specialist for an EU Based CSO with presence in Sierra Leone

> Sierra Leone has extreme lack of transparency on the GFF and therefore needs specific support on advocacy.
>
> –Health CSO Advocacy Specialist in Sierra Leone

### 7.8.6. Challenges

While the GFF has yielded some success, the mechanism has been faced with several challenges. The key challenges in Sierra Leone are elaborated below:

A. **Funding of CSOs**: The overall sustainability of CSOs in Sierra Leone is poor and the funding of the CSO coalition is a problem and this has made some individual CSOs apply for funding directly even with their poorly written proposals.

B. **Funds tracking**: CSOs find it hard tracking funds in Sierra Leone, for example, the Norway replenishment meeting where donors pledged to contribute to GFF Trust Fund, but the follow up on actual release of funds to GFF is poor and uncoordinated.

C. **Transparency and accountability**: The 0.5% increase in allocation of national budget to health is poorly accounted for by the government and CSOs ought to be better equipped to advocate on transparency and accountability by the government.

D. **Off budget financing**: CSOs are tracking the program-based budget but cannot attribute directly the GFF funding, traditional donors (off-budget support) and government tax to the improvements in RMNCAH-N outcomes.

E. **GFF is "Unknown" in Sierra Leone**: GFF work in Sierra Leone is not well known unlike the GAVI or Global Fund whose work is well understood by key stakeholders.

> I have no idea how GFF operates.
>
> –Medical Officer working in Sierra Leone

F. **Conflict of interest**: Private interests exist within the CSO coalition and this hampers objective collaboration and advocacy.

G. **Resource mapping**: Mapping of key stakeholders at the country platform is poor despite having a strong stakeholder mapping at the global level.

### 7.8.7. Opportunities for future work

The following opportunities merit consideration in future work on the GFF mechanism in Sierra Leone:

A. **Training CSOs**: There needs to be training on GFF when the countries are on-boarded into GFF or explanations by WBG and government on how GFF functions in Sierra Leone.

B. **Advocating for an inclusive country platform**: This is envisaged in the GFF Country Platform guidelines. It should encompass MoH, CSOs, private sector etc.

C. **Build M&E capacity for CSOs:** For example, through developing strong scorecards that can track GFF indicators and the utilization of the 5.5% government allocation to health.

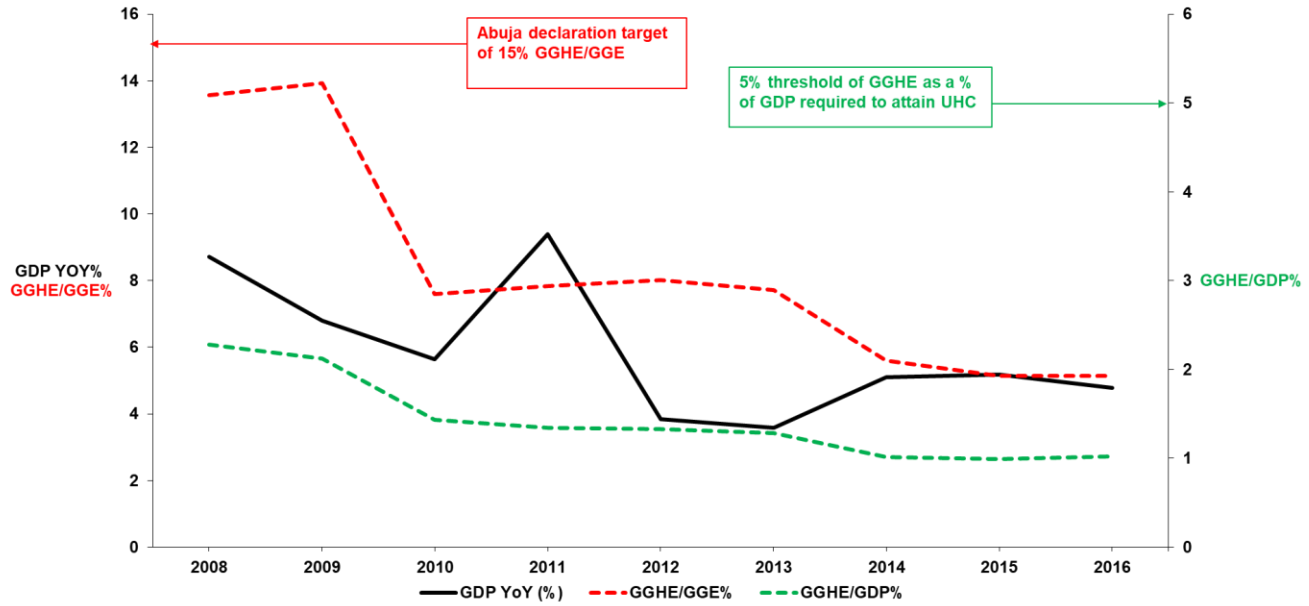
D. **Peer-to-peer learning:** This should be focused on studying and picking key lessons from other funding mechanisms like GAV and the Global Fund or other countries like Rwanda, Ethiopia and Senegal where the GFF process has a strong government-led element.

## 7.9. Uganda

### 7.9.1. Fiscal space for health

Uganda started preparations dubbed "Sharpened RMNCAH-N Plan" in 2013, which saw it join the GFF as a second wave GFF Country[91] and commenced work on the GFF process in 2015. Uganda`s population has grown steadily between 2008 and 2018 i.e. 30.4 million to 42.7 million in the respective years. The country's GDP growth rate fell almost twofold from 8.7% to 3.6% between 2008 and 2013 and rebounded in 2014 to 5.1%. The slow growth rate is attributed to productivity losses in the agriculture sector,[92] adverse weather, unrest in South Sudan, private sector credit constraints, and the poor execution of public projects.[93] GDP growth has since increased remarkably from 3.9% in 2017 to 6.1% in 2018 and is projected to remain steady at approximately 6.2% between 2019 and 2023.[94] Currently, the GDP stands at US$27.5 billion. GGHE/GGE has fallen dramatically from 13.6% in 2008 to 5.61% in 2017 while GGHE/GDP also plummeted in the same period from 2.3% to 1%. CHE/GDP also reduced in the period of 2008 to 2013 from 10.4% to 6.2%. Overall, Uganda's health financing indicators have deteriorated over the past years and key targets such as those spelt out in the Abuja declaration as well as those recommended by the World Bank have not been met (Figure A17).

**Figure A17: Fiscal Space for Health in Uganda**



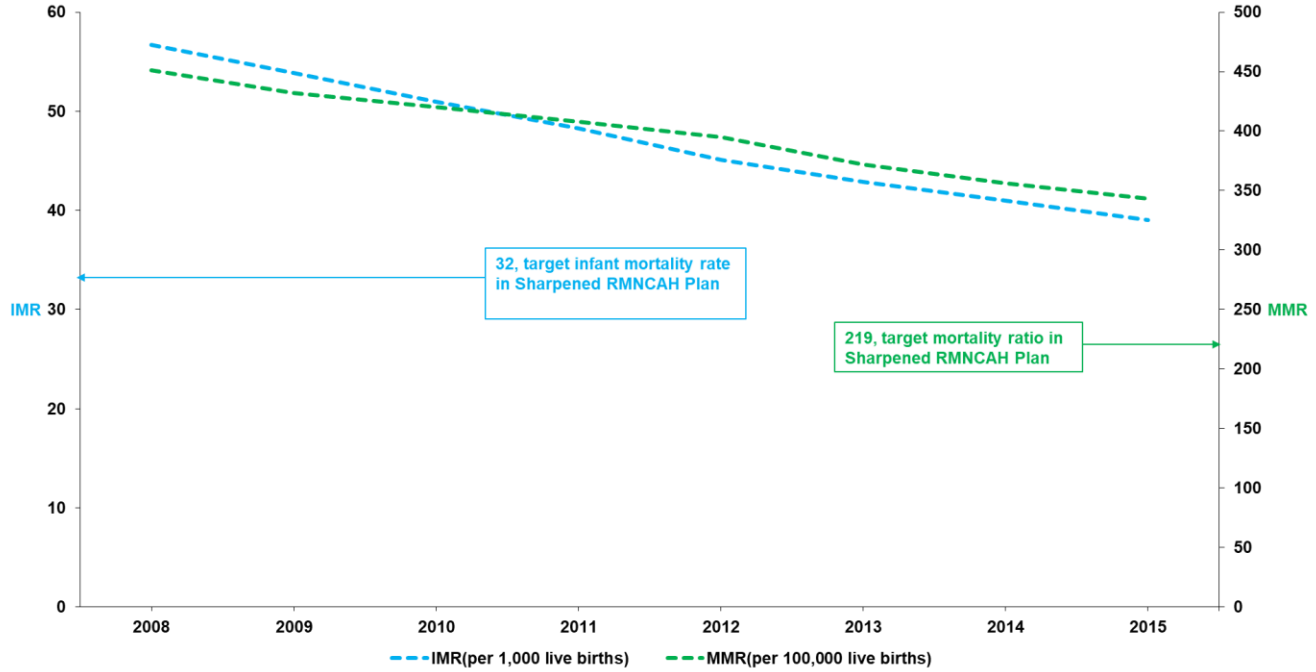

Note: GDP YoY% means GDP growth year-on-year; GGHE/GGE% means General Government Health Expenditure as a percentage of General Government Expenditure, GGHE/GDP% means General Government Health Expenditure as a percentage of GDP
Analysis: E&K Consulting Firm

[91] https://www.globalfinancingfacility.org/uganda
[92] https://www.pwc.com/ug/en/assets/pdf/ug-economic-outlook-2018.pdf
[93] https://www.worldbank.org/en/country/uganda
[94] Thomson Reuters Eikon (2019), Uganda's country overview

### 7.9.2. RMNCAH-N outcomes

Uganda has experienced improvements in RMNCAH-N outcomes notably infant mortality rate and maternal mortality ratio.[95] Infant mortality rate has decreased from 56.8 deaths per 1,000 live births in 2008 to 35.4 in 2017 while maternal mortality ratio decreased from 451 deaths per 100,000 live births in 2008 to 343 in 2015 (Pre-GFF Period). Since joining the GFF, maternal mortality has declined further and was estimated at 336 deaths per 100,000 live births in 2017. Uganda seems to be on course to achieving the infant mortality rate target of 32 deaths per 1,000 live births set out in the Sharpened RMNCAH-N Plan. The country seems to be further away from attaining the maternal mortality target of 219 deaths per 100,000 births set out in the same plan[96] (Figure A18).

**Figure A18: RMNCAH-N Indicators for Uganda**




Note: IMR means infant mortality rate per 1,000 live births, MMR means the maternal mortality ratio per 100,000 live births
Analysis: E&K Consulting Firm

### 7.9.3. The GFF mechanism so far

The investment case that is the "Sharpened RMNCAH-N plan" has been prepared and is currently being implemented. Results monitoring strategy is also being implemented through quarterly and annual reports. Further, resource tracking for the RMNCAH-N interventions and a scorecard for key indicators has been developed by GFF. Since January 2019, there has been an inclusive country platform unlike what was there before (the maternal health working group under MoH) which did not include the ministries of education, finance and the CSO. Currently there is a dedicated GFF focal point and liaison officer and CSO representative. The IDA and GFF disbursements have been initiated and so far, 22% of US$110 million has been released with GFF co-financing of US$30 million and US$35 million from SIDA. The private sector

[95] https://www.globalfinancingfacility.org/uganda
[96] https://www.globalfinancingfacility.org/sites/gff_new/files/documents/Uganda-Investment-Case.pdf

intervention strategy is being implemented, although according to primary research the private sector is struggling to form a coordination platform like the one the CSOs have (RMNCAH-N civil society coalition). Expansions of CRVS, computerization and development of integrated systems and supply chain management interventions have been funded.

### 7.9.4. Trends in advocacy

The service delivery by the CSOs has been excellent in the rural areas where there is no access to government services; creating awareness for HIV/AIDs at the community levels. They also tend to work together in the communities and are reaching households that are not reached by the government. Sometimes they compete but in most cases they collaborate. The CSOs have done poorly in monitoring and holding government accountable. Insights gathered from interviews with some of the CSOs indicate that CSOs in general are not very well coordinated.

### 7.9.5. Trends in transparency

In Uganda, the country platform was established after the drafting of the investment case had been finalized which suggests that the investment case development process was not inclusive of CSOs and this was not transparent to the CSOs. Complaints have been raised by CSOs in relation to the lack of clarity on what the GFF funds in Uganda even though this is clearly stipulated in the PAD[97] document—an observation that suggests that there is limited awareness among CSOs about the GFF. Insights gathered from the interviews conducted with CSOs suggest that CSOs seem to lack mechanisms to enhance inclusivity among themselves. Typically, CSOs meet in hotels where they draft proposals for funding and there are usually no mechanisms for communicating feedback to CSOs or communities in remote villages since most of the communication is done via email.

### 7.9.6. Key challenges

While the GFF has yielded some success, the mechanism has been faced with several challenges. The key challenges in Uganda are elaborated below.

A. **Lack of innovation:** The GFF mechanism in Uganda is regarded as lacking in innovation on the grounds that the high impact interventions being funded by the GFF were already in existence before the country joined the GFF. This has raised concerns about GFF's innovativeness among CSOs and bilateral donors.

B. **Opacity in the GFF process:** There is opacity around key GFF decisions such as how much money is allocated to a participating country such as Uganda. While the allocation is based, in part, on macro-level factors such as GDP, it does not seem to take in to account in-country factors such as health financing gaps of RMNCAH-N programs.

C. **Inefficiency**: Government systems are largely inefficient. For instance, any communication from the GFF liaison officer must go through the permanent secretary before it can be forwarded to the responsible technical officers in the ministry of health. This communication channel is often bureaucratic and time-consuming, resulting in very little time being available for the actual

[97] Project Appraisal Document (1795) for the Uganda reproductive, maternal and child health services improvement project http://documents.worldbank.org/curated/en/854971471534008736/pdf/PAD-07182016.pdf

implementation of interventions. Bureaucracies within government have also seen GFF-related activities being postponed for long periods. For example, in 2018 and 2019 the general assembly was delayed for up to five months because of the absence of the first lady.

D. **Misunderstanding of the GFF structure:** CSOs misunderstand the GFF to be a pool of funds that is available to fund CSOs yet the GFF is in principle not a funding resource for CSOs.

E. **Financing of CSOs:** In-country CSOs are generally poorly funded and spend a lot of time in unsuccessful grant applications. The limited funding precludes the CSOs from optimally playing their role in relation to the GFF.

F. **Monitoring of off-budget financing:** There is little, if any, monitoring of off-budget financing in Uganda. This represents a missed opportunity in the sense that some of the off-budget financing is not aligned with country priorities as outlined in the IC.

G. **Coordination:** Insights gathered from interviews carried out with CSOs indicate that they are not well coordinated and carry out their out roles superficially without engaging systematically and continuously.

### 7.9.7. Key opportunities for future work

The following opportunities merit consideration in future work on the GFF mechanism in Uganda:

A. **Enhancement of stakeholder engagement:** This would help to increase the participation of religious organizations and academia in the GFF mechanism.

B. **Development of the governance structures:** Developing and strengthening the CSO coalition should be done in order to enable CSOs to better self-govern themselves and resolve inter-CSO conflicts effectively.

C. **Development of the capacity of CSOs to be financially sustainable and engage in revenue generation activities:** This development would help avoid overreliance on donor funding e.g. by offering services to government and being paid in return.

D. **Collaboration at the district level**: There ought to be integrated planning for the CSOs at the district level where they agree on the services and divide the responsibilities among themselves.

E. **Development of a tracking mechanism:** This mechanism would allow for tracking of off-budget financing for RMNCAH-N in Uganda.