HAS 181: The Global Financing Facility
Progress, Additionality, Effectiveness

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TABLE OF CONTENTS

Acknowledgements i
Table of Contents ii
Abbreviations iii
1. Introduction 6
2. Main Findings 7
2.1 Mission, objectives and key principles 7
2.2 Working with and through the World Bank 8
2.3 Governance arrangements 11
2.4 The GFF Model 12
2.5 Partnerships and effective development cooperation 16
2.6 Private sector engagement 18
2.7 Civil Society engagement 18
2.8 Monitoring and evaluation, lesson learning and knowledge (MELK) 19
3. Conclusions 22
3.1 Progress 22
3.2 Additionality 23
3.3 Effectiveness 24
3.4 Risks and forward look 25
4. Recommendations 27
5. Annexes I
Annex 1 - A short description of the GFF I
Annex 2 - Methodology for the GFF Study VI
Annex 3 - List of Key Informants IX
Annex 4 - List of Documents consulted XII
Annex 5 - GFF Statement in response to EC Assessment XIV

Table of Boxes

Box A Leveraging IDA credits and IBRD loans 5
Box B: Evolving GFF practice based on lessons learned in its first two years 8

ABBREVIATIONS

BMGF	Bill and Melinda Gates Foundation
CRVS	Civil registry and vital statistics
DFID	Department for International Development
DRC	Democratic Republic of Congo
EDC	Effective Development Cooperation
EU	European Union
GAVI	Global Alliance for Vaccines Initiative
GFF	Global Financing Facility
GFF-TF	Global Financing Facility Trust Fund
GFATM	Global Fund to fight Aids, Tuberculosis and Malaria
GHIs	Global Health Initiatives
HRITF	Health Results Innovation Trust Fund
HMIS	Health Monitoring and Information System
IDA	International Development Association
IBRD	International Bank for Reconstruction and Development
JICA	Japan International Cooperation Agency
MoF	Ministry of Finance
MoH	Ministry of Health
M&E	Monitoring and Evaluation
PBF	Performance-Based Financing
PMNCH	Partnership for Maternal, Newborn and Child Health
RBF	Results-Based Financing
SWAP	Sector Wide Approach Program
SDGs	Sustainable Development Goals
UHC	Universal Health Coverage
WB	World Bank
WHO	World Health Organisation
RMNCAH	Reproduction, monitoring, newborn, child and adolescent health
+N	RMNCAH plus nutrition

EXECUTIVE SUMMARY

Introduction and background

The Global Financing Facility (GFF) aims to raise and direct financing towards short-term results and longer term systems strengthening investments to improve health outcomes for women, adolescents and children in line with the Global Strategy for Women's, Children's and Adolescents' Health 2015-2030 and the relevant targets in the Sustainable Development Goals. It also helps countries strengthen civil registry and vital statistics (CRVS) capacity. A description of the GFF is in Annex A. This report was commissioned by the European Commission (EC)[1] to provide an appraisal of GFF progress, additionality and effectiveness. The analysis is based on qualitative evidence drawn from across global and country experience primarily collected through semi-structured interviews with key informants including members of the GFF Secretariat, global health partners, and key informants in eight GFF countries at different stages of implementation (Cameroon, Democratic Republic of Congo (DRC), Ethiopia, Guinea, Liberia, Mozambique, Nigeria, and Tanzania). The methodology used for the study, including important limitations, is in Annex B, and a list of key informants is in Annex C.

Main Findings

Progress

The GFF has taken on a wide ranging, ambitious, high risk agenda centred on supporting the willingness, capacity and commitment of countries to take on increasing responsibility for a growing portfolio of quality investments to support women's, children's and adolescents' health. In this, the GFF has made some discernible progress at both global and country levels although it is early days and it is unlikely that any of the gains are yet irreversible. Operationalisng its global results framework to reflect cumulative progress will be an important step towards building evidence and enabling discussion around implementation and progress monitoring.

The qualitative review of findings set out in this report points to some promising green shoots in many countries. There has been significant demand from countries to implement the GFF approach (over forty formal letters of interest from Ministries of Health and Finance). Most GFF countries in our sample that have started implementation seem to have had fairly positive experiences developing an investment case, and report being in a stronger position to agree priorities and identify financial and operational gaps. The engagement of ministers of finance is certainly stronger than in the past. Progress – albeit slow – is just beginning to be visible around private sector engagement, and CSOs have worked very actively to organise themselves to engage in the GFF and increase accountability.

However, there remain outstanding challenges that need more progress (and more time) in order to demonstrate that the objectives of the GFF are likely to be achieved. Chief among these is domestic resource mobilisation, in many ways the heart of the GFF but also the most difficult and complex of its myriad areas of engagement. Some promising developments around domestic resource mobilisation have started taking shape in several countries but as the GFF itself has said, this is an area that will take time to move forward in all settings and contexts. It is unlikely that any partner considers that long-term shifts in domestic resource mobilisation is either an easy or simple achievement and there is much support from partners for this complex agenda. More proactive communication about progress, and consultations with others by the GFF would be sensible, politic even, in terms of building a common understanding about the challenges and plans going forward. The rate of GFF expansion (from the current 26 countries to an expected total of 50 countries within the next five years) should be managed carefully and in a practical manner to ensure quality

[1] The study was commissioned by the Health Team (Unit B4) in the Directorate-General for International Development and Cooperation. The full TORs are in Annex E.

and depth in all facets of GFF support and not just quantity. This is particularly the case when considering the significant effort needed to strengthen donor coordination, improve alignment of all partners and build a sound communication strategy. Ministry of Health counterparts are anticipated to take on a massive load under the GFF process, to lead and coordinate development partners, select and manage technical assistance and manage multi-sectoral negotiations which, even with additional help in the form of a GFF Liaison Officer, is a significant workload that is vital to success.

Efficiency gains seem to be within easier reach and innovative financing modalities have helped to drive up quality and improve attendance in some settings. There are questions about sustainability with all these modalities where they are not fully absorbed by national budgets. As in the case of other aid mechanisms or global health initiatives, the question remains: what will happen after they are gone?

Summary of additionality

The GFF has almost certainly raised more funds for RMNCAH+N. These are funds raised through concessional financing, through grant funding from the GFF Trust Fund, including through innovative funding modalities, and to a modest extent, from re-alignment of donor funding. In addition, there is potential in some GFF partner countries to maintain or increase government commitments to health as a direct result of GFF and World Bank engagement and negotiation (Nigeria, Mozambique). The recently launched World Bank Treasury bond will very likely raise additional funds for RMNCAH as well. Through supporting more efficient health spending in the short run in very challenging and fragile settings, the additionality component of the GFF should be assessed as a more than a financial and short-term one, but rather as a critical building block towards more additional and sustainable resource mobilisation for better health outcomes.

Beyond financing, there appears to have been early gains made around improved planning and tighter prioritisation of activities and investments out of existing health sector and/or RMNCAH plans and some specific programming is aimed at reaching vulnerable and underserved areas (for example in Guiinea and Cameroon). In some GFF countries – Nigeria being a good example – the potential systems reforms in primary health care could be far- reaching (it is too soon to tell).

The GFF works with and through the World Bank. The symbiotic relationship between the GFF and the World Bank is a strength and is certainly considered by many to be an important dimension of the unique offer that the GFF makes to countries. However, at country level especially, the GFF effort is largely cantilevered through World Bank staff over whom the GFF Secretariat and its partners have little direct influence. The extent to which the GFF will achieve results and additionality in countries will be determined in some part, by the motivation and capacity of World Bank staff to engage with the process, including equally important actions such as supporting government officials at the Ministries of Health and Finance around policy formulation, contributing to donor alignment, and fostering investment in efficiency gains. The Strategy Note signed between the GFF and the World Bank team leaders is thus an important instrument to advance this process. The Note sets out agreed objectives, commitments, expectations and, crucially, additional resources made available by the GFF to the World Bank team to support the achievement of these. Resources fund additional travel, technical assistance and policy support.

Summary of Effectiveness

Effectiveness is defined as the degree to which the GFF has been successful in producing preliminary results across its theory of change and through effective donor cooperation (EDC) principles. As summarised above, there has been discernable progress in a number of countries especially measured in terms of additional RMNCAH financing

approved (GFF grants and IDA/ IBRD financing). Investment cases are prepared in the majority of countries and learning from first and second wave countries is being applied effectively. Engagement of CSOs has strengthened over time and there are promising developments in engaging private sector financing, service delivery and support. There are a wide range of health systems and public financial management strengthening activities underway in many GFF countries.

GFF alignment with national health strategies and plans has been generally well perceived overall. The GFF has joined existing mechanisms and processes where these exist and in some countries, has channelled its resources through national pooled funds. On balance, the GFF approach has been to support national processes.

On the other hand, there is evidence of uneven performance especially around coordination, communication, and aspects of partnership building that collectively highlight how challenging it is to build effective cooperation within and between organisations.

GFF coordination and communications at country level have not (yet) been seen as fully effective around fostering and growing partnerships and engendering cooperation. There is a discrepancy between how the GFF aims to operate in countries and how it presents. This is probably amplified further by the confusion between the GFF trust fund, GFF partnership, and the GFF platform. In most settings the GFF is identified with the World Bank beyond a limited group of highly engaged partners. The platform is not fully operational in all countries and progress depends to some extent on the broader cooperation environment. RMNCAH development partners who do not directly fund country activities through the GFF Trust Fund are only minimally engaged or not at all. Communications have been inconsistent and patchy with some development partners feeling excluded and others feeling misrepresented. The depth of the GFF as an instrument or approach across ministries of health and/ or finance (beyond a few individuals) is still limited.

There is limited flexibility in the GFF with regard to financial management of funds as it uses World Bank rules and procedures (an advantage in some settings and a limitation in others). Above all, this has implications for some aspects of integration, especially where the GFF established a country-based trust fund to implement the funds of other partners (Bank executed funds) and to deepen partnerships with other major global spending agencies if they aim to join forces on the ground and work increasingly closer together.

The Investors' Group appears to be more focused on information sharing about the GFF and less on strategic agenda setting across RMNCAH. Although some participants did appreciate the information shared and the country focus of the Investors' Group meetings, many expressed concern that the meetings were less strategic than they should be. In developing its governance arrangements, the GFF Secretariat may not yet have identified the best way to maximise the value of having most major RMNCAH+N global players in a room together so regularly.

In operationalising its global framework and supporting countries to monitor (and communicate) progress, the GFF is currently increasing its range and scope of activity. The GFF could be proactive about demonstrating clearly that it avoids parallel indicators or tracking systems and supports, in a strategic and collaborative manner, the long-term development of HMIS in all partner countries. At a global level, what is considered the cumulative impact of the GFF is not yet fully transparent or easy to understand.

Key informants raised three main risks to making faster progress: (i) A failure to build deep and meaningful partnerships based on shared objectives and modalities, (ii) failing to ensure sustainability in the longer term, and, above all, (iii) a failure to be genuinely catalytic.

Recommendations

If the GFF can deliver its objectives, it would help transform the health system and significantly improve the prospects for women, children and adolescents in its partner countries. Building new institutions or systems is challenging and the process is rarely linear. These recommendations aim to strengthen GFF performance to help enable it, its

partners, and prospective partners to institutionalise its approach and support the achievement of an ambitious agenda.

Governance:

1. **Make sure the Investors' Group functions as a high level, consultative and dynamic forum**: Consider how to maximise the value and impact of the Investors' Group, not just for GFF governance but for the opportunities created by the Investors' Group to forge stronger alliances and harmonisation among major global health partners, notably the three main global health initiatives (3Gs) and the H6.

Partnerships:

2. The GFF should continue to take proactive steps to **develop a stronger partnership with the WHO**, and other H6 agencies, and continue building alignment with **GAVI** and the **Global Fund**. If country governments are really going to benefit from partner alignment, they need to also get one set of harmonised policy advice especially on issues as technical (and critical) as health financing strategies, public expenditure management and health management systems.

3. Linked to this, **formalise partnerships with the main UHC and health financing partners and associated capacity-building support networks**. The two networks, P4H and UHC2030 (UHC-P), should somehow be engaged more formally with the GFF, possibly even participating in the Investors' Group as full members or observers, in order to streamline country-facing efforts to embed RMNCAH+N in UHC plans.

Communications:

4. **Invest in better and more transparent communications**: The GFF Secretariat should strengthen its approach to, and consistency in, public communications, including communications with partners. This should happen in a number of ways, including: making the website more useful and accessible, increasing transparency, adopting a simpler language and communications style that reduces advocacy, and strengthening openness around lesson learning.

Capacity building and technical support:

5. **The need for a more consistent country presence**: The GFF should take steps to provide backstopping support, performance monitoring, and active supervision to the new group of country-based GFF Liaison Officers based in ministries of health to reinforce and support government focal points including in an increasingly multisector approach (nutrition).

6. **Support a process aimed at more clearly defining roles and responsibilities, especially among technical agencies** (such as the H6), including to continue dialogue at global and country levels to avoid duplication and overlap, and to streamline technical assistance on all aspects of RMNCAH+N**.**

Extending reach:

7. **Consider the pace of country expansion**: Despite considerable demand from countries, the GFF should ensure it achieves a sound level of depth and breadth in its delivery model, taking care to expand only as quickly as it is capable, to guarantee and sustain a minimum quality of partnership and technical support, given the size of the Secretariat and the extent to which delivery works through others. The GFF 'offer' is support to a complex set of reforms and should prioritise "doing it right" over "doing it everywhere".

8. **Private Sector Engagement needs additional resources:** Despite the interesting start, the GFF should consider investing in more capacity to support the private sector work, especially at country level.

9. **Civil society participation should be boosted through additional capacity building support:** Partners to the GFF (whether they are GFF funders or not) should ensure that CSOs are fully included in the GFF processes and might consider supporting the CSO platform hosted by the Partnership for Maternal, Newborn and Child Health that provides advocacy training, capacity-building and other forms of support to CSOs. Harmonising the several CSO platforms that currently co-exist may reduce costs and improve outcomes.

10. Monitoring & Evaluation, Learning and Knowledge (MELK)

There is a discrepancy between the work that the GFF is undertaking, its progress and partnership arrangements to pursue this work and the perception, communication and engagement of the broader RMNCAH community especially at country level. The GFF should take steps to address this discrepancy:

a. Identify the GFF Monitoring & Evaluation, Lesson learning and Knowledge (MELK) strategy more clearly to reflect the significant work that GFF is already undertaking, and to build partner confidence and opportunity for consultation on the approach.
b. Be transparent and open about operating assumptions used to calculate critical GFF monitoring and performance indicator data. For example, what is included in 38m lives saved, which partners' contributions are included/excluded in resource availability at country level ('leveraging' calculations and visualisation of RMNCAH+N alignment attached to investment cases)?
c. Develop a clear policy and process around contribution analysis in terms of the performance framework and include measures of effective donor cooperation (EDC) as well as outcome and impact results.

11. The GFF's support to Health Management Information Systems

Set out a clear plan to engage with other partners to support governments to develop/strengthen their HMIS systems (or make current plans more easily accessible). Most countries are implementing the DHIS2 with WHO and other UN Agency support. The GFF should be open and clear about its approach to HMIS and communicate how and where it supports information management systems, data collection and analysis and how it uses data. Papers presented to the Investors' Group with relevant updates should be made easily accessible (for example, posted on the website).

1. INTRODUCTION

The Global Financing Facility (GFF) aims to close the financing gap for RMNCAH+N in order to help achieve related Sustainable Development Goal targets. The GFF aims to raise and direct financing towards short-term results and longer term systems strengthening investments to improve health outcomes for women, adolescents and children in line with the Global Strategy for Women's, Children's and Adolescents' Health 2015-2030 and the relevant targets in the Sustainable Development Goals[2]. The GFF has a further objective to help countries strengthen civil registry and vital statistics (CRVS) capacity. A description of the GFF is in Annex A.

This report was commissioned by the European Commission[3] to provide an appraisal of GFF progress, additionality and effectiveness. Implementation of the GFF has been underway for just over two years and it is thus premature to attempt an assessment of results. However, experience with implementation in front-runner and first/second wave countries provides an opportunity to gauge important aspects of process, implementation challenges and the potential impact of the GFF.

The report is based on qualitative evidence drawn from across global and country experience primarily collected through semi-structured interviews with key informants. In addition to interviews with members of the GFF Secretariat and a range of global health partners, interviews were conducted with key informants in eight GFF countries at different stages of implementation (Cameroon, Democratic Republic of Congo (DRC), Ethiopia, Guinea, Liberia, Mozambique, Nigeria, and Tanzania). This is not an evaluation and the study has important limitations: only eight of a possible sixteen countries were appraised and due to the limited timeframe available to gather data, the number of key informants ranged between four and eight or ten within each country. Most countries had five to six key informants. While every effort was made to ensure at least one government official participated in an interview, this did not happen in two of the six countries and no ministry of finance officials could be reached within the restricted time available for interviews. The GFF Secretariat was engaged from the start, working closely with the study team and reviewing the first draft. In total, 34 of the key informants were permantly based in countries while more than half (46 out of 85 key informants interviewed) were directly associated with countries in the study and knew the countries well. This final draft reflects a balance between the empirical observations, a snapshot in time with the longitudinal, perspective of the Secretariat especially in relation to the implementation trajectory. A fuller description of the methodology (and limitations) of the study is in Annex B.

The report is structured in the following way: Section two sets out the main findings. Section three elaborates the conclusions drawn from these findings structured around the three main objectives of the report (progress, additionality, and effectiveness) and, looking forward, the notable risks arising out of the analysis. Section four presents recommendations arising from these conclusions both to the GFF, its partners, and prospective partners.

[2] The main targets are: 2.2 on malnutrition, 3.1 on child mortality, 3.2 on maternal mortality, 3.7 on SRH, 5.6 SRH and 16.9 on vital statistics.

[3] The study was commissioned by the Health Team (Unit B4) in the Directorate-General for International Development and Cooperation. The full TORs are in Annex E.

2. MAIN FINDINGS

This section reviews the main findings garnered from the interviews with key informants together with documentary evidence where available or relevant. All the main findings presented here were **corroborated by at least three key informants and often many more**. The full list of key informants is in Annex C.

2.1 Mission, objectives and key principles

There is widely shared and near universal support for the broad mission of the GFF to implement the 2015 *Global Strategy for Women's, Children's and Adolescents' Health* under the auspices of the UN's Every Woman and Every Child movement, in coordination with other health partners.

There is also considerable support for the GFF objectives, particularly its aim to increase domestic resource mobilisation and efficiency, strengthen the role and participation of the private sector and improve donor coordination and alignment within the health sector. The long-term need to accelerate domestic financing for health is widely understood and appreciated. Many key informants were vocal in their support of the GFF's ambition to "*shift the paradigm*", "*change the way things are done*", "*try an alternative approach*", especially in contexts where government coordination and leadership was perceived as weak. The GFF was also seen by many key informants as an important opportunity to increase the visibility of and funding for reproductive, maternal, newborn, child and adolescent health and nutrition (RMNCAH+N) at country level.

In most countries where it is already being implemented, the GFF has taken steps to align its efforts within the country health strategy and RMNCAH plan, in line with effective development cooperation (EDC) principles. It has made efforts to avoid creating new structures and rather has worked to further prioritise and/or operationalise existing plans. In some settings, the GFF has built on existing coordination arrangements. This was specifically mentioned as a strength by many key informants. In some settings such as the DRC, Tanzania, and Ethiopia, the GFF has joined pre-existing financial pooling arrangements and strengthened ongoing collaborative allocation and financial mechanisms in order to increase health expenditure efficiency.

However, there remains considerable confusion about what the GFF is exactly and how it works. For some key informants, the GFF is seen as a "*donor like any other*" (a partner that funds projects through grants and/or credits). However, interestingly, when asked what the greatest risk facing the GFF was, many key informants suggested that it would be "*to become like just another donor*". These key informants recognised very clearly that the GFF was trying a different approach and that it aimed to be "*game-changing*", using a relatively small pool of resources to catalyse significant changes in terms of source, amount and sustainability of funding for RMNCAH+N. Their perception was rooted in a number of other aspects of the GFF coordination and governance arrangements. A common one was the idea that, on the one hand, the GFF is presented as a *platform* (the GFF platform) that involves convening a wide range of partners to be coordinated under government leadership to better align around common objectives. But, on the other hand, the GFF is also a *funder* (its resources disbursed from the GFF Trust Fund, linked to World Bank financing) and is seen as making closed-door decisions about its own funds without necessarily engaging the broader platform (this is discussed further under Country Operations and Governance Arrangements).

Furthermore, the precise relationship between IDA/IBRD-funded programmes and the GFF grant funded programmes is not well understood by many partners. It appears that government officials had the greater knowledge of and confidence in GFF funding modalities

and arrangements than others such as health sector partners who were less involved in or informed about GFF-sponsored activities.

2.2 Working with and through the World Bank

The GFF is rooted in and hosted by the World Bank and this relationship both ensures leverage but also creates operational restrictions. On a presentational level, a large proportion of key informants were not clear why the GFF is cast as something *separate* from the World Bank nor why the Secretariat invested effort in distinguishing itself from the World Bank. Firstly they considered it a futile effort – the World Bank and the GFF seem, to most key informants, as inextricably linked; and secondly, many thought the GFF could not *be* the GFF without being firmly rooted in the Bank, given its financing and multisectoral dimensions.

The GFF model links grant funding to the use of IDA credits or IBRD borrowing for RMNCAH+N. In and of itself, this would not require the GFF to be based in the World Bank. However, there are other potential benefits to being situated in the World Bank including:

- The aims of the GFF to strengthen domestic resource mobilisation are best advanced through the World Bank, given its close relation with the IMF and with countries ministries of finance, and its expertise in economic development;
- The World Bank can therefore "*bring the Minister of Finance to the table*" and support the important link between the development of an investment case for health and its financing;
- Partnership with the World Bank introduces the possibility of using a range of financing instruments including distribution-linked indicators[4], loan buy-downs[5] and others;
- The World Bank is accustomed to working across sectors and multi-sectorally to achieve specific outcomes and has a mandate to do so;
- Improvements in efficiency, particularly in the allocation and use of public funds at the decentralised level, often require significant reforms to public financial management systems (including budget, procurement and audit reforms) that are well outside the usual remit of ministries of health or their usual partners;
- Through the World Bank, the GFF can tap expertise and commitment to focus support on these kinds of reforms as well as to build coherence between public financial management reform and health systems strengthening.

These benefits were identified by many key informants as significant strengths in the relationship between the GFF and the World Bank which, in turn, could be "*put to work in the service*" of RMNCAH.

However, there were **also some important limitations identified about the GFF – World Bank relationship** including:

- The requirement to use World Bank Trust Fund rules and procedures which were seen as too rigid and inflexible (although this was seen also as a strength by some key informants working in weaker operating environments);
- The adoption of results-based and performance-based funding in many, though not all, countries, as an approach promoted by the World Bank and other donors (this is further discussed below);

[4] A distribution linked indicator (DLI) is mechanism whereby a portion of IDA (of GFF TF) funds are only released on the achievement of a specific result. The proportion of funding may be 10 or 15% of the total. DLIs may be input, output or outcome oriented and are developed jointly by the World Bank/ GFF and countries.

[5] A loan buy-down is an innovative financing mechanism in which funds are paid upfront to reduce a loan's interest rate and lower the payment on the debt. In this case, GFF grant funds are used to lower IBRD rates to something closer to the IDA rate.

- Concerns and observations about the way in which the World Bank customarily works at country level, which is not always thought to prioritise important GFF objectives including donor alignment, coordination with multiple partners, and communication.
- Concerns about the use of concessional financing as a central plank in the strategy to raise funds for RMNCAH (discussed further below).

The central role of concessional financing

A number of global and country-based key informants raised a concern related to the central role of loan financing, even at concessional rates. For many health donors, this raises a concern in terms of sustainability, including debt sustainability. Indeed, some GFF countries are heavily indebted, often encumbered with private debt (for example, Mozambique).

Several other key informants were strong advocates for the link to IDA/IBRD financing pointing out a number of benefits:

- In spending concessional finance, resources are more likely to be on budget and, in some cases, this may mean that budget lines are created, sometimes for the first time, for certain expenditures, preventing substitution and strengthening the likelihood of being routinely funded in the future[6]; this in itself is welcome as a sign of increased awareness and commitment for health;
- Many of the reforms required for long-term health systems strengthening (including human resources for health, decentralisation, financing reforms aimed at universal health coverage), require significant levels of funding over a long period of time and are better suited to loan finance. These kinds of reforms are rarely funded by donors through common aid modalities especially because their locus is not generally speaking in the health sector, and are thus best funded from concessional loans;
- Concessional financing should be considered as domestic resources. Ministers of finance are required to be fully engaged at all stages of the programming process and this in turn requires the health minister to explain, justify, and remain accountable for the funds (and the results) and in the medium-term can strengthen the demand on the health ministry to justify its results, improve its efforts and demonstrate the value of health outcomes;
- Concessional finance should act as a bridge while the country increases domestic resource mobilisation for health through other means including by raising more funds through tax and through efficiency gains realised by removing systems barriers and increasing donor alignment;
- In the case of specific innovative financing mechanisms, such as loan buy-downs (used in Guatemala for example), concessional finance can create an incentive to both reduce debt levels and support on-going reforms to achieve specific health outcomes.

There is not yet sufficient evidence to support either position *in the context of the GFF,* making it an issue that requires close monitoring. Indeed, this issue would benefit from operational or health systems research, perhaps specifically focused on assessing the extent to which concessional finance does act as a bridge to sustainable growth in domestic resource mobilisation for RMNCAH and the conditions or drivers associated with that growth[7].

[6] A budget line in the state budget is a necessary but not sufficient condition of being funded from the public purse and although in and of itself, is no guarantee of budget commitment in the future, the opposite is almost always true.

[7] Countries are set loan ceilings by the IMF. The GFF modality does not, therefore, create a greater risk to *overall* debt levels but rather that concessional finance is directed towards recurrent expenditure such as salaries and commodities or service contracts that are not then fully absorbed into government budgets by the time the concessional financing term ends.

Box A - Leveraging IDA credits and IBRD loans

World Bank Group projects had been approved in fifteen GFF countries as of March 2018, totalling almost USD2.5 billion in concessional financing and USD387 million in grant resources from the GFF Trust Fund (a ratio of USD 6.46 concessional financing for every USD 1 grant financing). By the end of 2017, the World Bank expected to have disbursed about USD200m to support implementation. Some countries have been slow to build momentum around expenditure (for example, Liberia). The World Bank and GFF have published the following information about approved allocations:

Table: Approved GFF and IDA/ IBRD funding in USD millions as of March 28 2018

Country	Board Date	GFF Approved amount	IDA Amount	IBRD
Tanzania	5/28/2015	$40	$200	
DRC (AF-CRVS)	3/29/2016	$10	$30	
Cameroon	05/03/2016	$27	$100	
Nigeria (AF)	06/07/2016	$20	$125	
Kenya	6/15/2016	$40	$150	
Uganda	08/04/2016	$30	$110	
Liberia (AF)	2/23/2017	$16	$16	
Guatemala	3/24/2017	$9		$100
DRC (AF)	3/31/2017	$40	$320	
Ethiopia	5//2017	$60	$150	
Bangladesh	7/28/2017	$15	$500	
Bangladesh (Education)	12/18/2017	$10	$510	
Mozambique	12/20/2017	$25	$80	
Rwanda (Health)	2/28/2018	$10	$25	
Afghanistan	3/28/2018	$35	$140	
Rwanda (SP-AF)	4/13/2018	$8	$80	
Guinea	4/25/2018	$10	$50	
Indonesia	6/21/2018	$20		$400
Total Board approved		**$425**	**$2,586**	**$500**

Source: Global Financing Facility, June 2018.
AF – Additional Finance; CRVS – Civil registration and vital statistics; SP – Social Protection

Skills, incentives, and knowledge

One of the interesting and challenging elements of the GFF is that it does not have country-based representation. Instead, like other global health initiatives (GHIs) such as the GFATM and GAVI, it works through partners and aims to promote national ownership and leadership by passing responsibility for coordination to national authorities. It thus relies on others to embrace GFF aims and objectives and to be capable and sufficiently motivated to take forward the work of delivering the GFF programme and to support the government to strengthen donor coordination and alignment. Yet, as a new modality and given its level of ambition, its multisectoral scope (with nutrition becoming more important in new/second-wave countries), and the speed it aims to move at, it was identified by several key informants that this may not be realistic. This is a major operational concern that was linked by many key informants to the fundamental ability of the GFF to succeed in terms of its ability to

support better coordination and alignment and some aspects of its support to improved efficiency.

Linked to this, the skillset and institutional incentives required to be effective in the context of the GFF are somewhat different from the typical World Bank operational model. The *"Task Team Leader"* needs to place even more emphasis on coordination, take the time to build partnerships and invest energy into being inclusive, proactive in communicating with all partners. This amounts to adjusting the incentives for staff performance as well as investing in different skillsets. The most effective instrument identified was the Strategy Note signed between World Bank staff and the GFF Secretariat (also identified in Box B: Lessons Learned). The Strategy Note sets out the GFF objectives in a given country, together with roles and responsibilities. It then sets out the activities, commitments, behaviours, budgets, and time taken in-country, and assigns a budget to support that. This functions more or less as an accountability instrument between the GFF and the World Bank.

2.3 Governance arrangements

GFF governance is primarily delivered through the GFF Trust Fund Committee, which oversees the GFF Trust Fund and the Investors' Group. The remit of the GFF Trust Fund Committee is to approve grants awarded to countries, ensure accountability, and discuss and approve critical aspects of GFF operations including which countries should be invited to participate in the GFF[8]. The Investors' Group oversees the broader GFF platform[9].

The GFF Trust Fund Committee

The Trust Fund Committee is the locus of strategic and financial decision-making in all matters that concern the GFF Trust Fund. As the GFF grant drives GFF operational matters, including the work programme of the Secretariat and grant approvals to countries, it is, in many ways, the engine of the broader GFF instrument. Membership in the GFF committee is limited to those who fund above a certain threshold and so, de facto, excludes beneficiaries and other partners. The GFF Trust Fund Committee meets four times a year, and, where it coincides, meets the day before the Investors' Group.

The Investors Group

The Investors' Group is a unique forum in that twice yearly it assembles a group of influential global health partners including the main RMNCAH+N partners who, broadly speaking, already share common goals and objectives. This makes the Investors' Group potentially influential as a forum for shaping global RMNCAH+N policy and strategy (beyond the delivery of the GFF). However, although some key informants found the Investors' Group met their needs, many partners interviewed expressed concern that the meetings are more and more transactional and formal, with papers to be discussed, rather than strategic and decision-oriented. Participants are given a lot of information about the GFF during the course of a tightly packed agenda, which although considered by many to be of interest, leaves little time for strategic discussions, identification of common challenges, or interactions between group members aimed at building better coordination.

One issue raised by key informants is that the serious decisions concerning the GFF are taken the day before in the Trust Fund Committee meeting or even among a smaller group of sponsors. The *governance* element of the Investors' Group is therefore

[8] The Committee is made up of the GFF Secretariat, the World Bank, and the main development partners who contribute to the Trust Fund which are currently Norway, Canada, the Bill and Melinda Gates Foundation and the UK. Denmark and Japan may soon be joining as well.

[9] The Investors' Group has a much wider membership than the Trust Fund Committee and includes four GFF country partners, all development partners that contribute to the Trust Fund, two CSOs, two private sector partners, WHO, other UN agencies (currently UNICEF and UNFPA), the Global Fund for the fight against AIDS, TB and Malaria (the Global Fund), GAVI, the Office of the UN Secretary General, and the Partnership for Maternal Newborn and Child Health (PMNCH).

considered somewhat hollow and one key informant even said "*it is used to make the GFF look good*".

Several key informants pointed out that the Investors' Group was an important opportunity to hear from countries themselves (five partner country representatives participate) and that the voices of country partners is an important part of the meetings.

Processes around setting meeting agendas, developing and reviewing minutes of meetings, and operational follow-through were raised by key informants as areas where more consultative approaches could be developed. Some partners feel that it is too difficult to influence what the Investors' Group discusses. Over time, it appears that the attendance of the most senior representatives of partner organisations has increasingly been replaced by others who may not be in a position to take decisions. As one key informant said, the Investors' Group *"has the potential to really think about how to take forward actions for women and girls".*

2.4 The GFF Model

Government leadership

In country after country, government officials have engaged with the GFF in a consistently positive way, investing significant time and effort into making the GFF model a success. Several benefits were identified by ministry officials who reported that they felt more control over the way funds were programmed and were able to lead internal priority-setting processes, sometimes for the first time. Some felt more personally empowered to convene donors and demand more accountability from donors about their programmes and priorities. Many valued the technical assistance that comes with the GFF process and the support that the GFF offers in relation to challenging health systems problems. Lastly, some government officials referred to the more consistent engagement of the Ministry of Finance and the stronger dialogue that resulted from that, especially around the investment case for health and (sometimes) health financing strategies.

The depth or penetration of the GFF beyond a small group in ministries of health is, so far, limited. Genuine government ownership and leadership takes time and requires patience and persistence, so this should be seen as a longer term effort. Many health ministries have limited capacity (or rapid turnover) whereas donor coordination and alignment is time-consuming and often quite difficult, requiring a mix of specialist financing skills and more rudimentary process and communication skills. It was clear that, while unanimous about its importance, key informants had had highly variable experience of government leadership and coordination so far, and that additional resources and support in this area would potentially be useful in some countries. Some key informants considered there was a fine line between capacity-building for coordination and over-burdening already over-worked officials.

As identified in the Lessons Learned (Box B), the GFF has spotted this challenge and has developed a new cadre: the GFF Liaison Officer. The Liaison Officer post will be funded by the GFF, selected, appointed and managed by the government and embedded in the office of the relevant government GFF focal point. The TORs of the new post will be specifically focused on supporting the government to lead, coordinate and manage health sector partners including those directly supporting the GFF. As this is a new post, there is no current experience to report.

Investment cases

The Investment Case development process was widely appreciated for its focus on technical priorities. It was seen as a useful tool to improve planning, priority-setting, and

budgeting ("*a welcome break from fiduciary management*", "*making the investment case for health*", "*we had a good RMNCAH strategy but had no idea on how to implement it; the Investment Case came right on time*"). Almost all countries were enthusiastic about the process and indeed, the outcome. In a couple of countries, the existing plan was used instead of developing a new one (for example, in Tanzania and Ethiopia).

The main observations about Investment Cases – led by comments from the GFF Secretariat itself which has reflected on its experience in this area – included:

- Quality, depth, and breadth of the investment cases has varied across countries.
- The development processes were inconsistent in how they drew on available technical assistance in countries, primarily through UN organisations;
- A common experience was the subsequent drop in group energy on completion and the long gap between development and implementation, with sometimes no communication to accompany and explain this perceived "*sleeping phase*".

The GFF has developed guidelines to support new countries to develop quality investment cases and has held a number of workshops and other interventions to build capacity. It is too soon to report on the results of this process.

Health financing strategies

There was much less evidence about the relationship between the GFF and health financing strategies[10], and the complexity of building a long-term health strategy in any country clearly involves significant political engagement. In fact, not many key informants were aware of whether and how health financing strategies were being developed or finalized. The GFF has formally taken a step back from leading on health financing strategy development in its partner countries although certainly much of the GFF's technical support is aimed at strengthening efficiencies and would be better positioned in the context of a national strategy. In certain cases, the GFF seemed to be developing well for example, whilst the health financing strategy stagnated. The two processes are not always strategically coordinated (DRC, Guinea). Some key informants were very concerned about overlap or duplication of health financing policy-making and strategy development in countries that are also part of the P4H network[11] and/or the UHC-P network[12], which is linked to the UHC2030 movement. Certainly, many countries are trying to assess where they are with social and financial protection and to consider options for advancing universal health coverage. At a global level, despite the clear overlap, links between the GFF and other major health financing actors appear to be inconsistent and relatively weak.

Domestic resource mobilisation

Domestic resource mobilisation is the most challenging element of the GFF project but (not surprisingly) has been difficult to make progress on, despite being one of the main components of the GFF and a major element of its proposed additionality. It is both complex and vital to make progress in this area if the GFF is to deliver on its promise of being something new. With only two years in hand, however, it is too soon to make judgements about results and a longer timeframe is needed to assess the potential for the

[10] In many countries the GFF does not focus on the health financing strategy itself (according to their information) but rather works to remove the most pressing health financing bottlenecks. Every GFF country has access to technical assistance for analytical work to support the health financing policy process. Although often funded by the GFF, it is sometimes supported by other partners bilaterally at country level (for example, USAID).

[11] P4H is the Providing for Health network that supports more than 35 countries to work towards universal health coverage and social protection. It has a wide range of institutional supporters including WHO, the World Bank, the Global Fund, the African Development Bank and a range of bilateral donors. P4H focal points are based globally in Geneva as well as in many GFF countries yet they have not ever (it seems) been engaged on health financing or priority setting activities. https://p4h.world/en

[12] The UHC-P network is the Universal Health Coverage Partnership (a country level partnership for UHC2030) supported by the EC, WHO, Luxembourg and Irish Aid, and operates in over 35 countries. http://uhcpartnership.net

GFF approach to have impact. Nonetheless, one or two positive signs were identified by key informants:

- In Mozambique, the GFF and World Bank, working together with the Ministries of Finance and Health and using a Disbursement Linked Indicator (DLI), have agreed the government will maintain a minimum level of budget commitment to health for the next two years despite a challenging fiscal outlook, followed in year three by a budget increase.
- In Tanzania, the IDA/GFF operation will disburse to different levels of the government (from national down to facilities) against the achievement of six agreed disbursement linked indicators (DLIs), one of which is increasing the share of health in the government's budget. The amount will be USD 15m but all six DLIs need to be achieved.
- In Nigeria, government commitments to set aside 1% of the budget for primary health care may be realised for the first time since the policy was approved in 2014. This would translate into a significant additional funding commitment to health[13].
- In Ethiopia, the government is drawing on IDA to support health investments for the first time. This appears to be directly linked to the additional grant funding available through the GFF.

Elsewhere, among the other countries in this study, progress is a little slower and in some countries, there has been no discernible change yet. Some of the reasons suggested include the continued displacement of government funding by aid in health, the inevitable time lapse between identifying the case for investing in health and securing resources for it, and the time it takes for government budgets to evolve.

Key informants were keen to identify that the alternative to raising "*more money for health*" is to get "*more health for the money*" available. Efficiency gains, linked to both improved public expenditure management as well as better priority setting and alignment, were mentioned as promising opportunities to get more health out of the money that is already available in several countries including Guinea or Liberia. Cameroon presents a good example. The 2018 health budget was cut by 16% in response to low disbursements and other dysfunctional issues. The GFF has prioritised support to public financial management improvement to help improve effectiveness and 'win back' the previous budget level. Initial results show that the level of budget allocation from central to local operational levels has increased from 8% to 15% as execution improves. These efforts should, in the long-run lead to improved availability of public funds for health on the frontline.

Other investments in health systems strengthening and efficiency gains include those focused on ensuring a higher proportion of funds get to the frontline and to primary health care facilities (Mozambique, Cameroon, Liberia), strengthening the supply chain (Mozambique), and facility service delivery readiness (DRC).

The extent to which the GFF has been able to identify, track, address, or reduce out of pocket (OOP) payments as part of a broader approach to health financing efficiency, equity and effectiveness is unknown. For example, it was not clear from this brief review whether the GFF supports or underwrites free maternal and child care in any country. However, it was raised by several informants as an important dimension of equity, in

[13] The Nigerian 2018 Federal Budget was approved by the President on 20 June 2018. Included in the budget is a provision for states to scale up Primary Health Care (the 1% commitment made in 2014) with an estimated value of USD 150 million. It remains still to be seen whether the funds will be transferred but this is already an important step forward and promising for financing frontline health services. The GFF grant component (among other things) is supporting three states to develop and pilot systems that will enable them to scale up PHC including purchaser-provider split, standard setting, accountability and monitoring arrangements.

particular. In April 2018, at its most recent Investors' Group meeting, the GFF approved an OOP payment policy in the context of a broader financial protection agenda.[14]

Innovative Funding Modalities

All key informants said they were aware that the GFF included innovative funding modalities. The most commonly recognised was results-based financing (RBF). From discussions with the GFF Secretariat it is evident that there is growing knowledge and experience about where and when RBF works best (and where it does not). For example, in Tanzania, GFF resources are pooled with those of other donors. The fund provides upfront financing to health facilities to ensure a basic operating budget. The GFF funds though, have enabled the pool to support a RBF component creating an incentive for health facilities to perform better.

Some key informants identified a risk to sustainability of RBF modalities, especially where they are used to supplement staff salaries, and where government funding (or other long-term funding channels) did not materialise to absorb the funding obligations from the GFF. Other innovations were less often mentioned, but it is worth noting here that in both Guatemala and Vietnam, the GFF is financing loan buy-downs which appear to have attracted additional resources for MNCH. The World Bank has supported credit buy-downs in the past (for example, in Nigeria, for polio eradication) and learning from this experience could be useful to RMNCAH specific activities.

Box B: Evolving GFF practice based on lessons learned in its first two years

The GFF has learned some important lessons through the experience gained, implementing the GFF in the first 16 countries. A few of these are highlighted here to illustrate its adaptive learning:

- The government-based GFF focal point or champion should be able to work across the ministry of health at the very least and preferably across other sectors as well. More recent GFF countries have tried to identify ministers, deputy ministers or permanent secretaries to lead the GFF process.
- The *Fly in – Fly out* model doesn't work and even where there are permanent World Bank staff in-country, the demands of donor coordination and proactive communications are significant. Government officials leading the GFF need additional support. The GFF has created a cadre of "GFF liaison officers" who will be embedded in the MoH and will support ministries to improve coordination, as well as to take forward GFF partnership work. Their TORs will include proactive communication with health development partners, coordination, and information sharing.
- CSOs and the engagement platform: as discussed in the main text, the ambition to engage CSOs meaningfully and consistently needed to start early in the GFF implementation process. While still evolving, the establishment of the CSO platform in the PMNCH creates an additional forum and resource for CSOs.
- Supporting World Bank Task Team Leaders (TTLs) to do more and shifting incentives to engage them in delivering GFF outcomes is vital to making progress. The GFF signs "Strategy Notes" with World Bank teams that make the GFF objectives explicit, identifying critical outcomes to be achieved with deliverables. In turn, the GFF provides additional support to the World Bank team in the form of additional budget to fund much more frequent travel to the country and a flexible pot to fund TA.

2.5 Partnerships and effective development cooperation

Partnership principles

The GFF's partnership principles are consistent with Effective Development Cooperation principles focused on country ownership and donor alignment around country-led national priorities and systems, including results tracking, monitoring, and on improved donor coordination.

[14] Global Financing Facility "*Financing Protection in Health*", Investors' Group 7, paper 4, April 2018. Like many of its policy papers, this one is not on the GFF website and has had little distribution beyond a limited circulation.

GFF coordination and communication

All key informants agreed that the GFF's ability to strengthen coordination and alignment would be an important driver of success. It is one of the principal steps in the theory of change. A very large majority also suggested that GFF coordination efforts and, more specifically, the communications underpinning effective coordination, were inconsistent, often deficient or absent, and in need of reinforcement. This communication and coordination problem was identified in a range of different circumstances and settings. Some examples, to illustrate the pervasive nature of this challenge are listed:

- As mentioned above, many informants cited the investment case design phase as largely positive, and they felt meaningfully engaged and consulted. Once the investment case was finalised, for many key informants, they lost contact with the GFF process and were not sure how to re-engage or where the discussions about implementation were taking place.
- A diverse range of key informants believed that the most important discussions about the GFF (the grant from the Trust Fund and/or the associated IDA-funded programmes) were negotiated by the GFF and World Bank teams behind closed doors with the minister of finance.
- Teams from Washington have flown in/flown out without other (major) development partners being aware of the visit despite the focus being on GFF implementation.
- Several key informants in different countries said that when they tried to reach out to the GFF (or World Bank) staff for information, they were told "*it's the government's responsibility to do the coordination*".
- There were a number of examples given by key informants related to the way technical inputs and support are sought at different stages of GFF programme implementation.

The cumulative result of ineffective communication and coordination is to reduce confidence in the GFF as a partner. It is thus a matter that requires urgent attention. The appointment of the GFF Liaison Officer (section 2.3 above) will go some way towards improving in-country communication and coordination. However, much more needs to be done to address this challenge as it was a prominent theme emerging from the process. The full range of communication opportunities should also be optimised using existing coordination mechanisms, joint strategic reviews, and other types of lesson-sharing exercises.

Financial management and procedures

The GFF uses World Bank rules and procedures which are largely inflexible and require other donors and partners to hand over control of resources to the GFF. In some contexts, the rigour of World Bank procedures is very welcome and acts to encourage investments as partners consider the funds will be appropriately used and accounted for. However, for some partners, the lack of flexibility means that all the give has to come from others. For example, funds invested in a World Bank hosted pooled fund or multi-donor trust fund (MDTF) in support of Investment Case priorities are managed using World Bank rules and procedures and the donating partner "loses sight" of them in accounting terms. Thus, in order to fund the relevant pooled fund in DRC, the Global Fund had to get its Board to take an exceptional decision to release the funds, since the Global Fund's own financial scrutiny arrangements (through its Office of the Inspector General) would be waived. In this case, the question is whether there is scope for these two big funding mechanisms to agree some kind of framework for cooperation at country level. Other large agencies are doing this kind of cooperative working (for example, GAVI and the Global Fund) at least around information management, joint planning, and some elements of harmonised planning and budgeting.

The role of other technical partners[15]

Based on the comments of key informants from across almost all the countries studied, there remains a lack of clarity about the roles and responsibilities of the UN technical agencies (the H6[16]) in relation to the GFF. This is a challenging area since it is essential that countries are able to access the technical assistance they consider most useful and appropriate to them. Effective development cooperation principles require global partners to align behind country priorities and support nationally determined plans as a shared responsibility.

At a global level, the GFF contributes financially to the Geneva-based technical team supporting National Health Accounts; and the GFF director meets WHO officials regularly. Meetings between the Secretariat and UNICEF are held monthly. Several agencies including UNICEF (and a number of bilateral agencies including USAID, Japan and others) have seconded staff to the GFF as one means of strengthening links and improving coordination. There is more to do in this area however. For example, on health financing, which is WHO's clear mandate and area of expertise, together with the World Bank, WHO is not consistently involved in policy discussions either at global or country level. Discussions at global level seem to be formal and information focused. At country level, it was mentioned by several key informants across several countries that WHO and other agencies are not consistently included in/informed about GFF related technical discussions. WHO has a mandate to support ministries of health to lead sector coordination, yet it is not always clear how this mandate and the GFF's aim to improve coordination and alignment are harmonised.

In developing the investment cases, UN technical agencies in some countries were very involved whereas, in others, there was much less interaction. Some of this variation may be down to personalities or other country-specific circumstances. Nonetheless, across the scope of the global RMNCAH response, the GFF has been identified as the funding instrument while the H6 should lead on technical support. An unresolved component of this notable (and frequently raised) problem is related to being sufficiently resourced (technical skills, time commitment, participation, and funding) to take on the role.

Both USAID and the BMGF have created funding streams to finance TA in many GFF countries, that countries can access to secure the technical assistance they prefer. It is important to note that although this problem is not only one for the GFF, it does involve the GFF quite significantly. But it is a challenge for all actors in the RMNCAH arena including, of course, the H6 who need to help find a resolution or way forward.

2.6 Private sector engagement

Despite slow progress on private sector engagement, what has happened appears to be innovative, offering a glimpse of the potential impact that the GFF and its partners could have. Progress has been summarised in a recent Secretariat paper and will not be repeated here.[17] The paper identifies a range of mechanisms to promote private sector engagement in a wide range of ways including:

[15] The EU (which commissioned this study) supports the placement of technical experts in WHO offices in EU health priority partner countries. There is a particular interest therefore in understanding the coordination functions and challenges linked to technical partners in relation to the GFF.

[16] The H6 partnership is comprised of UNAIDS, UNFPA, UNICEF, WHO, UN Women and the World Bank. The H6 serves as the technical arm of the Global Strategy for Women's, Children's and Adolescents' Health, contributing leadership in the areas of reproductive, maternal, newborn and child health (RMNCH). Working together, the agencies of H6 aim to build on long-term and trusted relationships with each other and with governments committed to RMNCAH results.

[17] *Private Sector Engagement*, Seventh Investors' Group Meeting, Washington DC, April 23 2018.

- A USD 500 million World Bank Treasury bond recently launched to raise funding for RMNCAH+N;
- The delivery of a "Managing Markets for Health" course delivered to over 450 participants in April 2018;
- The GFF (with others) is finalising an investment of US$1 million as "first-loss" funding to de-risk about US$15 million raised from various private investors into a non-profit that works with local banks to improve access to finance for small and medium enterprises in healthcare in five African countries; and
- Loan buy-downs to reduce the cost of IBRD borrowing for GFF countries investing in RMNCAH (Guatemala, for example).

Engaging more, and more effectively, with the for-profit private sector in health remains a critical issue given the importance it plays in this sector in most developing countries (funding, service delivery) and the fact that it often operates outside of national plans and public regulatory control. Finding the right role for the private sector is an essential part of securing better outcomes in RMNCAH. The GFF has rightly pointed to the need to support better private sector engagement**.**

In most countries, the first challenge is to map the private sector engagement and to bring a self-organised and credible private sector platform into the policy dialogue together with more sector coordination and regulation. In Ethiopia, GFF resources have improved engagement between private sector actors and the government in order to support the development of a formal umbrella organisation for Private Sector groups. The challenge in Ethiopia is access to finance, and the World Bank is engaging in identifying how to improve access to financing for private providers (hospitals and commodities).

Although there was interest expressed in private sector engagement and a general concern about the challenges that lie behind that, most key informants had no specific information about private sector engagement or believed that little had happened yet. This is another area where the GFF could build on pre-existing work done in private sector health in Africa by the World Bank and other donors[18]. However, it is a complex area which requires specialist skills, not necessarily found in abundance in the World Bank or among the usual health partners. One key informant suggested that the GFF should bring in additional skills and capacity to support current efforts.

2.7 Civil Society engagement

When they become GFF partners, countries agree to include CSOs in RMNCAH planning and delivery (for example, as part of the process of developing an investment case). Based on the interviews with key informants, together with a review of relevant documents, there has been some visible progress in the way that civil society organisations are engaged in the GFF at various stages. All countries do have CSO representatives participating to at least some extent, although in some countries it has been impossible to identify clearly what types, and how representative or participative these CSOs are.

The main finding is that CSO engagement, despite progress made, remains patchy, both between and within countries. The establishment of a CSO platform supported by PMNCH has enabled wider involvement and supports CSOs to access information and support in relation to (a) understanding what the GFF is; (b) finding a way to engage with it either directly or through others; and (c) strengthening their own capacity-building. It also manages the process of electing CSO representatives to participate in the GFF Investors' Group (section 2.7).

[18] For instance, the analytical work initiated by the International Finance Corporation on the private sector in health in Africa and its recommendations implemented by the Health in Africa fund developed by a range of partners

In some countries including Kenya and Tanzania, CSOs have designed scorecards and other instruments to facilitate their "*most important role which is to hold government to account*". This oversight role was raised several times by key informants, but it was also clear that CSOs are still not consistently or automatically included. There remains progress to be made in carving out the role and function of CSOs in order to ensure meaningful participation. Some CSO informants recommended that the GFF process should be more proactive to identify independent oversight bodies in GFF countries to review and report on what is going well, and what needs to be done better as part of the broader commitment to leave no one behind. Some key informants also called on the GFF to avoid crowding out CSOs with limited capacities, but rather to explore the possibility of building on existing processes when they function well (such as the Global Fund CCMs) for better complementarity and synergies.

2.8 Monitoring and evaluation, lesson learning and knowledge (MELK)

Lesson learning

The GFF Secretariat has adopted an internal lesson learning process based on bringing multisectoral teams from ten GFF partner countries together to learn from each other over a one year iterative process. Each country team includes high level ministry of health and ministry of finance staff, and often others as well (for example, from education or nutrition). They meet together twice during the year for a week of face to face discussions and lesson learning interspersed with additional virtual contact and continued/on-going support. The objectives include practical results such as building a common approach to investing in health. This is an innovative and dynamic way to undertake policy shaping, capacity building and lesson learning. The GFF also hosts monthly webinars on topics suggested by countries. Topics have included DLIs, results tracking, and investment case development. It is unclear if there has been any analysis of progress made or benefits realised from the process.

GFF reflective lesson learning about its own performance and progress does certainly happen (see Box B) but it seems to be an unstructured process. Although the GFF also links into a collaborative effort on the Joint Learning Network, and there is probably quite a lot of learning going on, many key informants were unsure of whether there was a formal, reflexive learning process about the GFF itself as a broader instrument or approach. In other words, although there is a lot of learning going on about the issues that the GFF aims to support countries to address, there is less about how they do this. As a young institution just trying to become established, this kind of learning is vital. Examples of on-going data collection to provide partner feedback to the GFF could include surveys to Investors' Group members, a dropbox for comments, in-depth interviews through an independent body appointed for the purpose.

Results tracking and support to HMIS

The GFF is operationalising its global results framework agreed in 2016. As with other aspects of GFF engagement, there is a discrepancy between the range of activity undertaken by the GFF (globally and in countries) around results and information tracking and its presentation and communication to others (including the broader RMNCAH community in GFF countries). This rapid appraisal was not able to fully review all the GFF progress in relation to results tracking and support to HMIS capacity building in countries but some points have emerged.

Projects financed by IDA and the GFF always have attached results frameworks. The GFF Secretariat is working on streamlining indicators to enable cumulative results reporting, although this is work in progress. Indicators are systematically reported every six months as

part of the World Bank requirements.[19] The GFF Investors' Group regularly discusses the operationalization of the Global Results Framework with a particular focus on the use of local data systems, using data to monitor implementation and building partnerships around the results agenda (most recently in November 2017).[20]

The GFF Secretariat is working on a number of results tracking and monitoring processes. For example, several investment cases include targeted investments in data systems, and support to the strengthening of DHIS2 systems (Guinea, Cameroon, Ethiopia, and Tanzania). Funding has been allocated from various donors including through IDA/ GFF TF financed projects. In several countries the GFF partnership is funding the development of systems for budget allocation, tracking budgets, disbursements, and expenditure as important elements to track implementation, for example, in Liberia and Cameroon. This includes creating and improving interoperability between existing systems to improve reporting on the health financing agenda. The GFF Secretariat reports that it works closely with other development partners including WHO, UNICEF, the Global Fund, GAVI, bilaterals and others to support the development of monitoring and health information systems (through DHIS2, community-based monitoring, improved CRVS, tools for improved data quality, and RMNCAH-N visuals and others). It is the GFF Secretariat's aim to develop a more comprehensive approach to country data presentiation through a kind of dashboard.

Amidst the wide range of efforts undertaken around strengthening information and results tracking (and the systems to generate results), the GFF has not yet fully thought through its approach to contribution analysis (or attribution) or it has not publicly presented its approach. Communication around the GFF's approach to supporting to better Health Monitoring and Information Systems (HMIS) for RMNCAH+N was unclear to many key informants although evidence was available from some countries and demonstrates that the GFF is investing in HMIS. How to measure GFF contribution to successful development, either in a single country or globally, remains an open and challenging question (and an important one for the GFF to discuss more widely), as well as how resources are used (especially technical resources) to advance agreed priorities.

It is also not clear whether the results framework will focus only on results expressed in terms of health outcomes in countries, or whether it will also **track the performance of the GFF itself** and progress with the application of key principles (such as alignment, government leadership, improved efficiency) which would be an important opportunity to regularly focus on tracking improved effectiveness in the GFF approach and operationalisation. Many key informants pointed out that the absence of an agreed monitoring framework for the GFF itself makes it difficult to measure progress objectively. This has been raised as a concern even among some of the GFF sponsors.

Furthermore, the presentation of GFF resource maps can be confusing and lacks specificity, consistency, and nuance. For example, when presenting RMNCAH funding commitments at country level, such as in relation to the Investment Cases, published material often includes that of some other RMNCAH funders, like the Global Fund or Gavi (even where their funds are not channelled through GFF instruments). But then the same presentation will not include some major bilateral donor or other partner that invests as much or more in RMNCAH+N. This inconsistency is troublesome to both the included and the excluded partners because it obscures, or even contradicts, the principles of openness and transparency, and creates confusion. If the aim is to present the full alignment of partners around RMNCAH+N, all funders should be included. The next questions then – premature at this stage – are to ask what funding is linked to the results contained in the eventual results tracker, and what is the relationship between the funding and the results achieved?

[19] GFF Trust Fund Results Framework consultation presentation, May 2017
[20] Results Framework update, GFF Investors' Group 6, November 2017

Lastly, as mentioned in Section 2.6, civil society organisations are keen to be engaged in results monitoring processes, to "*ensure that no one is left behind in a process that is supposed to be bringing additional resources to this country"*. How this role will be negotiated is still to be determined, and each country will be taking a different approach. It is one of the capacity building objectives of the global civil society platform hosted by the PMNCH.

3. CONCLUSIONS

Based on the information provided by key informants, this section presents the study conclusions. These are structured around the research framework (progress, additionality, and effectiveness).

3.1 Progress

The GFF has taken on a wide ranging, ambitious, high risk agenda centred on supporting the willingness, capacity and commitment of countries to take on increasing responsibility for a growing portfolio of quality investments to support women's, children's and adolescents' health. In this, the GFF has made some discernible progress at both global and country levels although it is early days and it is unlikely that any of the gains are irreversible. Operationalising the 2016 global results framework will be an important step towards building evidence and enabling global or cumulative progress monitoring[21].

The qualitative review of findings set out in this report points to some promising green shoots in many countries. There has been significant demand from countries to implement the GFF approach (over forty formal letters of interest from Ministries of Health and Finance). GFF countries that have started implementation seem to have had fairly positive experiences developing an investment case, and report being in a stronger position to agree priorities and identify financial and operational gaps.

The GFF is rolling out in 26 countries following the expansion to ten new countries in November 2017. A total of 67 countries are eligible and the rate of expansion suggests that a sizeable proportion of these could eventually be involved. In the absence of evidence, but bearing in mind the GFF Secretariat is a light touch team, **the rate of expansion should be managed very carefully and in a practical manne**r to ensure quality and depth in all facets of GFF support and not just quantity. This is particularly the case when considering the significant effort now needed to strengthen donor coordination, improve alignment of all partners and build a sound communication strategy. Ministry of health counterparts are (quite rightly) anticipated to take on a substantial additional level of effort under the GFF and to lead and coordinate development partners, identify and manage technical assistance, negotiate with ministries of finance and design and oversee implementation. Even with additional help in the form of a GFF Liaison Officer, the additional burden may be significant (in terms of building coherence and better alignment within and across government as well as with development, technical and private sector partners).

Significant effort has been invested in the GFF and a relatively small team has accomplished an impressive amount in two years. Most GFF countries have had fairly positive experiences developing an investment case and are in a stronger position to agree priorities and identify financial and operational gaps. The engagement of ministers of finance is certainly stronger than in the past. Progress – albeit slow – is just beginning to be visible around private sector engagement and CSOs have worked very actively to organise themselves to engage in the GFF and increase accountability.

However, there remain outstanding challenges that need more progress (and more time) in order to demonstrate that the objectives of the GFF are likely to be achieved. Chief among these is domestic resource mobilisation, in many ways the heart of the GFF but also the

[21] The GFF global results framework was originally approved in 2016. Although each investment case and every GFF grant has its own results framework, the global framework is currently being operationalised (in that it's indicators are being updated, parameters re-evaluated, targets and baselines established). The GFF reports to the Investors' Group about progress on global results monitoring, most recently in November 2017, when an update was provided on the operationalization of the Global Results Framework with a particular focus on the use of local data systems and how to strengthen them, the use of data for monitoring of implementation and partnerships around the results agenda. This paper is not on the website or publically available.

most difficult and complex of its myriad areas of engagement. Some promising developments have started taking shape but as the GFF itself has said, this is an area that will take time to move forward in all settings and contexts. It is unlikely that any partner considers that long-term shifts in domestic resource mobilisation is either an easy or simple achievement and there is much support from partners for this complex agenda. More proactive communication about progress, consultations with others by the GFF would be sensible, politic even, in terms of building a common understanding about the challenges and plans going forward.

Efficiency gains seem to be within easier reach and innovative financing modalities have helped already drive up quality and improve attendance (apparently). There are questions about sustainability with all these modalities where they are not absorbed by national budgets. As in the case of other aid mechanisms or global health initiatives, the question remains: what will happen after they are gone?

3.2 Additionality

The GFF has almost certainly raised more funds for RMNCAH+N. These are funds raised through concessional financing, through grant funding from the (relatively modest) GFF Trust Fund, and to a modest extent, from re-alignment of donor funding. In addition, there is potential in some GFF partner countries to maintain or increase government commitments to health as a direct result of GFF and World Bank engagement and negotiation (Nigeria, Mozambique). The recently launched World Bank Treasury bond will very likely raise additional funds for RMNCAH as well. Innovative funding modalities, supported specifically by DFID through the GFF as well as Merck for Mothers, could lead to concrete additionality in a number of ways but also to improved quality, efficiency gains in service delivery and examples of contracting. Through supporting more efficient health spending in the short run in very challenging and fragile settings, the additionality component of the GFF should be assessed as a non-purely financial and short-term one but rather as a critical building block towards more additional and sustainable resources mobilisation for better health outcomes.

Beyond financing, there appears to have been potential gains made around improved planning and tighter prioritisation of activities and investments out of existing Health Sector and/or RMNCAH plans. Some specific programming is aimed at reaching vulnerable and underserved areas (such as in Guinea and Cameroon, for example). In some GFF countries – Nigeria being a good example – the potential systems reforms in primary health care could be far reaching (it is too soon to tell). However, this is much more in the future. The GFF does not yet have an objective results framework or monitoring process and without that, assessing additionality is an imprecise process.

The GFF works with and through the World Bank. The symbiotic relationship between the GFF and the World Bank is a strength and is certainly considered by many to be an important dimension of the unique offer that the GFF makes to countries. However, at country level especially, the GFF effort is largely cantilevered through World Bank staff over whom, the GFF Secretariat and its partners have little direct influence. The extent to which the GFF will achieve results and additionality in countries will be determined in some part, by the motivation and capacity of the World Bank staff to engage with the process, including equally important actions such as supporting government officials at the Ministries of Health and Finance around policy formulation, contributing to donor alignment, and fostering investment in efficiency gains. The Strategy Note signed between the GFF and the World Bank team leaders is an important instrument to advance this process.

3.3 Effectiveness

Effectiveness is defined as the degree to which the GFF has been successful in producing preliminary results across its theory of change and through effective donor cooperation (EDC) principles. As summarised above, there has been discernable progress in a number of countries especially measured in terms of additional RMNCAH financing *approved* (GFF grants and IDA/ IBRD financing). Investment cases are prepared in the majority of countries and learning from first and second wave countries is being applied effectively. Engagement of CSOs has strengthened over time and there are promising developments in engaging private sector financing, service delivery and support. There are a wide range of health systems and public financial management strengthening activities underway in many GFF countries.

GFF alignment with national health strategies and plans has been generally well perceived overall. The GFF has joined existing mechanisms and processes where these exist and in some countries, has channelled its resources through national pooled funds. On balance, the GFF approach has been to support national processes.

On the other hand, **there is evidence of uneven performance especially around coordination, communication and aspects of partnership building that collectively highlight how challenging it is to build effective cooperation within and between organisations.** For example, GFF coordination and communications at country level have not (yet) been seen as fully effective. There is evidence of uneven performance around fostering and growing partnerships and engendering cooperation (especially with development partners who do not directly fund country activities through the GFF Trust Fund). Communications have been reported to be inconsistent and patchy with some development partners feeling excluded and others feeling misrepresented. Furthermore, there does seem to be a discrepancy between the range of activities the GFF is implementing, its level of engagement with some government partners, and its outward communications and inclusion of other partners.

There is limited flexibility in the procedures and rules used by the GFF (as a World Bank hosted organisation) with regard to financial management of funds. Above all, this has implications for partnerships with other major global spending agencies if they aim to join forces on the ground or work in an increasingly integrated way.

In countries with well-established aid coordination processes such as Tanzania and Ethiopia, the GFF was seen by other development actors as a new partner, more or less similar to other partners. They joined the pooled funds, slotted into health partner dialogue fora and, in the experience of some partners in those countries, the GFF appeared to function like other partners. In these kinds of environments, the value of the GFF rests with leveraging additional funds including domestic resources, reducing fragmentation, increasing efficiency and strengthening heath financing policy among others. In contexts with weak aid coordination environments, there were a range of other experiences. In Mozambique, for example, the GFF has been identified as creating a (largely positive) alternative to the existing pooled fund that has lost support in recent years as a result of a corruption and other fiduciary problems. Whether the process can now progress to harmonise some of the six funding mechanisms for health will be an important test of EDC commitment. In Liberia, as in Guinea, many key informants (although not all) considered that the GFF has been an important force for improving and strengthening coordination and supporting the Ministry of Health to convene partners.

In institutionalising its governance arrangements, the GFF Secretariat will most likely continually revisit each component in order to improve effectiveness. The results of this appraisal suggest that at the country level, the GFF platform is not fully understood and

the way it operates may not (yet) reflect optimal effectiveness. There is confusion about the GFF Trust Fund, GFF partnership and GFF platform and what each is or does, where decisions are taken and how. In many countries, the roles and responsibilities of different partners **with respect to accelerating RMNCAH+N** are either not clearly articulated and agreed, or are not clearly communicated.

At the global level, the GFF has not yet identified the best way to maximise the value of having every major RMNCAH+N global player in a room together with such regularity. The Investors' Group appears to be more focused on information sharing about the GFF and less on strategic agenda setting across RMNCAH. By making the group meetings too focused on the GFF itself, too one directional in terms of providing information to group members, and not interactive or strategic enough, there is a risk that the Investors' Group will squander the value of its high level attendance. Ideally, the Investors' Group would either adopt a meaningful governance role in relation to the GFF funding processes (currently the responsibility of the GFF Trust Fund Committee) or it should become a forum to drive RMNCAH priorities, strengthen private sector and CSO engagement, increase integration at country level, and support broad GFF objectives including meaningful partnerships at country level, domestic resource mobilisation, and efficiency.

The GFF is scaling up its investment in monitoring and evaluation of its activities, but it would also be important to communicate its approach more proactively as part of a broader development partner and country effort to develop sound health information and monitoring systems and to track its own value added where possible. Based on concerns expressed by some, the GFF needs to demonstrate clearly that it avoids parallel indicators or tracking systems and supports in a strategic and collaborative manner the long-term and yet critical development of HMIS in all supported countries.

There are methodological issues to think through (preferably with partners) around contribution analysis. The GFF is operationalising its global results framework which will make it more feasible to estimate the cumulative impact of the GFF. Working more collaboratively with other health systems strengthening platforms and capacity building networks (P4H and UHC2030 for example) would support GFF efforts and better ensure steamlined approaches to information management and monitoring.

3.4 Risks and forward look

The GFF has two years of very intensive experience from which it has derived some lessons and could extract more many of which have been highlighted in Box B. When asked, key informants raised a couple of risks as well and these centre on three principle areas: Partnerships, sustainability and a failure to be catalytic (business as usual).

The GFF model relies heavily on **partnerships**. It is clear from the analysis that the role of partnerships in many different country contexts and globally is critical to success. The GFF (and the World Bank, through which the GFF operates) need to invest heavily in building and maintaining partnerships not just with governments but with other actors at both global and country level. Improving and deepening its capacity, motivation and incentives to nurture partnerships will be fundamental to success.

The GFF operates slightly differently in each country as one of its strengths is to have the flexibility to respond to the individual country needs and opportunities. Identifying and communicating the contribution of the GFF in shifting and evolving contexts is one component of building partnerships. GFF contribution analysis is always going to be challenging but being open about assumptions, calculations, country specific estimates and so on will help offset concerns about transparency.

The GFF could create a parallel track for health systems reform or it could become a force that brings parallel initiatives together. P4H, UHC-P under the UHC2030 partnership, H6 technical support are examples of processes, and partners, that share similar objectives but are not fully aligned. This inadvertent fragmentation would be an expression of poor harmonization (not entirely the responsibility of the GFF).

There are a set of risks related to **sustainability**. Where the quality improvements in health systems are driven by RBF modalities, the financing for this model needs to be fully absorbed into country budgets and financial management systems. While they remain funded by GFF grant funds, or even through concessional financing, there is a risk to sustainability when that external funding ends.

The processes supported by the GFF – health systems strengthening, improvements in financial management, allocative, management and technical efficiency gains – fundamentally require country ownership that is both deep and broad (to a greater or lesser extent). The capacity needs that underpin this are a huge challenge in many countries and the GFF will need to address (and measure, monitor and evaluate) this major barrier if it is to drive long-term progress.

In addition, moving too fast and pushing too hard for rapid results in order to meet the perceived needs of investors creates a risk in the medium term to sustainability and to the value of the approach itself. Spreading to too many new countries too quickly, likewise, risks over-stretching GFF technical resources.

Finally, there is a real risk that the GFF will settle into becoming **a partner like any other** (business as usual) and will be unable to “light the spark” that significantly transforms domestic engagement with long-term reform, commitment to mobilizing more resources for health, particularly RMNCAH+N, and accelerates health systems strengthening in the context of an advancing national commitment to UHC.

4. RECOMMENDATIONS

If the GFF can deliver its objectives, it would transform the health system and significantly improve the prospects for women, children and adolescents in its partner countries. Building new institutions or systems is challenging and the process is rarely linear especially where the approach requires the laying out of whole new pathway simultaneously across several policy tracks. The GFF has already shown that it is a learning organisation in many respects and it is adapting its approach based on experience. The evidence and feedback from over 60 key informants formed the basis of this appraisal and based on the analysis of that evidence, a number of recommendations are set out below. Together, these recommendations aim to strengthen the profile and performance of the GFF to help enable it and its partners and prospective partners to achieve an ambitious agenda.

Governance:

1. **Make sure the Investors' Group functions as a high level, consultative and dynamic forum**: Consider how to maximise the value and impact of the Investors' Group, not just for GFF governance but for the opportunities created by the Investors' Group to forge stronger alliances and harmonisation among major global health partners, notably the three main global health initiatives (3Gs) and the H6. Consultations with partners would be a sound place to start followed by an independent evaluation.

Partnerships:

2. The GFF should continue to take proactive steps to **develop a stronger partnership with the WHO**, and other H6 agencies, and continue building alignment with **GAVI** and the **Global Fund**. If country governments are really going to benefit from partner alignment, they need to also get one set of harmonised policy advice especially on issues as technical (and critical) as health financing strategies, public expenditure management and health management systems.

3. Linked to this, formalise partnerships with the main UHC and health financing partners and associated capacity building support networks. The two networks, P4H and UHC2030 (UHC-P) should be engaged more formally with the GFF possibly even participating in the Investors' Group as full members or observers, in order to streamline country facing efforts to embed RMNCAH+N in UHC plans. Although the Investors' Group should not be limitlessly expanded, given the central role of health financing and UHC in the GFF, it makes sense to include the main networks linked to UHC as they also work in GFF countries and have the same government counterparts as the GFF.

Communications:

4. **Invest in better and more transparent communications**: The GFF Secretariat should strengthen its approach to and consistency in public facing communications including communications with partners a number of ways:

    d. Take action to make the website more accessible and better organised and maintained up to date. The websites of other GHIs offer many lessons and ideas on structure, organisation, content, accessibility, and so on.
    e. Publish a clear and comprehensive summary of how GFF targets are developed (38m lives saved) and the methodology used to estimate such targets, the impact of contributions from partners (which contributions from which partners) and the GFF support received in country.

f. Consider developing a simpler language style (plain English) and use less jargon, fewer acronyms and clearer terminology, ensuring a suitable and consistent distinction is made between communication (fact-based communication about programme implementation, deliverables, results) on the one hand and advocacy on the other hand.
g. Produce a lessons learned summary regularly and identify ways that the GFF responds to learning.

Capacity building and technical support:

5. **The need for a more consistent country presence**: Government officials in partner countries tend to feel very positively about the GFF, particularly the leadership they have over the design of GFF Trust Fund resources and the support given to strengthen coordination among health sector partners. The GFF has introduced a new country-based cadre (the GFF Liaison Officer) based in the MOH with a TOR to reinforce government focal points. They have a very large brief. The GFF should take steps to provide backstopping support to GFF Liaison Officers and to undertake formal performance monitoring, supervision, and capacity building support to them.

6. **Support a process aimed at more clearly defining roles and responsibilities** in making the case for RMNCAH+N in health systems strengthening especially among technical agencies (such as the H6) and other health systems platforms, including to continue dialogue at global and country levels, avoid duplication and overlap, and streamline technical assistance on all aspects of RMNCAH+N particularly in the context of UHC**.**

Extending reach:

7. **Consider the pace of country expansion**: Despite considerable demand from countries, the GFF should ensure it achieves a sound level of depth and breadth in its delivery model, taking care to expand only as quickly as it is capable to guarantee a minimum quality of partnership and technical support, given the size of the Secretariat and the extent to which delivery works through others. The GFF 'offer' is to support a complex set of reforms that involve multiple government departments, at national and sub-national level, and a wide range of partners. Each country is different from the others. The risk of the GFF narrowing its ambition and scope to become primarily concerned with implementing World Bank concessional finance and GFF Trust Fund grants is probably increased as the number of countries expands especially if the capacity and incentives or motivation to work differently is not fully rolled out among World Bank staff. The GFF should thus prioritise "doing it right" over "doing it everywhere".

8. **Private Sector Engagement needs additional resources:** Despite the interesting start made in countries like Ethiopia and Cameroon or at global level, the GFF should **consider investing in more capacity to support the private sector work**, especially at country level. The private sector work of the GFF is progressing but very slowly. What constitutes the private sector includes a very broad range of options (with highly differentiated prospects for capacity, impact, sectoral development and so on) ranging from raising funds from private investors globally (the Treasury Bond), procurement and supply chain specialists (and other corollary services) globally and/ or at country level, health care service delivery providers (both small scale, informal type and large, modern, urban clinics), and country focused financing mechanisms to name a few. Many GFF countries haven't even started engaging with the private sector (such as Mozambique).

9. **Civil society participation should be boosted through additional capacity building support:** Partners to the GFF (whether they are GFF funders or not) should

ensure that CSOs are fully included in the GFF processes and might consider supporting the CSO platform hosted by the Partnership for Maternal, Newborn and Child Health that provides advocacy training, capacity building and other forms of support to CSOs. Harmonising the several CSO platforms that currently co-exist may reduce costs and improve outcomes.

10. Monitoring & Evaluation, Learning and Knowledge (MELK)

There is a discrepancy between the work that the GFF is undertaking, its progress and partnership arrangements to pursue this work and the perception, communication and engagement of the broader RMNCAH community especially at country level. The GFF should take steps to address this discrepancy:

a. Identify the GFF Monitoring & Evaluation, Lesson learning and Knowledge (MELK) strategy more clearly to reflect the significant work that GFF is already undertaking and to build partner confidence and opportunity for consultation on the approach.
b. Be transparent and open about operating assumptions used to calculate critical GFF monitoring and performance indicator data. For example, what is included in 38m lives saved, which partners' contributions are included/ excluded in resource availability at country level ('leveraging' graphics)?
c. Develop a clear policy and process around contribution analysis in terms of the performance framework and include measures of effective donor cooperation (EDC) as well as outcome and impact results.

11. The GFF's support to Health Management Information Systems

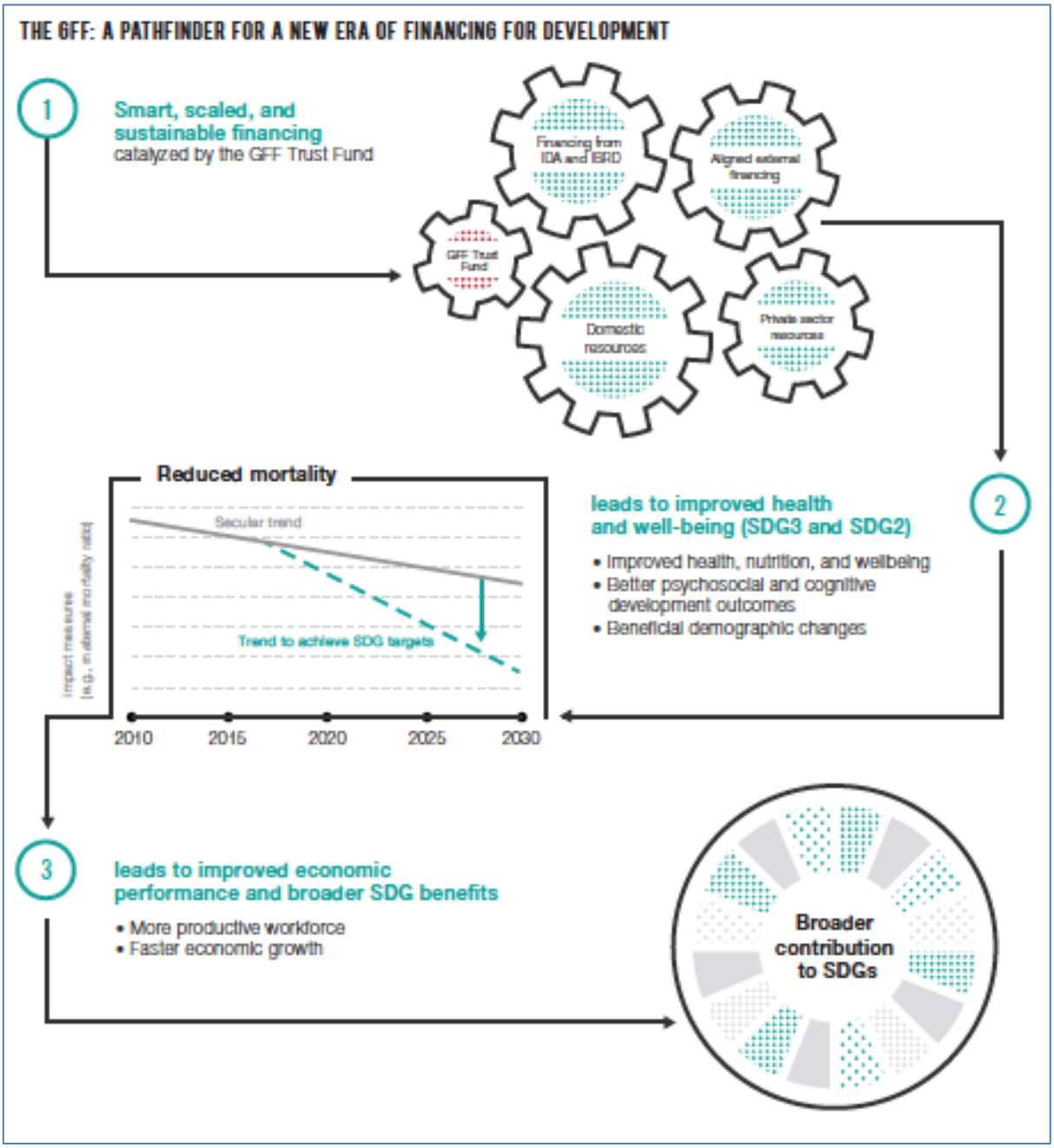
a. Set out a clear plan to engage with other partners to support governments to develop/ strengthen their HMIS systems (or make current plans more easily accessible). Most countries are implementing the DHIS2 with support from a range of partners including H6 and other GHIs. The GFF should be open and clear about its approach to HMIS and communicate how and where it supports information management systems, data collection and analysis and how it uses data. Papers presented to the Investors' Group with relevant plans, performance reviews and progress updates should be made easily accessible (for example, posted on the website).

5. ANNEXES

Annex 1 - A SHORT DESCRIPTION OF THE GFF

The Global Financing Facility is mechanism to building sustainable financing for RMNCAH. The GFF theory of change takes a multi-staged approach to support national governments to lead a process that includes (1) government-led planning for RMNCAH+N priorities through the development of a Costed Investment Plan; (2) increasing domestic and other funding to support the costed plan implementation and (3) addressing wider macroeconomic and systems barriers to build longer-term systems strengthening (including through the advancement of universal health coverage). Figure 1 shows the theory of change as set out currently by the GFF in its replenishment documents.

Figure 1: GFF Theory of Change



Source: GFF First Replenishment Document, The Global Financing Facility, World Bank, Washington DC (p.7).

The theory of change anticipates a number of workstreams that will be given more thrust as a result of the GFF platform. At the country level, these include:

- Increased **domestic financing** commitments through the allocation of more public resources or from specific ear-marked taxes, or other means determined by ministries of finance;
- **Loans financed through IDA/ IBRD** (the World Bank Group determines the allocation of the IDA/IBRD financing);
- An additional **grant from the GFF Trust Fund** determined by the size of the WB loan and by the available resources in the GFF Trust Fund;
- Aligned **external partner funding** from bilateral agencies, private foundations and other sources as agreed through a coordinated process in-country;
- **Engaging private sector partner support** which may be in-kind or additional financing; and
- **Civil Society** engagement and support.

It is the combination – synergistic value – of progress in each of these areas that drives the delivery of improved outcomes and ultimately contributes to impact.

GFF Results Targets

The GFF makes the case that it is uniquely placed to address some of the main obstacles to making progress on women's children's and adolescents' health specifically because of the World Bank's ability to straddle both sector-based challenges and macro-economic and public expenditure management issues, making outcomes for women and children a concern for (and of) ministries of finance. The GFF replenishment material refers to two overarching results:

a. Health returns: measured in terms of lives saved and improved health, nutrition, and well-being of women, children, and adolescents, with a particular focus on the relevant targets of SDGs 2, 3 and 5, by 2030:

- Reducing maternal mortality ratio to less than 70 per 100,000 live births,
- Reducing under five mortality rate to at least as low as 25 per 1,000 live births,
- Reducing neonatal mortality rate to at least as low as 12 per 1,000 live births,
- Ensuring universal access to sexual and reproductive health services,
- Achieving universal health coverage,
- Achieving internationally agreed targets for stunting and wasting.

b. Economic and Social returns: from the investment in human capital, which both leads to a more productive workforce and improved economic performance (contributing to realizing benefits of the demographic dividend) and to broader benefits to support the achievement of SDG targets, as a healthy population is a precondition to achieving progress in many other areas.

To contribute to these overarching results, the GFF aims to encourage more efficient use of existing funds (invest in priorities), reach out widely to achieve universal access, especially by those most in need and create an environment that is increasingly sustainable (demonstrable through increased domestic financing commitment and executed spending).

The GFF has explicit results targets in individual countries with regard to non-health results such as health systems reforms, larger public expenditure management improvements, private sector engagement and so on.

Thematic areas covered

The GFF is multi-sectoral in scope as long as results contribute to the delivery of the targeted results set out in section 2.1. To qualify for a GFF Trust Fund grant, countries can use their IDA/IBRD loans and domestic resources to support targeted investments in a range of sectors including nutrition, education, social protection and even climate change. Examples given by the World Bank include:

- Adolescent sexual and reproductive health in schools (or targeted to keep girls in school)
- Cash transfers for adolescent girls
- Household food security linked to health for women and children
- Hygiene promotion and latrines

Governance and operational arrangements

The GFF secretariat (around 25 staff) and the GFF Trust Fund are situated at the World Bank Headquarters in Washington DC. The GFF Trust Fund is governed by the **Trust Fund Committee** which supervises the trust fund and approves the disbursement of funds from it. The Committee is made up of the World Bank and the main development partners who contribute to the Trust Fund which are Norway, Canada, the Bill and Melinda Gates Foundation (BMGF) Japan, and the UK. Ostensibly, there is a USD 30m entry threshold to participate in the Committee.

The broader GFF platform is governed by an **Investors' Group** which aims to mobilize the resources and institutional commitment of key investors in RMNCAH required at the global and regional level to optimally support efficient collective action at the country level. The Group has a constituency-based make-up that is comprised of (1) all development partners that contribute to the Trust Fund, (2) partner countries, (3) civil society organisations, (4) UN partners (5) private sector groups, (6) global health funds and RMNCAH coordinating partners.

1. **Development partners**: All development partners are invited to sit on the Investors' Group. Other bilateral partners include the United States as a founding member. The US does not contribute directly to the GFF but aligns its contribution with it. Development partners supporting the GFF can channel support at the global level to the GFF Trust Fund housed in the World Bank and governed broadly by an Investors Group[22] or they can also channel resources at country level to support GFF aligned activities and investments. For example, in Nigeria, the BMGF reportedly added an additional USD2m to a locally held pooled fund to finance PBF in three pilot states primarily funded by a tranche from the GFF Trust Fund.

2. **Four country partners** have seats which rotate regularly. Seats are currently filled by Ethiopia, Kenya, Liberia and Senegal.

3. **Private sector partners** include Merck for Mothers, Phillips, and Abt Associates. Merck for Mothers has also invested USD 10 million in the GFF Trust Fund.

4. **Civil society organizations** have been very active, developing a CSO platform specifically to support engagement with the GFF. The platform is hosted by the Partnership for Maternal, Newborn and Child Health (PMNCH). CSO representation in the Investors' Group currently includes regional and global CSOs: the African Health Budget Network (based in Nigeria), JHPIEGO[23], and Plan International. The CSO constituency also includes a youth representative.

5. **UN Partners**: To support its role in strengthening global RMNCAH coordination, the Office of the UN Secretary-General (Every Woman Every Child), UNICEF, UNFPA and WHO are represented.

6. **Major Global Health funds and RMNCAH coordinating partners**: The major global health partners and health funds participate in the Investors' Group to advance the GFF aim to strengthen health development coordination and coherence at a global level. The seats are currently filled by Gavi, the Vaccine Alliance (Gavi), the Global Fund to Fight AIDS, TB and Malaria (the Global Fund), and the Partnership for Maternal, Newborn, and Child Health (PMNCH).

7. Foundations: Gates Foundation

ELIGIBLE COUNTRIES

[22] Immediate oversight of the GFF Trust Fund is by a Trust Fund Committee (World Bank and development partners to the Trust Fund) while governance of the larger GFF processes and of country engagement is done by the Investors' Group.
[23] An international, non-profit health organization affiliated to Johns Hopkins University and which has worked in over 155 countries for 40 years.

There are 67 countries eligible for financing through the GFF Trust Fund. These are the Countdown to 2030 countries[24] (minus the Democratic People's Republic of Korea which is not currently eligible for World Bank loans). As a group, these countries account for the majority of the global RMNCAH+N burden and are all low or lower-middle income countries. In the two years since it became operational, the GFF has extended its approach from four to sixteen countries with another ten announced in November 2017. The four front runner countries were DRC, Tanzania, Kenya and Ethiopia and they are furthest along the process. Second and subsequent waves included Bangladesh, Cameroon, Guatemala, Guinea, Liberia, Mozambique, Myanmar, Nigeria, Senegal, Sierra Leone, Uganda, and Vietnam. Afghanistan, Burkina Faso and eight other countries were approved as GFF countries in November 2017.

GFF APPROACH AT COUNTRY LEVEL

The GFF focuses its work at country level, by encouraging the establishment of a government-led, multi-sectoral platform rallying all relevant stakeholders to develop a country-led and costed Investment Case (IC) for RMNCAH fully aligned to the national health strategy. The national endorsement of this Investment Case is expected to lead to grant allocations from GFF Trust Fund, and linked IDA/IBRD grants or concessional loans. Concurrently, the GFF is providing assistance for the development of long-term plans for sustainable financing for the entire health sector. Performance-based financing is an important modality (although not used in every country). The GFF highlights its good collaboration with the Global Fund and GAVI in various countries around commodities, pooling of resources and use of joint platforms.

The GFF is being implemented in 16 'frontrunner' countries[25], has expanded to 10 additional countries[26] as of November 2017, and to a total of 50 countries in the next 4-5 years. As of March 2018, the GFF Trust Fund had granted 13 projects in 11 countries. In June 2018, approved financing was US$ 2.586 billion in IDA and US$ 500m IDRB grants or concessional loans.

LINKS TO PERFORMANCE-BASED FUNDING (PBF)

The GFF multi-donor trust fund has drawn on experience gained elsewhere in the World Bank including the Health Results Innovation Trust Fund[27] (the HRITF) which centres on performance-based funding (PBF) or results-based funding (RBF) as a modality to improve the performance and quality of health service delivery for women's and children's health. Although the GFF is much more than PBF/ RBF or indeed any individual financing modality, the experience gained in the HRITF continues to be relevant.

Several GFF funded programmes use PBF/ RBF approaches. A recently published mid-term evaluation[28] of the HRITF evidence shows mixed results. RBF worked well particularly in the short term, in relation to incentivising health workers and managers in many environments especially in fragmented and poorly managed health systems (for example, in Nigeria and Sierra Leone) but it has suffered from challenges to integrate the financing in government budgets. In Sierra Leone, once the externally funded PBF programme stopped, the significant benefits and systems improvements that had been achieved began to fall away almost immediately.[29] In Zimbabwe, the RBF program significantly increased coverage of maternal and child health services and quality of care, but had no impact on the availability of medicines, supplies and equipment[30]. However, it did lead to improved monitoring, reporting and information management in most countries. Despite the short-term results seen in some contexts therefore, there are a number of concerns arising about the use of PBF modalities to spearhead health systems strengthening (HSS)[31]. More broadly, there are a range of

[24] Countdown to 2030 (www.countdown2030.org) works to build RMNCAH visibility and momentum for RMNCAH results. Countdown to 2030 tracks progress in the countries that account for more than 90% of under-five child deaths and 95% of maternal deaths in the world.
[25] Bangladesh, Cameroon, DRC, Ethiopia, Guatemala, Guinea, Kenya, Liberia, Mozambique, Myanmar, Nigeria, Senegal, Sierra Leaone, Tanzania, Uganda and Vietnam
[26] Afghanistan, Burkina Faso, Cambodia, CAR, Cote d'Ivoire, Haiti, Indonesia, Madagascar, Malawi and Rwanda
[27] The programme, funded by Norway and the UK, is now called "RBF Health" http://www.rbfhealth.org
[28] Health Results Innovation Trust Fund: Mid Term Review Final Report, IOD Ltd, Sheffield, UK April 2018.
[29] Anecdotal evidence based on interviews with World Bank and DFID health teams in Freetown, February 2018.
[30] RBF results evaluation in Zimbabwe: http://www.rbfhealth.org/impact-evaluation/zimbabwe-impact-evaluation
[31] See, for example, Paul, E., Albert, L., et al. "Performance-based financing in low-income and middle-income countries: isn't it time for a rethink?" BMJ Glob Health. 2018 Jan 13;3(1):e000664. doi: 10.1136/bmjgh-2017-000664. eCollection 2018.

difficulties in measuring RBF outcomes, related to data management systems, quality standards, and others[32].

ROLE OF THE UN FAMILY

The UN health agencies form a group called the **H6** and include UNICEF, WHO, UNFPA, UNAIDS, UN WOMEN and the World Bank. In the context of the Global RMNCAH+N Strategy 2.0, the H6 has been given the role to provide technical support to countries under government leadership. The UN agencies have individual seats on the investors group and collaboration on country level as part of the country platform has improved over time. Discussions are ongoing how the agencies (individually or collectively as the H6) take this role forward in support of the GFF. This is particularly relevant in relation to specific components of the RMNCAH agenda including, for example, family planning and reproductive health (UNFPA), health financing and UHC (WHO).

GFF INVESTMENTS TO DATE AND REPLENISHMENT CALL

The GFF Trust Fund received US$ 582 million from Norway, Canada, Bill & Melinda Gates Foundation, Japan, Denmark, the UK and Merck for Mothers. It now seeks to raise US$ 2 billion "to respond to demand from a total of 50 countries most in need over the period 2018-2023". Since the replenishment launch at UNGA in September 2017, pledges worth US$ 234 million have been made by the Bill and Melinda Gates Foundation, Denmark, and Japan.

The GFF was presented at the UHC Forum in Tokyo in December 2017 and at the World Economic Forum in Davos 24 January 2018. Lobbying events are now scheduled at the IMF/WBG Autumn meetings in Bali, the UNGA in September, the WHO Global Health Summit in October before a final pledging event scheduled in November 2018.

[32] See the final report of the 2011 OECD-hosted Task team on health as a tracer sector to assess aid effectiveness in health.
https://www.uhc2030.org/fileadmin/uploads/ihp/Documents/Results___Evidence/HAE__results___lessons/TTAT%20Report%20aid%20effectiveness_Eng.pdf

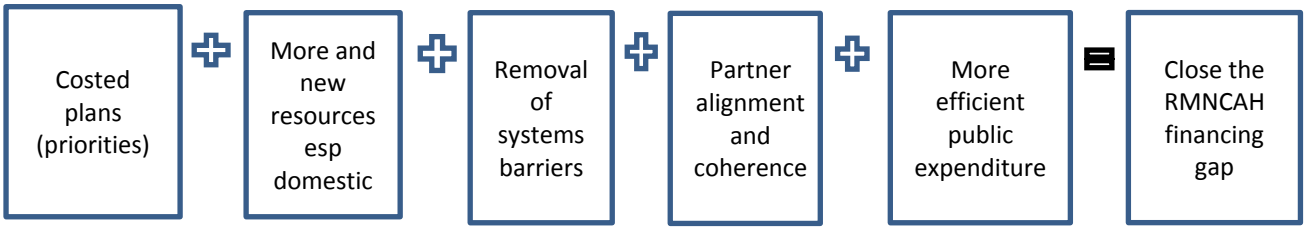
Annex 2 - METHODOLOGY FOR THE GFF STUDY

A study will be undertaken to assess progress, additionality and effectiveness in the experience of implementing the GFF in its first two years.

The GFF theory of change, set out in its first replenishment document and summarised in Figure 1, identifies a series of GFF supported actions that will combine to deliver "*improved health and well-being*" which in turn will lead "*to improved economic performance and broader SDG benefits*". The GFF theory of change will be used as the basis of the study's framework for data collection and analysis.

The study methodology will be based on qualitative evidence gathered through semi-structured questionnaires. Interviews will be conducted with partners at the global level, the Global Financing Facility/ World Bank and with key informants in eight countries.

Figure 1: GFF simplified theory of change:



Country selection (Annex A):
Countries selected for the study will, together, include the following characteristics:

- Anglophone, Francophone, and Lusophone countries
- Some countries with fragile contexts or conflict settings
- At different stages of GFF implementation
- Countries at different economic development stages if possible

The agreed list of countries to be studied include: Cameroon, Democratic Republic of Congo, Ethiopia, Guinea, Liberia, Nigeria, Mozambique, and Tanzania. However, an effort to include some experience from other countries if possible.

Key informants: Countries
In each country, between four to eight key informant interviews will be done including with:

- Government officials linked to the GFF (both ministry of health and finance)
- The EUD health officer (where there is one)
- Major development partners and the development partner coordinator where applicable
- The GFF focal point
- World Bank officials
- The NGO coordinator linked to the GFF and other CSOs as relevant.
- The main private sector partner (if there is one)

Key informants: Global level
Among global partners, interviews will be sought with

- The GFF Secretariat staff to the extent possible
- Investors' Group and GFF Trust Fund members
- Bilateral donors including among member states
- The main GFF sponsors including USAID, the Bill and Melinda Gates Foundation
- Main global health partners and The Global Fund, GAVI, and others to be determined.

Structure of the interviews
Interviews will loosely follow a similar structure exploring the progress made in relation to each element of the theory of change, the perceived additionality, and effectiveness of the GFF. Drawing on the evidence and experience emerging from this rapid review, a number of additional themes will also be explored including the role of the UN family, links to UHC, the influence on health systems development, national ownership and leadership, coordination and harmonisation, learning, results tracking and monitoring, and larger macroeconomic issues.

Timing for the study:
The timeframe will be six weeks from May 1st. It is expected that the interviews will be largely conducted in May. The first draft will be available by 18th of June.

Limitations:
A number of limitations are important to note. Only eight countries will be studied although the GFF is currently operating in 16, expanding to 26 countries. Although every effort will be made to conduct a full set of eight interviews in each country, time is short and the availability of key informants is unpredictable. A minimum of four interviews will be considered a "quorum" for each country.

Interview questionnaire
Interviews varied depending on the key informant and the time available. Questions were drawn for the following:

Global:
1. What role does the Investors' Group play to support progress in countries while supporting the Aid/EDC principles?
2. Does the coordination of the GFF at a global level translate into more coherence or alignment among the major global health partners?
3. What is the role played by the UN Family through the GFF governance and operational arrangements?
4. How does the GFF collect and benefit from initial lessons learned from country-level activities and from other global health partnerships (including IHP+)?
5. Are there plans that with more country benefiting from the GFF, the governance will change? Will there be impact on staff or on membership?
6. How has the GFF engaged the private sector? What are the main benefits (so far or expected) from private sector engagement?
7. How does accountability work ? Is the GFF reporting regularly to the WB Board? To other constituencies?
8. How do the Investors' Group and other governance groups function? What is their purpose and how do they contribute to and shape the GFF?

Questions at the country level

1. Please **describe the GFF in your country** (when it began, how it is progressing, key milestones). How is the GFF presented and/ or represented in your country?
2. **Before the GFF**, was there a national strategy, a RMNCAH investment plan or other sector strategy around which health partners coordinated their investments? How has the GFF incorporated this plan?
3. Did the GFF begin with a **Costed Implementation Plan** development process? Describe your engagement with this process? What was your role? Who led the process? What technical assistance was available? Does the plan include the existing priorities and commitments of government, development partners and UN actors (for example, family planning)?

4. **If the interviewee is an external partner**, a question on GFF-related coordination: How does this work? How are you engaged in GFF coordination? Are your investments aligned with the Costed Implementation Plan? Are you actively adjusting your portfolio to coordinate with the GFF?
5. **Role of the UN family**: Where does technical support for GFF related processes come from? For example, how was the costed implementation plan developed? Has the UN family been assigned a specific role? To what extent do UN partners participate in GFF related processes? How are they involved in the drafting of costed implementation plans? And the implementation of plans?
6. **Public expenditure commitment and reform**: Have domestic allocations for health been increased? Have other public financing interventions (increasing tax revenue collection, levying sin taxes on alcohol or tobacco, etc.) or public expenditure management reforms been undertaken?
7. **How is the private sector engaged**? Can you provide concrete examples about the ways in which the private sector plays a material role in the GFF platform or process?
8. **How is civil society engaged in the process**? Can you provide examples? (If a CSO being interviewed: How has your engagement in the GFF affected your priorities and role in RMNCAH+N?)
9. **What does success look like** for the GFF? What is the **main risk or threat to success** for the GFF?
10. Do you have additional **comments or observations** to make regarding the GFF, its progress or any of the processes attached to it?

Annex 3 - LIST OF KEY INFORMANTS

First Name	Last Name	Post held	Organisation	Country
Laure	Albert	Policy officer	Cooperation Française	Cameroon
Mark	Allen	Director of Strategic Partnerships	Merck for Mothers	USA
Kyaw Myint	Aung	Health Director	UNICEF	Tanzania
Anthony	Ayeke	Health Adviser	European Union Delegation	Nigeria
Amy	Baker	Director General Health and Nutrition	Global Affairs Canada	Ottawa
Anshu	Banerjee	Director, Global Coordination, Office of the Assistant Director-General, Family, Women's and Children's Health	World Health Organisation	Geneva
Hélène	Barroy	Senior Health Financing Specialist	World Health Organisation	Geneva
Martina Lukong	Baye	National Programme Coordinator, Reduction of Maternal, Newborn and Child Mortality	Ministry of Health	Cameroon
Katri	Bertram	Civil Society Specialist	Global Financing Facility	Washington DC
Kimberley	Boer	Results and Data Specialist	Global Financing Facility	Washington DC
Maria Eugenia	Bonilla	Health Financing expert	Global Financing Facility	Washington DC
Michael	Borowitz	Chief Economist	Global Fund to fight AIDS, TB and Malaria	Geneva
Mickey	Chopra	Task Team Leader	World Bank Group	Washington DC and Afghanistan
Mariam	Claeson	Director	Global Financing Facility	Washington DC
Margaret	Cornelius	Senior Program Officer	Bill and Melinda Gates Foundation	Ethiopia
Humberto	Cossa	Health Specialist	World Bank Group	Maputo, Mozambique
Susna	De	Senior Program Officer, Health Systems Strengthening	Bill and Melinda Gates Foundation	Nigeria
Luc	de Laviolette	Country Programme Coordinator	World Bank Group	Washington DC
Frank	de Looij	Health Expert, Health and AIDS Division	Ministry of Foreign Affairs	The Netherlands
Hélène	Degui	Regional Health Adviser	Embassy of France	Democratic Republic of Congo
Annette	Dixon	Vice President, Human Development	World Bank Group	Washington DC
Prosper	Djguimde	Technical Adviser	World Health Organisation	Geneva
James	Droop	Senior Health Adviser	Department for International Development (DFID)	Uk
Leslie	Elder	Senior Nutrition Specialist and Vietnam Focal Point	World Bank Group	Washington DC
Chris	Elias	President, Global Development Program	Bill and Melinda Gates Foundation	Seattle, USA
Tim	Evans	Practice Leader, Health Nutrition and Population	World Bank Group	Washington DC

Paul	Fife	Director, Division for Health and AIDS	Norwegian Agency for Development Cooperation	Oslo, Norway
Banji	Filani	Senior Technical Adviser to the Minister of Health	Federal Ministry of Health	Nigeria
Matthew	Flumo	Adviser, Minister of Health	Ministry of Health	Liberia
Helga	Fogstad	Executive Director	Partnership for Maternal, Newborn and Child Health	Geneva
Jean Claude Taptue	Fotso	Health Specialist	World Bank Group	Cameroon
Meena	Gandhi	Health Adviser	Department for International Development (DFID)	UK
Marco	Gerritsen	Health Adviser	Dutch Embassy	Ethiopia
Mamadou	Grovagui	Project Coordinator	PASSP	Guinea
Paula	Hacopian	Senior Fund Portfolio Manager, West Africa Region	Global Fund to fight AIDS, TB and Malaria	Geneva
Branden	Hayes	Sexual and Reproductive Health Adviser and GFF Focal Point for Cameroon	Global Financing Facility, World Bank	Washington DC
Munirat	Iyabode	Health Adviser	World Bank Group	Monrovia, Liberia
Abdoulaye	Kaba	Head of Strategy and Development Office	Ministry of Health	Guinea
Hypolite	Kalambay	Senior Health Adviser	World Health Organisation	Geneva
Monique	Kamphuis	Counsellor, Head of Cooperation	Dutch Embassy	Maputo, Mozambique
Sneha	Kanneganti	Private Sector Specialist	Global Financing Facility	Washington DC
Marina	Karagianis	Director, Planning and Cooperation Department	Ministry of Health	Mozambique
Adebe	Kedebe	Executive Director	CORHA	Ethiopia
Victoria	Kellett	Policy adviser, Health and Nutrition	Global Affairs Canada	Ottawa
Adrien	Kisi	Programme Coordinator	PASA Programme (EU)	Guinea
Preeti	Kudesia	Senior Health Specialist	World Bank Group	Washington DC
Karolina	Lagiewka	Health Adviser	European Union Delegation	Guinea
Tete	Lincoln	Health Adviser	Irish Aid	Monrovia, Liberia
Lene	Lothe	Head of Global Health	Norwegian Agency for Development Cooperation	Oslo, Norway
Alain Mboko	Lyéti	Senior Technical Adviser to the Minister of Health	Ministry of Health	Democratic Republic of Congo
Shunsuke	Mabuchi	Task Team Leader	World Bank Group	formerly Monrovia, Liberia
Jacqueline	Mahon	Country Director	United Nations Family Planning Association	Tanzania
Viviana	Mangiaterra	GFF Focal Point	Global Fund to fight AIDS, TB and Malaria	Geneva
Kaat	Matthys	Deputy General Representative of the Government of Flanders: Development Cooperation	Embassy of Belgium	Mozambique

Candace	Maynard	Policy Officer, Health and Nutrition	Global Affairs Canada	Ottawa
Raphaela	Meli	Health Adviser	Swiss Development Cooperation	Maputo, Mozambique
Claude	Meyer	Network Coordinator	Partners for Health (P4H)	Geneva
Izzetta	Minko-Moreau	Health Director	USAID	Democratic Republic of Congo
Nuria	Molina	Senior Program Officer	Bill and Melinda Gates Foundation	Tanzania
Michel	Mulohwe-Mwana-Kasongo	Health Adviser	European Union Delegation	Democratic Republic of Congo
Angelina	Mutunga	Advocacy Adviser	Advance Family Planning, JHPIEGO	Nairobi, Kenya
Anne	Nicolay	Health Adviser	European Union Delegation	Democratic Republic of Congo
Ayoka	Ogunlayi	Health Policy Officer	World Bank Group	Monrovia, Liberia
Olumide	Okunola	Health Specialist	World Bank Group	Abuja, Nigeria
Ingvar	Olsen	Policy Director, Global Health	Norwegian Agency for Development Cooperation	Oslo, Norway
Denis	Pourignon	Health Policy Expert	World Health Organisation	Geneva
Carole	Presern	Head of Donor Relations	Global Fund to fight AIDS, TB and Malaria	Geneva
Matt	Price	Deputy Director, Health Investment & Policy	Last Mile Health	Liberia
Aparejeta	Ramakrishnan	Deputy Director, Donor Government Relations	Bill and Melinda Gates Foundation	Tanzania
James	Sale	Health and Financing Policy and Advocacy Officer	Save the Children UK	London, UK
Hadia	Samaha	Task Team Leader	World Bank Group	Washington DC and DRC
Miguel Angel	San Joaquin Polo	Senior Economist and GFF Focal Point	World Bank Group	Maputo, Mozambique
Ruth	Schumacher	Policy officer	GIZ/ Germany	Cameroon
Mirja	Sjoblom	GFF Focal Point	Global Financing Facility	Washington DC and Mozambique
Thomas	Teuscher	Health Adviser	Swiss Development Cooperation	Tanzania
Aye Aye	Thwin	Special Adviser	USAID	Washington DC
Gillian	Turner	Senior Health Adviser	Department for International Development (DFID)	UK
Christopher	Twiss	Nutrition and Financing Policy and Advocacy Officer	Save the Children UK	London, UK
Ellen	van de Poel	Economist and Guinea Focal Point	Global Financing Facility	Washington DC
Petra	Vergeer	MELK Coordinator and GFF focal point Tanzania (formerly Liberia focal point)	Global Financing Facility	Washington DC and Tanzania
Monique	Vledder	Practice Manager,	Global Financing Facility	Washington DC
Marijke	Wijnroks	Chief of Staff	Global Fund to fight AIDS, TB and Malaria	Geneva
Lamine	Yansane	Senior Technical Adviser to the Minister of Health	Ministry of Health	Guinea
Mesfin	Zbelo	Health Policy and Service Delivery Adviser	World Health Organisation	Liberia

Annex 4 - LIST OF DOCUMENTS CONSULTED

GFF documents published by the World Bank

A wide range of documents from across the GFF web page (https://www.globalfinancingfacility.org) linked to content, country progress, guidance, replenishment and so on.

Specifically:

A new financing model for the sustainable development goals era: The Global Financing Facility in support of Every Woman, Every Child, The World Bank, The first document in a series to be produced in support of replenishment 2017-2018. Washington D.C. https://www.globalfinancingfacility.org/sites/gff_new/files/First-GFF-Replenishment-Document_EN.PDF

Frequently asked questions, GFF Website, accessed April 5th 2018.

Investors' Group papers specifically from IG 5, IG 6 and IG 7 including updates on health financing, private sector working, civil society engagement, and others.

"The GFF's Contribution to domestic Resource mobilization for health and nutrition: Fact Sheet", the GFF, Washington DC, undated.

The Global Financing Facility Business Plan, 2015, The World Bank, Washington D.C.

Global Financing Facility (GFF) Country Consultations Fact Sheet: Lessons learned from GFF Frontrunner countries – Kenya and Tanzania, IPPF, AFP, RHSC, 2017.

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"Guidance Note: Investment Cases" Working Version, GFF Washington DC, Feb 2016,

"Maximising impact: How the GFF Trust Fund complements and adds value to IDA: Fact Sheet", the GFF, Washington DC, undated.

"Private Sector Engagement" The Global Financing Facility, Washington DC, March 2016.

"Universal Health Coverage: Fact Sheet", the GFF, Washington DC, undated.

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Africa Health Budget Network, "The Global Financing Facility: A brief Overview", 2016.

"Civil Society Organisations' Engagement with the Global Financing Facility in Nigeria: The Task Ahead", Commissioned by MamaYe-Evidence for Action (E4A), Nigeria, 2017.

European Commission, "The roots of democracy and sustainable development: Europe's engagement with Civil Society in external relations", Brussels, 2012.

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International Organisational Development Ltd., *Health Results Innovation Trust Fund: Mid Term Review,* Final Report, IOD Ltd, Sheffield, UK April 2018

The International Planned Parenthood Federation, "Taking Stock: IPPF Recommendations on the Global Financing Facility (GFF)" London, February 2018.

John Snow Inc "GFF: Advancing smartly means keeping an eye on Family Planning product and the supply chains that delivery them", *The Pump*, JSI, 6 April 2018.

Oxfam Briefing Paper, "Private finance blending for development: Risks and Opportunities", Oxfam, UK, February 2017.

Paul, E and Renmans, D "Performance-based financing in the heath sector in low- and middle-income countries: Is there anything whereof it may be said, see, this is new?" Int J Health Plann Manage. 2018 Jan;33(1):51-66. doi: 10.1002/hpm.2409. Epub 2017 Apr 6.

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PMNCH, "Consultations on updating the Global Strategy for Women's, Children's and Adolescents' Health: Perspectives on the Global Financing Facility", Partnership for Maternal, Newborn and Child Health, Geneva, December 2014.

S. Dennis, "*Civil Society Guide to the GFF*" Civil Society Coordinating Group of the GFF, PAI, 2017.

Sale, J., "*The GFF: Budding with potential, Yet to bloom*", Blog Post, April 20 2018, Save the Children Fund UK.

Save the Children Fund, "*The Global Financing Facility: An Opportunity to get it right*", Policy Briefing, April 2018, UK

Tichenor, Marlee, and Devi Sridhar. "Universal Health Coverage, Health Systems Strengthening, and the World Bank." *The BMJ* 358 (2017): j3347. *PMC*. Web. 12 Apr. 2018. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5594415/

The World Bank "What is IDA", World Bank, Washington DC, Accessed 19 April 2018.

World Bank Documents from the "RBF Health" Website that contain information about the HRITF programme, Results-Based Financing approaches and the evidence accumulated to date.

Annex 5 - GFF STATEMENT IN RESPONSE TO EC ASSESSMENT

July 3 2018

Introduction

We welcome the timely assessment commissioned by the European Commission of the GFF partnership to date. It adds important perspectives to the GFF learning at an important juncture of the GFF, as we move from the first three years of early design, introduction and implementation in countries, to the expansion phase to respond to the needs and mounting demand from countries to join the GFF. We appreciate the insights the report provides from the early stage of the GFF, based mainly on the perceptions and experiences of key stakeholders. This gives the GFF partnership the opportunity to reflect and make some important modifications to further strengthen the GFF approach and model at both country and global level.

As the report acknowledges, the GFF is taking on an ambitious development agenda with important shifts in how we view and approach financing for development. We recognize that such changes challenge the way the development community operated in the MDG era, but we see a strength in being a learning facility and we welcome the feedback and input to move forward in the SDG era which puts new requirements on all of us to get more value for money and more money to invest in people: human capital.

Among the many positive findings of the assessment – and one of the most important for the GFF -- is the strong support for, and engagement with, the GFF among government officials. They acknowledge the genuine difference the GFF is making in empowering Ministries of Health and Finance to identify their own country priorities and with financial and operational gaps. While recognizing the limitations of this study, predominantly the fast-paced process and narrow time constraint, the assessment could have benefited from more of those country voices (5/85 interviews) their perspectives and experiences are critical to the success of the GFF.

How the GFF are addressing the main recommendations

We are pleased with the many positive finding of the report, but would like to focus on how we address the author's suggestions for improvements in areas such as coordination, engagement of partners, communications and our expansion plans. We also would like to address questions on the governance of GFF, raised in the report. For detailed comments on how the GFF is addressing each recommendation highlighted in the report, see attached table.

1. Country Coordination

We agree with concerns outlined in the report around the coordination challenges at country level, and are committed to strengthening the role of the country platform. This is consistent with our learning from the first phase of GFF supported country processes and the actions we are taking to strengthen coordination among key partners at the country level. Firstly these include finalizing the ongoing recruitment of GFF liaison officers in each GFF country to support the government to improve communication with all partners. The aim is to improve inclusivity and coordination led by the government. This process will be completed by September 2018.

In parallel, a human resource review is taking place of the World Bank health staffing in country offices of GFF supported countries. Measures are being taken by the World Bank to ensure stronger country presence and to strengthen the country office capacities to support the in-country coordination of GFF processes led by the government.

Secondly, implementation guidelines are under development including a source book in consultation with technical partners (including H6, bilateral technical partners and iNGOs) which will make available relevant tools developed and tested by partners in the various technical areas. The success of the GFF approach depends on the collective responsibility all members of the partnership making their contributions. These guidelines will help to clarify the roles and responsibilities of the country platform; including GFF process during implementation and the role of technical agencies and other partners. This will be finalized in 2018.

Thirdly, as part of the expansion phase, the GFF Secretariat is reviewing the roles of the existing lead donors in new GFF supported countries, learning from best practices in several GFF countries where the donor consortium and the lead agency have played a very critical role in support of the GFF processes and deliverables. This is to draw lessons for how the lead donor(s) can play a more central role in coordinating support throughout the GFF design and implementation phase under the government leadership, in many more countries.

2. The GFF Partnership Model:

The assessment correctly states that the success of the GFF model relies heavily on partnerships at country and global levels.

At global level: The GFF is actively engaged with partners in several ongoing efforts to simplify the currently fragmented, and often duplicative, global health architecture while strengthening partnerships for greater effectiveness and efficiency in support of a more country centric development aid structure. This includes our engagement in the development of the action plan of the WHO led the *Global Action Plan for Healthy Lives and Well-being for All*; our membership in The *Partnership for Maternal Newborn Child Health* (PMNCH) and our financing role in support of the UN *Every Women Every Child* initiative. The GFF has a special relationship with the H6 agencies that were actively involved in the development of the GFF business plan, and UNICEF, UNFPA, WHO and the UNSG office all have separate seats on the GFF Investors Group. We have detailed collaboration work programs with each agency and regular technical and political level meetings around specific technical themes of shared interest (prioritization, implementation research, health financing, results, country alignment among others).

Supported by our donors, the GFF, Gavi, and Global Fund are striving to further strengthen our collaboration at the country level through different initiatives such as the “Intensified Collaboration among the Global Fund, Gavi, GFF, and the World Bank, more joint missions at country levels, especially identifying opportunities for co-financing, and joint transition financing. We participate in the UHC2030 working group on Sustainability and Transition, but we can do more and better partnering with P4H and UHC2030 and formalize these partnerships, to streamline country-facing efforts and embed RMNCHA+N in UHC plans.

Regarding the GFF Investors Group (IG), we agree fully with the assessment of the report that we can improve active engagement of all GFF Investors Group members for a global dialogue on priority issues, as well as forge strong alliances among the members to maximize the value for all partners. Per this recommendation, we propose to do a review of the IG to strengthen its strategic role and to better reflect the priorities and views of partners in line with the advisory role of the IG in the governance structure. We also see immediate opportunities to draw more on the expertise and to engage the IG members more in the preparation of IG themes to be discussed (e.g. on financing topics), in the lead on topics

explored at the IG meetings, and in the follow up. It should be noted that the GFF IG includes both Gavi and Global Fund, while the GFF is not represented on the Gavi and GF Boards. It may also be helpful to recognize that the GFF is not a member of the H6 since the GFF is not a UN agency, while the World Bank is part of the H6 family. These factors are important, since they further underline the point made in the assessment of the important function of the GFF Investors Group as a platform for global dialogue on strategic issues, in support of countries progress on RMNCAH-N.

The central focus of the GFF Investors Group is the experience and priorities for national governments, and this is a key element of the IG deliberations which we are committed to maintain.

At country level: We see a great opportunity in leveraging the country platforms and Investment Case processes for increased collaboration and alignment at country level. As recommended by the report, improving communication, information sharing, and transparency are central to strengthening the country platform and partnership. This is apparent in each stage and facet of the development of the Investment Case; from identifying and pursuing health financing reforms, to technical assistance by partners in the implementation phase. We will focus on addressing these challenges that have been consistently raised by some partners, especially donor partners, in GFF countries that have a strong presence but have not joined the GFF, and by H6 partners who have technical mandates that the GFF country platform can benefit more from. Through a concerted effort with partners we will finalize the implementation guidelines that outline roles and responsibilities of partners, and by resourcing the government (GFF) and the local presence in World Bank country offices, discussed above.

3. Extending the Reach

The expansion plan of the GFF has been developed to respond to the strong demand from countries with the greatest need, and to contribute to achievement of the SDG targets, which will not be reached without rapid scale up and accelerated progress on UHC within the next five years. Countries are not on a trajectory towards achieving the SDG 3 mortality reduction targets, and in view of this urgency for more countries to join the GFF, we are developing a phased expansion plan that draws on the learning and consolidates experiences in the current GFF countries while being responsive to the strong demand and the need for aaccelerated results.

The GFF plan is to limit the phased expansion to 50 of the 67 eligible countries over six years, where the need and magnitude of the problem is the largest, for these countries to benefit from of the window of opportunity for the period 2018-2023. The GFF is thereby slowing down the pace of expansion by 50% from expansion to 27 countries in 3 years (2015-2017), to expand to 23 in six years (2018-2023) balancing responsiveness to needs and inclusivity, with GFF Secretariat and partnership capacity.

In a continued effort to maintain transparency and follow a consultative process with our partners, we will present the proposals for expansion to the Investors Group (who developed the principles for country enrollment) before proceeding. The role of the private sector and civil society is key to achieve the GFF objectives and we will continue to work with them to support and strengthen the effective participation on country and global level.

4. Communication

Communication is a cross-cutting issue among all aspects of the GFF and we agree with the importance for transparency and clarity, which we will continue to strengthen by communicating more about GFF successes and challenges, promoting country-level progress, and highlighting the GFF partnership. The GFF will bring on board a specialist in country-level communications to empower countries to share their experiences with the

GFF, and to use communications to advance their work. Additionally, we will continue to scale up communications through the website—which is fully available in both English and French—social media channels and other communications vehicles. We are l placing a special emphasis on sharing stories of country progress, including through video, photos and stories from countries that have partnered with the GFF.

EC Assessment Recommendations and GFF Response July 3 2018

RECOMMENDATION	HOW THE GFF WILL ADDRESS THE RECOMMENDATION
Governance: *Make sure the Investors' Group functions as a high level, consultative and dynamic forum: Consider how to maximise the value and impact of the Investors' Group, not just for GFF governance but for the opportunities created by the Investors' Group to forge stronger alliances and harmonisation among major global health partners, notably the three main global health initiatives (3Gs) and the H6.*	▪ The GFF agrees that strengthening the role and engagement of Investors Group members would add value to the meetings and maximize partner coordination for greater impact in country. ▪ We will increase the active engagement of GFF IG members in the preparation of topics to be discussed at the GFF IG meetings, and also during meetings, providing more opportunities for all members to present, discuss and make recommendations on how to strengthen core functions of the GFF – DRM, Investment Cases, alignment of partners etc. ▪ We do strongly believe that the IG provide an important forum for country voices including from government leadership and civil society, and that discussions at the meetings have helped set country-driven GFF policies and have contributed to removing some GFF implementation bottlenecks at country level.
Partnerships: 1. *The GFF should continue to take proactive steps to develop a stronger partnership with the WHO, and other H6 agencies, and continue building alignment with GAVI and the Global Fund. If country governments are really going to benefit from partner alignment, they need to also get one set of harmonised policy advice especially on issues as technical (and critical) as health financing strategies, public expenditure management and health management systems.* 2. *Linked to this, formalise partnerships with the main UHC and health financing partners and associated capacity-building support networks. The two networks, P4H and UHC2030 (UHC-P), should somehow be engaged more formally with the GFF, possibly even participating in the Investors' Group as full members or observers, in order to streamline country-facing efforts to embed RMNCAH+N in UHC plans.*	▪ The GFF engages in regular discussions with Gavi, Global Fund, UNICEF, UNFPA and WHO, both at leadership level, as well as on a policy/technical level and in countries. The GFF sees a great opportunity in leveraging the country platforms and investment case processes for increased collaboration and alignment at country level. ▪ The GFF is a member of the WHO led Global Action Plan for Healthy Lives and Well-being for All, and has excellent relationship at leadership level, with a common interest in accelerating progress on UHC. We are working together towards stronger purposeful partnerships with Gavi and Global Fund through different efforts such as the "Intensified Collaboration among the 4Gs (i.e. Global Fund, Gavi, GFF, and World Bank)", and a collaboration among the new GFF countries with Gavi and Global Fund, with a focus on transition and co-financing. These efforts will continue. We have with our partners, Global Fund and Gavi specifically, discussed planning and coordinating joint missions at country level, and ensuring that we are sharing timelines with each other, to better time collaboration at different stages of the process. GAVI, Global Fund and the GFF have already started carrying out joint missions (e.g., recent mission in Malawi) to enable closer collaboration. ▪ The GFF process at country level will increase its focus on harmonization of technical assistance through the preparation of implementation guidelines and a government-led TA matrix. This will facilitate engagement with and harmonized policy advice from a range of agencies. It will also provide an opportunity to harmonize the GAVI and Global Fund Health Systems Strengthening (HSS) grants with the overall support from other partners. The GFF Secretariat is also advising countries to make special efforts to reach out to partners who do not have a direct country presence (e.g., GAVI, Global Fund, BMGF) when developing the investment case. ▪ GFF is represented in the UHC2030 working group on

	Sustainability and Transition. Going forward, the Secretariat will reach out to both P4H and UHC2030 to formalize a partnership with them and discuss practical and specific ways to operationalize such a partnership to streamline country-facing efforts to embed RMNCHA+N in UHC plans. It would also like to extend the participation of the team in other relevant working groups sponsored by UHC2030.
Communications: *Invest in better and more transparent communications: The GFF Secretariat should strengthen its approach to, and consistency in, public communications, including communications with partners. This should happen in a number of ways, including: making the website more useful and accessible, increasing transparency, adopting a simpler language and communications style that reduces advocacy, and strengthening openness around lesson learning.*	▪ We agree with the recommendation to strengthen communications with partners, especially at the country level, and have taken steps to strengthen communications. This includes communicating GFF successes and challenges, promoting country-level progress, highlighting the GFF partnership, timely information sharing and transparency of the Investment Case process, (through GFF liaison persons in countries) and by posting the contact/point persons on the GFF website. ▪ The GFF website- which is fully available in both English and French- has recently undergone major improvements with regards to accessible and useful information, targeting broader audiences, and with a lead advocacy specialist joining us in 2018, we have strengthened advocacy, social media outreach and CSO engagement. Additionally, a special emphasis has been placed on sharing stories of country progress, including through video, photos and stories from countries that have partnered with the GFF.
Capacity building and technical support: 1. *The need for a more consistent country presence: The GFF should take steps to provide backstopping support, performance monitoring, and active supervision to the new group of country-based GFF Liaison Officers based in* ministries of health to *reinforce and support government focal points including in an increasingly multisector approach (nutrition).* 2. *Support a process aimed at more clearly defining roles and responsibilities, especially among technical agencies (such as the H6), including to continue dialogue at global and country levels to avoid duplication and overlap, and to streamline technical assistance on all aspects of RMNCAH+N.*	▪ The GFF fully intends to provide the necessary backstopping support, performance monitoring and active supervision to the new group of Liaison Officers which are currently being recruited. The primary support from the GFF will come from the Country Focal Point in the GFF Secretariat who will be the direct supervisor of the Liaison Officer. A community of practice for rapid knowledge sharing between Liaison Officers will also be established by the GFF Secretariat, with support provided by a firm. ▪ The GFF Secretariat is updating the Investment Case preparation guidelines and has prepared draft country implementation guidelines which will be finalized in consultation with GFF technical partners. Both documents outline the roles at the country level (and global level contributions as needed) through the operation of the Country Platform. They will form a basis for the induction of the Liaison Officers, who in turn will disseminate them on a regular basis with in-country stakeholders. Communication products will be developed based on these guidelines to help clarify roles. One of the steps in the Implementation guidelines is the signature by partners of an agreement that will state the role(s) that partner intends to play in the GFF engagement.
Extending reach: Consider the pace of country expansion: *Despite considerable demand from countries, the GFF should ensure it achieves a sound level of depth and breadth in its delivery model, taking care to expand only as quickly as it is capable, to guarantee and sustain a minimum quality of partnership and technical support, given the size of the Secretariat and the extent to which delivery works through others. The GFF 'offer' is support to a*	▪ The GFF Secretariat agrees with the recommendation and will continue with a phased expansion. GFF introduced a structured process for initiation of the most recent 10 countries which joined the GFF in November 2017, drawing on lessons learned from previous 16 countries. This includes "Initiation" missions to explain the details of the GFF process to national stakeholders, developing investment case roadmaps, etc. which has made the roll-out clearer for countries. The anticipated expansion to 50 countries in 2018-2023 would involve phasing the expansion. ▪ The GFF Secretariat intends to remain small and lean and will continue to depend on its members for technical quality; see the specific actions under capacity building and technical support

complex set of reforms and should prioritise "doing it right" over "doing it everywhere"	(above) for how to address recommendations regarding quality of partnerships and technical support. ▪ The GFF Secretariat is also able to remain small and lean in structure, because of its operational links to World Bank task teams, and has introduced a MOU with each of the World Bank task teams for the joint country operations to ensure clarity around roles, responsibilities and accountability for technical quality and results.
Private Sector Engagement needs additional resources: *Despite the interesting start, the GFF should consider investing in more capacity to support the private sector work, especially at country level.*	▪ In recognition of the country demand and the magnitude of potential opportunities for transformative partnerships, the GFF is in the process of scaling up its capacity building and the resources available for countries to engage strategically with private sector for RMNCAH-N, with a focus on low income women, children and adolescents. This will include resources for countries to conduct analytical work and private sector assessments, TA and capacity building to strengthen MoH capacity to effectively manage private sector, and continued support for governments to do strategic purchasing of services from private providers through GFF-supported projects, with a focus on results. ▪ The GFF will also continue to build on the successes of its innovative financing efforts by using a wide range of instruments (including the recently launched Sustainable Development Bond initiative that has raised US$170 million in its first month), as well as WBG and partner expertise to crowd in private capital for GFF countries to use to finance their Investment Cases. ▪ The GFF is also scaling up its partnerships with private sector companies to make their expertise available for governments to apply towards their priorities in areas such as supply chain, health data systems, nutrition, etc. ▪ The GFF will draw on the capacity of other, current partners who have expertise with private sector to support governments (e.g., USAID).
Civil society participation should be boosted through additional capacity building support: *Partners to the GFF (whether they are GFF funders or not) should ensure that CSOs are fully included in the GFF processes and might consider supporting the CSO platform hosted by the Partnership for Maternal, Newborn and Child Health that provides advocacy training, capacity-building and other forms of support to CSOs. Harmonising the several CSO platforms that currently co-exist may reduce costs and improve outcomes.*	▪ The GFF Secretariat fully agrees that harmonization of country/global CSO platforms is key, both for impact and efficiency. Together with PMNCH and the GFF CSO Steering Committee, and in consultation with other key platforms, the GFF is developing a CSO strategy for 2019 that will build on and take forward this harmonization. ▪ The GFF already provides support through PMNCH for CSO capacity building, including through a small grant mechanism that supports the capacity of CSOs to strengthen coalition work and meaningful engagement. This funding for capacity building across networks will be taken forward also in 2019. ▪ The GFF Secretariat, through the Implementation Guidelines, is defining how all members of the country platform (including GFF Liaisons) can more proactively engage with and more meaningfully include CSOs at the country level.
Monitoring & Evaluation, Learning and Knowledge (MELK): *There is a discrepancy between the work that the GFF is undertaking, its progress and partnership arrangements to pursue this work and the perception, communication and engagement of the broader RMNCAH community especially at country level. The GFF should take steps to address this discrepancy:*	▪ The GFF has developed two statistical models, which stipulate the goals of the GFF partnership and articulating the steps needed in health financing reforms to ensure that there is sufficient funding available for the urgent needs for RMNCAH-N. The first model was published in 2015, and the second will be released in July 2018. The data presented in this model is based on lessons learnt from the implementation of the GFF in 16 countries, and specifically 4 front runner countries. This model shows the vital contribution of all partners in health, and the mechanisms needed to increase the overall volume of funds.

***a**. Identify the GFF Monitoring & Evaluation, Lesson learning and Knowledge (MELK) strategy more clearly to reflect the significant work that GFF is already undertaking, and to build partner c*onfidence and opportunity for consultation on the approach. **b**. Be transparent and open about operating *assumptions used to calculate critical GFF monitoring and performance indicator data. For example, what is included in 38m lives saved, which partners' contributions are included/excluded in resource availability at country level ('leveraging' calculations and visualisation of RMNCAH+N alignment attached to investment cases)?* **c**. *Develop a clear policy and process around contribution analysis in terms of the performance framework and include measures of effective donor cooperation (EDC) as well as outcome and impact results.*	▪ Each Investment Case includes a results framework that is vital to monitor the success of the implementation of the IC. The country platforms, led by the government, aim to include all stakeholders in the RMNCAH-N agenda, and play an important role in ensuring targets are met and real-time changes are made based on data. More specific roles of the country platform, its constituents and expectations are presently being developed and will be shared soon. This will lead to more transparency and improved EDC. It is important to include all partners in these discussions and for all partners to bring their financial and programmatic data to discuss efficiencies and improvements that can be made across the government programs and all partner programs. ▪ Additionally, the GFF results framework, including process, outcome and impact indicators for both health financing reforms and RMNCAH-N outcomes has been approved by the GFF Trust Fund Committee; and will be published in the 2017-2018 annual report and presented on the GFF webpage.
The GFF's support to Health Management Information Systems: *Set out a clear plan to engage with other partners to support governments to develop/strengthen their HMIS systems (or make current plans more easily accessible). Most countries are implementing the DHIS2 with WHO and other UN Agency support. The GFF should be open and clear about its approach to HMIS and communicate how and where it supports information management systems, data collection and analysis and how it uses data. Papers presented to the Investors' Group with relevant updates should be made easily accessible (for example, posted on the website).*	▪ In areas where the routine data systems need support, these should be systematically presented in the IC, and financially mapped against current domestic and donor funding. In several countries we have seen large scale investments in HMIS laid out in the IC, including Guinea, Cameroon, Senegal, Ethiopia, Kenya and Tanzania. ▪ GFF will continue to expand its support to strengthen existing national health information systems. The GFF Secretariat and country teams are in continuous conversation with country managers, multilateral and bilateral partners to ensure GFF investments are well aligned at both country and global level for monitoring and health information systems support. ▪ The GFF is presently undertaking a robust assessment to determine the ability for countries to monitor their IC and determine where there are gaps in HMIS, survey data, financial data and more, to determine who is best to fill these gaps (government, partners, others) and where GFF's comparative advantage is and what investments should be made (including desk review). Where needed, the GFF will offer or access technical support to fill country gaps for monitoring their IC; including developing resource mapping, tracking and expenditure systems; as well support to existing HMIS systems, surveys and surveillance.