

Prioritizing Public Spending on Health in Lower-Income Countries: The Role of the Global Financing Facility for Women, Children and Adolescents

Janeen Madan Keller, Rachel Silverman, Julia Kaufman, and Amanda Glassman

Abstract

The Global Financing Facility (GFF), launched in 2015, is a partnership backed by a multi-donor World Bank trust fund that aims to “prioritize and scale-up evidence-driven investments to improve reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N) interventions” in low- and lower middle-income countries. A major component of the GFF’s operational model is centered around the investment case, described by the GFF as “a description of the changes that a country wants to see with regard to reproductive, maternal, newborn, child, and adolescent health (RMNCAH) and a prioritized set of investments required to achieve these results.” Looking retrospectively at investment cases and associated ongoing World Bank operations, this paper aims to shed light on specific aspects of the GFF’s operating model, approach, theory of change, and results to date related to the “development of a costed and prioritized investment case,” and whether the investment case helps to prioritize public spending on health in the real world. The portfolio-wide findings suggest that the GFF delivers a clear value-add within the global health architecture by directing more funding to flow directly through governments via increased World Bank lending for RMNCAH-N (especially in the context of COVID-19-related service disruptions and fiscal contractions). The role of the investment case in aligning and prioritizing resources behind a consensus set of highest-value RMNCAH-N interventions within a specific funding envelope is less well documented in the public domain; GFF efforts to directly influence government RMNCAH-N spending decisions and their efficiency seem to occur primarily through follow-on resource mapping and expenditure tracking. The paper concludes with three recommendations for the GFF and its donors: (1) pursue a deliberate strategy for prioritization of RMNCAH-N services and products within the realistic budget constraint to advance evidence-based decisions on certain trade-offs; (2) increase transparency and public visibility into GFF-supported activities and funding, especially related to RMNCAH-N product procurement and overall resource tracking; and (3) explore incentives for increased donor co-financing within the framework of World Bank projects as a strategy to pool and channel more resources through government coffers.

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1. Introduction and background

The Global Financing Facility (GFF), launched in 2015, is a partnership backed by a multi-donor World Bank trust fund that aims to “prioritize and scale-up evidence-driven investments to improve reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N) interventions”¹ in low- and lower middle-income countries. The GFF currently works with 36 partner countries, and recently launched a resource mobilization campaign to raise an additional \$2.5 billion in trust fund resources by 2025 (with an initial target to raise \$1.2 billion by end 2021), with a long-term expansion goal of 50 countries by 2030.² GFF grants to partner countries are frequently embedded within routine World Bank operations and aim to create country demand for the use of World Bank lending in support of RMNCAH-N services and products. The GFF is financially supported by a cohort of bilateral and philanthropic donors, most notably Norway, Canada, and the Bill & Melinda Gates Foundation.

A major component of the GFF’s operational model is centered around the investment case, described by the GFF as “a description of the changes that a country wants to see with regard to reproductive, maternal, newborn, child, and adolescent health (RMNCAH) and a prioritized set of investments required to achieve these results.”³ Given that these are intentionally country government-led documents, they vary substantially in form, objectives, and content. Within the GFF model, investment cases are used for two primary purposes: first, to identify and cost priority RMNCAH-N interventions and related reforms; and second, to align government and other bilateral and multilateral donors behind a cohesive and coherent approach to financing RMNCAH-N. Most notably and directly, the investment case is the basis on which GFF aims to inform governments’ decisions to allocate their own spending as well as the IDA/IBRD lending towards high-priority RMNCAH-N spending, thereby establishing an operational link between the GFF Trust Fund and IDA or IBRD lending.⁴

The GFF has now completed its sixth year of operations, gradually transitioning from “start-up” mode to an increasingly mature operating model. The model is dynamic, not static; the GFF Secretariat has iteratively refined its approach, “learning by doing” and responding to observed challenges. Its current replenishment cycle is also occurring amidst a generational global health crisis, in which both direct and indirect effects of COVID-19 have devastated populations and health systems in many countries, often undermining, or even reversing, the health gains of recent years. Delayed vaccine access and prolonged economic crisis may further exacerbate health losses in GFF partner countries, particularly

¹ GFF 2021–2025 Strategy. October 2020, p. 7. www.globalfinancingfacility.org/sites/gff_new/files/GFF-Strategy_2021-2025_EN_FINAL.pdf#page=7

² “Press release: Reclaim the Gains.” GFF, March 2021. www.globalfinancingfacility.org/global-financing-facility-launches-12-billion-funding-campaign-stop-secondary-health-crisis-women

³ “Guidance Note: Investment Cases.” GFF, February 2016. www.globalfinancingfacility.org/guidance-note-investment-cases

⁴ GFF Replenish Document, 2017-2018. www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF_Replenishment_Document_EN.pdf

if fiscal contraction leads to health spending cuts from donors and national governments alike. (The United Kingdom, one of the largest global funders of reproductive health, has already slashed its international assistance by nearly 30 percent).⁵ In this context, a successful GFF model—one which supports governments to protect and prioritize the highest-impact RMNCAH-N spending and service delivery within partner countries—is desperately and urgently needed.

Looking retrospectively at investment cases and related ongoing World Bank operations, this paper aims to shed additional light on specific aspects of the GFF’s operating model, approach, theory of change, and results to date related to the “development of a costed and prioritized investment case.” Specifically, it seeks to independently assess the extent to which the GFF—via country investment cases and associated World Bank trust fund and lending operations—has helped to prioritize and align budgets and spending to increase the coverage and equity of the most cost-effective RMNCAH-N interventions. Building on these findings, it also offers a forward-looking agenda for how the GFF can continue to evolve and improve its effectiveness as it operationalizes its 2021-2025 strategy, particularly given the current global crisis.

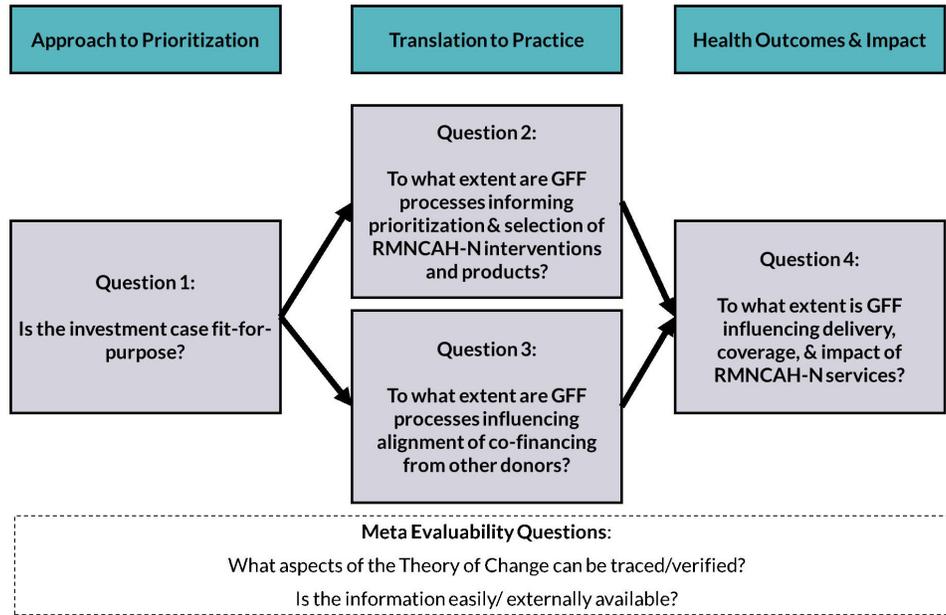
This paper proceeds as follows. First, it describes the scope and methodological approach in further detail, including our analytical framework. Second, it presents portfolio-wide findings that trace the GFF’s theory of change. Third, it discusses the broader implications of the portfolio-wide findings, including how partner countries, donors, and other partners should conceptualize the role and potential of the GFF within the broader global health architecture. It concludes with a set of policy recommendations for consideration by the GFF Secretariat and its donors.

2. Scope and approach

This paper uses an analytical framework (Figure 1) to trace one dimension of the GFF theory of change (Figure 2)—specifically, the role of the investment case in generating, prioritizing, and aligning resources for RMNCAH-N across donors, lenders, and national and/or subnational governments. The analytical framework starts with the content and form of the investment case itself as a prioritization exercise, asking whether the documents are fit-for-purpose given their intended use (Question 1). We then consider translation of the theoretical exercise to practical resource allocation—both to inform financing, prioritization, selection, and monitoring of RMNCAH-N interventions and products (Question 2) and the alignment of co-financing from other bilateral and multilateral donors (Question 3). Finally, we attempt to trace how the GFF is measuring its influence on spending, delivery, coverage, and impact of RMNCAH-N services within its partner countries (Question 4). We also consider higher-level questions about whether and to what extent the GFF theory of change can be traced and verified, both theoretically and practically given data availability and quality.

⁵ Worley, William. “Tracking the UK’s controversial aid cuts.” *Devex*, November 19, 2021. www.devex.com/news/tracking-the-uk-s-controversial-aid-cuts-99883

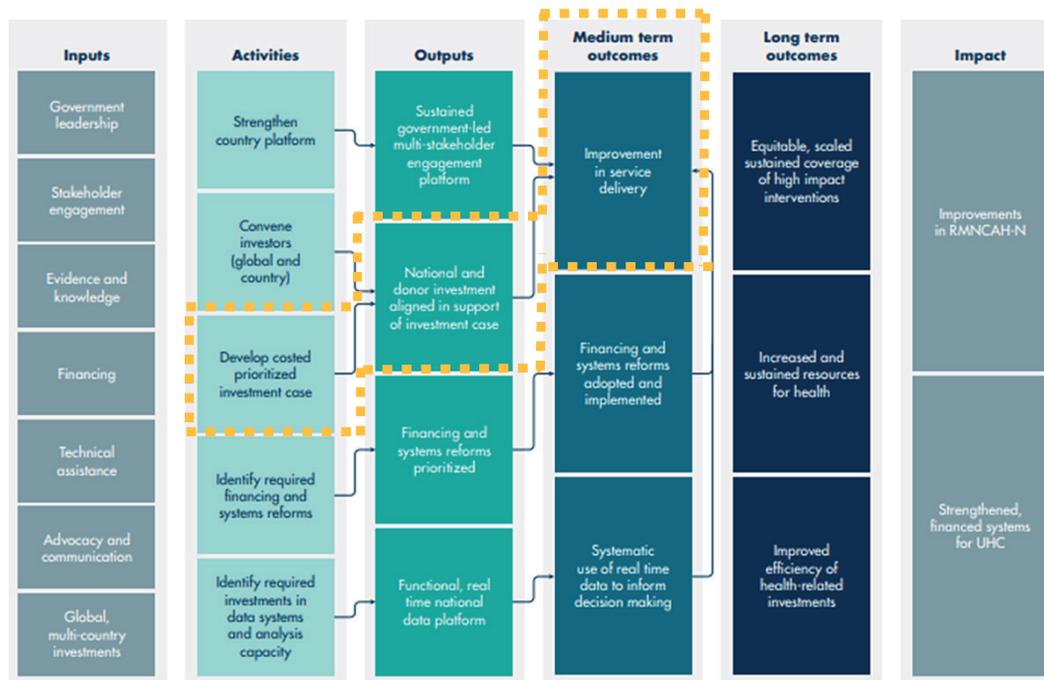
Figure 1. Analytical framework



Source: Authors.

Note: GFF processes referred to in questions 2 and 3 refer mainly to the development, role, and use of the investment case.

Figure 2. Focus of CGD analysis within GFF’s logic framework and theory of change



Source: Reproduced from GFF Strategy 2021–2025, October 2020, www.globalfinancingfacility.org/sites/gff_new/files/GFF-Strategy_2021-2025_EN_FINAL.pdf#page=12

We conducted a portfolio-wide analysis of 18 publicly available investment cases⁶ and 32 World Bank projects with GFF co-financing,⁷ alongside related World Bank, GFF, and national health sector documentation. In addition, we conducted detailed desk-based reviews in four countries: Tanzania, Kenya, Bangladesh, and Burkina Faso.⁸ These four were selected for their relatively longer implementation duration (see Figure 3), range of investment case objectives (see Table 2), and variety of health system contexts. Of the four, Tanzania and Kenya were among the frontrunner GFF countries, and their experience may not reflect lessons learned and adaptations made in the interim; in more recent GFF countries, COVID-19 has substantially slowed and influenced GFF processes, making it difficult to assess how the process, notably as it relates to investment case development, has evolved.

We also conducted a series of 20 contextual interviews with key partners at the global level and in-country stakeholders with collective experience in 18 GFF partner countries (e.g., GFF and World Bank staff, members of GFF's investors group, government counterparts, and other in-country stakeholders). As a complement to the document review, these discussions aimed to elicit stakeholder perspectives related to the investment case development process, GFF's country platform for multi-stakeholder engagement, and GFF engagement and influence via participation in negotiations and project development, among others (see Annex 2 for the interview guide and list of interviewees).

Notably, partner countries are at different stages of implementation (see Figure 3) and the role and accompanying process of the investment case has evolved since 2015. We also recognize the GFF Secretariat's and partners' ongoing efforts to address challenges and incorporate lessons learned to date, as reflected by stakeholder interviews, growing interest in how to continuously iterate investment cases as "living documents," and the focus of its new 2021–2025 strategy on "the need to be more explicit about what the GFF partnership can be expected to deliver," "allocative and technical efficiency of health expenditures," enhanced support for investment case implementation, and clearer roles and accountability structures for all GFF partners, among other strategic directions.⁹

⁶ Our analysis is based on all publicly investment cases (n = 18): Bangladesh, Burkina Faso, Cameroon, Central African Republic, Cote d'Ivoire, Democratic Republic of Congo, Ethiopia, Guatemala, Guinea, Kenya, Liberia, Mozambique, Nigeria, Rwanda, Senegal, Sierra Leone, Tanzania, Uganda. See Annex 1 for more details.

⁷ See Annex 1 for more details on the list of 32 World Bank projects included in our analysis. Note that some countries like the Democratic Republic of Congo and Bangladesh have more than one World Bank operation receiving GFF co-financing.

⁸ More in-depth reviews for Tanzania, Kenya, Bangladesh, Burkina Faso included additional World Bank documentation such as implementation status reports and procurement plans plus country-level documentation including health benefits plans, medicine lists, etc.

⁹ GFF Portfolio Update, April 2020, p. 11. www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF-IG10-2-Portfolio-Update.pdf#page=11; GFF 2021–2025 Strategy. October 2020, p. 17. https://www.globalfinancingfacility.org/sites/gff_new/files/GFF-Strategy_2021-2025_EN_FINAL.pdf#page=17; GFF Country Implementation Guidelines, 2019. www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF-Country-Implementation-Guidelines-En.pdf

Figure 3. GFF countries by years of engagement in GFF model and correspondent goals of implementation stage



Source: Authors.

Finally, we note that our analysis is limited in scope (Table 1) and constrained by important caveats. There are three particularly important issues. First, partner countries are at different stages of implementation (see Figure 2); our analysis primarily focuses on the more mature operations and may not fully reflect more recent changes to the GFF operating model in response to challenges and lessons learned. Second, this analysis is focused on the investment case and generally excludes other components of the GFF model/theory of change, including system reforms, technical assistance, and data platforms. The exception, to some extent, is analyzed under Question 4 on service coverage and impact, which cannot easily distinguish effects of the investment case process from other GFF activities. Finally, our findings are in large part dependent on the information contained within publicly available documents and databases. Though we use 20 stakeholder interviews to add context and complement the document review, we cannot fully account for elements of the GFF model which are not referenced in publicly available documents. We encourage the GFF and its funders to carry out a more comprehensive assessment of lessons learned in the future.

Table 1. Scope of analysis

In-Scope	Out-of-Scope
<ul style="list-style-type: none"> • Prioritization approach and outcome • Product selection approach and outcome • Financing modality • Monitoring and verification approach • Publicly available documents <ul style="list-style-type: none"> ○ RMNCAH-N Investment Cases ○ World Bank Project Appraisal Documents (PADs) ○ World Bank Implementation status reports and other evaluations and assessments ○ World Bank Procurement plans/documents • Investment case development processes—but only to the extent discussed as part of interviews in the context of select partner countries 	<ul style="list-style-type: none"> • Country platform for multi-stakeholder engagement • “Soft” GFF engagement and influence via participation in negotiations and project development, including efforts to align government and/or other donor funds, unless these are specifically reflected in the PADs • Financing and system reforms prompted by GFF intervention, where applicable • Technical assistance via GFF • Data systems strengthening • Impact of/adjustments to COVID-19

3. Portfolio-wide findings

Question 1: Is the investment case fit-for-purpose as a prioritization exercise?

As noted above, the investment case—led by government authorities—aims to prioritize resource allocation and spending to increase the coverage and equity of the most cost-effective RMNCAH-N interventions. Prioritization as an activity would imply that: (i) the most cost-effective services and products would be identified based on each country’s demographic and epidemiological context, (ii) existing coverage, expenditure on and costs of these services would be analyzed, (iii) gaps would be identified, and (iv) a set of recommendations indicating new allocation or reallocation of budgets available based on these analyses would be produced. *Most (but not all) of the investment cases reviewed:* (i) produced an inventory of interventions, (ii) assessed current coverage, costs, and expenditure, and (iii) established funding gaps. *Some of the investment cases* adapted the cost-effectiveness estimates to country context and issued general recommendations on how existing expenditure would need to be reallocated or optimized to expand coverage and equity.¹⁰ *None of the investment cases* included analyses of how different scenarios of incremental spending would need to be allocated to most efficiently increase coverage, equity, or other explicitly stated objectives. However, in some countries, GFF involvement in health financing functions (e.g., resource tracking, resource mobilization, and budget execution) has helped facilitate further prioritization after the investment case is developed (discussed further under Question 2).

Box 1. Importance of explicit priority setting

Given the universal reality of finite resources *in all countries*, policymakers must continuously make decisions about who receives which health interventions and products, either implicitly or explicitly. The goal of prioritization is to ensure that available resources are spent in ways that move closer to maximizing improvements in population health while also balancing other policy goals such as equity, dignity, and financial risk protection. Cost-effectiveness analysis (CEA), one type of economic evaluation used for prioritization, describes how much health an intervention will buy for each dollar, allowing decision-makers to rank different interventions and select the services that offer the greatest health impact *within the available budget envelope*.¹¹ In the absence of explicit selection of services (universally limited by a budget constraint), resources may be spent in ad hoc, inertial ways, resulting in inefficiencies and avoidable death and illness.¹² Many countries of all income

¹⁰ For example, the Mozambique investment case generally includes what existing expenditure should go towards (not clearly based on CEA) if the resource gap is not filled; see here: www.globalfinancingfacility.org/sites/gff_new/files/Mozambique-Investment_Case-EN.pdf#page=88

¹¹ Glassman, Amanda, Ursula Giedion, and Peter C. Smith. *What’s In, What’s Out: Designing Benefits for Universal Health Coverage*. Center for Global Development, October 2017. www.cgdev.org/publication/whats-in-whats-out-designing-benefits-universal-health-coverage

¹² Glassman, Amanda and Kalipso Chalkidou. “Priority-Setting in Health: Building Institutions for Smarter Public Spending.” *Center for Global Development*, June 2012. www.cgdev.org/publication/priority-setting-health-building-institutions-smarter-public-spending

levels do not sufficiently use prioritization to inform resource allocation for health and health products (including the wealthiest countries in the world like the United States, a practice that has resulted in very high costs and lower than expected outcomes). Prioritization—based on a combination of cost, equity, financial protection or other criteria—is especially critical where resources are most constrained. Explicit prioritization, informed by evidence and ethics, can thus improve health outcomes, save lives, and promote health equity.

At the time of our analysis, publicly available investment cases were available for half of GFF partner countries (18 of 36).¹³ As country-owned, country-driven documents, the investment cases are highly context-specific and vary in form, origin, and stated objectives (Table 2). Given the deference to country leadership, the GFF neither sets minimum requirements/standards for the Investment Case nor offers fixed templates for country use related to resource allocation and spending. Many of the documents used as investment cases are sectoral or thematic plans and/or strategies.

Table 2. Variation in the origin and purpose of selected investment cases

Country	Year Published	Investment Case Title	Main Objective*
Burkina Faso	June 2019	Améliorer la sante de la reproduction, de la mère, du nouveau-né, de l'enfant et de l'adolescent-jeune, de la nutrition et de l'état civil et statistiques vitales dossier d'Investissement [<i>Translation</i> : Investment Case to Improve Reproductive, Maternal, Newborn, Child and Adolescent Health, Nutrition, and Civil Registration and Vital Statistics]	Support for health financing reforms
Côte d'Ivoire	April 2019	Dossier D'Investissement 2020–2023 [<i>Translation</i> : Investment Case 2020–2023]	Advocacy for increased domestic resources for PHC
Democratic Republic of the Congo	September 2018	Plan National de Développement Sanitaire recadré pour la période 2019–2022: Vers la couverture sanitaire universelle [<i>Translation</i> : National Health Development Plan for the period 2019–2022: Towards universal health coverage]	Support implementation of program-based budgeting
Tanzania	June 2016	The National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child & Adolescent Health in Tanzania (2016–2020): One Plan II	Align partners behind RMNCAH-N focused health sector plan

Note: *Main objective for the investment case as reflected in GFF documentation.

¹³ See Annex 1 for a full list of investment cases included in this analysis.

Given this intentional diversity and lack of standardization, it is difficult to offer generalized findings across the entire set of investment cases. Nevertheless, our portfolio-wide review offers three important insights on whether investment cases are fit-for-purpose as input into or a method for prioritization of budgets and spending.

First, investment cases vary in their approach to prioritization amongst health services (Figure 4). Relevant excerpts from selected investment cases are included in Annex 3. In summary, most investment cases (15/18) include a costed list of RMNCAH-N services, often rank-ordered by overall health impact (e.g., lives saved). For example, in Sierra Leone's Investment Case, "the known evidence based high impact interventions were modelled through use of LiST tool, those averting more deaths were prioritized" and then "all investments needed for delivering the package of health interventions identified in this RMNCAH Strategy [were] included in the cost estimate presented."

Among this subset, most investment cases (10/15) included at least two different costing scenarios. However, less than half of investment cases (7/18) referenced use of either cost-effectiveness analysis or cost-benefit analysis to set out the list of interventions, and only three referenced service prioritization on that basis.

Put more pointedly, most investment cases do not explicitly prioritize or optimize amongst RMNCAH-N services using cost-effectiveness, cost-benefit analysis, or other systematic criteria evaluated within the existing or likely budget constraints. The starting point of the investment case is often a list of RMNCAH-N interventions that have been identified as cost-effective in the global health literature and that the country is interested in (or already) providing. The GFF then supports countries to conduct ongoing Resource Mapping and Expenditure Tracking (RMET) to monitor resource availability against the investment case and track spending within the health sector more broadly.¹⁴ In published investment cases, the budget envelope is typically used to demonstrate that all the services of interest cannot be covered with resources currently available and to help mobilize additional resources (rather than using the budget constraint to systematically decide which of these services will be covered or expanded, or how to reallocate resources). As discussed in the International Decision Support Initiative (iDSI) reference case, sound prioritization can be done using a range of criteria, but requires starting with the available resources and then analyzing the budget impact of specific interventions within the resource envelope.¹⁵

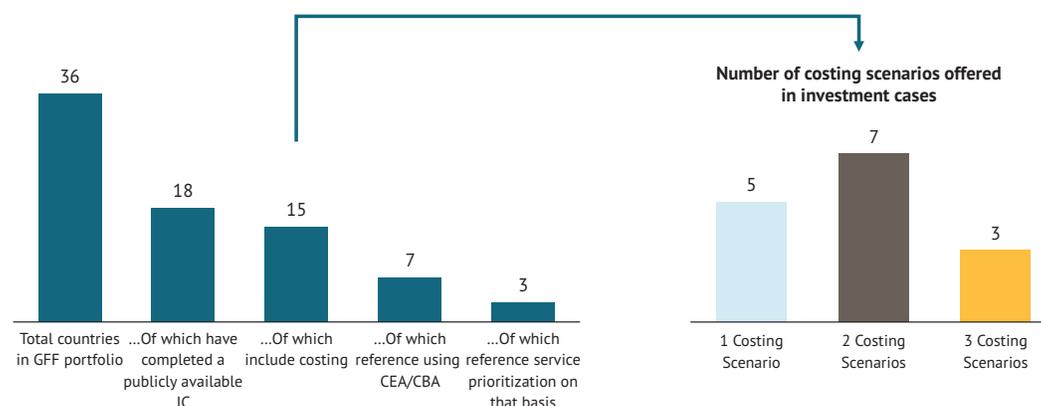
The GFF does offer some public domain guidance on prioritization using cost-effectiveness analysis, but our portfolio review suggests that this guidance is not typically reflected in investment case documentation; for example, investment cases for Liberia, Nigeria, and

¹⁴ "Resource Mapping and Expenditure Tracking: Lessons Learned from Countries." GFF, January 2020. www.globalfinancingfacility.org/resource-mapping-and-expenditure-tracking-lessons-learned-countries

¹⁵ Wilkinson, Thomas, Mark Sculpher, Karl Claxton, et al. "The International Decision Support Initiative Reference Case for Economic Evaluation: An Aid to Thought." *Value in Health*, 19, no. 8, December 2016. <https://doi.org/10.1016/j.jval.2016.04.015>

Uganda are the only ones that reference prioritizing included services on the basis of cost-effectiveness (see Annex 3 Box 1 for relevant quotes).¹⁶

Figure 4. Costing and prioritization within investment cases



Source: Authors' review of publicly available investment cases.

Table 3 provides an overview of the investment case prioritization approach for three early GFF partners: Tanzania, Kenya, and Bangladesh. Tanzania's investment case details activities across ten program areas but offers little guidance on how to prioritize amongst this list given existing spending or future budget scenarios. Similarly, Kenya's investment framework serves as a "menu" of interventions from which counties develop annual work plans, rather than a prioritization document; the framework includes "interventions with proven efficacy," strategies and immediate actions, and high-impact interventions, but it is not clear how these relate to each other to inform decision-making on resource allocation. Bangladesh, in contrast, is one of the three countries for which the investment case does not include costing. While this may be intentional due to a parallel effort to cost the country's essential service package, the investment case does not reference prioritization approaches or uses of cost-effectiveness data from other sources to determine the relative priority of different interventions and products given the budget constraint.¹⁷ The investment case builds on existing in-country structures and thus avoids duplication, but it is challenging to verify the catalytic impact of the GFF in the context of countries like Bangladesh with relevant pre-existing processes (e.g., SWAp implementation).¹⁸

¹⁶ Dutta, Arin. "The GFF Investment Case in Priority Countries: Why, What, How and Beyond." November 2016, p. 8. www.healthpolicyplus.com/ns/pubs/5127-5225_GFFRMNCAHInvestmentCasepresentationHPprojectN.pdf#page=8; GFF Country Workshop on Investment Case. January 2018, p. 27. www.globalfinancingfacility.org/sites/gff_new/files/documents/1.2%20Investment_Case.pdf#page=27

¹⁷ "The Costs of the Bangladesh Essential Health Service Package: Fourth Health Population and Nutrition Sector Programme." World Health Organization, July 2018. www.who.int/docs/default-source/searo/bangladesh/pdf-reports/year-2016-2018/the-cost-of-the-bangladesh-essential-health-service-package.pdf?sfvrsn=3d47225f_2

¹⁸ Ahsan, Karar Zunaid, Peter Kim Streatfield, Rashida -E- Ijdi, et al. "Fifteen years of sector-wide approach (SWAp) in Bangladesh health sector: an assessment of progress." *Health Policy and Planning*, 31, no. 5, June 2016. <https://academic.oup.com/heapol/article/31/5/612/2355616>

Table 3. Investment case prioritization approach in selected first wave countries

Tanzania	Kenya	Bangladesh
<ul style="list-style-type: none"> • Investment case details activities across 10 program areas • But little/no prioritization amongst this list • Lives Saved Tool (LiST) used to assess relative intervention impacts on lives saved • Unclear if/how the proposed interventions were selected based on the available resource envelope 	<ul style="list-style-type: none"> • Investment framework serves as a “menu” of interventions from which counties develop annual work plans • Framework includes “interventions with proven efficacy,” strategies and immediate actions, and high-impact interventions, but not clear how these (operationally) relate to each other • Used LiST but not clear if/how expected gains link to costing or prioritization 	<ul style="list-style-type: none"> • Investment case builds on pre-existing sector-wide approach; strong alignment with the Essential Service Package • No reference to prioritization approaches or uses of cost-effectiveness/cost-benefit analysis • Does not provide costing, likely because the Essential Service Package was being costed in a separate process

Source: Authors’ review of investment cases.

Second, few investment cases prioritize interventions *within* countries’ existing budget constraints. Instead, most investment cases set out coverage goals and then back out resource requirements to achieve them. In some cases, this results in large and perhaps insurmountable financing gaps (at least in the short- to medium-term) between the investment case resource requirements and available financing. In Kenya, the investment case projected a 25 percent financing gap of \$617 million over 5 years. In Burkina Faso and Sierra Leone, the investment cases projected a roughly 40 percent funding gap between the desired intervention package and available resources. In Ethiopia, the Investment Case states that “the overall funding gap... ranges from 10 percent in high resource case and base case costing scenario to 44 percent in high case costing and low resource projection model scenario.” It references future plans to “align targets and resource requirements,” explaining that, “If innovative financing and enhancing efficiency gains do not eliminate the funding gap, the sector will prioritize interventions and flagship programs during the annual evidence bases planning process”—but the document includes no other details on prioritization criteria.

The disparity between resources needed and resources required seems to be regularly used to advocate for additional spending. The GFF Secretariat suggests that ambitious investment cases have indeed helped motivate government officials behind health reforms and raised additional resources for RMNCAH-N; we discuss this in further detail below. In practice, additional mobilized resources are not usually sufficient to fulfill total resource requirements given the size of funding gaps between existing budget envelopes and costed investment cases; for example, resource mapping in Tanzania shows the investment case faced a 20 percent resource gap in 2018 and 2019, down from 30 percent in 2017.

Investment cases may help to fundraise for overall health sector financing that at least partially fills the gap. But the absence of a realistic budget constraint may preclude a meaningful effort to prioritize the most cost-effective services through the investment case

and can make it difficult to justify why the gap needs to be closed. Domestic resources are allocated across sectors with unavoidable trade-offs, meaning that the existence of resource gap, in and of itself, is not sufficient justification for increased government expenditure.

The GFF secretariat argues otherwise, suggesting that resource mapping helps contextualize country ambitions within the available budget; in turn, “the resource gap is used to trigger further prioritization or to advocate for more resources...It’s a difficult process that takes time and we need to be clear on which are the unfunded priorities and [not] expect results for those.”¹⁹ However, the broad remit can allow both government and external partners to describe their activities as “aligned” behind the investment case without necessarily adjusting their approach. As one interviewee described, “it feels like the investment case is a hugely broad document that serves to highlight needs around RMNCH, nutrition, and highlights the extent to which there are huge gaps and the things that need to be taken care of to address those gaps.” Then, donors (particularly the World Bank) select areas in which to invest, which may involve conducting their own prioritization.

Third, the investment case is usually oriented around health services—not health products. A group of technical experts convened by the GFF in 2016 found that investment cases “focused on broader health system constraints (human resources for health, infrastructure, and service delivery weaknesses) and as such did not delve deeper into commodity procurement and distribution.”²⁰ RMNCAH products are typically procured from a combination of local, regional, and global suppliers using national and subnational resources. Investment cases thus “do not usually include commodities as a line item in the proposed budgets” because national health procurement systems “do not easily accommodate visibility into individual commodities.” The group recommended that the GFF Secretariat “strengthen in-country technical capacity for countries to address RMNCAH product bottlenecks and invest in resolving them,” along with guiding “countries to technical resources and partners on RMNCAH commodity issues so that investment cases have sufficient level of detail on commodities.” However, our analysis found that investment cases rarely consider RMNCAH-N products in sufficient granularity to prioritize or select for procurement based on cost-effectiveness.

Zooming out, these three findings (on variability in the approach to prioritization, lack of consideration of realistic funding constraints to assess the impact of selected services on actual budgets, and limited focus on and prioritization and procurement of RMNCAH-N products) suggest that investment cases are more aspirational rather than operational prioritization documents. Most investment cases articulate aspirational goals and service levels as the basis for dialogue within government, funding appeals to the Ministry of Finance and external donors, and coordination between development partners. Investment cases are thus largely akin to previous generations of aspirational health planning documents, including National Health Plans, HIV National Strategic Plans, and Family Planning Costed

¹⁹ Stakeholder quote, GFF Secretariat.

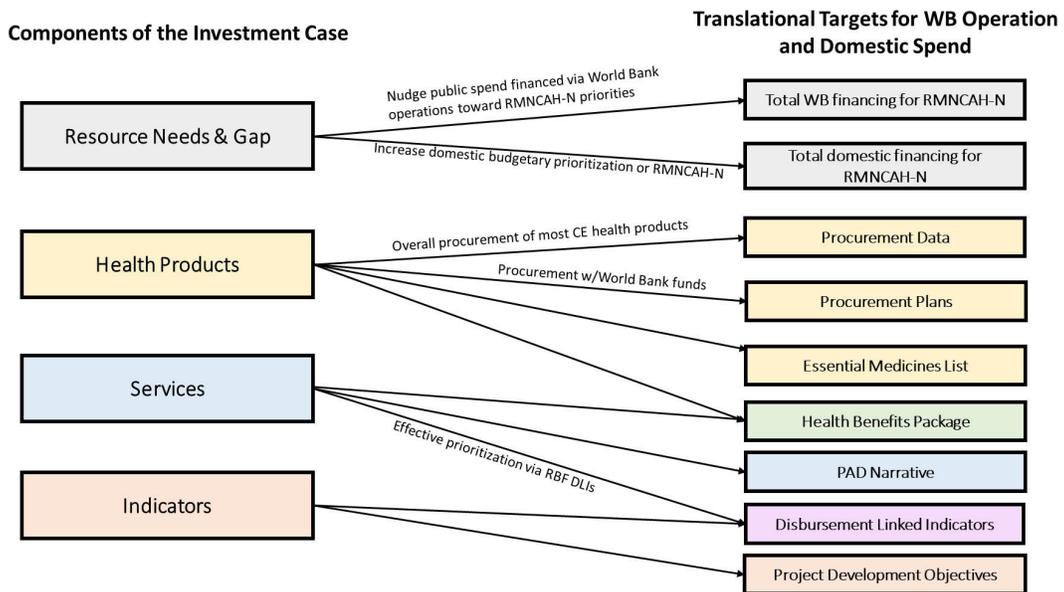
²⁰ “Improving Access to RMNCAH Commodities.” GFF, November 2016. www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF_IG4_Commodities_EN-FINAL.pdf

Investment Plans. They may be fit-for-purpose for goals such as convening stakeholders, motivating reforms, interrogating the data, and so forth, and useful as a precursor to potential follow-on prioritization decisions by policymakers—but not for direct prioritization of the most cost-effective interventions within a realistic budget constraint.

Question 2: To what extent are GFF processes informing prioritization & selection of RMNCAH-N interventions and products?

A second high-level question relates to the translation of the investment case into prioritization and selection of RMNCAH-N interventions and products. As illustrated in Figure 5—and building on the GFF theory of change—there are many potential pathways through which components of the investment case can manifest within domestic spend and associated World Bank operations, stemming from four main components of investment case. First, resource needs and gap analyses can help prompt increased use of resources for RMNCAH-N priorities. Second, the most cost-effective health products could be procured in greater quantities and included in the Essential Medicines List (EML) and the Health Benefits Plan where these exist. Third, with respect to World Bank operations, specific prioritized services and interventions could be reflected in the Project Appraisal Document (PAD) narrative for the World Bank operation, and within Disbursement Linked Indicators (DLI) for results-based operations. Finally, performance indicators used in the investment case can also be listed within the World Bank operation as DLIs or project development objectives.

Figure 5. Potential pathways for translation of the investment case



Source: Authors.

Note: Some investment cases also include descriptive plans for broader health financing reforms and provider payment strategies, which may translate into GFF-facilitated engagement to advance select reforms; follow-on activities to support the implementation of the investment case are not systematically documented in public domain.

However, at times, the potential for investment case priorities to follow these translational paths—particularly vis-à-vis the associated World Bank operations—is complicated by several factors. First, as discussed in the previous section, the lack of systematic prioritization in the investment cases themselves hampers their operational utility to guide budgeting and prioritization. Second, historically, there has been a general mismatch in timing between finalization of the investment case and development/approval of the World Bank project (see Table 4). For example, World Bank projects receiving GFF co-financing for countries like Tanzania, Burkina Faso, Malawi, and Rwanda were approved *before* finalization of the corresponding investment cases.²¹ It is nevertheless possible that concurrent investment case development processes influenced the corresponding World Bank operations; in Burkina Faso, for example, development of the investment case began in early 2018 and likely guided formulation of the World Bank operation, although project approval (July 2018) preceded investment case finalization (June 2019).

Table 4. Temporal relationship between investment case and GFF co-financed World Bank operation

GFF Country with Available Investment Case (n = 18)	Investment Case finalization* Predated World Bank Operation?
Bangladesh	Yes
Burkina Faso	No
Cameroon	No
Central African Republic	No
Côte d'Ivoire	No
Democratic Republic of the Congo	Yes
Ethiopia	No
Guatemala	No
Guinea	Yes
Kenya	Yes
Liberia	Yes
Mozambique	Yes
Nigeria	No
Rwanda	Yes
Senegal	Yes
Sierra Leone	--
Tanzania	No
Uganda	Yes
Total	9/18

Note: *For investment cases without a clearly stated finalization date, the beginning of the year in which the Investment Case went into effect was compared to the date of the (earliest) World Bank operation.

²¹ Silverman, Rachel, Janeen Madan Keller, and Amanda Glassman. “Family Planning and The Global Financing Facility: Current Evidence and a Learning Agenda.” *Center for Global Development*, September 2020. www.cgdev.org/publication/family-planning-and-global-financing-facility-current-evidence-and-learning-agenda

Finally, from the perspective of a client government, translation may be further hampered by a general mismatch between the investment cases and existing national budget cycles and systems. For example, investment cases are typically organized around “interventions”, yet most existing budgetary and expenditure systems within lower-income countries are organized around cross-cutting input costs, such as staff salaries and medicines. (Given the diversity of investment cases, however, there are of course exceptions; describing Cote d’Ivoire, an interviewee reported that “the IC is useful in the sense that it places emphasis on the supply chain and the establishment of an essential medicines list.”) Likewise, many donors have strict budget and project implementation cycles tied to either national domestic budgets or replenishment cycles and may not be able to align behind the investment case timeline. (Donor alignment is discussed further under Question 3).

Stakeholder interviews acknowledge challenges with using the investment case to inform government allocation and spending decisions for RMNCAH-N:

“Maybe due to misunderstanding on the government or partner side, the Investment Case is often seen as some kind of a stand-alone exercise. It should not be viewed as such – it should be widely understood that its purpose is to influence the government’s own plan and budget allocation.” —World Bank TTL

“This is where the frustration comes in with documents in a lot of programs. I felt once we wrote the document, we ticked a box and proceeded. I know for a fact we do not use the RMNCH investment case to follow up on deliverables. We really worked hard to ensure that the maternal implementation plan was used as our roadmap and guiding document. We tried, but if we did an evaluation, it would show that it did not guide us 100%.” —Government official

“Implementation, accountability, and knowledge-sharing processes must be undertaken by community-level actors to drive operationalization of the IC. Without this, the IC will remain very ambitious but not operational.” —GFF focal point

Nevertheless, and despite these temporal and structural mismatches between the IC documents and decision-making processes, some stakeholders suggest that the processes surrounding and following investment case development can translate to improved resource allocation and prioritization:

“The investment case is about more than the document itself. Its main avenue of impact is through evidence generation and dialogue between partners and the government to ensure that everyone is understanding the data in the same way. Through this process, the potential for prioritization is made possible.” —GFF focal point

“Shortly after Côte d’Ivoire entered the GFF, the government’s budget was presented to all partners in order to make them aware of what

is funded by the state and what needs remain. There is therefore a beginning of coordination between GFF partners, who have aligned with national funding and priorities as reflected in the investment case. A large part of the financing for prioritized interventions comes from the government’s budget, as well as funding from partners. However, they have identified gaps in this financing, and must therefore maintain a dialogue between partners to cover this deficit.” —GFF focal point

With this general context in mind, the following sections consider evidence of investment case translation across the four dimensions described above (Figure 5): 1) resource needs & gaps; 2) selection and procurement of health products; 3) prioritization of health services; and 4) selection of indicators to track RMNCAH-N coverage and quality improvements.

1. Translation of resource needs and gaps

Key takeaway: The GFF appears to have successfully leveraged trust fund resources to increase on-budget World Bank lending for RMNCAH-N priorities, but the causal effect of the GFF in increasing government health spending—especially for RMNCAH-N—is difficult to discern.

There is substantial evidence that the GFF model has helped increase available resources for RMNCAH-N in partner countries. Most clearly, the GFF model appears to have successfully leveraged trust fund resources to increase the share of on-budget World Bank lending used for RMNCAH-N priorities. An internal study of GFF countries demonstrates a 37 percent increase in the share of IDA financing for women and children’s health compared to earlier years.²² The GFF’s influence in nudging on-budget World Bank financed spending towards RMNCAH-N, and primary health care more broadly, is especially critical during the COVID-19 crisis phase and for longer-term economic recovery, as quality essential services continue to be at risk given mounting pressures on national health budgets.

Beyond World Bank lending, the role of the GFF in increasing countries’ domestic spend on RMNCAH-N overall, across the GFF portfolio, is more difficult to verify. Using data from RMET efforts, the WHO Global Health Expenditure Database, and other sources, the GFF offers dozens of examples in which GFF involvement corresponds with increases in either overall health spending by governments or health expenditure as a percentage of total government expenditure. The GFF also tracks domestic health expenditure allocated to RMNCAH, but GFF documentation highlights fewer examples related to increases in domestic spend specifically for RMNCAH-N priorities.

According to the 2020 annual report, eight partner countries increased their domestic budgets for health from 2018 to 2019.²³ The GFF points to the Democratic Republic of the

²² GFF Annual Report 2020–2021, p. 11. www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF-Annual-Report-2020-2021.pdf#page=11

²³ GFF Annual Report 2019–2020, p. 8. www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF-Annual-Report-2019-2020.pdf#page=8

Congo (which increased domestic resources for health from 7 to 10 percent of the country's total budget from 2017 to 2019), Kenya (where all counties increased health budgets to at least 20 percent of their total budget from 2017 to 2019), and Cote d'Ivoire (which increased its health budget by 16 percent from 2019 to 2020 following engagement with a GFF-supported CSO coalition) as notable examples.²⁴ Specifically, of the six countries that mention resource mobilization reforms in their investment cases and are three years into implementation of GFF processes, two show an increase in Domestic General Government Health Expenditure (DGGHE) per capita and one shows an increase in DGGHE as a percentage of total government expenditure.²⁵ Likewise, a 2020 review by E&K Consulting Firm, focused specifically on the GFF's additionality, identified an increase domestic resources for RMNCAH in two of the nine countries analyzed.²⁶

Despite these and a handful of other similar examples, the causal effect of the GFF in influencing increased resource allocation for health within partner country health budgets is challenging to discern given the impact of broader economic trends on revenues and spending in LMIC, the nonlinear nature of government decision-making and the involvement of other health multilaterals with co-financing requirements.²⁷ Increases in government health spending observed cannot be attributed to the GFF and investment case implementation alone. In light of these challenges and other obstacles to increasing public spending on health, the GFF's recent 2021–2025 strategy notes “the need for clearer communication and greater realism around GFF's contributions to domestic resource mobilization.”²⁸ As emphasized in the 2020 annual report, the economic and health effects of COVID-19 have in turn compounded challenges for domestic health budgets (though may have increased spending on health overall in some countries²⁹), making the need for a laser-sharp focus on what is essential and affordable under increasing budget pressures all the more important.

2. Translation of health products

Key takeaway: Investment cases include relatively little detail on health products and there does not appear to be a direct relationship between the health products (when mentioned) in the investment case, the products

²⁴ Ibid.

²⁵ GFF Annual Report 2019–2020, p. 7. www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF-Annual-Report-2019-2020.pdf#page=7

²⁶ “Comparative Analysis of Selected Global Financing Facility-related Investments.” E&K Consulting, 2020. <https://e-kconsulting.co.ke/2020/05/21/comparative-analysis-of-the-global-financing-facility/>

²⁷ Seidelmann, Lisa, Myria Koutsoumpa, Frederik Federspiel, et al. “The Global Financing Facility at five: time for a change?” *Sexual and Reproductive Health Matters*, 28, no. 2, 2020. www.ncbi.nlm.nih.gov/pmc/articles/PMC7887919/pdf/ZRHM_28_1795446.pdf

²⁸ GFF 2021–2025 Strategy. October 2020, p. 17. https://www.globalfinancingfacility.org/sites/gff_new/files/GFF-Strategy_2021-2025_EN_FINAL.pdf#page=17

²⁹ Kurowski, Christoph, David B Evans, Ajay Tandon, et al. “From Double Shock to Double Recovery : Implications and Options for Health Financing in the Time of COVID-19.” World Bank, September 2021. <https://openknowledge.worldbank.org/handle/10986/35298>

included in World Bank procurement plans, or the products ultimately purchased by countries and external partners.

The selection and prioritization of specific RMNCAH-N products is not systematically addressed within related World Bank operational documents. World Bank project documents offer limited information about RMNCAH-N products; decisions on products to be financed and procured were not documented or very broadly defined in the PADs and related procurement plans.³⁰ Resource allocation decisions for specific RMNCAH-N products and services are often made by client countries or sub-national units (e.g., central government in Tanzania or 47 county governments in Kenya). As such, disentangling exact dollar amounts or financing streams dedicated to specific products (e.g., contraceptives or even types of contraceptives) is challenging, especially for projects using results-based financing modalities.

This lack of visibility into spending on specific health products is largely expected for operations using results-based financing modalities, like the World Bank's Program for Results (PforR) instrument³¹ (discussed in further detail below). However, even within projects using the World Bank's Investment Project Financing instrument,³² procurement documents tend to lack details to assess the specific products selected and procured (e.g., the most recent procurement plans for operations in Afghanistan, Senegal, Tajikistan, and Vietnam). And while Tanzania's most recently updated EML (published in 2017, after the investment case) includes most of the products specified in the investment case, public resources do not shed light on whether the EML revision process explicitly considered the investment case.³³

³⁰ A 2020 study by Results for Development on MNCH products sheds light on procurement volumes and values in five GFF countries (Ethiopia, Tanzania, Uganda, Kenya, Nigeria) from 2016 to 2018. The study reflects aggregate market spend, making it difficult to draw insights related to which funding sources are going towards which products.

³¹ In PforR operations, disbursement of funds is directly contingent upon the delivery of defined results, or DLIs (see www.worldbank.org/en/programs/program-for-results-financing#1)

³² Most World Bank projects with GFF co-financing in our sample are Investment Project Financing, which provides IBRD loan, IDA credit/grant and guarantees financing to governments, and is used in all sectors over a medium to long-term (5-to-10-year horizon), see www.worldbank.org/en/what-we-do/products-and-services/financing-instruments/investment-project-financing

³³ Tanzania Standard Treatment Guidelines 2017. http://www.tzdp.org.tz/fileadmin/documents/dpg_internal/dpg_working_groups_clusters/cluster_2/health/Key_Sector_Documents/Tanzania_Key_Health_Documents/STANDARD_TREATMENT_GUIDELINES__CORRECT_FINAL_USE_THIS-1.pdf

Box 2. Inclusion of contraception in World Bank/GFF PADs

Due to a variety of reasons, granularity on the use of GFF/IDA resources for contraception, like other health products, is not feasible.

First, procurement plans provided as project documentation on the World Bank website typically lack sufficient information to understand which specific products will be or have been procured. Of the 19 countries with publicly available procurement plans for GFF co-financed World Bank operations for health, 8 of the most recent (as of September 2021) include any information on specific health products. Of those procurement plans, 6 include some mention of contraceptive products, each with varying detail on cost, quantity, and specific method (although IUDs and implants are mentioned). Overall, public information on procurement is limited and does not seem to reflect the full picture of GFF involvement in health product purchasing. For example, one interviewee highlighted that procurement plans in Afghanistan, Nigeria, and DRC include performance-based contracting for NGOs covering both services and inputs (including contraceptives).

18 World Bank projects have a contraception-specific PDO or Intermediate Results Indicator.³⁴ Examples of contraceptive-specific indicators include: modern contraceptive prevalence rate (CPR), CPR in specific regions, number of new and existing acceptors of modern contraceptive use, adolescent girls acceptant of modern contraceptives, number of women who receive post-partum family planning services, number of Couple Years of Protection (CYP), and percentage of secondary and technical schools offering SRH services.

Second, results-based financing operations are structured to enable countries to independently determine how to allocate resources amongst products and services to meet agreed upon indicators, meaning that the specific input-based uses of World Bank/GFF money are intentionally not predetermined or tracked. Nonetheless, of the 5 PforR projects with GFF co-financing, 3 included DLIs that are specific to contraception: 1. Bangladesh (post-partum family planning services are improved for \$37 million, or 7 percent of the project); 2. Ethiopia (increases in contraceptive prevalence rate for \$20.5 million and contraceptive prevalence rate for rural women for \$17 million, totaling 16 percent of the project); and 3. Mozambique (percentage of secondary schools offering sexual and reproductive health services [information and contraceptive methods] based on visits by health professionals at least monthly for \$15 million and CYP for \$12.5 million, totaling 18 percent of the project).³⁵

³⁴ Contraception-specific indicators refer to indicators that explicitly mention contraception or family planning. Several other more general indicators are still related to contraceptive products and service provision (e.g., indicators on commodity stockouts and “people who have received essential health, nutrition, and population services”), but unless the project *also* included a contraceptive-specific indicator, it was not included in the tally.

³⁵ World Bank PAD for Bangladesh Health Sector Support Project. July 2017. www.globalfinancingfacility.org/sites/gff_new/files/Bangladesh-PAD.pdf; World Bank PAD for Ethiopia Health Sustainable Development Goals Program for Results. April 2017. www.globalfinancingfacility.org/sites/gff_new/files/documents/Ethiopia-

3. Translation of services and interventions

Key takeaway: Alignment between the health services included in the investment case, the services included in PADs, the services included in countries' benefits packages, and the services eventually purchased is variable. Where alignment exists, the operational role of the investment case in informing budget formulation and execution is not evident.

Since the interventions detailed in the investment case are often not affordable within the available resource envelope, a secondary prioritization effort takes place—often implicitly—to translate the investment case to an operational budget and allocation approach to guide implementation of RMNCAH-N services. After developing investment cases and collecting RMET data to identify financing gaps, the GFF aims to support government policymakers in making follow-on prioritization decisions. For example, in Malawi, GFF-supported resource mapping was used to prompt iterative prioritization processes at the national and district levels to eventually decide on a realistically fundable set of services; resource mapping continues to be undertaken annually so that government entities can tag costed activities as either funded or unfunded, along with their priority levels for investment. And in Senegal, identification of a 69 percent funding gap from initial resource mapping led to further prioritization of the plan and a reduced funding gap of 33 percent. While these are helpful narrative examples, prioritization decisions and adjustments that follow investment case publication are not systematically documented or explained in the public domain.

Despite driving an increased flow of World Bank resources towards RMNCAH-N priorities *overall*, the GFF's early experience suggests prioritization of *specific* RMNCAH-N interventions within World Bank lending operations has been inconsistent. To inform resource allocation within World Bank operations, a subset of the RMNCAH-N priority areas outlined in the investment case must be incorporated into the PADs, which specify the interventions and products that will be financed by a World Bank project.

Such prioritization could manifest either as inputs/activities within the operation or as DLIs used for results-based financing. Our analysis of 29 World Bank projects with GFF co-financing³⁶ identified five PforR operations that tie disbursements to the achievement of specific results (see Figure 6). Another 18 projects incorporate some form of results-based financing (RBF) or performance-based financing (PBF)³⁷ from a payer or fund to providers or subnational governments charged with provision of services—although the share of

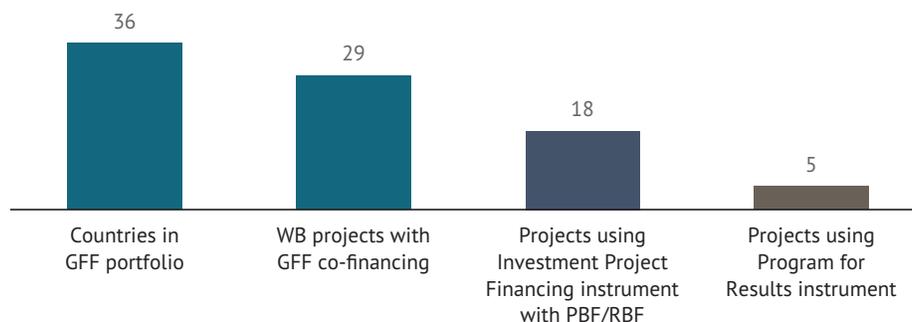
PAD.pdf; World Bank PAD for Mozambique Primary Health Care Strengthening Program. November 2017. <https://documents1.worldbank.org/curated/en/443651513005902836/pdf/MOZAMBIQUE-HEALTH-PAD-12012017.pdf>

³⁶ This analysis is based on 29 World Bank operations with GFF co-financing for which we were able to track down the Project Appraisal Documents (PADs) that provide information on the financing instrument/incorporation of PBF/RBF. Our search yielded some World Bank projects with GFF co-financing where investment cases were not available (e.g., Haiti, Indonesia, Mali, Myanmar, Tajikistan, Vietnam). Some countries, such as DRC, have more than one World Bank project receiving GFF co-financing.

³⁷ Performance-based financing (PBF) is a financing arrangement in which part of the payments are contingent upon achievement of predefined and verified results. Through this instrument, funding is provided when results are achieved, thereby delivering development outcomes and improving accountability and efficiency.

total financing under PBF/RBF varies widely across projects, ranging from 14 percent to 75 percent of total project cost.

Figure 6. Performance-based financing across World Bank projects in the GFF portfolio



Source: Authors based on review of World Bank PADs.

Note: This analysis is based on 29 World Bank operations with GFF co-financing for which we were able to track down the Project Appraisal Documents (PADs) that provide information on the financing instrument/incorporation of PBF/RBF. Within this sample, we identified 5 operations that used the World Bank’s Program for Results instruments. An additional 18 operations incorporate some form of PBF/RBF from a payer/fund to providers/subnational govts charged with provision.

Many GFF co-financed operations link most or all of the results-based disbursements to improvements in RMNCAH-N coverage and quality indicators. Across the 18 operations with PBF/RBF components and 5 projects that use the PforR instrument, 71 percent of overall spend is tied to RMNCAH-N coverage or quality indicators versus other indicators and input costs. In Bangladesh, for example, the performance-based financing component links 80 percent of total project financing (e.g., \$400 million of \$500 million total) to RMNCAH-N outcomes. In Tanzania, 60 percent of the \$300 million operation is linked to improvements in maternal, neonatal, and child health service delivery and quality.

At the country level, the relationship between the investment case and service packages is highly variable; in some cases, the documents are closely aligned but the directionality of influence is difficult to parse. Findings from Kenya, Burkina Faso, and Bangladesh are similar in that there is broad, high-level overlap in documentation, but without clear operational links between investment cases and domestic budgets. While limited linkages between investment cases and government budgets remain a challenge, some partner countries stand out as exemplifying best practice. In the Democratic Republic of the Congo, for example, the GFF has supported the Ministry of Health to implement program-based budgeting—a process by which different priorities are mapped to individual budget lines in the health budget, thereby linking budget inputs to expected outcomes and making spending more transparent.³⁸

³⁸ GFF in DRC. www.globalfinancingfacility.org/democratic-republic-congo; GFF Annual Report 2019–2020, p. 21. www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF-Annual-Report-2019-2020.pdf#page=21

The GFF Secretariat and World Bank are working to implement this approach in additional partner countries.

In Kenya, the health benefits package (HBP) Advisory Panel identified the country's latest EML as part of the basis for defining HBP services, and there is significant overlap between the Investment Case, EML, and proposed HBP in service areas such as family planning, maternal and newborn health, malaria, HIV, immunization, and child health. Nevertheless, the linkages between the HBP/EML and spending on and delivery of the services listed are not evident.³⁹ In Burkina Faso, the investment case and national health financing reform efforts are closely aligned and the World Bank project supports Burkina Faso's broader UHC agenda (including efforts to move toward pooled insurance mechanisms through a National Health Insurance Fund); however, the specific *role* of the investment case in informing budgeting and execution is not documented. In Bangladesh, the existing essential service package was explicitly revised to inform (and is thus included in) the investment case, demonstrating strong alignment between the services and processes in the investment case and domestic priorities, but there is not yet public evidence of how this alignment on paper has translated to better practice.

In other countries, alignment is more limited. In Tanzania, operational links between the investment case (which launched in June 2016 and serves as a health sector plan for RMNCAH-N) and the country's essential benefits package are unclear from information in the public domain. The GFF has supported the finalization of Tanzania's Health Financing Strategy for 2016–2025 to turn the vision of the single national health insurance scheme into a reality, suggesting that the Investment Case was likely used to inform the development of the minimum HBP, but the approval of the Health Financing Strategy seems to be delayed and implementation of the related insurance scheme and HBP has stalled.⁴⁰ The HBP also explicitly excludes contraception, which is prioritized in the investment case, and may not cover “preventive and promotive activities”.^{41,42} Notably, while “on paper” inclusion in essential benefits packages can be associated with improved access to health services, listing does not automatically assure actual purchasing, provision, or even budgeting, underscoring the need for expanded technical support for HBP implementation.⁴³ In countries with HBPs, ensuring that investment cases link to benefits design is one step towards impact, but the need to directly inform purchasing decisions presents an additional step for investment case influence.

³⁹ Kenya Essential Medicines List 2019, p. 12. www.health.go.ke/wp-content/uploads/2020/03/Kenya-Essential-Medicines-List-2019.pdf#page=12

⁴⁰ GFF Annual Report 2019–2020. www.globalfinancingfacility.org/sites/gff_new/GFF-Annual-report/united-republic-of-tanzania.html

⁴¹ Prabhakaran, Shree and Arin Dutta. “ACTUARIAL STUDY OF THE PROPOSED SINGLE NATIONAL HEALTH INSURANCE SCHEME IN TANZANIA.” *Health Policy Plus*, November 2017. www.healthpolicyplus.com/ns/pubs/7168-7306_TanzaniaActuarialBriefvEDITED.pdf

⁴² Tanzania Mid Term Review of the Health Sector Strategic Plan IV 2015–2020. September 2019, p. 64. <https://drive.google.com/file/d/1xzwJP4jqgW1KHA5wVUYxwSUEjKqNwGk/view?usp=sharing>

⁴³ Silverman, Rachel and Julia Kaufman. “Evaluating Contraception for Inclusion in Health Benefits Packages: Conceptual Issues and a Proposed Analytical Framework.” *Center for Global Development*, January 2021. www.cgdev.org/publication/evaluating-contraception-inclusion-health-benefits-packages-conceptual-issues-and

4. Translation of indicators from investment cases to World Bank operations

Key takeaway: Indicators in the investment case are typically aligned with the high-level results objectives of World Bank projects. While specific targets and baseline levels may vary, GFF co-financed World Bank projects are generally aligned with the RMNCAH-N priorities in investment cases.

GFF co-financed World Bank projects are generally well-targeted to RMNCAH-N priorities in investment cases. First, as described in more detail above, most operations with results-based indicators link a substantial portion of funding to improvements in RMNCAH-N coverage and quality indicators. Second, there is a broad degree of alignment between the high-level results objectives of World Bank projects—known as Project Development Objectives—and those included in the investment cases. The Tanzania, Kenya, and Bangladesh health sector operations include project development objectives that reflect a high degree of alignment with the priorities outlined in the investment cases. The Tanzania PAD, for example, includes five project development objectives that are all translated from the investment case (see Table 5). The Mozambique PAD also includes both a project development objective and DLI on institutional deliveries that specifically reference the Investment Case.

However, in certain operations (including Tanzania, Kenya, and Bangladesh), the targets and baseline levels for indicators in the PAD differ substantially from those in the investment case (see Table 5 and Annex 4). While these instances of indicator misalignment between the investment case and PAD can create fragmented results tracking, these differences might reflect a form of priority-setting aimed at establishing more conservative or realistic targets and timelines given that the World Bank operation is meant to operationalize a subset of the investment case interventions.

Table 5. Comparison of World Bank project development objectives and investment case indicators—Tanzania

Investment Case Indicator*	WB Project Development Objective	Investment Case Targets (Baseline to Target)	WB Targets (Baseline to Y5)
80% of CEMONC facilities quality improved to 3 stars	PHC facilities with 3-star ratings and above	→ 80%	0% → 50%
ANC 4	Pregnant women attending four or more antenatal care (ANC) visits	43% → 70%	41.2% → 60%
IPT2 doses	ANC attendees receiving at least 2 doses of intermittent preventive treatment (IPT2) for malaria	32% → 80%	45.5% → 60%
Health facility deliveries	Institutional deliveries	79% → 90%	44.7% → 60%
Vitamin A coverage	Proportion of children 12–59 months receiving at least one dose of Vitamin A supplementation during the previous year	61% → 90%	51% → 65%

Source: Investment case Indicators & Targets: Tanzania Health Sector Strategic Plan (HSSP) IV 2015–2020; World Bank PDOs & Targets: PAD.

Note: Investment case includes significantly more indicators than the WB PDOs in the PAD. Investment case indicators were not systematically represented in the document and were sourced from different sections.

Takeaways on investment case translation across the four dimensions

The GFF appears to have influenced use of World Bank lending to support RMNCAH-N priorities, and in some cases appears associated with an increase in domestic expenditure on these highly cost-effective services. This is a substantial value-add of the GFF model—at least from a health perspective⁴⁴—and may help protect essential services given COVID-related contractions in fiscal space or competing uses, and related consequences for social spending. World Bank operations also clearly reflect RMNCAH-N priorities within DLIs and project development objectives, often directly lifting (or slightly adapting) indicators from within the corresponding investment cases. Across the other potential avenues of influence, however—translation of the investment case into health products procurement and service prioritization—the relationship between the investment case, and GFF processes more generally, appears more inconsistent.

Altogether, many of the finalized investment cases are not structured to directly influence a country's own budget formulation and execution processes. Based on the broad high-level alignment in available documentation, the investment case and related GFF activities do not seem to be siloing or hindering country processes, but the value-add of the investment case in systematically driving improvements in domestic spending beyond World Bank loans is not evident.

Question 3: To what extent are GFF processes influencing alignment of co-financing from other donors?

Beyond influencing World Bank resource allocation, a proposed value-add of the GFF is its role in helping the government to crowd in and align additional resources in support of the investment case. A key component of the GFF's theory of change is to increase national and donor investment in support of the investment case. To this end, the GFF model links trust fund resources to on-budget World Bank lending for health targeted to RMNCAH-N priorities; it is also intended to align non-World Bank donors behind the country-led investment case. The GFF's own accounting suggests that they are crowding-in very large quantities of donor funding, with a reported 25+ development partners contributing 49 percent of total investment case commitments (\$4.5 billion) for 2020.⁴⁵ GFF's April 2020 portfolio reports that “more donors have aligned with the investment case over time, with an average of 10 donors aligned to the investment case in the 15 countries” based on internal RMET data.⁴⁶

We categorize donor co-financing of the investment case into two broad buckets. The first is “on-project” co-financing, defined as co-financing that is reflected in the World Bank Project

⁴⁴ Given the limited IDA/IBRD window, greater lending for health is likely to have an opportunity cost vis-à-vis other sectors.

⁴⁵ Note, the \$4.5 billion total excludes IDA/IBRD resources; it represents committed resources by other bilateral/multilateral partners. Total figures are based on GFF internal documentation, drawing from RMET analysis conducted in individual countries (PPT on file with authors).

⁴⁶ GFF Portfolio Update, April 2020, p. 19. www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF-IG10-2-Portfolio-Update.pdf#page=19

Appraisal Document (PAD) and pooled behind a single World Bank/GFF operation. While the GFF has stressed that on-project co-financing with World Bank projects is not how the GFF partnership defines alignment, we consider its significant benefits for integration with country budget cycles and related country ownership, institutional capacity, and mutual accountability (as was highlighted in a recent World Bank publication on the importance of donor alignment via use of public financial management structures in-country⁴⁷) to warrant further consideration as part of the GFF alignment agenda. As one stakeholder reported:

“The major obstacle the country is facing today is the fragmentation of funding, which continues to be transmitted vertically and in parallel rather than through pooled or mutual funds. Despite the state investment program which is currently underway, a large part of external financing is directly managed by partners and thus ‘escapes’ the state in the form of off-budget financing. It is therefore difficult to determine how to orient this funding towards priority areas.” —GFF liaison officer

The second alignment mechanism is “off-project” co-financing, defined as all co-financing that is not explicitly tied to the World Bank/GFF operation. This second category is how the GFF typically conceptualizes its alignment agenda and includes all other grants and lending to national or sub-national governments; in-kind donations of medicines or other health products; and direct service delivery via NGOs or private contractors.

The GFF’s effectiveness in generating on-project co-financing can be clearly assessed via a portfolio review of PADs for the relevant World Bank operations (see Table 6). Across 32 World Bank operations with GFF co-financing, we find a high degree of portfolio leverage: each GFF dollar is associated with \$7.56 in IDA/IBRD lending, \$1.05 from other World Bank Trust Funds, and \$0.56 from other donors. (Each GFF dollar is also associated with \$19.17 in counterpart financing from country governments, though this figure generally accounts for health sector spending writ large).

Table 6. On-project sources of financing for GFF co-financed operations, portfolio-wide

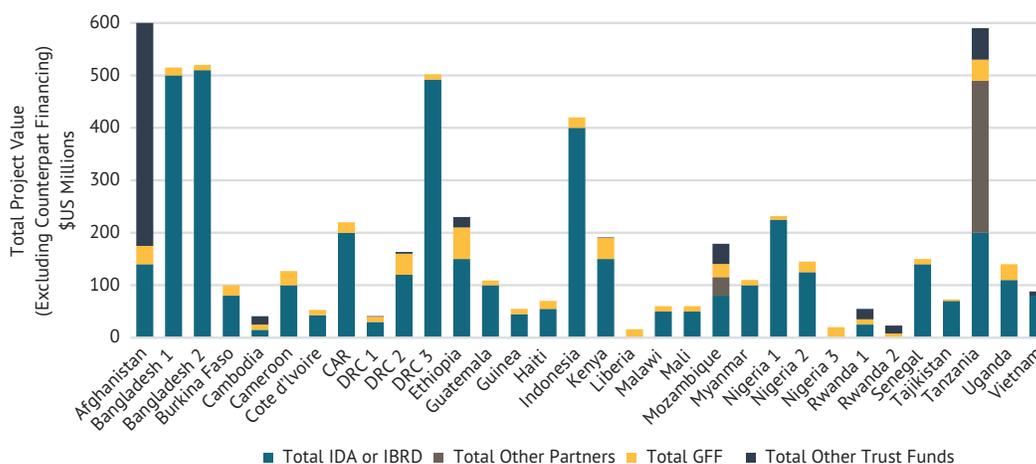
Source of Funds (N = 32 projects)	Total (US\$ millions)	% of Total Portfolio
IDA/IBRD	4,385	74%
GFF	580	10%
Other Trust Funds	608	10%
Other Partners	326	6%
Counterpart/Borrower	11,124	—

Note: Percentages exclude counterpart financing, which is only listed for a handful of World Bank projects.

⁴⁷ Piatti, Moritz, Ali Hashim, Sarah Alkenbrack, and Srinivas Gurazada. “Following the Government Playbook? Channeling Development Assistance for Health through Country Systems.” World Bank, 2021. <https://documents1.worldbank.org/curated/en/332531634794859261/pdf/Following-the-Government-Playbook-Channeling-Development-Assistance-for-Health-through-Country-Systems.pdf>

With just a few relatively small-value exceptions (e.g., Liberia and Nigeria⁴⁸), all GFF co-financed operations have leveraged a significant quantity of IDA/IBRD co-financing (Figure 7). However, co-financing from other partners and World Bank trust funds is highly concentrated in just a few countries. Half of GFF co-financed projects (16/32) include no on-project co-financing from these external sources.

Figure 7. Sources of on-project financing by GFF co-financed operation



Source: Authors' review of World Bank PADs.

Note: Figure excludes counterpart financing, which is only listed for a handful of World Bank projects.

Tanzania and Afghanistan⁴⁹ have been noteworthy exemplars for “on-project” co-financing. In Tanzania, the GFF-co-financed World Bank project pools co-financing from two additional Trust Funds (USAID and Achieving Nutrition at Scale), plus \$290 million from other partners (including the health basket fund with Canada, Denmark, Ireland, Switzerland, and UNICEF).⁵⁰ Some partners also aligned behind a set of disbursement-linked indicators. The operation in Afghanistan included \$425 million from the Afghanistan Reconstruction Trust Fund (comprising 70 percent of the total project value).

Definitionally, the remainder of donor co-financing is *off-project*, meaning it is not reflected in the World Bank PADs. Public domain information on off-project co-financing is scarce; there is limited information about the allocation and results of such funding, and it is difficult to assess whether and to what extent such expenditure is meaningfully aligned behind the investment case and/or with the World Bank operation. In theory, such co-financing could have a very high degree of alignment. For example, an external donor could coordinate

⁴⁸ This refers to one of three World Bank operations in Nigeria that receives GFF co-financing; see Annex 1 for a complete list of World Bank projects included in our analysis.

⁴⁹ At the time of writing, Afghanistan's geopolitical context is rapidly evolving; the future of GFF support, and World Bank lending more broadly, is highly uncertain.

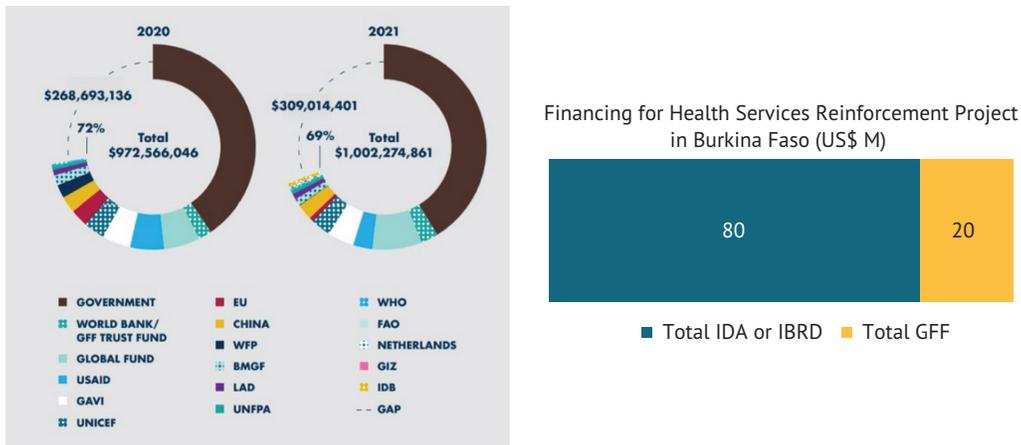
⁵⁰ GFF in Tanzania. <https://www.globalfinancingfacility.org/tanzania>; “The Global Financing Facility in Tanzania: A brief summary.” Wemos, 2019, p. 4. www.wemos.nl/wp-content/uploads/2019/12/Wemos_The-Global-Financing-Facility-in-Tanzania-2019-2.pdf#page=4

with the government and World Bank to procure specific reproductive health commodities that are included in the investment case but not included in the PAD. Likewise, Country Coordinating Mechanisms could intentionally allocate Global Fund grant funding to investment case priorities that fall within the Global Fund’s mandate, e.g. malaria programs targeting women or school-based sexual education and HIV prevention campaigns.

However, such co-financing could also have a very low degree of alignment with the investment case and World Bank project. For example, pre-existing donor RMNCAH-N projects might be considered “aligned” if they broadly address one or more of the investment case priorities, but they may lack any broader coordination or coherence.

As one example, the Burkina Faso operation does not include other counterpart co-financing (Figure 8). However, GFF’s resource mapping exercise in Burkina Faso suggests that 16 donors (including the World Bank/GFF) aligned behind Burkina Faso’s UHC strategy; the most recent portfolio update also suggests that Burkina Faso has seen a “stronger alignment among partners, and an increase in donor financing and domestic resources to finance priorities.”⁵¹ These statements are difficult to assess given the information available in the public domain.

Figure 8. Reported sources of co-financing, Burkina Faso



Sources: GFF annual report available at: www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF-Annual-Report-2019-2020.pdf#page=33 (left); adapted by authors from World Bank PAD (right).

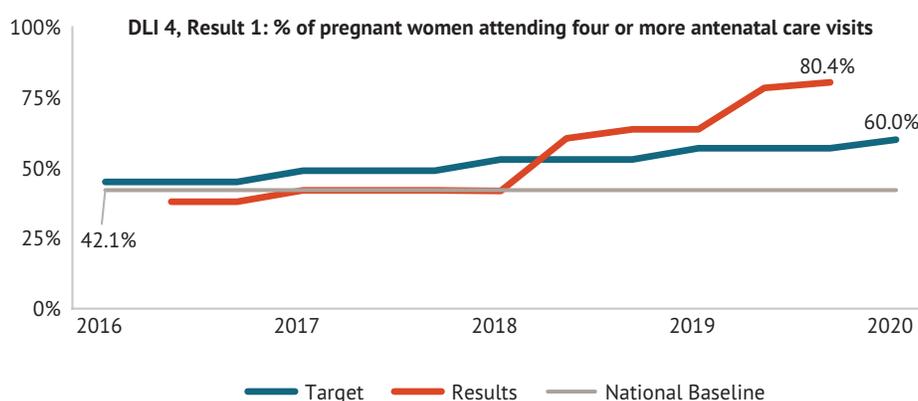
Question 4: How is the GFF measuring/demonstrating its influence on overall delivery, coverage, and impact of RMNCAH-N services?

The GFF—and its related World Bank operations—generally have clear indicators and measurement arrangements included, and report on the related progress in implementation reports issued several times a year. Regularly reported performance data for World Bank operations enables some analysis of trends over the implementation period. However, progress against these indicators is not necessarily evidence of the GFF’s causal effect.

⁵¹ GFF Annual Report 2019–2020, p. 20. www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF-Annual-Report-2019-2020.pdf#page=20

Available data from World Bank project reporting to date paints a mixed picture on RMNCAH-N coverage and service delivery improvements within and across countries. Some first wave countries, for which data are available for multiple years, report improvements for certain indicators. In Tanzania, for instance, certain coverage indicators show substantial increases. The reported percentage of pregnant women attending >4 ANC visits more than doubled from about 40 percent in 2016 to 80 percent in 2019. Such dramatic gains are truly exceptional (see Figure 9), although the exact effects of increased ANC visits on health outcomes should be further investigated. However, other indicators (for example, the number of women between the ages 15–49 years using modern family planning methods) appear stagnant in both Tanzania and Kenya (see Figure 10). This could be due to a range of measurement challenges, including issues accounting for those who shift to long-acting methods (and thus do not seek repeat visits in a given year) and other quality issues.⁵² Results from the 2022 DHS program will help to shed light on more reliable trends and may motivate government policymakers to adjust routine performance measures. In other countries, data was limited due to a combination of delays with performance verification (e.g., Bangladesh), shorter duration of implementation, and/or early operational challenges (e.g., Burkina Faso).

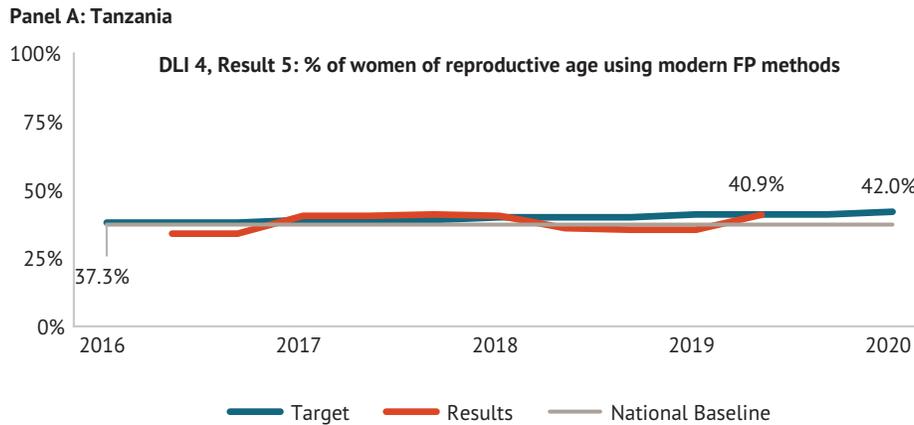
Figure 9. Progress on coverage of antenatal care visits in Tanzania



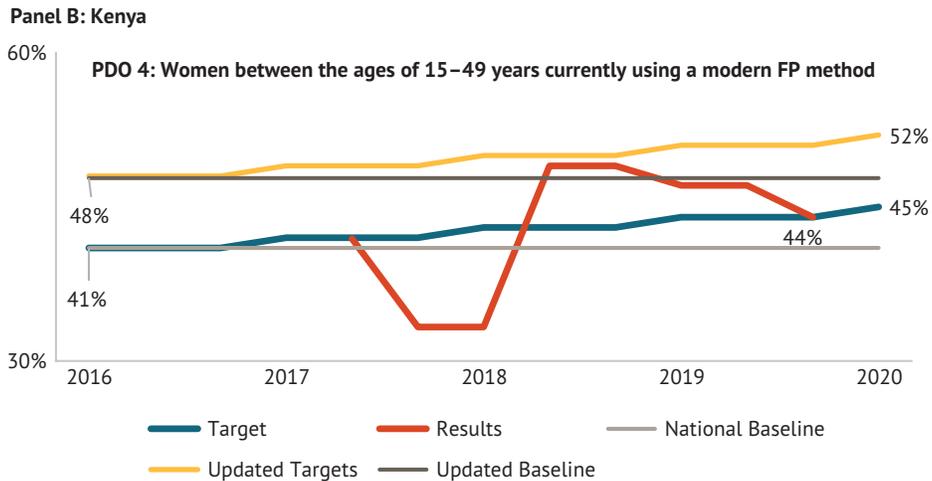
Sources: National Baseline: PAD; Targets: PAD; Results: Tanzania Implementation Status and Results Reports from 10/2016, 05/2017, 12/2017, 06/2018, 12/2018, 06/2019, 12/2019 & 06/2020.

⁵² Dasgupta, Aisha, Michelle Weinberger, Ben Bellows, and Win Brown. “New Users” Are Confusing Our Counting: Reaching Consensus on How to Measure “Additional Users” of Family Planning.” *Global Health: Science and Practice*, 5, no. 1, March 2017. www.ghspjournal.org/content/5/1/6

Figure 10. Progress on the proportion of women using a modern family planning method



Sources: National Baseline: PAD; Targets: PAD; Results: Tanzania Implementation Status and Results Reports from 10/2016, 05/2017, 12/2017, 06/2018, 12/2018, 06/2019, 12/2019 & 06/2020.



Sources: National Baseline: PAD; Targets: PAD; Results: Kenya Implementation Status and Results Reports; Updated Targets: Restructuring Paper.

Further, some positive reported results should not necessarily be taken at face value—particularly when they are linked to World Bank disbursements vis-à-vis a PforR operation or other results-based financing modalities that create financial incentives to inflate positive results. In countries like Kenya and Bangladesh, for example, DLI reporting relies on administrative data and health information systems with underlying weaknesses.⁵³ Perhaps most worrying is the arrangement in Tanzania—a country with a well-documented history

⁵³ “Country Perspectives on Kenya’s Family Planning Program.” Strategic Purchasing for Primary Health Care, July 2020. https://thinkwell.global/wp-content/uploads/2020/08/Family-planning-brief_31-July-2020.pdf; “Strengthening Routine Health Information Systems through Electronic Management Systems in Bangladesh.” MEASURE Evaluation, 2018. www.measureevaluation.org/resources/publications/tr-18-249.html

of official data manipulation to serve political and financial ends.⁵⁴ Tanzania’s World Bank operation relies on the government itself to self-report data, which is then verified by a government-appointed Internal Auditor with oversight and due diligence from the World Bank and other basket fund partners. Despite this being a standard arrangement in countries where the Bank aims to use and build national data systems, this approach in the context of Tanzania (and its unexpectedly high results) raise some questions around data integrity. The 2019 mid-term review of Tanzania’s Health Sector Strategic Plan found that 25 percent of indicators in the investment case could not be analyzed due to lack of data, posing challenges to performance-based funding and underscoring the importance of performance verification.⁵⁵

Alongside the challenges associated with tracking results data, there is an overall need for more rigorous evaluation to understand the *why* behind performance trends. This includes deeper analysis of the portfolio of impact evaluations of results-based financing programs conducted under the multi-donor Health Results Innovation Trust Fund (HRITF), which was a precursor to the GFF and that represents funding approaches that were continued under related World Bank operations with GFF co-financing, to learn where and how its approach worked better than other global health financing strategies. This kind of evidence is critical to help inform the GFF’s scale-up to additional partner countries as well as to influence future rounds of investments in existing partner countries. It is also important to note that while results-based financing has been found to improve facility delivery and quality of care, recent work in Burundi, Lesotho, Senegal, Zambia, and Zimbabwe suggests that these projects may not have significant measurable impact on health outcomes.⁵⁶

Beyond World Bank operations, there is limited information in the public domain about specific results associated with “off-project” co-financing of investment cases from different development partners, making it difficult to track the overall use and performance of these funding flows.

4. Discussion

The GFF’s mission is ambitious: “to build a new model for development financing for the SDG era, bringing together multiple financing sources in a synergistic, country-led way that closes the funding gap for reproductive, maternal, newborn, child, and adolescent health and

⁵⁴ “Why Tanzania’s statistics look fishy.” *The Economist*, July 2020. www.economist.com/middle-east-and-africa/2020/07/23/why-tanzanias-statistics-look-fishy

⁵⁵ Tanzania Mid Term Review of the Health Sector Strategic Plan IV 2015–2020. September 2019, p. 59. <https://drive.google.com/file/d/1xzwJP4jqgW1KHAv5wVUYxwSUEjknwGk/view?usp=sharing>

⁵⁶ Gage, Anna and Sebastian Bauhoff. “The effects of performance-based financing on neonatal health outcomes in Burundi, Lesotho, Senegal, Zambia and Zimbabwe.” *Health Policy and Planning*, 36, no. 3, April 2021. <https://academic.oup.com/heapol/article/36/3/332/6118441>

nutrition by 2030.”⁵⁷ GFF literature suggests two primary paths to impact: first, “act[ing] as a catalyst for financing, with countries using modest GFF Trust Fund grants to significantly increase their domestic resources alongside the World Bank’s IDA and IBRD financing, aligned external financing, and private sector resources;” and second, “bringing governments and partners together around a country-led plan, prioritizing high-impact but underinvested areas of health.”⁵⁸ More succinctly, the model suggests that the GFF would (1) substantially increase overall resources for RMNCAH-N; and (2) align and prioritize those resources behind a consensus set of highest-value, cost-effective RMNCAH-N interventions.

Yet this transformative vision stands in contrast with its relatively modest size and budget, at least compared with overall resource flows for RMNACH-N and global health more broadly. Between 2016 and June 2021, the GFF disbursed a total of \$350 million⁵⁹—an average of about \$70 million per year—though total commitments and disbursements have scaled over time. (As of June 2021, the GFF reports total cumulative trust fund commitments of \$815.5 million across 46 projects in 36 countries.)⁶⁰ The annual disbursement rate comprises less than 0.6 percent of total international financing for maternal and child health in 2019, as estimated by IHME (\$13.3 billion).⁶¹ An additional \$20 billion per year flows into related health areas, including HIV, malaria, other infectious diseases, and health systems strengthening.⁶²

These are not apples to apples comparisons; the IHME figures are global, while GFF disbursements are concentrated in a handful of partner countries. Yet country-level figures paint a similar if slightly less dramatic story, especially when domestic resource flows for health are also considered. Our back-of-the-envelope calculations suggest that across the 18 countries with publicly available investment cases, GFF resources account for an average of roughly 5 percent of total RMNCAH spending over multi-year periods (ranging from 1 percent in Ethiopia to 12 percent in Guinea). Further—and in contrast to other externally financed health programs like HIV or immunization—the GFF does not require any hard conditionalities to access trust fund resources. Projects must be Board-approved, but there are no strict pre-requisites on the use of funds related to co-financing, process, or allocation.

In this context, the impact of the GFF in directing World Bank lending toward RMNCAH-N priorities is all the more impressive (effect 1 described above). In its short period of operations, the GFF has led to a notable increase in World Bank lending for RMNCAH-N;

⁵⁷ GFF Replenish Document, 2017–2018. www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF_Replenishment_Document_EN.pdf

⁵⁸ “10 Reasons to Invest in the GFF.” GFF, 2018. www.globalfinancingfacility.org/sites/gff_new/files/documents/10-Reasons-Why-Invest-in-GFF_EN_Web.pdf

⁵⁹ GFF Annual Report 2020–2021, p. 63. www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF-Annual-Report-2020-2021.pdf#page=63

⁶⁰ Ibid.

⁶¹ Institute for Health Metrics and Evaluation (IHME). Financing Global Health Visualization. 2021. <https://vizhub.healthdata.org/fg/>

⁶² Ibid.

in some countries GFF engagement has also been associated with substantial increases in domestic resources for health, although directly causality is less clear.

Enabling more health funding to flow directly through governments is a very large value-add of the GFF model within the broader global health financing landscape. This contribution is particularly important in helping preserve essential services given COVID-related contractions in fiscal space.⁶³ GFF co-financed World Bank operations also clearly reflect RMNCAH-N priorities within DLIs and project development objectives, often directly lifting (or slightly adapting) indicators from within the corresponding investment cases. Stakeholder interviews echo this benefit:

“GFF provides on-the-ground resources where a gap in RMNCAH-N would otherwise exist – even with the presence and involvement of the World Bank. GFF resources looked at provision of women’s resources for health and RMNCAH-N and if GFF resources did not focus on that, it would create a huge gap.” —GFF focal point

“The investment framework drew attention to the need for having investment in family planning. When the project was first designed, were not even going to finance family planning. But there was a big push, in part due to the investment framework.” —World Bank Task Team Leader

Across the second proposed avenue of impact, however—aligning and prioritizing resources behind a consensus set of highest-value, cost-effective RMNCAH-N interventions—the role of the GFF is less clear. Based on our analysis, many claims related to alignment amongst donors are difficult to trace and confirm with information in the public domain. Most finalized investment cases are currently not set up to inform what is spent and purchased based on a country’s own planning cycles and processes. Other donor funding is reported as “aligned” behind the investment cases in very large quantities, but what this means in practice is not systematically documented or defined. And while general high-level alignment in documentation suggests that the investment case and accompanying GFF-supported activities are not necessarily complicating or duplicating in-country processes, the value-add of the investment case in systematically influencing public spending is not clear.

Within the investment cases themselves, we observe limited use of systematic criteria (e.g., cost-effectiveness evidence or equity optimization) to guide prioritization decisions within the available budget; we also note limited links between the investment case and countries’ essential medicines lists and health benefits packages. The GFF Secretariat acknowledges that “priority setting in the investment cases should be improved” but considers “that focusing on CEA evidence to define a package would not be very helpful in many countries.”⁶⁴ In many countries, they argue, priority-setting is either highly political

⁶³ Further analysis should explore the potential impact of the GFF on countries’ debt levels.

⁶⁴ Stakeholder quote, GFF Secretariat.

or the selection of high-priority interventions should be “fairly obvious” in context. It is plausible that explicit use of CEA may be neither necessary or desirable in some country contexts, at least for selection of interventions (though not for product selection); nevertheless, an explicit budget constraint is required to force deliberate prioritization based on *any* criteria. Some stakeholder interviews also suggest that the underlying processes and activities accompanying the investment case development process may be more influential than the document itself in influencing World Bank operations and government decision-making (see quotes and examples under Question #2), but more independent, in-depth analysis is needed to understand the impact of GFF-specific activities on government health budget decisions, processes, and execution across the portfolio. Relatedly, stakeholder interviews and other documentation on lessons learned suggest that engagement and guidance on prioritization and alignment processes accompanying investment case development have evolved since the GFF’s launch in 2015 (including recent plans to explore how to design and use investment cases as “living documents”), but the documents themselves do not yet tell that story.

One insight is that the initial pitch for the GFF was a stretch relative to the facility’s size, endowment, and influence as well as its very broad set of partner countries, and with respect to the political economy of resource allocation; its accomplishments are highly impressive given its scale, but its capacity to transform the broader health financing ecosystem in-country is understandably more limited. The GFF is clearly delivering increased resources for RMNCAH-N, and there are impressive in-country success stories, but limited evidence of prioritization and outside of World Bank project alignment. With due consideration to this broader context, the next section offers three recommendations for the GFF to increase its relative leverage and impact via the investment case and project development process.

5. Policy recommendations

Since its inception in 2015, the GFF has demonstrated its ability to influence partner government resource allocation in support of RMNCAH-N goals. Most notably, the GFF serves as an important mechanism to influence IDA/IBRD operations’ resource allocation towards RMNCAH-N priorities and other primary health care interventions, which is itself a critical role for protecting and sustaining essential health services as countries face a protracted pandemic recovery period. Yet the facility’s broader agenda—prioritization of specific RMNCAH-N services and products *within* the resource constraint and alignment of other external partners behind national priorities via the investment case and related processes—for now remains a work in progress.

Our portfolio analysis suggests three areas where the GFF Secretariat, its investors, and other partners could strengthen the GFF’s value-add within the next Strategic Plan for 2021–2025: (1) prioritization and resource allocation; (2) partner alignment; and (3) transparency and accountability.

Recommendation 1: Pursue a more deliberate and explicit strategy for prioritization as part of investment cases

The GFF Secretariat and Bank project teams can better support partner governments via co-production of analytical products that explicitly prioritize along two dimensions: first, defining *which* RMNCAH-N services and products should be prioritized within a set, realistic budget constraint and given existing spend that cannot be reallocated (e.g., hospital spend); and second, identifying *how* specific financing modalities, health system transformations, and service delivery reforms can best support more efficient and equitable delivery of the prioritized interventions and products. The GFF's investors should scale Secretariat resources for prioritization as needed, especially through staff and consulting capacity, to offer sufficient technical support for a deliberative country-led prioritization process that accounts for various trade-offs between different resource uses. It is important to note that discrete prioritization exercises within specific disease areas can undermine prioritization efforts across full health systems (e.g., through HBPs). GFF support in this area should ideally help countries (and nudge other donors) to move towards a sector-wide approach to prioritization.

- *Nudge partner countries to use priority setting approaches with explicit budget constraints.*

Our analysis shows that several prioritization tools are used in the investment case development process; these are typically used to rank order interventions by health impact (e.g., deaths averted). Still missing, in most cases, is a prioritization exercise *within* a realistic budget constraint or set of probable budget and aid scenarios. The Secretariat should nudge countries to use rigorous prioritization approaches using explicit budget constraints and provide proactive advice to governments and country-level partners on how best to incorporate such analyses into the investment case development process. Further, World Bank operations that include a performance-based component should consider cost-effectiveness criteria to determine the highest priority services to incentivize and track, where feasible. Other relevant approaches for context-specific consideration include rapid review of EML/medicines procurement to identify inefficiencies and opportunities for cost savings⁶⁵ (discussed further below); a league table approach⁶⁶; and/or rapid budget impact analyses to identify cost-ineffective interventions which are significant cost drivers. Since our analysis suggests that prioritization of *specific* RMNCAH-N interventions within World Bank lending operations has been inconsistent, improved prioritization would also enable better resource allocation within World Bank operations through the incorporation of a specific subset of

⁶⁵ Silverman, Rachel, Janeen Madan Keller, Amanda Glassman, Kalipso Chalkidou. "Tackling the Triple Transition in Global Health Procurement: Final Report of CGD's Working Group on the Future of Global Health Procurement." *Center for Global Development*, June 2019, p. 33. www.cgdev.org/sites/default/files/better-health-procurement-tackling-triple-transition.pdf#page=33; Teerawattananon, Yot, Nattha Tritasavit, Netnapi Suchonwanich, et al. "The use of economic evaluation for guiding the pharmaceutical reimbursement list in Thailand." *The Journal of Evidence and Quality in Health Care*, 108, no. 7, 2014. [https://zefq-journal.com/article/S1865-9217\(14\)00154-8/fulltext](https://zefq-journal.com/article/S1865-9217(14)00154-8/fulltext)

⁶⁶ Horton, Susan, Hellen Gelband, Dean Jamison, et al. "Ranking 93 health interventions for low- and middle-income countries by cost-effectiveness." *PLoS One*, 12, no. 8, 2017. www.ncbi.nlm.nih.gov/pmc/articles/PMC5552255/

RMNCAH-N services and products into PADs and more consistently aligned indicators between investment cases and PADs.

We recognize that political economy dynamics often complicate efforts to explicitly defining priorities at the national and/or sub-national levels. However, such exercises nevertheless prompt an important conversation among the government and its partners, forcing all parties to understand trade-offs and reckon with the costs of deprioritizing (e.g., not funding) specific services. In this way, explicit prioritization processes within a budget constraint can help avoid *ad hoc* allocation leading to inequity, and potentially prompt additional resource mobilization.

- *Review RMNCAH-N product selection and procurement, and create regionally focused menus/plans of cost-effective RMNCAH-N products to inform future purchasing.*

Product selection and procurement represent a core health system function that may also be “low hanging fruit” for further prioritization and visibility. The Secretariat should work with relevant partners to conduct a comprehensive review of existing RMNCAH-N procurement in the cohort of countries that have finalized investment cases and/or host active World Bank operations. This diagnostic exercise would identify inconsistencies between procurement guidance/recommendations and actual procurement practice at national and sub-national levels. Findings of the review should be used to develop regionally focused menus/plans of cost-effective RMNCAH-N products, which can in turn inform future procurement practice.

Such an exercise should consider existing evidence on RMNCAH-N products (e.g., Lancet Commission, WHO Guidance, PATH Asset Tracker) and provide context-appropriate guidance to countries. Regional bodies with norm-setting mandates, for example the Africa CDC, would be well placed to lead this effort. (See, for example, the experience of Salud MesoAmerica Initiative in developing regional procurement plans and essential commodity lists in partnership with Central American countries, regional public health research centers and COMISCA, the sub-regional association of health ministers.) In the future, regional groups of partner countries could also explore joint price negotiations and procurement, as in the African Medicines Supply Platform, for products where pooling could represent value for money and be feasible.⁶⁷

The GFF Secretariat can serve as a broker in facilitating development of these regional menus/plans, and ideally facilitate their application within each country’s investment case and World Bank procurement plans. Our analysis—alongside previous related efforts⁶⁸—has surfaced the need for future investment cases to include additional technical details about

⁶⁷ Chalkidou, Kalipso and Robert Hecht. “Why HTA and Pooled Purchasing Must Be at the Heart of Global Health Transitions.” *Center for Global Development*, January 2020. www.cgdev.org/blog/why-hta-and-pooled-purchasing-must-be-heart-global-health-transitions

⁶⁸ “Improving Access to RMNCAH Commodities.” GFF, November 2016. www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF_IG4_Commodities_EN-FINAL.pdf

procurement of RMNCAH-N products. To this end, World Bank operations can also use the menu to nudge procurement at the national and sub-national levels towards the most cost-effective RMNCAH-N products. Going forward, the Secretariat should also encourage partner countries to conduct a detailed and standardized analysis alongside the investment case development process on the prioritization of RMNCAH-N products, drawing on recommendations included in the regionally focused menus/plans.

- *Develop a formal diagnostic, alongside the investment case process, to assess existing health system constraints and identify reforms required to improve delivery of RMNCAH-N services and products.*

The Secretariat should develop a more formal diagnostic to assess systems challenges and inform health financing and systems reforms—linked to specific service delivery indicators—in order to enhance the equity and coverage of key RMNCAH-N services. Such an exercise would assess factors such as the relative importance of existing constraints to service scale up and/or greater impact; scenario-planning (including projected impact) vis-a-vis a set of possible reforms; and the relative cost-effectiveness of different delivery modalities/platforms, among others. This diagnostic should ideally be conducted alongside the investment case, leveraging the GFF’s convening power vis-a-vis the government and other relevant partners for RMNCAH-N priorities.

Specifically, the diagnostic could include the following dimensions: allocation between geographic areas; allocation to specific population groups (including via fee waivers, vouchers, or cash transfers); allocation between levels of care or types of providers (hospital vs. clinic); purchases of medicines and other products; amount of funding that reaches frontline providers; autonomy given to providers in use of resources; and execution of spending by different budget-holders, among others. This kind of analysis is generally common in World Bank sectoral operations, knowledge products and public expenditure reviews; greater synergy is needed between the GFF IC work and the Bank’s routine accompanying Analytic and Advisory Activities.⁶⁹

The diagnostic would inform more deliberate and systematic consideration of the factors related to *how* interventions and products can be delivered in the most efficient manner to achieve the highest impact, enhancing the GFF’s contributions to addressing critical health system constraints and building more resilient, equitable, and sustainable health financing systems at the country level.

⁶⁹ Notes on World Bank’s Analytic and Advisory Activities (AAA): These kinds of health system reforms are included in many World Bank health operations and some of the operations co-financed by the GFF, for example: the geographic reallocation of monies according to need in Ethiopia; and strengthening health system capacity is one of three components of the Burkina Faso operation which receives GFF co-financing and focuses on providing financing and technical assistance for the roll out of health financing reforms. See more here: https://elibrary.worldbank.org/doi/abs/10.1596/978-1-4648-0484-7_analytic_and_advisory

Recommendation 2: Explore incentives for greater “on-project” co-financing

The COVID-19 fiscal crisis, coupled with uncertainty around development assistance for health, is likely to constrain RMNCAH-N financing in many GFF-eligible countries. As countries face mounting fiscal pressures in the pandemic recovery period,⁷⁰ World Bank operations—alongside other sources of external support—represent a critical source of financing to support delivery of essential RMNCAH-N and other primary healthcare services and products. In tandem, greater ‘on-project’ financing—pooled, on-budget resources that are aligned within World Bank operations—offers an opportunity for more efficient use of available external funds in support of national RMNCAH-N priorities through integration with countries’ own budget cycles.⁷¹ Exploring options to incentivize greater ‘on-project’ co-financing should be a priority for the GFF’s next strategic period and a key objective to guide the efforts of its newly formed working group on partner alignment.⁷² Specific options to pursue include the following actions.

- *Explore additional flexibilities for donor co-financing within World Bank operations.*

As discussed earlier, several operational and political factors limit ‘on-budget’ co-financing by other external donors. Where individual donor project/budget cycles do not align with development and approval of the World Bank operation, a rolling arrangement that enables buy-ins by other donors during the implementation period could be considered. Where ‘on-project’ co-financing is not technically or politically possible, the GFF Secretariat and relevant World Bank teams should at minimum ensure that ‘off-project’ co-financing for RMNCAH-N is explicitly described and accounted for in World Bank project documents.

- *Conduct additional analysis to understand the trade-offs across different alignment approaches.*

Additional analysis is needed to better understand the trade-offs between (1) co-financing for RMNCAH-N results within World Bank IDA/IBRD operations; (2) Sector-wide Approaches (SWAp); and (3) ‘off-project’ financing which remains dominant in countries within the GFF portfolio. The GFF should increase transparency and facilitate such analysis by reporting more explicitly about any ‘off-project’ co-financing included in its figures, including source (donor/government), purpose, and modality. Further analysis is also required to identify conditions under which off-project co-financing can be most effectively aligned with government priorities, given potentially high transaction costs for on-project co-financing or prohibitive donor regulations/budget cycles. A new World Bank report on donor alignment

⁷⁰ Kurowski, Christoph, David B Evans, Ajay Tandon, et al. “From Double Shock to Double Recovery : Implications and Options for Health Financing in the Time of COVID-19.” World Bank, September 2021. <https://openknowledge.worldbank.org/handle/10986/35298>

⁷¹ Piatti, Moritz, Ali Hashim, Sarah Alkenbrack, and Srinivas Gurazada. “Are development partners using government systems?” World Bank, November 2021. <https://blogs.worldbank.org/health/are-development-partners-using-government-systems>

⁷² “GFF Alignment Working Group: Terms of Reference.” March 2021. www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF-IG12-4-Strategy-Operationalization-Alignment-TOR.pdf

and government systems offers a set of diagnostic criteria for each stage of a country's budget cycle (prioritization, budget formulation and financing, budget execution, and budget evaluation) to help development partners and countries establish a public financial management baseline and identify opportunities to support greater use of country systems.⁷³ This framework could be useful for the GFF and its partners to more deliberately outline the roles of each stakeholder in aligning to country systems. A more complete understanding of the benefits and drawbacks offered by different alignment approaches should guide the GFF's future efforts at external partner alignment.

Recommendation 3: Increase transparency and accountability, particularly for co-financing and resource tracking, procurement, and performance tracking

Our portfolio analysis and related assessments⁷⁴ have highlighted the overall need for more transparency and accountability along three important dimensions: co-financing by external partners and resource tracking; procurement of RMNCAH-N products; and progress and results for coverage and impact of RMNCAH-N services, accompanied by independent performance verification as relevant.

Going forward, the GFF Secretariat and its investors should pursue the following efforts to improve overall transparency and accountability and further strengthen engagement of civil society, the private sector, and other partners in the investment case and related processes.

- *Publish more data and information on parallel co-financing and overall resource tracking in the public domain.*

More information is needed to understand how other donors operationally align behind the investment case in each country context. To date, this has been poorly defined and not systematically documented in the public domain. Beyond top-line information about the amount of resources committed towards the investment case by the government and each external donor, more granular information on what specific interventions is being supported by different sources of financing and where resource gaps remain would be a helpful start.

The GFF Secretariat should work with partner countries to release the data and information in a consolidated manner and with regular frequency—potentially on an annual or bi-annual basis as feasible. Putting this information in the public domain would enable independent/civil society organizations at the local, regional, and global levels to conduct more in-depth

⁷³ Piatti, Moritz, Ali Hashim, Sarah Alkenbrack, and Srinivas Gurazada. "Following the Government Playbook? Channeling Development Assistance for Health through Country Systems." World Bank, 2021. <https://documents1.worldbank.org/curated/en/332531634794859261/pdf/Following-the-Government-Playbook-Channeling-Development-Assistance-for-Health-through-Country-Systems.pdf>

⁷⁴ "Comparative Analysis of the GFF." E&K Consulting, 2020. www.csogffhub.org/wp-content/uploads/2019/12/Comparative-Analysis-of-the-Global-Financing-Facility-Enhancing-inclusivity-transparency-and-accountability-2019.pdf

analyses on the overall alignment agenda, enabling greater transparency and accountability of both partner governments and donors.

- *Report on GFF-supported procurement of RMNCAH-N products in the public domain.*

Additional information about what specific RMNCAH-N products are being procured in GFF partner countries is also needed in the public domain. This information should ideally be provided on a regular basis in a structured database (e.g., not exclusively in text-based procurement plans).

- *Share additional information on progress and results of coverage and impact of RMNCAH-N services, particularly for ‘off-project’ co-financing.*

While the GFF provides high-level consolidated reporting on progress and results for key RMNCAH-N coverage and impact indicators, there is limited information in the public domain about specific results associated with ‘off-project’ co-financing of investment cases from different development partners. This makes it difficult to track the overall use and performance of these funding flows. In turn, the lack of visibility limits accountability for progress and results, but also curtails efforts to learn lessons about what is and is not working as the GFF scales to support additional partner countries during its next strategic period.

6. Annexes

Annex 1. List of all investment cases and World Bank projects included in analysis

Country, n = 27	Publicly Available Investment Cases, n = 18	World Bank Operations, n = 32	World Bank Project ID, n = 32
Afghanistan	–	Afghanistan Sehatmandi Project	P160615
Bangladesh	Health, Nutrition and Population Strategic Investment Plan (HNPSIP) 2016–21	Health Sector Project Transforming Secondary Education for Results Operation	P160846 P160943
Burkina Faso	Améliorer la sante de la reproduction, de la mère, du nouveau-né, de l'enfant et de l'adolescent-jeune, de la nutrition et de l'état civil et statistiques vitales dossier d'Investissement	Health Services Reinforcement Project	P164696
Cambodia	–	Cambodia Nutrition Project	P162675
Cameroon	Dossier D'Investissement Pour L'Amélioration de la Santé de la Reproduction, Sante de la Mère, du Nouveau-Né, de L'enfant et de L'Adolescent/Jeune au Cameroun	Health System Performance Reinforcement Project	P156679
Central African Republic	Dossier D'Investissement Pour La Réduction de la Mortalité Maternelle, Néonatale et Infanto-juvénile, et Pour L'Amélioration de la Santé des Adolescents	Health System Support and Strengthening Project	P164953
Côte d'Ivoire	Dossier D'Investissement 2020–2023	Strategic Purchasing and Alignment of Resources and Knowledge in Health Project	P167959
Democratic Republic of the Congo	Plan National de Développement Sanitaire recadré pour la période 2019–2022: Vers la couverture sanitaire universelle	Human Development Systems Strengthening Project Health System Strengthening for Better Maternal and Child Health Results Additional Financing Multisectoral Nutrition and Health Project	P156421 P157864 P168756
Ethiopia	Health Sector Transformation Plan 2015/16–2019/20	Additional Financing for the Health Sustainable Development Goals Program for Results	P160108
Guatemala	Cruzada Nacional por la Nutrición 2020–2024	Crecer Sano: Guatemala Nutrition and Health Project	P159213
Guinea	Dossier D'Investissement Pour la Santé Reproductive, Maternelle, Néonatale, Infantile, Adolescente (SRMNIA) en Guinée 2017–2020	Health Service Capacity and Strengthening Project	P163140
Haiti	–	Strengthening Primary Health Care and Surveillance Project	P167512

Country, n = 27	Publicly Available Investment Cases, n = 18	World Bank Operations, n = 32	World Bank Project ID, n = 32
Indonesia	*	Investing in Nutrition and Early Years Project	P164686
Kenya	Kenya Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Investment Framework	Transforming Health Systems for Universal Care Project	P152394
Liberia	Investment Case for Reproductive, Maternal, Newborn, Child, and Adolescent Health 2016–2020	Health Systems Strengthening Project	P162477
Malawi	–	Investing in Early Years for Growth and Productivity Project	P164771
Mali	*	Accelerating Progress Towards Universal Health Coverage	P165534
Mozambique	Global Funding Mechanism in Support of All Women and All Children – Investment Case Proposal Version IV	Primary Health Care Strengthening Program Project	P163541
Myanmar	–	Additional Financing: Essential Health Services Access Project	P160208
Nigeria	Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition Investment Case 2017–2030	Accelerating Nutrition Results	P162069
		Nigeria States Health Investment Project	P120798
		Basic Healthcare Provision Fund (HUWE Project)	P163969
Rwanda	NECDP National Strategic Plan 2018–2024: Rwanda Integrated Early Childhood Development Investment Case	Rwanda Stunting Prevention and Reduction Project	P164845
		Strengthening Social Protection Project Additional Financing	P166720
Senegal	Réduction De La Mortalité Maternelle, Néonatale, Infanto-Juvenile, des Adolescents Et Des Jeunes: Dossier D’Investissement	Investing in Maternal, Child and Adolescent Health	P162042
Sierra Leone	Reproductive, Maternal, Newborn, Child & Adolescent Health Strategy 2017–2021	–	–
Tajikistan	–	Early Childhood Development to Build Tajikistan’s Human Capital Project	P169168
Tanzania	The National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child & Adolescent Health in Tanzania (2016–2020): One Plan II	Strengthening Primary Health Care for Results Program	P152736
Uganda	Investment Case for Reproductive, Maternal, Newborn, Child and Adolescent Health Sharpened Plan for Uganda 2016/17–2019/20	Reproductive, Maternal and Child Health Services Improvement Project	P155186
Vietnam	–	Investing and Innovating for Grassroots Health Service Delivery	P161283

Note: *Investment cases posted after June 2020 are not included in our analysis; the investment cases for Mali and Indonesia were made publicly available after our analysis began and are excluded from our sample.

Annex 2. Stakeholder interviews

Background

To complement the desk-based review, CGD partnered with Impact for Health International to lead discussions with key stakeholders at the global and national levels to help ground and provide nuance to the project's findings and recommendations. Specifically, the interviews focused on two main areas: 1) GFF's model for prioritization and selection of RMNCAH-N interventions/products (specifically related to the development of the investment case) and 2) the extent to which GFF processes influence alignment of RMNCAH-N resource allocation by other bilateral and multilateral donors.

20 in-depth, qualitative interviews were conducted. Interviewees were selected based on first-hand knowledge about the GFF and its associated processes and included a range of perspectives including in-country, global, internal, and external. GFF Focal Points and World Bank Task Team Leaders were interviewed first to allow for efficient introductions to be made to GFF Liaison Officers and government counterparts. Donor perspectives were gathered from Canada, Norway, Germany, and the UK.

Interview questions

The interview guide was structured around the following questions:

1. From your perspective, to what extent do you feel that prioritization in the RMNCAH-N investment cases aligns with resource availability?
2. To what extent do you feel that GFF processes, including the investment case development process, influence resource allocation from other donors?
3. Do you have any recommendations for how to revise the investment case development and GFF funding processes to increase their relevance to and impact on government resource allocation decisions?
4. Where do you see specific value add of a financing mechanism like GFF?

List of interviewees

Name	Organization	Title
Aboubacar Begou Chaibou	Global Financing Facility	Liaison Officer, Niger
Alain-Desire Karibwami	Global Financing Facility	Secretariat Focal Point, Burkina Faso, Chad, Senegal
Ayodeji Oluwole Odutolu	Global Financing Facility	Secretariat Focal Point, Sierra Leone, Tanzania, Zimbabwe
Bastian Schwarz	Deutsche Gesellschaft für Internationale Zusammenarbeit	SRHR Advisor
Charlotte Nielsen	Global Financing Facility	Secretariat Focal Point, Cote d'Ivoire, Mauritania, Niger
Djéneba Ouattara	Ministry of Health, Cote D'Ivoire	

Name	Organization	Title
Cheikh Oumar Diop	Ministry of Health, Mauritania	
Patron T. Mafaune	Global Financing Facility	Liaison Officer, Zimbabwe
Ingvar Theo Olsen	Norwegian Agency for Development Cooperation	Policy Director
James Droop	UK Foreign, Commonwealth & Development Office	Senior Advisor
Matt Boxshall	ThinkWell Global	Program Director
Matthew T.K. Flomo	Ministry of Health, Liberia	
Meena Gandhi	UK Foreign, Commonwealth & Development Office	Health Advisor
Munirat Iyabode Ayoka Ogunlayi	Global Financing Facility	Secretariat Focal Point, Bangladesh, Liberia, Nigeria
Patrick M. Mullen	World Bank	Task Team Leader, Ghana, India, Bangladesh
Paul Jacob Robyn	World Bank	Task Team Leader, Cameroon, Burkina Faso, Ethiopia, Myanmar
Samora Otieno	British High Commission	Health Team Leader, Kenya
Toni Lee Kuguru	World Bank	Task Team Leader, Kenya, Malawi
Tracey Bender	Global Affairs Canada	Senior Policy Analyst
Wangui Muthigani Mbuthia	Ministry of Health, Kenya	

Annex 3. Investment case excerpts by prioritization approach

Annex Box 1. Excerpts, investment cases with service prioritization based on CEA/CBA

- *Liberia*: “The Liberia Country Team decided to use the MBB tool for the development of RMNCAH Investment case (GFF)... Upon comparison of outcomes, the team chose to use the moderate scenario as the basis for investment; its impact was comparable to the comprehensive package and yet it cost less to implement. In addition, the cost per capita required in this package was in tandem with the cost of the basic package for essential health services.” (p. 83–84)
- *Nigeria*: “In line with the goals and guiding principles of the National Strategic Health Development Plan II and the IRMNCAH + N Strategy, priority was given to the most effective interventions that can be delivered at the lowest cost to the highest number of people, to yield the greatest health gains.” (p. 31)
- *Uganda*: “A package of high-impact interventions for each level of the health system has been defined... This package was identified through a combination of modelling the potential lives saved using the Lives Saves Tool (LiST) and expert judgment.” (p. 20); “The costing analysis weighs three scenarios... An average annual per capita investment of US\$ 1.42 in scenario two, MMR would translate into a 2.2% annual reduction rate in MMR compared to US\$ 2.88 average annual per capita investments and 3% annual reduction rate in MMR under scenario three. This translates to annual per capita investment of US\$ 0.65 for each percentage point in maternal mortality reduction for scenario two compared to US\$ 0.96 under scenario three. Similarly, US\$ 0.23 compared to US\$ 0.36 is need for a percentage point reduction in U5MR. Therefore, scenario two is adopted as the best buy for investment as it is more cost efficient.” (p. 37)

Annex Box 2. Select excerpts of investment cases with CEA/CBA but no explicit prioritization

- *Kenya*: “The results... show that scaling up coverage through the RMNCAH investment framework would confer benefits in terms of child and maternal lives saved. These estimates of additional deaths averted (lives saved)... were used to carry out cost benefit analysis of the investment framework.” (p. 67)
- *Mozambique*: “A preliminary analysis of the cost-effectiveness ratio of the IC confirms that the cost per year of life year gained is 2.3 times Mozambique’s current GDP per capita, which is within the range defined by the World Health Organization, despite the high proportion of investment in human resources and infrastructures.” (p. 13); “It is suggested that the investments that can not be jeopardized in case of limitations of available financing are...” (p. 88).
- *Cameroon*: « L’atelier de renforcement des capacités utilisant l’outil EQUIST qui était plus technique et a permis de créer un certain nombre de scénarios avec différentes interventions portant sur diverses entités pathologiques pour voir les résultats possibles, ce qui a abouti à :

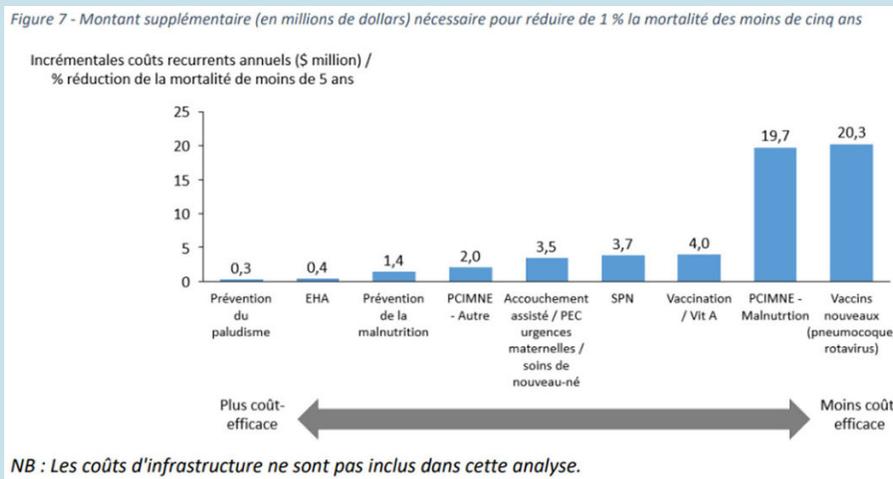
- Définir les populations prioritaires
- Prioriser les problèmes de santé
- Prioriser les interventions de santé à haut impact
- Prioriser les goulots d'étranglement
- Identifier les causes des goulots d'étranglement
- Sélectionnez les stratégies nécessaires pour dénouer les goulots d'étranglement et
- Estimer le coût-efficacité de différents scénarios d'interventions et le nombre de vies sauvées. » (p. 217)

“The capacity building workshop using the EQUIST tool, which was more technical, enabled the analysis of different intervention scenarios and possible outcomes, which resulted in:

- Defining priority populations
- Prioritizing health problems
- Prioritizing high impact health interventions
- Prioritizing bottlenecks
- Identifying the causes of bottlenecks
- Selecting the strategies to resolve bottlenecks and
- Estimating the cost-effectiveness of different intervention scenarios and the number of lives saved.”

- *Guinea*: « La Figure 7 indique le rapport coût/efficacité de différents programmes d'intervention de SRMNIA. » (p. 28)

“Figure 7 shows the cost-effectiveness of different RMNCAH interventions”



Annex Box 3. Excerpts, investment cases with ranked interventions by health impact

- *Burkina Faso*: Compares the cost of interventions for minimum, medium, and maximum scenarios based on coverage; minimum scenario is based on slightly increasing coverage by 5 percent, the medium scenario is based on attaining targets outlined in the investment case, and the maximum scenario is based on projects included in the National Health Development Plan 2011–2020.

« Aussi, les coûts des interventions des différents programmes de santé, intervenants dans l'amélioration de la santé de la mère, des enfants et des adolescents/jeunes ont été pris en compte dans leurs volets « interventions ». Le scénario minimum repose sur le maintien des acquis en matière de couvertures des interventions avec une légère augmentation de l'ordre de 5% sur les couvertures. Le scénario moyen repose sur les couvertures attendues dans le DI- SRMNEAN-ECSV. Le scénario maximum repose sur les projections du PNDS 2011–2020. » (p. 106)

- *Central African Republic*: Outlines different scenarios for targeted regions, coverage levels, and 2 intervention packages: full and minimum. Used EQUIST to identify a packet of priority interventions. The adopted scenario was selected based on lives saved and RMNCAH-N indicators.

« L'analyse de la situation menée au début du processus—appuyée par le développement et l'exploitation d'une application EQUIST—avait permis de ressortir un paquet d'interventions prioritaires essentielles à la santé de la mère, du nouveau-né de l'enfant et de l'adolescent. Le premier exercice de priorisation a permis de décomposer le pays en 3 zones selon le niveau de couverture et de dégager 3 scénarios de mise en œuvre du même paquet d'interventions prioritaires à haut impact retenu. » (pp. 48 et 54)

- *Cote d'Ivoire*: Only presents resource requirements for scenario involving nation-wide rollout. The financing gaps section (5.5) lays out different budget hypotheses—reference scenario; realistic scenario; optimistic scenario based on the govt contributions to health. But then they don't go any further in saying how to prioritize based on available resource envelope; Regional targeting based on “needs” (aka RMNCAH-N indicators) Used EQUIST to calculate lives saved for different regional targeting scenarios.

« D'après les calculs de l'outil EQUIST, 388 décès maternels pourraient être évités chaque année dans le cadre du scénario N° 1 par rapport au niveau de 2016, 1 373 décès selon le scénario N° 2 et 2 553 décès d'après le scénario N° 3 qui couvre les 11 régions.

L'outil EQUIST montre qu'investir dans les services de premières lignes et dans les systèmes nécessaires à l'ensemble du pays entraînera une baisse importante du nombre de décès maternels et des moins de 5 ans. » (pp. 33–34).

- *Democratic Republic of the Congo*: Uses One Health Tool (see p. 59); In discussing the financing gap, presents a range of high-level strategies to minimize the financing gap (e.g., increase allocation to health, improvements in tax admin, new/additional taxes, etc. see p. 62).

« Pour estimer le cout total du paquet de soins de la CSU formulé par les experts, le MSP, avec l'appui des consultants de la Banque Mondiale, a employé le logiciel One Health Tool (OHT). Pour chaque intervention incluse dans le paquet, l'OHT est renseigné sur son cout unitaire à partir de suppositions sur les intrants requis (ressources humaines, médicaments, véhicules, équipement, infrastructure, etc.). L'utilisation de ces interventions est obtenue en multipliant la couverture de la population et les taux de couverture espérés dans chaque année. Le cout total est obtenu en multipliant le cout unitaire de chaque intervention par l'utilisation attendue.» » (p. 59)

- *Ethiopia*: “The OneHealth Tool (OHT) was used to compute the resource requirements for implementing this health sector transformation plan.” (p. 122); “The overall funding gap of HSTP ranges from 10% in high resource case and base case costing scenario to 44% in high case costing and low resource projection model scenario.” (p. 139); “The annual resource constrained evidence based planning process will align targets and resource requirements. If innovative financing and enhancing efficiency gains do not eliminate the funding gap, the sector will prioritize interventions and flagship programs during the annual evidence bases planning process.” (p. 140).
- *Sierra Leone*: “The known evidence based high impact interventions were modelled through use of LiST tool, those averting more deaths were prioritized.” (p. 36); “All investments needed for delivering the package of health interventions identified in this RMNCAH Strategy have been included in the cost estimate[s] presented... These scenarios represent the investments required to execute the key actions, strategies and interventions to meet the outcomes and targets presented in the RMNCAH strategy. The interventions modelled by these policy scenarios were established by the Live Saved Tool (LiST) analysis to have the biggest impact on mortality and development outcomes.” (p. 56).
- *Tanzania*: “For the purpose of costing all activities prioritised in the One Plan II; each program identified key interventions activities to be costed... The costing of the One Plan II activities was conducted in two-stages. Stage one involved using the Lives Saved Tool (LiST) to estimate intervention impact. The second stage used UN One Health Costing Tool for the financial projections required to address the identified priorities and implement planned activities. It estimates the costs by health program and the implications for health system components, it also estimates health impact achieved by scale-up, using UN approved epidemiological and impact models.” (p. 56).

Annex 4. Snapshot of disbursement-linked indicators in select World Bank operations

Annex Table 1. Overview of disbursement-linked indicators in Tanzania PforR operation

DLI	Disbursement Frequency and Approach	US\$ M	% of Total Project (\$300M)	Other Partners Adopted DLI
1. Recipient has completed all foundational activities	US\$2 million each for the first five activities upon achievement and US\$10 million for the sixth activity	20	6.7%	–
2. Recipient has achieved all of the Program annual results in institutional strengthening at all levels (national, regional, LGA and facilities)	Annual All-or-nothing	75	25.0%	“Other development partners”
3. PHC facilities have improved maternal, neonatal and child health service delivery and quality as per verified results and received payments on that basis each quarter	Quarterly Sliding scale	100	33.3%	USAID
4. LGAs have improved annual maternal, neonatal and child health service delivery and quality as measured by the LGA Balance Score Card	Annual Sliding scale	82	27.3%	“Other development partners”
5. Regions have improved annual performance in supporting PHC services as measured by regional Balance Score Card	Annual Sliding scale	2.4	0.8%	“Other development partners”
6. MOHSW and PMO-RALG have improved annual PHC service performance as measured by the national Balance Score Card	Annual Sliding scale	5.6	1.9%	“Other development partners”
7. Completion of annual capacity building activities at all levels	Annual Sliding scale	15	5.0%	–

Annex Table 2. Comparison of World Bank project development objectives and investment case indicators—Kenya

Investment Case Indicator	WB Project Development Objective	Investment Case Targets (Baseline to Target)	WB Targets (Baseline to Y5)	Updated Targets (Baseline to Y5)
Children receiving all basic vaccinations by 12 months of age: BCG, measles and three doses each of DPT-HepB, polio (excluding polio vaccine given at birth)	Children younger than 1 year who were fully immunized *Children immunized with the third dose of Pentavalent	71.3% → 76%	73% → 76%	79.5% → 84%
Women aged 15–49 who had at least 4 prenatal visits attended by trained health personnel	Pregnant women attending at least four ANC visits	58% → 69%	40% → 46%	39.7% → 52%
Deliveries by skilled provider	Births attended by skilled health personnel	62% → 87%	57% → 64%	57% → 67%
Currently married women using modern contraceptive method	Women between the ages of 15–49 years currently using modern FP method	53% → 72%	41% → 45%	47.8% → 52%
–	Inspected facilities meeting safety standards	–	0% → 50%	0% → 50%
–	*Pregnant women attending ANC supplemented with IFA	–	31% → 40%	31% → 73%

Source: Investment Case Indicators & Targets: Kenya Investment Framework; WB PDOs & Targets: PAD; Updated Targets: Restructuring Paper.

Note: *Indicates changes made after restructuring.