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The Global Financing Facility at five: time for a change?

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The Global Financing Facility (GFF) was initiated in 2015 to contribute to filling the existing financing gap to implement the United Nations' "Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)", with the objectives of ending preventable deaths and achieving a better quality of life for women, children, and adolescents in low- and middle-income countries (LMICs). It aims to contribute to universal health coverage (UHC) with high-impact, cost-effective interventions in areas that are often underfunded, such as sexual and reproductive health and rights (SRHR), by mobilising additional resources for reproductive, maternal, neonatal, child, and adolescent health and nutrition (RMNCAH-N).

The GFF, a platform bringing together different stakeholders in RMNCAH-N, manages a multi-donor trust fund at the World Bank to catalyse additional funding for RMNCAH-N and SRHR projects in 67 potentially eligible countries based on gross national income (GNI), disease burden, and unmet need related to SRHR. Country grants from this fund are intended to leverage loans from the World Bank, specifically the International Development Association (IDA) and International Bank for Reconstruction and Development (IBRD), to finance RMNCAH-N activities. The GFF states that 30% of its funds will go to family planning¹ in the beneficiary countries, putting SRHR high on the agenda.

When joining the GFF, governments commit to developing the RMNCAH-N Investment Case, which determines priorities for the national strategy for women's, children's and adolescents'

health, and defines which interventions will be part of the funded benefit package. The GFF grant itself is meant to pay for a fraction of this comprehensive strategy but allows the leveraging of loans for health, thus potentially increasing total health expenditure, provided that the government commitment remains at the same level and that the resources will not become fungible. The country-specific "Project Appraisal Documents", developed by the World Bank, explain how these resources will be spent over the project's lifespan, usually five years. While governments are expected to raise most resources domestically, international donors can also contribute. As part of the process, the GFF also aims to stimulate the development or revision of an up-to-date sector-wide health financing strategy to indicate how revenues will be raised sustainably and allocated efficiently.

In 2018, the GFF was successfully replenished with above an additional US\$ 1 billion from a variety of donors, including bilateral cooperation agencies, the European Union, private sector donors and foundations. With nine new countries joining in 2019, the GFF expanded to a current total of 36 beneficiary countries worldwide, one third categorised as "fragile and conflict-affected states".² By 2030, the GFF envisions covering the 50 of the 67 eligible countries that are most in need regarding RMNCAH-N. As of June 2019, US\$ 629 million was committed in 27 countries with an additional US\$ 4.8 billion from IDA/IBRD funds. However, only US\$ 120 million from GFF and US\$ 901.5 million from IDA/IBRD are disbursed so far.²

After five years of implementation in a high variety of country contexts, a “Strategy Refresh”³ and a governance reform of the GFF Investors Group have been announced. We find it timely to take stock of how the GFF has been operating at global and country level, how it has been governed and whether it has achieved its objectives. We will first present the GFF governance model including recent developments, and then focus on aspects of two strong GFF promises: increasing domestic resource mobilisation for health, and strengthening health systems. We base the following commentary on observations in GFF countries – such as the Democratic Republic of the Congo (DRC), Kenya, Malawi, Mozambique, Tanzania and Uganda – that include stakeholder interviews and were already part-published as briefing papers,⁴ as well as on GFF-specific documents including from other GFF countries. The country briefing papers were informed by a variety of stakeholders in the respective countries and put together by Wemos Foundation together with national partners (The Center for Human Rights and Development in Uganda, Health Promotion Tanzania, Malawi Health Equity Network, and WACI Health Kenya).

From model to country reality

As reported by the GFF, indicators have started to show improvements in health care provision and delivery in at least seven recipient countries (DRC, Ethiopia, Kenya, Mozambique, Nigeria, Tanzania and Uganda), following a trend that had begun for these countries in the era of the Millennium Development Goals. For instance, antenatal coverage in Tanzania has improved from 35.8% of women receiving four antenatal care visits in 2014 to 64.1% in 2018. In Nigeria, the government committed to increasing the budget allocated to the basic health care provision fund, providing a free minimum benefit package that included antenatal care, facility-based delivery, family planning, and other services to all Nigerians.² Of course, it is important to note that a variety of external partners have been contributing to the health sectors in GFF countries and, therefore, that improvements in health indicators can be attributed neither to the GFF-linked investments, nor to any other single source of funding.

Country studies in three out of the seven countries mentioned in the GFF’s Annual Report as well as others, however, reveal challenges in different aspects of the GFF model.⁴ GFF and

World Bank representatives, as well as recipient government officials, have been found to fail to align with GFF-stated core values such as transparency and inclusiveness for all stakeholders and specifically for civil society. Furthermore, there are concerns about the level of domestic resource mobilisation that the GFF has achieved, and how this translates into more investment in health with the potential to address key health system bottlenecks such as insufficient numbers of employed health workers.⁵

Governance issues at global level

Three key bodies collectively govern the GFF at global level. The *Trust Fund Committee (TFC)*, a set of donor representatives contributing over US\$ 30 million each annually and World Bank representatives, has the main decision-making power. For example, it decides which countries are eligible to benefit from GFF Trust Fund support and approves the selection of countries for GFF Trust Fund financing. It also provides strategic guidance, defines the principles and priorities of the GFF, reviews the annual plans and approves the allocation of GFF financing to global public goods.⁶ The TFC is strategically advised by the *Investors Group*, a now 32-seat multi-stakeholder group including financially and technically contributing donors, civil society, private sector, and recipient country representatives. The seats of recipient country representatives increased from four to nine in the recent Investors Group reform. This large and heterogeneous group of stakeholders in RMNCAH-N is intended to contribute with diverse and comprehensive expertise. The *GFF Secretariat* supports the TFC and Investors Group and carries out GFF operations and daily management.

Given the multitude of stakeholders involved in GFF governance, there have been challenges regarding each group’s mandate. The Investors Group commissioned an independent review to clarify the roles of the TFC, the Secretariat and its own, in order to increase effectiveness and accountability.⁷ This review resulted in an Investors Group governance reform plan, presented and decided on in November 2019, that included a refinement of the Investors Group functions. A new governance document was approved including the intention to foster joint ownership and alignment around country platforms and country-led investment cases; enhance health

financing support in countries and increase the total volume of health financing; systematically review the GFF performance as a facility; and provide strategic advice to the TFC. Other decisions include the institution of a co-chair function for a country representative and the establishment of two standing committees, one on country engagement and one on monitoring country progress. However, this reform does not concern the TFC. While representation of recipient countries has now increased in the Investors Group, the TFC, as a decision-making entity, does not include representatives of recipient countries and civil society, a concern already addressed to the GFF Secretariat prior to the 2018 replenishment in an open letter by civil society.⁸ The inclusion of recipient country representatives in the TFC with equal voting rights could ensure true ownership of the GFF programmes in line with the Paris Declaration on Aid Effectiveness.⁹ One of the TFC's roles regards resource mobilisation and the promotion of increased domestic resources to support countries' Investment Cases and would benefit from active participation of recipients' representatives.⁶

Civil society now holds 3 seats out of 32 at the Investors Group, with alternates. The third seat with its alternate, representing the youth constituency, was added in 2019, after combined advocacy efforts of the global civil society community. Apart from the newly created space in the Investors Group, civil society needs to sit at the decision-making table of the TFC with full voting power to make best use of its knowledge, experience and expertise. This guarantees that the GFF can fully leverage civil society's ability to promote and uphold good governance, social accountability and legitimacy.

Importantly, the manner in which the GFF multi-donor trust fund is set up necessitates tight adherence to World Bank policies and regulations. While the proximity between the GFF and the World Bank carries advantages such as low transaction costs, access to IDA/IBRD financing and a rather small secretariat compared to other global financing mechanisms, it also comes with a strict set of rules that may limit the use of funds in line with World Bank policy.

Governance issues at national level

At national level, the Country Platform (CPF), led by the respective Ministry of Health, is the GFF's

governance structure where key documents and resource mobilisation plans are developed, and coordination of technical assistance and monitoring takes place. The CPF is meant to facilitate collaborative action, transparent decision-making and mutual accountability at all stages of the planning, design, monitoring and evaluation of the implementation of the Investment Case and health financing strategy. Importantly, CPFs are supposed to be built on existing country structures and local systems, wherever possible, and not to create new mechanisms. It is up to the country to formulate its CPF, but the GFF suggests that the platform should include representatives from the government, academia, adolescents and youth, donors and foundations, other global financing mechanisms, UN agencies, healthcare professional associations, civil society and the private sector. Civil society is in fact particularly recognised by the GFF as an asset for improving the outcomes of the investments, due to their technical expertise and closeness with communities and health system users.¹⁰ Since the GFF was launched, CPFs have faced several challenges in different country contexts.

Many CPFs remained non-functional or dormant after their creation, e.g. in Tanzania and Uganda, and the GFF's principle of inclusivity was hardly met in their setup.⁴ Civil society groups are often not invited to meetings at the CPF in an inclusive manner; governments often select only a few, some hand-picked, and information and meeting invitations are not shared in a timely way. This leads to a lack of or late engagement of civil society in setting priorities in Investment Case development.¹¹ Realising the sub-optimal functioning of CPFs, the GFF employed Liaison Officers, based in the Ministry of Health or World Bank offices, to facilitate coordination and engagement of the various stakeholder groups and encourage an effective and inclusive government-led partnership process.¹² However, meaningful engagement of civil society varies and challenges remain.⁴

With an ineffective governance setup at country level, the GFF risks not achieving its objectives. As a possible second round of funding approaches first-wave GFF countries, the GFF now proposes the criterion of a functioning CPF for further eligibility. This criterion has also been adopted for new joining countries. CPF assessments are currently taking place, with the results expected by end 2020.¹³ Based on these assessments, the GFF is expected to take additional measures to achieve full

inclusiveness and transparency. Wemos Foundation has reported that a fast-tracked approach at country level could impede meaningful engagement of all stakeholders involved.⁴

Domestic resource mobilisation

One of the main objectives of the GFF is to raise additional resources from a variety of sources, emphasising a model of partnership that unites different actors around the same goal of improving the lives of women, children and adolescents. However, emphasis has been put on leveraging loans, combined with domestic resource mobilisation, to raise additional funds for RMNCAH-N. The 2018–19 Annual Report points to the GFF's success with governments allocating more resources to health, both per capita and as a percentage of government expenditure, and supporting Ministries of Health to advocate for a higher share of the government's budget. However, how much of this can be attributed to the GFF is unclear, and a recent study suggests that the GFF funds did not catalyse many new resources in the majority of the nine countries studied.⁵ This was also expressed in the diagnostic report commissioned by the GFF to provide input to the current GFF's Strategy Refresh process. The development of health financing strategies to guide governments on new and more efficient ways to raise additional domestic resources often lags behind in the GFF process, with several beneficiary countries not having made progress to date; for instance, Kenya and Malawi still lack a final health financing strategy.⁴ The GFF now puts less emphasis on requiring finalised health financing strategies and changed its course focusing on health financing reforms; however, the specifics are still unknown.

The GFF intends to support Ministries of Health to advocate for more funding for the health sector, for instance in Côte d'Ivoire where the allocation to health was declining despite increasing general revenues. At the GFF replenishment conference, the Ivorian government announced the commitment of increasing the budget's relative health share by 15% annually. The GFF plans to further build up its advocacy power with governments lobbying for more domestic resources for health.

Naturally, many of the alternative approaches to raising additional resources for health touch upon wide-ranging political and macroeconomic challenges that go beyond the health sector, such

as the risk of high indebtedness and limited public spending. The current COVID-19 pandemic will fundamentally lower capacity for domestic resource mobilisation and reshape fiscal space for health in most countries.

Civil society can bring added value in addressing these wider challenges in health financing with alternative solutions. To do so successfully requires that they are truly included and listened to in policy processes, without any fear of victimisation from the government, in order to build their capacity and strengthen their advocacy work. Therefore, we expect the GFF to value and support civil society independently, including groups active in advocacy on health financing and those serving a watchdog role.

Reducing financial barriers linked to out-of-pocket expenditure (OOP)

It is well recognised that out of pocket expenditure (OOP) is a key reason for women and children to forego necessary health care, resulting in higher neonatal, infant and maternal mortality.¹⁴ Women especially can benefit from free care, making them less dependent on their husband for health-care-seeking decisions.¹⁵ Focusing on the health of women, children, and adolescents, the GFF embeds its interventions in a broader health systems approach and means to contribute to UHC by reducing financial barriers. It promotes the generation of additional public resources for health and agrees to support countries in moving away from user fees. However, the GFF and the World Bank often fall short in addressing OOP expenditures in their "Project Appraisal Documents".

Neither Investment Cases nor Project Appraisal Documents systematically address the issue, as they do not suggest measures to mitigate OOP. The GFF Investment Case for Senegal, for instance, as well as the World Bank/GFF Project Appraisal Documents for Tanzania and Mozambique, fail to mention OOP at all.^{16–18} Without proactive measures to reduce user fees, they imply that additional resources towards increased provision of health services are unlikely to benefit the most vulnerable and those most in need of care.

In fact, during the revision of health financing strategies, the importance of reducing OOP is rarely stressed and sometimes even increased copayment schemes have been proposed.¹⁹ Additionally, as exemplified in the case of Nigeria, when GFF Investment Cases do mention OOP

reduction to improve equity, they may do so along with strong promotion of the role of the private sector for service delivery.²⁰ They do not mention the inherent tension between the delivery of health services by private for-profit corporations and the low or absent ability to pay for health services among most people in eligible countries.

On the contrary, reduction of OOP and exemption of user fees should be in fact an indicator of success for the GFF. The new monitoring committee of the Investors Group could include this in order to make sure that the GFF contributes to RMNCAH-N, SRHR and equity.

Strengthening the health workforce

The GFF Investment Case summarises the specific country's situation including population health and the setup of the healthcare system, specifically regarding women, children, and adolescents. It outlines the system's bottlenecks and the most cost-effective interventions. Of the 14 Investment Cases available on the GFF homepage, 13 reflect in one way or another that the lack of skilled health personnel is one of the major bottlenecks hampering the provision of good quality health services, e.g. counselling for safe pregnancies and deliveries, safe abortion and post-abortion care, as well as prevention and treatment of sexual and reproductive health conditions. The governments of Cameroon, Côte d'Ivoire, DRC, Ethiopia, Guinea, Kenya, Liberia, Mozambique, Senegal and Uganda refer to insufficient numbers of skilled health personnel in their health systems in their respective Investment Cases while Bangladesh made the establishment of a high quality health workforce a strategic objective. Tanzania set an increased number of skilled health workers as a target for 2020, and Guatemala formulated the goal of a 60% increase of health personnel. A fit-for-purpose, educated, motivated and supported health workforce is core to the attainment of SRHR but in many countries health workers per population ratios fall short of WHO standards. Even in countries that train enough health workers – for example, in Uganda – governments face severe challenges in employing the needed number of doctors, nurses, and midwives.²¹

The GFF and the World Bank take this severe lack of human resources into consideration, investing in in-service training and incentive programmes for existing personnel in GFF projects.

Thus, they address, among others, health personnel shortages in rural or underserved areas, lack of motivation, or a specific missing skillset. While these efforts are important, this will fall short of overcoming the key problem of insufficient health worker posts in the public sector. Moreover, the loans that the GFF can leverage can mostly not be allocated to expanding the health workforce.²² Other donors motivated to contribute to the national Investment Cases might attend to this major bottleneck with the creation of health posts. However, to our knowledge this has not been the case so far in any of the GFF countries.

It is urgently important to start dialogue with Ministries of Finance and Health and other relevant actors on ways to create new posts under the government's wage bill including lifting the wage bill ceilings and recruitment freezes that often confront governments of LMICs.²³ In its current form as a multi-donor trust fund, the GFF is not sufficiently independent of the World Bank and needs to follow Bank policy regulations which do not foresee investments in recurrent expenditures such as remuneration of health workers. In order for the GFF to contribute to increased numbers of health workers, the World Bank would need to revise its way of allocating funds and allow for more deliberate investment in the social sector, in line with its own human capital project launched in 2018. Former World Bank President Dr. Jim Kim called for a change in the mindset of global actors, including the international financial institutions, regarding their social spending policies.²⁴ The Investors Group could leverage its full potential as advisory body to the TFC, initiating dialogue between stakeholders on how to address the shortage of health personnel constructively. Another way for the GFF to become more deliberate in how to invest resources would be a change of the multi-donor trust fund model to a financial intermediary fund model. The Global Partnership for Education and the Global Fund to fight Aids, Tuberculosis and Malaria are both examples of such a set-up, allowing for more deliberate decision-making around funding allocations.

Conclusions

With supporting the creation of the GFF, the World Bank has shown willingness to collaborate

with many other donors and country governments to invest in people's health and moreover in groups often left behind – women, children, and adolescents – in order to contribute to the Sustainable Development Goals. Though relatively new in global health financing, the GFF has rolled out to 36 LMICs and demonstrated its agility reacting to emerging challenges, e.g. by creating the new position of Liaison Officers to facilitate information sharing targeted at improved inclusion of all stakeholders. Yet challenges remain to fulfil its potential to strengthen health systems and contribute to more equitable health service delivery.

Inclusive and transparent governance at both global and national levels is a crucial element of effective GFF project development and implementation, to achieve positive impacts on population health, particularly among the most vulnerable. This can only be achieved when the model of partnership is taken seriously and all key stakeholders are represented in the TFC, with gender parity and inclusion of civil society representing both the global North and the global South. The recent governance reform process focuses on the distribution of mandates among the different governing bodies, but risks to stop short of the necessary overhaul that assures seats and voting power for recipient country representatives and civil society in the main decision-making body. An expanded reform process that includes the TFC would better leverage all stakeholders' expertise for the GFF's objectives in RMNCAH-N, SRHR, and UHC.

With the GFF "Strategy Refresh" undertaken this year, the opportunity has come to restore the GFF to become fully inclusive and capable of targeting the most precarious problems in GFF countries. In particular, we would welcome more room for manoeuvre regarding the allocation of funds to activities and recipients, such as to health workers, or to financially support national civil society in recipient countries.

At the national level, more action needs to be taken to ensure CPFs are fully inclusive. While the GFF has started to react to challenges emerging from malfunctioning CPFs, the proposed solutions might be insufficient and need to be reinforced. The ongoing assessment of CPFs is expected to trigger additional pathways and solutions to overcome this challenge.

The GFF aims to be catalytic in unlocking more domestic resources for RMNCAH-N in an

equitable manner, promoting public revenue generation and more efficient spending for health. To achieve this, the feasible avenues for governments to increase public domestic resources and to mobilise additional external funds for RMNCAH-N need to be placed high on the agenda. Options for increased health financing will need to be tailored to specific country situations, following realistic assessments of the amounts that can be mobilised via different pathways. Additional resource mobilisation cannot rely only on external loans for health as these will remain insufficient, will need repayment, and may risk substituting domestic government allocations instead of adding to them. The current COVID-19 crisis calls for an updated reality check and most probably a revision of expected financing scopes and timelines.

The COVID-19 pandemic has significantly increased the vulnerability of people in terms of socio-economic and health status; it has or will also hit strongly the ability of health systems to provide essential RMNCAH-N services, jeopardising previous achievements, creating additional health needs and service gaps. Now more than ever, the GFF's contribution to fund and support health service provision is critical, particularly to attain an adequate frontline health workforce and to remove financial access barriers.

To achieve the GFF's objective of strengthening health systems of LMICs, the provision of a fit-for-purpose health workforce needs more attention, including a dialogue on job creation in resource-constrained settings. Moreover, the GFF should promote and support country-specific, proactive measures to reduce OOP expenditure contributing significantly to UHC, especially for the most vulnerable.

Now is the moment for the GFF and its partners to take stock and adapt, to ensure the ambitions set five years ago can be realised as soon as possible, in order not to fail those women, children and adolescents who are in dire need of better access to care.

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