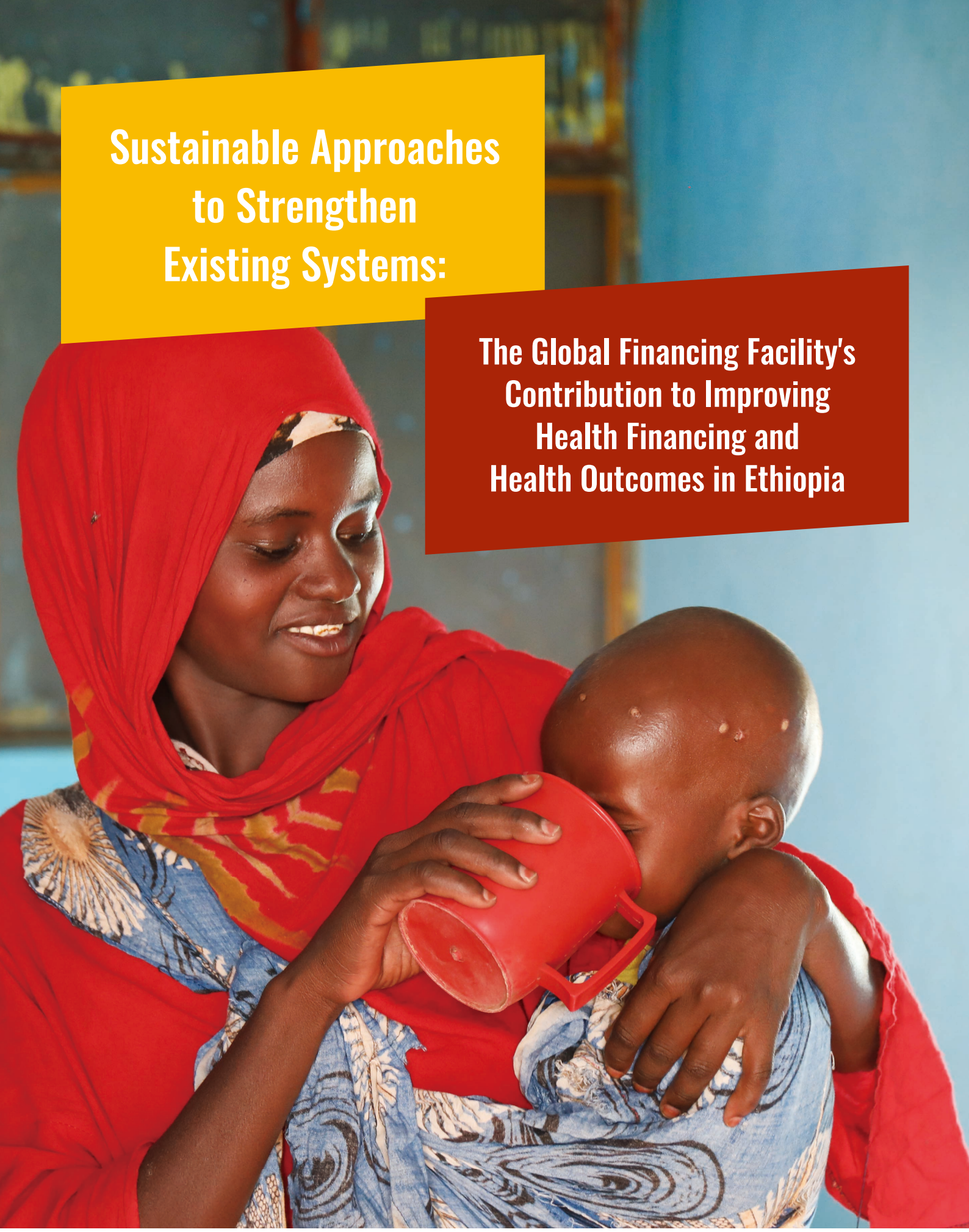
Sustainable Approaches to Strengthen Existing Systems:

The Global Financing Facility's Contribution to Improving Health Financing and Health Outcomes in Ethiopia



Save the Children

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We know we can't do this alone. Together with children, partners and supporters, we work to help every child become whoever they want to be.

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Cover photo: Jamilah, 25, feeding her daughter Leila, 20 months, receiving treatment for severe acute malnutrition in Kelafo Stabilisation Centre
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CONTENTS

FOREWORD

"During my tenure as the Minister of Health for Ethiopia, I actively participated in the co-creation of GFF. From the beginning, the partnership was founded on unwavering commitment to core values like country leadership and ownership, with a strong emphasis on aligning and prioritizing services and outcomes for Reproductive, Maternal, Newborn, Child Health, and Nutrition. Eight years later, we can see that the significance and relevance of this development model and partnership has only grown stronger."

Dr Amir Aman Hagos
Ex Minister of Health, Ethiopia
Currently serving as Country Operation Lead for the GFF

LIST OF ABBREVIATIONS

CBHI . . . . . Community Based Health Insurance
CSO . . . . . Civil Society Organization
CSCG . . . . . Civil Society Coordinating Group
DTP3 . . . . . Diphtheria Tetanus Toxoid and Pertussis
DRUM . . . . . Domestic Resource Utilisation and Mobilisation
ENAP . . . . . Every Newborn Action Plan
ETB . . . . . Ethiopian Birr
FMOH . . . . . Federal Ministry of Health
GFF . . . . . Global Financing Facility for Women, Children and Adolescents
GoE . . . . . Government of Ethiopia
HEWs . . . . . Health Extension Workers
HSTP . . . . . Health Sector Transformation Plan
IBRD . . . . . International Bank for Reconstruction and Development
IC . . . . . Investment Case
IDA . . . . . International Development Association
KII . . . . . Key Informant Interview
MoF . . . . . Ministry of Finance
NGO . . . . . Non-Governmental Organisation
PforR . . . . . Program for Results
PFM . . . . . Public Financial Management
RMET . . . . . Resource Mapping and Expenditure Tracking
RMNCAH-N . . . . . Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition
SDG PF . . . . . Sustainable Development Goals Performance Fund
SHI . . . . . Social Health Insurance
SRH . . . . . Sexual Reproductive Health
TA . . . . . Technical Assistance
UHC . . . . . Universal Health Coverage
WHO . . . . . World Health Organisation

Sustainable Approaches to Strengthen Existing Health Systems:

At a time of growing fragmentation, limited fiscal space, and greater demand for health care, the global health architecture needs more modalities that support governments to improve self-sufficiency, and unleash more resources beyond the dollar value committed by donors. The GFF is one step ahead in many respects. Importantly, the GFF's country driven model promotes efficiency and effectiveness in domestic and external resource use, reduces fragmentation, duplication of efforts and maximises the impact of investments.

The GFF holds tremendous potential to continue making significant strides in improving RMNCAH-N outcomes worldwide. As well as building on successes in GFF programming to progress universal health coverage, an opportunity presents itself at a time when critical questions are being raised on the effectiveness of the current global health architecture, for sharing learning and good practice with others. Highlighted below, the GFF model has provided valuable insights that could support others to improve aid effectiveness in practice:

Support governments to promote inclusive agenda-setting in country platforms

Align with a range of partners behind national priorities

Provide support to governments in leveraging additional resources for health

Enhance resource mapping and expenditure tracking by supporting governments to make this data available to the public

Strengthen links between funding and results

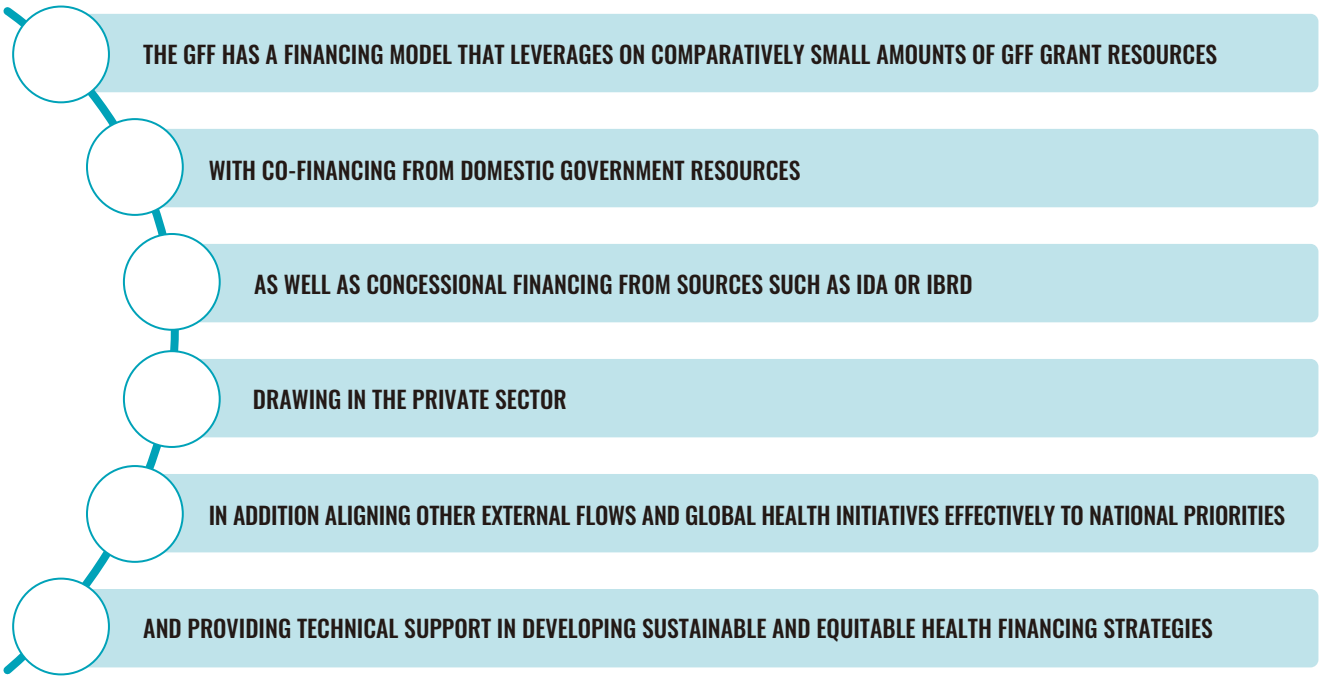
Provide equitable technical solutions based on best practice

Strengthen civil society engagement by improving funding and maximising local to global linkages

Introduction

The Global Financing Facility for Women, Children and Adolescents (GFF) is a multi-stakeholder country-led global partnership. Founded in 2015 to implement the UN Secretary General's updated Global Strategy for Women's, Children's, and Adolescents' Health between 2016 to 2030, the GFF addresses inequities and improves access to health for women, children and adolescents by strengthening health systems[1]. The GFF aims to prevent 3.8 million maternal deaths, 101 million child deaths, and 21 million stillbirths in high-burden, GFF-supported countries by 2030 [2] by working with countries to build systems capacity, align funding behind a prioritised health plan, and unlock policies, financing, and systems that improve health. Based on the International Health Partnership (IHP+) principles, the GFF's country-driven partnership approach brings together stakeholders behind government priorities, including development partners, civil society organisations (CSOs), multilateral institutions, and the private sector. The GFF's financing model leverages comparatively small grants with co-financing from other modalities, such as additional domestic resources and concessional financing, whilst aligning external sources of funding and providing technical support for health financing reforms.

FIGURE 1. A HOLISTIC FINANCING MODEL



Through this approach, the GFF seeks to develop a sustainable financing approach and depart from the current dependency on aid to fill health financing gaps.

The GFF's current Deliver the Future campaign seeks to secure at least US$800 million by the end of 2023[3]. This essential funding will enable the GFF to mobilise an additional US$20.5 billion to enhance its impact.

With this increased financial support, the GFF intends to provide second-round financing to 27 existing partner countries and extend its assistance to an additional seven countries. This is also a timely opportunity for the GFF to hone its scope, expand its scale, capitalise on gains made, reflect on lessons learnt and provide examples of best practice and models for other global health initiatives.

Context, Scope, and Methodological Approach

The GFF models a country-led approach, yet it can be difficult to understand and assess as the support provided differs depending on the country. In addition, assessing attribution in complex approaches can be challenging when considering the role of multiple stakeholders, indirect and long-term effects, and complex pathways.

In order to identify research gaps, Save the Children carried out evidence generating exercise across seven donor markets to gather policymakers and civil society perceptions of the GFF in 2022 prior to this research. These views reflected:

- An interest in gaining deeper insights into the accomplishments and the leverage achieved through GFF funding up to the present moment.
- Limited comprehension of the impact of the GFF efforts on specific thematic areas, such as Sexual and Reproductive Health (SRH).
- Limited clarity on exactly how the GFF operates in country, which may hinder further endorsement.
- A need for improved understanding of how low interest loans, such as those facilitated through IDA, contribute to reducing debt burdens and enhancing RMNCAH-N.
- A limited understanding of global health institutions endeavours that emphasise broader systems strengthening approaches over more tangible progress indictors and service delivery support.

OBJECTIVES AND AREAS OF ASSESSMENT

As the exercise above suggests, there were gaps in understanding of the GFF and its contribution by stakeholders, including donors. Therefore, our role included carrying out an independent assessment of the GFF to review its processes, successes, and challenges, aiming to address the gaps in knowledge outlined above.

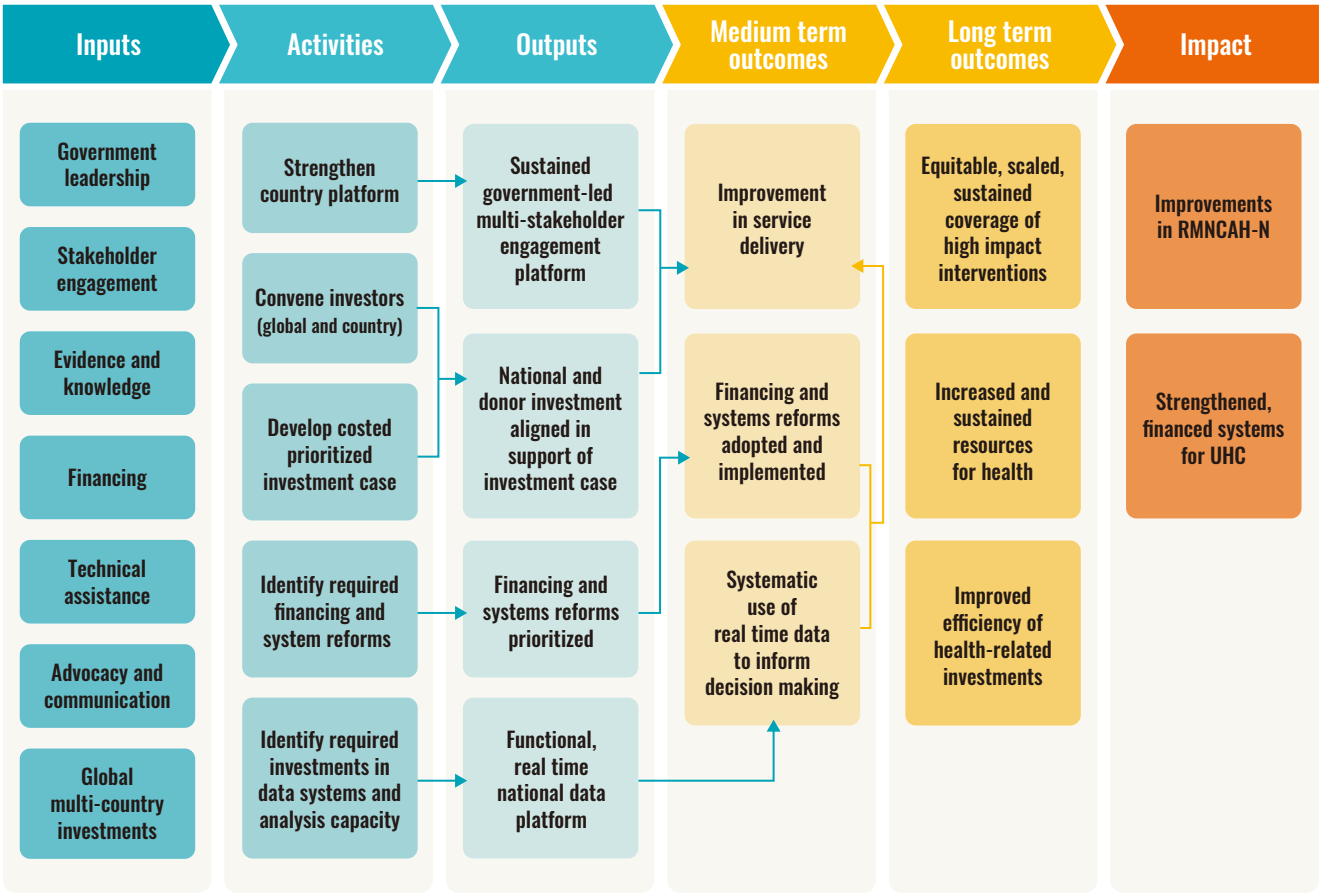
As such, the objectives of this assessment are to:

1. **Highlight GFF processes in practice using a country example.**
2. **Determine whether the GFF model has successfully improved the delivery of reproductive, maternal, newborn, child and adolescent health and nutrition (RMNCAH-N) services and strengthened financing systems for Universal Health Coverage (UHC), using qualitative and quantitative evidence.**
3. **Develop an impartial and unbiased evidence base, compiled by an independent third-party organisation, to inform decision-making and accountability.**
4. **Identify successes, challenges, and recommendations to guide future investment and programmatic decisions.**

GFF'S THEORY OF CHANGE

The research areas are situated and interpreted within the scope of the GFF's overall logic framework and theory of change for the strategic period 2021–25[4]. Given that this assessment will not investigate causality, we will focus on inputs, activities and outputs.

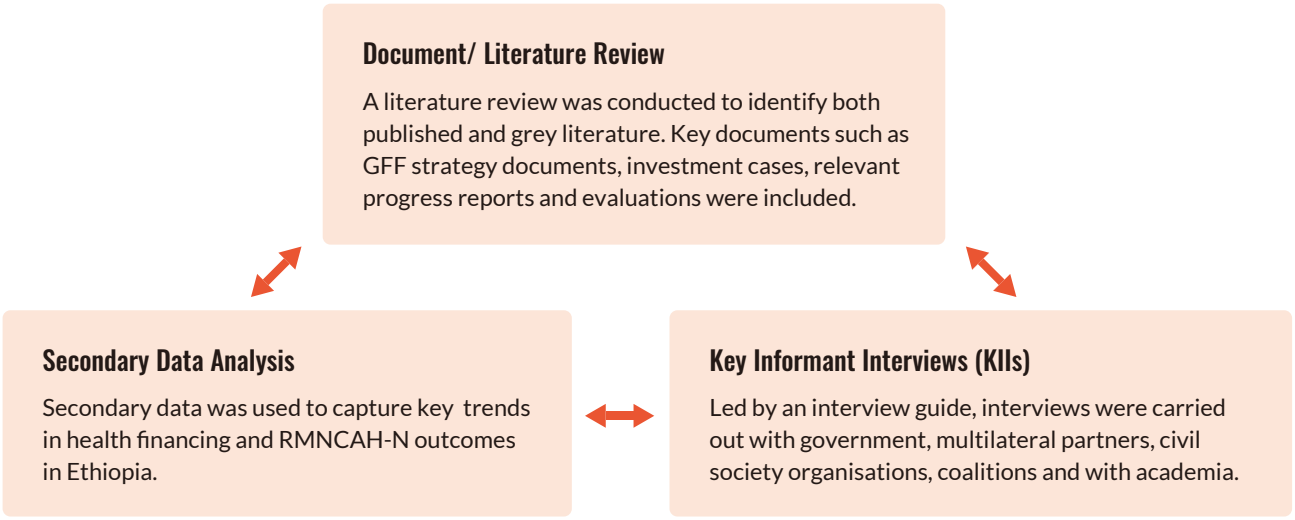
FIGURE 2. GFF'S LOGIC FRAMEWORK AND THEORY OF CHANGE



METHODOLOGY

We used a mixed methods approach and triangulated evidence:

FIGURE 3. MIXED METHODS APPROACH



A stabilisation centre nurse at Kelafo Health Centre examines Ayaan © Asseged Seifu/ Save the Children

COUNTRY SAMPLE SELECTION

In selecting the sample of countries, a cluster sampling approach was applied based on an inclusion/exclusion criteria (Annex 1). The study country was selected to focus on a) health financing reforms and b) equity. All country Investment Cases (IC) that were available on the GFF website were assessed to identify a country where programming in these areas had progressed further than in others. Both health financing reforms and a focus on equity came through strongly in Ethiopia's investment case, as per the sampling matrix (Annex 1). Ethiopia is also one of the countries in which the GFF has operated in longest. The survey was conducted by Save the Children UK, Save the Children Ethiopia, and Save the Children Japan. Fieldwork was conducted in Addis Ababa from 14–24 March 2023.

In this study, both qualitative and quantitative evidence was used using a mixed method approach (see Figure 3) that combined a literature review, analysis of secondary data, and key informant interviews (KII) with stakeholders. Key informants include representatives from the Ministry of Health, multilateral organisations, civil society organizations (CSOs), and academia. In total, 46 individuals were engaged in the assessment, with evidence gathered through 14 key informants, who were purposively selected, and data from a workshop attended by 32 participants from CSOs working in health sector in Ethiopia. The KII questionnaire is provided in Annex 2.

LIMITATION OF THE RESEARCH

We acknowledge that this research is based on the data collected at a certain point in time in a specific country and the KII as well as the participants who attended the CSOs workshop were not representing all the stakeholders working with the GFF in Ethiopia. Therefore, this report does not reflect the full picture of the GFF's work in Ethiopia nor any other countries supported by the GFF. In addition, the research only focused on the national level.

State of Play

The Government of Ethiopia (GoE) has made considerable gains in strengthening its health system, expanding access to essential health services, and reducing maternal and child mortality rates [5]. Ethiopia is one of the first countries that joined GFF in 2015, and has shown progress on reducing under-five mortality, maternal deaths, and adolescent fertility over time [6]. According to global estimates from World Health Organisation (WHO), there was a decline in maternal mortality in the country between 2000 and 2020. However, Ethiopia still accounted for 3.6% [7] of global maternal deaths in 2020 (10,000 deaths) and women and girls of reproductive age have one in 86 lifetime risk of maternal death.

Similarly, the country has experienced a roll back in immunisation coverage for children under 5 in recent years, with DTP3 [8] coverage falling from 71% to 65% between 2020 and 2022 [9]. This is considered to be one of the effects of the COVID-19 pandemic on health systems.

Recently, due to a combination of the pandemic, continuing internal conflict, climate-related challenges, and economic struggles, Ethiopia is facing significant challenges in delivering good-quality health services. Ranked as a fragile and conflict-affected situation [10], the northern conflict-affected region has experienced damage to health facilities and water systems, which require reinvestment, and travel restrictions preventing health care workers reaching populations in many areas. In addition to drought and conflict-driven chronic food insecurity, the rising price of commodities has impacted the availability of medicines contributing to preventable deaths across Ethiopia [11] [12]. Recent events have been particularly detrimental for outcomes for teenage girls. Gender-based violence (GBV) and unmet Adolescent Sexual Reproductive Health (ASRH) need during the pandemic led to a spike in pregnancies that would consequently affect maternal deaths [13].

The GoE has recognised the need to accelerate efforts to strengthen the national health system. This demands additional resources to scale up equitable access to good-quality health services.

Neela (34) brought her daughter Kia (2) to be treated for a chest infection at an Emergency Health Unit clinic in Tigray, Ethiopia © Sacha Myers/ Save the Children

Findings and Insights

INVESTMENT CASES: UNTAPPED POTENTIAL FOR RMNCAH-N

The GFF supported the Government of Ethiopia in the development of the current Health Sector Transformational Plan ('Investment Case') (HSTP II) for the strategy period spanning 2020/21 to 2024/2025 [14]. Using an evidence-based approach fostered in the development process, the plan aims to ensure resources are targeted towards high impact, effective, efficient, and sustainable interventions. The HSTP II aims to build on the successes of the initial transformational plan, which covered years 2015/16–2019/20, with a focus on improving primary and community-based services, data systems, the health care workforce, and sustainable health financing, as well as strengthening leadership and governance. The plan also focused on addressing disparities across regions and woredas to improve uptake and service coverage. The HSTPs became the foundation for prioritising investments from both domestic and external financing sources, such as the GFF, to narrow health inequalities and strengthen the health system.

To encourage greater participation and engagement in the development of the sector plans, the GFF played an integral role in encouraging and supporting the GoE to work through a multi-stakeholder platform. KIIs revealed there was markedly more consultation with civil society in the design of the HSTP II compared with the initial transformation plan, as well as during mid-term reviews and progress monitoring exercises. However, some remarks suggested challenges still exist, including limited engagement in agenda setting and information asymmetry, with limited follow up after workshops.

HEALTHCARE WORKER CAPACITY STRENGTHENING:

Between 2021 and 2023, health extension workers (HEWs) are provided with in-service training on reproductive health, maternal and child health, and social and behavioural change. Using the current exchange rate, $6.7 million was contributed to training provision for 32,874 agrarian and pastoralist HEWs in rural communities. The Health Extension Program is supported by nearly 39,000 HEWs across all regions. $8 million was provided by the GFF, in the form of on-budget support in the SDG PF, which would scale up these two training modules for all HEWs in Ethiopia, going a long way to fill the gap in health care worker performance and improve quality of care.

(Data provided by the FMOH Ethiopia)

HARMONISING PRIORITIES THROUGH ALIGNMENT

Many countries rely heavily on external aid to fund essential health services. Over-reliance on aid makes health systems vulnerable to fluctuations in funding, hindering long-term progress in improving health service access and quality. The multi-stakeholder platform aims to unite all stakeholders in the health sector, including government departments, external partners, the private sector, and civil society, around a shared vision and common goal. This includes promoting close collaboration and policy dialogue between the Ministry of Finance (MoF) and the Federal Ministry of Health (FMOH) in efforts to increase the share of total health spending from the total government budget [15]. In addition, the MoF facilitates communication between the FMOH and other development partners about annual budgeting, planning and reporting to ensure alignment with national plans and budgets.

The 'One Plan, One Budget, One Report' framework has emerged as a foundational approach in implementing the HSTP. According to insights gathered from KIIs, this framework represents a significant shift towards preventing duplication of efforts and improving aid effectiveness, resulting in

more efficient health spending. Additionally, it places the national government in the driver's seat for health planning and decision-making. The HSTP II is the "One Plan" that stakeholders in Ethiopia are aligning behind.

The GFF has also established a multi-stakeholder alignment working group with pilot countries including Ethiopia. With the objective of advancing a sector-wide aid effectiveness approach across multiple partner countries, this group seeks to catalyse discussions on how external and domestic financiers can better align with country priorities and systems. To assess progress in alignment, a diagnostic exercise has been conducted collaboratively by the GoE, development partners, private sector, and civil society [16] [17]. This assessment examines alignment in three critical domains: planning, budgeting and reporting. As per the IHP+, by fostering alignment among all stakeholders in the health sector, the GFF aims to enhance cooperation, coordination and effectiveness in achieving shared health goals. The KIIs did however highlight misunderstandings in some CSOs on the "One Plan, One Budget, One Report" framework. While there are some communication challenges seen within the CSO coalition, continuous engagement with CSOs and keeping them abreast of developments, as well as reiterating the benefits of the framework is important for reduced misconceptions and increase buy-in.

> "This approach involves donors contributing funds, and in collaboration with the government, setting clear priorities and agreements on areas of focus. An important feature of the Sustainable Development Goals Performance Fund (SDG PF) is the retrospective evaluation of expenditure data, which allows for monitoring and assessing partners' actual spending against their commitments. This accountability mechanism ensures that resources are effectively channelled to priority areas and that partners' contributions align with agreed-upon objectives."
>
> Reflections from an FMOH official

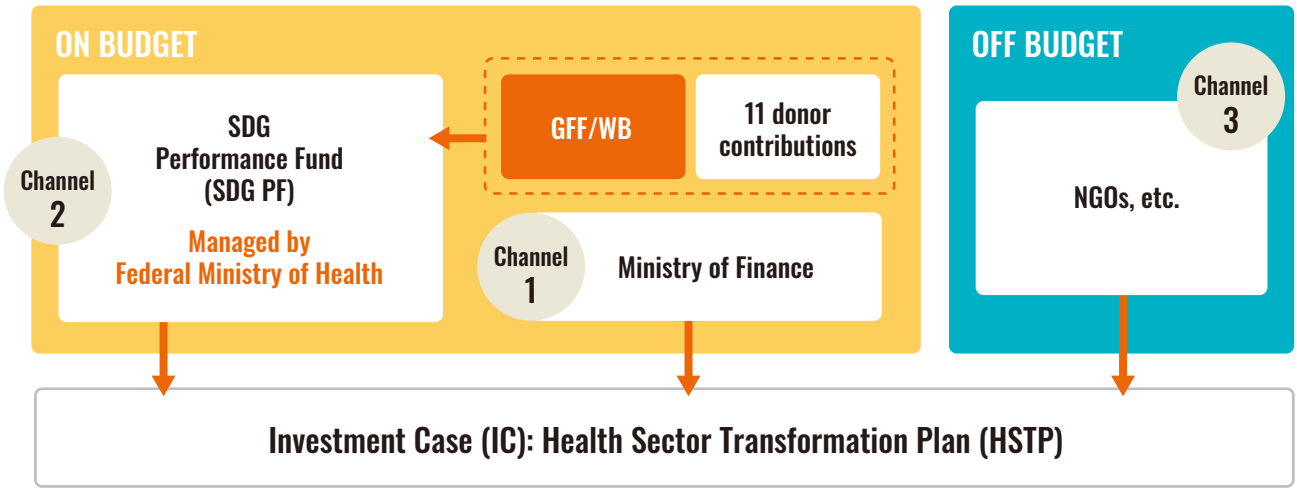
ENHANCING DEVELOPMENT IMPACT THROUGH ON-BUDGET SUPPORT

The GFF grant is provided as on-budget support to the GoE, directed into a pooled funding mechanism managed by the FMOH, known as the Sustainable Development Goals Performance Fund (SDG PF)[18]. The SDG PF, consisting of both domestic and external resources, provides flexible funding for the implementation of the transformational plan. A respondent from the FMOH suggested approximately 30–40% of the funds from the SDG PF are specifically allocated for improving maternal, child and adolescent health, demonstrating a strong commitment to addressing pressing health needs in these populations. The trend in budgeting shown in HSTP II is broadly in line with these findings. In addition, the fund allows for flexible allocation of resources aligned with emerging challenges or shifting local contexts.

As one of 12 donors contributing to the SDG PF, the GFF mandate includes catalysing efforts to coordinate and harmonise these external financing flows to improve resource optimisation and aid effectiveness. This coordinated approach has supported the government in taking ownership of their health policies under the principle of "One Plan, One Budget, One Report." [19]

Figure 4 shows the flow of financing towards HSTP priorities. The majority of external financing flows on budget (channels 1 and 2) into the SDG PF, with some additional funds provided by donors through other channels, such as those earmarked for Non-Governmental Organisations (NGOs). We noted that, without better transparency in reporting, direct contracting with entities through these alternative channels limits the government's ability to track off-budget contributions. KIIs suggested that to support the GoE in allocating resources effectively

FIGURE 4. HEALTH FINANCING CHANNELS (MADE BY AUTHORS BASED ON THE WORLD BANK'S PROGRAM PAPER (2017))



and avoiding duplication, more transparency is needed on the sources and objectives of financing flows off budget (channel 3 funding on Figure 4).

CATALYTIC EFFECTS: CALIBRATING IDA FOR RMNCAH-N

In addition to direct grants, the GFF leveraged additional funds for RMNCAH-N from the World Bank's International Development Association (IDA). In Ethiopia, the GFF grants are co-financed with IDA Program-for-Results (PforR) projects, which are aimed at enhancing health outcomes [20] [21] [22]. To be eligible for GFF funding, countries must demonstrate their commitment to mobilising additional domestic resources for health and utilising their IDA or International Bank for Reconstruction and Development (IBRD) grants or credits on RMNCAH-N [23].

Since its inception in Ethiopia in 2015, the GFF has directly contributed $110 million, which, in turn, mobilised an impressive $1,090 million for RMNCAH-N from the partnership with IDA. This leverage effect amounts to nearly 1:10, so that for every dollar provided by the GFF, close to ten additional dollars of concessional financing were secured for RMNCAH-N initiatives from external sources. The GFF's catalytic ability has become even more evident over time. During PforR round 1, the leverage effect was around 1:5. This effect increased further during the second round of the PforR, reaching over 1:9.

At a global level, as of June 2022, the GFF has allocated $817.5 million in grant financing and leveraged WB IDA/IBRD co-financing to secure an additional $5.85 billion, with a combined total of financing mobilised of circa $6.66 billion [24]. For every $1 provided by the GFF, an additional $7.2 was harnessed from external sources.

In addition, the GFF carried out an analysis of the percentage of IDA commitments for RMNCAH-N between GFF-supported countries and a comparator group of GFF-eligible countries that are not yet supported. The analysis showed the percentage of overall IDA allocated to RMNCAH-N increased 71% when comparing the time periods before and after GFF engagement, up to February 2020. Interestingly, in the comparator group, the share of IDA increased by only 15% over the equivalent time period.

In Ethiopia, as set out above, the leverage effect is greater than the global average, and has demonstrated further increases between PforR rounds 1 and 2. GFF's extended presence in Ethiopia, compared with other operating contexts, may be a factor behind the success in attracting additional financing. At the same time, the data on IDA allocations to RMNCAH-N at a global level indicates that the GFF's support to countries contributed to their success in attracting additional financing.

Beyond the additional volume of financing attained, joint GFF–IDA contracts reduced administrative burdens associated with multiple reporting requirements and management costs associated with establishing additional management and contracting systems.

FIGURE 5. LEVERAGE EFFECT IN ETHIOPIA (GFF AND IDA+OTHER CO-FINANCING IN ETHIOPIA)

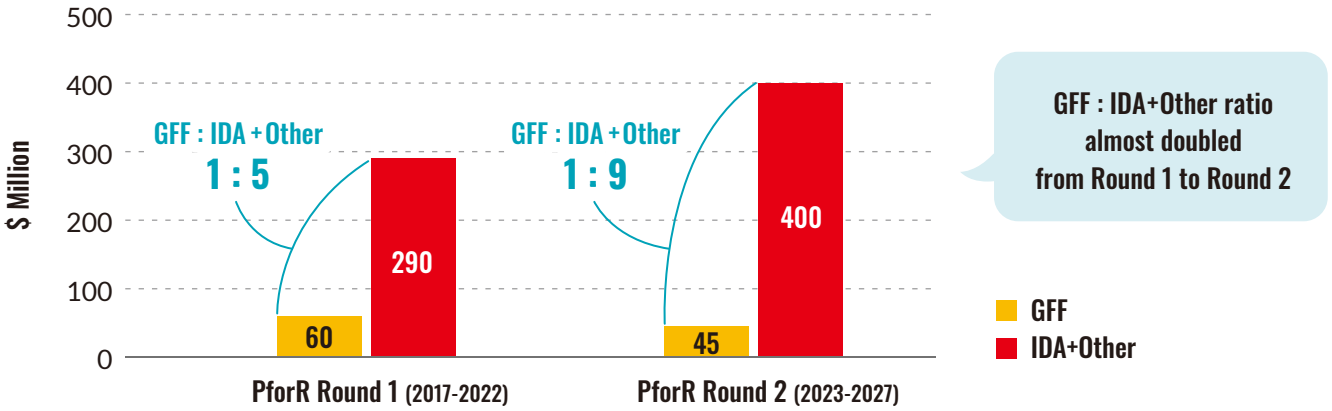
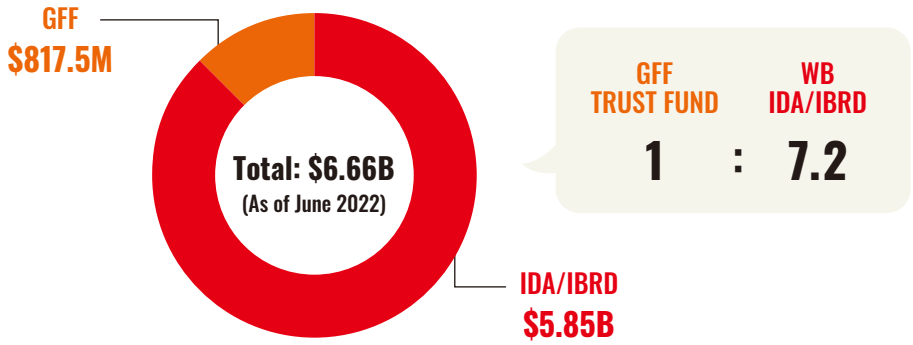


FIGURE 6. GFF TRUST FUND AND WB IDA/IBRD CO-FINANCING



CO-FINANCING FAMILY PLANNING COMMODITIES [26]

The cut to UK Official Development Assistance during the pandemic, along with inflationary pressures, led to a significant shortage of funding for contraceptive commodities in Ethiopia. At the request of the Government of Ethiopia, the GFF conducted a costing exercise and found that domestic resources would be insufficient to cover the shortfall. The total cost of procuring supplies for 2022/23 came to $41.1 million, with provision for only $17.4 million. The GFF technical support facilitated a co-financing arrangement between the GoE and donors, including the United States Agency for International Development, the Bill and Melinda Gates Foundation, the Susan Thompson Buffett Foundation and the David and Lucile Packard Foundation, contingent on the GoE demonstrating an increase in domestic spending on family planning.

To transition away from reliance on external financing for family planning commodities, a co-financing arrangement was agreed that incentivised the GoE to progressively take on higher levels of financing. In year one, the GoE would cover 25% of costs, increasing to 50% and 85% in the second and third years.

A senior FMOH official provided this example to support our understanding of the GFF's catalytic role in capturing new funding for priority RMNCAH-N areas. Although the GFF did not commit additional grant financing, "they supported technically in conducting analysis and gave overall support", resulting in an injection of $24.8 million in external sources and an additional $11.3 million allocated through domestic sources.

RESULTS-BASED APPROACH TO PROGRESS HEALTH OUTCOMES

A results-based approach, where disbursement of PforR funds is contingent upon achieving pre-agreed performance targets, aims to incentivise the achievement of specific results. During the process of developing the disbursement-linked indicators (DLIs) for the PforR projects, the FMOH, with support from the GFF, collaborates with the World Bank to agree on specific criteria for measurement. These targets are carefully selected to accelerate progress in key priorities and areas of improvement identified in HSTPs. The DLIs are designed to align with the goals outlined in the HSTPs, aiming to drive meaningful improvements in these areas.

IDA financing is conditional upon progress against these indicators, with a clear baseline and targets to be achieved. Data was drawn from national data systems, such as the Survey Availability and Readiness Assessment, Demographic Health Surveys, health management information systems and other administrative surveys. KIIs suggested that through provision of capacity strengthening on national data systems, the GFF support contributed to improving sustainability and coherence in decision-making, rather than risking fragmentation by setting up parallel data systems.

TECHNICAL SUPPORT IN HEALTH FINANCING TO INFORM RESOURCE ALLOCATION

Supporting health financing reforms is a core aspect of the GFF. In addition to providing grant funding, the GFF offers technical assistance (TA) in health financing, aiming to promote the effective utilisation and mobilisation of domestic resources in Ethiopia. The support provided to the FMOH on resource mapping and expenditure tracking (RMET) plays a key role in informing resource allocation decisions, national planning and budgeting processes, enhancing the efficiency and equity of health spending. The RMET contributed to share of SDG PF spending on family planning, maternal health commodities, nutrition, and other programmatic activities, such as the health extension program, improving supply chains, regulatory systems and health financing, increased from 27% in 2015/16 to 67% in 2021/22. Over the same period, spend on public health infrastructure, investments associated with low value for money, dropped from 15% to only 4%[27]. By actively costing, prioritising, and mapping resources to priority interventions, the GFF RMET exercise supports the FMOH to present more rigorous cases to the MoF when requesting more financing for health.

The forecast financing gap between the initial and subsequent HSTPs fell from 21%, covering 2015/16 for the next five years, to 14.6% from 2020/21 for the following five-year period. Total (predicted) financing between these two periods, at the time of developing the two plans, had increased by 20%[28].

Further support has been provided on pooling and purchasing efforts while supporting activities that strengthen public financial management (PFM) capacity, through embedded TA in the FMOH, TA to the GoE, and collaboration with health financing expertise based in Ethiopia. Table 1 indicates the breadth of the technical support provided.

Barey, 24, holds her daughter Salma, 20 months old
© Eduardo Soteras Jalil / Save The Children

TABLE 1. KEY AREAS OF GFF TECHNICAL SUPPORT ON HEALTH FINANCING REFORMS

KEY AREAS OF GFF HEALTH FINANCING SUPPORT
Resource mobilisation and expenditure tracking
Facilitated engagement on feasibility and political acceptability of strategic purchasing reforms
Part of a consortium of donors exploring the introduction of results-based financing into the PFM system
Support for an assessment of introducing social health insurance for the formal sector
Supporting the scale-up of community-based health insurance and its benefit package costing and design
Health financing training for leadership in FMOH
Assessment of performance-based financing
Revitalisation of SDG Performance Fund operations and guidelines
Costing Primary Health Care
Fiscal space analysis

HEALTH FINANCING REFORMS: OPPORTUNITIES TO FORGE A PATH TO GREATER EQUITY

The expansion of community-based health insurance (CBHI) is a key example of the GFF's support for health financing reforms towards more sustainable financing for health equity. Initially introduced by the GoE in 2011, CBHI is a health insurance scheme to address the lack of equal access to health care services, address high out-of-pocket expenditure, and mobilise financial resources for health [29] [30]. This scheme is aimed at improving coverage for low-income residents in rural areas and workers in urban informal sectors, where households/members contribute a flat rate premium that is pooled to cover basic healthcare costs. However, guidance from WHO suggests such schemes only play a marginal role in progressing towards UHC and advocates instead for national mandatory schemes, which subsidise coverage of those on low income and a greater onus on the role of the government in financing health [31] [32].

Between 2019 and 2020, enrolment increased from 44% to 50% of the target population, leading to higher healthcare utilisation, revenue generation and patient satisfaction [33]. However, despite its expansion, CBHI's revenue only contributes around 1% of the total governmental health expenditure, and a significant portion of the intended population remains without coverage. More than 900 CBHIs have been established at the district level, incurring high administrative costs. As each CBHI can only enrol members within its district, each CBHI has a small pool of members, resulting in limited resources per scheme. Some districts risk adverse selection where those with higher disease burdens consume more health care than total contributions, affecting financial sustainability as cross-subsidisation across CBHIs isn't currently possible [34]. Our informants suggested that some CBHI schemes are facing financial difficulties. The extent of the fragmentation may likely be a factor contributing to the sustainability challenges.

Furthermore, voluntary contributory-based insurance schemes, such as CBHI, are unlikely to be an equitable form of health insurance. Such schemes are largely regressive as they potentially exclude those on low incomes unable to contribute premiums. Although the GoE provides free coverage to the poorest 10% [35], this may not sufficiently address the financial constraints faced by marginally less deprived households in the next income group or those below the poverty line who don't benefit from fee waivers [36] [37]. If anything, between 2015 to 2019,

out of pocket spending increased, albeit marginally, by a percent to 38% [38]. Guidance from WHO suggests such schemes only play a marginal role in progressing towards UHC and advocates instead for national mandatory schemes, which subsidise coverage of those on low income and a greater onus on the role of the government in financing health [39] [40].

In addition, the GFF has supported an assessment of introducing social health insurance (SHI) for the formal sector. Discussions are under way that include negotiating employee, employer and governmental contributions for SHI. However, SHI could further drive inequalities and direct more financing towards the middle class. Moreover, a senior official, when reflecting on what additional support could benefit the GoE, suggested "more advocacy from GFF regarding SHI". They suggested that community buy-in for SHI would accelerate progression towards UHC in Ethiopia. Interestingly, CBHI, or enhanced coverage for disadvantaged groups, was not mentioned during the KII. Furthermore, these groups often lack positions of influence and have limited ability to advocate for programmes that would be advantageous to their well-being.

THE SAVING LITTLE LIVES PROJECT

The Saving Little Lives Project has been named the flagship programme of the Ethiopian Ministry of Health. Since 2021, this three-year programme has been implemented jointly by UNICEF, four universities in Ethiopia, and seven regional health bureaus, among others. Funded through the GFF's Innovation-to-Scale Grant, USD $4,520,000 has been allocated to scale up minimum care packages for labour and delivery, neonatal intensive care packages, and kangaroo mother care, targeting the key drivers of mortality in preterm and low birth weight babies across 290 hospitals. As of end 2022, 75 hospitals received clinical mentoring in the above packages, medical equipment such as digital weighing scales, CPAP, pulse oximeters, kangaroo mother care beds, refrigerators, and 16 newborn units had renovations carried out. The Saving Little Lives project is currently supporting additional 147 hospitals.

(Narrative provided by Addis Ababa University)

STRENGTHENING CIVIL SOCIETY ENGAGEMENT

The GFF has supported the engagement of civil society in health sector agenda setting and decision-making since 2015. This is guided by the GFF's Civil Society and Youth Engagement Framework to expand participatory practices in developing health sector strategies. The framework includes CSO inclusion in multi-stakeholder country platforms as per the Guidance Note: Inclusive Multi-stakeholder Country Platforms in Support of Every Woman Every Child [41]. Funding for CSO and youth engagement is channelled through a $5 million grant, aiming to support and encourage community-led initiatives to address health challenges and support innovative solutions. Currently, the grant is managed by the GFF NGO host, Population Action International. $3.3 million is earmarked for grants to local CSOs, with a further $902,750 availed for technical assistance, capacity strengthening and enhancing CSOs' constructive advocacy and collaborative accountability [42]. This financing builds on previous commitments for civil society engagement, totaling $1.6 million from 2019–22 [43].

Two consortia represent and coordinate the engagement of Ethiopian CSOs in the multistakeholder platform [44]. During a workshop we held as part of the fieldwork phase with more than 30 CSOs in the health sector in Addis Ababa, we carried out an interactive survey to gauge the level of understanding among participants. 59% of respondents suggested communities and CSOs had been included in the development of the HSTP, while 41% said they hadn't. KIIs with the FMOH indicate challenges in effectively engaging and involving CSOs, while FDGs with local CSOs revealed that they found their involvement in the process of implementing the HSTP limited. According to a survey published in early 2023 carried out among CSOs, challenges within the CSO/Youth Led Organisation (YLO) Country GFF Coalition was identified in Ethiopia as a barrier to meaningful CSO/YLO engagement in GFF processes [45]. Although there is CSO representation on the multistakeholder platform, this suggests an opportunity to further strengthen coordination and representation within CSO coalitions, in aims to ensure greater voices are reaching and reflected by representatives on the platform.

Furthermore, during the workshop, only two

respondents had awareness of the GFF's work. This suggests a possible challenge with the GFF's visibility among civil society in Ethiopia. The GFF operates within country systems, therefore the HSTP II is the country IC for Ethiopia. While stakeholders in Ethiopia rally behind the HSTP II, they may not be aware that it is actually the GFF which supported the GoE in developing and implementing the HSTP II in the country. Additionally, a FGD reflected a lack of understanding and visibility of the GFF Global Civil Society Coordinating Group (CSCG), as well as the potential financing opportunities it presented for local CSOs. This is despite CSO representatives from Ethiopia participating in the CSCG, and suggests an opportunity for the CSCG and its members to re-engage and diversify their engagement with civil society in Ethiopia.

Through investments in the Joint Learning Agenda (JLA), the GFF facilitated health financing training for CSOs. Two trainers from Ethiopia were trained on a month-long course on health financing, who subsequently trained a further 17 local CSOs, covering topics such as health systems and financing, UHC, fiscal space, budget cycles, risk pooling and health insurance. The "Ethiopian UHC Coalition" was established as an indirect result of the training provided, aiming to further strengthen the capacity of CSOs to understand budget cycles and track expenditure. CSOs reflected positively on the health financing and budget advocacy training, and insights from our KIIs hinted at the potential for even greater effectiveness at building momentum in advocacy efforts through regular capacity strengthening opportunities and prospects.

During our field work, there was ambiguity regarding the NGO host's contribution of capacity strengthening and technical assistance to date to civil society in Ethiopia. Whilst cross-referencing with publicly available documents, such as the Implementation Status & Results Report for 2022, we found the document only offered high-level progress updates, though the document wasn't intended to contain specific details on country level support. The CSO community would benefit from transparency on progress on the implementation of the grant provided to the NGO host. Additionally, Component 1: Technical Assistance and Capacity Building was indicated as delayed [46]. However, financial audit records for the corresponding period indicate that 90% of the total budget allocated to this activity has been spent [47].

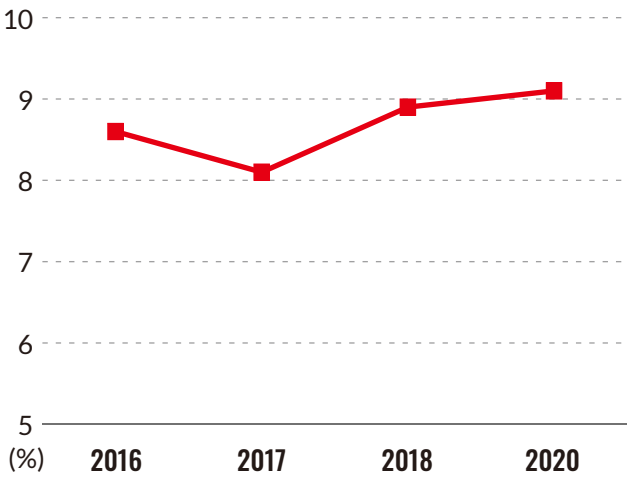
Recently, two new grassroots organisations in Ethiopia have received direct grants to 'develop their capacity and empower youth networks in addressing the sexual reproductive health challenges of marginalised populations' [48]. Other KIIs reflected that until recently, resources and opportunities had benefitted the same individuals in civil society, monopolising access and information, posing challenges to equitable engagement.

CONTRIBUTION TO PROGRESSING LONGER-TERM OUTCOMES AND IMPACT

As highlighted above, attributing progress in outcomes and impact-related indicators defined in the Theory of Change to the GFF is challenging due to the collaboration of multiple stakeholders in advancing health outcomes. Nonetheless, this section aims to highlight change since the GFF became operational in Ethiopia.

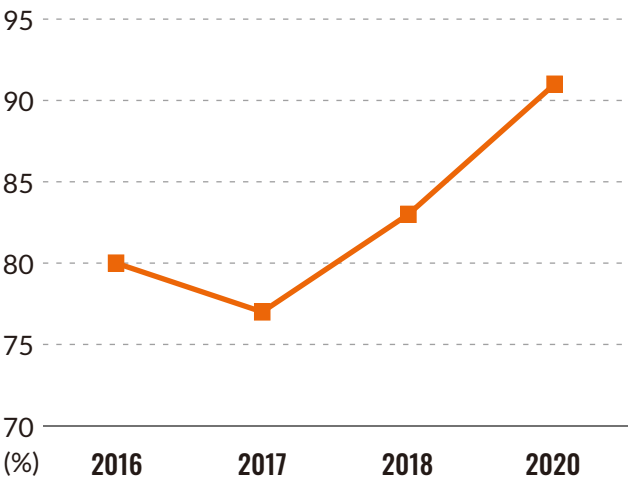
From 2016 to 2020, the share of the government budget allocated to health rose from 8.6% to 9.1%, indicating a commitment to higher health expenditure [49]. However, 5% of total health spend in 2019/20 was related to COVID-19 spending, and increased priority for health in budgets during the pandemic was also a trend in other countries [50] [51]. In addition, health as a share of government final expenditure remained stagnant at around 5% between 2016 to 2019, and declined as a share of total health expenditure. Over this period, external sources of financing rose from 18% to over a third [52] [53].

FIGURE 7. SHARE OF GOVERNMENT BUDGET ALLOCATED TO HEALTH (%)



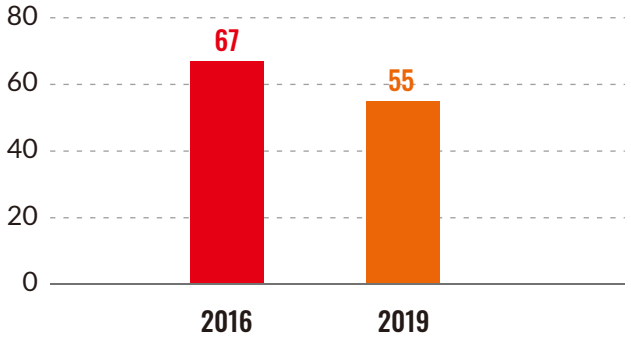
It is also important to note that despite budgetary increases, committed funds may not be fully disbursed as intended, resulting in low budget execution. In 2016, 80% of the health budget was utilised; in 2020 there was only a 9% underspend, meaning an increase in the proportion of allocated domestic funds being spent.

FIGURE 8. HEALTH BUDGET EXECUTION (%)



The Every Newborn Action Plan (ENAP), led by WHO and UNICEF, sets the goal for a maximum rate of 12 stillbirths or fewer per 1,000 total births per country by 2030 [54]. In 2016, Ethiopia had dropped just below this threshold. Unfortunately, data on this indicator is not routinely reported beyond Ethiopia's Demographic and Health Surveys, which take place every few years. However, as part of efforts to improve global data availability, the results on stillbirth rates in each country will be included in the routine reporting required for the GFF's annual reporting from 2023 onwards. This will contribute to better monitoring and tracking of progress towards the ENAP goals and support efforts to reduce stillbirths worldwide.

FIGURE 9. UNDER 5 MORTALITY RATE IN ETHIOPIA



In 2016, Ethiopia's under-five mortality rate was 67 deaths per 1,000 live births, notably higher than the 2030 target set by the Sustainable Development Goals of 25 deaths per 1,000 live births. Three years later the under-five mortality rate dropped to 55 deaths per 1,000 live births [55].

- The percentage of births attended by skilled health staff increased from **28% in 2016 to 50% in 2019** [56].
- Proportion of pregnant women with four or more antenatal care visits increased from **32% to 43% between 2016 and 2019** [57].
- The prevalence of stunting in children under five, when assessing height for age, decreased from **38.3% to 36.8% between 2016 and 2019** [58].
- Modern contraceptive use among married women aged increased from **35.3% to 40.5% between 2016 and 2019** [59].
- The maternal mortality ratio is estimated to have decreased from **399 per 100,000 live births in 2015 to 267 per 100,000 live births in 2020** [60].

Highlights and Key Recommendations

At a time of growing fragmentation, limited fiscal space, and greater demand for health care, the global health architecture needs more modalities that support governments to improve self-sufficiency, and unleash more resources beyond the dollar value committed by donors. The GFF is one step ahead of other global health institutions in many respects, as raised in the highlights below. Importantly, the GFF's country driven model promotes efficiency and effectiveness in domestic and external resource use, reduces fragmentation, duplication of efforts and maximises the impact of investments.

As well as building on successes in GFF programming to progress universal health coverage, an opportunity presents itself at a time when critical questions are being raised on the effectiveness of the current global health architecture, for sharing learning with others. The GFF is well placed to share successful strategies and challenges, to shape global health partners' support with national plans and to influence national and global partners to improve aid effectiveness in practice. This could include setting out practical solutions, such as those that reduce administrative burdens and associated costs, like the joint GFF-IDA contracts.

In addition, the partnership with IDA enabled governments to prioritise investments for RMNCAH-N. IDA generally increases countries' fiscal space, allowing for more resources to be spent on essential services. Given the current fiscal constraints and debt servicing commitments governments are facing, the grants and concessional loans provided by IDA, characterised by minimal interest rates and longer repayment windows, play a critical role in reducing interest payments.

The ongoing GFF resource mobilisation campaign and the IDA replenishment in 2024 provide two opportunities, if supported well, to expand fiscal space for governments to spend more on essential services, such as health services for women, children, and adolescents.

Reflecting on what has worked well so far, the following recommendations identify key steps that could further boost the GFF's impact to provide learning for others:

1. SUPPORT GOVERNMENTS TO PROMOTE INCLUSIVE AGENDA-SETTING IN COUNTRY PLATFORMS:

What works: The GFF played an instrumental role in supporting the government to convene multistakeholder platforms. This is considered fundamental to improving collaboration and partnership between government, civil society, private sector and external partners. By integrating civil society, more perspectives are considered during the development of health sector strategies, enabling community led development.

Building on success: To further sustain the engagement and collaboration in health strategies of CSOs and other stakeholders, lead on revising the guidance note on Inclusive Multi-stakeholder Country Platforms [61] by expanding on:

- a clear, structured approach when soliciting input into agenda and priority setting.
- a transparent follow-up process after workshops and consultations so that stakeholders are kept informed about how their contributions to influence decision-making.

2. PROVIDE SUPPORT TO GOVERNMENTS IN LEVERAGING ADDITIONAL RESOURCES FOR HEALTH:

What works: Evidence shows the GFF harnessed up to 10 times more financing through securing funding from other external sources beyond the amount directly invested through GFF grant funding. Beyond aligning more IDA funding for RMNCAH-N, the GFF also provides technical support in negotiating co-financing arrangements with external partners, this facilitates access to financing for ongoing as well

as acute needs.

Building on success: Given current fiscal constraints, continue providing support to governments in leveraging additional resources. Potentially expanding into areas such as debt swaps for health, as appropriate. Additionally, in the run up to IDA replenishment in 2024, continue to highlight to international donors the positive contribution of IDA on RMNCAH-N.

3. ENHANCE RESOURCE MAPPING AND EXPENDITURE TRACKING BY MAKING THIS DATA AVAILABLE TO THE PUBLIC:

What works: Through its health financing support, the GFF supports governments to better understand their fiscal space for health. This enables informed decision making on resource allocation, prioritisation, and allows for more progress on reducing health disparities.

Building on success: Given that the general timeframe for obtaining health expenditure data for many countries typically involves a two-year cycle before the data is made available, in addition to resource mobilisation, work with governments to share disaggregated expenditure data timelier.

4. STRENGTHEN LINKS BETWEEN FUNDING AND RESULTS:

What works: The World Bank and GFF used results-based approaches with governments where disbursements of GFF, and associated IDA funding, is contingent upon achieving pre-agreed performance targets. This incentivises and drives meaningful improvements on health outcomes.

Building on success: Similarly to such arrangements with governments, consider expanding these contracting arrangements for use with other entities, such as CSOs. For example:

- Contracts could be structured to link pre-determined payment amounts to milestones and/or progress against key performance indicators, with payments made once these achievements are evidenced. In this case, cascading from the GFF to the NGO host to subcontracts with grantees. (Importantly, specifying a proportion of the contract value as an up-front payment addresses cash flow issues and reduce barriers for smaller CSOs.)
- Agreeing on a mechanism and touch points for funders and grantees to review and approve critical activities and decisions before they are implemented would improve quality, impact and value for money.

5. PROVIDE EQUITABLE TECHNICAL SOLUTIONS BASED ON BEST PRACTICE:

What works: The GFF's technical assistance adopts a country led approach. Providing targeted support helps governments on areas of health financing, such as mobilising resources, improving efficiency, strengthening health financing systems, and managing expenditure accelerates progress towards UHC.

Building on success:

- As part of TA provision, prioritise raising awareness and generating discussion on matters often given low priority, in efforts to develop equitable solutions. Many institutions are working to find a harmonious balance between responding to governments' TA requests and offering evidenced based solutions. Getting this right could result in closer alignment with established global best practice than, in the case of Ethiopia, where donors, in coordination with government direction, have played a role in the conceptualisation of parallel contributory schemes that offer varying benefits to different populations.
- Health financing reforms take time, resources, and political will. When political intent exists to stagger reforms with a view to progressing subsidisation for disadvantaged groups downstream, advocate for a model that facilities this from the outset.
- Furthermore, the benefits of anchoring technical assistance in the latest global best practice and guidance and iterating these to the government is clear. These practices have been tested and refined to promote equitable and sustainable impact. Moreover, these are often at the forefront of innovation and emerging trends that may be otherwise overlooked due to capacity and time constraints.

- Recognising the finite pool of proficient global experts in health financing, with only a handful of hubs hosting such valuable specialised knowledge. Deepening collaboration further with these experts when addressing countries' technical assistance needs would further enhance evidence-based support, facilitating the creation of fair and effective health financing reforms.

The following recommendations are intended to provide the NGO Host, the Civil Society Coordinating Group as well as the GFF with suggestions to further strengthen civil society and youth engagement:

6. STRENGTHEN CIVIL SOCIETY ENGAGEMENT BY IMPROVING FUNDING:

What works: By tripling the funding for CSO engagement, the GFF has empowered local organisations to develop community-led initiatives that address health challenges and support innovative solutions.

Building on success:

- Increase funding allocated to CSO engagement further, considering high inflation in the environment that many CSOs operate in.
- Further ensure resources and opportunities are distributed equitably among a range of CSOs to prevent monopolisation and encourage a diverse range of voices and perspectives.
- Develop targets on gender balance and inclusion of early career professionals across all aspects of the GFF CSO engagement – from GFF grantees to representatives in local and global networks.
- Allocate mentors from within the GFF Secretariat to these early career professionals, so they are supported and empowered to engage effectively with government stakeholders and senior colleagues in civil society.

7. MAXIMISE LOCAL TO GLOBAL LINKAGES THROUGH THE CIVIL SOCIETY COORDINATING GROUP:

What works: The CSCG provides civil society with a platform to be actively engaged, empowered, and represented in partnership with the GFF, contributing to inclusive decision making. Many representatives active in the CSCG are also able to cascade knowledge on global debates and best practice for country level country specific initiatives, harnessing the global to local continuum.

Building on success: Engagement with the CSCG provides an additional opportunity to strengthen civil society engagement. CSCG representative roles are advertised to support the objectives of the CSCG, such as 'mobilizing resources for civil society' and 'monitoring the performance of CSOs Focal Points and Multi-stakeholder Country Platforms'. It is essential that all parties aim to ensure diversification in awarding these opportunities across different players. This would ultimately result in more RMNCAH-N champions.

Annex 1: Country Identification

TABLE 2. SAMPLING MATRIX

HEALTH FINANCING REFORMS	EQUITY FOCUS
Ethiopia	Bangladesh
Rwanda	Cambodia
Tanzania	Cameroon
Ghana	**Ethiopia**
Uganda	
Zimbabwe	

TABLE 3. SUMMARY OF INTERVENTIONS AND EXCLUSION JUSTIFICATION (AT THE TIME OF RETRIEVAL IN DECEMBER 2022)

COUNTRY	SUMMARY	EXCLUSION JUSTIFICATION
Afghanistan	IC not available on GFF site	No IC
Bangladesh	IC out of date: 2016 -2021. Covered - Nutrition; Adolescent health services; Public financial management, equity, financial protection analyses, TA health budgets	Outdated IC
Burkina Faso	IC available. Francophone	Language
Cambodia	IC available Equity focused – operational in seven priority provinces; Donor and domestic alignment	
Cameroon	IC out of date. Covered – Performance based financing, equity focused	Outdated IC
Central African Republic	IC available. Francophone	Language
Chad	IC under development	No IC
Cote d'Ivoire	IC available. Francophone	Language
Dominican Republic of Congo	IC available. Francophone	Language
Ethiopia	IC available . Community Based Health Insurance; Health Data; Equity, resource mobilisation and expenditure tracking	
Ghana	IC available. Spending efficiency; Performance based financing; alignment with development partners	
Guatemala	IC available. Hispanophone	Language
Guinea	IC available. Francophone	Language

TABLE 3. SUMMARY OF INTERVENTIONS AND EXCLUSION JUSTIFICATION (CONTINUED)

COUNTRY	SUMMARY	EXCLUSION JUSTIFICATION
Haiti	IC unavailable Primary health care strengthening	No IC
Indonesia	IC available. Nutrition; Early childhood development; Sanitation/ hygiene	
Kenya	IC dated. Covers – Alignment; Public Financial Management; Health Information Systems; Human Resources for Health	Outdated IC
Liberia	IC dated Spending efficiency; health financing reforms; HIS	Outdated IC
Madagascar	IC under development	No IC
Malawi	IC available. District level health financing capacity development; Human resources for health; data use	
Mali	IC available. Francophone	Language
Mauritania	IC unavailable	No IC
Mozambique	IC available. Primary Health Care strengthening; Human resources for health; essential drugs	
Myanmar	IC unavailable	No IC
Niger	IC available. Francophone	Language
Nigeria	IC available Co-financing the Basic Health Care Provision Fund; Nutrition – in NE region	
Pakistan	IC unavailable	No IC
Rwanda	IC available. Community Health Workers; PBF reforms; Early childhood development; social protection	
Senegal	IC available. Francophone	Language
Sierra Leone	Dated IC. Covers – Health System Strengthening; Performance based financing; spending efficiency; financing Primary Health Care; Public Financial Management	Outdated IC
Somalia	IC available. Health financing and Public Financial Management strengthening; Human resources for health; essential medicines; Health information systems	
Tajikistan	IC unavailable	No IC
Tanzania	IC available. Alignment – Domestic Resource Mobilisation; health financing reform – National Health Insurance; strengthening Primary Health Care	
Uganda	IC available. Health Financing reforms	
Vietnam	IC unavailable	No IC
Zambia	IC unavailable	No IC
Zimbabwe	IC available Health Financing reforms; alignment	

Findings during the country identification process: Out of 36 GFF countries, 15 investment cases were found missing–either not developed, out of date or for other reasons.

Annex 2: Interview Guide

QUESTIONS FOR GOVERNMENT OF ETHIOPIA OFFICIALS

1. To what extent have the GFF investments strengthened health systems?

a. How has the GFF supported health systems and improved access to services for women, children and adolescents?
b. Through the GFF partnership how did service coverage extend/improve especially for the most vulnerable?
c. What GFF resources and approaches were used in respective countries to improve RMNCAH-N?
d. How do you see the GFF supported reforms contributing to improving services downstream?
e. How did the work of the GFF translate to improvements in the poorest regions?
f. How has the GFF contributed to improved alignment between the FMOH, development partners and other stakeholders?
g. How has the GFF's engagement with the FMOH been different to other development partners?
h. How does the FMOH and GFF see the role of CSOs?

2. What changes have been seen in countries' health financing landscape/domestic resource mobilisation and utilisation efforts due to GFF initiatives?

a. How has the GFF contributed to mobilisation of more resources for health?
b. To what extent has the GFF supported dialogue between the FMOH and MoF to improve DRM?
c. How has the GFF contributed to improving tracking resources?
d. What technical assistance has the GFF provided that has helped in improving health financing?
e. How else can the GFF help in addressing bottlenecks in the PFM system and improve the flow of financing?
f. In your opinion, is the GFF helping to address the main bottlenecks in the health financing systems? What other areas can be addressed?
g. How did the GFF contribute to improving financial barriers to access? (CBHI etc)
h. How did the GFF leverage the private sector and what governance procedures were put in place to mitigate risks?

3. How did the GFF support country-led programming and policy development in GFF implementing countries?

a. How did the FMOH drive the IC development process?
b. What were the positives and which areas require more support?
c. What were the challenges faced by GFF implementing countries in delivering on the investment case?
d. How were these addressed and what lessons were learnt?

QUESTIONS FOR WORLD BANK STAFF

4. How did the GFF leverage other resources, such as IDA, in respect to the specific countries?

a. How does the GFF work with IDA in unleashing new resources?
b. How much extra resources has this partnership unleashed for the health sector?
c. How did the GFF link (WB) indicators to payments and how did this contribute to improved prioritisation and improve results?

QUESTIONS FOR CIVIL SOCIETY ORGANISATIONS

5. To what extent has the GFF leveraged the capacity of CSOs to advocate for financing reforms and increase DRM for health?

a. How did the GFF support developing health financing capacity in civil society?
b. What do you consider the biggest wins from this advocacy?
c. What else do you/other civil society organisations need to further advocacy efforts?

6. Has the GFF encouraged participation of communities and CSOs in development of the investment case and health financing strategies?

a. What were the positive aspects of the collaboration?
b. What would you like to see done differently in future ICs?
c. To what extent is it possible to track and measure results/progress related to the IC?
d. What other information do you require?

Glossary

Community Based Health Insurance (CBHI) ... CBHI is a form of micro health insurance, which is an overarching term for health insurance targeted to low-income people.

Co-Financing ... Financing that is additional to GFF grant financing.

Demographic Health Surveys ... Nationally-representative household surveys that provide data for a wide range of monitoring and impact evaluation indicators in the areas of population, health, and nutrition.

Diphtheria Tetanus Toxoid and Pertussis (DTP3) ... DTP3: combined diphtheria, tetanus, and pertussis vaccines.

Domestic Resource Utilisation and Mobilisation (DRUM) ... The key pillars of the DRUM window include: 1) leveraging IDA funding for health financing reforms; 2) supporting health financing technical assistance and analytics to inform IDA lending and strengthen reform design and implementation at the country level; 3) enhancing planning, budgeting and execution, and transparency through resource mapping and expenditure tracking; 4) mobilising the World Bank's public sector governance and public financial management expertise for GFF supported countries; and 5) increasing global, regional, and local-level advocacy efforts for more efficiently-used resources for health.

Every Newborn Action Plan (ENAP) ... The Every Newborn Action Plan presents evidence-based solutions to prevent newborn deaths and stillbirths.

Fragile and Conflict-affected Situations (FCS) ... These are the countries that are affected by fragility and conflict classified by the World Bank.

Health Equity ... Health equity is achieved by eliminating unfair, avoidable, and remediable differences among groups of people of their health status.

Health Extension Workers (HEW) ... The HEWs plays critical roles in providing and facilitating the access to the basic, largely preventive, primary health services especially for children and mothers at the community level.

Health Financing Reforms ... Health Financing Reforms aims to improve effectiveness of service coverage and financial protection by addressing the health system functions and policies. Health financing policies and reforms are tools to improve equity in access to health services and progress UHC.

Health Sector Transformation Plan (HSTP) ... The health sector strategic plan in Ethiopia.

Innovation to Scale Grant ... The Innovation-to-Scale initiative offers a grant to organisations aiming to accelerate the adoption of innovations that are shown to reduce maternal and neonatal mortality rates.

Investment Case (IC) ... The Investment Case is a description of the changes that a country wants to see with regard to reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N) and a prioritised set of investments required achieve these results.

International Development Association (IDA) ... The International Development Association is a development finance institution which offers concessional loans and grants to the world's poorest developing countries.

International Health Partnership (IHP+) ... IHP+ is an international partnership that aims to enhance the aid effectiveness and development cooperation by avoiding the fragmentation and duplication which create inefficiency.

Kangaroo Mother Care ... Kangaroo mother care is a method of care of preterm infants. The method involves infants being carried, usually by the mother, with skin-to-skin contact.

Neonatal Intensive Care Unit ... Newborn babies who need intensive medical care are often put in a special area of the hospital called the neonatal intensive care unit.

Out-of-Pocket Expenditure ... Household out-of-pocket payment means a direct payment for healthcare goods and services from the household primary income or savings, where the payment is made by the user at the time of the purchase of goods or the use of the services.

Program for Results (PforR) ... PforR' s unique features include using a country' s own institutions and processes, and linking disbursement of funds directly to the achievement of specific program results.

Public Financial Management (PFM) ... Public Financial Management (PFM) is concerned with aspects of resource mobilisation and expenditure management in the public sector.

Primary Health Care (PHC) ... Primary health care is a whole-of-society approach to effectively organise and strengthen national health systems to bring services for health and wellbeing closer to communities.

Resource Mapping and Expenditure Tracking (RMET) ... RMET aims to secure the priorities in the health sectors to be funded, prioritised, and implemented and support the planning and budgeting process throughout. RM is an annual exercise to rapidly capture budget data for the most recent fiscal year. ET, on the other hand, is conducted to capture retrospective expenditure data.

Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition (RMNCAH-N) ... RMNCAH-N involves health of adolescent girls and women before and during pregnancy and delivery, to newborns and children over the course of their lives.

Service Availability and Readiness Assessment (SARA) ... SARA is a systematic survey for the assessment and monitoring of health facility service delivery.

Sustainable Development Goals Performance Fund (SDG PF) ... The Sustainable Development Goals Performance Fund (SDG PF) is a pooled funding mechanism managed by the Federal Ministry of Health using the Ethiopian Government's procedures.

Social Health Insurance (SHI) ... SHI is a risk pooling scheme for financing and managing health care. It pools both the health risks of the people, and the contributions of individuals, households, enterprises, and the government.

Technical Assistance (TA) ... The transfer or adaptation of ideas, knowledge, practices, technologies, or skills to foster economic development for policy development, institutional development, capacity building, and project or programme support.

Universal Health Coverage (UHC) ... UHC is a state that all people have access to the full range of quality health services without financial difficulties whenever and wherever needed. It ensures the access to essential health services including health promotion to prevention, treatment, rehabilitation, and palliative care at all stages of life.

Endnotes

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