

World Bank Multi-Donor Trust Fund Mid Term Review

24 September 2019

**Specialist
Health
Service**

Strategic input on health to the Australian Government

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Executive Summary

Background

A growing number of countries are approaching a point of transition in health financing in which economic growth potentially increases the availability of domestic resources while reducing eligibility for external funding.

The Multi-Donor Trust Fund (MDTF), proposed and financed by DFAT and managed by the World Bank, was established “to support countries in strengthening their health systems to accelerate and sustain progress towards key health output and outcomes that contribute to Universal Health Coverage, with a particular focus on assessing and supporting the financial and programmatic sustainability of externally financed programs”.

Since it began, the MDTF has attracted additional donors (Gavi, Global Fund, and the Bill and Melinda Gates Foundation) and expanded to several other countries. However, this Mid-Term Review (MTR) applies only to DFAT-supported activities in the Asia-Pacific Region and has been undertaken from a DFAT perspective.

Relevance

The MDTF addresses two of the most pressing issues in health and development facing countries in Southeast Asia and the Pacific: a) how to make progress towards Universal Health Coverage while effectively managing the transition from externally financed health programs and b) how to establish financially sustainable systems that enhance health security, within countries and across the region.

The MDTF aligns with Australia’s foreign policy priorities for the Indo-Pacific Region¹ in a constructive and effective way, with a focus on strengthening health systems, health security, and improving health governance - in the context of a shared agenda for security, prosperity and stability. In the countries visited, the MDTF is positively associated with financial support from Australia.

DFAT’s investment has been influential in expanding the World Bank’s role in health in Southeast Asia and the Pacific, based on a shared analysis of priorities. It continues to benefit from the expertise available in the World Bank, a trusted partner, in technical areas related to the MDTF’s objectives: macro-fiscal analysis, public financial management, health financing and health sector reform.

The MDTF model is particularly suitable in middle-income and countries in transition from external to domestic funding for health programs. The work is both strategic and opportunistic – pursuing long-term goals but seizing openings to make progress as and when they arise – often in complex and rapidly changing environments. This requires flexibility, a high degree of trust and a consistent country presence. The focus on middle-income countries also recognises that it is these countries that will soon lose the benefits of technical cooperation and capacity building that comes with external support.

The use of MDTF grant funding has been used strategically to complement and enhance the effectiveness of World Bank lending, in line with overall MDTF objectives, both in countries with and without an Australian bilateral health presence. The MTR supports the proposition made in the Terms of Reference that in the latter case – through its partnership with the World Bank – DFAT can have a significant influence on health outcomes in the wider Southeast Asia Region at relatively modest cost.

While not an explicit objective of the MTR, the Review Team has not identified any alternative modalities that could be used by DFAT to support foundational capacities such as public financial management, while also strengthening disease control and health security or that provide the flexibility, accountability and rigour of the MDTF.

¹ <https://www.fpwhitepaper.gov.au/>

The MDTF is more than a series of country interventions. Its regional role is expressed in several ways: (i) sharing knowledge and experience through regional training courses and the annual conference in parallel with Prince Mahidol Awards Conference (PMAC); (ii) regional public goods in the form of common methodologies for analytic work and syntheses of country experience on issues relevant to the MDTF's mandate; and (iii) influencing policy and practice (particularly in relation to health security) through interactions with regional integration organizations. The MTR suggests that the MDTF is currently more influential in relation to the first two modalities than the third.

Effectiveness

The World Bank approach has been to define transition in terms of programmatic and financial sustainability and to locate it in the broader context of ongoing or planned health financing reforms; focusing particularly on fiscal space, prioritisation, and health systems strengthening.

Financial and programmatic sustainability

The MDTF has pioneered the alignment of interests that underpinned its creation and given a greater sense of urgency to the issue of financial transition both in the region and globally. Experience to date and practical lessons learned – specifically on what has been learned with regard to financial transition – merit wider global dissemination (Recommendation 3).

The MTR supports the proposition that a focus on health financing and transition can act as a springboard to address a wide range of systemic health service delivery issues. Several examples are evident from the review:

- a) Work on Public Expenditure Reviews and service costing, particularly in Pacific Island Countries, has revealed (often for the first time) how health budgets are actually spent. This work has been reinforced by ensuring donor contributions are on budget. Combined with work on the basic elements of Public Financial Management (PFM), including planning, budgeting and performance, this has led to discussions on priorities, equity (including gender equity), criteria for allocation between districts and islands, service standards, and monitoring systems;
- b) In countries with newly established purchasing agencies (e.g. Indonesia, Laos) work has focused on pooling of different sources of funding, defining benefit packages, introducing the idea of strategic purchasing and strengthening provider payment mechanisms.
- c) In the transition from externally financed programs, a necessary step has been to integrate program activities (such as outreach), demand generation, accountability and reporting systems (as with the Gavi transition in Laos). Financial incentives in the form of Disbursement Linked Indicators (DLIs) have been used at facility level to reinforce new patterns of provider and beneficiary behaviour.

Progress from understanding the seriousness of the issue of financial transition to actions that will ensure the sustainability of post-transition outcomes varies across countries. Overall, however, progress in relation to intermediate objectives is positive and work is being undertaken that will be effective in achieving the MDTF's higher-level objectives. The work to date has also made a contribution to (i) increasing aid effectiveness (joint funding with the World Bank by Gavi and – in the future – Global Fund, of health reforms in Laos); (ii) increasing the effectiveness and efficiency of current and future donor support (through PFM in Pacific Island Countries); and (iii) influencing the focus on results and provider behaviour (through DLIs).

The road to Universal Health Coverage (UHC)

MDTF activities are not just an optional adjunct to World Bank loan operations. Rather they constitute a set of foundational elements central to the achievement of national and development partner health objectives and as a pre-requisite for making progress on UHC. The contribution that the work of the MDTF can make towards the achievement of UHC depends on a number of factors: the sequence of activities from analysis to intervention; the synergy between MDTF activities and loan operations (plus or minus MDTF contributions); the work of other development partners; and systems changes through health systems strengthening.

Given that UHC is a policy objective in all MDTF countries, Recommendation 4 proposes that the role of the MDTF could now be framed or branded in terms of support for the achievement of UHC. This will require a much clearer theory of change to show how activities funded by the MDTF lead to universal access to services and financial protection. A focus on UHC as the overarching purpose of the MDTF also requires a much greater focus on issues of equity and exclusion.

Measuring performance (Windows 1 and 2)

The MDTF is not a typical development project in which there is a clear line of sight between discrete interventions and the achievement of an overall development objective. Rather, it uses limited resources strategically, alongside those of national governments and other partners, to overcome systemic constraints and introduce efficiencies in the delivery of services en route to Universal Health Coverage, in ways that would be unlikely through discrete small-scale projects. That said, the MTR details tangible achievements. In the three countries visited as part of the MTR, there was evidence of directly attributable impact in one (significant increases in immunisation coverage in previously under-performing districts in Laos) and a body of robust foundational Public Finance Management (PFM) and health systems work that can be expected to bear fruit soon in all three countries.

There is a fundamental problem in the way the MDTF is monitored. The World Bank currently uses process objectives and indicators to capture, at the activity level, the type of work that the MDTF is supporting. The results framework then jumps to high-level objectives on coverage and financing of essential services.

The consequence is that it is difficult to explain the assumptions that underpin the MDTF's strategy or to monitor progress along the causal chain that, say, links improving PFM with more efficient budgetary allocations, more effective health expenditures, and increases in program coverage. Countries make progress towards UHC at different rates. Success is, therefore, relative, but without the currently "missing middle" objectives and indicators, it cannot be properly measured. Recommendation 1 suggests the need for indicators and measurement strategies at output level.

Window3: sustainable health security

Work on health security uses the World Bank's expertise in PFM and financial analysis but is conceptually different in that it is not primarily focused on transition and the integration of externally financed programs.

Window 3 also has a three-part structure: generating evidence on health security financing and institutions to inform policy and planning at national and regional levels; strengthening financial and institutional capacities for health security through technical assistance; and increase political and economic commitment to improve regional health security.

The review of Window 3 was less extensive than for Windows 1 and 2: the number of interviews was limited (in part due to absence of key personnel in countries) as was the availability of documentation. While the MTR notes some achievements under each pillar, it was difficult to ascertain clear evidence of policy influence from analytic or technical support to date. In addition, we noted divergent views among World Bank interlocutors as to the future and/or direction of work under this window. Recommendation 7 recognizes that there will be no additional funding for Window 3 but goes further to reflect the need for more clarity on focus, expectations and deliverables if the current work of Window 3 is to be continued.

Gender and equity

Measures to address gender inequality are a priority for DFAT and the World Bank. Despite the commendable achievement of all three Pillar 4 operations now being 'gender tagged' in the World Bank system, and the existence of policy guidance, the expectation that gender concerns and gaps would be incorporated and mainstreamed within the analytic and policy advocacy work financed by the MDTF and the loan operations to which the analytic work contributes, has not been realized to the extent expected.

The review points to several areas where gender concerns and opportunities have been overlooked and to insufficient involvement of gender expertise in MDTF activities. On a more positive note, gender and gender-

based violence considerations are built into the design of some projects within the MDTF portfolio. These have the potential to institutionalize the collection and use of sex-disaggregated and gender data for health and local government multi-sectoral planning and design of interventions (for example, in Laos). Recommendation 8 reinforces the need for greater effort to increase the focus on gender and highlights the need for an agreement on specific actions across the portfolio.

Efficiency

Value for money

The MDTF leverages a great deal of internal World Bank capacity and reputation at no additional cost over and above the additional investment. The MTR concludes that the MDTF is undertaking work that will be effective in achieving its higher-level objectives; if confirmed (and see points on impact below), then the MDTF will emerge as a highly cost-effective vehicle for DFAT investment that represents value for money. This is particularly the case in the Pacific Island Countries where there are no other sources of technical assistance dealing with the same foundational issues and World Bank support comes at a very modest cost to DFAT.

Pace of implementation

The overall completion rate for the MDTF was 36% at the end of Year 3 of a seven-year program (with new activities having started since then). The high level of disbursement and activity completion suggests that the MDTF is an efficient mechanism for undertaking interventions to strengthen health systems. While progress varies across the 12 countries, this is in part due to variable start dates.

Improving health outcomes

Most of the Health Financing Systems Assessments rightly stress the importance of increasing efficiency as a way of creating more fiscal space for health. In the case of the Pacific Island Countries (PICs) this is the most important route given the combination of limited economic growth, declining donor receipts, and increasing health care costs. By contrast, many of the Southeast Asian countries supported by the MDTF, as well as Papua New Guinea, have growing economies but spend less on health than countries with similar levels of Gross National Income. The MDTF has an important role, reflected in Recommendation 6, in ensuring that the level of effort in analytic work keeps the issue of more money for health (and not just more health for the money) clearly in the policy frame.

Cross country learning

Results-based financing (RBF), using disbursement-linked indicators (DLI), is now a feature of most World Bank lending operations in health. In all three countries visited DLIs have the potential to act as powerful and positive incentives for change. Recommendation 5 suggests that convening in-country workshops is an efficient means of learning from experience, contributing to aid effectiveness as well as making a contribution to capacity building and sustainability.

The MDTF is a complex initiative, and the right combination of interventions in each context may only become apparent over time. Success requires experimentation and adaptation, something that the MDTF, with its flexible management arrangements, is well positioned to do. To gain from this flexibility, the MDTF could provide more systematic opportunities for cross-country learning (Recommendation 2) by framing and addressing policy questions common to countries in the Pacific and Southeast Asia, building on the success of PMAC workshops.

Impact

There is already evidence of impact defined in terms of program coverage from Laos, which, also shows the potential impact of MDTF grant contributions to World Bank loan operations. However, the MDTF's full contribution to achieving overall financing and program objectives will only be fully measurable later in the life of the program. There are two reasons for this. The work currently being done on PFM and health systems strengthening will take time to feed through into changes in program coverage and changes in levels of

domestic financing. In addition, measures of health system performance are subject to a lag period of one to two years. As such, most of the metrics on coverage and financing that are available today reflect the situation that pertained at the start of the MDTF. They do, however, provide a baseline to be used in future as well as an indication of the context in which the MDTF is working.

The MDTF has also had an impact by influencing thinking on financial transition beyond individual East Asia and Pacific (EAP) countries. In Gavi, for example, by offering a model for linking funding with World Bank investments tied to DLIs, with similar mechanisms being considered by the Global Fund. The work of the MDTF has the potential to influence a range of global initiatives concerned with partner coordination and Universal Health Coverage including the UHC 2030 Working Group on Transition, the Global Action Plan Health Financing Accelerator, the Global Preparedness Monitoring Board, and the Secretariat for the Sustainable Development Goal (SDG) Global Action Plan.

Sustainability

The MDTF is an investment in the future of health and development in the Indo-Pacific Region. Its strength lies in the fact that it is set up to achieve long-lasting goals through building a foundation for future investment by governments and their partners, rather than through short-term projectized outputs.

Given that the aim is to enhance the ability of partner countries to finance and lead their own development, future metrics should take this into account, avoiding any tendency to prioritise short-term results over lasting change.

Final note

The MDTF is an important initiative which arguably merits a higher profile in DFAT. One of the challenges in achieving this is that there is no single document that sets out the scope, structure, theory of change and achievements to date of the MDTF. The Review Team hope that the MTR report may help in this respect.

Recommendations

Recommendation 1: Strengthen measurement of performance

The World Bank, in consultation with DFAT, should identify a set of output level, health-specific PFM indicators, with related measurement strategies, that can be applied across different settings to allow measurement of progress across countries and to inform cross-country learning. It would be useful to include gender and equity in output indicators based on agreements on what is to be achieved through the MDTF in these areas.

Recommendation 2: Increase learning and documentation

Pillar 3 (knowledge generation and exchange) of the MDTF would benefit from a more systematic approach to learning from and documenting cross-country experience. A possible starting point would be a) to build on the success of meetings held prior to the Prince Mahidol Award Conference, ensuring in the future that conclusions are both documented and widely disseminated, and b) to establish a community of practice among those attending regional workshops so as to get greater value from these exchanges. The World Bank should also consider ways in which to ensure that key country analyses are updated when circumstances require and that current documentation on work in each country is more accessible to other partners, including DFAT.

Recommendation 3: Disseminate EAP experience on transition towards sustainability and integration

The programmatic and financial sustainability of priority programs is an issue of growing importance in low- and middle-income countries. Experience in the EAP Region, on new ways to advance the integration of formerly separate programs through innovative working arrangements, have broader global relevance. This experience merits further dissemination beyond the region so that it can inform current global debates on health financing in the context of UHC and the Global Action Plan to achieve SDG 3.

Recommendation 4: Chart the route to UHC

- a) Given the importance of UHC as a policy objective and as an outcome of financial and programmatic sustainability in EAP countries, DFAT and the World Bank should consider re-branding the MDTF in relation to Universal Health Coverage (UHC).
- b) To complement a revised monitoring framework (see Recommendation 1), it is necessary to show how the work of the MDTF leads to systemic change and how synergy with other investments works in different country contexts. This could take the form of a pathway or theory of change towards UHC, perhaps prepared for individual countries and should include a consideration of gender equality and social inclusion.
- c) Increasing equity of access and outcome is a key objective of UHC and needs to be given greater prominence in MDTF work at country level – including through the work of civil society organisations.

Recommendation 5: Learn from DLI experience

In countries where DLIs are planned or in operation, World Bank in-country staff should conduct regular participatory sessions to examine and discuss lessons learned – expected and unexpected – with government and development partner stakeholders. This process need not be complex or expensive. Focusing on the practical lessons learned can help avoid unhelpful division between agencies that hold different views on the merits of RBF.

Recommendation 6: Increase the focus on investment for health

The analytic work of the MDTF should continue to highlight the low level of public investment in health in Southeast Asia and PNG. For countries which have signed up as early adopters (PNG, Indonesia), the World Bank Human Capital Project represents one potential channel for renewed advocacy with Ministries of Finance.

Recommendation 7: Clarify expectations and deliverables of MDTF health security funding

Window 3 needs a further reset. Achievements in EAP countries to date justify continuing MDTF engagement

under this window only if there is clear agreement on focus, expectations and deliverables. It is critical to agree on the extent to which MDTF finance is used to address institutional (particularly health system) bottlenecks that constrain health security financing in individual countries versus further development and implementation of regional processes and advocacy. The two approaches are not mutually exclusive but given limited resources and a wealth of other institutional players and potential sources of finance, being explicit about the role of the World Bank's use of MDTF funding is essential.

Recommendation 8: Increase the focus on gender and equity

Given the importance of gender to achieving health sector outcomes for both the World Bank and DFAT, the resources of the MDTF should be considered an opportunity to pursue gender-informed and responsive strategies in analytics, policy advocacy and programming. Both organisations prioritise realising gender equality through their support. However, further work is needed to define and agree what this looks like in the MDTF and how to implement it. Given the many gender and social exclusion risks that come from transition, this will mean reaching agreement on a limited number of critical actions that are required in specific country contexts and factoring this into World Bank human resourcing. This will feed into sector learning and contribute to the gender-smart programming that DFAT and World Bank both support. Inclusion of gender and equity in a revised monitoring framework (Recommendation 1) and theory of change on UHC (Recommendation 4) will help focus attention in this regard. In addition, it will be useful to explore the potential for the MDTF to work with other trust funds (as proposed in Vietnam and Indonesia) that have a specific focus or window on gender as a way of complementing the work of the MDTF portfolio and in line with World Bank Country Gender Action Plans.

Contents

Table of Tables & Figures	x
Review of the World Bank Multi-Donor Trust Fund, 2019	1
1. Introduction	1
1.1. Overview	1
1.2. Structure of the MDTF	2
1.3. The Mid-Term Review (MTR).....	3
2. MDTF Performance	4
2.1 Results framework.....	4
2.2 Countries supported by the MDTF	4
2.3 DFAT financing for the MDTF	5
2.4 MDTF activities and achievements.....	6
2.5 Countries: In-depth studies	9
2.6 Countries: Illustrative achievements	10
2.7 Analysis of Performance	11
2.7.1 Key conclusions.....	12
2.7.2 Measuring performance	13
2.7.3 Reflection, adaptation, learning and documentation.....	14
2.7.4 Value for money	14
2.8 MDTF: partnerships, management and governance	15
3. The influence of the MDTF	17
3.1 Overall assessment	17
3.2 Health Financing Transition	17
3.3 The route to Universal Health Coverage	19
3.4 Learning from results-based financing	21
3.5 More money for health: increasing investment in human capital	22
3.6 MDTF as a regional initiative	23
3.7 Window 3: health security financing	24
3.8 Gender and social exclusion	26
3.9 Looking to the future.....	28
Annexes	30
4. Annex 1: Terms of Reference	31
5. Annex 2: Monitoring Framework	36
6. Annex 3: Programmatic and financial sustainability data	37
6.1 HIV: prevalence, ART coverage, and domestic expenditure	38

6.2	TB: incidence, treatment coverage, and domestic expenditure	39
6.3	Malaria: high risk population, ITBN, and domestic expenditure	40
6.4	Immunisation: DPT3 & MCV1 coverage, and domestic expenditure	41
7.	Annex 4 a: Aide Memoire - Laos	42
8.	Annex 4 b: Aide Memoire - Papua New Guinea	45
9.	Annex 4 c: Aide Memoire - Indonesia	48
10.	Annex 5: Country summaries	51
10.1	Summaries of MDTF MTR countries	51
4.1	In-depth visits	51
10.2	Indonesia	52
10.2.1	Activity Summary	52
10.3	Laos	55
10.3.1	Activity Summary	55
10.4	Papua New Guinea	57
10.4.1	Activity Summary	57
11.	Other Countries (not visited)	59
11.1	Cambodia	59
11.2	Myanmar	60
11.3	Philippines	61
11.4	Vietnam	62
11.5	Kiribati	63
11.6	Samoa	64
11.7	Solomon Islands	65
11.8	Tonga	66
11.9	Vanuatu	67
12.	Annex 6: MDTF Activity Tables	68
13.	Annex 7: Gender equality and social inclusion analyses – Laos and Cambodia	72
14.	Annex 8: Persons Consulted	80
15.	Annex 8: List of key documents	84

Table of Tables & Figures

Table 1: MDTF Financial Report.....	5
Table 2: Status of Gavi and Global Fund Grants to MDTF countries. Source: World Bank 2018 with updates provided during the Mid-Term Review	7
Table 3: Programmatic and Financing Achievements, Indonesia. Source: MDTF Annual Report to DFAT, 2018.	52
Table 4: Programmatic and Financing Achievements, Laos. Source: MDTF Annual Report to DFAT, 2018	55
Table 5: Programmatic and Financing Achievements, Papua New Guinea. Source: MDTF Annual Report to DFAT, 2018.....	57
Table 6: Programmatic and Financing Achievements, Cambodia. Source: MDTF Annual Report to DFAT, 2018.	59
Table 7: Programmatic and Financing Achievements, Myanmar. Source: MDTF Annual Report to DFAT, 2018.	60
Table 8: Programmatic and Financing Achievements, the Philippines. Source: MDTF Annual Report to DFAT, 2018.....	61
Table 9: Programmatic and Financing Achievements, Vietnam. Source: MDTF Annual Report to DFAT, 2018...	62
Table 10: Programmatic and Financing Achievements, Kiribati. Source: MDTF Annual Report to DFAT, 2018...	63
Table 11: Programmatic and Financing Achievements, Samoa. Source: MDTF Annual Report to DFAT, 2018. ..	64
Table 12: Programmatic and Financing Achievements, Solomon Islands. Source: MDTF Annual Report to DFAT, 2018.....	65
Table 13: Programmatic and Financing Achievements, Tonga. Source: MDTF Annual Report to DFAT, 2018. ...	66
Table 14: Programmatic and Financing Achievements, Vanuatu. Source: MDTF Annual Report to DFAT, 2018. 67	
Figure 1: The health financing transition. Source: Produced by Ajay Tandon for the World Bank Group, based on World Development Indicators and WHO Global Health Expenditure Databases	1
Figure 2: Monitoring and Evaluation Framework, World Bank Multi-Donor Trust Fund	36
Figure 3: HIV prevalence. Source UNAIDS Country Profiles, 2018.	38
Figure 4: Estimated ART coverage among people living with HIV. Source: MDTF 2018 progress reports, data from 2016/2017.....	38
Figure 5: Share of government health expenditure on HIV that is sourced domestically. Source: MDTF 2018 progress reports; data from 2016/2017, except PNG (2018).	38
Figure 6: TB incidence per 100,000 population and levels of drug resistance (MDR-TB & RR-TB, % of new cases). Source: WHO	39
Figure 7: TB treatment coverage, new and relapse TB cases. Source: MDTF progress reports, 2018; data from 2016/2017.	39
Figure 8: Share of government health expenditure on TB that is sourced domestically. Source: MDTF progress reports 2018; data from 2016/2017, except PNG and Vanuatu (2018).	39
Figure 9: Proportion of total population living in areas of high malaria transmission. Source: WHO.....	40
Figure 10: Proportion of people at high risk of malaria infection who are sleeping under insecticide treated bed nets. Source: MDTF progress reports, 2018; data from 2016/2017.....	40
Figure 11: Share of government health expenditure on malaria that is sourced domestically. Source: MDTF progress reports 2018; data from 2016/2017, except PNG and Vanuatu (2018).	40
Figure 12: Proportion of districts with >80% DPT Coverage. Source: MDTF progress reports, 2018; data from 2016/2017	41
Figure 13: Proportion of districts with >95% MCV1 coverage. Source: MDTF progress reports, 2018; data from 2016/2017	41
Figure 14: Share of vaccine expenditures on routine immunisation sourced by government. Source: MDTF progress reports, 2018; data from 2016/2017; figures for Laos and Vanuatu updated by WB during MTR.	41
Figure 15: Indonesia Strategic health purchasing for TB. Source: World Bank	53

Acronyms

ADB	Asian Development Bank
AIDS	Acquired immunodeficiency syndrome
AMR	Antimicrobial resistance
ARMM	Autonomous Region in Muslim Mindanao
ART	Antiretroviral treatment
ASEAN	Association of Southeast Asian Nations
ATMI	AIDS, TB, Malaria and Immunisation (programs)
AUD	Australian dollar
BMGF	Bill and Melinda Gates Foundation
CCM	Country Coordinating Mechanism (Global Fund)
CHE/THE	Current Health Expenditure
CNP	Cambodia Nutrition Project
COD	Cash on Delivery - a form of Results-Based Financing (qv)
CSO	Civil Society Organization
DAH	Development Assistance for Health
DFAT	Australian Department of Foreign Affairs and Trade
DHIS2	District Health Information System 2 (web-based platform)
DLI	Disbursement Linked Indicator
DRM	Domestic resource mobilization
DTP3	3 rd dose of Diphtheria, Tetanus, Pertussis vaccine
EAP	East Asia and the Pacific (World Bank Regional Grouping)
Gavi	Gavi, the Vaccine Alliance
GFF	Global Finance Facility
Global Fund	Global Fund to Fight AIDS, TB and malaria
GNI	Gross National Income
GoPNG	Government of Papua New Guinea
GPMB	Global Preparedness Monitoring Board
HANSA	Health and Nutrition Services Access (WB Project - Laos)
H-EQIP	Health Equity and Quality Improvement Project (Cambodia)
HFSA	Health Financing Systems Assessment
HGNDP	Health Governance and Nutrition Development Project (Laos)
HIV	Human immunodeficiency virus
HSFA(T)	Health Security Financing Assessment (Tool)
HSR	Health Systems Review
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
IHME	Institute of Health Metrics and Evaluation
IO	Intermediary Objective
I-SPHERE	Indonesia Strengthening Primary Health Care Reform
ITBN	Insecticide Treated Bed Net
JEE	Joint Evaluation Exercise
LMIC	Lower-middle income country
Laos	Lao Peoples Democratic Republic
M&E	Monitoring and evaluation
MCH	Maternal and Child Health
MCV1	1 st dose of Measles Containing Vaccine
MDTF	Multi-Donor Trust Fund
MDTF	Multi-Donor Trust Fund
MHMS	Ministry of Health and Medical Services (Pacific Island Countries)
MIC	Middle income country
MTDP	Mid-Term Development Plan

MTR	Mid-Term Review
NCD	Noncommunicable Disease
NDOH	National Department of Health
NEPO	National Economic Planning Office (Kiribati)
NHIMU	National Health Plan Implementation and Monitoring Unit (Myanmar)
NMR	Neonatal mortality rate
OOP	Out of Pocket (Expenditure)
PASA	Program of [WB] Analytic and Advisory Services
PETS	Public Expenditure Tracking Survey
PF4	Pacific Facility IV
PFM	Public Finance Management
PHA	Provincial Health Authority (PNG)
PHC	Primary Health Care
PIC	Pacific Island Countries
PMAC	Prince Mahidol Award Conference
PNG	Papua New Guinea
RBF	Results-Based Financing
SBCC	Social Behaviour Change Communication
SDG	Sustainable Development Goals
SEAOHUN	Southeast Asia One Health University Network
SHIFT	Sustainable HIV Financing in Transition (Indonesia)
SIG	Solomon Islands' Government
TB	Tuberculosis
THE	Total Health Expenditure
U5MR	Under five years mortality rate
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USD	United States' dollar
VFM	Value for Money
WB	World Bank
WHO	World Health Organization

Review of the World Bank Multi-Donor Trust Fund, 2019

1. Introduction

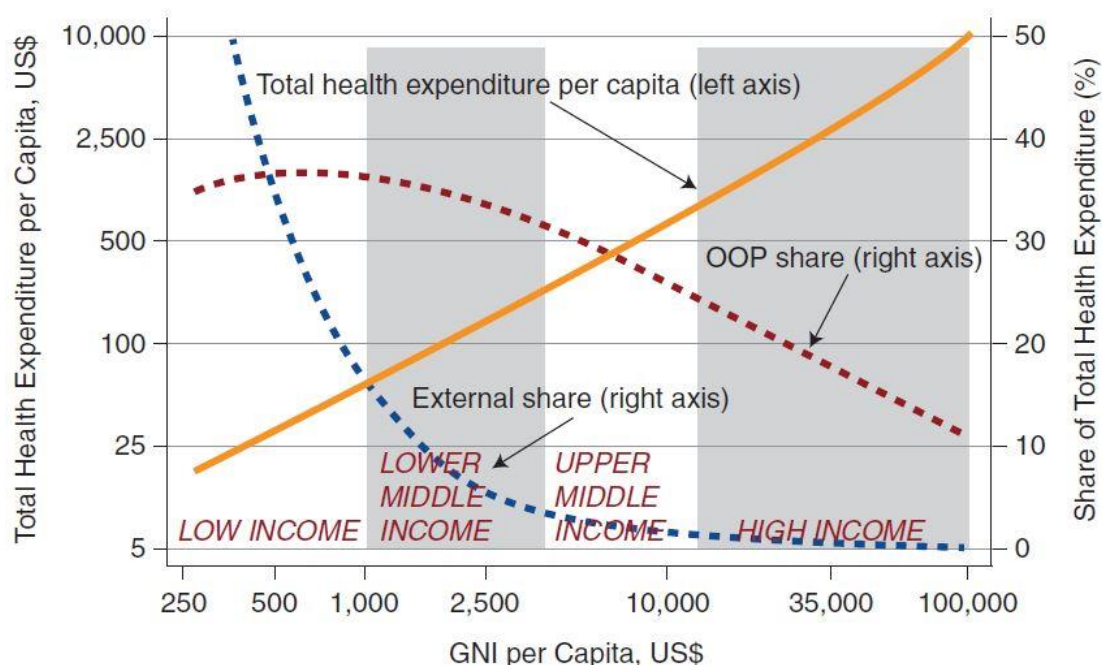
1.1. Overview

The Development Objective of the World Bank Multi-Donor Trust Fund (MDTF) is “to support countries in strengthening their health systems to accelerate and sustain progress towards key health output and outcomes that contribute to Universal Health Coverage (UHC), with a particular focus on assessing and supporting the financial and programmatic sustainability of externally financed programs”.

The founding idea is that a growing number of countries are approaching a point of transition in health financing in which economic growth increases the potential availability of domestic resources while reducing eligibility for external funding.

The definition of “transition” used by the MDTF entails more than simply replacing expiring external financing². Financial transition happens in concert with demographic and epidemiological changes, in which chronic conditions and ageing populations place new demands on health care systems; institutional changes, in which out-of-pocket payments are replaced by different forms of pooling and/or pre-payment for health care; and growing expectations that people should have more equitable and affordable access to the benefits of new health technologies (see Figure 1). Universal Health Coverage (UHC), which incorporates these ideas, is thus an end point of all these transitions in which people are able to access the health services they need, of adequate quality, without suffering financial hardship as a result.

Figure 1: The health financing transition. Source: Produced by Ajay Tandon for the World Bank Group, based on World Development Indicators and WHO Global Health Expenditure Databases



Economic growth in many middle-income countries means that external development assistance for health (DAH) now makes up a relatively small proportion of Total Health Expenditure (THE) in most Asian countries, although it is still a significant proportion of THE in Papua New Guinea (PNG) and the Pacific Islands. But this is

² Health Sector Review, Indonesia (World Bank contribution), 2018

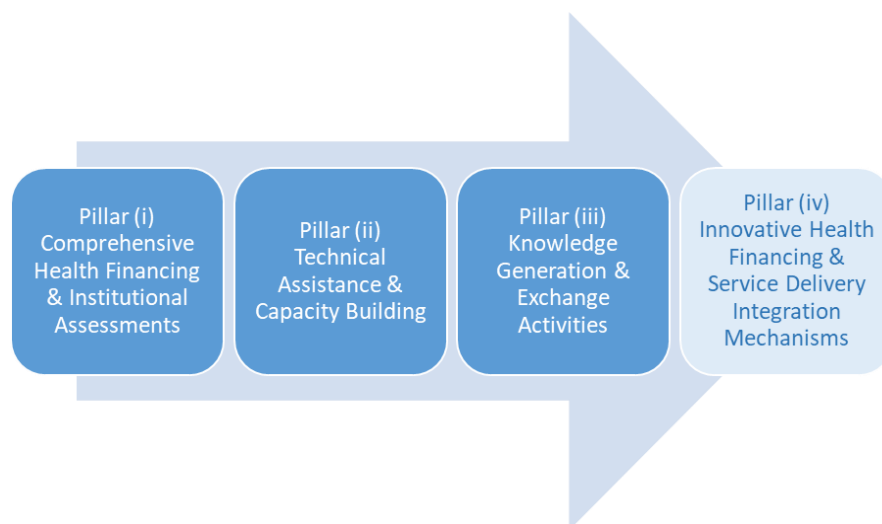
often not the case for priority programs that have been financed by vertical global funds such as Gavi, the Vaccine Alliance (Gavi) or the Global Fund to Fight AIDS, TB and Malaria (the Global Fund) – which remain dependent on external resources. The MDTF was established to give greater political prominence to this issue and to help countries prepare and plan for transition. The key point, therefore, is that while sustaining the gains achieved through external financing provides the *raison d’être* of the MDTF, the changes required go far beyond substituting one source of finance with another. They are inextricably bound up with several other strands of systemic reform, of which UHC is an ultimate goal.

1.2. Structure of the MDTF

At the time of the review DFAT funding for the MDTF is available in 12 countries in the World Bank Region of East Asia and the Pacific (EAP): Cambodia, Indonesia, Kiribati, Laos, Myanmar, Papua New Guinea, Philippines, Samoa, Solomon Islands, Tonga, Vanuatu and Vietnam³. It is organized around three windows. **Window 1** focuses on HIV/AIDS, TB and malaria; **Window 2** on immunisation, and, as a later addition, **Window 3** on the financing of health security. Window 3 has its own sub-objective: *to strengthen the financial and institutional capacity of selected countries to ensure sustainability of health security in the EAP region*.

The MDTF is managed by the World Bank and the work is carried out by World Bank staff in the countries concerned or, on an intermittent basis, by staff travelling from offices within the region. The World Bank’s work is organized around four pillars, which represent a logical sequence (see Figure 2). The MDTF was originally designed to have three (1-3) Bank Executed ‘pillars’ of activities and one (4) Recipient (Government) Executed pillar: **Pillar 1:** Analysis –comprehensive financing and institutional assessments; **Pillar 2:** Technical Assistance and capacity building; **Pillar 3:** Knowledge generation and exchange; and **Pillar 4:** Implementation of health systems integration/strengthening interventions (through MDTF grant contributions to complement World Bank IDA or IBRD loan operations). Window 3 on health security has no funding for Pillar 4.

Figure 2: MDTF Theory of Change



At the time of the MTR, DFAT had pledged AUD 57.7 million to the MDTF for activities between 2015 and 2023. Gavi and the Global Fund have made contributions to the Fund for work in the EAP Region and beyond, and the Bill and Melinda Gates Foundation (BMGF) has contributed to the Fund for work outside the EAP region. In Laos, Cambodia and Vietnam, DFAT has contributed MDTF grant funding alongside World Bank loan operations.

³ Timor Leste was added as a 13th country in 2019 but not included in the MTR

1.3. The Mid-Term Review (MTR)

Purpose

The purpose of the MTR is to assess “*the continued relevance of the MDTF investment and the progress made toward achieving its planned objectives*”. Subsequent questions set out in the TORs for the Review (Annex 1) relate to the intermediate objectives, targets and indicators set out in the detailed Monitoring Framework developed for the MDTF (Annex 2).

In addition to the **objectives and indicators** in the formal project management structure, an additional agenda considered by the MTR - extending beyond the list of intermediary process outcomes - is concerned with how the investment in the MDTF influences policy and practice, within and between countries as a regional and global initiative. An internal DFAT briefing note (25 February 2019) sets out five propositions that summarise key aspects of this agenda. “The MDTF can be seen to be modelling:

- Strategic, relatively low-cost ways of influencing and supporting health sector performance in lower-middle income countries LMICs in transition
- A way of driving the practical coordination of health sector financing among the World Bank, Gavi, the Global Fund, the Global Financing Facility and others
- Using blended finance approaches to leverage health sector loans with the injection of DFAT grant funding
- Using health financing entry points as a springboard to address systemic health service delivery issues in a way not generally seen in traditional health projects
- Deploying the World Bank’s comparative advantage to support health sectors in the region, even in the absence of DFAT bilateral health engagement.”

Lastly, the MTR was asked to examine the extent to which **gender equality and equity of health financing** and delivery has been considered and addressed through the MDTF.

Process

The review took place over two months from 1st May 2019, starting with a review of key documents. This was followed by in-person discussions in Geneva and Bangkok, phone briefings in Canberra and three one-week country visits (to Laos, Papua New Guinea and Indonesia). The visits permitted in-depth discussions between the MTR team, World Bank staff, government officials from the relevant health, planning and financing ministries in each country and representatives of key development partners. Discussions with a further eight countries⁴ took place through conference calls before and after the country visits.

Because the three country visits help in understanding the role and work of the MDTF in three very different national settings, the aides-memoire from the three visits are included at Annex 4. An overall list of persons met, and key documents consulted is at Annex 8. The gender and social exclusion analysis of key documentation from MDTF-supported work in Laos and Cambodia is included at Annex 7.

The MDTF is a complex enterprise with many moving parts, involving a large number of stakeholders, directly and indirectly, across a wide range of different country contexts. Part of the role of the MTR is to assess what has been achieved against agreed objectives. At the same time, the MDTF is an instrument for influencing policy and practice in complex and dynamic environments. While much can be gleaned from written reports, assessing influence, and soliciting opinions about the performance of development partners at a distance is difficult and is only really possible through face-to-face interviews with opportunities to triangulate responses. A **limitation of the MTR** is the large number of interviews that had to be conducted by telephone (Annex 8).

⁴ Samoa and Timor Leste were not included in phone interviews. Discussions on Cambodia were limited to a video conference (from Vientiane) with World Bank staff. Representatives of the Government of Cambodia were not available for phone interviews. The MTR did not interact with staff at Post, only with a contracted DFAT staff member.

However, the World Bank has made extensive **use of data** to track progress of the different development and financing MDTF objectives, using quantitative measures where available, and qualitative assessments for other indicators. Progress reports have been provided on a six-monthly basis since 2016. The 2018 Annual Report contained the most recent data available for the MTR⁵, including a summary financial report on allocation and expenditure of DFAT funds. The progress reports provide a substantive overview of health reforms and issues related to transition, as well as a detailed report on progress with individual activities in each country, covering all pillars and windows. The World Bank, in response to concerns regarding visibility of MDTF aims and results, has also prepared a set of infographics laying out the main data related to MDTF financial and program coverage objectives.

Structure of the report

Part 2 summarizes performance against the objectives and outcomes in the MDTF monitoring framework. More detail on the current status of financial and programmatic sustainability is found in Annex 3 and on activities and achievements in all MDTF countries in Annex 5. **Part 3** analyses the influence of the MDTF and is organized around a series of specific issues and responds to the process questions in the TORs and some of the broader propositions about the role of the MDTF.

2. MDTF Performance

2.1 Results framework

The MDTF has two ‘development’ objectives (1) *To support countries in strengthening their health systems to accelerate and sustain progress towards key health output and outcomes that contribute to Universal Health Coverage (UHC) with a particular focus on assessing and supporting the financial and programmatic sustainability of externally-financed programs;* and for Window 3 (2) *To strengthen financial and institutional capacity of selected countries to ensure sustainability of health security in the EAP region.* The MDTF also has 5 Process, 2 Programmatic, and 3 Financing Intermediary Objectives (IOs), each with a set of indicators agreed between the World Bank and DFAT (Annex 2).

Part 2 of the report focuses primarily on work under Windows 1 and 2. Comments on the performance and influence of work under Window 3 follows in Part 3.

2.2 Countries supported by the MDTF

The MDTF financed by DFAT supports work in 13 EAP countries. The report does not cover Timor Leste as activities had not started at the time of the MTR. Samoa was also not formally covered in the MTR, but examples of planned activities are included in the section on gender and in Annex 5.

Figure A in Annex 5 shows how MTR countries vary in terms of size, economy, levels of poverty, and health (assessed through under-five (U5) and neonatal mortality (NMR) rates). They fall into two distinct groups: small Pacific Island Countries (PICs) with very sluggish economic growth (all <3.5%) but lower levels of poverty as compared to Southeast Asian countries with more rapid growth (all >5%) but with higher levels of poverty. PNG stands out as an exception with moderately high Gross National Income (GNI), low growth and very high poverty levels. Laos has the highest under-5 mortality rate, closely followed by PNG, Myanmar and Kiribati.

⁵ Some country data have been updated by the World Bank following submission of a first draft report.

2.3 DFAT financing for the MDTF

At the time of the MTR, DFAT had pledged AUD 57.7 million (USD 40.61 million)⁶ to the MDTF for activities between 2015 and 2023, of which 83% (USD 33.58m) is programmed and being implemented and 28% (USD 10.01m) already spent at the time of the 2018 Annual Report (Table 1). This latter figure does not include most of the USD 14 million committed up-front under Pillar 4 to co-finance World Bank projects in Laos, Cambodia and Vietnam under grant agreements with the respective governments. Allowing for the gradual start up, this represents a good disbursement rate with 28% of funds spent by 38 months or 40% into the implementation period (assuming MDTF ends in September 2023).

The amount of funds allocated to each country is likely to vary over time according to demand, opportunities arising, and the availability of funds from other sources, including other DFAT-financed Trust Funds (e.g. PF4 in PNG and the Pacific). The MDTF also receives funds from other donors, including from the Global Fund (USD 4.5m), Gavi (USD 14.93m), and the Bill & Melinda Gates Foundation (BMGF; USD 3.03m), for EAP countries as well as other countries in Africa and South Asia (as detailed in the introduction of the 2018 Annual Report). However, expenditures outside the EAP region are not reported on in the MTR or in the progress reports to DFAT. Rates of expenditure vary considerably between countries mainly due to different start dates for work (see Annex 6, Table A). Many activities took place in individual countries, such as the Health Financing Systems Assessments (HFSA) in Pacific countries.

Table 1: MDTF Financial Report

MDTF Financial Performance
Source: 2018 Annual Report to DFAT (US\$ million)

Smillion	Start	Window 1 (ATM)				Window 2 (Immunisation)				Window 3 (Health Security)				Total Committed
		Commit	Program	Spend	% spend	Commit	Program	Spend	% spend	Commit	Program	Spend	% spend	
Cambodia	Dec-17	\$0.41	\$0.00	\$0.00	0%	\$6.00	\$6.00	\$0.10	2%	**				\$6.41
Indonesia	Nov-15	\$1.36	\$1.36	\$1.36	100%	\$0.62	\$0.62	\$0.32	51%	**				\$1.98
Kiribati	Jan-16	**								**				
Lao PDR	May-16	\$0.41	\$0.00	\$0.00	0%	\$5.50	\$5.50	\$1.95	35%	**				\$5.91
Myanmar	Jan-17					\$1.50	\$1.50	\$0.82	55%	**				\$1.50
Philippines	Dec-16					\$2.52	\$2.52	\$0.68	27%					\$2.52
PNG	Feb-16	\$2.33	\$2.33	\$0.46	20%	\$0.11	\$0.11	\$0.11	100%					\$2.45
Samoa	Jul-18	**								**				
Solomon Islands	Jan-16	**								**				
Timor Leste	Apr-19	***												
Tonga	Jul-18	**								**				
Vanuatu	Jan-16	**								**				
Vietnam	Oct-17					\$5.30	\$5.30	\$0.22	4%	**				\$5.30
Regional	Oct-16	\$2.50	\$2.50	\$1.82	73%	\$2.24	\$0.50	\$0.09	4%	**	\$5.34	\$5.34	\$2.08	39%
TOTALS		\$7.01	\$6.19	\$3.64	52%	\$23.79	\$22.05	\$4.28	18%		\$5.34	\$5.34	\$2.08	39%

Window 1
 ** 2 countries
 *** 5 countries
 *** AUD 2.95 for Timor Leste and Samoa committed in Apr 2019 (not included in MTR)

Window 3
 ** 5 countries
 (\$3.26m Pillar I, \$2.08m Pillar II&III)

Summary	
Pledged	\$40.61
Committed (Programmed)	\$36.14
(Unprogramme)	\$33.58
Spent (%)	\$2.56
Admin	\$10.01 28%
	\$4.47 11%

⁶ This includes an additional AUD 2.95m made available for W1 in April 2019 to expand work in the Pacific, with an initial emphasis on Samoa, and to add Timor Leste as new country under the MDTF making total commitment to AUD 57.7 million. The remaining of the MTR will be in USD, in line with WB reporting.

2.4 MDTF activities and achievements

The MDTF is already able to demonstrate significant and tangible results; details of work undertaken and what has been achieved in each country is summarised in Annex 6.

Progress with process indicators

A database constructed for the MTR shows all activities undertaken and makes it possible to analyse the level of completion of agreed work as reported by the World Bank. A total of 152 activities have been identified and were coded according to the Process Intermediary Objectives and Indicators in the MDTF Monitoring and Evaluation (M&E) Framework to provide a snapshot of the type of work undertaken. Annex 6 presents tables setting out activities by year started and level of completion (Table A), activities completed by Window (Table B), Intermediary Process Indicators in aggregate (Table C) and by country (Table D).

Four streams of work stand out as priorities: informing government expenditures (e.g. HFSA); assisting in the formulation of government policies and strategies; building capacity; and regional knowledge exchanges. Lastly, several countries have started to design health systems projects ('innovations') that are 'Recipient' (i.e. government) executed, some of which will include co-financing from the MDTF through Pillar 4.

Progress toward the achievement of MDTF programmatic and financing objectives

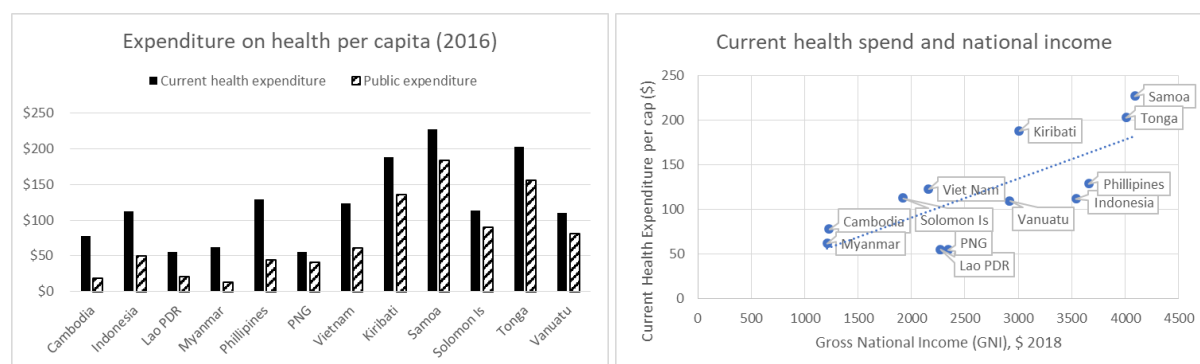
The values for the higher-level financing and programmatic indicators provided by the World Bank in the latest progress report (end of 2018) represent the status in countries in 2016/2017, in other words when the MDTF started. They, therefore, offer insights about the *context* in which the MDTF is working in each country and provide a *baseline* against which future progress can be measured.

The World Bank also reports whether the latest available figures represent an improvement, the status quo, or a worsening from the last time that measure was undertaken (details of which vary across the indicators). While these are not true trends (as they do not cover three data points) we have included these data for each country (as positive or negative change, or status quo) as they give an indication as to whether the MDTF is operating in an environment where program coverage and/or domestic financing is improving or deteriorating. These data are found at the beginning of each country report in Annex 5. In the areas where the MDTF has already directly contributed to a change in the high-level indicators, these are also highlighted in the country summaries.

Financing

Figure 4 summarises the financing context in MDTF countries. Cambodia and Myanmar have the lowest overall per capita expenditure and very high out of pocket payments. These countries are at a very early stage of transition from external financing. Positive change is nevertheless possible as illustrated below in relation to HIV financing in Cambodia, as exemplified by the figures below and the fact that the Ministry of Economy and Finance has become the Principle Recipient for Global Fund monies (see below). PNG and Laos are wealthier but have relatively low overall spending on health, suggesting that major changes in policy and the health system are required to achieve MDTF objectives. Philippines and Indonesia both under-spend on health for their level of GNI, and of the larger countries only Vietnam spends more than the average. Public spending on health follows the same pattern. The higher spending countries such as Vietnam might be expected to take on a larger future role in domestic financing of essential, externally financed, public health programs, whereas, for countries such as PNG and Laos, it is reasonable to expect that this will be more difficult and take longer.

Figure 4. National health expenditures (Source WB)



Financing from Global Fund and Gavi

The timetable and process for achieving MDTF financing and programmatic objectives, in particular for those related to HIV, TB, Malaria and Immunisation, also depends on the application of Global Fund and Gavi criteria for provision of grant funding. Gavi criteria are based primarily on GNI, supporting countries that are Low Income status (as defined by the World Bank) or with a rolling average GNI of less than USD 1500, and with clear guidance on how ‘transition’ should be interpreted⁷. Global Fund eligibility is more complex. Future transition is determined not just by a country’s income classification (with a much higher cut off point than Gavi) but also by disease burden for each of three diseases separately. Table 2 provides an update on the official status of World Bank, Gavi and Global Fund funding and whether they have explicitly agreed a timetable or process to transitioning away from financial support.

Table 2: Status of Gavi and Global Fund Grants to MDTF countries. Source: World Bank 2018 with updates provided during the Mid-Term Review

	GNI per capita	World Bank	Gavi	Global Fund			
	2017			Transition	Transition	HIV	TB
	USD						
Cambodia	1,230	IDA	>2017	✓	✓	✓	-
Indonesia	3,540	IBRD	2016	✓	✓	✓	-
Laos	2,270	IDA	2022*	✓	✓	✓	HIV
Myanmar	1,190	IDA	>2025	✓	✓	✓	-
Philippines	3,360	IBRD	-	✓	✓	✓	Malaria
PNG	2,410	Blend	2025#	✓	✓	✓	-
Vietnam	2,170	IBRD	2019	✓	✓	✓	-
Kiribati	2,780	IDA	2016	✓	✓	-	HIV
Samoa	4,100	IDA	-	✓‡	✓‡	-	-
Solomon Is.	1,920	IDA	2021	✓	✓	✓	HIV
Tonga	4,010	IDA	-	✓‡	✓‡	-	-
Vanuatu	2,920	IDA	-	✓	✓	✓	HIV

* Due to Rota & HPV introduction, support expected to continue to 2022

PNG support from Gavi extended from 2020 to 2025 in June 2019

✓‡ Tonga & Samoa to receive a small allocation for TB and HIV from the Global Fund Pacific multi-country grant

Program coverage – HIV, TB, Malaria and Immunisation

The indicators on coverage and domestic financing use data from around the start of the MDTF. They provide a baseline for future measurement, but also show that the challenge of programmatic and financial

⁷ Gavi Alliance Eligibility and Transition Policy Version 3.0

sustainability is very different across MDTF countries. Detailed data on programmatic and financial sustainability, summarized below, are found in Annex 3.

HIV

Of the 12 countries, PNG has the highest HIV prevalence, at 0.9% in adults (15-49), with Myanmar next at 0.7%. The Pacific Island Countries have the lowest HIV prevalence, with each having fewer than 100 cases. Cambodia, despite its low GNI, is ahead of others with regards to financial and program sustainability, with a prevalence of 0.5%, ART coverage of 87% and with 98% of program financing covered from domestic resources. Indonesia, Laos and Myanmar are doing least well, each with domestic funding under 10%. In the Solomon Islands, the World Bank notes that domestic expenditure as a percentage is high but that this is due to poor execution of the external budget. Table 3 shows latest coverage figures (2018), compared to those in the latest MDTF progress report (2017); all show improvements except for Cambodia.

Table 3: Comparison of ART coverage: 2017 (in MDTF 2018 Report) and 2018 (UNAIDS)

	Proportion of PLHIV on ART	
	2017 MDTF	2018 UNAIDS
Cambodia	87%	81%
Indonesia	14%	17%
Laos	47%	54%
Myanmar	66%	70%
Philippines	36%	44%
PNG	55%	65%
Vietnam	50%	65%

TB

The Philippines has the highest burden of TB, with an annual incidence of 554 cases per 100,000, and with treatment coverage recently decreasing to only 55% of cases. Levels of drug resistance are a particular problem in Myanmar (5.1% of new cases) and Vietnam (4.1%), the rest being below the 2017 global average of 3.5%. Vietnam and the Pacific Island Countries, except Vanuatu, have treatment coverage above the required 80% level. Levels of domestic financing are much lower than for HIV, with only three countries, the Philippines, PNG and Vanuatu, above 30%.

Malaria

The proportion of the population living in high transmission areas is over 80% in PNG, Solomon Islands and Vanuatu. The proportion of those at risk of malaria sleeping under an Insecticide Treated Bed Net (ITBN) is reported as 100% in Cambodia, Myanmar, Solomon Islands and Vanuatu, and 84% in PNG. With regards to domestic financing, the World Bank reports that the Philippines covers 100% financing domestically; the next highest are the Solomon Islands and Vanuatu at 43% and 36% respectively.

Spot checks confirm that the data appearing in the World Bank Annual Report 2018 (on HIV and AIDS, TB and malaria) are consistent with other sources except for estimates for the proportion of domestic funding for malaria (Table 4). One reason proposed to explain the discrepancies is in the way that international databases track expenditure. Differences occur if reports are based on development partners' financial transfers to the country as opposed to tracking the amounts actually spent.

Table 4: Comparison of different data sources covering government spending on malaria

Heading	Share of Malaria expenditure from domestic sources	
	IHME April 2019	WB MDTF Nov 2018
Cambodia	13.8%	n/d
Indonesia	46.0%	1.0%
Laos	12.5%	1.0%
Myanmar	14.5%	10%
Philippines	46.3%	100%
PNG	35.6%	29%
Vietnam	40.1%	n/d
Solomon Islands	25.9%	43%
Vanuatu	70.7%	36%

Immunisation

Eight countries have over half of their districts with DPT3 coverage greater than 80%, led by Kiribati (100%) and Vietnam (83%). PNG is the lowest with only 12% of districts achieving coverage of 80% or higher – *a figure that appears to be worsening*. Coverage of measles immunisation is much worse across all countries. Only Vietnam has more than half of its districts (83%) reaching the required level of 95% coverage. Domestic financing for immunisation was very high in Philippines (100%) and Indonesia (90%), but low and declining in Cambodia (27%) and Laos (31%).

Comment on data

Comparing this type of data across countries can be challenging. As noted by DFAT, there are some discrepancies between international and national financial estimates, largely due to challenges recording off-system partner contributions to the health sector. This is true both for national official documentation, such as the Solomon Islands Government (SIG) budget books, where accuracy and completeness of data are questionable, and international databases. There are also differences between national and international health outcome indicators. When possible, the Pacific team has tried to use domestic data, as these are used by governments to make budget allocation decisions.

2.5 Countries: In-depth studies

The MTR undertook three in-depth country reviews. Aides memoire from those visits are found in Annex 4 with a brief summary of the findings below. A fuller account from 12 countries, each starting with a graphic showing key MDTF developments against financial and programmatic objectives, is found in Annex 5.

Indonesia: MDTF-funded activities have laid the foundations for achieving MDTF objectives. The analysis of health spending has been instrumental in the Government of Indonesia's decision to take a World Bank loan for health (the first in 13 years). The size of the country and the relatively early stage of the health financing reforms mean that it will take many years for the largely externally financed HIV, TB and malaria programs to be sustainably supported through domestic resources, although immunisation is in a better position. The MDTF-supported 'deep dive' analyses have provided essential information to inform policy. The move to improve PFM and strategic purchasing of priority public health programs, starting with TB and the work on clarifying legal strategies by which the government can fund Civil Society Organizations (CSOs) for HIV services following transition from Global Fund support are all moves in the right direction but are at an early stage. The new World Bank supported I-SPHERE project should reinforce a focus on essential public health programs and has the potential to transform health sector performance and accelerate the transition agenda.

Laos: There is a clear link between the introduction of the new Disbursement Linked Indicators (DLIs) for immunisation, brought about through MDTF support to the Health Governance and Nutrition Development Project (HGNDP), and the reported increase in district immunisation levels in the worst performing areas. Assuming data are available to confirm this effect, it can be directly attributed to MDTF – showing how the MDTF can influence system-wide change. Analytic work has informed the design of the next World Bank supported Health and Nutrition Services Access project (HANSA) that will expand the use of DLIs to other essential health services and the roll out of broader reforms. The success of the work with Gavi and immunisation has led to Global Fund examining the potential for similar involvement. The co-financing of the future HANSA with Global Fund/Gavi grant funds is innovative and provides a new model of integrated external financing that is likely to be relevant for transition in other countries. The work on integration in Laos a) shows the value of linking analysis, technical support and investment; b) illustrates how, through very most levels of investment, the MDTF is able to influence system-wide health systems strengthening in ways that would be unlikely through discrete small-scale projects; and c) the relationship between programmatic sustainability and health systems strengthening.

World Bank and the Global Fund in Laos

“The Global Fund and the World Bank work closely in Laos, and the Global Fund is now planning to contribute 70% of its future funding into the upcoming WB support to the health sector. This will include a lot of TA and capacity building for Lao systems. The joint design is fairly new for Global Fund, and it takes a lot of effort and is time-consuming but will be worth it with regards to planning for transition and sustainability, as it allows for building on synergy in WB and Global Fund work, reduces transaction costs and builds country ownership.”

Laos Global Fund Portfolio Manager

PNG: The MDTF has provided support to essential analysis and to building foundational PFM capacity in government, but the country is at a relatively early stage of setting up the sustainable provincial financing mechanisms needed to establish more stable, progressively expanding essential health services. The move to Provincial Health Authorities (PHA), supported by the World Bank/MDTF, and the start of the performance-based Health IMPACT project, with sub-national DLIs, has the potential to be transformative if PHAs have sufficient finance, capacity and leadership. The political and geographic context in PNG will, however, remain challenging. World Bank analytics have been particularly influential in twice demonstrating that social health insurance is not sustainable in the context of PNG and, working with Gavi, in building the case to be presented to the Gavi Board for more substantive support than would normally be available through transition funding. This additional funding has now been agreed.

2.6 Countries: Illustrative achievements

HFSA in Myanmar

Following a decrease in government spending on health the World Bank convened a meeting of the Ministry of Planning and Finance with the Ministry of Health and Sports and the Ministry of Education. The meeting was the first of its kind ever, and the first time financial issues were discussed across these ministries. Already there have been changes in the way expenditure will be reported in ways that will facilitate financial flows.

The HFSA provides evidence on what is realistic for health financing in Myanmar. It also lays out steps that the Government could consider taking if it wants to enact the financing reforms that are suggested in the National Health Plan. Implementing a system of social health insurance in Myanmar is currently unrealistic. At the same time, PFM in the public sector as it presently exists precludes rapid progress in improving both the quantity and quality of spending. Promoted by the National Health Plan Implementation and Monitoring Unit (NHIMU), the alternative is to establish a semi-autonomous public body which would channel funds to townships,

informed by assessed needs and an agreed benefit package. Supporters of this approach argue a) that this is a long-term goal, and b) that by creating an institution with a degree of separation from government, it will be possible to bring together (through a common financing system) government-run facilities and ethnic health authorities that would otherwise be reluctant to conform to government authority.

Donor finances in Kiribati

PFM work in Kiribati illustrates the problems of increasing aid effectiveness. “NEPO provides guidance on budget preparation, indicative allocations and medium-term projections. Capacity in the Ministry of Health and Medical Services is thin and overstretched. The demands of multiple donors all focusing on their own projects make the problem infinitely worse – diverting capacity from strengthening core systems. The United Nations agencies compound this issue, with accounting demands for a large number of small-value individual projects. The 2019 development budget lists all line item projects receiving donor support – WHO has 51 separate projects (UNFPA is similarly prominent)⁸. Progress on getting fewer, larger allocations and thus being able to concentrate on strengthening core government systems has been slow, and donors have not been particularly cooperative. World Bank policy advice has been useful. The analytic work has started to show where funds are being spent, developing spread sheets that can be discussed by health officials. Hopefully this will result in better and more rational decisions and better allocation of resources.” *Senior planner, Kiribati*

Clarifying budgets and understanding finances in Tonga and the Solomon Islands

The work of the MDTF has – often for the first time – helped national authorities understand how the budget of Ministries of Health and Medical Services are being spent. This has been reinforced by seeking to ensure that donor finances are more fully reflected in national budgets. “The plan (by the World Bank MDTF team) presented did not always reflect our priorities, but there are things that have been very useful, such as support for the practical aspects of planning and budgeting. This is much more operational. Senior managers are now much more aware of budgets and ceilings.... They understand that service planning should be based on health needs and information.... before it was just a shopping list”. *Senior official, MHMS, Solomon Islands*

“Financing in Tonga is very centralised, and we had no idea what we spent our health budget on. The World Bank has been very helpful in this. Things are still far from perfect and we have much more work to do, but we now know how much it costs to treat a woman who presents with diabetes.... We have also started to look at quality and outcomes so we can start to think about cost-effectiveness.” *MHMS, Hospital Superintendent, Tonga*

The MDTF in Vanuatu

The PICs face many similar problems but work on the budget in Vanuatu has made significant progress. “World Bank support is hugely valuable and complements the bilateral program.... The fundamental problem is that there is no clear idea as to what is being spent where. The work on costing and support for planning and budgeting thus provides a starting point for rational decision making” *DFAT First Secretary*

“On a recent visit, we found colleagues from the MHMS celebrating after presenting the health budget to Parliament. Not only had the budget passed without any problems, but they had been complimented for making the best presentation of any sector.” *World Bank program manager*

Vietnam

In Vietnam, government policy does not allow loan funds to be used to finance recurrent costs. As such, the MDTF contribution will increase the effectiveness of the forthcoming World Bank loan by financing training and testing service delivery innovations.

2.7 Analysis of Performance

⁸ <http://www.mfed.gov.ki/sites/default/files/Development%20Budget%202019.pdf>

2.7.1 Key conclusions

Progress

The conclusion of the MTR is that MDTF is on track and making progress and that the work being undertaken will be effective in achieving the higher-level objectives in the monitoring framework. Performance measurement needs to be enhanced at the output level as discussed below.

The in-depth country reviews concluded that in one country (Laos) there is a direct, attributable link between MDTF work and MDTF financial and programmatic objectives, and in the other two countries the work has plausible links to higher objectives and with some evidence of effect, but this will take more time to deliver.

Relevance to Australia's priorities in the Indo-Pacific Region

The MDTF supports engagement in the region in a constructive and effective way that is consistent with the priorities laid out in Australia's foreign policy for the region⁹. The work supports financial and economic governance reforms that will help bring stability and prosperity to the Indo-Pacific region while supporting countries to develop their own capacity for sustainably financed essential health services. The focus on middle income countries (MICs) where the role of traditional project-based development is declining is appropriate as it these countries that are closest to losing the benefits of external financing and the technical cooperation and capacity building that comes with external support. The Review Team have not identified any other modalities that support foundational capacities such as PFM, while also strengthening disease control and health security or that provide the flexibility, accountability and rigor of the MDTF.

Pace of implementation

The overall completion rate for MDTF-supported activities was 36% at the end of Year 3 of a seven-year program (with new activities having started since then). The high level of disbursement and activity completion suggests that the MDTF is an efficient mechanism for undertaking interventions to strengthen health systems. While progress varies across the 12 countries, this is in part due to variable start dates.

MDTF theory of change

The World Bank approach has been to locate transition from external financing in the broader context of ongoing or planned health financing reforms; focusing particularly on fiscal space, prioritisation and health systems strengthening. These activities are not just an optional adjunct to World Bank loan operations but need to be seen as a set of foundational activities central to the achievement of national and development partner health objectives and a pre-requisite for making progress on UHC.

The MTR supports the proposition that a focus on health financing and transition can act as a springboard to address a wide range of systemic health service delivery issues. While there is no single path, several elements are evident in the work of the MDTF. Three examples:

- a) work on Public Expenditure Reviews and service costing, particularly in Pacific Island Countries (PIC), has revealed (often for the first time) how health budgets are actually spent. Combined with work on the basic elements of PFM, including planning, budgeting and performance, this leads to discussions on priorities, equity (including gender equity), criteria for allocation between districts or islands, service standards, and monitoring systems
- b) in countries with newly established purchasing agencies the pathway leads through pooling of different sources of funding, defining benefit packages to strategic purchasing and provider payment mechanisms
- c) in the transition from externally financed programs a necessary step is to integrate program activities (such as outreach for Gavi supported work), demand generation, accountability and

⁹ 2017 Foreign Policy White Paper. <https://www.fpwhitepaper.gov.au/>

reporting systems. Financial incentives can be used at the facility level to reinforce new patterns of provider and beneficiary behaviour (Cambodia, Laos).

2.7.2 Measuring performance

Development objectives

The MDTF is not a typical development project in which there is a clear line of sight between discrete interventions and the achievement of an overall development objective. Rather, it uses limited resources strategically, alongside those of national governments and other partners, to overcome systemic constraints and introduce efficiencies in the delivery of services *en route* to Universal Health Coverage.

While achievements are already evident at the output level, the MDTF's full contribution to achieving overall financing and program objectives will be measurable later in the life of the program. There are two reasons for this. The work currently being done on PFM and health systems strengthening will take time to feed through into changes in program coverage and changes in levels of domestic financing. In addition, measures of health system performance are subject to a lag period of one to two years. As such, most of the metrics on coverage and financing that we are seeing today reflect the situation that pertained at the start of the MDTF work. They do, however, provide a baseline to be used in future and an indication of the context in which the MDTF is working.

Comparing current levels with earlier measures of performance where they are available shows that in some countries levels of coverage were already improving *prior* to the work of the MDTF, while in others they were deteriorating. The challenge in the latter case will be for the MDTF to reverse the decline.

Simplifying the M&E framework

The World Bank has made an assessment of all 44 indicators in the latest MDTF annual report. This is impressive and shows a willingness to use data to inform the MDTF activities. This was reinforced by the infographics prepared in 2018 (although we were not able to assess how well these have been disseminated and used by their intended audience). However, the sheer number of measures can make tracking progress quite challenging. The World Bank might, therefore, consider reducing the number of indicators, giving more emphasis when reporting on progress, for example through simple dashboards in the annual reports.

The missing middle

While attribution will always be difficult in an initiative like the MDTF that seeks to influence policy, the way the MDTF is being monitored raises a more fundamental problem. The World Bank currently uses process objectives and indicators to capture, at the *activity* level, the type of work that the MDTF is supporting. The results framework then jumps to high-level objectives on coverage and financing of essential services.

The consequence is that it is difficult to explain the assumptions that underpin the MDTF's strategy (see points on the theory of change above) or to monitor progress along the causal chain that, say, links improving PFM with more efficient budgetary allocations, more effective health expenditures, and ultimately increases in program coverage. Countries will make progress towards increasing coverage and financial sustainability at different rates. Success is, therefore, relative, but without the currently "missing middle" objectives and indicators, there is no way that it can be measured.

Recommendation 1: Strengthen measurement of performance

The World Bank, in consultation with DFAT, should identify a set of output level, health-specific PFM indicators, with related measurement strategies, that can be applied across different settings to allow measurement of progress across countries and to inform cross-country learning. It would be useful to include gender and equity in output indicators based on agreements on what is to be achieved through the MDTF in these areas.

2.7.3 Reflection, adaptation, learning and documentation

The MDTF is a complex initiative and the right combination of interventions in each context may only become apparent over time. Success requires experimenting and adapting, something that the MDTF, with its flexible management arrangements, is well positioned to do. To gain from this flexibility, the MDTF could provide more systematic opportunities for cross-country learning – by framing policy questions common to countries in the EAP region and beyond (e.g. How can DLIs be used to reduce inequities in service delivery? How can co-financing World Bank health system reform projects lead to sustained gains in priority program coverage? What is the potential for introducing strategic purchasing in decentralised health systems?).

Within individual countries, the learning process is equally important. HFSAs, for example, provide a comprehensive picture of key health financing issues, but they do so at a single point in time. If circumstances change - as they did in Laos with the establishment of a National Health Insurance Fund - an update is needed to keep the analysis live and relevant.

Recommendation 2: Increase learning and documentation

Pillar 3 (knowledge generation and exchange) of the MDTF would benefit from a more systematic approach to learning from and documenting cross-country experience. A possible starting point would be a) to build on the success of meetings held prior to the Prince Mahidol Award Conference, ensuring in the future that conclusions are both documented and widely disseminated, and b) to establish a community of practice among those attending regional workshops so as to get greater value from these exchanges.

The World Bank should consider ways to ensure that a) key country analyses are updated when circumstances require, and b) current documentation on work in each country is more accessible to other partners, including DFAT.

2.7.4 Value for money

The MTR uses a standard VFM framework to examine this aspect of the MDTF work in line with other examinations of VFM of external assistance.

- **Economy: is the MDTF buying inputs of the appropriate quality at the right price?**
All technical work is through the World Bank, a trusted partner, using its staff, consultants and internal procedures. The World Bank is known to have good quality assurance mechanisms in place, and internal procedures to control costs.
- **Efficiency: How well does the World Bank convert inputs into outputs?**
Work is progressing faster in some countries than others, with variable activity completion levels, but this is all as would be expected in such a diverse region, the stage of implementation, and with the level of challenges being taken on. Discrete outputs are being delivered and used by national stakeholders, although this seems dependent on the level and seniority of engagement by the World Bank and DFAT staff in-country. The move to co-financing, with a mixture of grants and loans, should, if successful, lead to an overall reduction in transaction costs for the government.
- **Effectiveness: How well are the MDTF outputs achieving the desired objectives?**
The in-depth country reviews concluded that in one country (Laos) there is a direct, attributable link between MDTF work and MDTF financial and programmatic objectives. In the other two countries, the work has plausible links to higher objectives with some evidence of effect, but this will take more time to deliver.
- **Equity: Does the MDTF help reduce the disadvantage of women and marginalized groups?**
Equity should be included in VFM assessments in recognition of the need for extra effort and cost for this aspect of the SDGs. The MDTF can influence this through WB operations, as was demonstrated through increases in immunisation levels in poorer, underserved parts of Laos. The Vietnamese co-

financed operation also focuses on poorer provinces and disadvantaged groups. However, this influence could be greater, and is an issue of concern to the MTR, discussed in more detail in Part 3.

- **Cost-effectiveness: How much impact does the MDTF achieve relative to the inputs?**

The MDTF leverages a great deal of internal World Bank capacity and reputation at no additional cost over and above the additional investment. The MTR concludes that the MDTF is undertaking work that will be effective in achieving its higher-level objectives; if confirmed (see measuring performance above), then the MDTF is likely to emerge as a highly cost-effective vehicle for DFAT investment. This is particularly the case in the Pacific Island Countries where there are no other sources of technical assistance dealing with the same foundational issues and World Bank support comes at a very modest cost to DFAT.

The MDTF could continue to look for more efficiency, particularly with regard to the number of regional workshops. While valued by participants they may not need to be so numerous (see also Window 3 analysis).

The key point on value for money is that *the MDTF is an investment in the future of development in the Indo-Pacific Region*. While there is a need for a measurement strategy that can help in tracking progress (as noted above) the overall strength of the MDTF lies in its aim of enhancing the ability of partner countries to finance and lead their own development.

2.8 MDTF: partnerships, management and governance

A creative partnership

The work of the MDTF in the EAP region has grown out of a shared analysis between individuals in DFAT the World Bank, Gavi and the Global Fund around the challenges of the health financing transition. An effective institutional relationship has benefitted significantly from the sustained involvement of committed individuals from all these organisations, which in turn has helped to generate high-level support from senior management in Washington and Geneva. The transfer of the former MDTF manager from Bangkok to the World Bank Office in Geneva helps to ensure consistency in direction and, in addition, provides a link through which the in-country work of the MDTF can influence a range of global initiatives concerned with partner coordination and Universal Health Coverage including the UHC 2030 Working Group on Transition, the Global Action Plan Health Financing Accelerator, the Global Preparedness Monitoring Board, and the secretariat for the SDG Global Action Plan.

The importance of an in-country presence

The nature of the work under Windows 1 and 2 requires being both strategic and opportunistic – pursuing long-term goals but seizing openings to make progress when they arise – often in complex and rapidly changing environments. This requires flexibility and a high degree of trust. In Vientiane, for example, it was evident that the World Bank's operations had received a positive boost once resident in-country staff had been deployed. In PNG and Indonesia, we observed that resident technical staff successfully operate in this way – allowing them to be effective conveners and facilitators in the fragmented and siloed systems that are evident in both countries. The question to keep under review is whether the World Bank has sufficient capacity at country level – given the breadth of the MDTF agenda and the growing loan portfolio. Ideally, analytic support and operations should be linked so that the urgent demands of project management do not displace the important work of the MDTF. In particular, DLI based operations require significant technical engagement on the ground.

The limitations of fly-in fly-out support

Posting senior World Bank staff to each Pacific Island Country is unrealistic, and it makes sense for support to be provided on a visiting basis. We also note that in some PICs the World Bank is posting more junior resident staff to ensure continuity of work and to facilitate communication with the Sydney office. In other MDTF countries, we note the limitations of visiting staff and consultants. PNG stands out in this regard. The Task Team Leader visits for 7-10 days every month. While the World Bank work is clearly of high quality and well-

regarded, and the regular visits ensure a degree of continuity, we question whether this is sustainable given the increase of workload that will come when the Health IMPACT loan comes on stream. We would propose that this arrangement is kept under review. More fundamentally, the MDTF work program in PNG relies on a number of visiting consultants. The individuals involved know the country well and have, in some cases, held long-term posts. So, the problem is not lack of understanding or familiarity. Rather, it is that off-shore support risks taking responsibility from those directly involved in the work and means there is no chance for opportunistic influence that comes from the informal and formal networking of in-country technical experts. If data are collected and analysed remotely it is unlikely that conclusions will be fully owned and acted upon. It is self-evident that in a country with limited institutional capacity visiting consultants are always going to be required. However, it is important that they do not undermine the capacity that MDTF technical support is designed to build.

Visiting missions

A key part of the synergy that is needed to move towards UHC depends on the link between the analytic work of the MDTF and the design of World Bank loan operations. It is also the case that while the partnership between the World Bank, DFAT, Gavi and the Global Fund underpins the MDTF's success, we observed in all three countries visited that the relationships with other development partners are less strong. This should not be hard to remedy. We have suggested elsewhere that bringing a wider group of partners into real-time discussions around the implementation of DLIs would help build relationships and help refine the approach to results-based financing. The point about missions, however, is the perception that some in-country development partners are excluded from discussions and that, in practice, consultations take the form of providing information (through an aide memoire) after the event. The World Bank might like to consider changing this approach, especially when the results of its analyses (for example the feedback on DLIs and their verification) are of immediate use to a wider number of development partners.

DFAT-World Bank Meetings

Management meetings take place twice a year: in January in the margins of the Prince Mahidol Award Conference (PMAC) in Bangkok, when representatives from Gavi and the Global Fund are also present, and on an ad hoc basis in August in Canberra, if World Bank travel schedules allow. Both meetings are used to review achievements and discuss funding allocations. Specific issues from the minutes of the August 2018 and January 2019 meetings were plans for Window 3, gender, Terms of Reference for the Mid-Term Review, and DFAT's concern that the World Bank remains engaged in the Pacific Island Countries. Proposals for changing the format of reporting were suggested in August 2018 and have since been implemented.

Raising the profile of the MDTF in DFAT

In the countries visited, and in interviews with DFAT Posts (Annex 8), the work of the MDTF is highly appreciated. For others in DFAT who are less familiar with the initiative, the MDTF is at something of a disadvantage, which can result in losing opportunities to build on MDTF influence¹⁰. There are a number of reasons for this. First, it is not a typical development project as we have discussed in this report. Secondly, despite the improvements made by the World Bank to their six-monthly reports it is hard to get a clear picture of the whole enterprise. Of particular concern is the fact that there is no single document that sets out the scope, structure, theory of change and achievements to date of the MDTF. Thirdly, it was valuable on the visit to Indonesia to be accompanied by someone from the country desk in Canberra. Including country representatives from DFAT in MDTF management and governance meetings could increase recognition of the value of the initiative.

¹⁰ In Laos, for example, the DFAT investment is likely to have a profound effect in country, but there is little engagement from the DFAT Post.

3. The influence of the MDTF

3.1 Overall assessment

The MDTF addresses two of the most pressing issues in health and development facing countries in Southeast Asia and the Pacific: a) how to make progress towards Universal Health Coverage while effectively managing the transition from externally-financed health programs and b) how to establish financially sustainable systems that enhance health security, within countries and across the region. MDTF activities are judged to be relevant to these high-level objectives. Results to date (as noted in Part 2) show progress toward agreed objectives, and the partnership established with the World Bank is both effective and influential.

While the MDTF has attracted additional donors and expanded to several other countries, its technical and geographical focus in the EAP Region responds to DFAT priorities in ways that might not be possible with a global trust fund with fixed global objectives.

DFAT's investment has been influential in expanding the World Bank's role in health in Southeast Asia and the Pacific, based on a shared analysis of priorities. It has benefitted from the expertise available in the World Bank in technical areas related to the MDTF's objectives: macro-fiscal analysis, public financial management, health financing and health sector reform.

The MDTF is making a significant contribution to aid effectiveness in EAP countries. In Laos, the model established with GAVI is likely to be replicated elsewhere. Ensuring synergy between World Bank, GAVI and Global Fund financing through joint use of DLIs contributes to greater policy coherence. In PNG it is important that the same degree of coherence is achieved between the World Bank DLIs and Asian Development Bank policy triggers. In the Pacific Island Countries the MDTF has encouraged other development partners to ensure their financial support is reflected in national budgets, and the work on PFM (as noted in Section 9) enhances the efficiency and, potentially, equity of health spending.

The use of MDTF grant funding has been used strategically to complement and enhance the effectiveness of World Bank lending, in line with overall MDTF objectives, both in countries with and without an Australian bilateral health presence. The MTR supports the proposition that in the latter case, DFAT – through its partnership with the World Bank - can have a significant influence on health outcomes in the wider Southeast Asia region at relatively modest cost.

3.2 Health Financing Transition

While there are significant differences in the sustainability, transition and co-financing policies of Gavi and the Global Fund (set out in Part 2 above), issues concerning the transition from external funding are considered together.

Graduation from Gavi and the Global Fund, and by extension the need for greater fiscal space and domestic resource mobilisation for health, poses problems for governments across the EAP Region. The World Bank approach has been to locate transition from external financing in the broader context of ongoing or planned health financing reforms; focusing particularly on fiscal space, prioritisation and health systems strengthening. Even in countries like Indonesia where external financial assistance constitutes a relatively small proportion (0.4%) of Current Health Expenditure (CHE), for HIV and AIDS, TB, malaria it still accounts for a major proportion of program expenditures.

The alignment of interests between DFAT and the World Bank that underpinned the original creation of the MDTF ("It all started with Australia..."¹¹) has given more prominence and a greater sense of urgency to the

¹¹ Toomas Palu, Adviser, Global Coordination, Health, Nutrition & Population. Interview 15th May 2019

issue (and risks) of financial and programmatic transition - regionally and globally. Gavi and the Global Fund working jointly with the World Bank leverages the World Bank's comparative advantage in public financial management, macro-economic analysis, and health financing reform, as well as carries greater weight with ministries of finance.

Progress from understanding the seriousness of the issue to actions that will ensure the sustainability of post-transition outcomes varies considerably across countries. In Indonesia, there was a clear recognition of what needs to happen, whereas, in other countries, such as Laos for Gavi, some government officials still expect another donor to step into the breach. For PNG, MDTF work has been influential in helping to demonstrate to the Gavi Board that plans for transition were premature (despite the GNI ceiling) and that substantial support will be needed to avoid further deterioration of immunisation coverage.

Overall there are sufficient signs of concrete progress to give cause for optimism. Laos is something of a global exemplar in this regard. Confidence in the process initiated by the World Bank (improving access and integrating performance monitoring through web-based information systems, DHIS2) has been further enhanced by the contribution of MDTF resources to the HGNDP operation. More recently, there are plans for the Global Fund to follow the example of Gavi and eventually join a joint financing arrangement linked to common disbursement indicators¹².

Social contracting in Indonesia

In Indonesia financing for NGOs and private entities from the Global Fund will be at risk following transition. The role of private providers is critical in the treatment of TB; to address malaria in the high-burden eastern provinces requires building relationships with plantation and mining companies, and CSOs play a vital role in relation to HIV and AIDS through advocacy and access to key populations. The Country Coordinating Mechanism (CCM) see progress on this issue as justification for channelling USD 3 million of Global Fund funds through the MDTF. The World Bank's analytic work has helped clarify ways in which government can legally support CSOs, NGOs and private entities in the future. Building the capacity they need to receive and account for funds remains a key challenge for the future.

Adapted from interview with Indonesia CCM co-chair

While the transition agenda acts as a trigger for addressing systemic reforms, it also raises several specific issues:

- **Maintaining the ambition of priority programs**
Transition is not just about maintaining a steady state. In many of the MDTF countries, coverage of priority programs is both inequitable and inadequate. In Indonesia, for example, only 18% of those that need them receive ARVs, and the country is home to one-fifth of the world's unimmunized children. Scaling-up and addressing the needs of under-served areas and populations brings priority programs into direct competition with other emerging health needs (notably NCDs in PNG and the PICs). Financing and prioritization thus need to be considered for the sector as a whole rather than on a program by program basis.
- **Sustaining the policy influence of global funds**
The transition from Gavi and Global Fund financing gives rise to challenges other than the direct cost of commodities and other inputs. For example, promoting the introduction of new vaccines (e.g. rotavirus and HPV) in the case of Gavi and the leverage on governments exerted by the Global Fund in

¹² As an additional sign of confidence, the Government of Japan also contributed USD 1m to HGNDP noting that it offered greater visibility than a bilateral project.

relation to policies such as “test and treat” and separate funding windows for non-state actors, all of which remain important in the context of progress toward UHC.

- **Mitigating the impact of transition on UN partners**

UNICEF and WHO country offices are increasingly dependent on financial support from Gavi and the Global Fund for staff positions and activities that support priority programs. With transition, this support will decline - creating new financial pressures on their country operations.

- **Assessing the broader transition landscape**

HIV and AIDS, TB, malaria are not the only programs dependent on external support for commodities. In many of the EAP countries, family planning, reproductive and maternal health services are also heavily dependent on external resources and international advocacy and are thus vulnerable in the face of declining assistance.

The MDTF complements DFAT’s investments in the Global Fund and Gavi

The focus on financial and programmatic sustainability at country level gives practical expression to global partnership between the two global funds and the World Bank. By supporting innovative approaches (as in Laos) the MDTF enhances aid effectiveness and influences transition planning in Gavi and the Global Fund more broadly.

The MDTF also strengthens the World Bank’s leadership role in the health financing “accelerator” (under the Global Plan of Action to achieve SDG3). Recent discussions in Geneva suggest that the experience of MDTF has been a factor in prompting an active discussion about the best way to coordinate support for health financing in low- and middle-income countries.

Recommendation 3: disseminate EAP experience on financial and programmatic transition

The programmatic and financial sustainability of priority programs is an issue of growing importance in low- and middle-income countries. Experience in the EAP Region, on new ways to advance the integration of formerly separate programs through innovative working arrangements, have broader global relevance. This experience merits further dissemination so that it can inform current global debates on health financing in the context of UHC and the Global Action Plan to achieve Sustainable Development Goal 3.

3.3 The route to Universal Health Coverage

The MDTF plays a major role in countries efforts toward Universal Health Coverage (UHC). There are several different routes through which influence is brought to bear.

Sequence

The early concept notes for the MDTF outline a theory of change based on a *sequence of activities*: from assessment and analysis through technical support and capacity building, sharing knowledge across countries, and implementation of health systems interventions. Work in Laos best exemplifies a linear sequence from assessment to MDTF-financed intervention, which in turn has led to a clear outcome (increased immunisation coverage) that contributes to UHC. In most countries the sequence is iterative rather than purely linear, but the World Bank is well positioned to facilitate and help implement all these steps.

Synergy

Using limited resources to influence systemic change requires that the MDTF works with others. This can take many forms – not least partnership with the World Bank’s macro-fiscal team for analytic work on fiscal space issues. In all the Southeast Asian countries and PNG, the most obvious synergy is with the World Bank’s own health loan operations, which provide an opportunity to influence policy and practice, translating analysis into health systems strengthening. DFAT’s influence can be further enhanced either by contribution to loans through the MDTF (as in Laos, Cambodia and Vietnam) and/or through seeking greater synergy with bilateral

investments as in Cambodia. In Vietnam, the contribution of a USD 5 million grant from DFAT helps overcome the Government's restriction of using loan funds to finance recurrent costs, such as service delivery innovations and training.

Systems

A missing part of the theory of change is the network of health systems strengthening steps that lead from the situation ex-ante (programmatic silos, fragmented information and supply systems, inefficient resource allocation, inequitable access and outcome, etc.) toward universal access to quality services combined with financial protection – the two fundamental pillars of UHC. While there is no single path, several elements are evident in the work of the MDTF. We illustrate this point with examples in the section on measuring performance in Part 2.

Scenarios

While no two countries are the same there are several common scenarios that both demonstrate the value of a regional approach and help in defining pathways to UHC. In Pacific Island Countries¹³, in the absence of WB lending, synergy depends primarily on working relationships with bilateral partners and UN agencies. Health systems work is less concerned with financial protection (due to low OOP) and more concerned with increasing the efficiency of spending and adapting the package of services. In Southeast Asia, a common scenario is low government spending, national health insurance designed to reduce high levels of OOP, and implementation in decentralized administrations designed primarily in line with political objectives.

Social inclusion

Lastly, inequity is a common feature across the whole region. Who is left behind and why may vary. It may be purely a function of geography and terrain but is just as likely to be due to identity according to gender, poverty, sexual orientation, disability, ethnicity or religious faith - or circumstances such as forced migration or human trafficking. The common theme that ties into the role of the MDTF is that the pathway to UHC cannot ignore exclusion, nor can it rely on the state alone to address it. Forging links between state's capacity to legislate and regulate and the capacity of non-state actors to advocate for and reach out to excluded groups does not feature strongly in the current MDTF portfolio yet should be seen as key to reaching its objectives. There is significant scope to continue to strengthen the equity focus of MDTF work with government.

Recommendation 4: chart the route to UHC

- a) Given the importance of UHC as a policy objective and as an outcome of financial and programmatic sustainability in EAP countries, DFAT and the World Bank should consider re-branding the MDTF in relation to Universal Health Coverage.
- b) To complement a revised monitoring framework (see Recommendation 1), it is important to show how the work of the MDTF leads to systemic change and synergy with other investments in different country contexts. This could take the form of a pathway or theory of change towards UHC, perhaps prepared for individual countries and including gender equality and social inclusion. Its prime purpose would be to explain to a wider non-health systems audience the role and influence of the MDTF.
- c) Increasing equity of access and outcome is a key objective of UHC and needs to be given greater prominence in MDTF work at country level – including through the work of CSOs.

¹³ PNG is not included here as a Pacific Island Country. While it has some characteristics in common with the Pacific countries covered by the MDTF, it also has much that sets it apart (see PNG aide memoire)

3.4 Learning from results-based financing

Results-based financing (RBF) is an increasingly common development strategy and takes many forms. It is a feature of most World Bank lending operations in health; and it is being used increasingly by the Global Fund (in the form of Cash on Delivery in the Solomon Islands, for example); as well as by many bilateral agencies. RBF features in the WB projects in the three countries visited as well as in Cambodia and Myanmar¹⁴. The form that it takes in these operations is that the achievement of specified actions or levels of performance at national and sub-national level is rewarded through additional payments of flexible funding. The triggers for measuring performance in each case are called Disbursement Linked Indicators (DLIs). Payment is made conditional on a separate and independent process of DLI verification. The approach can be applied in many different ways: for example, timely release of funds from central to provincial agencies; use of score cards that assess provider performance in health centres; and outreach programs that combine MCH with nutrition and immunisation, covering under-served populations.

Results-based financing pre-dates the involvement of the MDTF, but widespread use of DLIs creates a strong association in the minds of client governments and development partners. It is also the case that while RBF is close to becoming a development orthodoxy, it is not without its critics¹⁵. RBF interventions require careful, participatory design and the ability to learn and adapt during implementation¹⁶.

In all three countries visited DLIs have the potential to act as powerful and positive incentives for change. At the same time, as was noted by the Vice Minister of Health at a meeting of Provincial Health Directors in Vientiane, there is a tendency to focus on positive results and overlook problems and unintended consequences (see box below). DLIs are designed to change the way that health systems operate and the way the people that manage and use them behave. This, in turn, raises important questions about the role of external agencies in influencing this kind of change, the need for transparent sharing of lessons, and about the degree to which such change will be sustained by national authorities in the absence of external incentives.

Experience globally on RBF using DLIs has shown the importance of having regular participatory sessions to examine and discuss lessons learned, expected and unexpected, with all stakeholders – not only those closely involved in specific World Bank projects. This allows for course corrections in reform plans and builds stronger, more sustainable health systems. This process need not be expensive and can be carried out in real-time. It, therefore, does not need to await formal evaluations or publication of research (although these, of course, have their own benefits). Further, while the objective of the MDTF is concerned with integrating external financing and not donor coordination *per se*, it is important to use lessons learned from RBF mechanisms to avoid unhelpful division between agencies and to bring a wider constituency of players into the debate.

¹⁴ The new World Bank loan for *Innovation in Grassroots Health Service Delivery* in Vietnam is an exception in this regard.

¹⁵ See for example: <https://gh.bmj.com/content/3/1/e000664>

¹⁶ Many reviews of RBF are available, for example https://www.researchgate.net/publication/221834634_Paying_for_performance_to_improve_the_delivery_of_health_interventions_in_low_and_middle-income_countries_Review

Immunisation in Luang Prabang

As part of the MDTF contribution to the current World Bank project (HGNDP) in Laos, an additional DLI was added to reward increased immunisation coverage in 50 under-performing districts.

However, Luang Prabang, the province with the most under-performing districts and largest non-Lao ethnic population, lagged behind other provinces by a significant margin.

Interviews revealed that the problem came not from poorer performance but from one of the methods used for independent verification. A criterion used to assess immunisation status was the possession of an immunisation card or Maternal and Child Health Card (MCH Pink) Book that monitors the child's immunisation records. No visible card or MCH pink book to verify immunisation records, it had been assumed, meant no immunisation.

What had not been anticipated was that the majority of women in the districts concerned were from ethnic minorities and were either illiterate or did not understand Lao - the only language in which the cards and MCH pink book were printed. Written records were not regarded as important and so often lost or discarded, giving a false impression of low immunisation coverage. It has subsequently transpired that coverage was actually similar to that in other provinces and new record keeping methods are in place. The key point, however, which shows the importance of investigating unexpected results, is that low performance initially led to reduced payments and took repeated reviews and negotiations for the problem to be resolved.

While financial incentives should be designed to reward good performance, it is important that they do not act in ways that further disadvantage poor populations or neglected areas.

Recommendation 5: learn from DLI experience

In countries where DLIs are planned or in operation, the World Bank in-country staff should conduct regular participatory sessions to examine and discuss lessons learned – expected and unexpected – with government and development partner stakeholders. This process need not be complex or expensive. Focusing on the practical lessons learned can help avoid unhelpful division between agencies that hold different views on the merits of RBF.

3.5 More money for health: increasing investment in human capital

Most of the Health Financing Systems Assessments rightly stress the importance of increasing efficiency as a way of creating more fiscal space for health. In the case of the PICs, this is the most important route given the combination of limited economic growth, declining donor receipts and increasing health care costs. Indeed, in all countries reducing waste and increasing efficiency – *getting more health for the money* – is a critical issue. However, many of the Asian countries supported by the MDTF, as well as PNG, have growing economies but spend less on health than countries with similar levels of GNI. In PNG, health budgets have suffered major cuts in recent years when its geography and past under-investment suggests the need for major future investment if it is to have any chance of progressing towards UHC. In Indonesia the constitutionally mandated 5% of government expenditure allocated to health acts not as a minimum floor, as intended, but as a maximum ceiling no matter the level of additional, external funds committed. The draft HFSA suggests that Cambodia spends between 6-7% of GDP on health, a higher rate than many countries in the region, but most of this comes from out of pocket payments, with publicly-financed spending making up only 33% of Current Health Expenditure (around USD 18 per capita) – one of the lowest rates in the region. In Laos - a Lower Middle-Income country with high levels of inequity, uncertain levels of future revenue and rapidly increasing levels of

demand following the introduction of national health insurance - increased health spending is urgent if current levels of achievement are to be sustained.

In the face of these challenges there is much work underway: for example, through increasing sub-national spending in PNG (an explicit strategy of the forthcoming IMPACT loan), regular health economic updates prepared for government and development partners, and a long-running dialogue on increasing the tax base in Indonesia (including through tobacco taxation).

Nevertheless, with the exception of Vietnam, it is hard to avoid the conclusion that spending on health is a relatively low priority for governments in the Asian countries included in this review. In PNG, macro-fiscal professionals from the World Bank have been quite clear that there is little appetite for increasing spending on health at central level. This despite the fact that PNG has signed up as early adopter of the World Bank Human Capital Project, which aims to encourage spending on health, education and nutrition as a route to greater productivity and inclusive growth.

Increasing the level of public spending on health – particularly in the growing economies of Southeast Asia - should be a concern to all development partners. In its absence, achieving UHC and more equitable health outcomes is unlikely. It cannot be achieved through greater efficiency alone. Responsibility for changing this situation cannot be laid solely at the door of MDTF. However, analytic work should continue to highlight the problem so as to inform advocacy by other levels of the World Bank and by other concerned partners.

Recommendation 6: Increase the focus on investment in health

The analytic work of the MDTF should continue to highlight the low level of public investment in health in Southeast Asia and PNG. For countries which have signed up as early adopters (PNG, Indonesia), the World Bank Human Capital Project represents one potential channel for renewed advocacy with Ministries of Finance.

3.6 MDTF as a regional initiative

Does the MDTF as a regional initiative constitute more than the sum of its parts? Clearly, the primary beneficiaries of its influence are individual countries. However, there is evidence that the MDTF is more than a series of country interventions.

The MDTF's regional role is expressed in several ways: (i) sharing knowledge and experience through regional training courses and the annual conference in parallel with Prince Mahidol Awards Conference; (ii) regional public goods in the form of common methodologies for analytic work and syntheses of country experience on issues relevant to the MDTF's mandate; and (iii) influencing policy and practice through interactions with regional integration organizations such as ASEAN and the Pacific Community and regional networks such as the Southeast Asia One Health University Network (SEAOHUN). The MDTF is more influential in relation to the first two than the third.

All the country interviews suggest that sharing experience across countries and participation in regional training courses is highly appreciated by participants and potentially builds awareness among national policy makers. The extent to which these interactions actually make a difference to what happens on return is harder to evaluate (which does not mean they are ineffective). The meeting that consistently gets the highest rating is the annual get together at PMAC, which brings together participants from health and finance and mixes participants from Asian and Pacific countries. Over the last four years, this meeting has become more structured and better organized. To date, however, there appears to be no written record of outcomes.

In relation to regional public goods, the MDTF has had a clear impact, with the most prominent product being the Health Systems Financing Assessment and its associated deep-dive methodologies. The health security financing assessment tool (HSFAT) – a further example - is discussed in the following section. Another example

is the transition process itself: as MDTF experience grows across countries there is considerable scope for synthesis work that would have value both regionally and globally. The World Bank has now set up an MDTF web site¹⁷ which provides a medium for disseminating lessons learned if linked to some form of social marketing.

Institutionally, the MDTF links primarily to the World Bank's regional networks. Interaction with regional political and economic integration organizations such as ASEAN and the Pacific Community has been limited and largely concerned with health security. There have however been some productive interactions on transition with WHO's Regional Offices in Delhi and Manila.

A broader question relates to the status of regional initiatives in both DFAT and the World Bank. The issue was raised specifically at the MTR debriefing meeting in Indonesia: how is the MDTF as a Regional initiative perceived within the Country Office of the World Bank – for example with the Human Development Coordinator and with country-specific cross-sectoral initiatives in poverty reduction, nutrition and governance. The implication is that there could be more read-across with other priorities within the World Bank's portfolio. This was not resolved during the MTR and is a point which might usefully be raised at future MDTF management meetings.

3.7 Window 3: health security financing

Window 3 has three pillars: Analytic: generating evidence on health security financing and institutions to inform policy and planning at national and regional levels; Capacity building: strengthening financial and institutional capacities for health security through technical assistance; and Political: convening and brokering across sectors, including ministries of finance and regional fora, to increase political and economic commitment to improve *regional* health security¹⁸.

In October 2017, it was agreed that health security needs to be seen in the context of health systems strengthening and progress toward UHC and that work should leverage the World Bank's comparative advantage in analytics, macro-fiscal context, multisectoral brokering and health financing.

While this suggests common ground between Windows 1, 2 and 3, in the countries visited by the MTR (Lao and Indonesia) Window 3 still felt like something of an outlier. In neither country did the issue of health security come up spontaneously in briefings. Rather, it had to be raised by the MTR team toward the end of each visit. Meetings with government officials in Window 3 countries were limited in part because of cancelled meetings or absences of key staff.

Documentation for the MTR was limited to the progress report referred to in the footnote below, the *draft* HSFA from Vietnam, a case study on financing the response to H5N1 outbreaks in Vietnam and a brief (and very basic) note on the Economic Case for Investing in Health Security (Economic Brief #1, undated).

Window 3 is primarily a regional initiative and one carried out in partnership with a wide range of national authorities, bilateral government agencies and the full range of multilateral organizations involved in One Health (as exemplified by the membership of the Regional Technical Task Force for Health Security Financing). To do justice to the Window would require that the MTR sought the opinion of other non-health and other JEE partners as to the added value of the World Bank, but given the time constraints of the review, and the focus of countries on Windows 1 and 2, this was not possible and reflects a limitation of the MTR in relation to Window 3.

These caveats notwithstanding, we offer the following observations:

¹⁷ <https://www.worldbank.org/en/programs/multi-donor-trust-fund-for-integrating-externally-financed-health-programs>

¹⁸ In the World Bank undated progress report covering the period February 2017- December 2018 the wording for the third pillar was changed significantly to: improving knowledge generation/sharing, promoting innovations and learning.

- **Pillar 1:** Despite delays and difficulties in conducting the Health Security Financing Assessment, the work in Vietnam has been an important learning experience and shows a readiness to adapt. It is generally agreed that the process and the HSFA assessment instrument were over-elaborate, and a more streamlined approach is needed. Nevertheless, it asked important questions (i) how much is spent on health security (based on 19 JEE technical areas)? (ii) where does the money come from; (iii) who manages funds at the national and sub-national levels; and (iv) what services or functions are the monies spent on? It also brought together all the relevant ministries in a joint exercise and the Health Strategy and Policy Institute (HSPI) that was responsible for data collection, analysis and field work has gained valuable experience.
- We support the view that the study's lasting value is better understood in terms of helping to document and understand the complexity and fragmented nature of financing flows for health security, comparing the HSFA to a National Health Accounts exercise. Equally important to note is that the Health Security Financing Assessment Tool (HSFAT) - developed jointly by officials from the five Window 3 governments with other global and regional agencies as a regional public good – was *piloted* in Vietnam, the country from which it was felt the most valuable lessons would be learnt for regional health security a whole.
- However, we note that the Government of Vietnam will not formally act on the HSFA findings until they are in possession of a finalized hard copy; this was said to be soon forthcoming although no date was given. We also note conflicting views on the form that future HSFAs will take. One view held that surveys will go ahead using a simplified version of the original HSFAT. However, in Cambodia, as in Vietnam, the government has requested that data be collected from all provinces. This is likely to be a lengthy undertaking. In Indonesia, by contrast, we understand that the survey will go ahead using random sampling in two provinces and two districts following the now completed central level regulatory and institutional assessment. In Myanmar, a more issue-based and operational approach may now be envisaged following the initial introductory workshop.
- Other outputs from Pillar 1 include two financing indicators for the WHO Joint External Evaluation (JEE) Tool and conceptual framework for linking four areas of activity that lead to the undefined goal of “Universal Health Security through adequate and sustainable financing”. The financing indicators have been incorporated into JEE following endorsement at the World Health Assembly.
- **Pillar 2:** The main focus of work, as evidenced by the recent progress report, has been the preparation of a range of post-JEE multi-sectoral preparedness plans (with work underway in Cambodia, Myanmar, Vietnam, Indonesia and Laos). The MTR did not have the opportunity to review these plans.
- While a growing number of countries have produced such plans, many remain under-financed - creating a sense of unfulfilled expectation. In the view of one senior Geneva-based WHO official such plans are necessary but insufficient without more active follow-up. The World Bank, it was suggested, needs to use its leverage with cabinets and parliamentarians to help get the preparedness work adequately funded. This, in turn, requires that the concern displayed for health security by the leadership of the World Bank at headquarters is shared by Regional and Country managers.
- **Pillar 3:** the political focus of this pillar agreed in October 2017 appears in the latest progress report to take a back seat to more technical activities: a learning event at PMAC in 2018; work with WHO HQ on developing economic scenarios for simulation exercises; and further analytic products, including work on the economic impact of AMR.
- Direct engagement with political process (as would appear to have been envisaged at the October 2017 meeting) has been limited. The experience of Vietnam has contributed to the World Bank's submission to the Global Preparedness Monitoring Board, and a proposal to collaborate with ASEAN on knowledge exchange on sustainable health security financing was presented at the ASEAN Health Cluster 2 meeting in Myanmar in September 2018.

The striking thing about work under Windows 1 and 2 is how well the World Bank in-country teams have adapted their approach and program of work to the needs and circumstances of the countries concerned. In this regard, the Window 3 management team with its more region-wide outlook has a much harder task.

As with National Health Accounts, countries are much more likely to be amenable to collect data if they also receive support to solve real time problems and if the frequency of data collection is determined by local needs and is not driven by the requirements of international organizations.

On a positive note, the MDTF has enabled the World Bank to re-enter the health security arena in the EAP region. Interviews suggest that this has not been an easy process but having the financial expertise of the World Bank involved is now appreciated. However, the downside of a regional initiative in a crowded institutional space is the time and resources that need to be invested in regional meetings, workshops inter-agency coordination and dialogue, which account for a significant proportion of MDTF spending.

Finally, while the MTR notes achievements under each pillar of Window 3, the key take away that emerges is one of *uncertainty and ambivalence*. Should the World Bank focus more MDTF resources on Windows 1 and 2 and limit/reduce involvement in health security, or should it reinvigorate this aspect of the work? The Review Team heard completely divergent views from senior interlocutors. Despite an agreement by the Technical Task Force that the HSFA tool would not aim to collect comparable data, interviews suggest that the debate around comparable country data has yet to be fully laid to rest. The same ambivalence is evident in the progress report with regard to the political versus technical objectives in Pillar 3. Further, should the definition of health security be broadened to cover all communicable diseases as a way of linking more with health sector interests, or would a focus on AMR be more appropriate? The future of Window 3 needs clarity and a more solid agreement on objectives.

Recommendation 7: Clarify expectations and deliverables of MDTF health security financing

Window 3 needs a further reset. The World Bank is engaged in global health security globally. Achievements in EAP countries to date justify continuing MDTF engagement, but only if there is clear agreement on focus, expectations and deliverables. In particular, it is critical to agree on the extent to which MDTF finance is used to address institutional (particularly health system) bottlenecks that constrain health security financing in individual countries versus further development and implementation of regional processes and advocacy. The two approaches are not mutually exclusive but given limited resources and a wealth of other institutional players and potential sources of finance, being explicit about the role of the World Bank's *use of MDTF funding* is essential.

3.8 Gender and social exclusion

The objectives and results framework of the MDTF do not explicitly mention gender equality, but the World Bank Gender Strategy (2016-2023) and DFAT Gender Equality and Women's Empowerment Strategy (2016), set alongside national commitments to gender equality, underpin the imperative for the MDTF to be gender-informed and responsive.

A solid foundation but missed opportunities

The two gender strategies overlap and the World Bank's objective of improving human endowments squarely captures health. The World Bank approach for operationalising its Gender Strategy is directly relevant to the MDTF: undertake country diagnostics that go beyond stating a gender gap exists, identify constraints to be lifted if gender inequality is to be narrowed and ways in which the World Bank will contribute to this; support governments in filling sex disaggregated data gaps to enable meaningful policy dialogue on gender issues; and build evidence of what works to improve gender-smart programming.

The joint World Bank-DFAT Guidance Note on Gender draws on the World Bank Gender Strategy and sought to build consensus between the two agencies on how the MDTF integrates gender. It was finalised after most of the HFSA's had been completed and while most mention gender as a gap they fail to go much beyond this and miss the important intersection between gender and other areas of social exclusion. As a result, the space for gender in policy dialogue on health financing and the health system through the medium of the HFSA has been lost. Looking ahead, Cambodia's HFSA has the opportunity to apply the Guidance Note and the findings of a World Bank Gender Assessment for the Health Equity and Quality Improvement Program (H-EQIP). Practically, this should mean that it includes: a) consistent use of sex-disaggregated data for health indicators and human resources; b) inclusion of gender-specific indicators of health significance, in addition to routine measures of maternal and reproductive health, including data on gender-based violence and women's empowerment; c) analysis of how health financing schemes benefit different groups in the population by gender, age and other social identifiers; d) analysis of gender in leadership roles, including oversight of health and community facilities; and e) identify gender concerns for policy dialogue. The drill down of the HFSA in Cambodia to community health and nutrition services provides an opportunity to follow the gender thread from top-to-bottom, from policy and systems through health services to the socio-cultural, financial and geographical context and barriers that underpin key health behaviours and risk factors of which gender, ethnicity and language are important factors¹⁹. This kind of comprehensive analysis has the potential to connect the gender dots at each level of the health system and identify gender-based system gaps which can be framed to inform government policy and practice.

Gender in the MDTF: good intentions, partially realised

The gender deep dive of this MTR concentrated on Laos and Cambodia supplemented by interviews with World Bank staff (see Annex 7). Laos, in particular, provides a good example of MDTF activities with varying levels of gender inclusion.

The Lao Health Governance and Nutrition Development Project (HGNDP) as presented in the appraisal document is a good example of a gender-informed design that explicitly sets out how the project will contribute to gender equality and connects high level outcomes to gender responsive implementation. Explaining for instance how the project will improve maternal and reproductive health through gender responsiveness in service delivery, in the recruitment and training of women from non-Lao-Tai ethnic groups, in interaction with women's groups and by involving men in family health. The project's support for sex-disaggregated data in DHIS2 lays the foundation for gender disaggregated planning and monitoring of services²⁰.

However, evidence suggests that attention to gender during implementation has slipped. While the intent to benefit women and children remains, the way that gender norms and gender inequality affect access and service delivery have received less attention. What this means in practice includes a lack of female Village Facilitators and a failure to recognise the difficulties that female health workers face in providing outreach services to remote populations. In addition, there is a risk that the use of DLIs may inadvertently be holding more disadvantaged provinces back (see Box on immunisation in Laos). To fully understand and address how gender inequality plays out in service delivery and health systems – particularly around issues such as hiring and deploying midwives - requires conscious identification of gender-based systems constraints and how the project can contribute to lifting them; this cannot depend on DLIs alone.

It is important that opportunities created by HGNDP that could foster greater gender and social inclusion are not overlooked: a) the DHIS2 platform and the family folders (including data on births, adolescent health, early marriage and female headed households) that are being wrapped into DHIS2 in remote ethnic areas have the

¹⁹ The full HFSA has yet to be published. At the time of the MTR we have seen a 107-slide deck summarising the HFSA which shows little evidence that these concerns have been taken into account.

²⁰ The project design also included gender disaggregation of project performance indicators to the extent possible to track gender inequalities and preparation of a Gender Action Plan.

potential to strengthen the availability and use of gender and social inclusion data in planning and budgeting for health and other sectors; and b) the social and behaviour change communication (SBCC) platform for the four northern provinces is grounded on an understanding of gender norms and gender roles. Without understanding gender inequalities and the differential burden of women's and men's work there is the risk that SBCC interventions will focus on knowledge-based solutions, ignoring the need for transformational changes to empower family members to change health behaviours.

Finally, despite good intentions, the limited involvement of gender expertise in MDTF activities has contributed to the gaps identified above and the absence of gender themes from MDTF capacity building and learning activities.

Looking to the future: Gender and NCDs in Samoa

While not officially part of the MTR, the MDTF-funded design work for the new Samoa project on NCDs includes evidence gathering to distil the gender determinants of NCDs and has factored this into the design. A household and health facility survey has explicitly looked at the difference between men's and women's lifestyle risks, screening, referral and treatment of NCDs. The project design recognises the importance of gender norms and division of labour for diet and household food preparation and targets women as the custodians of the family diet. The design includes the use of village women's committees for screening and referrals.

Recommendation 8: Increase the focus on gender and equity

Given the importance of gender to achieving health sector outcomes for both the World Bank and DFAT, the resources of the MDTF should be considered an opportunity to pursue gender-informed and responsive strategies in analytics, policy advocacy and programming. Both organisations prioritise realising gender equality through their support. However, further work is needed to define and agree on what this looks like in the MDTF and how to implement it. Given the many gender and social exclusion risks that come from transition, this will mean reaching agreement on a limited number of critical actions that are required in specific country contexts and factoring this into World Bank human resourcing. This will feed into sector learning and contribute to the gender smart programming that DFAT and World Bank support.

Inclusion of gender and equity in a revised monitoring framework (recommendation 1) and theory of change on UHC (recommendation 4) will help focus attention in this regard.

In addition, it will be useful to explore the potential for the MDTF to work with other trust funds (as proposed in Vietnam and Indonesia) that have a specific focus or window on gender as a way of complementing the work of the MDTF portfolio and in line with World Bank Country Gender Action Plans.

3.9 Looking to the future

The approach adopted by the MDTF to date, which seeks to ensure the financial and programmatic sustainability of externally financed programs, has already broadened into a concern for supporting countries' efforts in relation to Universal Health Coverage. The MDTF is a flexible and strategic instrument and the World Bank is a trusted and influential partner in the countries of East Asia and the Pacific. The MTR, therefore, suggests (as noted in Recommendation 4) that the link with UHC be made more explicit.

Before looking at future options in this regard, we return briefly to the issue of health security and Window 3. There is no doubting the importance of sustainable financing for preparedness and response in the EAP region. There is much that falls under the rubric of "health systems strengthening" that contributes to this agenda, and there is significant read-across between the analytic skills needed to understand financial flows in health systems and health security more broadly. Beyond these overlaps, however, the health security agenda is

more extensive and requires interaction with a much wider range of global and regional partners. The World Bank has and will continue to play a vital role in health security financing, but the key question from the review is whether combining what too often appear as two separate initiatives is the best way forward for the MDTF. Our specific recommendation (recommendation 7 above) is that MDTF health security financing should only continue if there is clear agreement on focus, expectations and deliverables. We would suggest that if these concerns are not met by the next annual meeting, then DFAT should consider phasing out Window 3 and consolidating Windows 1 and 2 around the UHC agenda.

Expanding the role of the MDTF to support UHC will need to be tailored to country needs; we see three potentially complementary avenues:

- *Widening the focus of programmatic and financial sustainability* to look at the needs of other programs that are heavily dependent on external resources, including but not limited to, family planning and reproductive health. As with HIV, TB, malaria and immunisation it is important that financing and prioritization be considered for the sector as a whole, not just on a program by program basis.
- *Engaging a broader network of partnerships engaged in UHC*: the current partnership focuses primarily on the interests of Gavi and the Global Fund. Working more closely with WHO, other UN agencies and concerned bilaterals would allow the MDTF to respond to national priorities including NCDs (a much more pressing concern in the Pacific than HIV). Working with WHO also offers the opportunity for greater engagement in other systems issues such as human resources for health and access to medicines and vaccines. There is a strong case to be made for offering the MDTF as practical vehicle for taking forward the SDG Global Action Plan at country level.
- *Enhancing World Bank loan operations*: The experience in Laos shows how a bilateral grant contribution to a World Bank operation not only enhances the overall operation but delivers rapid and measurable results. Contributions can be linked to specific areas of achievement or be used to build capacity through financing training and experimentation as in Vietnam. Financial contributions to loan operations enhance DFAT's influence over priority issues and ensures greater visibility. While there is potential for synergy with DFAT bilateral operations (as in Cambodia or potentially in PNG), the experience of Laos and Vietnam shows that it is possible to use the World Bank presence to extend health support to countries even in the absence of DFAT bilateral health engagement.

Annexes

1. Terms of Reference
2. Monitoring Framework for Multi-Donor Trust Fund
3. Programmatic and Financial Sustainability data
4. Aides memoire
 - a. Laos
 - b. Papua New Guinea
 - c. Indonesia
5. Country summaries
6. MDTF Activities
 - a. Table 1: by year started
 - b. Table 2 completed activities by window
 - c. Table 3 completed activities by country
 - d. Table 4 by intermediary objective process indicators
 - e. Table 5 by intermediary objective process indicators and country
7. Gender Equality and Social Inclusion Review of MDTF
 - a. Laos
 - b. Cambodia
8. Persons met and key documents

4. Annex 1: Terms of Reference

World Bank Multi-Donor Trust Fund on Integrating Donor Financed Health Programs: Mid Term Review
(extract)

Background:	<p>The Specialist Health Service (SHS) provides strategic input on health to the Australian Government Department of Foreign Affairs and Trade (DFAT). The SHS allows DFAT to source high quality technical advice to support health policy, strategic planning and health programming across the aid management cycle.</p> <p>The Multi-Donor Trust Fund (MDTF) for Integrating Donor Financed Health Programs was established by DFAT and the World Bank Group in June 2015. The development objective as described in the initial Monitoring and Evaluation Framework (attached at Annex 1) is:</p> <p style="padding-left: 40px;">To support countries in strengthening their health systems to accelerate and sustain progress towards key health output and outcomes that contribute to Universal Health Coverage (UHC) with a particular focus on assessing and supporting the financial and programmatic sustainability of externally-financed programs.</p> <p>The Intermediary Outcomes (IO's) were couched as follows:</p> <p><u>Financing</u></p> <ul style="list-style-type: none">• Increase/maintain overall level of domestic public prepaid, pooled financing and commitment to health, including priority programs and health security;• Maintain/increase predictability of financing;• Increase efficiency of health of health resources; <p><u>Programmatic</u></p> <ul style="list-style-type: none">• Increase or maintain effective coverage of health services, including for priority programs• Increase capacity for health system functions (budgeting, planning, monitoring and evaluation and surveillance) <p><u>Process</u></p> <ul style="list-style-type: none">• Development financing informed;• Policy strategy informed;• Clients' capacity increased;• Knowledge deepened;• Innovative approaches and solutions generated <p>The Review team will be briefed on the evolving approach to reporting against the M&E Framework during the course of implementation but, meanwhile, the framework at Annex 1 captures the initial conceptualization for the investment.</p> <p>A key driver for the establishment of the MDTF was the high reliance of many countries in the region on donors to finance their disease and immunisation programs and the risk that</p>
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reductions in donor funding jeopardise the gains that have been made so far. Transitioning from externally-financed disease and immunisation programs to sustainable domestic financing is a key challenge for the Southeast Asia and Pacific region.

DFAT has provided a total of AUD 54.75 million to the MDTF for three funding ‘windows’ covering the period 2015-2023

- Window 1 (\$10.75m) with a particular focus on financial and programmatic sustainability of malaria, HIV and TB programs.
- Window 2 (\$36m) with a particular focus on immunisation.
- Window 3 (\$8m) with a focus on sustainability of health security in the region.

The three windows cover 12 countries:

- Window 1: Indonesia, Laos, Cambodia, PNG, Solomon Islands, Vanuatu, Kiribati, Tonga and Samoa;
- Window 2: Indonesia, Viet Nam, Laos, Myanmar, Cambodia, Philippines, PNG;
- Window 3: Indonesia, Viet Nam, Laos, Myanmar, Cambodia.

Other contributors to the MDTF include GAVI, Global Fund and the Bill and Melinda Gates Foundation.

In all three windows, activities fall under one of four pillars

- Comprehensive Health Financing and Systems Assessments: depending on the country context, this may include a ‘deep dive’ analysis on HIV, malaria, TB, immunisation and/or health security.
- Technical Assistance and Capacity Building: Includes support for development of pathway options toward equitable and sustainable financing for immunisation, disease programs or health security, including strategies for addressing health financing transition challenges and mainstreaming the benefits of donor-financed health programs.
- Knowledge Generation and Exchange Activities: Compilation and sharing of lessons learned from countries graduating from donor-financed health and immunisation programs.
- Health Systems Integration/Strengthening Interventions: Resources provided for recipient-executed activities within new World Bank operations in the target countries. This window can provide blended finance resources to governments to help leverage IDA/IBRD-financed operations.

A management committee of World Bank and DFAT representatives meets on a six-monthly basis to discuss the achievements and challenges presented in World Bank six-monthly reports and to agree on future actions.

Key documents produced by this investment can be found at:

<https://dfat.gov.au/aid/topics/investment-priorities/education-health/health/Pages/regional-health-initiatives.aspx>

This joint mid-term Review of the MDTF provides an opportunity to assess and measure progress and achievements to date, as well as highlight challenges and lessons learned. It will help inform decisions about the future direction of the MDTF and will also help inform

	<p>decisions about how DFAT can work in lower-middle income countries. The MDTF is one of many trust funds developed by the World Bank and the Review further offers the opportunity to assess the suitability of this type of funding mechanism for health sector support. The report will be written for the use of counterpart governments, the World Bank, The Australian Department of Foreign Affairs and Trade and other donors to the MDTF and for publication.</p>
<p>Purpose and objectives:</p>	<p>The purpose of the mid-term Review is to assess the continued relevance of the MDTF investment and the progress made towards achieving its planned objectives. It provides an opportunity to both make modifications to ensure the achievement of these objectives within the lifetime of the MDTF and to improve the communication of its work and achievements.</p> <p>The World Bank and DFAT’s initial mutual conceptualization of the difference that the MDTF could make is captured in the Monitoring Framework at Annex 1. In addition, the Review should also capture more qualitative examples of the influence and the impact of the MDTF’s work in brief case studies that can be communicated across a variety of platforms.</p> <p>The initial questions to be considered by the Review are set out below. These will be further considered by the DFAT and the Review team once selected.</p> <p><u>Development and Window Objectives/Outcomes</u></p> <ul style="list-style-type: none"> • Is the MDTF on track to achieve/contribute to its overall development objective and window specific objectives/outcomes? <p><u>Financing and Programmatic Intermediary Outcomes</u></p> <ul style="list-style-type: none"> • To what extent have the intermediary outcomes (financing and programmatic) already been achieved? How likely are intermediary outcomes to be achieved from this point on? • Are there qualitative examples of change created by the MDTF – expected or unexpected? • What were the major factors influencing the achievement or non-achievement of the expected objectives and intermediary outcomes? • What evidence is there regarding the actual impact of this investment? • Did the MDTF contribute to capacity building as planned and how? • Which institutions have benefitted from the MDTF and how? What has changed for whom? <p><u>Process Intermediary Outcomes</u></p> <ul style="list-style-type: none"> • Is the program using appropriate, effective and efficient strategies and activities to progress outcomes? • Is the level and balance of funding to each country and its allocation between windows and pillars commensurate with desired outcomes? • Have/how have the MDTF’s analytical products influenced health-related policy and programming?

	<ul style="list-style-type: none"> • Has/how the MDTF effectively engaged with and influenced the political economy of health resource allocation? What has changed as a result? • How has technical assistance through the MDTF influenced health sector policy and programming? • Is the technical support provided to countries of high quality, relevant and responsive to local needs? Is it an effective and efficient model? • Which tools or processes employed under the MDTF are proving the most effective in a) the Pacific context and b) the context of lower middle income countries in SE Asia? • Within the work of the MDTF, how and to what extent has the World Bank engaged with partners, including GAVI, Global Fund, WHO and others? To what extent has the work of the MDTF driven cooperation between these partners? • Is the MDTF being implemented in an efficient way (time, personnel, and resources)? Have any issues emerged from which lessons can be learned? <p><u>Governance</u></p> <ul style="list-style-type: none"> • Are MDTF M&E arrangements adequate and fit for purpose? To what extent are they aligned with routine World Bank M&E processes? • Are program governance processes appropriate for overseeing the program and managing risks? • What are the strengths and weaknesses of MDTF planning, management, implementation, monitoring, risk management and reporting? How could they improve? <p><u>Cross Cutting Issues</u></p> <ul style="list-style-type: none"> • To what extent has gender equality and equity of health financing and delivery been considered and addressed through the MDTF and how might these approaches be strengthened?
<p>Review Approach:</p>	<p>The Review team will have the following composition:</p> <ol style="list-style-type: none"> 1. A Team Leader/Health Sector Development Specialist; 2. A Health Financing Specialist <p>A DFAT funded Gender and Health Adviser will be available to provide advice and input to the Review team in developing the Review plan and analysing the findings from a gender perspective, under the direction of the team leader.</p> <p>The World Bank will be consulted on the TORs for the Review and the Review plan and will be invited to comment on the Review report.</p> <p>Representatives from DFAT and the World Bank will accompany the team on its field work.</p> <p>Jane Pepperall (Senior Health Adviser) and Kirsty Dudgeon (Assistant Director, Health Policy and Performance Section) will lead engagement with the Review on DFAT’s part.</p> <p>The Review questions will be addressed at both the regional and country level through a combination of program documentation review, key informant interviews, and case studies of activities and impact in a selected number of participating countries. The</p>

Review will proceed as per the following phases. An indicative schedule of the time required from each team member for each of these phases is at [Annex 2](#).

1. Preparatory Phase

Inception/Planning

- Inception briefing with DFAT and the World Bank
- Review information and documents

Review Plan

- Develop and finalise a Review plan, including the methods and analytical techniques to be used to answer the Review questions and a rationale for the selection of country case studies. This may involve modifying the questions and methodology described in the TOR, while retaining a focus on the purpose of the Review, in consultation with DFAT.

2. Data Collection

Document Review

A systematic document review will enable an assessment of country contexts, reported progress against planned activities, and reported constraints and achievements. The initial list of documents to be reviewed include:

- Concept notes for all Windows
- Monitoring and Evaluation Framework and related Infographics
- 6-monthly Progress Reports to DFAT
- Knowledge products including Health Financing System Assessments
- Outcomes of management meetings

Interviews with key stakeholders

The Review team will undertake face-to-face and phone interviews with relevant stakeholders. These might include DFAT staff (both in Canberra and at post), World Bank staff, Gavi, Global Fund, WHO, Gates Foundation, SPC etc.

Country case studies

DFAT and the Review team will decide upon a limited number of country case studies (likely up to 3). In-country stakeholders will include, but not be limited to, representatives from ministries of health and finance/treasury (both technical and policy making units), other ministries and units; WB country team members; local participants in WB activities and their managers; DFAT post; others as identified through country documentation and discussion in country.

3. Analysis and Writing

Draft a report based on findings and submit to SHS and DFAT for review and finalisation. The consultants would also need to draft aide-memoires for each country visit providing a brief overview of activities and key findings in each country.

5. Annex 2: Monitoring Framework

Figure 2: Monitoring and Evaluation Framework, World Bank Multi-Donor Trust Fund

Monitoring Framework for Multi-Donor Trust Fund (MDTF)									
Development Objective	To support countries in strengthening their health systems to accelerate and sustain progress towards key health output and outcomes that contribute to universal health coverage (UHC) with a particular focus on assessing and supporting the financial and programmatic sustainability of externally-financed programs								
Sub-objective (Window 3)	To strengthen financial and institutional capacity of selected countries to ensure sustainability of health security in the EAP region								
Development Indicators	MDTF-financed activities implemented in countries	Countries have developed strategy for integrating donor-funded programs	Domestic government's share of financing priority programs has increased.	MDTF funds in countries are leveraged to complement IBRD/IDA operations					
Financing IOs	IO: Increase/maintain overall level of domestic public prepaid, pooled financing and commitment to health, including priority programs and health security			IO: Maintain/increase predictability of financing	IO: Increase efficiency of health resources				
Financing Overall	Total health exp. p.c. & government health exp p.c.	Share of total government expenditure allocated to health	Share of government health expenditure sourced domestically	Share of total health expenditure sourced from OOP (%) and from SHI (%)	5-yr past/future revenue, expenditures, GDP p.c. growth, deficit & debt	Share of original approved budget for health that is spent	Share of on-budget ext. financing for health delivered through the gov system	Financing pressures (including from reduced DP funding) are taken into account during planning and budgeting process	Percent of current health expenditures on hospital services (proxy for the inverse of PHC)
Financing Window 1		Share of government health expenditures allocated to HIV/TB/malaria	Share of government health expenditure sourced domestically			Share of original approved budget for HIV/TB/malaria that is spent	Share of all on-budget external financing from Global Fund delivered through the government system		Prices of WHO-recommended HIV/TB/malaria pharmaceuticals at national level in reporting year
Financing Window 2	Total expenditure per capita on vaccines per targeted child		Share of vaccine expenditures on routine immunization sourced by government				Share of all on-budget external financing from GAVI delivered through the government system		Vaccine prices for routine vaccines are not more than 10% above UNICEF-SD prices
Financing Window 3	A budgetary allocation is made for human health, veterinary, public health, agriculture and other relevant sectors to support implementation of IHR capacities at the national level			A financing mechanism for public health emergencies exists and funds are available for the timely response to public health emergencies.					
Programmatic IOs	IO: Increase or maintain effective coverage of health services, including for priority programs			IO: Increase capacity for health system functions (budgeting, planning, monitoring and evaluation and surveillance)					
Programmatic Window 1	Percent of people living with HIV and eligible for treatment receiving treatment	Percent of new cases of TB diagnosed and completed treatment in a given year	Percent of people sleeping under an insecticide treated bed net	Information from HFSAs includes service readiness, including availability of equipment guidelines, staff training on ART treatment, TB, EPI, stock-outs for HIV/TB/malaria etc.		Country is able to take a lead role in preparing plans and budgets for HIV/ TB/ Malaria programs		MSE data on HIV/TB/malaria is integrated with country's health information systems	
Programmatic Window 2	Percent of children immunized with DTP3/B/C/measles-1 and 2/PPV/rotavirus, pneumococcal	Percent of children immunized with DPT3/ measles/PPV/ fully immunized among 1 yr olds (by sex)	Percent of districts with DTP3 coverage >80%; Percent of districts with measles coverage >95%			Country is able to take a lead role in preparing plans and budgets for immunization programs		MSE data on immunization is integrated with country's health information systems	
Process IOs and Indicators	Development financing informed 1. Government expenditure informed 2. Availability of health security financing assessment tool (Window 3) 3. Number of countries that conducted HSA (Window 3)	Policy strategy informed 1. Government policy/ strategy informed 2. Development community/ partner policy/ strategy informed 3. Number of countries that have developed and /or updated multi-sectoral pandemic preparedness plan to improve health security (Window 3)	Client's capacity increased 1. Design capacity strengthened 2. Implementation capacity strengthened 3. Monitoring and evaluation capacity strengthened	Knowledge destined 1. Facilitated exchange of best practice with clients 2. Facilitated exchange of best practice with partners 3. Disseminated best practices 4. Number of regional fora to promote sustainable health security financing (Window 3)	Innovative approaches and solutions generated 1. New innovative approach fostered 2. New innovative approach developed				
Process Targets	Overall and Windows 1&2 Health financing and institutional assessments conducted and discussed with MOF, Finance, Planning and other stakeholders in 5 countries by end of year 5 Window 3 1. Health security financing assessment tool finalized 2. HSA conducted and results disseminated and discussed with stakeholders in 5 countries	Overall and Windows 1&2 Pathway options and transition plans for integration of donor-financed health programs informed in 5 countries by end of year 5 Window 3 Multisectoral pandemic preparedness plan developed and/or updated in 5 countries	Overall and Windows 1&2 Technical assistance and capacity building activities for integration of donor-financed health programs implemented in 5 countries by the end of year 5	Overall and windows 1&2 Knowledge exchange activities implemented in 5 countries by the end of year 5. Window 3 At least 2 regional fora organized to promote sustainable health security financing	Overall and Windows 1 Innovative health financing and service delivery pilots implemented in 2 countries by the end of year 5 Window 2 1. Financing for immunization-related health system strengthening interventions implemented in 2 countries by the end of year five 2. Immunization supply-side readiness increased in at least 2 countries as a result of MDTF financing				

6. Annex 3: Programmatic and financial sustainability data

Country data presented on the following page, by programmatic area

6.1 HIV: prevalence, ART coverage, and domestic expenditure

Figure 3: HIV prevalence. Source UNAIDS Country Profiles, 2018.

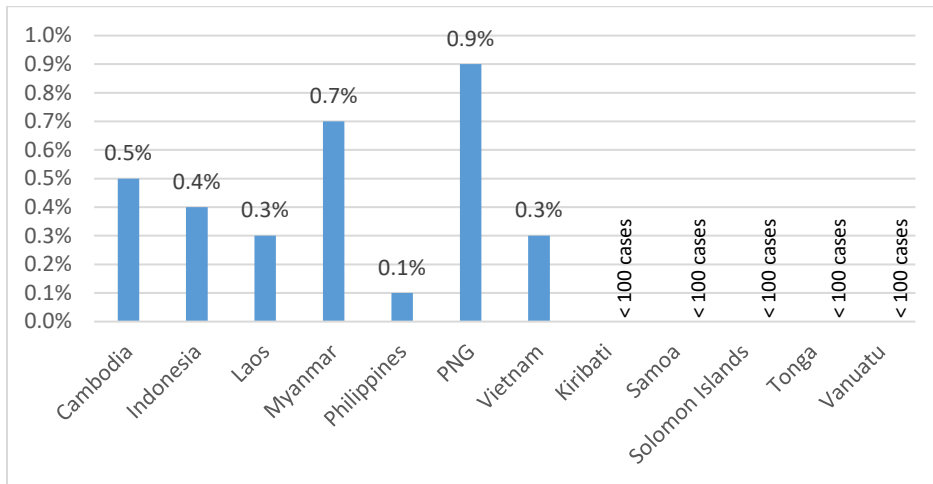


Figure 4: Estimated ART coverage among people living with HIV. Source: MDTF 2018 progress reports, data from 2016/2017.

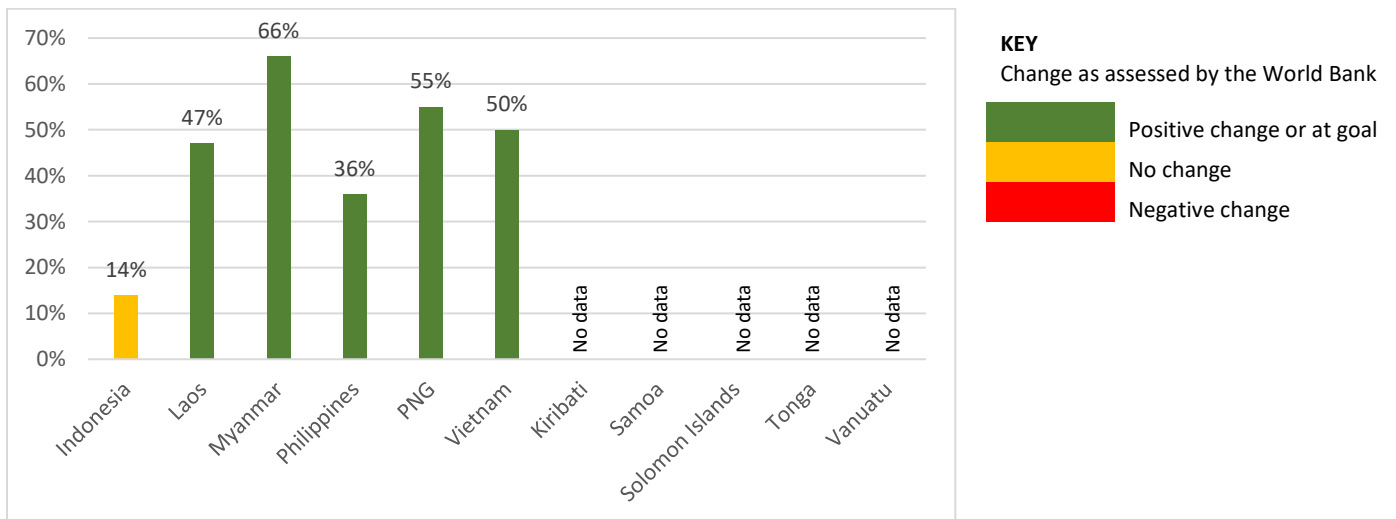
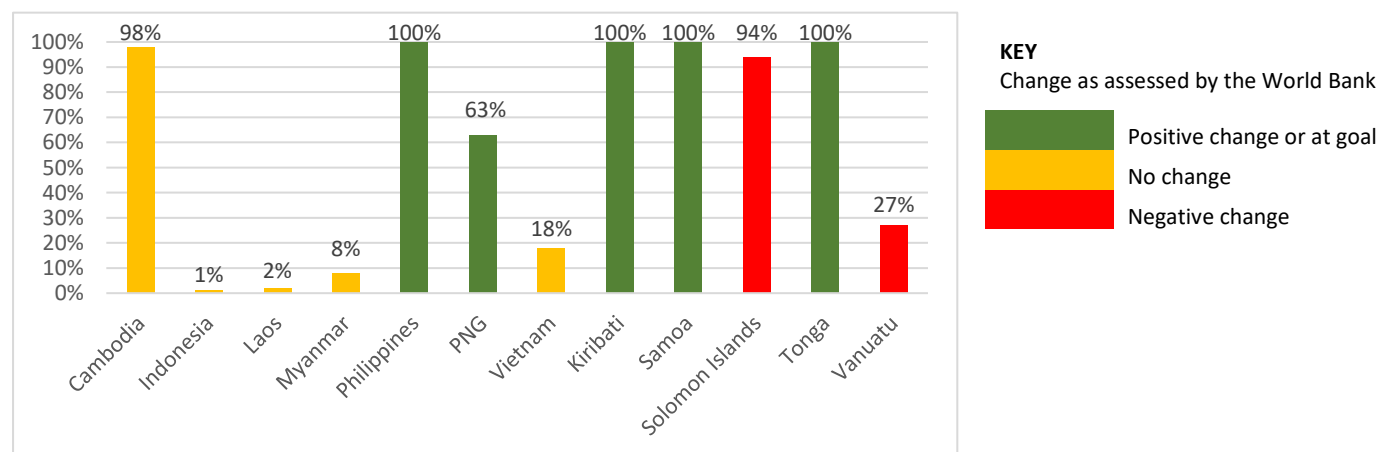


Figure 5: Share of government health expenditure on HIV that is sourced domestically. Source: MDTF 2018 progress reports; data from 2016/2017, except PNG (2018).



6.2 TB: incidence, treatment coverage, and domestic expenditure

Figure 6: TB incidence per 100,000 population and levels of drug resistance (MDR-TB & RR-TB, % of new cases). Source: WHO

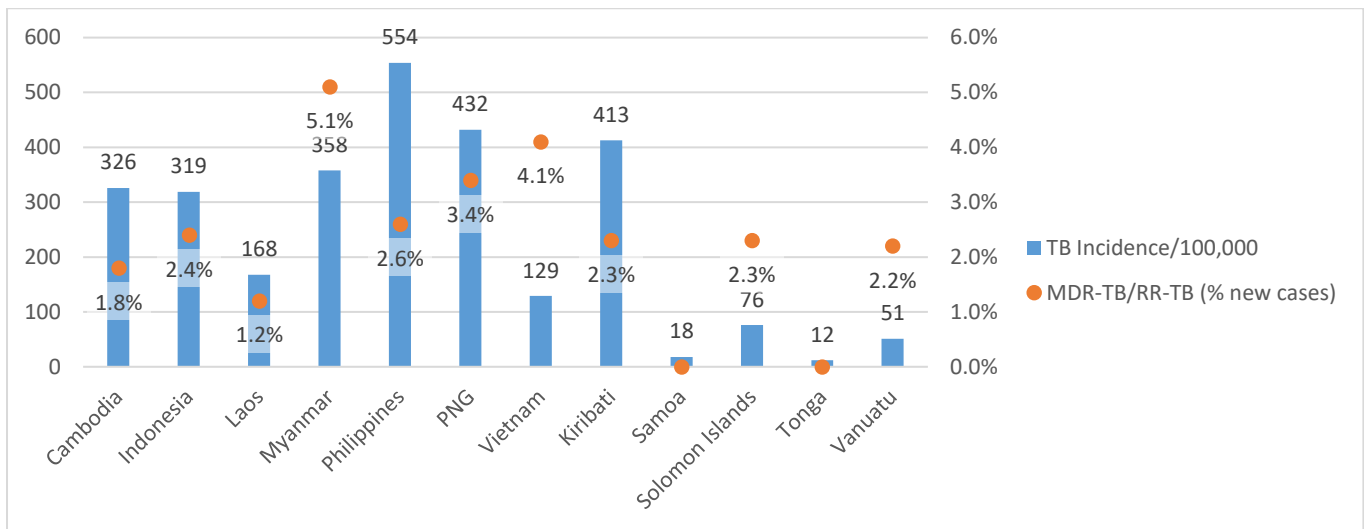


Figure 7: TB treatment coverage, new and relapse TB cases. Source: MDTF progress reports, 2018; data from 2016/2017.

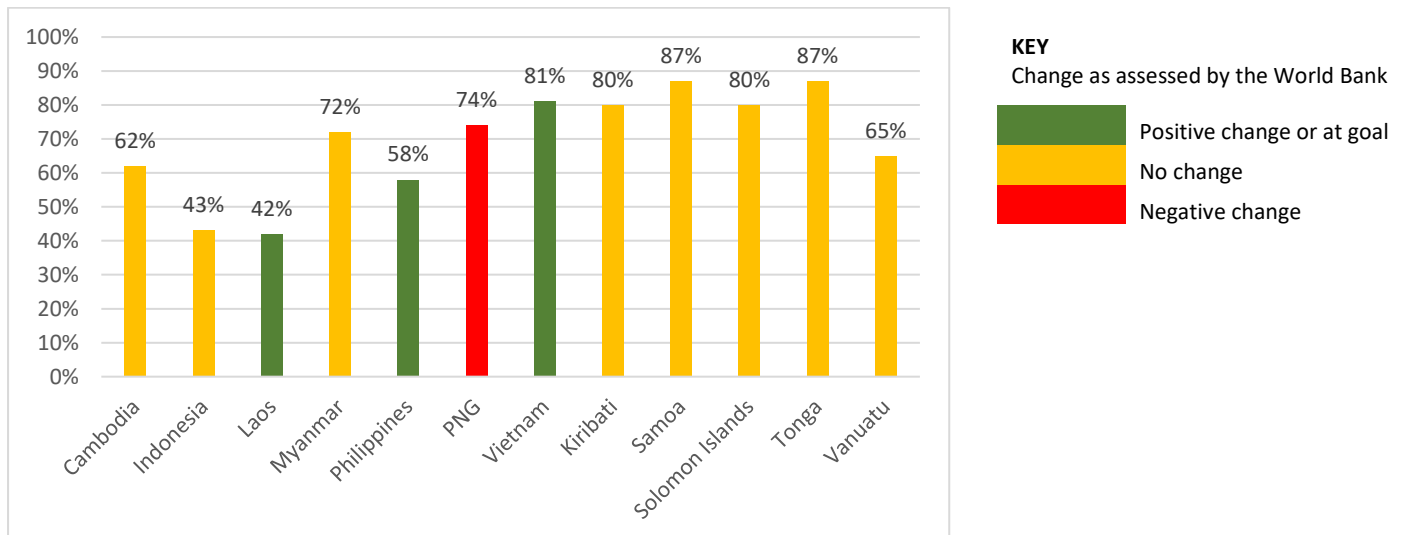
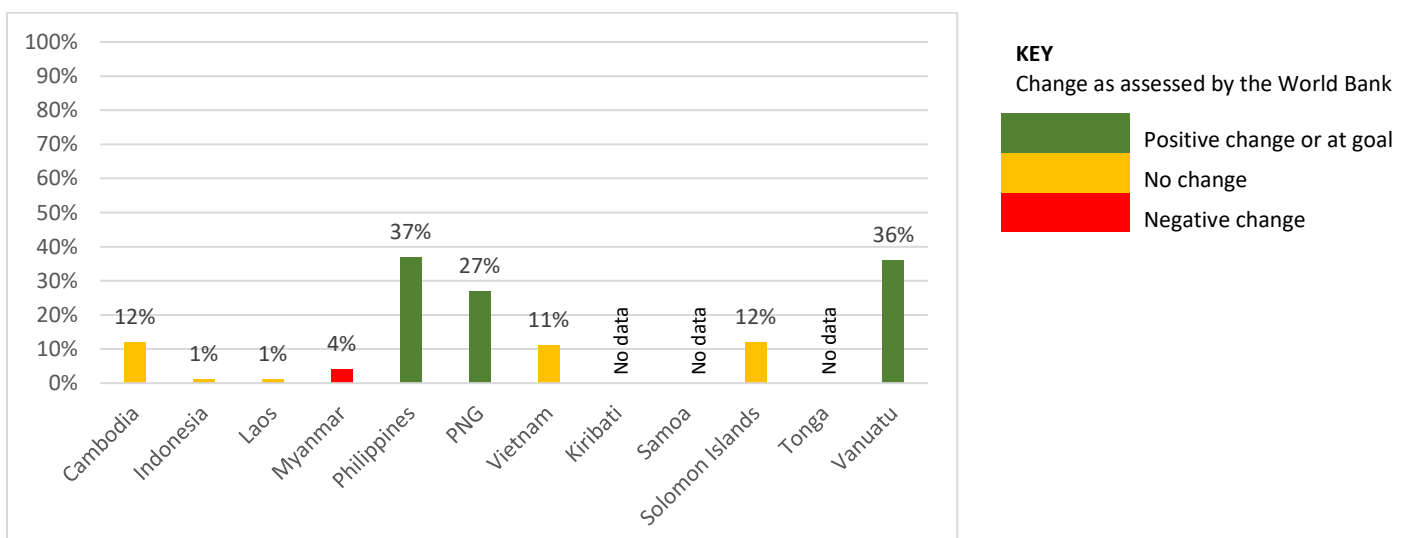


Figure 8: Share of government health expenditure on TB that is sourced domestically. Source: MDTF progress reports 2018; data from 2016/2017, except PNG and Vanuatu (2018).



6.3 Malaria: high risk population, ITBN, and domestic expenditure

Figure 9: Proportion of total population living in areas of high malaria transmission. Source: WHO

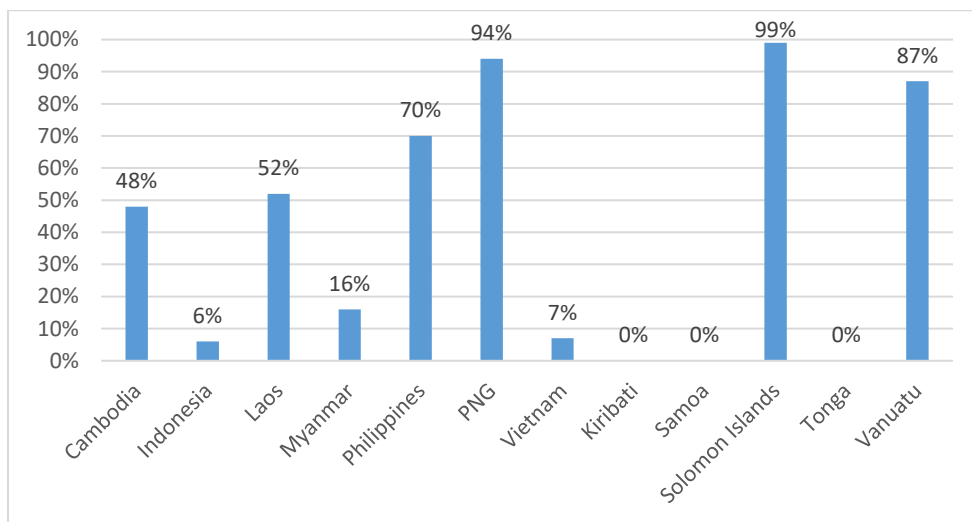


Figure 10: Proportion of people at high risk of malaria infection who are sleeping under insecticide treated bed nets. Source: MDTF progress reports, 2018; data from 2016/2017

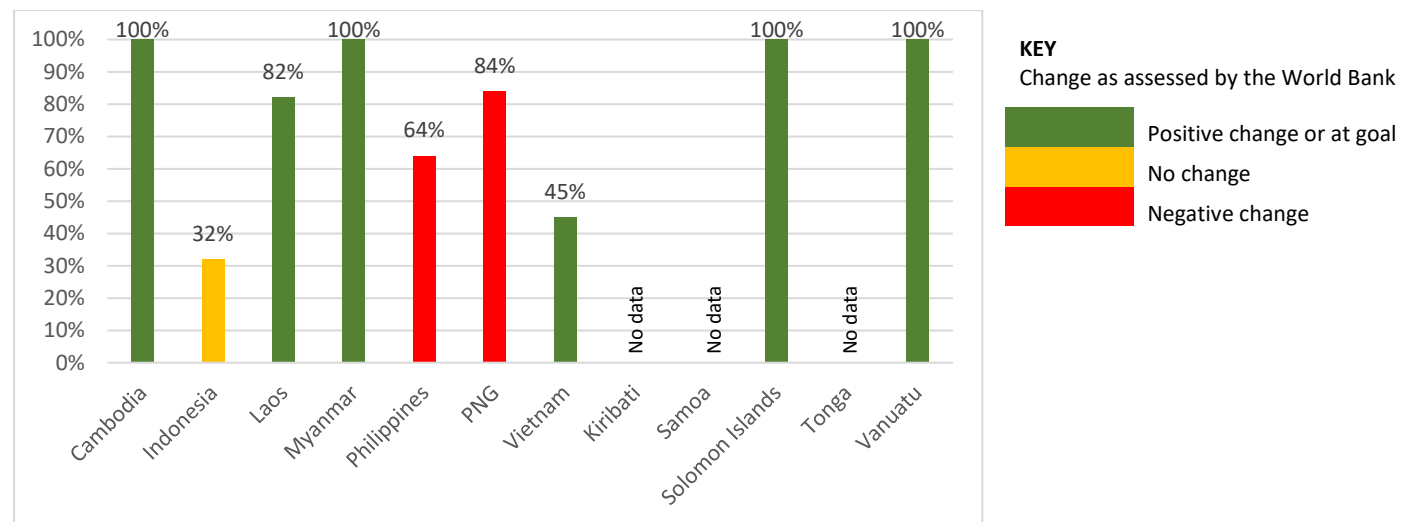
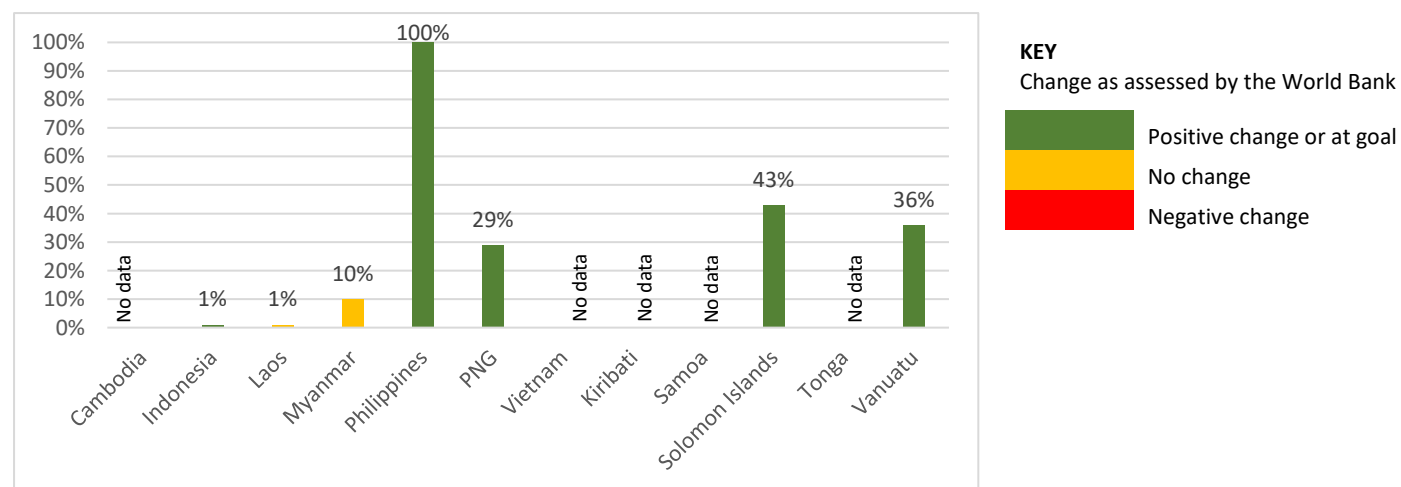


Figure 11: Share of government health expenditure on malaria that is sourced domestically. Source: MDTF progress reports 2018; data from 2016/2017, except PNG and Vanuatu (2018).



6.4 Immunisation: DPT3 & MCV1 coverage, and domestic expenditure

Figure 12: Proportion of districts with >80% DPT Coverage. Source: MDTF progress reports, 2018; data from 2016/2017

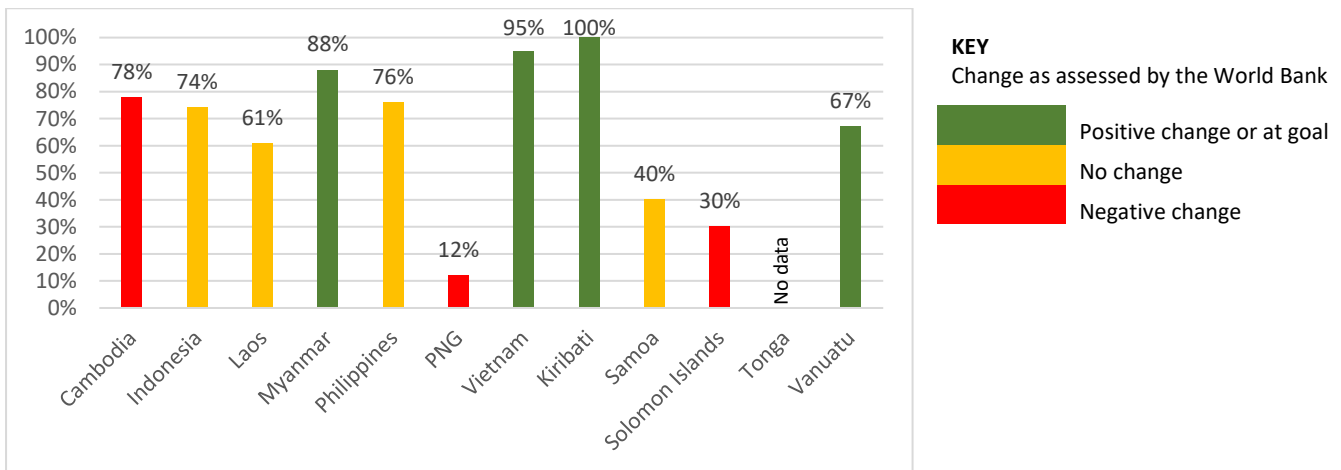


Figure 13: Proportion of districts with >95% MCV1 coverage. Source: MDTF progress reports, 2018; data from 2016/2017

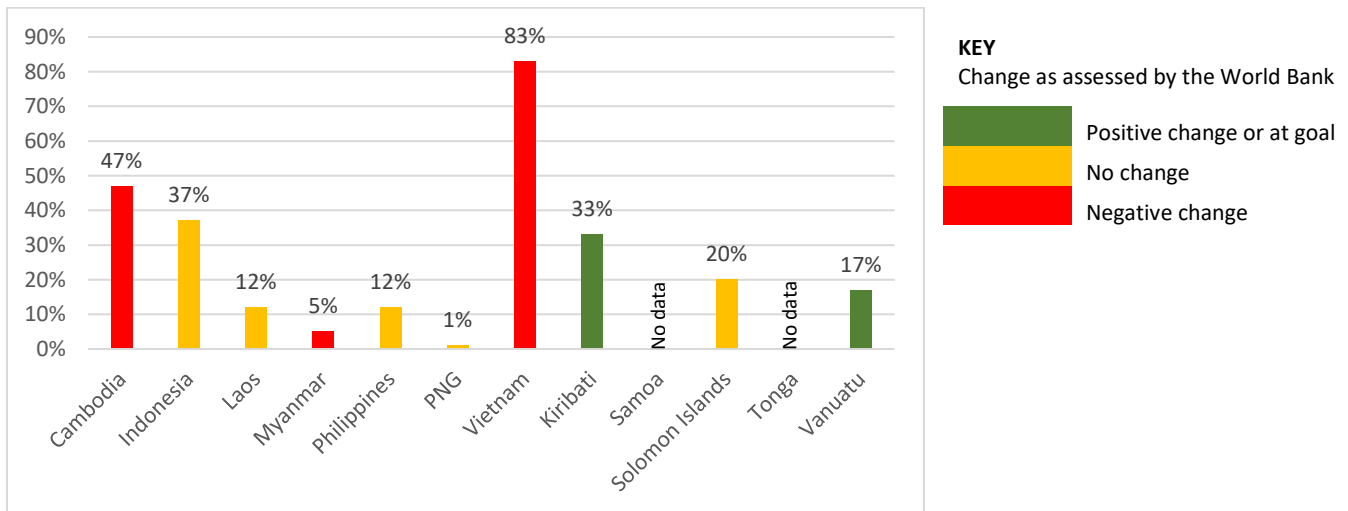
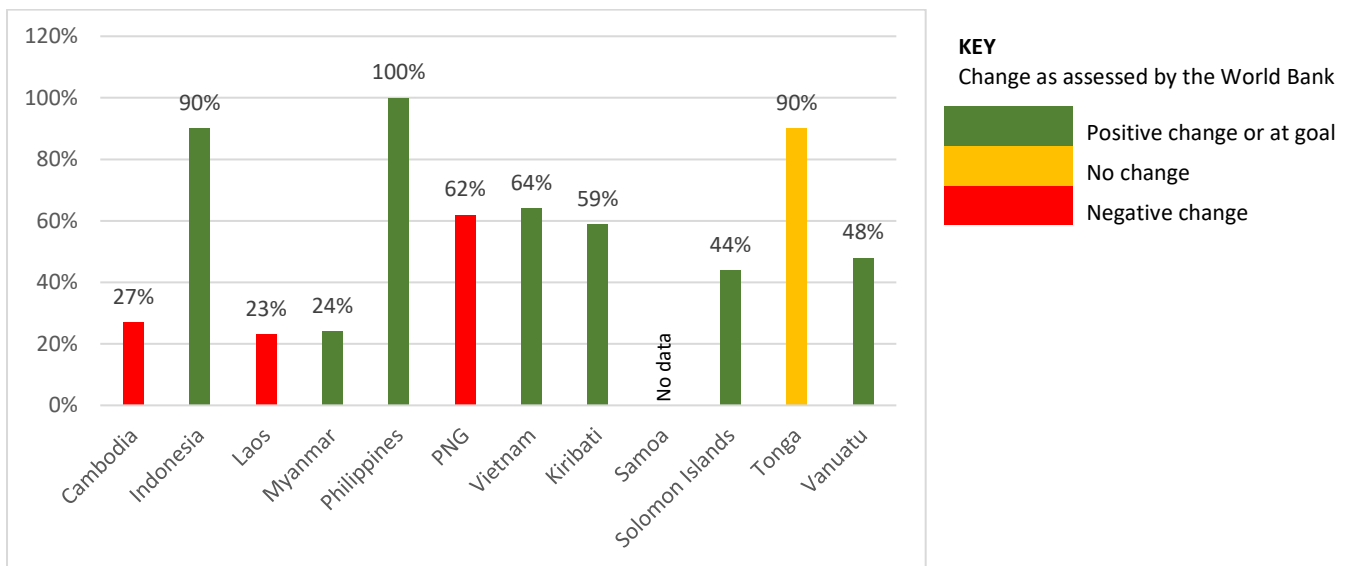


Figure 14: Share of vaccine expenditures on routine immunisation sourced by government. Source: MDTF progress reports, 2018; data from 2016/2017; figures for Laos and Vanuatu updated by WB during MTR.



7. Annex 4 a: Aide Memoire - Laos

MID-TERM REVIEW OF THE WORLD BANK MULTI-DONOR TRUST FUND (MDTF) FOR INTEGRATING DONOR FINANCED HEALTH PROGRAMMES

AIDE MEMOIRE: LAOS

1. **The purpose of the Mid-Term Review (MTR)** is to assess the continued relevance of the MDTF investment, and the progress being made toward achieving its planned objectives. The MDTF supports developing countries in sustaining progress on Universal Health Coverage (UHC) while effectively managing the transition from and integration of externally financed health programs. It has three ‘Windows’ focusing on (I) HIV, TB and Malaria; (II) Immunisation; and (III) Health Security
2. **The MTR team²¹ visited Laos from May 27-31, 2019.** We would like to thank the local World Bank team for organizing an informative series of meetings in Vientiane; for inviting us to attend a day-long workshop chaired by the Vice-Minister of Health, attended by all Provincial Directors of Health to discuss progress on the current World Bank project and the design of its successor²²; and for arranging a field visit to Luang Prabang Province, enabling us to interact with staff at Provincial, District and Health Centre level. We would also like to express our gratitude to the government officials and development partner representatives we met during our stay in Laos.
3. **The MDTF in Laos links all pillars of activity from analysis through technical support, knowledge exchange to recipient executed health systems interventions.** The main activities were:
 - a. **The Health Financing Systems Assessment (HFSA):** prepared in 2016/2017, set health financing in historical and macro-fiscal context, provided an overview of the health system, and demographic and population health outcomes. A ‘deep dive’ on immunisation analysed service availability and preparedness.
 - b. **Program integration:** prior to the 2021Gavi transition technical support has focused on integrating EPI with other primary care services through joint outreach with MCH, integrated information using the DHIS2 web-based platform, and supportive supervision.
 - c. **Strengthening public financial management:** technical support aims to build capacity for planning and budgeting at sub-national level through on-the job training, mentoring support, and learning exchanges across districts and health centres.
 - d. **South-south exchange:** officials from MOF and MOH, have taken part in national, regional and global workshops and through the Joint Learning Network - sharing lessons on health reforms, UHC and transition of externally-financed programs.
Results-based financing: additional financing of USD 4m from the MDTF for the Health Governance and Nutrition Development Project (HGNDP) aims to increase immunisation coverage in the 50 lowest-performing districts. Independent verification of two new Disbursement Linked Indicators (DLIs) tracks increased coverage and integrated outreach.
 - e. **Expanding integration:** the new WB loan (HANSA) will use DLIs to incentivise the integration of immunisation, TB, malaria and HIV/AIDS programs with co-financing from GAVI and the Global Fund. The transfer of the Global Fund Principal Recipient to government offers the prospect of a “one window” approach to external financing.
4. **Achievements:** This Aide Memoire now reviews how work financed through the MDTF has addressed the major issues facing the health sector in Laos, starting with the Health Financing Systems Assessment. The HFSA is acknowledged by government officials and development partners as a useful reference point on health financing issues. More specifically, it helped to put the issue of transition on the policy agenda and provided the basis for a strong alignment of interests between DFAT, the World Bank and GAVI around the need to integrate immunisation programs prior to transition in 2020. Confidence in the process initiated by the World Bank has been further enhanced by the contribution of MDTF resources to the HGNDP and, more recently, the plan for the Global Fund to follow the example of GAVI and eventually join a pooled

²¹ Andrew Cassels, MTR lead, Bob Fryatt, Health Financing Specialist, Deborah Thomas (remote), Gender Specialist

²² The workshop also provided an opportunity for the MTR team to meet Dr Enis Baris, Regional Manager of the MDTF

financing arrangement linked to common disbursement indicators²³. Lao is now also being held up as an exemplar in the World Bank's flagship courses on financing transition.

5. **Progress toward development objectives:** The MDTF it is not a typical development intervention in which there is a direct link between discrete interventions and the achievement of development objectives such as coverage and sustainability of essential health services. It uses limited resources strategically, alongside those for national programs and services, to overcome systemic constraints. It influences system-wide change to integrate, scale up and sustain essential services in a complex and dynamic environment. For some areas of work, there is no clear line of sight between activities funded and improvements in health outcomes, as the work maybe one or two steps on a long road with many obstacles along the route. In Laos, however, because of the Pillar 4 contribution to HGNDP, the link between analytics and outcomes is more easily traceable. Evidence from monitoring DLI 8 shows that a modest financial contribution from DFAT has led to an increase in immunisation coverage in nearly all of the 50 lowest performing districts.
6. **Health financing reform:** The HFSA provided a detailed review of the status of health financing: low levels of government expenditure with limited prospects for revenue growth; significant inequities in access and outcome along economic and ethnic lines; high out of pocket spending, including for co-payments in the public sector; fragmented financial support from development partners; and a number of poorly coordinated contributory and non-contributory health insurance schemes. While the HFSA was valuable, it only captures a point in time in a dynamic situation. In 2016, the government gave priority to the rapid expansion of National Health Insurance, with the aim of nation-wide coverage by 2018. Whilst it has not moved at that pace, the NHI, designed to integrate Community Based Health Insurance, Health Equity Funds and Free MNCH, has the potential to have a transformative effect on the health system. Experience in other countries suggests that a considerable amount of technical support will be required to develop meaningful benefit packages, ensure quality standards, gain consensus on governance arrangements, and ensure the increases in revenue that will be needed to cover the expected expansion and uptake of health services. The WB has a major role to play in this very dynamic environment.
7. **DLIs, collaboration, learning and adaptation:** The basic approach adopted to reform (DHIS2 web-based integrated information platform, results-based financing and disbursement linked indicators) under HGNDP pre-dates the MDTF. At the same time, the DLIs being used in the HGNDP project have clearly shown the potential benefits of this approach, linked to independent verification, but equally some of the drawbacks. As highlighted by the vice-Minister in the workshop for Provincial Health Directors, the tendency is to focus on positive results, and overlook problems and unintended consequences. Experience globally has shown the importance of having regular participatory sessions looking at all the lessons, expected and unexpected, with all stakeholders – and not only those closely involved in the WB project. This allows for course corrections in reform plans, and builds stronger, more sustainable health systems. This can be in-expensive and carried out in real-time, with no need to wait for formal evaluations or publication of research, although these of course have their benefits in addition. Further, while the objective of the MDTF is concerned with integrating external financing and not donor coordination *per se*, it is important to use lessons learned from RBF mechanisms to avoid unhelpful division between agencies and to bring a wider constituency of players into the debate.
8. **Transition:** We agree with the proposition made by senior members of the World Bank team that transition from external to domestic financing provokes “a broader set of questions and challenges” and that transition acts, in effect, as new stimulus to address a raft of familiar issues around scaling up, efficiency and management. However, it is important to not lose sight of the original narrow ‘transition’ question completely. It was evident, for instance, from several of our interlocuters that when it comes to finding new resources to take over the purchase of vaccines, the response is still to hope that a new donor will come forward to pick up the tab.
9. **Forthcoming work: Window 1** work includes a proposed HFSA ‘deep dive’ on TB and HIV to inform the integration of programs into primary care services and use of DLIs in the forthcoming HANSA project. **Window 3** work will focus on the **Health Security Financing Assessment**, once lessons have been drawn from its use in other countries in the region. There is no intention, however, to replicate the detailed exercise undertaken in Vietnam. Preparatory work has started in collaboration with WHO, and the intention is take advantage of the World Bank's access to MoF and other sectoral actors required to collaborate for effective health security. The World Bank's experience in promoting ‘convergence’ of sectors around nutrition will be of particular value.

²³ As an additional sign of confidence, the Government of Japan also contributed USD 1m to HGNDP noting that it offered greater visibility than a bilateral project.

10. **Gender:** Gender analysis is largely absent from the Health Financing System Assessment (HFSA)²⁴ and the policy and practice linkages between gender inequality and Universal Health Coverage are not made. Instead, the HFSA presents the poor, ethnic minorities and remote populations as the most vulnerable populations, without analysing the relationship between gender and other domains of social exclusion. The HFSA is not gender informed. However, the design of HGNDP does include gender and social inclusion analysis, a focus on under-served populations, the intention to strengthen gender data, and achieve and track gender results. In the context of HGNDP at district and health centre level, it is clear that staff are acutely aware of barriers to access, contingent on language and topography. Moreover, as the services being provided are *exclusively* for women and children, there would appear to be no intent for gender inequality. However, the lack of attention to the interaction between gender norms and gender inequality and the delivery and accessibility of health services means that gendered bottlenecks are at risk of going under the radar including for example the lack of female Village Facilitators and the difficulties that female health workers face in providing outreach services to remote populations. However, with further integration to include a broader range of services (including HIV, TB and malaria and NCDs), the need for a more gendered approach cannot be ignored²⁵. Lastly, the learning process suggested in paragraph 7 above needs to look closely at the impact of DLIs on exclusion/inclusion: do they, for instance, reward capacitated and better resourced provinces and increase the gap? Does the verification process (involving checking household vaccination cards) discriminate against groups with high levels of illiteracy, as was claimed in our visit?

11. Conclusions

- a. The MDTF has established a platform for integrating external finance in the health sector, creating a health financing environment likely to increase the effectiveness and efficiency of programs financed by government and development partners. The experience of Lao has significance beyond its borders, through regional exchange and global training courses, in addition to influencing on-going work of the World Bank in Cambodia and elsewhere in the Region. From the perspective of DFAT a modest contribution to HGNDP has already started to pay dividends in term of increasing immunisation coverage and decreasing inequity.
- b. Many uncertainties remain, the most prominent of which concerns the overall amount of financing for the health sector in the face of falling government revenues and the increases in demand that will emanate from expanding National Health Insurance (with the as yet unknown consequences for funding public health programs). The HFSA has a strong bias toward efficiency - more health for the money. But given the low levels of spending and high levels of inequity, more money for health needs to remain firmly on the agenda. High level advocacy for increasing the public spending on health needs to be a concern for all development partners.
- c. The World Bank is keen to “de-projectise” successive investments in order to avoid the risk that health sector reform is seen as synonymous with HGNDP and HANSA. The degree of local ownership shown by Provincial Health Directors at the meeting in this regard is very encouraging.
- d. Health financing remains a moving target. MDTF should therefore continue to support World Bank production of regular analyses and briefs in response to needs expressed in the Technical Working Group on health financing, and to keep an updated HFSA ‘slide deck’ to keep the analysis live.
- e. As noted above, MDTF should support an explicit ‘real time’ learning agenda linked to the DLI mechanisms, so the lessons are shared and discussed on a regular basis, with questions arising generating an operational research agenda, ideally involving local academic institutions, with QA provided by the World Bank.
- f. The level of attention to gender in MDTF activities has been variable. Opportunity to lever health system gains under HGNDP (such as DHIS2) to achieve gender and socially inclusive local planning across sectors to impact health and nutrition outcomes deserves further attention.

²⁴ Important to note that both the HFSA and HGNDP predated the agreed DFAT-World Bank gender guidelines for the MDTF.

²⁵ The availability of gender disaggregated data through DHIS2 provides an opportunity to develop a more gender sensitive strategy as implementation proceeds.

8. Annex 4 b: Aide Memoire - Papua New Guinea

MID-TERM REVIEW OF THE WORLD BANK MULTI-DONOR TRUST FUND (MDTF) FOR INTEGRATING DONOR FINANCED HEALTH PROGRAMMES

AIDE MEMOIRE : PAPUA NEW GUINEA

- 1. The purpose of the Mid-Term Review (MTR)** is to assess the continued relevance of the MDTF investment, and the progress being made toward achieving its planned objectives. The MDTF supports developing countries in sustaining progress on Universal Health Coverage (UHC) while effectively managing the transition from and integration of externally-financed health programs. It has three 'Windows' focusing on (I) HIV, TB and Malaria; (II) Immunisation; and (III) Health Security.
- 2. The MTR team²⁶ visited Papua New Guinea from June 3 – 7 2019.** We take this opportunity to thank officials at the World Bank office and the High Commission of Australia for organizing a rewarding and informative program of meetings and interviews. We would also like to express our gratitude to the government officials and development partners we met during our week in Port Moresby.
- 3. PNG provides a challenging context for the work of the MDTF.** Economic growth and increases in the health budget between 2010 and 2014 did not translate into improvements in access to health services or health outcomes. Health and human development indicators have shown little change in over 10 years²⁷ and Total Health Expenditure (THE) has subsequently fallen and is low compared to international and regional standards²⁸. In 2017 the health sector budget was cut by 21% and further decreases are likely. Dependence on external assistance remains high (around one-fifth of THE) at a point when DFAT and Global Fund financing for health is set to decline, and PNG's GDP per capita dictates that it should graduate from GAVI support. Outbreaks of measles, vaccine derived polio, multi-drug resistant TB and static levels of maternal mortality are indicators of a poorly functioning health system. There has been progress in the establishment of Provincial Health Authorities, but the relationship with District Development Authorities (DDAs) in which MPs control separate lines of funding, makes for a complex and fragmented institutional environment, exacerbated by continuing problems of cash flow from the central government.
- 4. Since 2016 the MDTF has contributed to the World Bank's Program of Analytical and Advisory Services (PASA) in PNG.** Work carried out includes:
 - a) *The Health Financing Systems Assessment (HFSA)* focused on the financial and programmatic sustainability of externally financed priority health programs within the broader context of health systems strengthening. This was followed by more detailed work on *immunisation transition*: supporting the development of the GAVI transition framework and a broader analysis of *health financing options*.
 - b) *Sector reviews and analysis* focused on lessons learned from the Health Sector Medium Term Development Plan (MTDP) 2011-2015 relevant to the financial and physical execution of the MTDP 2018-2022 as well as contributing to the PNG Health in Transition study.
 - c) *Technical support to the National Department of Health (NDOH) and Provincial Health Authorities (PHAs)* includes: short courses on PFM and strengthening health sector expenditure analysis with a view to improving budget submission to Treasury; developing guidelines on the use of the Integrated Financial Management System; mapping donor funding by province and category; and developing expenditure tracking tools to be used in preparing quarterly reports. For provinces: comparisons of government and church-run providers; assessing quality and efficiency of outreach activities; mentoring and training for PHAs to prepare Annual Activity Plans; and developing performance scorecards, and supervision checklists for provinces and districts.
 - d) *Regional and global knowledge sharing events*: Participation in PMAC workshops on health financing, UHC, integration of externally financed health programs and health security as well as the MDTF workshop in Siem Reap on the donor transition agenda. PNG has also benefitted from involving national officials in occasional briefings from WB technical experts.
- 5. Achievements:** a) The analytic and technical work under the PASA has clearly shown both the importance and complexity of increasing the effectiveness and efficiency of frontline services and the critical challenge of PFM. It has influenced, arguably

²⁶ Andrew Cassels, MTR lead, Bob Fryatt, Health Financing Specialist, Deborah Thomas (remote), Gender Specialist

²⁷ A finding likely to be confirmed by forthcoming Demographic and Health Survey (DHS) data – notably in relation to rates of stunting.

²⁸ Estimates for per capita expenditure have been revised downwards following the completion of the HFSA based on new data from WHO.

making possible, the World Bank's forthcoming Health IMPACT loan operation, as well as informing more detailed work on Disbursement Linked Indicators (DLIs). The loan operation, in turn, provides greater leverage over the health financing issues identified than would be possible through PASA alone. b) There is a great deal more work to do to develop a health financing strategy (also see below) but the options paper has been helpful in highlighting the fact that social health insurance is currently not feasible or sustainable in the context of PNG. c) The work on immunisation has highlighted the importance of the transition agenda – keeping it squarely on the policy agenda – but also prompting GAVI and the government to review the realism of the original timeline. Following a proposal for an additional tranche of funding over and above earlier transitional grants the GAVI Board have just approved a new grant of USD 60 million for five years. The aim being to be able to demonstrate that improvement of performance is possible, prior to a new final transition date in 2025.

6. **Progress toward development objectives:** The MDTF it is not a typical development intervention in which there is a direct link between discrete interventions and the achievement of development objectives such as coverage and sustainability of essential health services. It uses limited resources strategically, alongside those for national programs and services, to overcome systemic constraints. It seeks to influence system-wide change to integrate, scale up and sustain essential services in a complex and dynamic environment. For some areas of work, there is no clear line of sight between activities funded and improvements in health outcomes, as the work maybe one or two steps on a long road with many obstacles along the route. The task of the review is thus to assess whether the activities carried out are relevant and effective in relation to the health systems and policy issues that allow externally financed essential health programs to be integrated, and scaled as part of the broader effort to reach UHC and achieve of better health outcomes. The remainder of this note provides a brief summary of key issues currently being addressed by the MDTF.
7. **Analytic studies:** The World Bank's internal review of the 2015-2017 PASA recommended the new program of work pay increased attention to technical assistance. This has paid dividends in terms of capacity building at national and provincial level. Nevertheless, we suggest that continuing analytic work is still worthwhile, even if immediate uptake at policy level is limited. At the same time, the current model of detailed peer-reviewed studies bears examination: faster, light-touch, qualitative work needs should be considered. We acknowledge the scarcity of local institutions that are in a position to undertake such work, but the need for such capacity needs to remain on the agenda. National and provincial stakeholders should remain fully engaged in the prioritization, oversight and dissemination of WB analytical work.
8. **Linking funding to performance through DLIs:** has the potential to be a powerful tool to influence institutional performance, but context is important. It is critical that it does not become a divisive issue between development agencies that hold different views. Rapid analysis and learning can help understand successes, unintended consequences, and the ways that incentives are used to game the system. It also provides a way of bringing a wider range of players into the discussion, beyond those directly involved with the World Bank project. At a more practical level, given the limited bandwidth of government and the World Bank office, the use of score cards linked to DLIs is one way of showing that strategically important matters, such as gender sensitivity in health centre and hospital performance is being actively monitored.
9. **Decentralization:** The HFSA highlighted some of the shortcomings evident in the way that Provincial Health Authorities were operating. Our interviews suggested that in provinces where effective CEOs have been posted, overcoming some of the inherent problems of decentralization is possible, and ways have even been found of binding independent DDAs into a more coherent provincial strategy (for example as procurement agencies). However, the high performers appear to be in a minority and the lack of sufficient committed, experienced leaders and managers (and institutions to develop them) may limit future success. With regard to central funding, Health Function Grants (HFGs) are intended as an equalizing measure, being reduced (ultimately to zero) in Provinces with the fiscal capacity to finance services from their own revenues (e.g. from mining or other industries). However, there is no guarantee that an adequate proportion of internally generated revenues in the wealthier Provinces will be used to fund health. More broadly, there is little evidence that the role of the NDOH is adapting to a new role in a decentralized system. In addition, key national bodies that can assist the NDOH and MoF, such as the NEFC, do not seem to be adapting sufficiently to the new environment, for example only focusing on financial allocations and expenditure and not on sector performance.
10. **Health financing and financial management:** Work to date has rightly focused on the immediate problems of public financial management. There is, however, an equally urgent need to focus on health financing and the development of a health financing strategy that addresses core functions of raising resources, pooling risk and allocating funds strategically.

Raising an adequate level of resources for health is urgent given recent cuts and requires high-level advocacy. MDTF work has shown just how little the state actually spends on priority programs (in addition to dependence on GAVI and the Global Fund, the state spends virtually nothing on reproductive health). Out of pocket expenditure (around 10% of THE) is relatively low, but the persistently low measures of health status suggest that this is due to foregone care. Most facility financing is currently passive, suggesting a greater role for strategic purchasing, particularly in the more forward thinking and better functioning PHAs. Lack or inconsistency of data currently precludes drawing any reliable conclusions about the link between financing and performance.

11. Implications for future work under MDTF: World Bank staff in Port Moresby are supported by a Task Team Leader who visits monthly from the World Bank Office in Sydney. A significant proportion of this capacity is devoted to technical support in the NDOH, with additional fly in-fly out support from two UK based and one Australia-based consultant²⁹. Improving the quality of budget submissions has been welcomed by the NDOH but has had limited impact in the way submissions are treated by Treasury. It has been suggested that the next stage would be to conduct Public Expenditure Reviews. Whilst a broad-brush analysis of major cost drivers would be valuable and would respond to the Treasury's request, the level of detail suggested by the template shown to the MTR team in the NDOH risks a lengthy period of nugatory work. Instead, given the focus on PHAs, work on comparisons of financing flows and performance at provincial and district level merits greater attention in future.

12. Coordination among Development Partners: A high-level coordinating committee (HSACC) has been proposed to be chaired by the Minister and involving senior representatives of development partners and central agencies. A consultant funded through a DFAT-supported partnership has been recruited to support the Secretariat function that such a body will need. While HSACC is necessary, it is likely to be far from sufficient. However, less formal mechanisms to bring development partners together have not lasted. Donor coordination is not part of the MDTF mandate. Nevertheless, there is a need for mapping related initiatives, informal meetings between partners, and stronger links between key agencies. The Asian Development Bank – a longer-term partner in PNG than the World Bank - is providing USD 300m in general budget support linked to triggers set out in a policy matrix for the health sector. During our visit, the matrix was not to publicly available. However, it will be important to ensure coherence and synergy between the IMPACT DLIs and the ADB's health sector triggers.

13. Conclusions

- a. The challenges facing the health sector in PNG are formidable and the country is a long way from being ready to transition from externally financed support to the health sector. However, the potential influence of the World Bank will be increased through Health IMPACT loan which, in turn, has been informed by activities financed by the MDTF. While the route between analysis, technical cooperation and intervention will be lengthy, the focus of work to date has successfully targeted the major issues facing the financing of the sector. Meaningful health reforms are now appearing which could be transformational if sufficient resources are mobilized.
- b. In terms of course correction, our key proposal would be a shift in focus from the national to the provincial level as the key locus of analysis – learning, inter alia, from the implementation of disbursement linked indicators and drawing government and other partners into the learning process.
- c. At a higher level, inadequate levels of health financing are likely to constrain achievements into the future. There is thus an urgent need for a shared narrative among all development partners, informed by the MDTF, around the key political and financial issues to be addressed by government. PNG's decision to become an early adopter of the Human Capital Project offers one possible starting point for the dialogue.
- d. The challenges facing PNG – a country of growing geo-political importance in the Region - are exceptional. Arguably, they have too often been overlooked or assumed to be part of a common set of problems faced by much smaller Pacific Island States. The MDTF makes an important contribution by making PNG's challenges more visible - to its regional development partners and to a global health community that has ignored them for too long.

²⁹ MDTF is just one source of TA support for the NDOH, contributing to the perception of TA overload/fatigue.

9. Annex 4 c: Aide Memoire - Indonesia

MID-TERM REVIEW OF THE WORLD BANK MULTI-DONOR TRUST FUND (MDTF) FOR INTEGRATING DONOR FINANCED HEALTH PROGRAMMES

AIDE MEMOIRE: INDONESIA

1. **The purpose of the Mid-Term Review** is to assess the continued relevance of the MDTF investment, and the progress being made toward achieving its planned objectives. The MDTF supports developing countries in sustaining progress on Universal Health Coverage (UHC) while effectively managing the transition from and integration of externally-financed health programs. It has three 'Windows' focusing on (I) HIV, TB and Malaria; (II) Immunisation; and (III) Health Security.
2. **The MTR team³⁰ visited Indonesia from June 10 – 14 2019.** We take this opportunity to thank officials at the World Bank office in Jakarta and the Embassy of Australia for organizing a rewarding and informative program of meetings and interviews. We would also like to express our gratitude to the government officials and development partner representatives we met during our week in Jakarta.
3. **There is a clear and positive story to tell about the MDTF in Indonesia.**
 - a) Analytic work carried out by the World Bank team, starting from the Health Financing Systems Assessment (HFSA), is valued and is used by government and other development partners;
 - b) Subsequent work – including a health chapter in the Public Expenditure Review, expenditure tracking studies, a supply-side service readiness assessment, policy briefs on priority programs, strategic health purchasing and CSO funding – has kept the issue of transition from external to domestic financing on the national policy agenda;
 - c) Analytic and technical work (under Pillars 1 -3 of the MDTF) paved the way for the World Bank's forthcoming loan operation (I-SPHERE) and influenced its focus on sub-national service delivery;

the additional investment in the MDTF of USD 3 million from the Global Fund grant to Indonesia indicates a degree of confidence in the work of the World Bank and a sense of ownership on the part of the Country Coordinating Mechanism (CCM); and,

 - d) in addition to their technical work the World Bank team have been skillful in managing process: particularly with regard to dissemination of products and convening different stakeholders (acknowledged particularly by the Ministry of Health in relation to the Health Systems Financing Working Group and the Centre for State Budget Policy in the Ministry of Finance).
4. **Progress toward development objectives:** The MDTF it is not a typical development intervention in which there is a direct link between discrete interventions and the achievement of development objectives such as coverage and sustainability of essential health services. It uses limited resources strategically, alongside those for national programs and services, to overcome systemic constraints. It influences system-wide change to integrate, scale up and sustain essential services in a complex and dynamic environment. For some areas of work, there is no clear line of sight between activities funded and improvements in health outcomes, as the work maybe one or two steps on a long road with many obstacles along the route. The task of the review is thus to assess whether the activities carried out are relevant and effective in relation to the health systems and policy issues that allow externally financed essential health programs to be integrated, and scaled as part of a the broader effort to reach UHC and achieve of better health outcomes. This note provides a brief summary of key issues currently being addressed by the MDTF.
5. **Spend more:** Benchmarking shows that public spending on health in Indonesia is lower than many of its regional neighbours and other countries at similar levels of economic development. The analysis of health spending carried out through the MDTF helped persuade the Government of Indonesia to take a loan for health, the first from the WB in 13 years, and in focusing that loan on sub-national services. However, the 5% constitutionally mandated national allocation to health acts not, as was intended, as a minimum floor for health spending, but as a maximum ceiling. Unless funds are off budget (as is currently the case for the Global Fund) additional external financing risks displacing domestic resources. In addition, the

³⁰ Andrew Cassels, MTR lead, Bob Fryatt, Health Financing Specialist, Deborah Thomas (remote), Gender Specialist

increasing deficit of JKN (see below) suggests increasing expenditures on curative care rather than priority public health programs (such as those part-funded by Global Fund and Gavi). The World Bank's analytic work has highlighted these issues, but real progress on increasing public spending on health requires concerted advocacy from *all development partners* – focusing on the importance of investment in human capital in health *and* nutrition³¹. Timing is critical given the preparation of a new Medium-Term Development Plan in coming months.

6. **Spend right, spend better:** With overall economic growth of 5% a year, health spending should be growing at more or less the same rate, but this is currently limited by the growing deficit accrued by BPJS, the agency that manages JKN, the social health insurance program. The recent apparent decrease in the MoH budget actually reflects a *shift* in resources to JKN. However, in the absence of agreement on reimbursement tariffs and no link between funding and performance, there is little immediate prospect that JKN spending will become more efficient. At the same time, priority programs and preventive work – including immunisation - dependent on central MoH funding risk being compromised. The MDTF response – focusing on introducing the concept of strategic purchasing (initially in priority programs such as TB) – is appropriate, but at an embryonic stage. Further progress will depend on addressing the poor quality and consistency of data – in ways that make it possible to link performance with spending. This will be addressed through the I-Sphere loan, including through the use of the DHIS2 information platform and Disbursement Linked Indicators (DLIs). In reality, however, Indonesia faces many years of work to adapt health financing to a decentralized political system (in which a single purchasing agency may also struggle to keep up with diverse demands of 34 Provinces and more than 500 districts).
7. **Transition from external financing:** While external financial assistance now constitutes only 0.4% of Total Health Expenditure, for HIV/AIDS, TB, malaria and Immunisation (ATMI) it accounts for between 60% (malaria) and 15% (immunisation) of the costs of priority programs. However, while finance remains an issue, maintaining or increasing program performance faces many other challenges. First, it is important not to think about transition in terms of maintaining a steady state: work in ATMI needs to scale up (given ARV coverage at only 18%, and Indonesia as the home to 1/5th of the world's unimmunized children). Second, priority programs face the systemic problems referred to above (not least a lack of consistent and reliable data for measuring performance) and from an approach to decentralization in which the centre no longer exerts the control it had in the past over districts. In this regard, AIDS, TB and Immunisation are recognized in revised Minimum Service Standards, which should result in more consistent support from decentralized district budgets. Malaria however has so far been excluded from these standards. Third, external agencies like the Global Fund can influence the introduction of new practices (for example Test and Treat policy in relation to HIV). In response to these challenges the MDTF has financed an expenditure tracking study which helps elucidate and quantify financial flows for priority programs at district level. This study has also informed a series of policy briefs summarizing key issues and recommendations that can form the basis of transition plans for each program.
8. **Beyond the public sector:** Global Fund financing provides resources to NGOs and other organizations beyond the public sector. This funding will be at risk following transition. The role of private providers is critical in the treatment of TB. To address malaria in the high-burden eastern Provinces, where government services are weakest, requires building relationships with plantation and mining companies. CSOs play a vital role in relation to HIV/AIDS through advocacy and access to key populations, and more generally, in promoting a more gender sensitive approach to service access and provision. CSO funding is unsurprisingly the prime concern of the CCM Chair and Executive Secretary, who see progress on this issue as the main rationale for agreeing to channel Global Fund funds through the MDTF. The World Bank's analytic work has helped clarify some of the challenges faced by government in legally supporting CSOs, NGOs and private entities in the future. Nevertheless, building the capacity that CSOs need to receive and account for funds remains a key challenge.
9. **Health security:** We did not have an opportunity to discuss the World Bank's role in the financing of health security with the relevant government officials. However, it is clear that a) the intention is not to repeat the detailed exercise that was undertaken in Vietnam, b) a good working relationship has been established with WHO where specialist staff are engaged in the development of the post-JEE action plan, and c) the focus of the MDTF work will be on PFM and related institutional governance issues and, in particular, overcoming bottlenecks that impede the rapid release of funding following outbreaks and emergencies. This plays to the World Bank's strengths. We note incidentally that much of funding under Pillar 3 has been used for attending regional workshops on health security. Lastly, we understand that working relationships in the MOH are now stronger, but there remains an issue that the National Agency for Disaster Management focuses only on

³¹ Indonesia is one of 30 early adopter countries of the Human Capital Project, providing a focus for advocacy on social sector spending.

natural disasters and that the Ministry of Human Development and Culture has been mandated to manage pandemics and non-natural emergencies in a recent draft presidential instruction.

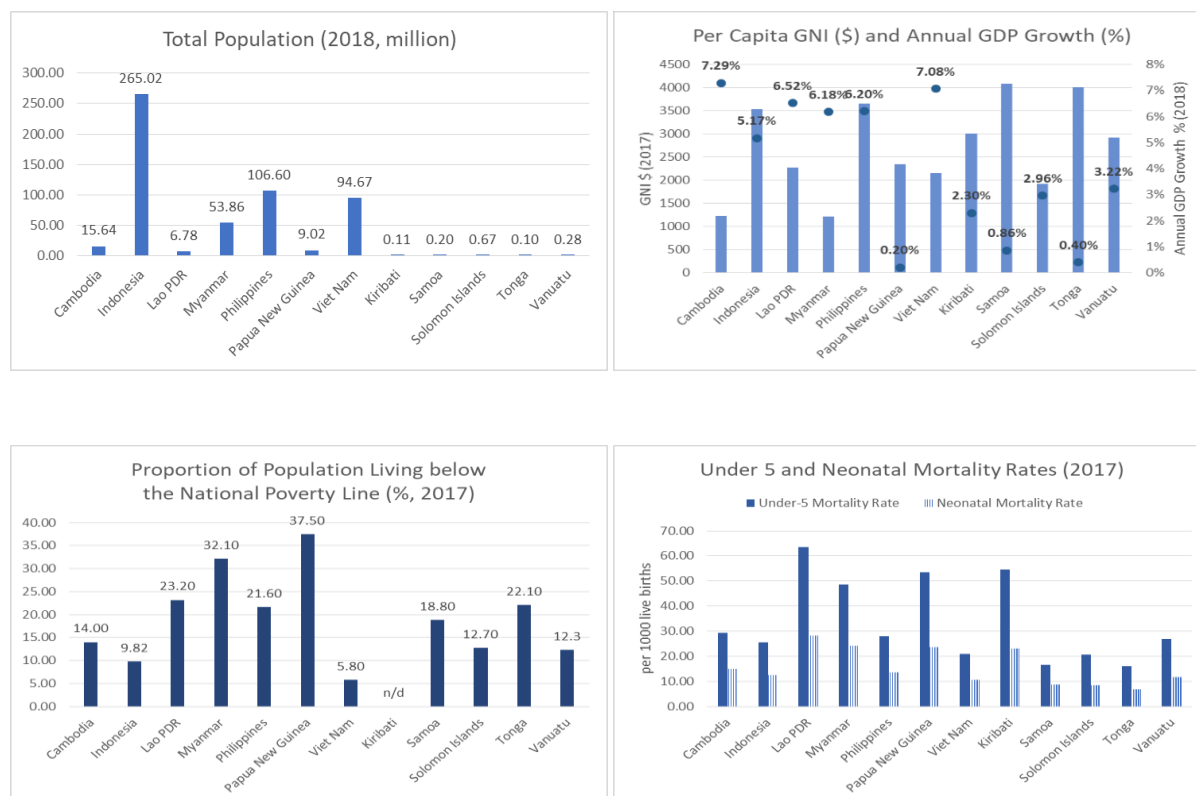
10. **Development Partner Coordination:** We met with representatives from WHO, UNICEF and USAID. At present there is no formal, government-led process for coordination, nor, in its absence, any regular forum for dialogue between DPs. While it is not a specific focus of the MDTF, there is an opportunity for the World Bank to initiate a process of discussion and learning among other DPs that draws on the experience of introducing DLIs. We note from other countries differences of opinion among development partners about the use of DLIs. Encouraging dialogue on the basis of practical experience can help refine the design and implementation of indicators.
11. **Looking ahead:** The World Bank's program of work under the MDTF will focus on analysis and technical support in relation to accountability and information systems in the context of the new loan; tracking and analyzing financial flows and PFM issues at district level; work on public-private partnerships in collaboration with USAID; and continuing efforts to introduce strategic purchasing³². One reason that the new loan is attractive to the Ministry of Finance is that it offers a degree of control over resource use in the health sector – and thus the opportunity for a fruitful partnership to explore with the MoF the practical potential for results-based financing/strategic purchasing. Lastly, we note the importance of issues around procurement for the transition agenda – in particular the extent to which the priority afforded to State Owned Enterprises influences the financial sustainability of immunisation and ATM programs.
12. **Synergy with the bilateral program:** A round-up discussion based on the points in this aide memoire with DFAT staff highlighted three key areas of important synergy between the MDTF and other DFAT bilateral programs: a) channels, systems and capacity building for financing CSOs; b) overcoming bottlenecks for rapid fund release in the face of outbreaks and epidemics; and c) joint advocacy for increased public financing for health (5% as a floor rather than a ceiling). It will also be important to explore links with the Knowledge Section Initiative (KSI) with regard to their work on government funding for CSOs. Lastly, while all our interlocutors in government acknowledged the role of Australia as the main financier of the MDTF, there would appear to be nothing preventing DFAT from seeking greater branding and visibility for a well-received and influential initiative.
13. **Conclusions**
 - a) Indonesia faces many challenges in making progress towards Universal Health Coverage. In addition to adapting to the demands imposed by political decentralization and the rapid expansion of national health insurance, the sheer size and diversity of the country poses its own risks: of growing inequities in access and outcome; of under- and over-nutrition; of children at risk of preventable communicable diseases, while adults face the costs of life-long treatment for chronic illness.
 - b) Health financing and financial management – the focus of the MDTF – provides a way of addressing systemic issues in health service delivery that would not be possible through a traditional project. The World Bank – through the trust it has established with the MOH, with the National Development Planning Agency (Bappenas) and, critically, with the Ministry of Finance is the obvious and appropriate partner.
 - c) The risk for the MDTF is that the path is between interventions and development objectives is lengthy and, necessarily, subject to sometimes being blown off course. It is not that the interventions being pursued are ineffective, illogical, or unlikely to result in the achievement of agreed goals.
 - d) Understanding and communicating the potential of the MDTF could be improved by setting out more clearly the route between intervention and outcome in a way that is currently missing from the monitoring framework. We intend to return to this issue in more detail in the full report of the MTR.

³² An issue that we did not have the opportunity to take up in the review is the question of how the position of the MDTF is seen within the Bank. For example, how does the status of the MDTF as a Regional as opposed to a country-specific initiative affect management relationships within the Country Office (e.g. with the Human Development Coordinator) and with other cross-sectoral initiatives in poverty reduction, governance etc. An issue to be tabled at the next MDTF management meeting, perhaps.

10. Annex 5: Country summaries

10.1 Summaries of MDTF MTR countries

Figure A: Total population (MDTF review countries; Proportion of people living below the national poverty line (MDTF review countries, 2017); Per Capita GNI in 2017, and Annual GDP Growth in 2018 (MDTF review countries); Under 5 and neonatal mortality rates (MDTF review countries, 2017). Source: ADB Basic Statistics.



4.1 In-depth visits

The MTR involved three in-depth country reviews that allowed for more in-depth consultation with stakeholders inside and outside government, with development partners and with World Bank and DFAT staff. The visits³³ helped clarify the context within which the MDTF activities took place and provided commentary and views on the value of MDTF supported work, as part of the broader World Bank engagement. These reviews, together with a review of WB MDTF progress reports, have been used to summarize MDTF activities to date in these countries, to assess whether planned work is being completed, and to draw some conclusions on the extent to which activities are likely to contribute to the achievement of MDTF objectives. Following the in-depth reviews, we provide short summaries of activities in the other nine countries. Each country review starts with a graphic summary of key MDTF development, financial and programmatic objectives.

The table at the beginning of each country section presents the status (improving, worsening or no change since last measurement) for the key programmatic coverage and domestic resource mobilization (DRM) indicators, and also the World Bank assessed status of level of external financing 'on budget'. This latter is seen as an important milestone in enabling externally financed programs to be recognized and later financed through government. The tables also present a summary of the volume of work undertaken (MDTF activities, detailed in Annex 6), and a World Bank qualitative assessment of whether the country, at end of 2018, had in place an explicit strategy integrating donor funded programs within national systems.

³³ Summarised in three aides-memoire in Annex 4

10.2 Indonesia

Overview of MDTF-related activities in Indonesia

Strategy for integrating donor-funded programs in place “Ongoing”

MDTF-financed activities

- Commenced 31
- Completed 21 (68% of those commenced)

Table 3: Programmatic and Financing Achievements, Indonesia. Source: MDTF Annual Report to DFAT, 2018³⁴

	Program Coverage			Domestic Resource Mobilization % of total budget			% of on-budget external financing that is delivered through government systems		
	Year	%	Change as assessed by WB [‡]	Year	%	Change as assessed by WB [‡]	Year	%	Change as assessed by WB [‡]
ART	2017	14	↑	2016	1	↔	2016	46	↑
TB	2016	43	↔	2016	1	↔			
Malaria [*]	2016	32	↔	2016	1	↔			
DPT3 [†]	2016	74	↔	2016	90	↔			

Key ↑ Positive change; ↓ Negative change; ↔ No change/not updated; n/d = no data

[‡] Change as assessed by the World Bank; period of change unknown; data not independently verified

^{*} Percentage of people at high risk of malaria infection sleeping under an insecticide-treated bed net

[†] Percentage of districts with > 80% DPT3 coverage

10.2.1 Activity Summary

Pillar 1: Understanding of baselines, context and challenges

The MDTF work started in 2016 with the **Health Financing System Assessment (HFSA)** that provided a baseline assessment of trends in levels and composition of health financing, including analysis of OOP health spending, government budgetary expenditures, social health insurance expenditures, and external financing.

This was followed by a more detailed review of financing, service delivery, and governance assessments of immunisation, HIV, TB and Malaria services, including a **service delivery assessment** and a **Public Expenditure Tracking Survey (PETS)** to capture the size, flow, distribution, and health expenditures sourced from public and external donors on HIV, TB, malaria, and immunisation. These analyses identified the systemic challenges, inequities, and potential solutions for successful transition.

Pillar 2: Finding solutions to transition and to achieve UHC

The initial analyses provided a basis to design specific solutions with government, development partners and non-government agencies for a successful transition as part of the broader move to UHC. These included:

A National Health Sector Review (HSR)

Development partners in the sector worked together on the HSR. This included a funding landscape study covering financial need projections for implementing the four transitioning health programs, including costs of introducing new vaccines and identification of potential financial resources.

Strategic planning

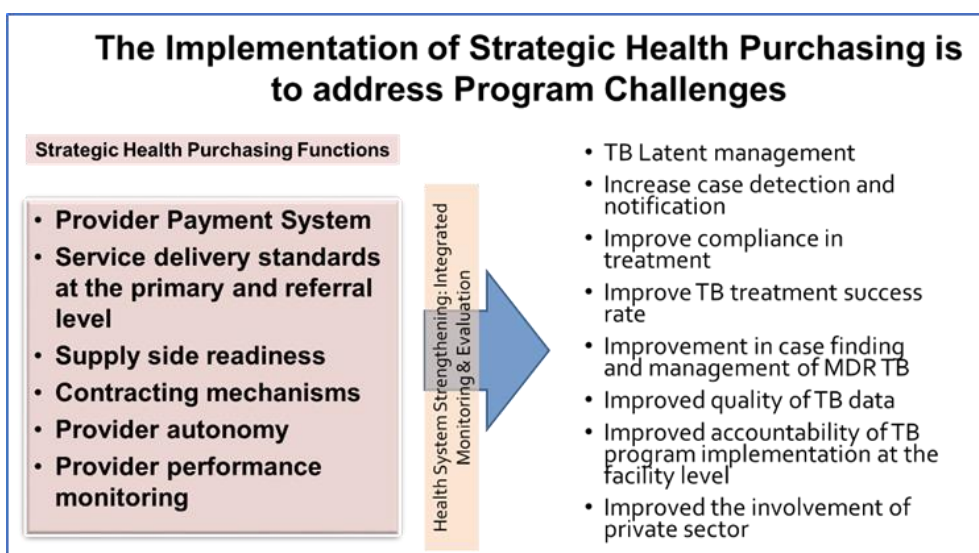
³⁴ Some figures taken from the 2018 Annual Report have been subsequently updated by the World Bank.

The World Bank agreed with the Ministry of Planning (Bappenas) that the issue of sustainability for externally funded health programs be a key topic in the development of the country's forthcoming Medium-Term Development Plan.

Strategic health purchasing

The problem of fragmented, inefficient, and poorly understood financing - both supply and demand side - is being resolved through the gradual introduction of strategic purchasing, with an initial focus on TB (see below, as presented by WB) and the sustainability of HIV, TB, Malaria and Immunisation programs. The strategic purchasing function will help federal and provincial governments define service requirements and develop provider payment mechanisms, as part of a package of services. TB was chosen as something of a pathfinder given its public health importance and the willingness of program leadership to engage in new activities.

Figure 15: Indonesia Strategic health purchasing for TB. Source: World Bank



Public Financial Management

The World Bank supported program-specific PET survey filled in information gaps on government financing for health at the sub national level. In a highly decentralized setting, the existing public financing reporting has not been able to collect budget allocation and expenditure, while almost 70% of it occurred at the province and district levels. The focus of the PET exercise was on the transitioning health programs (AIDS, TB, Malaria, and Immunisation (ATMI). A particular focus on TB aimed at improving quality of planning, budgeting, and program spending; it is too early to show impact, but there is good evidence from other countries that improved PFM leads higher quality, more efficient service delivery.

Fund channelling to CSOs (or 'Social contracting')

Ensuring the sustainability of CSO involvement in HIV, TB, malaria, and immunisation programs required specific work to identify required legislation, existing models of government-CSO partnership, and bottlenecks to be resolved such as capacity mapping, CSO registry development, CSO quality assurance, and strengthening of the accountability mechanisms.

Pillar 3: Building and sharing knowledge on transition across the region

Given the many similar challenges facing countries in the region, a series of events and task forces were used for policy makers and practitioners from across different institutions to share experiences on the transition of externally financed programs as part of their move to UHC. Interviews undertaken during the MTR consistently revealed that country participants found these events useful. Topics included:

- Financing for UHC: fiscal sustainability of health systems; public financial management; sustainable financing for UHC; Sustainable HIV Financing in Transition (SHIFT) – covering financing for CSOs and integration of HIV programs into national social health insurance programs;

- Efficiency in the Health Sector: Health Technology Assessment; Strategic Purchasing in a decentralized context; resilient systems for health security; and quality Primary Health Care.

Pillar 4: Introducing sustainable health system reform to achieve UHC

The World Bank has used the analysis, systems strengthening and knowledge work to design a USD 150 million project, co-funded with the Government of Indonesia, to help bring the required changes and improvements in essential service across the country. The ‘Indonesia Strengthening Primary Healthcare Reform’ (I-SPHERE) Project at the time of MTR had been approved and implemented for one year. Its objective is “strengthening governance, financing, and frontline service delivery to improve access to quality primary health care and nutrition services in priority districts”. The project is designed to bring together the various reforms in the health sector that will make the various transitions more likely to succeed, while also helping the Government ensure its combination of health financing and decentralization reforms are a success. Its design includes the use of performance-based financing, with independent verification, in ten areas including performance - through PHC capitation and performance dashboards; expansion of m-health and integrated referral health information systems; accreditation at district levels and central capacity; human resources in under-served areas; and quality of services.

Window 3: Strengthening health security

Work has started on the Health Security Financing Assessment, aiming to improve funding and respond to the gaps and problems identified in the Joint External Evaluation (JEE) mission in November 2017. The work will draw lessons from the Vietnam HSFA and will be supported by a national task force to support activities related to the health security financing assessment. Work is being carried out in close collaboration with WHO and will look specifically at bottlenecks for rapid fund release during outbreaks and epidemics potentially using TA supported by the MDTF.

Indonesia: Have MDTF outputs contributed to reaching MDTF objectives?

There has been a large amount of work undertaken in Indonesia through MDTF-funded support activities that has laid the groundwork for achieving the objectives in the country. The sheer size of the country and the relatively early stage of the health financing reforms means that it will take many years for the largely externally financed HIV, TB and malaria programs to be sustainably supported through domestic resources, although immunisation is in a better position. The MDTF-supported ‘deep dive’ analyses have provided essential information to inform policy, and the move to improve PFM and strategic purchasing of priority public health programs, starting with TB, and the work on funding of CSOs for HIV services are all moves in the right direction but are at an early stage. The new World Bank supported I-SPHERE project could reinforce a focus on essential public health programs and has the potential to transform health sector performance and accelerate the transition agenda.

10.3 Laos

Overview of MDTF-related activities in Laos

Strategy for integrating donor-funded programs in place Yes (HANSA project)

MDTF-financed activities

- Commenced 13
- Completed 3 (23% of those commenced)

Table 4: Programmatic and Financing Achievements, Laos. Source: MDTF Annual Report to DFAT, 2018

	Program Coverage %			Domestic Resource Mobilization % of total budget			% of on-budget external financing that is delivered through government systems		
	Year	%	Change as assessed by WB [‡]	Year	%	Change as assessed by WB [‡]	Year	%	Change as assessed by WB [‡]
ART	2017	47	↑	2016	2	↔	2016	32	↑
TB	2016	42	↑	2018	1	↑			
Malaria [*]	2017	82	↔	2016	1	↔			
DPT3 [‡]	2016	61	↔	2017	23	↓			

Key ↑ Positive change; ↓ Negative change; ↔ No change/not updated; n/d = no data

[‡] Change as assessed by the World Bank; period of change unknown; data not independently verified

^{*} Percentage of people at high risk of malaria infection sleeping under an insecticide-treated bed net

[‡] Percentage of districts with > 80% DPT3 coverage

10.3.1 Activity Summary

Pillar 1: Understanding of baselines, context and challenges

Health Financing Systems Assessment: This was prepared in 2016/2017 and set health financing in a historical and macro-fiscal context, and provided an overview of the health system, demographics, and population health outcomes. A ‘deep dive’ on immunisation analysed service availability and preparedness.

Global Fund transition: Most work to date has been under MDTF Window 2, focused on Gavi transition and immunisation. However, as a direct result of the positive influence that work has had, the Global Fund is now working with the WB through the MDTF. This will include a proposed HFSA ‘deep dive’ on TB and HIV to inform the integration of programs into primary care services and use of DLIs in the new HANSA project, following on from what is seen as a successful experience with Gavi and immunisation services, with financing through HGNDP.

World Bank and the Global Fund in Laos

“The Global Fund and the World Bank work closely in Laos which is good, and Global Fund is now planning to contribute 70% of its future funding into the upcoming WB support to the health sector. This will include a lot of TA and capacity building for Lao systems. The joint design is fairly new for Global Fund and it takes a lot of effort and is time-consuming, but feels it will be worth it with regards to planning for transition and sustainability, as it allows for building on synergy in WB and Global Fund work, reduces transaction costs and builds country ownership.”

Laos Global Fund Portfolio Manager

Pillar 2: Finding solutions to transition and to achieve UHC

Building efficiencies

To prepare for 2021 Gavi transition, the main MDTF achievements have been getting various strands of technical support underway aimed at integrating the EPI program with other primary care services. This included integrating immunisation and maternal child health outreach services, integrated information systems (using the DHIS2 web-based platform), and supportive supervision of health facilities. The work on integration in Laos illustrates how, through very most levels of investment, the MDTF is able to influence system-wide health systems strengthening in ways that would be unlikely through discrete small-scale projects.

Strengthening public financial management

Technical support aims to build capacity for planning and budgeting at sub-national level through on-the job training, mentoring support, and learning exchanges across districts and health centres.

Pillar 3: Building and sharing knowledge on transition across the region

Officials from MOF and MOH, have taken part in national, regional and global workshops and through the Joint Learning Network and the Prince Mahidol Award Conference - sharing lessons on health reforms, UHC and transition of externally financed programs.

Pillar 4: Introducing sustainable health system reform to achieve UHC

An additional financing of USD 4 million from the MDTF for the pre-existing Health Governance and Nutrition Development Project (HGNDP) helped increase immunisation coverage in the 50 lowest-performing districts. Independent verification of Disbursement Linked Indicators (DLIs) linked to routine immunisation tracked the increase in coverage and integrated outreach.

Building on the lessons gained from the HGNDP project, the new WB support to Laos (HANSA) will expand the use of DLIs to sustain and expand integration of immunisation, TB and HIV/AIDS services with co-financing from Gavi and the Global Fund, amongst others.

Window 3: Strengthening health security

Window 3 will start with a focus on a Health Security Financing Assessment, once lessons have been drawn from its use in other countries in the region. Preparatory work has been started in collaboration with WHO. The analytical work will be enhanced through the WB's access to MoF and the high number of sectors required to collaborate for effective health security. The WB experience on its 'convergence' of sectors for nutrition will be of particular use.

Laos: Have MDTF outputs contributed to reaching MDTF objectives?

There is a clear link between the introduction of the new DLIs for immunisation, brought about through MDTF support to the HGNDP, and the reported increase in district immunisation levels in the worst performing areas. Assuming data is available to confirm this effect, it can be directly attributed to MDTF. Other important groundwork analysis has informed the design of the next WB supported project (HANSA) that will expand the use of DLIs to other essential health services and to the roll out of broader reforms. The success of the work with Gavi and immunisation has led to Global Fund requesting similar involvement. The co-financing of the future HANSA with Global Fund/Gavi grant funds is innovative and provides a new model of integrated external financing that may be of use for transition in other countries. This shows the value of the MDTF in bring together analysis, technical support and investment all mutually supporting each other in Laos to enable Gavi transition whilst also strengthening the health system.

10.4 Papua New Guinea

Overview of MDTF-related activities in Papua New Guinea

Strategy for integrating donor-funded programs in place	No
MDTF-financed activities	
• Commenced	29
• Completed	13 (45% of those commenced)

Table 5: Programmatic and Financing Achievements, Papua New Guinea. Source: MDTF Annual Report to DFAT, 2018

	Program Coverage %			Domestic Resource Mobilization % of total budget			% of on-budget external financing that is delivered through government systems		
	Year	%	Change as assessed by WB [‡]	Year	%	Change as assessed by WB [‡]	Year	%	Change as assessed by WB [‡]
ART	2017	55	↑	2018	63	↑	2016	22	↑
TB	2017	74	↓	2018	37	↑			
Malaria [*]	2017	84	↓	2018	29	↑			
DPT3 [‡]	2017	12	↓	2018	62	↓			

Key ↑ Positive change; ↓ Negative change; ↔ No change/not updated; n/d = no data

[‡] Change as assessed by the World Bank; period of change unknown; data not independently verified

^{*} Percentage of people at high risk of malaria infection sleeping under an insecticide-treated bed net

[‡] Percentage of districts with > 80% DPT3 coverage

10.4.1 Activity Summary

Pillar 1: Understanding of baselines, context and challenges

Health Financial System Analysis

The HFSA focused on the financial and programmatic sustainability of externally-financed priority health programs within the broader context of health systems strengthening. This was followed by more detailed work on *immunisation transition*: supporting the development of the Gavi transition framework and a broader analysis of *health financing options*.

Health sector reviews

The review focused on lessons learned from the Health Sector Medium Term Development Plan (MTDP) 2011-2015 relevant to the financial and physical execution of the MTDP 2018-2022 as well as contributing to the PNG Health in Transition study. In a country in which development partner coordination has been challenging, interviews with national stakeholders confirmed the high value put on the collaborative effort that went into this review.

Pillar 2: Finding solutions to transition and to achieve UHC

PFM Technical Assistance & Training

The World Bank arranged for a sequence of short courses to be provided for government staff, with the aim of strengthening health sector expenditure analysis, and removing some of the capacity constraints and knowledge gaps around budget submission at NDOH. Support also covered building NDOH's capacity to produce quarterly reports on public health spending. Formal evaluations were not available at the time of the MTR.

Support to immunisation transition dialogue

The World Bank supported the development of a scoping report, providing an analysis of the challenges to be addressed, and a Gavi transition framework that informed the development of an immunisation financing sustainability report. The latter provided clear steps to be followed for a future, as yet unspecified, Gavi transition.

Health Financing Options Paper

In response to a Ministerial request, this assessed the feasibility of social health insurance and other alternative sources of revenue for the health sector, including private health insurance, concluding that such reforms were not feasible or sustainable in PNG.

Provincial Health Authorities

A considerable amount of support was focused on helping to establish the PHAs, including addressing bottlenecks in the flow of funds in and out of PHAs, analysing the drivers of performance comparing government- and church-run providers and assessing the quality and efficiency of outreach activities. Several tools and guidelines were developed for prioritization, use of an Integrated Financial Management System (at NDOH), expenditure monitoring, and performance tracking tools (e.g. performance scorecards, supervision checklists for province/district authorities, etc.). Mentoring and training plans for PHAs were developed, including enhanced Provincial Activity Implementation Plans (AIP) in selected provinces. The WB supported an updated map of donor funding (by province, by economic category), including technical assistance funded through donor funding.

Pillar 3: Building and sharing knowledge on transition across the region

Technical exchange and policy briefs:

This included a “technical breakfast series” to stimulate technical discussions around pressing issues by leveraging technical expertise from World Bank’s global experts; and policy briefs to disseminate key messages arising from the analytic work in an accessible and easy-to-read manner. Those interviewed commented on the utility of these discussions, in particular to assist the policy dialogue that accompanied the design of future WB support.

Regional knowledge sharing events:

GoPNG participated in a number of regional exchanges including PMAC Workshops on health financing, UHC, and integration of externally-financed health programs, and another on health security. They also attended the workshop in Siam Reap focusing on the donor transition agenda.

Support to health reform

The potential influence of the World Bank will be increased through Health IMPACT loan which, in turn, has been informed by activities financed by the MDTF. The introduction of a performance-based element, if designed well, could be of significant help in setting up new systems under the Provincial Health Authorities. Meaningful health reforms are now appearing which could be transformational provided sufficient resources are mobilized.

PNG: Have MDTF outputs contributed to reaching MDTF objectives?

The MDTF has provided support to essential analysis and to building foundational PFM capacity in government, but the country is only at a relatively early stage of setting up the sustainable provincial financing mechanisms which are needed to establish more stable, progressively expanding essential health services. The World Bank analyses have made clear the long road to transition, with a likely need for sustained external support in some areas such as immunisation for some time to come. The move to Provincial Health Authorities (PHA), supported in part through World Bank/MDTF support, and the start of the performance-based Health IMPACT project, with sub-national DLIs, has the potential to be transformative if PHAs have sufficient finance, capacity and leadership. The political and geographic context in PNG will however remain challenging.

11. Other Countries (not visited)

11.1 Cambodia

Overview of MDTF-related activities in Cambodia

<i>Strategy for integrating donor-funded programs in place</i>	Ongoing
<i>MDTF-financed activities</i>	
• Commenced	5
• Completed	0

Table 6: Programmatic and Financing Achievements, Cambodia. Source: MDTF Annual Report to DFAT, 2018.

	Program Coverage %			Domestic Resource Mobilization % of total budget			% of on-budget external financing that is delivered through government systems		
	Year	%	Change as assessed by WB [‡]	Year	%	Change as assessed by WB [‡]	Year	%	Change as assessed by WB [‡]
ART	2017	87	↑	2016	98	↔	2016	15	↑
TB	2016	62	↔	2018	12	↔			
Malaria[¶]	2017	100	↔	2016	n/d	n/d			
DPT3[‡]	2017	78	↓	2017	27	↓			

Key ↑ Positive change; ↓ Negative change; ↔ No change/not updated; n/d = no data

[‡] Change as assessed by the World Bank; period of change unknown; data not independently verified

[¶] Percentage of people at high risk of malaria infection sleeping under an insecticide-treated bed net

[‡] Percentage of districts with > 80% DPT3 coverage

The MDTF complements the knowledge work and operations already underway in the context of the World Bank project, Health Equity and Quality Improvement Project (H-EQIP) (2016-2021) which is co-financed by Australia, Germany and Korea. The level of MDTF activities has been limited compared to other Asian countries, but these have been strategic and influential. The HFSA, started in February 2018, has not yet been published but an extensive presentation is available, and the analysis has been used to inform the development of Pillar 4, the co-financing of the Cambodia Nutrition Project (CNP). The CNP includes specific actions to close gaps in routine immunisation. Policy makers have been participating in regional knowledge sharing events, supported by the MDTF and the country is a new member to the Joint Learning Network. While progress is being made on health financing, overall public expenditure on health is low, with high OOPs compared to other countries in the region (see also discussion of financing for health in Part 3). Government expenditure on TB, malaria and immunisation is low. A step towards financial and programmatic sustainability is being made with the upcoming change to making the Ministry of Finance the Principal Recipient for future grants (instead of NCHADS, the National Centre for HIV/AIDS, Dermatology and STIs).

11.2 Myanmar

Overview of MDTF-related activities in Myanmar

Strategy for integrating donor-funded programs in place	No
MDTF-financed activities	
• Commenced	9
• Completed	4 (44% of those commenced)

Table 7: Programmatic and Financing Achievements, Myanmar. Source: MDTF Annual Report to DFAT, 2018.

	Program Coverage %			Domestic Resource Mobilization % of total budget			% of on-budget external financing that is delivered through government systems		
	Year	%	Change as assessed by WB [‡]	Year	%	Change as assessed by WB [‡]	Year	%	Change as assessed by WB [‡]
ART	2017	66	↑	2013	8	↔	2016	18	↑
TB	2016	72	↔	2018	4	↓			
Malaria [*]	2016	100	↔	2015	10	↔			
DPT3 [‡]	2017	88	↔	2016	24	↑			

Key ↑ Positive change; ↓ Negative change; ↔ No change/not updated; n/d = no data

[‡] Change as assessed by the World Bank; period of change unknown; data not independently verified

^{*} Percentage of people at high risk of malaria infection sleeping under an insecticide-treated bed net

[‡] Percentage of districts with > 80% DPT3 coverage

The HFSA was published in 2018 and informed the completion of a new National Health Plan, in particular the development of a national health financing strategy. The process was participatory, but from the government side the group most involved is the National Health Plan Implementation and Monitoring Unit (NHIMU) and the Social Security Board, which does not guarantee wider ownership across the Ministry of Health and Sports. Nevertheless, facilitated workshops have focused on planning, resource mobilization, risk-pooling and strategic purchasing, with wide participation, including from Ethnic Health Organizations. The advantage offered by the World Bank is that it can leverage the involvement of their governance and financing specialists to take a detailed look at health. This is particularly evident in the first chapter of the report which looks at the financing context for health in Myanmar.

Health spending from domestic resources in Myanmar has increased significantly from a dramatically low base in 2011. However, in the last year or so it has dropped slightly – by 0.1 percent of GDP - as a result of poor budget execution, despite World Bank support for PFM work. There are multiple, interrelated challenges with regard to the overall PFM system. Townships' inability to absorb the increased budget allocations is one of the more noticeable symptoms of the PFM system.

Influence of the HFSA in Myanmar

Following a decrease in government spending on health the World Bank convened a meeting of the Ministry of Planning and Finance with Ministry of Health and Sports and the Ministry of Education (which faces similar challenges). The meeting was the first of its kind ever and the first time financial issues were discussed across these ministries. Already there have been changes in the way expenditure will be handled, that will facilitate financial flows.

The HFSA provides evidence on what is realistic for health financing in Myanmar. It also lays out options and requisite steps that the Government of Myanmar could consider taking if it wants to enact the financing reforms that are suggested in the NHP. Implementing a system of social health insurance in Myanmar is currently unrealistic. At the same time, PFM in the public sector as it presently exists precludes rapid progress in improving both quantity and quality of spend. Promoted by NHIMU, the alternative is to establish a semi-autonomous public body which would channel funds to townships, informed by assessed needs and an agreed benefit package. While this approach assumes that a new public institution will have the

capacity to carry out these functions, the supporters of this approach argue a) that this is a long-term goal, and b) that by creating an institution with a degree of separation from government, means it will be possible to bring together (through a common financing system) government- run facilities and ethnic health authorities that would otherwise be reluctant to conform to government authority.

The country has been participating in many of the regional knowledge exchanges supported by the MDTF. For Window 3 an orientation workshop, attended by representatives from all relevant ministries has been held on financing health security. The next step is for government to nominate a cross-sectoral task force to start work on the Health Security Financing Assessment.

11.3 Philippines

Overview of MDTF-related activities in the Philippines

<i>Strategy for integrating donor-funded programs in place</i>	No
<i>MDTF-financed activities</i>	
• Commenced	4
• Completed	0

Table 8: Programmatic and Financing Achievements, the Philippines. Source: MDTF Annual Report to DFAT, 2018.

	Program Coverage %			Domestic Resource Mobilization % of total budget			% of on-budget external financing that is delivered through government systems		
	Year	%	Change as assessed by WB [‡]	Year	%	Change as assessed by WB [‡]	Year	%	Change as assessed by WB [‡]
ART	2017	36	↑	2016	100	↔	2016	100	↔
TB	2016	58	↑	2018	37	↑			
Malaria[*]	2017	64	↓	2016	100	↔			
DPT3[‡]	2016	76	↔	2017	100	↑			

Key ↑ Positive change; ↓ Negative change; ↔ No change/not updated; n/d = no data

[‡] Change as assessed by the World Bank; period of change unknown; data not independently verified

^{*} Percentage of people at high risk of malaria infection sleeping under an insecticide-treated bed net

[‡] Percentage of districts with > 80% DPT3 coverage

The MDTF work has enabled the World Bank to better understand basic service delivery and financing as the country undertakes a series of major reforms on its Service Delivery Networks. This includes a proposed impact evaluation comparing public and private delivery of services. The MDTF support has been of particular relevance for the Autonomous Region in Muslim Mindanao (ARMM), which is undergoing a fundamental political transition. The HFSA is being completed and has been extensively used by the DOH-ARMM to inform the health budget and to provide insight into supply-side readiness in under-served parts of the country. The work has included surveys looking at access and coverage of immunisation services. Technical support has included 'vertical integration' - focusing on the integration of services and developing a diagnostic and readiness tool for looking at immunisation services. The HFSA analysis has similarly been used to inform dialogue with new leaders of other semi-autonomous provinces. The country still has very high out of pocket (OOP) expenditures and low levels of domestic financing for HIV and TB services. Future work under the MDTF will likely be driven by the recently passed UHC Bill that includes a commitment to expanded health insurance, strengthening the Service Delivery Networks and strengthening population-based health services.

11.4 Vietnam

Overview of MDTF-related activities in Vietnam

Strategy for integrating donor-funded programs in place	No
MDTF-financed activities	
• Commenced	6
• Completed	5 (83% of those commenced)

Table 9: Programmatic and Financing Achievements, Vietnam. Source: MDTF Annual Report to DFAT, 2018.

	Program Coverage %			Domestic Resource Mobilization % of total budget			% of on-budget external financing that is delivered through government systems		
	Year	%	Change as assessed by WB [‡]	Year	%	Change as assessed by WB [‡]	Year	%	Change as assessed by WB [‡]
ART	2017	50	↑	2013	18	↔	2016	81	↑
TB	2016	81	↑	2018	11	↔			
Malaria [*]	2017	45	↑	n/d	n/d	n/d			
DPT3 [‡]	2017	95	↓	2017	64	↑			

Key ↑ Positive change; ↓ Negative change; ↔ No change/not updated; n/d = no data

[‡] Change as assessed by the World Bank; period of change unknown; data not independently verified

^{*} Percentage of people at high risk of malaria infection sleeping under an insecticide-treated bed net

[‡] Percentage of districts with > 80% DPT3 coverage

Vietnam has seen major improvements in health outcomes in recent years, but still has major inequities with low quality services in poorer and more remote areas. The country faces major fiscal challenges, with high levels of debt and a relatively large share of public expenditure already going to health. MDTF funds allocated to Vietnam are currently fully used; if more funds were available it could be used to provide analytical support on fiscal and financial sustainability in health, as well as monitoring and accountability.

To date the MDTF has helped expand World Bank work in a number of areas. Health financing systems and fiscal space analysis has included an assessment of key issues for priority program transition. The work is being coordinated with and disseminated by WHO, as part of their own work on transition for HIV, TB, malaria and immunisation.

The MDTF is co-financing the recently approved WB Project '*Investing and Innovating for grassroots health service delivery*' with a USD 5m grant. In Vietnam, government policy does not allow loan funds to be used to finance recurrent costs so the MDTF contribution increases the effectiveness of the project by funding training and testing service delivery innovations. Vietnam and Laos are the two countries where MDTF funds are being used to co-finance World Bank loans in the absence of any DFAT bilateral investment. In both cases the MDTF contribution serves a specific developmental purpose (in Laos to extend immunisation coverage, in Vietnam to finance training etc.). In neither case are grants being used as a way of reducing the cost of borrowing. In Vietnam, the Global Financing Facility (GFF) is providing USD 17m in grant funds specifically to lower loan costs, and another Trust Fund (financed by a group of pharmaceutical companies) is providing an additional USD 3m. The grant money has been seen as being instrumental in increasing the chance of the loan being effective in delivering on its objectives.

The design did not include an RBF component despite suggestions from the WB that this would be useful to monitor results to inform disbursements (through DLIs).. The MDTF contribution, as in Laos, is to a Bank project in a country with no bilateral DFAT investment, which can be seen as an efficient way of reaching DFAT Foreign Policy objectives, and a sign of support for the multilateral system.

The MDTF has also supported work on Primary Care Scorecards, at national and provincial level, to help strengthen oversight of ‘grassroot’ services, helped by a collaboration with the World Bank’s PHC Performance Initiative, funded by the Bill & Melinda Gates Foundation.

The methodology for the first Health Security Financing Assessment (HSFA) was piloted in Vietnam and has been overseen by a regional multi-country Task Force. The draft HSFA report is now available. Much has been learnt from the analysis of national and provincial expenditures and the WB and government stakeholders are now developing a slimmed down, more qualitative methodology that looks at the policy issues and constraints from past JEE exercises.

11.5 Kiribati

Overview of MDTF-related activities in Kiribati

<i>Strategy for integrating donor-funded programs in place</i>	“Ongoing”
<i>MDTF-financed activities</i>	
• Commenced	8
• Completed	1 (13% of those commenced)

Table 10: Programmatic and Financing Achievements, Kiribati. Source: MDTF Annual Report to DFAT, 2018.

	Program Coverage %			Domestic Resource Mobilization % of total budget			% of on-budget external financing that is delivered through government systems		
	Year	%	Change as assessed by WB [‡]	Year	%	Change as assessed by WB [‡]	Year	%	Change as assessed by WB [‡]
ART	n/d	n/d	n/d	2016	100	↑	2017	66	↓
TB	2017	80	↔	2017	0	↔			
Malaria[‡]	n/d	n/d	n/d	n/d	n/d	n/d			
DPT3[‡]	2017	100	↑	2017	59	↑			

Key ↑ Positive change; ↓ Negative change; ↔ No change/not updated; n/d = no data

[‡] Change as assessed by the World Bank; period of change unknown; data not independently verified

[‡] Percentage of people at high risk of malaria infection sleeping under an insecticide-treated bed net

[‡] Percentage of districts with > 80% DPT3 coverage

Key challenges for Kiribati: a small population (120,000) in a vast area with no economies of scale. Health is particularly problematic because external support is so fragmented.

An extensive program of support has been delivered in Kiribati, including a Health Financing note and the HFSA, which was completed in 2018, both of which informed budget discussions and the definition of priorities for WB support in the 2018-2022 PASA. Work also included reports on annual expenditure trends covering TB, HIV and immunisation programs, and assisting the MHMS develop its Transition Plan for graduation of donor financed health programs (Global Fund etc.). Technical support has been delivered in a wide number of areas including health facility costing, improving efficiency and equity through resource allocations, and assisting the preparation of reports on ‘pressures’ on national health finances, service delivery/out-patients and referral, and integration and capacity building of financial management systems. The government has participated in regional knowledge sharing workshops on health financing, transition and health security. The country has high levels of ill-health, in particular NCDs, considering its relative wealth. The HFSA put this down to difficult geographic, environmental and social determinants that require a strong collaboration across sectors if this is to be addressed. These challenges mean that World Bank assistance continues to be in demand in areas such as PFM, resource allocation, and inputs to infrastructure and health workforce planning.

Interview with senior planner, Kiribati

“NEPO provides guidance on budget preparation, indicative allocations and medium-term projections. Capacity in the Ministry of Health and Medical Services is thin and overstretched. The demands of multiple donors all focusing on their own projects makes the problem infinitely worse – diverting capacity from strengthening core systems. The UN agencies compound this issue, with accounting demands for a large number of small-value individual projects. The 2019 development budget list all line item projects receiving donor support – WHO has 51 separate projects (UNFPA is similarly prominent)³⁵. Progress on getting fewer, larger allocations and thus being able to concentrate on strengthening core government systems has been slow and donors have not been particularly cooperative.

WB policy advice has been useful. The analytic work has started to show where funds are being spent, developing spread sheets that can be discussed by health officials. Hopefully this will result in better and more rational decisions and better allocation of resources.”

11.6 Samoa

Overview of MDTF-related activities in Samoa

Strategy for integrating donor-funded programs in place	No
MDTF-financed activities	1
• Commenced	0 (0% of those commenced)
• Completed	

Table 11: Programmatic and Financing Achievements, Samoa. Source: MDTF Annual Report to DFAT, 2018.

	Program Coverage %			Domestic Resource Mobilization % of total budget			% of on-budget external financing that is delivered through government systems		
	Year	%	Change as assessed by WB [‡]	Year	%	Change as assessed by WB [‡]	Year	%	Change as assessed by WB [‡]
ART	n/d	n/d	n/d	2016	100	↔	2016	41	↔
TB	2017	87	↔	n/d	n/d	n/d			
Malaria [*]	n/d	n/d	n/d	n/d	n/d	n/d			
DPT3 [‡]	2017	40	↔	n/d	n/d	n/d			

Key ↑ Positive change; ↓ Negative change; ↔ No change/not updated; n/d = no data

[‡] Change as assessed by the World Bank; period of change unknown; data not independently verified

^{*} Percentage of people at high risk of malaria infection sleeping under an insecticide-treated bed net

[‡] Percentage of districts with > 80% DPT3 coverage

The only work underway is in preparation for the World Bank’s support to the Government of Samoa’s efforts in strengthening primary health care with a focus on NCD management, through the preparation of a USD 10 million health system strengthening investment operation (see also box on gender in Samoa in Part 3). This has included in late 2018 an ongoing annual expenditure and trend analysis focused on TB, HIV, immunisation and NCDs, and an assessment of NCD taxation policies in Samoa.

³⁵ <http://www.mfed.gov.ki/sites/default/files/Development%20Budget%202019.pdf>

11.7 Solomon Islands

Overview of MDTF-related activities in the Solomon Islands

Strategy for integrating donor-funded programs in place	“Ongoing”
MDTF-financed activities	
• Commenced	15
• Completed	5 (33% of those commenced)

Table 12: Programmatic and Financing Achievements, Solomon Islands. Source: MDTF Annual Report to DFAT, 2018.

	Program Coverage %			Domestic Resource Mobilization % of total budget			% of on-budget external financing that is delivered through government systems		
	Year	%	Change as assessed by WB [‡]	Year	%	Change as assessed by WB [‡]	Year	%	Change as assessed by WB [‡]
ART	n/d	n/d	n/d	2017	94	↓	2019	59	↓
TB	2017	80	↔	2017	12	↔			
Malaria [‡]	2017	100	↑	2017	43	↑			
DPT3 [‡]	2017	30	↓	2017	44	↑			

Key ↑ Positive change; ↓ Negative change; ↔ No change/not updated; n/d = no data

[‡] Change as assessed by the World Bank; period of change unknown; data not independently verified

[‡] Percentage of people at high risk of malaria infection sleeping under an insecticide-treated bed net

[‡] Percentage of districts with > 80% DPT3 coverage

The health financing situation in the Solomon Islands is challenging with low economic growth, decreasing donor contributions, increasing population numbers and increases in health care costs, not least as a result of NCDs. The MDTF supported work has been extensive, mostly co-financed using funds from the PF4 Trust Fund, also DFAT financed and managed by the World Bank. The HFSA was completed in 2018 and the World Bank team have documented its influence in a number of PFM areas: (i) improved PFM support to provinces; (ii) identification of unspent funds from Global Fund Cash on Delivery (COD) disbursements for National Vector Borne Disease Control Program (NVBDCP), and the Tuberculosis (TB)/Leprosy and the HIV/Sexually Transmitted Infections (STI) national programs; (iii) improved national/provincial linkages resulting in improved service delivery for the malaria program; and (iv) a comprehensive review of the 2019 planning and national MJMS budgeting process. The HFSA was not explicitly used for some time, but with new MHMS leadership there is now a real appetite for using analytic products from the World Bank. Technical support has been provided in a large number of areas, much of which is still ongoing and linked to the ‘Role Delineation Policy’ which has taken several years to develop. Support for PFM enables better oversight and more integration of priorities, annual operational plans and budgets, getting development partners ‘on plan and on budget’ through the newly established Partnership Co-ordination Unit (PCU), building a better understanding of what that means and implications of being on or off system, and assisting annual expenditure and trend analysis, including for malaria, TB and HIV programs. Regular workshops focus on sustainable health financing, highlighting the transition issues. Government staff have also participated in regional work-shops on health security. There is widespread awareness about future graduation from Gavi support and broader changes in external financing, and MHMS has been involved in a 5-year transition plan.

MDTF in the Solomon Islands

“The plan [the World Bank MDTF team] presented did not always reflect our priorities, but there are things that have been very useful, such as support for the practical aspects of planning and budgeting. This is much more operational. Senior managers are now much more aware of budgets and ceilings.... They understand that service planning should be based on health needs and information....before it was just a shopping list”. *Senior official, MHMS*

11.8 Tonga

Overview of MDTF-related activities in Tonga

Strategy for integrating donor-funded programs in place No

MDTF-financed activities

- Commenced 3
- Completed 0 (0% of those commenced)

Table 13: Programmatic and Financing Achievements, Tonga. Source: MDTF Annual Report to DFAT, 2018.

	Program Coverage %			Domestic Resource Mobilization % of total budget			% of on-budget external financing that is delivered through government systems		
	Year	%	Change as assessed by WB [‡]	Year	%	Change as assessed by WB [‡]	Year	%	Change as assessed by WB [‡]
ART	n/d	n/d	n/d	2016	100	↑	2016	19	↔
TB	2017	87	↔	n/d	n/d	n/d			
Malaria [*]	n/d	n/d	n/d	n/d	n/d	n/d			
DPT3 [‡]	n/d	n/d	n/d	2017	90	↔			

Key ↑ Positive change; ↓ Negative change; ↔ No change/not updated; n/d = no data

[‡] Change as assessed by the World Bank; period of change unknown; data not independently verified

^{*} Percentage of people at high risk of malaria infection sleeping under an insecticide-treated bed net

[‡] Percentage of districts with > 80% DPT3 coverage

The MDTF work only started in Tonga in 2018, but the World Bank report a significant level of activity on core PFM capabilities and the team works closely with in-country DFAT expertise. This includes working with the MoH Finance Unit in a number of areas including: an annual expenditure and trend analysis; national workshop on sustainable health financing titled ‘Rolling out the Essential Package of Health Service in the Health Financing Context of Tonga’; and the launch of a health facility costing exercise. There has been technical support in a number of areas including sustainable health financing; reporting requirements for development partners; a functional analysis of MoH Financing Unit; and work to address the problems of overuse of central referral hospital and under-utilisation of peripheral facilities through a costing and benchmarking exercise. The Tonga Package of Essential Health Services (PEHS) aims to address this challenge (amongst other things) and will help MOH look at resource use to inform any changes MOH might wish to implement. Tonga has a relatively high spend in health, with significant domestic resources dedicated to health, but with relatively high levels of poverty. However, the main challenge in Tonga is low capacity - MoH has 1000 posts but over 100 vacancies and all sectors are competing for limited talent. This arises from the lack of workforce planning, and lack of performance management. Compared to other countries in the Pacific where the World Bank work, Tonga has a very highly educated workforce.

The MDTF in Tonga

“Sometimes [the WB] push too hard, but they listen and understand our constraints...” *Senior MHMS Official*

“Financing in Tonga is very centralised, and we had no idea what we spent our health budget on. The World Bank have been very helpful on this. Things are still far from perfect and we have much more work to do, but we now know how much it costs to treat a woman who presents with diabetes.....We have also started to look at quality and outcomes so we can start to think about cost-effectiveness.”

MHMS, Hospital Superintendent.

11.9 Vanuatu

Overview of MDTF-related activities in Vanuatu

Strategy for integrating donor-funded programs in place “Ongoing”

MDTF-financed activities

- Commenced 13
- Completed 3 (23% of those commenced)

Table 14: Programmatic and Financing Achievements, Vanuatu. Source: MDTF Annual Report to DFAT, 2018.

	Program Coverage %			Domestic Resource Mobilization % of total budget			% of on-budget external financing that is delivered through government systems		
	Year	%	Change as assessed by WB [‡]	Year	%	Change as assessed by WB [‡]	Year	%	Change as assessed by WB [‡]
ART	n/d	n/d	n/d	2016	27	↓	2017	92	↑
TB	2017	65	↔	2018	36	↑			
Malaria [*]	2017	100	↔	2018	36	↑			
DPT3 [†]	2017	67	↑	2017	48	↑			

Key ↑ Positive change; ↓ Negative change; ↔ No change/not updated; n/d = no data

[‡] Change as assessed by the World Bank; period of change unknown; data not independently verified

^{*} Percentage of people at high risk of malaria infection sleeping under an insecticide-treated bed net

[†] Percentage of districts with > 80% DPT3 coverage

The MDTF, together with funds from the PF4, have supported a large program of World Bank support. A ‘limited progress’ finding at the review in 2017 resulted in a smaller, more targeted program of work for 2018 and 2019 to ensure that the World Bank was providing support in areas that were gaining traction within the Ministry. The HFSA was completed in 2018, together with a health facility costing study, and the World Bank team report that analytical work “continued to stimulate discussion” on various PFM matters including allocation of resources, costs of services and funding gaps in rural areas. This led to an increased allocation of funding for community health services in 2019. A Medium-Term Expenditure Pressures Note was also completed in 2018, highlighting many of the transition issues and graduation from the Global Fund. The country has never had Gavi support but is now getting USD 11 million (with a USD 2 million loan) from ADB to introduce HPV, PCV, RV vaccines and a DFAT continuing partnership with UNICEF for vaccines purchase and systems support. Technical support has been provided in a number of areas including: support to provincial management teams, integrated plans and budgets, ongoing work on the costing of core health services at different levels, improving efficiency and quality of expenditure in high cost centres, annual expenditure and trend analysis and development of annual business plans and budgets. The aim has been to support the use of health information and financial information to inform the health sector budget and priorities

The MDTF in Vanuatu

“World Bank support is hugely valuable and complements the bilateral program....The fundamental problem is that there is no clear idea as to what is being spent where. The work on costing and support for planning and budgeting thus provides a starting point for rational decision making.”

DFAT First Secretary

“On a recent visit we found colleagues from the MHMS celebrating after presenting the health budget to Parliament. Not only had the budget passed without any problems, but they had been complemented for making the best presentation of any sector.”

World Bank program manager

12. Annex 6: MDTF Activity Tables

Table A MDTF Activities³⁶ – by year started and level of completion

Activities by Year					Completion			
Row Labels	2016	2017	2018	Grand Total	?	No	Yes	%
Cambodia		5		5		5		0%
Indonesia	11	12	8	31	2	8	21	68%
Kiribati	1		7	8	2	5	1	13%
Lao PDR	3	8	2	13		10	3	23%
Myanmar	1	4	4	9	1	4	4	44%
Phillipines	1	3		4	1	3		0%
PNG	8	6	15	29	3	13	13	45%
Regional		15		15	2	8	5	33%
Samoa			1	1	1			0%
Solomon Is	7	3	5	15	4	6	5	33%
Tonga			3	3		3		0%
Vanuatu	5	3	5	13	6	4	3	23%
Vietnam	1	5		6		1	5	83%
Grand Total	38	64	50	152	22	70	60	39%

Table B MDTF activities completed - by Window

Activities completed By Window					%
Row Labels	?	No	Yes	Grand Total	Completed
1 + 2	2	8	17	27	63%
1 ATM	16	32	22	70	31%
2 Imm	3	22	11	36	31%
3 HS	2	12	5	19	26%
Grand Total	23	74	55	152	36%

Table C MDTF Activities - by Intermediary Objective Process Indicator

MDTF Intermediary Objectives - Process Indicators	Process Indicators	%
1.1DF Government expenditure informed	31	20%
1.2DF Availability of health security financing assessment tool	2	1%
1.3DF Country conducted HSFA	4	3%
2.1PS Government policy/ strategy	22	14%
2.2PS Development community/ partner policy/ strategy informed	7	5%
2.3PS Country developed and /or updated P_P plan to improve health security	3	2%
3.1CC Design capacity strengthened	5	3%
3.2CC Implementation capacity strengthened	28	18%
3.3CC Monitoring and evaluation capacity strengthened	13	9%
4.1KD Facilitated exchange of best practice with clients	23	15%
4.3KD Disseminated best practices	3	2%
4.4KD Number of regional fora to promote sustainable health security financing	3	2%
5.1IA New innovative approach fostered	2	1%
5.2IA New innovative approach developed	6	4%
Grand Total	152	100%

³⁶ The description of activities in the progress reports sometimes changed, so it was not always possible to assess if they were completed (represented as '?' in the tables).

Table D MDTF Activities - by Country and Intermediary Objective Process Indicator

MDTF Intermediate Objectives (IO) - Process Indicators Countries and IO indicators	Complete?			Grand Total	% complete
	?	No	Yes		
Cambodia		5		5	0%
1.1DF Government expenditure informed		1		1	
1.3DF Country conducted HSFA		1		1	
3.2CC Implementation capacity strengthened		1		1	
4.1KD Facilitated exchange of best practice with clients		1		1	
5.2IA New innovative approach developed		1		1	
Indonesia	2	8	21	31	68%
1.1DF Government expenditure informed		3	4	7	
1.2DF Availability of health security financing assessment tool			1	1	
2.1PS Government policy/ strategy		2	4	6	
3.1CC Design capacity strengthened		1	1	2	
3.2CC Implementation capacity strengthened		2		2	
4.1KD Facilitated exchange of best practice with clients	1		11	12	
5.2IA New innovative approach developed	1			1	
Kiribati	2	5	1	8	13%
1.1DF Government expenditure informed		3	1	4	
2.1PS Government policy/ strategy	2			2	
3.2CC Implementation capacity strengthened		1		1	
3.3CC Monitoring and evaluation capacity strengthened		1		1	
Laos		10	3	13	23%
1.1DF Government expenditure informed		1	2	3	
1.3DF Country conducted HSFA		1		1	
3.2CC Implementation capacity strengthened		4		4	
3.3CC Monitoring and evaluation capacity strengthened		1		1	
4.1KD Facilitated exchange of best practice with clients		1	1	2	
5.1IA New innovative approach fostered		1		1	
5.2IA New innovative approach developed		1		1	

MDTF Intermediate Objectives (IO) - Process Indicators Countries and IO indicators	Complete?			Grand Total	% complete
	?	No	Yes		
Myanmar	1	4	4	9	44%
1.1DF Government expenditure informed			1	1	
2.1PS Government policy/ strategy		1		1	
2.3PS Country developed and /or updated P_P plan to improve health security		1		1	
3.2CC Implementation capacity strengthened		2	1	3	
4.1KD Facilitated exchange of best practice with clients			2	2	
5.1IA New innovative approach fostered	1			1	
Philippines	1	3		4	0%
1.1DF Government expenditure informed		1		1	
3.1CC Design capacity strengthened	1			1	
3.2CC Implementation capacity strengthened		1		1	
3.3CC Monitoring and evaluation capacity strengthened		1		1	
PNG	3	13	13	29	45%
1.1DF Government expenditure informed		1	3	4	
2.1PS Government policy/ strategy	2	2	2	6	
2.2PS Development community/ partner policy/ strategy informed		1	1	2	
3.1CC Design capacity strengthened			1	1	
3.2CC Implementation capacity strengthened		5	2	7	
3.3CC Monitoring and evaluation capacity strengthened	1	3		4	
4.1KD Facilitated exchange of best practice with clients		1	2	3	
4.3KD Disseminated best practices			2	2	
Regional	2	8	5	15	33%
1.2DF Availability of health security financing assessment tool			1	1	
1.3DF Country conducted HSFA	1			1	
2.1PS Government policy/ strategy		1		1	
2.2PS Development community/ partner policy/ strategy informed		3		3	
2.3PS Country developed and /or updated P_P plan to improve health security		1	1	2	
3.2CC Implementation capacity strengthened		1		1	

MDTF Intermediate Objectives (IO) - Process Indicators Countries and IO indicators	Complete?			Grand Total	% complete
	?	No	Yes		
4.1KD Facilitated exchange of best practice with clients	1	1		2	
4.3KD Disseminated best practices		1		1	
4.4KD Number of regional fora to promote sustainable health security financing			3	3	
Samoa	1			1	0%
3.1CC Design capacity strengthened	1			1	
Solomon Is	4	6	5	15	33%
1.1DF Government expenditure informed		2	2	4	
2.1PS Government policy/ strategy	1		2	3	
2.2PS Development community/ partner policy/ strategy informed			1	1	
3.2CC Implementation capacity strengthened	1	3		4	
3.3CC Monitoring and evaluation capacity strengthened	2	1		3	
Tonga		3		3	0%
3.2CC Implementation capacity strengthened		3		3	
Vanuatu	6	4	3	13	23%
1.1DF Government expenditure informed	2	2	2	6	
2.1PS Government policy/ strategy		2	1	3	
2.2PS Development community/ partner policy/ strategy informed	1			1	
3.2CC Implementation capacity strengthened	1			1	
3.3CC Monitoring and evaluation capacity strengthened	2			2	
Vietnam		1	5	6	83%
1.3DF Country conducted HSFA		1		1	
3.3CC Monitoring and evaluation capacity strengthened			1	1	
4.1KD Facilitated exchange of best practice with clients			1	1	
5.1IA New innovative approach fostered			2	2	
5.2IA New innovative approach developed			1	1	
Grand Total	22	70	60	152	39%

13. Annex 7: Gender equality and social inclusion analyses – Laos and Cambodia

a) Gender Equality and Social Inclusion Review of the Multi-Donor Trust Fund for Integrating Donor Financed Health Programs in Laos

Key messages

- Gender analysis is overwhelmingly absent from the Health Financing System Assessment (HFSA) and the policy and practice linkages between gender inequality and Universal Health Care are not made.
- The HFSA presents the poor, ethnic minorities and remote populations as the most vulnerable populations without analysis of the intersection with gender and disability and other domains of social exclusion.
- The HFSA's lack of attention to gender inequality on both the supply and demand side means that the assessment of systems and service gaps fail to join the gender dots and weakens the overall analytical quality of the report. It is not gender informed.
- Design of the Health Governance and Nutrition Development Project (HGNDP) includes gender and social inclusion analysis, the intention to strengthen gender data, achieve and track gender results. It is gender informed.
- The Aide Memoire of the Mid Term Review of HGNDP does not provide evidence that the comprehensive gender intentions of the project are being implemented. The focus on improving health and nutrition outcomes of women and children remains but the necessary gender and inclusion awareness and analysis to achieve gender informed systems strengthening and gender responsive social and behaviour change communications is not conveyed by the Aide Memoire.
- The DLI approach in HGNDP to strengthen service delivery may be rewarding capacitated and better resourced provinces and increasing the equity gap of more disadvantaged provinces where system bottlenecks hinder achievement of DLI targets.

Introduction

1. This note presents the findings of a mini review of how implementation of the Multi-Donor Trust Fund for Integrating Donor Financed Health Programs (referred to as the MDTF) in Laos is addressing gender equality and social inclusion (GESI). It is based on a review of the Health Financing System Assessment (2017) as an example of a Pillar I product and the Mid Term Review of the Health Governance and Nutrition Development Project (HGNDP) as an example of a Pillar IV activity. The following World Bank documents were reviewed:
 - Managing Transition. Reaching the Vulnerable while Pursuing Universal Health Coverage. Health Financing System Assessment. December 2017.
 - Project Appraisal Document. Health Governance and Nutrition Development Project. June 2015.
 - Health Governance and Nutrition Development Project. Mid-Term Review Aide-Memoire. November 2018.
 - World Bank Country Gender Action Plan for Lao People's Democratic Republic 2017-2021.

Managing Transition. Reaching the Vulnerable while Pursuing Universal Health Coverage. Health Financing System Assessment (HFSA)

Country context

2. Overall, the HFSA gives very little attention to gender in the report. Gender is mentioned as a gap in setting out the country context but without depth or discussion. The report doesn't explain how gender norms or gender-related barriers play out to impact women's and men's health outcomes or utilization of health services in either Laos broadly or for specific population groups such as disadvantaged ethnic minority groups. The lack of depth given to gender inequality in setting the context means that the paper does not make the connection between gender and the pursuit of Universal Health Coverage (UHC) and this gap in the framing of the paper continues through into analysis and recommendations. This is in contrast to the more rigorous conceptual and evidence-based analysis of gender included in the Project Appraisal

Document (PAD) of the Health Governance and Nutrition Development Project (HGNDP) and the World Bank Country Gender Action Plan (CGAP) which make a strong argument for prioritising reproductive and maternal health and nutrition and link this to national development plans and the SDGs.

3. Health inequities in the country by geographical area (province), poverty and ethnic group receive more detailed discussion and this is a recurring theme in the report. The message is that the vulnerable groups to be reached are the poor, the geographically remote and ethnic minority groups. The lack of discussion of the vulnerabilities of women and girls means they are not explicitly defined as a vulnerable population although the unfinished MDG health agenda is very much addressing women's specific health problems. There is no mention in the report of the special needs of persons with disabilities and very limited discussion of the intersection of social exclusion.

Sex disaggregated data

4. There is an absence of sex disaggregated data in the entire report including for indicators related to child health, outpatient utilization, burden of disease data. The Lao Social Indicator Surveys (LSIS) 2012 and 2017 include data disaggregated by sex, province, wealth quintile, ethno-linguistic group and mother's education. Reporting sex disaggregated data whenever available for key indicators is a minimum expectation. It is strongly advocated by the UN in monitoring the Sustainable Development Goals (SDGs) and included in the DFAT and World Bank Guidance Note on Gender Considerations for the MDTF.

Health system

5. Discussion of the health system is presented with very limited reference to gender. The report mentions the Government's Health Personnel Development Strategy 2010-20 which includes commitment to equity and equality of opportunity and strategies to include a mix of persons in recruitment and training representing among others different genders, ethnicity and age groups. However, the HFSA provides no data on the gender breakdown of the health workforce or village health workers. The report mentions the functioning of the Health Personnel Information System but does not state whether this includes sex and other social indicators such as ethno-linguistic group. Gendered workplaces practices and the influence of cultural norms and attitudes on the roles defined as appropriate for women and men respectively, including undertaking outreach visits to remote areas, are not discussed though this is likely to impact service delivery. The report is silent on the barriers that women face progressing into leadership positions in the health system though the ADB and World Bank Country Gender Assessment (2012) note that women face greater challenges in moving into decision making positions especially at sub-national level.

Health financing

6. Analysis of government spending on health per capita picks up the thread of geographical (provincial) inequities with large variation in provincial government spending on health. Discussion of social health insurance schemes including Health Equity Funds lend themselves to analysis of how they protect the poor from out of pocket payments. There is however no analysis of how they have benefitted women and men differently though the Free Maternal and Child Health Program has the obvious intention of protecting pregnant women. Similarly, in discussion on out of pocket spending the report lacks a gender lens and does not make the connection between women's lack of control over household resources and decision-making on health care, out of pocket spending and women's and children's health access.

Immunisation assessment

7. The report refers to large disparities in child mortality by socio-economic status, provinces, ethnicity and mother's education. It does not mention or provide information on child mortality by sex though this is available in LSIS 2017 and 2012; child mortality indicators are lower for girls than boys.

8. The HFSA states “A gender gap in immunisation coverage could exist and can be a potential source of concern; however, the current immunisation data is not gender disaggregated. Gender differences, therefore, cannot be assessed.” [page 107]. This statement is a good example of how gender is dismissed in the report. While government data may not disaggregate by sex/gender, the LSIS does and one would expect the HFSA to draw on this source to note how gender does not seem to be a differentiating factor in immunisation coverage at the national level; more detailed analysis would be required to assess if gender is a barrier for specific target populations. The quote noted above raises the question of whether DHIS2 includes sex disaggregated data so that this can be reported on in future but the HFSA does not answer or speak to this obvious systems gap.
9. The failure to join the gender dots comes out strongly in discussion of immunisation service delivery where the possible gender barriers for female staff to undertake outreach in remote areas (for example availability of transport, agency to travel and overnight in remote villages, security concerns, cultural norms, family-child care responsibilities) are not mentioned and this seems to be a serious gap in the analysis. Discussion of the introduction of HPV in the report as a springboard to discuss adolescent girl’s health and connect this to poor maternal and child health outcomes is not grasped though the report does note that this target group currently receives little attention from health services.
10. In contrast to the lack of attention to gender norms and the barriers that women face in accessing health services, the cultural and demand-side barriers faced by ethnic minorities and other underserved populations is more clearly spelled out in this chapter. The latter draws on work by UNICEF’s equity and bottleneck analysis and various pieces of research. Disappointingly, the intersection of gender, ethnicity and poverty are missing from the report’s analysis of immunisation coverage and socio-cultural factors related to language and communication are absent from the report’s recommendations for strengthening the immunisation program.

Report recommendations

11. Given the dismissive approach to gender in the analytical sections of the report, it is not surprising that gender is absent in the report’s recommendations. The recommendations also shift the focus from ethnic minorities, remote communities and the broader poor as the most vulnerable populations to the more generic language of ‘the poor and vulnerable’ and in places this section of the report seems disconnected to the analysis in the main part of the document.

Health Governance and Nutrition Development Program

12. The HGNDP Project Appraisal Document (PAD) (2015) includes a robust analysis of sectoral issues, health and nutrition inequities and explicitly explains how the project will contribute to gender equality through improved health and nutrition outcomes, through gender responsiveness in service delivery, in recruitment and training of women from non-Lao-Tai ethnic groups, in interaction with women’s groups and by involving men in family health. The PAD also states that health planning will be based on sex-disaggregated data and that the project’s support to DHIS2 will improve gender disaggregated monitoring of services. It states that project performance indicators will be gender disaggregated to the extent possible to track gender inequalities and notes a Gender Action Plan will be prepared. HGNDP is flagged in the World Bank CGAP and is directly linked to achievement of specific gender results and categorized as a World Bank Category 2 project which has the potential to impact priority gender inequality areas either through activities and mechanisms which are part of project implementation and/or TA and diagnostic work linked to operations and policy dialogue. HGNDP is marked in the CGAP as doing both.
13. The World Bank classifies projects as gender informed if they meet the three dimensions of gender analysis, gender actions and gender monitoring. In Q3 2017, 85% of the World Bank’s Laos projects were classified as gender informed.
14. Attention to gender in the Mid Term Review (MTR) Aide Memoire is significantly weaker than in the PAD.

- a. Component 1: Health sector governance. Considerable attention is given to the development of the DHIS2 but no reference is made to whether the intentions to include sex-disaggregated data set out in the PAD are coming to fruition. It is also not clear if the DHIS2 includes other social markers such as ethno-linguistic group, persons with disability or households classified as poor. As the information systems for programs other than maternal and child health and nutrition are being wrapped into the DHIS2 one would expect that gender and social inclusion indicators are being included for these too, such as malaria cases disaggregated to identify pregnant women who are at greater risk. However, it is not clear from the report if this is the case.

A particularly important development is the absorption of village health information (family folders) into DHIS2. This is potentially a platform to strengthen the availability and use of gender and social inclusion data at the local level to inform planning and budgeting. In remote areas, family folders have in the past collected information on births in the absence of accessible birth registration. Other key gender evidence around adolescent health and early marriage, female headed households (which are known to be poorer than male headed households) could also be collected at this level. Opportunity to harness GESI evidence and coherence across the social determinants of health and nutrition through the village health information mechanism on DHIS2 warrants further discussion in country.

- b. Component 2: Service delivery. The 14 project provinces include those with the lowest health and nutrition outcomes and lowest human development index scores. The MTR report is structured around progress against individual service delivery DLIs at central and provincial level. While this is succinct it does not lend itself to analysis of progress in each province or for geographical areas where more disadvantaged ethno-linguistic groups reside. It is difficult to gauge if provinces are failing to meet targets across several DLIs but it does appear that XYB [Xayxomboun] and SVK [Savannakhet] have missed at least provincial DLI1, DLI2 and DLI3 targets related to delivery by a skilled birth attendant, at least 4 ANC and long-term family planning respectively; the cause of which is likely to be interlinked. The aide-memoire lacks narrative explaining weak performance for central or provincial level DLIs and their linkages, and how the project intends to address system gaps. There is the risk that the least underserved provinces which are not reaching DLI targets are falling further behind the national average and greater clarity is needed on how the project is benefitting those provinces that are not achieving DLI targets and planned remedial action. This does question the limitations of taking a purely DLI driven approach to service delivery which may be rewarding the more resourced and capacitated provinces and failing to benefit the more neglected and disadvantaged. The trade off in the context of the SDGs and the equity and inclusive development goals of the government and the World Bank warrants further discussion in-country.

Gender and equity issues may well be woven into the system gaps that are leading to weak performance in some areas. For example, the 133 health centres without a community midwife (Central DLI3) may be related to the poor performance of XYB and SVK provinces on provincial DLI1, DLI2 and DLI3. This in turn may be linked to the challenges of hiring community midwives in these provinces where the pool of qualified staff may be lower or the additional challenges of retaining them in remote health centres. Without unpacking the system gaps especially around human resourcing the gender and equity issues constraining performance are difficult to tease out and risk being unaddressed.

The complexity of framing and verifying progress against DLIs is noted but Provincial DLI4 and Provincial DLI5 deserve further attention to ensure they measure disaggregated coverage as far as feasible and reward individual provinces. The target for DLI4 seems to be aggregate number of

children under two receiving growth monitoring and promotion. This aggregate indicator does not identify coverage by province, sex, ability or ethnic group and scope to revise this with the operationalisation of DHIS2 needs investigation. Provincial DLI5 appears to be the aggregate number of villages in zones 2 and 3 which have received integrated outreach sessions. Again, this does not lend itself to tracking performance by province or remote areas.

- c. Component 3: Implementation of social and behaviour change communication (SBCC). The implementation challenges of working in the four northern provinces and the language and communication barriers, literacy levels and cultural norms that need to be factored into design and implementation of social and behaviour change communication are presented in detail. However, analysis of how gender norms and roles among the ethnic groups residing in the focal areas need programming into community mobilisation and communications is missing, even the gender of Village Facilitators is not discussed.

The Aide-Memoire notes that getting the SBCC platform right is especially important given the multisectoral nutrition convergence approach leveraging HGNDP in the four northern provinces. For gender equality and social inclusion this will be an opportune space to build coherence around gender equality and social inclusion across multiple programs and leverage beyond HGNDP. Further discussion in country is recommended to assess how the Government and World Bank are conceiving the nutrition convergence approach as a vehicle for addressing cross-sectoral gender equality and social inclusion issues in line with the World Bank CGAP and how this could be used as a focus for progressing DFAT gender and social inclusion priorities.

15. The MTR mission recognises that greater attention needs to be given to safeguarding of indigenous peoples interests and implementation of the Indigenous People's Plan; basic gaps in the capacity of safeguarding focal points is indicative. Integration of gender into the Indigenous People's Plan also needs to be advocated and monitored. The Gender Action Plan noted in the PAD was not referenced by the MTR and may still need to be developed and may partly explain the lack of attention to gender by the MTR.
16. There are potential entry points for including gender and equity in the recommended public financial management actions in Annex 5 especially around strengthening sector analysis, budget preparation and links to the health sector reform strategy; these are points for further discussion with the World Bank and could be included in the Gender Action Plan.

Leads to follow up on in-country and for our own reflection

- How can the gender intentions of the HGNDP PAD be put into practice and the visibility and importance of gender equality and its intersection with social inclusion protected in implementation?
- DHIS2 broadly and the SBCC platform in the four northern provinces have the potential to leverage multiple programs and build coherence on gender equality and social inclusion at a systems and local level. How can this opportunity to go beyond HGNDP on gender equality and social inclusion be taken forward?
- From the Laos experience, what will it take for the MDTF to achieve consistently high-quality attention to gender?

b) Gender Equality and Social Inclusion Review of the Multi-Donor Trust Fund for Integrating Donor Financed Health Programs in Cambodia

Key messages

- The H-EQIP Gender Assessment (GA) has contributed to the design of the Cambodia Nutrition Project (CNP) and some of the specific recommendations have been integrated.
- The CNP PAD sets out a design that has a strong equity foundation and scope to achieve stronger gender integration than currently framed. Leveraging this space early into implementation will be critical to realising and measuring stronger gender benefits.
- Disability inclusion is completely absent from the PAD and requires more thorough analysis and discussion with the World Bank.
- The draft Aide-Memoire of the H-EQIP Mid Term Review suggests very little progress on the recommendations of the GA.
- H-EQIP's broad failure to take gender equality and disability seriously needs to be understood and factored into how DFAT approaches assistance to CNP to avoid a repeat.

Introduction

17. This note presents the findings of a review of how the Multi-Donor Trust Fund for Integrating Donor Financed Health Programs (referred to as the MDTF) in Cambodia is addressing gender equality and social inclusion (GESI). It reviews how the findings of the World Bank-DFAT Gender Assessment of the Health Equity and Quality Improvement Program (H-EQIP) (2018) have been: (i) applied in the design of the Cambodia Nutrition Program; and (ii) progressed and reported on in the draft Aide Memoire of the Mid Term Review of H-EQIP (May 2019).

Project Appraisal Document (PAD). Cambodia Nutrition Project. March 19, 2019.

Project approach

18. CNP targets pregnant and lactating women and children under two in the seven provinces with the worst maternal and child health and nutrition (MCHN) outcomes. It selects priority health and nutrition interventions from the Investment Case prepared for the Global Financing Facility for Every Women, Every Child. It builds on the structures and areas of success of H-EQIP, namely Service Delivery Grants (SDGs) and Health Equity Funds (HEFs), and leverages the space for local government to take ownership and leadership of community health created by the national deconcentration and decentralisation (NCDDS) process. In contrast to H-EQIP, CNP is designed to work through community structures and the local government system as well as the health system, and aims to create a community platform for delivering health and nutrition services to women and children. The introduction of SDGs to local government (communes and sangkats) to incentivise delivery of a package of community MCHN interventions has the potential to unblock structural and operational bottlenecks to the community health system though there are substantial risks.

Application of the H-EQIP gender assessment findings

19. The selected CNP provinces give the project a strong equity foundation. They include rural and remote underserved populations with indigenous and ethnic minority populations that face economic, cultural and geographic barriers to accessing health services. Some of the H-EQIP GA findings related to HEFs have been woven into CNP such as expansion of HEFs to include transport allowances to health centres and scope to set HEF transport allowances as per market rates in remote areas. The inclusion of integrated outreach services and social and behaviour change communication (SBCC) provide opportunity to embrace other GA findings. The community platform for women's and children's health which CNP will support is for example a means of promoting HEF utilisation and mobilising families and communities for MCHN.

20. The PAD notes that the findings from the GA will be incorporated into project design including having a woman on the quality assessment teams underpinning SDGs. As the PAD is not an operational document and the design is complex it is understandable why some of the operational level GA findings are not covered. Some GA points which were purposefully grounded in the practicalities of delivering SDGs and HEFs, such as the recommendation to include respectful, non-discriminatory behaviour and caring and compassionate communication towards disadvantaged groups in the quality assessment tools have been lost. While the PAD is not the place for details related to the quality assessment tools, it is disappointing that the broader issue of respectful and inclusive provider attitudes and behaviours was not picked up. Given the lack of attention to communication and counselling skills in basic medical and health training, addressing this gap will be essential to delivering health and nutrition counselling and providing client-centred and inclusive quality care. It is not clear how this gap will be addressed via the project or H-EQIP and is one of several areas that will likely need attention during inception and implementation.
21. Similar to points made in the review of the Laos Health Governance and Nutrition Development Project, there is a risk that the focus on the most disadvantaged provinces will be seen to be sufficient in terms of addressing equity. This point is picked up below in discussion on the results framework. The GA recommendation to increase the allocation of SDGs to remote/difficult to access areas and to encourage use of SDGs to address gender and social inclusion bottlenecks has not been included in CNP.
22. Results framework: the GA recommendation to include gender sensitive indicators and sex-disaggregated data in the results framework is poorly taken onboard.
 - a. The majority of child health and nutrition indicators are not sex-disaggregated. While there is no significant gender difference in child mortality, stunting, infant and young child feeding, and immunisation coverage as per the latest DHS (2014), it is good practice that all child health indicators are sex-disaggregated when data is available, especially as the project includes strengthening gender disaggregated data collection, reporting and analysis at national and subnational levels.
 - b. Women and children with disabilities are not mentioned in the PAD narrative or results framework. Monitoring of disability inclusion via the HMIS is likely to be difficult at present but this could be factored into implementation research and planned evaluation. The community platform could also be used to ensure inclusion of women and children with disabilities in community activities and monitoring.
 - c. The HEF Patient Management and Registration System identifies patients by sex, indigenous and ethnicity, physical appearance of disability, and province but none of this disaggregation is included in the HEF indicator in the results framework.
 - d. Most indicators are aggregate numbers and are not broken down by province. This will make it difficult to identify province specific progress and hide possible inequities and lagging geographical areas.

The general lack of attention to tracking sub-populations in the results framework is surprising and deserves further discussion.

23. Gender analysis: The gender section in the PAD is probably sufficient for the project to be defined by the World Bank as gender informed; though it would be good to confirm this. The narrative meets minimum expectations but doesn't deepen and explain how gender inequality contributes to MCHN and the project objectives. No discussion is presented of gender norms and attitudes, and gendered division of labour in the home and society that contribute to poor MCHN outcomes. Naively the PAD notes "convenience plays an important role in the selection of complementary foods both for primary and secondary caregivers, with little evidence of caregiver willingness to invest the time and energy in the preparation of enriched porridge" (page 101). Women are generally primary and secondary caregivers. Rather than absence of 'willingness' it would be more gender informed to reference women's time deficit and the unequal burden women carry for child care, domestic responsibilities, productive work and community obligations compared to men.

Without understanding the gender inequalities and unequal burden of work women absorb, there is the risk SBCC will focus on knowledge solutions without appreciating the need for enabling transformational gender changes.

24. The lack of discussion on gender and local government and gendered politics is disappointing and this gap in understanding of the political economy in commune/sangkat decision-making is an area of concern. For example, the narrative on page 113 states “the CCWC [Commune Coordinator for Women and Children] demonstrated relatively weak capacity and low negotiation skills in the commune investment plan process and additional training will be needed to empower the CCWC in this area.” Empowering CCWCs is to be fully supported but it is naïve to think training the CCWC will be sufficient to challenge gendered power structures that influence local government investment decisions and a more gender informed and politically astute analysis of the situation is needed; including leveraging the practice whereby central government issues instructions on how the commune budget is to be spent. Male involvement and harnessing men’s support for the women and children agenda is missing from discussion of local government and family MCHN behaviours, and there is a lack of attention to the dynamics and relationships that perpetuate gender inequality and how this impacts MCHN outcomes and behaviours.
25. The narrative in the PAD does not mention the lack of sex differences in child health and nutrition outcomes though speaks at length about wealth and province differentials, and this perhaps illustrates how gender is filtered out of analysis. There is also an absence of attention to adolescent girls though they are a key target group for improving maternal outcomes and notably 28% of 15-19 year olds are thin.

Community based approaches

26. The package of community approaches including community mobilisation, demand side accountability and local government leadership, have the potential to empower women and disadvantaged populations to apply new knowledge and agency in decisions and behaviours that impact MCHN. This aspect of the project is underplayed. It would be good raise the profile of women’s empowerment as a contributing factor to achieving the projects objectives and include measurement of women’s empowerment. This would likely qualify the project to receive a ‘gender tag’ in the World Bank’s management system which would increase internal scrutiny.
27. Beyond GESI: The community health system has been neglected by the Ministry of Health as reflected in the fact that the draft Community Participation Policy, 2008 has not been finalised and a plethora of community health volunteers for various vertical programs have mushroomed in an uncoordinated manner. Structural barriers such as the difficulty of attracting people to take on volunteer community health roles especially in areas where labour migration is common, and the high turnover in these positions are examples of the challenges of working at the community level. The community platform proposed by the project is a good step forward but it is unclear where the locus of effort and know-how will be located to drive this area of the project. The PAD suggests district government will play a key role but experience shows limited capacity at this level. Past experience from various civil society programs working in this space highlight the intense capacity building and supervision and financial support necessary to facilitate community processes and engagement and it is not clear how this support is factored into CNP.

Draft Aide Memoire of the Mid Term Review of H-EQIP (May 2019)

28. The draft aide-memoire suggests very little progress on the recommendations of the GA. The proposed review of progress against the GA and intersection with other areas of social inclusion is to be welcomed. However, it would be good to hear the World Bank health and social development teams’ perspectives on why the GA recommendations appear to have received such little attention. This could help prevent a repeat performance with CNP.

14. Annex 8: Persons Consulted

Washington, Geneva, Bangkok, Sydney, Canberra

Tim Evans, (former) Senior Director of Health, Nutrition and Population at the World Bank Group (by phone)

Joe Kutzin, Coordinator, Health Financing, WHO, Geneva

Matthew Jowetts, Health Financing Specialist WHO

Maria Skarphedinsdottir, Secretariat for UHC 2030 Working Group on Transition

Mike Ryan, Health in Emergencies, Executive Director, WHO, Geneva

Santiago Cornejo, Director, Immunisation Financing and Sustainability, GAVI, the Vaccine Alliance

Anthony Swan, Senior Program Manager, GAVI

Alexa Reynolds, SCM Asia Pacific, GAVI

Michael Borowitz, Chief Economist, the Global Fund to fight AIDS, TB and Malaria

Eline Bos, Portfolio Manager, formerly for the Pacific, now for Lao and Cambodia

Jim Tulloch, Chair of the Global Fund, TERG

Tim Poletti, Health Adviser, Australia Permanent Mission to the UN in Geneva

Alex Ross, WHO Director of the Secretariat for the Global Preparedness Monitoring Board

Ludy Suryantoro, WHO National Plan IHR Capacity Development, WHO, Geneva

Toomas Palu, Adviser, Global Coordination Health, Nutrition & Population, World Bank Office, Geneva

Enis Baris, Practice Manager for Health, Nutrition and Population for East Asia and the Pacific, World Bank Regional Office, Bangkok

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Sutayut Osornprasop, Senior Human Development Specialist, World Bank Regional Office, Bangkok (by phone)

Jane Pepperall, Senior Health Adviser, DFAT

Stephanie Williams, Principal Health Specialist, DFAT (by phone)

Greta Cranston, Deputy Director, DFAT

Robin Davies, Head of Centre for Health Security, DFAT (by phone)

Michael Newman, Assistant Director Health and Education Funds, DFAT Multilateral Development and Finance Division

Niamh Dobson, Health and Education Funds, DFAT (by phone)

Leslie Cho, World Bank Section, DFAT (by phone)

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Dr Siale Akau'ola CEO MHMS

Dr Lisiate K 'Ulufonua Medical Superintendent Vaiola Referral Hospital

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Laos

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Emiko Masaki, World Bank, Resident TA, Vientiane

Banthida Komphasouk, World Bank, Vientiane

Birte Holm Sorenson, World Bank, Consultant

Hironori Obara, former JICA policy adviser (by video link)

Hironori Okabayashi, JICA Policy adviser, Vientiane

Masaki Aoki, Project Formulation Adviser, JICA
Dr Chansay Pathammavong, EPI, MoH
Dr Somphone, DG, Department of Finance, MoH
Dr Suphab, DDG, Department of Finance, MoH
Mr Soulivath, DDG External Finance and Debt Management, MoF
Provincial Consultation Workshop for HGNDP and HANSA
Assoc. Prof. Dr Phouthone Muongpak, Vice Minister, MoH
All Provincial Directors of Health
Dr Chansaly, Director-General, DPC, MoH
Mark Jacobs (WHO Representative) and team, WHO Vientiane
Provincial Health Office, Luang Prabang
Provincial Director of Health and team
Health Centre and District Health Office

Cambodia

Megan Counahan, DFAT Health Adviser, Phnom Penh (by phone)
World Bank HNP team, by video link

Papua New Guinea

Benedict David, Minister-Counsellor, Economics and Security, Australia High Commission
Will Robinson, Counsellor, Public Policy and Health Security, Australia High Commission
Gini Gabina, Public Policy and Health Security, Australia High Commission
Elise Newton, Public Policy and Health Security, Australia High Commission
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Wilfred Moses, NDoH
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Ilma Gani, Dept. of National Planning and Monitoring
Loy D'Souza, TA at NEFC
Nikunj Soni, Iain Smith, Bill Rowell Economic Governance and Inclusive Growth Partnership
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Anna Maalsen, WHO Health Systems Specialist
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DFAT Consultant supporting H-SACC

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Enda Pehulisa, Health Section, DFAT, Australian Embassy
Pandu Harimurti, World Bank, Jakarta
Bob Magnani, World Bank, consultant
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Dr Kalsum, Dr Yuli Farianti, Centre for Health Financing and Risk Protection, MoH
Dr Inong Nurjannah, National TB Program
Dr Nadia Wiweko, Director, Vector Transmissible Diseases and Zoonoses
Dr Ann Umar, National HIV Program
Dr Hidyat Amir and colleagues, Centre for Budget Policy, Ministry of Finance
Mr Pungkas B Ali, Director of Health and Community Nutrition, Bappenas
Dr Vinod Bura, Medical Officer, WHO
Navaratnasamy Paranietharan, WHO Representative (by phone)
Rooswanti Soeharno, Child Survival and Development, UNICEF
Sowmya Kadandale, Head of Health, UNICEF
Edhie Rahmat, Senior Health Adviser (plus two colleagues) USAID, Jakarta

Vietnam

Caryn Bredenkamp, World Bank

15. Annex 8: List of key documents

MDTF CONCEPT NOTES

Window 1: <https://dfat.gov.au/about-us/publications/Documents/world-bank-multi-donor-trust-fund-window-1.pdf>

Window 2: <https://dfat.gov.au/about-us/publications/Documents/world-bank-multi-donor-trust-fund-window-2.pdf>

Window 3: <https://dfat.gov.au/about-us/publications/Documents/world-bank-multi-donor-trust-fund-window-3.pdf>

Pacific Health Analytical and Advisory Services (PASA) 2018-2022 Concept Note - revised August 2018

HEALTH FINANCING SYSTEMS ASSESSMENTS

Indonesia: <http://documents.worldbank.org/curated/en/453091479269158106/pdf/110298-REVISED-PUBLIC-HFSA-Nov17-LowRes.pdf>

Indonesia: (policy brief) <http://documents.worldbank.org/curated/en/165591486975596621/pdf/112735-BRI-P154841-P157663-PUBLIC-author-Pandu-Harimurti-HFSA-PolicyBrief-final.pdf>

Kiribati: <http://documents.worldbank.org/curated/en/471011528376870220/pdf/AUS0000154-WP-PUBLIC-P155137-KiribatiSpendBetterHealthFinancingSystemAssessmentfinal.pdf>

Laos: <http://documents.worldbank.org/curated/en/861981512149155081/pdf/121809-REVISED-v2-HFSA-Main-report-FA-ully-report.pdf>

Myanmar: <http://documents.worldbank.org/curated/en/506281543467798250/pdf/132560-28-11-2018-13-35-16-MyanmarHFSAFINAL.pdf>

Papua New Guinea: <http://documents.worldbank.org/curated/en/906971515655591305/pdf/122589-WP-P154901-PUBLIC-23994-PNG-HEALTH>

FIN<http://documents.worldbank.org/curated/en/481931528443850077/pdf>

Solomon Islands: <http://documents.worldbank.org/curated/en/481931528443850077/pdf/AUS00001537-6-2018-18-19-31-SolomonIslandsSpendBetterHealthFinancingSystemAssessmentfinal.pdf>

Vanuatu: <http://documents.worldbank.org/curated/en/716131528786888780/pdf/Vanuatu-Health-Financing-Systems-Assessment.pdf>

HEALTH SECURITY

Vietnam: Health Security Financing Assessment. Draft for Peer Review, January 2019

Health Security Financing Brief #1 Economic Case: Investing in Health Security (undated)

Vietnam: A case study on financing the response to Avia Influenza H5N1 outbreaks 2003-6 Draft for Peer Review, January 2019

World Bank MDTF Window 3. Minutes from a two-day meeting in Washington DC 16-17, October 2017

GENDER

Guidance Note for Gender Considerations for the MDTF

PROGRESS REPORTS

Summary report Nov 2016

Progress report Jan-Jun 2017
Annual report 2017
Progress report Jan-Jun 2018
Annual report 2018
Multi-Year Review of Pacific Islands Health Sector Program of Advisory Services and Analytics 2015-2017,
December 2017

MONITORING FRAMEWORK

MDTF Monitoring Framework FINAL

WORLD BANK PROJECT DOCUMENTS

Project Appraisal Document for Cambodia Nutrition Project
Project Appraisal Document for Vietnam Investment and Innovation for Grassroots Health Service Delivery
Cambodia: Health Equity and Quality Improvement Project – Aide Memoire
Indonesia: Supporting primary health care reform (i-sphere) program – project appraisal document
Laos: Health Governance and Nutrition Development Program – Mid Term Review Aide Memoire

MANAGEMENT MEETING DOCUMENTS

Key areas of interest from the Biannual Management Meeting, Canberra, August 2018
Key areas of interest from the Biannual Management Meeting, Bangkok, January 2019
Decision Note Pacific and PNG, PASA 2018 Review and 2019 Plan

MEDIA RELEASES

Laos to improve Health & Nutrition Coverage http://www.worldbank.org/en/news/press-release/2017/11/06/lao-pdr-to-improve-health-and-nutrition-for-mothers-and-children?cid=EAP_E_Lao_EN_EXT

Laos to Improve Health & Nutrition for Mothers and Children with WB Support:

<http://www.worldbank.org/en/news/press-release/2017/09/28/lao-pdr-to-improve-health-and-nutrition>

Early Findings from the World Bank Group's Multi-Donor Trust Fund for Integrating Donor-Financed Health Programs: <https://dfat.gov.au/about-us/publications/Documents/building-strong-sustainable-immunisation-programs-east-asia-pacific.pdf>

MDTF NEWSLETTERS

[Vol. 2, No. 3, July-September 2019](#)

[Vol. 2, No. 2, April-June 2019](#)

[Vol. 2, No. 1, January-March 2019](#)

[Vol. 1, No. 2, October-December 2018](#)

[Vol. 1, No. 1, June-August 2018](#)

COUNTRY SPECIFIC PUBLICATIONS

<https://www.worldbank.org/en/programs/multi-donor-trust-fund-for-integrating-externally-financed-health-programs/publications>

Papua New Guinea: Demographic and Health Survey 2016-18

PNG: Immunisation Financial Sustainability, March 2018

Indonesia: Improving State Budget Mechanism to support Civil society Organization's role in Health Sector, May 2019

Sustainability of Externally-Funded Health Programs in Indonesia: Issues and Priorities, December 2018

Australian Aid: Package of Essential Health Services -Tonga, March 2019

INFOGRAPHICS

D18 1188737 Draft Infographics WB-DFAT MDTF Pacific countries.pdf June 2018

D18 1188738 Draft Infographics_ WB-DFAT MDTF SEA countries.pdf June 2018

OTHER ANALYSES/POLICY DOCUMENTS

The Southeast Asia component of the DFAT-World Bank Multi-Donor Trust Fund for Integrating Externally Financed Health Programs

Policy Influence: Lessons from a synthesis of 2017 evaluations

Health for Development Strategy 2015-2020: Performance Assessment Note, March 2016

The Regional Health Financing Facility, Asian Development Bank, June 2018

UHC2030: Technical Working Group Reports on Sustainability, Transition from Aid and Health Systems Strengthening March 2017, November 2017

UHC2030: Statement on Sustainability and transition from external funding