

WORLD BANK GROUP MULTI-DONOR TRUST FUND CONCEPT NOTE
Integrating Donor-Financed Health Programs
Window 1

Program Development Objective

The development objective of the multi-donor trust fund (MDTF) is to support countries in strengthening their health systems to accelerate and sustain progress towards key health outputs and outcomes that contribute to UHC with a particular focus on assessing and supporting the financial and institutional sustainability of donor-financed health programs.

Strategic Context & Rationale

Over the past 10-15 years, three trends in global health are notable. First is the 2000 adoption of the Millennium Development Goals (MDGs) which stimulated significant policy attention towards realizing improvements in maternal and child health (MCH) as well as reducing the burden associated with prominent communicable diseases across developing countries. Three of the eight MDGs are directly related to health: these include two time-bound targets that call for country-specific relative reductions in under-five and maternal mortality; in addition, the sixth MDG calls for halting and reversing the spread of HIV, malaria, and tuberculosis (TB) by 2015. Second, following the adoption of the MDGs by all UN member states, there was a substantial increase in development assistance for health (DAH), often earmarked for financing MDG-related interventions. Overall, DAH doubled from less than US\$6 billion in 1990 to about US\$11 billion in 2000; subsequently, over the period 2001-2013, DAH more than tripled to an estimated US\$31 billion in 2013 (Table 1).

Table 1: Trends in development assistance for health, 1990-2013

Development assistance for health	1990	2000	2005	2010	2013
Total	US\$6 billion	US\$11 billion	US\$17 billion	US\$29 billion	US\$31 billion
Share GFATM	--	--	7.4%	11.4%	12.8%
Share GAVI	--	--	1.9%	2.7%	4.9%

Source: Institute of Health Metrics and Evaluation Financing Database

In addition to the rise in DAH, the global health landscape has seen the entry of new players in the past decade: several new private and public initiatives and organizations have become prominent, including the Global Alliance for Vaccines and Immunization (GAVI) and the Global Fund for AIDS, TB, and Malaria (GFATM). Most of these new DAH initiatives have an MDG-related focus -- providing targeted financial and technical assistance to governments and to non-traditional providers such as NGOs -- and with specific procurement, financial management, human resource management, and reporting modalities that are often significantly different from (and sometimes superior to) those in the rest of the health system in recipient countries. Even when the amounts financed by DAH are small relative to total or public expenditures on health, they are often large relative to the amounts spent by countries on the specific diseases of focus, and DAH resources are often used for targeting specific vulnerable population sub-groups. Many of the new DAH initiatives also have explicit eligibility and graduation clauses that are dependent on recipient country incomes and other related criteria. For example, GFATM determines eligibility based on a series of factors that include country income and disease burden: as

countries become richer, there are restrictions on the envelope of GFATM financing that is available and how it can be utilized. For GAVI, eligible countries are those with GNI per capita less than US\$1,570 (for new vaccine support, eligible countries must also have DPT3 immunization rates in excess of 70%). Graduating countries are those whose income is above US\$1,570: these countries can no longer apply for new vaccine or cash-based program support but can continue to receive support for existing vaccine or cash-based program support. GAVI graduating countries also have co-financing requirements: after one year, co-financing requirements increase linearly over four years until 100% of the cost is covered by domestic sources (some countries have mobilized domestic resources as a part of their national response, but in most countries domestic sources remain unpredictable).

Third, and more recently, there has been a concerted push across the developing world towards attaining universal health coverage (UHC), bringing to the forefront not only issues related to coverage of health interventions but also of ensuring adequate financial protection from the risk of health-related catastrophic payments. UHC -- the objective of which is for everyone to have access to quality health care when needed without experiencing financial hardship as a result -- is now an explicit and prominent policy objective in more than 100 developing countries. UHC is also a likely candidate for the post-MDG Sustainable Development Goals (SDGs). UHC can be conceptualized as consisting of three key dimensions: (i) *population coverage* ("breadth"); (ii) *service coverage* ("depth"); and (iii) *cost coverage* ("height"). UHC is not only about increasing the breadth of coverage in terms of number of people with access to affordable health care, although this is clearly one important dimension of UHC, but also about assessing to what extent are benefits and service coverage realized and financial protection accorded.¹ Present attainment of UHC varies significantly across developing countries: some Pacific countries and others such as China and Thailand now provide almost universal breadth of coverage; others such as Indonesia, Philippines, and Vietnam cover 40-60% of the population under UHC programs; and progress has been made in some of the lower income countries such as Cambodia and Lao PDR in removing financial barriers for targeted sub-groups such as the poor and for certain services such as those related to MCH. Challenges remain with regard to depth and height of coverage even in countries claiming universal breadth of coverage.

Given this backdrop, one of the key policy challenges facing countries is that of strengthening their health systems to accelerate and sustain progress towards key health outputs and outcomes that contribute to UHC while effectively managing the transition from and integration of donor-financed health programs. This implies ensuring not just adequacy in terms of levels of domestic-sourced replacement financing but also that such financing is pooled and utilized equitably and efficiently, and that countries have both the financial and institutional capacity to deliver these services effectively. In many countries, implementation capacity and political prioritization are likely to be just as critical (if not more) than financial considerations in ensuring sustainability of donor-financed programs. Furthermore, with implementation of UHC, there are additional

¹ It is important to note that the three dimensions of UHC ("depth", "breadth", and "height") are neither independent nor mutually exclusive: ensuring depth of coverage has implications for the breadth and height of UHC as well. Universal availability of the benefit package for all -- not just those who are well-off and live in urban areas -- is a key aspect of ensuring that UHC is not a hypothetical aspiration but a realized policy designed to enhance health and improve social protection. And high out-of-pocket (OOP) payments -- i.e., low height of UHC -- can (and is) often a result of poor depth of coverage if patients have to pay OOP for drugs or seek care elsewhere in private facilities that are outside the network.

challenges related to whether or not benefits adequately stipulate and deliver comparable interventions to those that were previously donor financed, and to what extent some of the programs continue to be managed separately from UHC implementation modalities.

With regard to abetting sustainability of donor-financed programs, the key is to assess and mitigate some of the transition challenges within a broader health systems strengthening framework and within the context of UHC. In other terms, what are some of the key challenges, in addition to the loss in financing, that might have a harmful impact on the coverage and sustainability of donor-financed programs in transition countries as they strive to achieve UHC, and what can be done to help overcome some of these challenges? Some related issues include assessing if UHC benefits packages include coverage for immunization and MDG-related interventions that were previously donor financed? Does everyone have coverage under UHC programs? Are these interventions adequately financed from domestic sources in the foreseeable future? Are there mechanisms for updating benefits as new technologies become available? Are all providers within the health system empowered to deliver such services? Do financing mechanisms, including provider payment methods, provide the correct incentives to ensure access to and continuity of care? Are there mechanisms to ensure adequate supply-side readiness? Do countries have the capacity to procure and supply commodities and monitor the implementation of interventions and of results? Are there challenges related to procurement, financial management, and transitions from human resource management policies under donor-financed programs? Are there equity considerations in managing the transition, especially in terms of sustaining access for vulnerable population sub-groups? To what extent might targeted technical assistance be needed in order to help overcome some of the transition challenges?

Sustaining improvements in health outcomes and financial sustainability of the health sector are integral to the overall World Bank Group's (WBG's) strategy of eliminating extreme poverty and boosting shared prosperity in a sustainable manner. The central contribution of the Health, Nutrition, and Population Global Practice (GHNDR) to the WBG's twin goals is to enable the achievement of UHC. The proposed work is also aligned with the WBG's latest (2007) Strategy for Health, Nutrition, and Population (HNP) Results, particularly with regard to Strategic Objective 3 which is geared towards improving financial sustainability in the HNP sector and its contribution to sound macroeconomic and fiscal policy and country competitiveness. Strategic Objective 3 provides clear and overarching guidance for the proposed work while emphasizing that, in order to "ensure people's access to essential services and financial protection, countries need to raise stable, sufficient, long-term public and private financial resources, predictably, equitably, efficiently, and in a way that minimizes economic distortions."²

GHNDR is developing a new health financing business line with the objective of supporting countries to strengthen their health financing systems to accelerate and sustain progress towards UHC. The business line will focus on assisting countries in: (i) raising adequate levels of funding; (ii) using these resources efficiently; and (iii) protecting individuals from financial hardship, and helping countries pursue all of the above in an equitable manner. The activities financed under the MDTF will be fully consistent and aligned with the overarching objective of the new health financing business line. More generally, the activities proposed will emphasize the "delta" of engaging on transition issues within the context of WBG engagement in countries related to

² World Bank (2007), *Health, Nutrition, and Population Strategy*, Washington, DC.

broader questions on UHC and engagement with Ministries of Finance. The activities will also emphasize issues related to decentralization where relevant, and the MDTF will engage via the process of an internal WBG consultative group with other countries facing similar decentralization challenges such as in Pakistan, India, Ethiopia, Nigeria, and Brazil. The activities will underscore engagement across GHNDR from a learning and knowledge-sharing perspective.

The proposed program is also in full alignment with the Global Financing Facility in Support of Every Woman Every Child (GFF) which is expected to be one of the main WBG financing vehicles for attaining the post-2015 Sustainable Development Goals (SDGs) including UHC. The GFF will act as a pathfinder in a new era of financing for development by pioneering a model that shifts away from focusing solely on donor financing to an approach that combines donor support, domestic financing, and innovative sources for resource mobilization and delivery (including the private sector) in a synergistic way. The GFF will serve as a major vehicle for financing the proposed SDG on healthy lives and will play a special role in scaling up financing to support the UN Secretary-General's renewed "Global Strategy for Women's and Children's Health".

The activities proposed under this MDTF will complement GAVI co-financed piloting of the GHNDR's financial and institutional health financing assessments in several countries (including Indonesia). The activities financed by the MDTF will, in essence, also be a subset of broader support currently being provided to improve public financial management (PFM; i.e., budgeting, accounting, funding flows, internal controls, reporting, and auditing) in some of the recipient countries. The transition plans will feed into the revisions of national health strategic plans and complementary medium term expenditure plans, as well as the ongoing annual operational plans and budgets. Some of the proposed activities have also been outlined in the recently reviewed and approved Pacific Health Programs of Technical Assistance (TA)/Analytical and Advisory Services (AAA) for 2015-2018 and the Indonesia Health Program of TA/AAA for 2015-2016.³

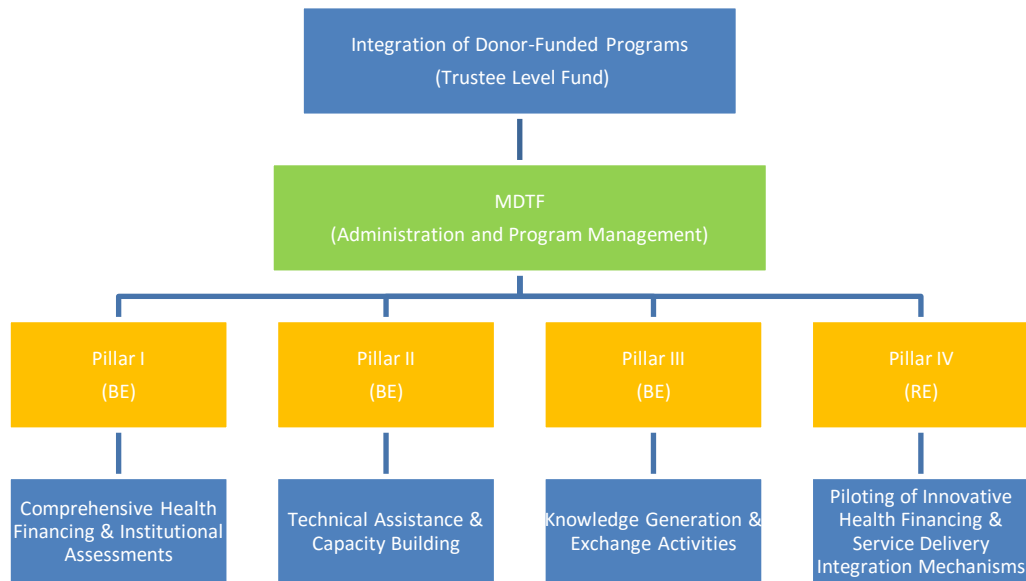
Project Components/Activities

The program will provide resources to WBG task teams and to governments to support countries in strengthening their health systems to accelerate and sustain progress towards key health outputs and outcomes that contribute to UHC with a particular focus on assessing and supporting the financial and institutional sustainability of donor-financed health programs.

The MDTF will comprise four Bank Executed (BE) and/or Recipient Executed (RE) activity pillars (see Figure 1): (i) *comprehensive health financing and institutional assessments (BE)*; (ii) *technical assistance and capacity building (BE)*; (iii) *knowledge generation and exchange activities (BE)*; and (iv) *piloting of innovative health financing and service delivery mechanisms (RE)*. Each of these is outlined in more detail below. All four pillars will finance activities for which the primary focus will be on the institutional and financing sustainability of donor-financed programs. The only differences across the pillars is to do with the implementation modality (i.e., BE versus RE) and nature of support (diagnostics, technical assistance, knowledge sharing, and piloting of innovative interventions).

³ This includes P153469 for Papua New Guinea, and P153778 for Pacific.

Figure 1: Outline structure for the MDTF



Pillar I: Comprehensive Health Financing & Institutional Assessments

This pillar will provide resources to WBG task teams in order to undertake comprehensive health financing and institutional assessments (HFIAs) using the framework developed by GHNDR and with a particular focus on assessing the financial and institutional sustainability of donor-financed health priority programs. As noted above, GHNDR is developing a new business line re-oriented towards provision of support to countries on a range of health financing issues and challenges, including those faced by countries transitioning away from donor-sourced financing. As part of this effort, GHNDR is developing a comprehensive health financing and institutional assessment framework to assess the performance of health financing systems.⁴ In countries facing specific transition challenges, the assessment will include modules focused on assessing financial and institutional sustainability of support for specific diseases or programs, albeit these will be embedded within the broader assessment of the ability of health financing systems to facilitate attainment of UHC. In addition to financial sustainability considerations, the comprehensive analytical framework will assess health financing from a variety of perspectives including adequacy of resources; equity in health financing revenue generation and allocation; efficiency in how revenue are raised, pooled, and allocated; and predictability of financing, among others. With regard to financial sustainability considerations, several sets of issues are likely to be paramount: whether the financing needs of the health sector are being adequately met in order to help countries make progress towards attainment of UHC (including in countries transitioning away from donor-sourced financing); the macro-fiscal country context and its impact on health financing, including issues of prioritization for health in the government budget; and whether or not financing for health is crowding-out legitimate

⁴ Note that the GHNDR health financing and institutional assessments are analytical tools that will be next-generation public expenditure reviews (PERs) and will build on the framework of PER and other related assessments.

resource needs of other sectors and/or adversely impacting the economy in other ways. With regard to institutional sustainability considerations, the assessment will include a focus on issues related to public financial management, human resource management, procurement and strategic purchasing capabilities, and challenges related to decentralization and governance in the health sector more generally.

Activities under this pillar may include support for:

- Collection, compilation, and analysis of data on health financing flows and service delivery – including by source and use – disaggregated by donor-financed, priority programs, and across different levels of government.
- Support for tracking budgetary allocation and processes including monitoring of funding flows to areas of impact.
- Institutional assessments to identify key areas of discord and facilitate integration of donor-financed and other priority programs.
- Support for development and implementation of disease specific health accounts, especially for those countries that have implemented NHAs on a regular basis.
- Assessment of technical and allocative efficiency of existing programs.

Pillar II: Technical Assistance & Capacity Building

This pillar will provide resources to strengthen the capacity of governments and other key stakeholders for health systems strengthening, including in the key areas of health financing, information management, and service delivery for UHC and in the context of integration of donor-financed health programs. Although in principle some of the activities financed under this pillar could help inform project preparation, the MDTF will not explicitly earmark funds for this purpose.

Activities under this pillar may include support for:

- Development of pathway options toward equitable and sustainable financing for UHC, including for addressing health financing transition challenges and for mainstreaming of donor-financed health programs.
- Engagement with non-health sector actors at the national level (e.g., ministries of finance and planning, public service, and executive offices) and sub-national governments for dialoguing on health financing, information management, and service delivery, including with regard to financial and institutional implications of transitions from donor-financing in the context of UHC.
- Training of key stakeholders on the equitable and efficient generation and utilization of resources, including issues related to integration and/or optimizing the complementarity of donor-financed health programs.
- Technical assistance and capacity building for enhancing the technical and allocative efficiency of programs as they undergo transition from donor-financing to domestic-financing.
- Capacity building for improving health system monitoring and evaluation systems, including for design of pilots and development of monitoring and evaluation mechanism including performance indicators.

Pillar III: Knowledge Generation & Exchange Activities

This pillar will provide resources to task teams and governments to share and disseminate good practice knowledge and experiences on integration of donor-financed and other priority programs.

Activities under this pillar may include support for:

- Developing an advocacy strategy and facilitating policy discussions at the country level.
- Impact evaluations to generate evidence to inform policies for financial and institutional sustainability.
- Analysis of country case studies based on health financing and institutional assessments and identification of enablers of sustained transition from cross-country experiences, including of experience of countries in improving technical and allocative efficiency of program facing transition-financing challenges.
- Compilation and sharing of lessons learned from countries graduating from donor-financed programs, including via financing of South-South and North-South study tours to help provide exposure to policy-makers and other stakeholders to implementation of innovative integration strategies.
- Regional and global knowledge-exchange, consultation, and dissemination activities including cross-country comparative analytical work and contributions to global knowledge-based related to transition challenges.
- Documentation of good practices and consultations to discuss and disseminate findings. Outputs of the activities could be summarized in a series of working papers (4,000-5,000 words) to enable capture and dissemination of pertinent issues and to help inform integration efforts across countries.

Pillar IV: Piloting of Innovative Health Financing & Service Delivery Integration Mechanisms

This pillar will provide resources to governments to pilot innovative health financing and service delivery integration mechanisms.

Activities under this pillar may include support for:

- Piloting of innovative procurement, financial management, human resource management, service delivery, and monitoring interventions.
- Support for investigating and testing different implementation mechanisms for integrating donor-financed and other priority programs within UHC programs.

Program Criteria

The key selection criteria for activities to be funded by the MDTF will be: (i) alignment with governments' development strategies; (ii) contribution to achieving the program development objective; (iii) alignment with the development strategy and priorities of WBG; and (iv) alignment with the development strategy and priorities of donors contributing to the MDTF.

The first set of activities under the MDTF will initially be financed by DFAT and will include assessing and supporting the financial and institutional sustainability of GFATM-financed health programs in three East Asia and Pacific (EAP) region countries: Indonesia, Papua New Guinea, and Solomon Islands. Additional countries of focus could include Cambodia and Vanuatu at a later stage (see Annex 1 for country-specific information on these five countries). In each of these initial priority countries, GFATM allocations make up a considerable proportion of total budget allocations and expenditures for HIV, TB, malaria programs (this ranges from 25-90% of total funds with variations between programs and countries). Indicative country-specific activities are outlined in Annex 2. Other country engagements will be decided as additional funds come in. Proposed activities in each of the countries, as well as those that may cut-across countries, will have their own reviews via the WBG's Grant Funding Request (GFR) process (see also section of Governance Arrangements below).

The teams are and will continue to be in regular dialogue with other partners and stakeholders (including key development partners and academia) who are also conducting activities related to the health sector in the focus countries in order to ensure that activities and outputs proposed are not duplicating other activities and are complementary to work being done by other partners and stakeholders. For the initial set of activities in the three EAP countries financed by DFAT, the scope has been discussed and coordinated with DFAT and GFATM, at both headquarters and country levels. The team has also reviewed the main country level programs being conducted by relevant partners for the three known focus countries to ensure complementarity and avoid duplication. Individual GFRs will also be required to specify modalities for stakeholder engagement at the concept, implementation, and completion stages. Activities that are conducted in close coordination with key stakeholders and global partners such as WHO will be encouraged.

Results Framework

In order to identify progress towards attainment of the program objective, several indicators will be monitored that will provide the basis for monitoring results under the MDTF. Indicators will be country-specific and developed under each of the four pillars of the MDTF depending on the nature of support that is provided. These indicators will be measured and reported at the country level and aggregated to assess results of the overall program. It is envisaged that a small number of additional indicators will be developed to capture intermediate outcomes and outputs of the different investments under the MDTF support depending on the nature of support provided across countries (e.g., the number of HFIs completed and disseminated; indicators for measuring provision of technical assistance; strengthened government capacity to integrate and implement donor-financed and other priority programs; generation, capture, and exchange of operational knowledge with regard to health system strengthening and integration of donor-financed interventions). Table 2 summarizes the proposed results framework for the MDTF.

Table 2: Proposed results framework

Development objective	Indicators	Targets
Support countries in strengthening their health systems to accelerate and sustain progress towards key health outputs and outcomes that contribute to UHC with a particular focus on assessing and supporting	<ul style="list-style-type: none"> Number of countries where MDTF-financed activities aimed at assessing and supporting the financial and institutional sustainability of donor-financed 	<ul style="list-style-type: none"> At least three countries where MDTF-financed activities have been implemented by the end of year three, and at least five countries by the end of year five.

the financial and institutional sustainability of donor-financed health programs.	<ul style="list-style-type: none"> health programs have been implemented. Number of countries that have developed their strategy for integrating donor-funded programs (transition plan). Proportion of externally-financed activities that are domestically-financed. Key output indicators (to be finalized after coordination with core indicators that will be tracked by GHNDR). 	<ul style="list-style-type: none"> At least three countries have developed strategy for integrating donor-funded programs. At least three countries where domestic financing has replaced at least 50% of external financed activities by end of year five.
Intermediate objectives	Indicators	Targets
Development financing informed	<ul style="list-style-type: none"> Government expenditure informed. 	<ul style="list-style-type: none"> Health financing and institutional assessments conducted and discussed with Ministries of Health, Finance, and Planning and other stakeholders in five countries by the end of year five.
Policy strategy informed	<ul style="list-style-type: none"> Government policy/strategy informed. Development community/partner policy/strategy informed. 	<ul style="list-style-type: none"> Pathway options and transition plans for integration donor-financed health programs informed in five countries by the end of year five.
Client's capacity increased	<ul style="list-style-type: none"> Design capacity strengthened. Implementation capacity strengthened. Monitoring and evaluation capacity strengthened. 	<ul style="list-style-type: none"> Technical assistance and capacity building activities for integration of donor-financed health programs implemented in five countries by the end of year five.
Knowledge deepened	<ul style="list-style-type: none"> Facilitated exchange of best practice with clients. Facilitated exchange of best practice w/ partners. Disseminated best practices. 	<ul style="list-style-type: none"> Knowledge exchange activities implemented in five countries by the end of year five.
Innovative approaches & solutions generated	<ul style="list-style-type: none"> New innovative approach fostered. New innovative approach developed. 	<ul style="list-style-type: none"> Innovative health financing and service delivery pilots implemented in two countries by the end of year five.

Governance Arrangements

Trust Fund Management and Administration. WBG shall serve as Administrator of the MDTF. In this capacity, it will establish and maintain appropriate records and accounts to identify the contributions to the MDTF and the commitments to be financed out of the contributions. As specified earlier, this will be a hybrid MDTF and will include both RE and BE activities.

Managing Unit. GHNDR (Global Practice for Health, Nutrition & Population).

Geographical Scope. Global, with initial focus on EAP countries.

Potential Donors. Australia (initially, but others may choose to contribute over time).

Recipients. WBG task teams and government institutions.

Proposed Governance Structure. The working of the proposed MDTF shall be governed by: (i) Administration Agreements between WBG and donors; and (ii) Grant Agreements between WBG and grant recipients for RE activities. WBG will administer the MDTF in accordance with WBG policies and procedures and fiduciary terms agreed with trust fund donors. Activities financed from the MDTF will be administered under the Operational Policies and Procedures that apply to IBRD/IDA financing, including the WBG's framework regarding governance and anti-corruption. The governance arrangements proposed for the MDTF will consist of two tiers:

GHNDR Board. The overall framework and strategic direction of the MDTF will be guided by the GHNDR Board. Members include, *inter alia*, the GHNDR Senior Director and Director, and Practice Managers assigned to different regions. This Board will be responsible for overseeing the implementation of the MDTF and contributing to decisions on activities, approval of funding proposals, prioritization, etc. The MDTF will be established as a parent MDTF managed by GHNDR with individual child TFs under the MDTF. The oversight of the MDTF will be the responsibility of the GHNDR Senior Director.

MDTF Management Team. The day-to-day management of the MDTF will be the responsibility of the GHNDR MDTF Program Manager who is a Senior/Lead Health Specialist/Economist in GHNDR. The Program Manager will ensure that all activities and financial reports are carried out and completed in accordance with WBG policies and procedures and the Administration Agreements signed with donors. Individual child trust funds to support global, regional, and/or specific country work will be individually managed by GHNDR task team leaders. Resources will be allocated to child trust funds based on WBG GFRs that detail grant development objectives, grant financed activities, risks, and amount requested to deliver the work. To the extent that allocations are made on a global or regional/country basis, standard WBG global/regional/country supervision and management processes will apply.

Operating Guidelines. The MDTF will operate under standard WBG guidelines with regard to financial management, procurement, environmental, and social safeguards.

Quality Assurance. The program will follow existing internal WBG quality assurance processes based on the nature of the activities supported. As per the WBG's existing quality assurance processes, donors and government counterparts may be invited to provide comments at the activity-specific concept note and/or activity-specific completion stages.

Trust Fund Cost Recovery Arrangements. The proposed MDTF arrangements provide for full cost recovery. The cost recovery arrangements will finance trust fund administration and program management.

Reporting. The MDTF Program Manager will be responsible for providing to the donors an annual report outlining the work and activities undertaken. The MDTF Program Manager will coordinate the global/regional/country progress report inputs. WBG will report to the donors to the MDTF using three modalities:

Annual Activities Reporting. A yearly activities report will be prepared. It will document progress and results of programs financed by the MDTF and additional activities that these

programs may have helped leveraged. The report will also update the donors on the upcoming annual work program outline. Annual planning, review, and reporting will be done in line with the respective countries own planning and budget cycles. The financial reporting to donors will be done on the WBG fiscal year basis (July-June). Senior Bank staff from GHNDR will take part in the annual meeting with the donors.

Financial Reporting. Financial reporting will follow established WBG procedures. WBG shall provide to the donors, within six months following the end of each WBG fiscal year, an attestation from an independent auditor concerning the adequacy of internal control over financial reporting for TFs as a whole (called the “Single Audit”). The cost of such attestation is borne by WBG. In addition to the Single Audit, the donors will have 24 hours a day access to WBGs Donor Center, a web platform which provides donors (not the public) with detailed financial data on their IBRD/IDA trust fund portfolio in a secure, access-controlled environment. On an exceptional basis, the donors may request an external audit of the trust fund financial statement. WBG will determine the necessity of such an audit, and agree on the scope and terms of reference of such audit. All costs associated with an external audit, including costs incurred by WBG, will be borne by the donors.

Individual Activity Reporting. The Bank will provide annual Grant Reporting and Monitoring reports (GRM) for individual activities.

MDTF Final Reporting. Within six (6) months of the final disbursement date of the MDTF, WBG will furnish to the donors a final report on activities financed by the MDTF.

Resources & Schedule

The MDTF is expected to commence in mid-2015 and last a period of about five years. The MDTF will include a first infusion of AUS\$8 million from DFAT to support work in five EAP countries over an initial three year period. These resources will be transferred to WBG as one lump sum payment upon finalization of related administrative agreements. Additional financing from DFAT and other donors is anticipated.

Timeline for Preparation

An indicative timeline for the preparation and establishment of the MDTF is as follows:

- | | |
|--|---------------|
| ▪ MDTF concept note review | by April 2015 |
| ▪ Trust fund proposal (TFP) sent for clearance | by April 2015 |
| ▪ TFP cleared | by April 2015 |
| ▪ Administrative Agreement(s) prepared | by May 2015 |
| ▪ Administrative Agreements signed | by May 2015 |
| ▪ Initial call for funds | by May 2015 |
| ▪ First GFRs and commencement of activities | by June 2015 |

ANNEX 1

Burden of Disease and GFATM Financial Support in Cambodia, Indonesia, Papua New Guinea, Solomon Islands, and Vanuatu

Infectious diseases such as HIV/AIDS, TB, and malaria accounted for more than 800,000 deaths in the Asia Pacific region in 2012. Although Cambodia, Indonesia, Papua New Guinea (Papua New Guinea), Solomon Islands, and Vanuatu (the five focus countries for proposed DFAT support) have made notable progress, attainment of health-related MDG outcomes for HIV/AIDS, TB, and malaria remain a challenge, especially among poor and vulnerable population sub-groups. While the share of communicable diseases in the overall burden has been declining in these countries, TB's share of the overall disease burden has remained largely unchanged and relatively high [in the range of 3-7% of all disability-adjusted life years (DALYs) lost] over the period 1990-2010 in Indonesia, Cambodia, and Papua New Guinea; over the same time period, the burden from HIV/AIDS has actually increased in Indonesia, Cambodia, and Papua New Guinea (Table 1).

Table 1: Share of disease burden by country and communicable disease, select years

Country	Year	Communicable disease burden as % of total burden	Burden of disease		
			TB	Malaria	HIV
Cambodia	1990	66.9%	3.3%	5.1%	--
Cambodia	2000	57.4%	3.3%	4.8%	--
Cambodia	2010	38.9%	3.6%	2.1%	1.6%
Indonesia	1990	56.4%	7.5%	2.6%	--
Indonesia	2000	42.6%	7.6%	1.9%	--
Indonesia	2010	33.2%	7.6%	1.0%	0.9%
Papua New Guinea	1990	59.6%	3.4%	5.8%	--
Papua New Guinea	2000	54.9%	3.3%	4.9%	--
Papua New Guinea	2010	45.8%	3.5%	3.3%	2.5%
Solomon Islands	1990	47.4%	3.7%	4.7%	--
Solomon Islands	2000	39.2%	3.3%	3.5%	--
Solomon Islands	2010	32.9%	3.0%	2.4%	0.0%
Vanuatu	1990	41.1%	3.2%	1.1%	--
Vanuatu	2000	35.6%	2.7%	0.8%	--
Vanuatu	2010	30.7%	2.3%	0.8%	0.0%

Source: Institute of Health Metrics and Evaluation Database

The MDGs call for halting and reversing the spread of HIV, malaria, and TB by 2015. As noted above, while progress has been made, many of the five focus countries are not on track to achieve certain MDG targets: (a) HIV/AIDS, off track: Cambodia, Indonesia, Papua New Guinea; and (b) TB, off track: Papua New Guinea (incidence). While Cambodia, Indonesia and Solomon Islands exceeded WHO's recommended TB treatment indicator target of 85%, Papua New Guinea (69%) lagged considerably behind and Vanuatu (82%) was slightly below the threshold.

HIV/AIDS

There are wide variations of HIV prevalence across and within the countries (Table 2). For example, Indonesia is one of nine countries where the estimated incidence rate of HIV infection among adults (15-49 years of age) increased over 25% between 2001-2011, and the prevalence of HIV/AIDS varies significantly across the country.⁵

Table 2: HIV prevalence among population aged 15-49 years, 2010-2012

Country	HIV prevalence among population aged 15-49 years (%)		
	2010	2011	2012
Cambodia	0.8	0.8	0.8
Indonesia	0.4	0.4	0.4
Papua New Guinea	0.6	0.6	0.5
Solomon Islands	n.a.	n.a.	.004 a/
Vanuatu	--	--	--

Source: World Development Indicators; MDG Indicators, UN, 2014; Ministry of Health, Solomon Islands, Solomon Islands Global AIDS Response Progress Report, 2014; Note: a/ 2013 data.

Tuberculosis

The countries include two of the 22 high-burden TB countries: Cambodia and Indonesia.⁶ In Cambodia, the estimated incidence rate of TB was 424/100,000 population, the prevalence rate was 817/100,000 population, and the death rate was 63/100,000 population in 2011 (Table 3). Indonesia has an estimated TB prevalence of 730,000 cases or 6.1% of the world's TB cases, and is the fifth highest contributor to missed cases (cases which are not diagnosed or diagnosed but not reported) globally suggesting deficiencies in the surveillance, diagnosis, and treatment of TB.⁷

Table 3: Select TB indicators by country, 2010-2012

Country	Incidence of TB (per 100,000 people)			TB prevalence rate (per 100,000 people)		
	2010	2011	2012	2010	2011	2012
Cambodia	437	424	411	875	817	764
Indonesia	189	187	185	306	301	297
Papua New Guinea	348	346	348	568	549	541
Solomon Is	108	103	97	171	160	151
Vanuatu	69	67	65	105	97	89

Source: World Development Indicators, 2014; MDG Indicators, UN, 2014.

Malaria

Many of the countries still have a high burden of malaria (Table 4). In Indonesia, malaria prevalence is highest in six provinces, and around 117 million people are at varied degrees of risk

⁵ UNAIDS (2012), Global Report: UNAIDS report on the global aids epidemic, UNAIDS, Geneva.

⁶ WHO (2013), Global Tuberculosis Report 2013, Geneva: World Health Organization.

⁷ WHO (2013).

of contracting malaria in Indonesia; about 17% of Indonesia's population – largely in the eastern part of the country -- live in areas deemed "high transmission" for malaria (i.e., with >1 case per 1,000 population).⁸ Also, in recent years, the artemisin-resistant malaria strain has emerged in several locations alongside border areas of Cambodia, elevating a public health risk of losing an effective anti-malaria drug due to counterfeit and substandard drugs and poor prescription practices that can spread to other countries and regions very much like chloroquine in 1970s.

Table 4: Select malaria indicators by country

Country	Notified cases of malaria per 100,000 population (2012)	Proportion of children under 5 sleeping under insecticide-treated bed net	Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs
Cambodia	2,219	4.0 ^{a/}	0.3 ^{c/}
Indonesia	5,817	3.0 ^{b/}	0.8 ^{d/}
Papua New Guinea	14,384	n.a.	n.a.
Solomon Islands	7,168	40.0 ^{b/}	19.0 ^{e/}
Vanuatu	3,799	55.7 ^{b/}	53.1 ^{e/}

Source: MDG Indicators, UN, 2014.

Notes: a/ 2005 data; b/ 2007 data; c/ 2010 data; d/ 2012 data; e/ 2007 data.

GFATM Support

Since 2002, GFATM has provided increasing levels of resources for the five focus countries. Over 2010-2012, GFATM disbursements amounted to an average of US\$74 million in Indonesia, US\$45 million in Cambodia, and US\$19 million in Papua New Guinea (Table 5). Even though donor sources are a proportionally a small share of health financing in the countries, in each of the countries GFATM allocations make up a considerable proportion of the total budget allocations and expenditures for HIV, TB, malaria programs (this ranges from 25% to 90% of total funds but varies between programs and countries). In addition, some donor financing is generally targeted to vulnerable population sub-groups via NGOs and a loss of this type of targeted support can potentially have negative implications for these sub-groups, particularly in countries such as Indonesia where central and local government agencies are not accustomed to directly working with or channeling funds to NGOs. Some of the donor-financed programs also have parallel monitoring systems that are often superior to health management information systems.

⁸ East Nusa Tenggara, Gorontalo, North Maluku, North Sulawesi, Papua, and West Papua.

Table 5: GFATM disbursements by country and year, 2003-2012, US\$ million

Country	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	Ave 2010-2012
Cambodia	6.49	5.51	18.85	22.17	21.07	38.60	46.41	61.22	58.62	15.11	44.98
Indonesia	6.02	18.18	22.86	34.88	10.30	43.01	88.67	83.22	81.04	58.24	74.17
Papua New Guinea	--	2.19	5.89	0.88	8.05	10.02	33.68	7.11	13.65	36.23	19.00
Solomon Islands	--	--	--	--	--	--	--	1.51	0.44	1.44	--
Vanuatu	--	--	--	--	--	--	--	--	--	--	--

Source: OECD (2014). OECD for financing data.

Under its new funding model, GFATM has indicative country allocations for the three-year period 2014-2016 (Table 6Table). It is expected that GFATM's new funding model is likely to lead to decreasing grants to some of DFAT's priority countries in the Asia-Pacific region (such as Vanuatu, Solomon Islands, and Indonesia) reflecting their relatively low disease burden and transition to middle-income status. The considerable gains in disease prevention and treatment achieved with GFATM support (e.g., malaria gains in Vanuatu and Solomon Islands) are at risk of being eroded with the reduction in GFATM financing, while all five countries still face numerous challenges in preventing and controlling HIV, TB, and malaria.

Table 6: GFATM country allocations for 2014-2016, by disease, US\$ million

Country	Country allocation (2014-2016)		
	HIV/AIDS	TB	Malaria
Cambodia ^{a/}	80.8	15.9	52.1
Indonesia ^{a/}	116.1	107.8	78.4
Papua New Guinea	25.2	13.7	44.3
Multi-country Western Pacific (TB-HIV) ^{b/}	21.2		--
Multi-country Western Pacific (Malaria) ^{b/}	--	--	9.7

Source: GFATM (2014).

Notes: a/ Country has existing funding in a health systems strengthening grant. This funding has been included proportionally in each eligible component.

b/ The multi-country Western Pacific allocation for TB and HIV includes the following eligible countries: Kiribati, Marshall Islands, Micronesia, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu. The multi-country Western Pacific allocation for malaria includes the following eligible countries: Solomon Islands and Vanuatu.

ANNEX 2

Overview of Indicative Activities

SOLOMON ISLANDS

Outcome: Strengthened government-led analysis, operational planning, budgeting, management and monitoring that supports evidence-based policy and actions that contribute to more efficient, equitable and quality health service delivery.

Experience/lessons will be used to inform a broader regional knowledge base on health financing and sector performance.

Indicators:

1. Completed assessment and transition plan for institutional and financial sustainability of current GFATM (and GAVI) activities.
2. Completed integration of all GFATM (and GAVI) activities into the annual operational plan, budget and monitoring framework (by mid-2016 for implementation from 2017 onwards)⁹
3. Annually completed/updated health public expenditure analysis that is used to inform sector and central agency policy dialogue on progress with transition arrangements and broader sector performance.

Activity	Rationale
<p>Assist MHMS to complete an assessment of institutional and financial sustainability of current GFATM (and GAVI) activities. This includes developing a transition plan for full integration of GF (and GAVI) activities over the next few years as part of a graduation strategy from these donor funding sources. This includes:</p> <ul style="list-style-type: none"> - getting all activities 'on plan and on budget', with integration of all necessary project staff and resources (e.g. including HR, Finance, HIS/M&E); and - planning for and moving to local procurement of commodities. <p>The transition plan will feed into the medium term expenditure pressures (MTEP) work, complementing the National Health Strategic Plan 2016-2020.</p>	<p>This is a subset of the broader health systems work the World Bank and other partners are assisting Solomon Islands with to strengthen core planning, budgeting, implementing and monitoring. Over recent years, Solomon Islands has received substantial donor grants from the Global Fund and Australian Department of Foreign Affairs and Trade (DFAT) to finance disease specific activities (as well as from GAVI for introduction of new vaccines). While there has been an effort to broaden the impact of funding received so that core health systems are strengthened as part of the disease specific funding support, the level of integration varies. Solomon Islands is now faced with significant reductions in these funding allocations as part of pressures on global financing institutions and/or changing eligibility criteria requiring graduation from funding support.</p>
<p>The GFATM and GAVI activities noted above will be incorporated into the broader long-term technical support for core public financial management within the Ministry of Health and Medical Services (MHMS). This is focused on assisting MHMS and development partners (DPs) to improve efficiencies and reduce leakage working within the Government's own planning, budgeting and monitoring cycle, using Government systems and processes wherever possible to prepare, implement,</p>	<p>Analytical work to date has highlighted the need to improve both allocative and technical efficiencies in order to increase fiscal space within MHMS. By working closely with the MHMS Finance Unit as well as with the national and provincial managers the WB team is able to assist MHMS to use findings from analytical work to help make evidence-informed decisions on resource allocation and use.</p>

⁹ The Government of Solomon Islands' annual planning and budgeting cycle starts 1 January through to 31 December. The following year's plan and budget submission are routinely completed mid-year, so there will not be time to complete the full assessment and transition plan for the 2016 plan and budget as that will be completed mid-2015.

<p>report and monitor an integrated annual operational plan and budget (this means Government and donors working to one plan, one budget, one monitoring and evaluation framework etc. for both provincial and national programs). This includes work to: (i) build a broader understanding across management of the unit costs for service delivery and how differences between provinces and health facility levels might be reduced (ranging from major expenditure for staff costs and allowances, to smaller costs for utilities, food and other supplies); (ii) develop a more systematic and consistent approach to allowances such as leave fares, housing, transport etc.</p> <p>Mutually agreed capacity development targets have been established between WB and MHMS management and finance unit to get the best value from this TA.</p>	<p>Work to develop more systematic approaches to management of allowances, procurement arrangements for preferred suppliers etc. could be used as pilot activities to help inform broader Solomon Islands Government expenditure management at central and other line agencies. This is consistent with the Ministry of Finance and Treasury's (MoFT) desire for more 'action learning' pilots rather than more passive reviews.</p>
<p>Assist MHMS to complete annual/regular updates of costing and expenditure analysis to inform ongoing management of all domestic and donor resources (allocation and expenditure):</p> <ul style="list-style-type: none"> - Line Ministry Expenditure Analysis - Medium Term Expenditure Pressures Framework - Health Equity Analysis (using HIES 2012 data) 	<p>This work will help to improve the linkages between key policy priorities and expenditure at the sector/line level as well as at central agencies, particularly MoFT and the Ministry of Development Planning and Aid Coordination (MDPAC). This is an important part of efforts to improve the quality of expenditure for both recurrent (MoFT) and development/capital (MDPAC) budgets - regardless of the funding source.</p>
<p>Participate in quality sector policy dialogue as part of the quarterly health SWAp meetings (chaired by the MHMS Permanent Secretary), including the Joint Annual Performance Review of the Health Sector. The WB health team contributions to policy dialogue aim to assist MHMS to maintain the difficult balance of a relatively equitable, accessible and affordable health system that achieves broad based service and health improvements for Solomon Islanders. The WB team is assisting MHMS to increase its focus on results, including benchmarking its performance internally (between provinces etc.) as well as against a range of other countries.</p>	<p>The SWAp meetings are part of MHMS's governance arrangements for the health sector. They provide an opportunity for regular oversight of health sector performance for both SIG/MHMS and DPs. The World Bank team assists MHMS and SWAp partners to reflect on the management of resources within MHMS - looking at financial reporting and expenditure management and linking this with broader sector performance using health service and outcome data (from the routine HIS and intermittent survey data) and human resources data.</p> <p>Key issues affecting health service delivery and overall sector performance can be used to inform policy dialogue at the central agency level through the WB's and/or other DPs engagement in the Core Economic Working Group and related fora. WB and/or other DPs can use this information and central policy role to support continued improvements in broader expenditure allocations and management, including specific PFM reforms (particularly those aimed at improving the flow of funds, internal controls and related accountability for service delivery).</p>

VANUATU

Note: More discussion is needed with the Government of Vanuatu on this proposed work. Given the immediate demands of the emergency response to Cyclone Pam over recent weeks and the early reconstruction efforts it has not been possible to do this.

Outcome: Strengthened government-led analysis, operational planning, budgeting, management and monitoring that supports evidence-based policy and actions that contribute to more efficient, equitable and quality health service delivery.

Experience/lessons will be used to inform a broader regional knowledge base on health financing and sector performance.

Indicators:

1. Completed assessment and transition plan for institutional and financial sustainability of current GFATM activities.
2. Completed integration of all GFATM activities into the annual operational plan, budget and monitoring framework (by mid-2016 for implementation from 2017 onwards)¹⁰
3. Annually completed/updated health public expenditure analysis that is used to inform sector and central agency policy dialogue on progress with transition arrangements and broader sector performance.

Activity	Rationale
<p>Assist the Ministry of Health (MoH) to complete an assessment of institutional and financial sustainability of current GFATM activities. This includes developing a transition plan for full integration of GFATM activities over the next few years into MoH's recurrent budget as part of a graduation strategy from these donor funding sources. This includes:</p> <ul style="list-style-type: none">- getting all activities 'on plan and on budget', with integration of all necessary project staff and resources; and- planning for and moving to local procurement of commodities. <p>The transition plan will feed into the development of a new National Health Strategy 2017-2021.</p>	<p>Over recent years, Vanuatu has received substantial donor grants from GFATM and Australia's DFAT to finance disease specific activities. While there has been an effort to broaden the impact of funding received so that core health systems are strengthened as part of the disease specific funding support, the level of integration varies. Vanuatu is now faced with significant reductions in these funding allocations as part of pressures on global financing institutions and/or changing eligibility criteria requiring graduation from funding support.</p>
<p>The GFATM activities noted above will be incorporated into the broader long-term technical support for core public financial management within the MoH. Focus on assisting MoH and DPs to improve efficiencies working within the Government's own planning and budget cycle, using Government systems and processes wherever possible to prepare, implement, monitor and report against an integrated annual Business Plan and budget (this means Government and donors working to one plan, one budget, one monitoring and evaluation framework etc. for both provincial and national programs). Mutually agreed capacity development targets</p>	<p>Analytical work to date, including the Health Financing Options Paper in 2013, has highlighted the need to improve both allocative and technical efficiencies in order to increase fiscal space within MoH. Demonstrating more efficient use of resources will also help improve the credibility of MoH and its bids for increased budget allocations each year; in recent years with multiple management changes in MoH there has been a breakdown in the relationship between MoH and the Ministry of Finance & Economic Management (MFEM). By working closely with the MoH Finance Unit as well as with the national and provincial managers the WB</p>

¹⁰ The Government of Vanuatu's annual planning and budgeting cycle starts 1 January through to 31 December. The following year's plan and budget submission are routinely completed mid-year, so there will not be time to complete the full assessment and transition plan for the 2016 plan and budget as that will be completed mid-2015.

have been established between WB and MoH management and finance unit to get the best value from this TA.	team is able to assist MoH to use findings from analytical work to help make evidence-informed decisions on resource allocation and use and, in doing so, to contribute to a more constructive relationship with MFEM.
<p>Assist MoH to complete core costing and expenditure analysis to inform ongoing management of resources (allocation and expenditure):</p> <ul style="list-style-type: none"> - Core vaccine sustainability - Basic Medium Term Expenditure Pressures (MTEP) Framework 	This work will help to improve the linkages between key policy priorities and expenditure at the sector/line level as well as at central agencies, particularly MFEM and the Prime Minister's Office. This is an important part of efforts to build a stronger base of evidence and improve the quality of expenditure for better health outcomes.
<p>Participate in quality sector policy dialogue as part of the Joint Partner Working Group (JPWG) meetings (held three times a year). The WB health team contributions to policy dialogue aim to assist MoH with the difficult challenge of achieving a relatively equitable, accessible and affordable health system that delivers broad based service and health improvements for the population of Vanuatu. The WB will assist MoH national and provincial teams to increase their focus on stronger management of resources through to output results, including benchmarking its performance internally (between provinces etc.) as well as against a range of other countries.</p>	<p>The JPWG meetings are part of MoH's governance arrangements for the health sector. They provide an opportunity for regular oversight of health sector performance for both Government of Vanuatu/MoH and DPs. The World Bank team plays a key role in assisting MoH and DPs to reflect on the management of resources within MoH – looking at financial reporting and expenditure management and linking this with broader sector performance using health service and outcome data (from the routine HIS and intermittent survey data) and human resources data.</p> <p>Key issues affecting health service delivery and overall sector performance can be used to inform WB and other DPs policy dialogue at the central agency level. This may also assist with central agencies ongoing efforts to improve expenditure allocations and management, including specific PFM reforms (particularly those aimed at improving the flow of funds, internal controls and related accountability for service delivery).</p>

PAPUA NEW GUINEA

Outcome: Strengthened government-led analysis, operational planning, budgeting, management and monitoring that supports evidence-based policy and actions that contribute to more efficient, equitable and quality health service delivery.

Experience/lessons will be used to inform a broader regional knowledge base on health financing and sector performance.

Indicators:

1. Completed assessment and transition plan for institutional and financial sustainability of current GFATM (and GAVI) activities.

2. Completed integration of all GFATM (and GAVI) activities into the annual operational plan, budget and monitoring framework (by mid-2016 for implementation from 2017 onwards)¹¹
3. Annually completed/updated health public expenditure analysis that is used to inform sector and central agency policy dialogue on progress with transition arrangements and broader sector performance.

Activity	Rationale
<p>Assist the National Department of Health (NDoH) to complete an assessment of institutional and financial sustainability of current GFATM (and GAVI) activities. This includes developing a transition plan for full integration of GF (and GAVI) activities over the next few years as part of a graduation strategy from these donor funding sources. This includes:</p> <ul style="list-style-type: none"> - getting all activities 'on plan and on budget', with integration of all necessary project staff and resources (e.g. including HR, Finance, HIS/M&E); and - planning for and moving to local procurement of commodities. <p>The transition plan will feed into the medium term planning and budgeting work.</p>	<p>This is a subset of the broader health systems work the World Bank and other partners are assisting Papua New Guinea with to strengthen core planning, budgeting, implementing and monitoring. Over recent years, Papua New Guinea has received substantial donor grants from the Global Fund (as well as from GAVI for introduction of new vaccines) to finance disease specific activities. While there has been an effort to broaden the impact of funding received so that core health systems are strengthened as part of the disease specific funding support, the level of integration varies. Papua New Guinea is now faced with significant reductions in these funding allocations as part of pressures on global financing institutions and/or changing eligibility criteria requiring graduation from funding support.</p>
<p>The GFATM and GAVI activities noted above will be incorporated into the broader long-term technical support for core public financial management within the NDoH. This is focused on assisting NDoH and development partners (DPs) to improve efficiencies within the Government's own planning, budgeting and monitoring cycle, using Government systems and processes wherever possible to prepare, implement, report and monitor an integrated annual operational plan and budget (this means Government and donors working to one plan, one budget, one monitoring and evaluation framework etc. for both provincial and national programs).</p>	<p>Analytical work to date has highlighted the need to improve both allocative and technical efficiencies in order to increase fiscal space within NDoH. By working closely with the NDoH Finance Unit as well as with the national and provincial managers the WB team is able to assist NDoH to use findings from analytical work to help make evidence-informed decisions on resource allocation and use.</p>
<p>Participate in quality sector policy dialogue as part of ongoing health partner meetings. The WB team is assisting NDoH to increase its focus on results, including benchmarking its performance internally (between provinces etc.) as well as against a range of other countries.</p>	<p>The health partner meetings are part of NDoH's governance arrangements for the health sector. They provide an opportunity for regular oversight of health sector performance for both Papua New Guinea/NDoH and DPs. The World Bank team assists NDoH and health partners to reflect on the management of resources within NDoH – looking at financial reporting and expenditure management and linking this with broader sector performance using health service and outcome</p>

¹¹ The Government of Papua New Guinea's annual planning and budgeting cycle starts 1 January through to 31 December. The following year's plan and budget submission are routinely completed mid-year, so there will not be time to complete the full assessment and transition plan for the 2016 plan and budget as that will be completed mid-2015.

data (from the routine HIS and intermittent survey data) and human resources data.

INDONESIA

Outcome: Strengthened government-led transitional plan for donor funded health programs with strong emphasis on financial, institutional, and programmatic sustainability analyses in the wider context of UHC implementation and in a decentralized setting to ensure continuity of these programs. Informed policy and actions that contribute to more efficient, equitable and quality health service delivery.

Experience/lessons will be used to inform a broader regional knowledge base on health financing and sector performance.

Indicators:

1. Completed assessment and transition plan for financial, institutional, and programmatic sustainability of current GFATM (and GAVI) funded health programs.
2. Informed policy and action-plan related documents such as annual operational plan, budget and monitoring framework with the sustainability analysis for the aforementioned donor funded programs fiscal year 2017 onwards
3. Monitoring and evaluation framework is developed to measure progress of the integration and is used to inform sector and central agency policy dialogue on progress with transition arrangements and broader sector performance.

Activity	Rationale
<ul style="list-style-type: none"> - Analysis of data on health financing flows and service delivery – including by source and use – disaggregated by donor-financed, priority programs, and across different levels of government. - Support for tracking budgetary allocation and processes including monitoring of funding flows to areas of impact. - Analysis of integration of health services of donor funded programs such as TB and Malaria (and vaccination) into UHC based on the model used in the HIV Integration analysis. - Institutional assessments to identify key areas of discord and facilitate integration of donor-financed and other priority programs. - Development of Country Case studies based on the health financing and institutional assessment and review of other enablers of sustained transition. - Support development and implementation of disease specific health accounts especially for those that have implemented specific disease health accounts, such as NASA, on a regular basis. <i>(Note: There is an ongoing activity in country to improve NHA, so this activity is still to be discussed)</i> 	<p>Despite the increase in the proportion of domestic funding, doubled between 2004 and 2010, the country's response to HIV epidemic remains dependent to donor sources. The proportion of donor funding remains significant, accounted for almost 60% at the National level, while in some Provinces or districts donor funding may reach more than 70% of total HIV program funding. The Global Fund continues to be the primary donor and is projected to decline further with the uncertainty of GFATM continuation after the Grant ends at the end of 2017.</p> <p>The Government of Indonesia is facing challenges in ensuring sustainability of HIV programs with the ending of GFATM funding at the end of 2017. This is expected to have significant effect to HIV interventions if the contribution from resources other than donor sources is not mobilized.</p> <p>The World Bank has initiated a series of analytical works at the end of 2014 to support the development of the country's HIV financial sustainability plan. The analytical works include optimization analysis HIV resource allocation, and integration of HIV into UHC. The activities proposed under this Trust Fund are the continuation of the initial analytical works.</p>

<ul style="list-style-type: none"> - The activity will be focusing on assisting MOH and development partners (DPs) to identify determinant factors of inefficiencies and identify the most appropriate service modality and to improve efficiencies in service delivery. - Analysis of technical efficiency for selected program interventions based on the country program priorities - Analysis of human resource for health which has been identified as one of the major drivers of inefficiency in health service delivery; including HR needs, availability, and qualification to deliver services of aforementioned programs 	<p>One of the potential funding sources to finance these health programs may be derived from generating saving from improved efficiency in service delivery. Addressing bottlenecks that prevent efficient service delivery will enable re-allocation of the amount of saving to other programs or to scale up already proved effective program interventions.</p> <p>Analytical work to date has highlighted the need to improve service delivery efficiency in order to increase fiscal space within the health sector. This analytical works will identify determinant factors of inefficiencies in service delivery and will emphasize on providing practical solutions. This activity will be done in close collaboration with the main counterparts especially MOH and NAC and in using the findings from analytical work to support evidence-informed decisions on resource allocation and use.</p>
<p>The development of framework to monitor and evaluate integration of previously donor funded programs into the country's health system, availability of funding, accessibility and continuity of service delivery.</p>	<p>The demand for country to demonstrate results has been on the rise over the years. Especially with resources scarcity, the pressure to show evidence that optimum results can be reached with the least financial input is growing. Therefore, countries need to have a strong monitoring and evaluation mechanism to measure results of program interventions.</p>
<ul style="list-style-type: none"> - Actively participate in policy dialogue and disseminate results of the analytical works to support informed policy making. The WB team will be working with the country team including NAC, Ministry of Health, and major development partners to increase its focus on results, including benchmarking its performance internally (between provinces etc.) as well as against a range of other countries. - The WB team involves and facilitates in policy discussion with Ministry of Finance and National Planning Agency/Ministry of National Planning (Bappenas) in identifying financial gap and potential sources of efficiency (for reallocation) and new sources of funding. 	<p>Integrating previously donor funded programs into the domestically funded health system means that there will be shifts of priorities and in resource allocation. The country coordination mechanisms for specific health programs exist and are relatively active. These mechanisms provide an opportunity for regular oversight of health sector performance for both MOH/NAC and DPs. However, these mechanisms tend to operate vertically in isolation from the sector, and have not established communication lines with relevant and influential ministries or agencies/institutions such as MoF, Bappenas, and the Parliament.</p>

CAMBODIA

Outcome: Strengthened government-led analysis, operational planning, budgeting, management and monitoring that supports evidence-based policy and actions that contribute to more efficient, equitable and quality health service delivery.

Experience/lessons will be used to inform a broader regional knowledge base on health financing and sector performance.

Indicators:

1. Completed assessment and transition plan for institutional and financial sustainability of current GFATM (and GAVI) activities.

2. Completed integration of all GFATM (and GAVI) activities into the annual operational plan, budget and monitoring framework (by mid-2016 for implementation from 2017 onwards)
3. Annually completed/updated health public expenditure analysis that is used to inform sector and central agency policy dialogue on progress with transition arrangements and broader sector performance.

Activity	Rationale
<ul style="list-style-type: none"> - Collection, compilation, and analysis of data on health financing flows and service delivery – including by source and use – disaggregated by donor-financed, priority programs, and across different levels of government. - Support for tracking budgetary allocation and processes including monitoring of funding flows to areas of impact. - Institutional assessments to identify key areas of discord and facilitate integration of donor-financed and other priority programs. - Development of Country Case studies based on the health financing and institutional assessment and review of other enablers of sustained transition. 	<p>This is a subset of the broader health systems work the World Bank and other partners are assisting Cambodia aiming to strengthen core planning, budgeting, implementing and monitoring. Over recent years, Cambodia has received funding to finance disease specific activities (as well as from GAVI for introduction of new vaccines). While there has been an effort to broaden the impact of funding received so that core health systems are strengthened as part of the disease specific funding support, the level of integration varies. Cambodia is now faced with significant reductions in these funding allocations as part of pressures on global financing institutions and/or changing eligibility criteria requiring graduation from funding support.</p>
<p>Participate in quality sector policy dialogue as part of ongoing health partner meetings. The WB team is assisting Ministry of Health to increase its focus on results, including benchmarking its performance at sub national level as well as against a range of other countries.</p>	<p>The health partner meetings are part of MoH's governance arrangements for the health sector. They provide an opportunity for regular oversight of health sector performance for MoH and DPs. The World Bank team assists MoH and health partners to reflect on the management of resources within MoH – looking at financial reporting and expenditure management and linking this with broader sector performance using health service and outcome data (from the routine HIS and intermittent survey data) and human resources data.</p>