CIVIL SOCIETY ORGANIZATIONS (CSOs) ENGAGEMENT IN THE GLOBAL FINANCING FACILITY (GFF); AND THEIR CONTRIBUTION IN RMNCAH GAINS.

A case from Tanzania

Produced by Health Promotion Tanzania on behalf of Tanzania CSOs GFF Coordinating Group

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SECTION 1:

1.1. Background and introduction

Globally, women, children and adolescents (WCA) continue to be the most vulnerable groups and their health and well-being can be quickly eroded, if strategic investment is not in place. According to World Health Organization (WHO) about 295,000 women died during and following childbirth in 2017 and 5.1 million of babies are stillborn or die during their first month of life. Globally, there has been a significant progress in reducing maternal and infant mortality, according to WHO maternal mortality significantly declined by 44% between the years 1990 and 2015 and infant mortality rates declined by 49% between the years 1990 and 2017. The vast majority of maternal deaths (94%) occurred in low-resource settings, and most could have been averted. Out of the 295,000 maternal deaths, sub–Saharan Africa and Southern Asia accounted for approximately 86% (254,000) of the global estimated deaths in 2017. Sub-Saharan Africa alone accounted for nearly 196,000 of all maternal deaths, while the remaining 58,000 deaths were accounted for in Southern Asia. In most cases, the leading causes of maternal direct obstetric deaths are hemorrhage, hypertensive diseases of pregnancy, and sepsis. Indirect non-obstetric causes such as anemia and HIV are a growing proportion of deaths. For newborns, the three main causes of death are prematurity, intrapartum-related complications, and sepsis.

Responding to the 2030 Sustainable Development Goals, the Global Strategy for Women's Children's and Adolescent's Health (2016 – 2030) a broad and bold roadmap for ending all preventable maternal, newborn and child deaths, including stillbirths was developed. While the Global strategy places women, children and adolescents at the core and heart of Sustainable Development Goals, it furthers thrives to unlocking their vast potential for transformative change. The Strategy takes pride in ending preventable deaths (Survive), ensuring health and well-being (Thrive) and expanding enabling environment so that all women, children and adolescents across the world can reach their full potential (Transform).

In Tanzania, in 2015/16 about 556 women died of maternal deaths out of 100,000 live births, and lifetime risk of maternal deaths estimates that 1 in 33 will die during pregnancy, at childbirth, or within 42 days after birth or termination of pregnancy. While the estimated maternal mortality rates of 556 is lower than that recorded in 2004-05 (578), it remains relatively higher than the ratios reported in 2010 (454) and in the 2012 Population and Housing Census (432) See figure 1). Likewise, neonatal, infant and under five mortality ratios have declined over the years unlike maternal mortality. According to 2015/16 TDHS, it is reported to be 25, 43 and 67 per 1,000 live births respectively (See figure 2).

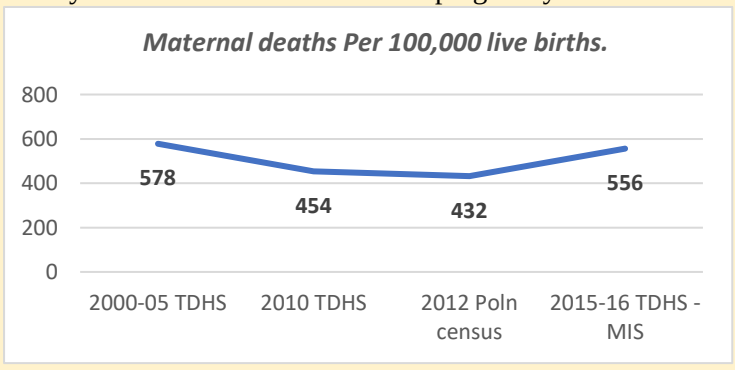

Figure 1Trends of maternal mortality in Tanzania

In Tanzania, low quality of care remains a major setback. In many cases, low quality of care reduces utilization of services. For example, there are studies showing that community perceptions of the quality of the local health system influence women's decisions to deliver in a clinic[1]. Similar findings were reported by Ashley et al[2] in their study "*Understanding client and provider perspectives of antenatal care service quality: a qualitative multi-method study from Tanzania".*

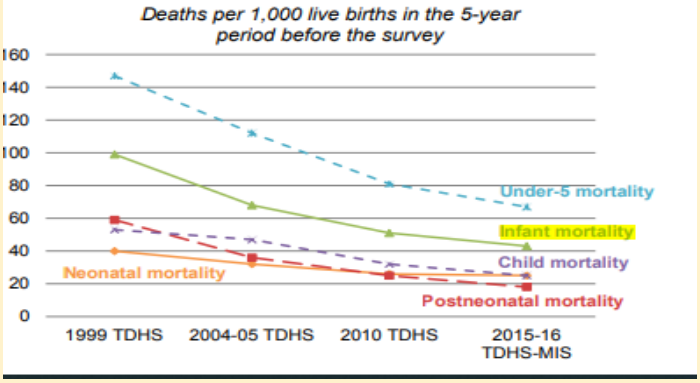

Figure 2 Trends of child mortality in Tanzania

Health facilities providing RMNCAH services have increased from 3,369 in 2007 to 7,268 in 2019. The majority (82.7%) of all health facilities in 2019 were providing childbirth services for pregnant women. The number of pregnant women delivering with skilled birth attendance has increased from 51% in 2015 to 79% in 2019. The number of health facilities providing comprehensive emergency obstetric and newborn care (CEmONC) services has increased, but still only around 22% of health centres provide the full package (HSSPV) The national average ratio of clinicians and nurses per 10,000 population is low at 7.7 (compared to 22.8 as per WHO recommendations).

To address the above, Tanzania was among the forerunner country to implement Global Financing Facility (GFF) a five years program which was co-financed by World bank loan, Trust fund grant and other donors. In order to move smoothly to phase II of GFF, it was imperative to learn from the past phase to inform the new phase, and also inform other new countries beginning to implement GFF. GFF was implemented in lake zone and western zone regions that are low preforming in RMNCAH indicators.

1.2. Rationale of the case study

Tanzania, being one of the developing countries in sub-Saharan Africa that globally contributes to high rates of maternal, neonatal, infant and under 5 mortality continues to strive and transform towards ending preventable maternal, newborn and child deaths. As such, in the year 2015, Tanzania through the Ministry of Health received support from the World Bank through the Global Financing Facility (GFF), marking its position as one of the frontrunner countries to receive financial resources to support investment in strengthening primary healthcare, and addressing health inequalities that affect health outcomes among women, children and adolescents.

This case study intends to document the programmatically added value, lessons learned and challenges of the Global Financing Facility "Strengthening Primary Healthcare for Results program. The program was implemented for a period of 6 years in the Lake Zone regions[3] of Tanzania. The development of the GFF case study has been consolidated through both literature review and interviews with GFF program implementers (Government), service providers at health facilities, and service recipients in the regions of Mwanza and Kigoma. The two regions were selected from the beneficiary regions, Kigoma being low performing and Mwanza best performing. These decisions were made in consultation with Ministry of Health.

[1] Kruk ME, Rockers PC, Mbaruku G, Paczkowski MM, and Galea S. Community and health system factors associated with facility delivery in rural Tanzania: a multilevel analysis. Health Policy. 2010 Oct;97(2-3):209-16.

[2] Ashley Sheffel[1], Rebecca Heidkamp[1], Rose Mpembeni[2], Peter Bujari[3], Jaya Gupta[1], Debora Niyeha[1],Tricia Aung[1], Victor Bakengesa[4], John Msuya[5], Melinda Munos[1], Caitlin Kennedy[1]

[3] Geita, Simiyu, Tabora, Mwanza, Kagera, Mara, Kigoma, Shinyanga.

SECTION 2:

2.1. About Global Financing Facility in Tanzania

The Global Financing Facility (GFF) is head-on focused on prioritizing and scaling up evidence-driven investments to improve reproductive, maternal, newborn, child and adolescent health and nutrition through targeted strengthening of primary health care systems. Tanzania was among the four frontrunner countries[4] to implement GFF for strengthening primary healthcare program results with a focus on maternal, neonatal and child health services. On May 28th 2015 the world bank approved the program and it became effective on November 5th 2015. Tanzania used the One Plan II[5] as the investment case to guide national RMNCAH priorities to be funded. From the investment case, GFF Program Appraisal Document was developed by the World Bank in collaboration with the Ministry of Health and Ministry of Finance in a rather limited consultation. The GFF's Program Appraisal Document highlights implementation of GFF through the Program for Results (PforR) which was to support the Government's primary health care (PHC) with a strong focus on a key government initiative, the Big Results Now in Health.
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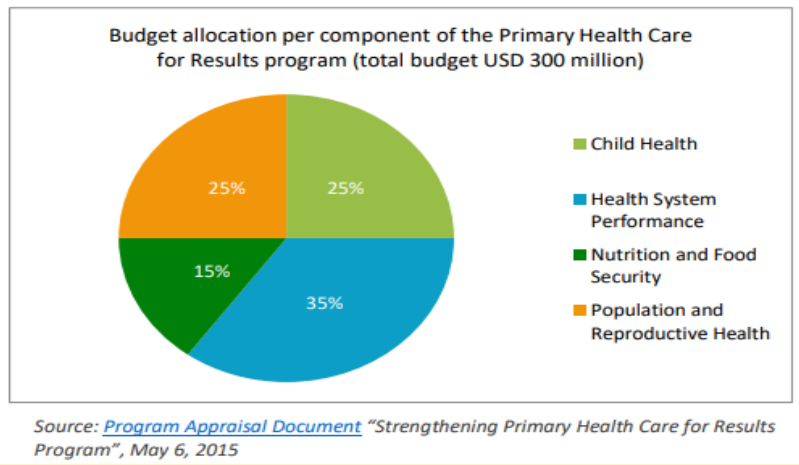
Tanzania's Primary Health Care (PHC) program under the Health Sector Strategic Plan IV (HSSP IV) was estimated at US$2.6 billion that represented 55 percent of the government health sector budget over the five years. Out of the total estimated budget, the government of Tanzania was to finance 78 percent of the national PHC program cost. In support of the national PHC program, The Global Financing Facility pledged to finance an estimated amount of US$274.5 million which equated to 11 percent of the total PHC program, and other development partners were expected to contribute an amount estimated at US$290 in support of the overall PHC program.

Financier	Allocation (million US$)
International Development Agency	200
GFF Trust Fund	40
Achieving Nutrition Impact at Scale	20
USAID	14.5
Total	274.5

The GFF catalytic funding aimed at enabling Tanzania to leverage on its domestic resources to yield maximum MNCH outcomes. As it was initially agreed between the World Bank and the government of Tanzania, Tanzania was to receive a sum of US$274.5 million, out of which $200 million would be a loan from the International Development Agency (IDA), US$40 million from the Multi-Donor Trust Fund for the Global Financing Facility in support of Every Woman and Every Child, US$20 million from the "Achieving Nutrition Impact at Scale" and US$14.5 million from United States Agency for International Development Grants (USAID). As highlighted in the GFF program appraisal document, to achieve better health outcomes and improvement in maternal, newborn and child health it became clearly important that investment in MNCH should be strategically



Source: Program Appraisal Document "Strengthening Primary Health Care for Results Program", May 6, 2015

[4] Kenya, Uganda and Nigeria

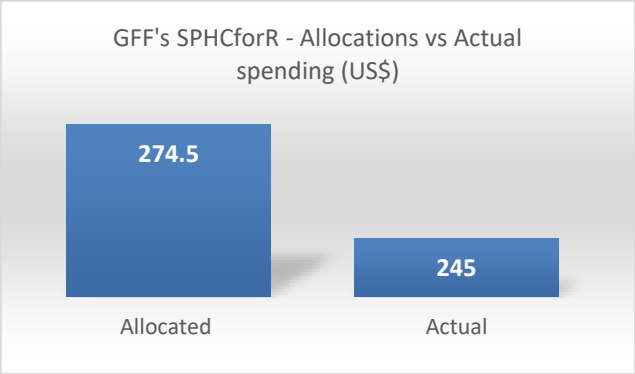
[5] A National Roadmap Strategic Plan to Improve Maternal, Newborn, Child and Adolescent Health in Tanzania (2016-2020)

placed across key thematic areas or components that would contribute to the project's primary goal. See the chart below.

Figure 3 Functional allocation of GFF resources

The GFF's PforR program was implemented in the 8 lake zone regions of Tanzania, which were identified as regions with the lowest RMNCAH performance. The GFF's PforR was guided by a set of pre-agreed Disbursement Linked Indicators which upon performance and verification by the Internal Audit General (IAG), form the basis for disbursement of GFF resources in respective councils.

While the GFF's Strengthening Primary Healthcare for Result committed US$274.5 million, the actual cost dropped by 9 percent, which was equivalent to US$245 million. As highlighted by the World Bank in Implementation Completion Report (ICR), the moderately incomplete fund utilization was contributed by a slow-down in results-based financing (RBF) implementation during the previous 2-3 years of the operation. This resulted from turnover of senior officials at the Ministry of Finance with new leadership that was not in favor of the payment of RBF bonuses to health workers. Subsequently, in 2020 and 2021, these issues were further escalated by COVID-19 pandemic disruptions. Apart from the two mentioned reasons, it was further reported that the underutilization of funds was also contributed by the non-achievement of DLIs on employment permit for HRH, share of health budget and star-rating assessment.



2.2. GFF added value in improving MNCH (2015 – 2021)

This section summarizes some of the achievements that can be attributed to GFF operations.

Construction and renovations of nearly 308 CEmONC facilities across the country including in the eight (8) regions of GFF implementation. With the increase in demand for RMNCAH+N services, these health facilities stand to cover the ratio gap that has existed for years and serve to bring health facilities and services close to the clients who are the beneficiaries of RMNCAH services. For instance, in the regions of Mwanza and Kigoma, the GFF program through the Results Based Financing mechanism, has supported renovation of health facilities that needed upgrading to meet standards. In some areas, women and children who visited health facilities for specific RMNCAH services had no waiting areas and, in some instances, had to sit under big trees while they wait for services. With the GFF programs,

facilities within the GFF regions constructed waiting areas for expecting mothers and children. Both health care provider and leaders exemplify this.

"Through the RBF program under GFF, here in Kigoma we have been enabled to renovate the theatre building at Ujiji health center, which has helped our health facility to perform emergency C-sections that have saved lives of expecting mothers with complication during birth"
Pendo Samizi- Acting Regional Medical Officer – Kigoma

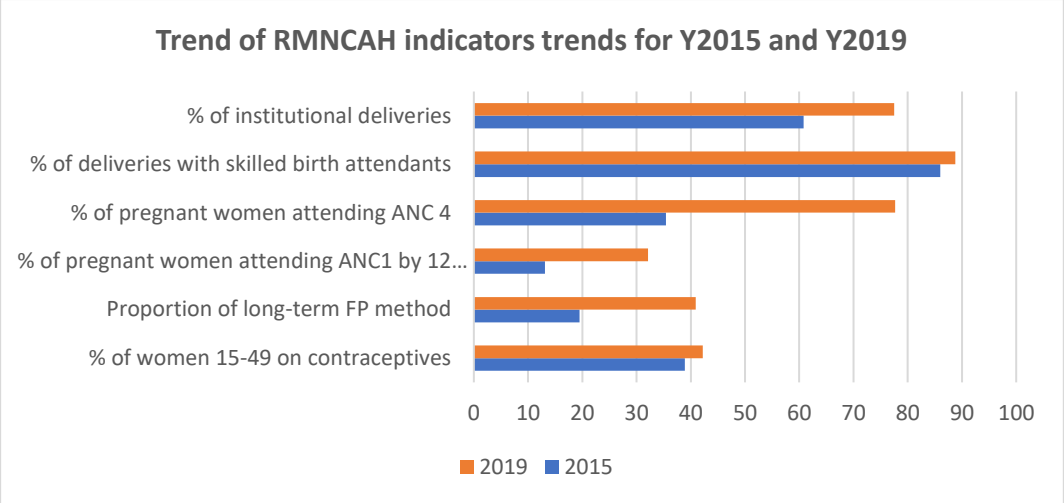
Before RBF under GFF, we didn't have a maternity ward at Ujiji dispensary. There were instances where women would deliver under big trees. From the GFF program, we have constructed a maternity ward that serves thousands of women around the area. As we are thankful to GFF, our dispensary still needs youth friendly services and programs that engage men.
-Victoria Msagama- Health Care Provider

With GFF support, expecting mothers no longer have to travel long distance to seek for health services. But we still need infrastructures that accommodate to the needs of women living with disabilities. They shouldn't feel left out.
-Samwel Kibabi- Chairperson of Health Facility Governing Committee.

In addition to construction, and renovation of health facilities the program also supported the following:

Procurement of medical supplies and equipment: Most of the health facilities that were situated in the interiors of rural areas lacked basic medical supplies and equipment that are vital in providing RMNCAH services. Councils that benefited from the GFF program, through the RBF resources, were able to procure basic medical supplies like oxytocin, family planning commodities, Vitamin A supplements just to mention a few. Prior to GFF, expecting mothers and those about to deliver constantly complained about sharing hospital beds during delivery, with GFF, facilities were also presented with resources to procure equipment like hospital beds and mattresses, blood pressure machines, diabetes check machines and the like.

The two above intervention lead to increased demand for RMNCAH services by creating a friendly and conducive environment for clients. With the construction and renovation of health facilities, procurement of medical supplies and equipment, and healthcare providers who were incentivized for their work done ensured availability of services and client-friendly environment where healthcare providers have the best customer care. Below we provide a trend of a few selected RMNCAH service indicators with a comparison of 2015 and 4th quarter of 2019. Looking at the performance below, it is clear that most of the indicators increased quite tremendously except for deliveries by skilled providers and contraceptive use which had marginal increase due to freezing hiring of human resource for health.



SECTION 3:

3.1. CSO contribution into increased stakeholders' involvement and accountability in GFF in Tanzania.

While Global Financing Facility (GFF) in Tanzania operated from 2015, it was not until two years later when PANITA and Health Promotion Tanzania (HDT) convened a first CSOs meeting to begin learning about GFF processes in the country and how best CSOs can begin to engage as highlighted in the GFF Guidance Note. During the meeting that brought forth stakeholders and partners in RMNCAH and the Government, it was learned that;

(i) While CSOs in Tanzania were not systematically organized to strategically engage in GFF dialogues, CSOs like SIKIKA and White Ribbon Alliance (WRA) were erratically involved in the initial processes of GFF formulation but remained unaware of the processes that proceeded thereafter.
(ii) Even within the Ministry of Health, there had been limited consultation among important departments such as one responsible with nutrition.
(iii) Tanzania had decided that RMNCAH-TWG to be the country platform that facilitates national dialogues on GFF, but the scope of work for the same had not been revised to suit the purpose and so no discussion had taken place.

From the meeting, it was recommended to send a delegation to the World Bank and Ministry of Health to explore critical issues such as (i) How GFF upholds the two GFF key principles: *inclusiveness and transparency;* and process of selecting CSO's representative(s) in the technical decision-making bodies and (ii) How they have been engaging CSOs in GFF processes.

On 14th and 15th December of 2017, Health Promotion Tanzania (HDT) with the support from Options Consultancy convened another meeting with a wide range of CSOs that included local CSOs, International Non-Governmental Organizations, World Bank, Ministry of Health and the media. During this meeting, partners learned on (a) Kenya's experience on CSO engagement, (b) Project Approval Document (PAD) and how accountability is done, (c) World Bank representative shared that there will be GFF-PAD review, which provided an opportunity for further CSOs engagement. To better position themselves, CSO proposed a two years program that comprised of four objectives.

The goal for 2018 was: Civil Society Organizations in Tanzania are meaningfully engaged in GFF mechanism from National, Regional and District Level	
Obj#1	By June 2018 CSO-GFF platform is formed, well-coordinated and functional

Obj#2	By Oct 2019 CSOs in Tanzania have increased capacity to effectively engage in GFF processes
Obj#3	CSOs continuously generate evidence-based information and advocate for increased domestic resource mobilization, efficient allocation and utilization for RMNCAH+N to achieve one Plan II targets
Obj#4	By June 2019 accountability framework developed and GFF forum embrace transparency and inclusiveness (Citizen Engagement=SAM)

In May 2018, CSOs engagement in GFF began to intensify, first by forming CSO-GFF coordinating group made of CSOs representatives from nine regions[6] which were GFF priority regions and forming leadership. CSOs also conducted its first performance scorecard that assessed both the process and performance. The score card underpinned the following framework, see figure 4. It assessed RMNCAH country platform existence, inclusive and functionality, availability of country investment framework, availability and operationalization of health financing strategy, financial performance of IDA and GFF grant and finally complementary financing. CSOs went further to develop memorandum of understanding for their engagement at national, regional and district level.

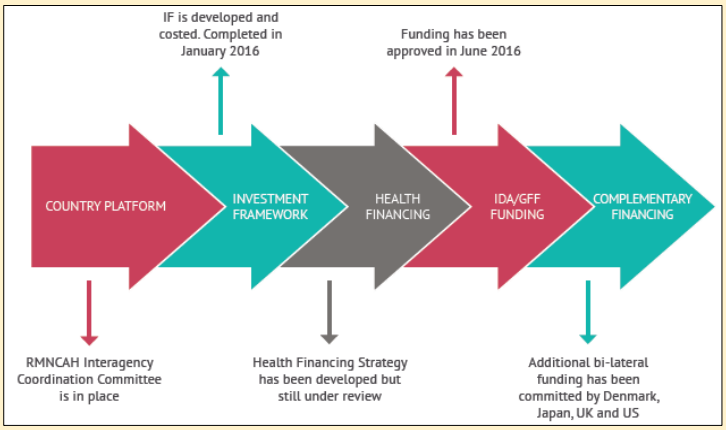


Figure 4: Tanzania CSOs GFF scorecard framework

CSO-GFF secretariat coordinated national and regional CSO teams to form three task teams that engaged the government and development partners. The three task teams formed were monitoring and accountability, capacity building and advocacy teak teams, see figure 5. These task teams had leadership and each developed terms of reference to guide their operations. While regional level engagement was rather weak because of limited financial resources, national level engagement was sustained over years by financial and technical support from PAI, ACTION and OPTIONS.

Figure 5: CSOs GFF Coordinating Group Task Teams

In consultation with regional CSOs under their task teams, CSO-GFF coordinating group secretariat produced several analysis and recommendations that informed decisions and GFF operations in Tanzania. The first analysis that impacted GFF operation was this which was used to advocate to ministry of health and president office public service management and led to employment of 6,180 health care providers, 30% of them were allocated to GFF regions which had high shortage of human resources for

[6] Pwani, Tabora, Shinyanga, Simiyu, Mwanza, Kagera, Mara, Geita, Kigoma

health. CSOs also issued a number of policy papers to inform decision and operations, including CSO recommendations for GFF2, GFF spotlight, increasing GFF impact in Tanzania etc.

These efforts increased trust to Health Promotion Tanzania (HDT) as secretariat to CSO-GFF and triggered not only being invited to the meeting to discuss reproductive, maternal newborn and child health, but also increased access to information. Health Promotion Tanzania (HDT) has since then become a permanent member of Reproductive Maternal Newborn and Child Health – Technical Working Group (RMNCAH-TWG), see meeting minutes here. Although the government had committed to release RMNCAH score card every quarter, this information was not released from 2019 to 2021. Efforts to advocate for release of the scorecard did not yield positive results, but one of the successes of this sustained engagement is Health Promotion Tanzania (HDT) being a trusted partner to support Ministry of Health on analysis of RMNCAH scorecard and produce actionable report for decision makers and implementing partners. Example of data being accessed now for this role is available here.

CSO engagement in GFF processes in Tanzania has journeyed from no consultation to not only invited partner, but a trusted partner to support Government in information management and use. We look forward for a greater engagement providing supportive role to government and GFF in general to increase its impact in Tanzania.

SECTION 4:

4.1. Lessons Learned

Tanzania being one among the frontrunner countries for GFF implementation, it serves as a hub for lessons that can be shared across GFF implementing countries. Below we present critical lessons learned.

- ✓ **Establishment of an independent country platform dedicated for GFF dialogue is crucial in placing GFF high on the agenda.**

In 2015, when GFF kicked off its implementation, it was rather clear that as a country there is a need to have a country platform that will serve as an avenue to openly have dialogues related to GFF. While forming a country platform seemed to be a great idea, decision makers opted to avoid forming parallel structures which could have resulted to difficulties in logistical arrangements and fragmentation of efforts or initiatives. Prior to GFF, the Ministry of Health had formed RMNCAH Technical Working Group, which served as a dialogue forum for all issues related to RMNCAH. On the grounds mentioned above, it was decided that RMNCAH TWG will also serve as the country platform for GFF. However, for the period of 5 years of GFF implementation, GFF was either not placed high on the agenda or did not form part of the agenda during RMNCAH TWG meetings which took place quarterly. Even though the RMNCAH Technical Working Group comprises of NGOs, INGOs and Development partners, there was no representation of any CSOs within the CSOs GFF coordinating group and such jeopardized the extent to which CSOs are informed on GFF updates. Concurrently, CSOs within the CSOs GFF coordinating group kept advocating for GFF visibility in the RMNCAH TWG which was also declared a GFF country platform – even so, it was ***not*** until 2021 when CSOs in the CSOs GFF coordinating group secured membership in the RMNCAH TWG through Health Promotion Tanzania as a representative.

While avoiding parallel structures serves as a good idea, with GFF it was rather a con than a pro. The RMNCAH TWG has conflicting priorities all fighting for a spot in the agenda, making it difficult for GFF to earn visibility. As such, given the complexities of GFF and the broader goal it serves to help developing countries like Tanzania accomplish, it remains rather important to establish and launch an independent country platform for GFF with a solid mechanism for coordination which will solely be dedicated to scrutinize issues related to GFF without bias. Having an independent country platform will also provide visibility for GFF, and with visibility comes political will and commitment to act upon.

- ✓ **Results Based Financing is a game changer.**

With programs big or bigger than GFF, the focus has always been on "Money for Results", where financiers give money and seek results later. While GFF is contextualized per country, the formulation and implementation of GFF in Tanzania is based on "Results for Money". All the stakeholders, implementers and players in the GFF implementation are guided by a set of performance indicators which are to be achieved for disbursements to be made. With such mechanism, we have witnessed a huge shift in the mentalities of implementers who now have the urge to put in the work to achieve results. While the attainment of these results such as increase in facility delivery, increase in birth attendants with skills, ANC visit increase and many more means disbursements of resources are to be made, it further signifies the improvement of health care especially in improving maternal, adolescents and child health.

The Results Based Financing (RBF) has been a game changer when it comes to CSOs engagement in GFF. From the RBF mechanism, several structural adjustments had to be made to ensure a steady momentum in achieving GFF's Program Development Objectives for Tanzania. As such, Direct Health Facility Financing (DHFF) was introduced – a system that calls for disbursements of funds directly to the health facilities which gives health facilities mandate to plan for RMNCAH programming. Both RBF and DHFF allowed for greater CSOs engagement since planning and budgeting of RMNCAH programmes devolved to the health facility level through the Health Facility Governing Committee (HFGC) thus giving room for CSOs to input and hold decision makers accountable.

The system of Results Based Financing has not only ensured attainment of pre-set indicators but most importantly has created the spirit of accountability among implementers. For instance, every day, the RCHS unit at the Ministry of Health convenes virtual meetings with ALL DMOs from ALL the 26 administrative regions of the country, to get daily reports on number of deliveries and maternal deaths, and in these meeting ALL maternal deaths are critically examined to ensure such similar cases do not appear and healthcare providers are held accountable in instances of poor misconduct. Countries with prospects of GFF renewal or kicking off GFF implementation can benefit from a Results Based Financing as it maximizes results, holds implementers to account and provides CSOs with an opportunity to meaningfully engage.

- ✓ **Aligning CSOs efforts in GFF advocacy in crucial in maximizing impact**

It remains inevitably true that CSOs have a vital role to play in advocacy and accountability. However, in most cases, the work done by CSOs ends up unnoticed due to lack of visibility and fragmentation of efforts. In advocacy and accountability for GFF it is important that CSOs align themselves through formation of a coalition that is strategically set with members organizations who have a blend of skills and expertise to advocate for GFF and hold decision makers accountable. CSOs in Tanzania were not presented with a seat at the table to discuss GFF formulation in its initial stages, as such CSOs began engagement in the GFF in the year 2018 and in the same year they formed a CSOs GFF coordinating group with 35 members – bringing CSOs from the GFF implementing regions and those at the national level. Within the CSOs GFF coordinating group which is led under Health Promotion Tanzania (HDT) as the secretariat, CSOs formed three (3) task teams being i) advocacy ii) accountability and iii) capacity building task teams which has specific tasks and the teams were formed based on individual members and organizational capacities with an aim of aligning efforts.

Since the formation of the CSOs GFF coordinating group, CSOs in Tanzania have been on the frontline to advocate for GFF and hold decision makers to account regardless of the political environment between the years 2015-2020 that seems rather unfriendly. With the CSOs GFF coordinating group in Tanzania we have learned that forming coalitions i) helps to align CSOs efforts and avoid fragmentation ii) leverage of existing knowledge, skills and expertise within members of the coalition iii) unifies voice and provides essence to the advocacy efforts laid down. Hence CSOs in countries with GFF implementation can benefit from a dedicated coalition to elevate not just their voices but those of the society. If the existing structures in the Government won't give CSOs a seat at the table, CSOs should mobilize themselves, make their own table, own the seats and voice up.

Despite the added value that CSOs bring, the extent to which CSOs engage in the GFF is strongly determined by availability of resources. While the Global Financing Facility in its guidance note stresses on the importance of CSOs to engage in seeking accountability and advocating for the same, engagement in GFF processes require resources which haven't been presently available to CSOs. While CSOs acknowledge the importance of GFF and their role, due to limited resources some find it tedious to meaningfully engage.

- ✓ **In doing advocacy for GFF, it is of importance to generate evidence and outsource knowledge and capacity from expertise.**

Given that advocacy serves to influence decision makers to act on a certain course of action, it then lacks meaningfulness when it is not backed up with data and evidence. Advocacy endeavors in most cases face resistance because they may not necessarily resonate with what decision makers care about. But when an advocacy effort is informed with evidence on why a certain action need be taken and if not take what could be impact and if taken what will be the benefit, then decision makers are most likely to pay attention and act. It is also evident that knowledge gap among CSOs hinders their meaningful engagement. However, knowledge gap, should not form a block as to the extent to which CSOs meaningfully engage in the GFF.

For instance, in 2020 CSOs in Tanzania organized themselves to develop CSOs recommendations for GFF renewal, while this advocacy journey was vital to inform GFF phase II in Tanzania, it was also going to serve as a win with a bang as CSOs were not previously engaged in the set of GFF in the year 2015. To see that through, Health Promotion Tanzania (HDT) – secretariat for the CSOs GFF coordinating group formed a dedicated task team with high level personnel and expertise needed to complete the CSOs recommendations paper. With inputs from healthcare providers and service recipients and high-level insights from members of the task team, the CSOs recommendations for GFF renewal paper was successfully submitted to the Government of Tanzania through the Ministry of Health and The World Bank. Successfully, some of the recommendations put forth like the focus on adolescent and youth interventions were taken to account and further build on to be incorporated in the GFF Program Appraisal Document.

4.2. The Missing Gap – way forward

1. Sustainability

Overall, in the period of 6 years of GFF implementation there has been remarkable results that contribute to strengthening of primary healthcare in Tanzania through the lens of MNCH. Reports from THMIS RMNCAH scorecard highlight on the increase in percentage of vital indicators such as institutional deliveries, deliveries by a skilled healthcare provider, antenatal and postnatal care visits, family planning uptake and use of vitamin A supplements just to mention a few. While these results set the tone and grounds for reduction in maternal and infant mortality, there remains questions around sustainability and how Tanzania is set to maintain such results and even greater in the long run. The modality of GFF in Tanzania manifested through Results Based Financing (RBF) a system that not only makes disbursements based on performance but also incentivized health care workers (25%) and health facilities (75%) for achieving end target. It remains undeniably true that incentivizing healthcare workers and health facilities had a huge impact in ensuring quality and access of MNCH services to the end users.

With such incentives out of the equation, it is important to explore and look into ways through which quality of services providers and customer care to clients is maintained. Apart from the incentives that did boost the morale of healthcare providers, GFF played a huge role in scaling up resources for RMNCAH through IDA and the GFF Trust Fund that is tied to the loan. Looking at reports from RMNCAH scorecards, it remains clear that after Nov 2015 when GFF implementation became effective, Tanzania as a country started to record tremendous changes in MNCH which were largely

positive. While needs and demands in RMNCAH increase as population increases, and as it is undeniably true that GFF support will not last for eternity, hence there is a need for a smooth transition which lays a solid plan for resource mobilization to cater to the needs. To achieve this, continued advocacy to put to effect operation of health financing strategy.

2. Strengthened CSOs meaningful engagement

While the GFF guidance note and engagement strategy call for a meaningful CSOs engagement, the journey to reach such heights requires dedication, commitment, consistency and even more so solid strategies that keep up the momentum. In many cases, CSOs are seen as "the enemy" rather than the "critical friend" to the government whose intentions are to support and complement the ongoing efforts to strengthen provision of RMNCAH services and reduce maternal deaths. While there are remains a long way to go for CSOs to have a seat at the table and voice out issues vital to achieving results, it remains rather important for CSOs to be systematic and coordinated through formation of coalitions that move together to achieve a common goal. And even more so, CSOs will need to continue being capacitated to be able to understand challenges and be positioned to provide sustainable solutions to challenges as such. In this regard, CSOs in the context of GFF can seek to conduct different analysis that look at trends of indicators performance and disbursements, and through their coalitions – they can incorporate activities around analysis of the GFF investment case and the extent to which it responds to the needs of the people in the community, review of the GFF PAD, documentation of results and consult the community on what works and what does not work so they are better placed to advice the government and donors on way forward as far as attaining results is concerned.

3. Establishment of youth friendly services in health facilities to foster health seeking behavior among youth and adolescents.

While GFF has largely supported interventions that aim at improving the health of women, the past 6 years of implementation have sidelined interventions that focus on responding to special needs of youth and adolescents who account nearly 50% of the population. With the widespread of HIV/AIDS, STIs and teenage pregnancies among young people, it certainly raises the need to embed youth friendly services in health facilities that will be built upon comfort and trust and aim at providing a wide range of services to young people and adolescents. In the year 2019 through 2020, CSOs in the CSOs GFF coordinating group under the leadership of Health Promotion Tanzania (HDT), developed a paper on CSOs recommendations for GFF renewal which considered inputs from service providers and recipients from all the eight regions of GFF implementation. One of the key recommendations was prioritization of youth-friendly services. CSOs advocated for its consideration in the GFF Investment Case and GFF project formulation. As such, this remains to be an advocacy opportunity going forward and sits as an advocacy priority for the CSOs GFF coordinating group.

4. Improvement and upgrading of RCH facilities to accommodate special groups such as people living with disabilities.

From the lens of service recipients of recommendation during GFF documentary development, it was noted that services provided in the councils supported by GFF do not accommodate women with disability, as such jeopardizing the extent to which they seek healthcare. This calls for a need of improved infrastructure. While GFF has supported the upgrading of health facilities including construction and renovation of RCH buildings, there still remains a need to ensure coverage. For instance, in both Kigoma and Mwanza which are 2 of the 8 regions of GFF implementation, both service providers and recipients in some of the councils called for construction of RCH building as some stated that those services were still being provided under the tree.

5. **Strengthened collaboration and feedback loop between World Bank, Government and CSOs.**

There have been enormous efforts by CSOs to engage in GFF processes in the country, thus not only advocating for GFF performance but also enhancing accountability for the same. While such efforts have yield impact to a certain tune, there is a great need to strengthen collaboration between Government, World Bank and CSOs especially in information sharing, providing inputs and recommendations as well as feedback. Such collaboration can be effective with a liaison officer bridging the gap between CSOs and decision makers. Unlike 2nd, 3rd and 4th wave GFF countries, Tanzania being a GFF frontrunner countries suffered the absence of a liaison officer for nearly 3 years. The lubricative role of a GFF liaison officer cannot be stressed enough especially in creating an enabling environment for CSOs to meaningfully engage.

Conclusion

The establishment of Global Financing Facility (GFF) supports developing countries like Tanzania to transform policies into action, leverage resources and build systems that ensures improvement of maternal and child health through a strengthened primary health care. While countries had existing efforts that address RMNCAH, GFF complements these efforts by understanding gaps and contextualizing country tailored interventions that respond to those gaps. Tanzania being one of the countries in the sub-Saharan Africa, has continued to suffer from maternal deaths. Nationally, the Government in collaboration with stakeholders has developed a number of national strategies that respond to issues around RMNCAH including the One Plan which derives from the National Health Sector Strategic Plan. While having strategies in place is important, the implementation of these strategies requires ***both financial and human*** resources to effectively and efficiently implement them. For years, Tanzania has and continues to suffer from inadequate resources allocated to address RMNCAH in its totality.

Global Financing Facility being implemented in Tanzania from 2015 through 2021[7] has supported Tanzania to yield results in RMNCAH that are vital in not just improving maternal and child health but also primary healthcare which serves a larger population. For the period of 6 years, we have seen construction and renovation of health facilities, procurement of medical supplies and equipment, incentives for healthcare providers and most importantly increased demand for RMNCAH services. As such there has been an increase in institutional deliveries, increase in deliveries by skilled birth attendants, increase in number of pregnant women attending ANC visits, provision of vitamin A supplements, post-natal care and many more. While these results are to be applauded, there still remains the question of sustainability. Stakeholders at national and sub-national level need to have open and honest dialogues on how Tanzania and other GFF implementing countries are positioned to sustain such results without the support of GFF in place.

Apart from sustainability, for instance in Tanzania there has been national dialogues and discussions on GFF renewal, while GFF has performed great we cannot turn a blind eye on the red flags. While information is vital for CSOs engagement, the level of privacy and secrecy between the World Bank and the Government of Tanzania machinery like The Ministry of Health, hinders the extent to which CSOs can meaningfully engage. Though bureaucracy, protocols and procedures are important it should never be at the cost of the lives of mothers, children and adolescent health. It is equally important to recognize that GFF interventions need to have a touch and feel of the beneficiaries – and that can only be done through a human centered design that places the beneficiary at the center by understanding their needs and responding to them accordingly.

[7] GFF was initially set to end in 2020, but due to major restructuring that were agreed between the Government and The World Bank, Tanzania earned a 1-year extension of GFF implementation to allow disbursements of remaining resources.