CENTER FOR GLOBAL DEVELOPMENT

Designing Direct-to-Government Assistance

Three Case Studies in Global Health Financing

DEBORAH COOK KALIEL AND PHILLIP PALMER

CASE STUDY • AUGUST 2026

Designing Direct-to-Government Assistance: Three Case Studies in Global Health Financing

Deborah Cook Kaliel
Independent consultant

Phillip Palmer
Independent consultant

Deborah Cook Kaliel and Phillip Palmer. 2026. "Designing Direct-to-Government Assistance: Three Case Studies in Global Health Financing." CGD Case Study. Washington, DC: Center for Global Development. https://www.cgdev.org/publication/designing-direct-government-assistance-three-case-studies-global-health-financing

CENTER FOR GLOBAL DEVELOPMENT
2055 L Street, NW Fifth Floor
Washington, DC 20036
202.416.4000

1 Abbey Gardens
Great College Street
London
SW1P 3SE

www.cgdev.org

Center for Global Development. 2026.

The Center for Global Development works to reduce global poverty and improve lives through innovative economic research that drives better policy and practice by the world's top decision makers. Use and dissemination of this Case Study is encouraged; however, reproduced copies may not be used for commercial purposes. Further usage is permitted under the terms of the Creative Commons License.

The views expressed in CGD Case Studies are those of the authors and should not be attributed to the board of directors, funders of the Center for Global Development, or the authors' respective organizations.

Contents

Figure

Tables

Foreword

It has been almost a year since the State Department unveiled its America First Global Health Strategy, a document that envisions major changes to US global health engagement. But despite an ambitious timeline outlined in the strategy, officials are still working to put the 30-plus agreements signed with partner countries into practice. Rebuilding and reorienting US international health assistance is no small endeavor—and there are big questions on the table about how precisely the State Department will structure the transition of health service delivery, commodity procurement, and workforce support to partner country governments.

In recent decades, the United States has allocated only a modest share of its aid directly to governments for health and development outcomes, but there's an important opportunity to learn from past experience—including that of other donors—providing direct assistance to governments to advance health outcomes.

New case studies from Phillip Palmer and Deborah Cook Kaliel—formerly of USAID, each with years of experience in G2G programming—spotlight important lessons for the Department of State as it works to operationalize its new global health agreements. Each of the three case studies examines an arrangement involving direct, performance-based assistance for health, across nine areas: goals and objectives; design; risk management; indicators and disbursement; flow of funds; data monitoring, reporting, and verification; sustainability and co-financing; staffing, management, and technical assistance; results.

- Using its Program-for-Results instrument, the **World Bank** provided a financing package to Ethiopia, supporting maternal and child health services under the Ethiopian government's national plan. This model operated through a pooled donor fund, linked disbursements to a narrow set of indicators, and used many of the government's existing systems instead of creating parallel structures.
- **The Global Fund** shifted its portfolio in Rwanda toward a performance-based approach that disbursed funds linked to performance indicators on a sliding scale, aimed at facilitating accountability and flexibility. Given Rwanda's strong governance and data systems, the program has relied on Rwanda's Auditor General and national health information management system, allowing for a small donor staffing footprint.
- **USAID** provided direct assistance to the government of Jordan in support to the Jordan Health Fund for Refugees, a pooled donor fund, and incentivized policy reform while strengthening systems and facilitating country contributions to refugee health programming.

These examples showcase how design decisions matter and fundamentally shape donor capacity, oversight, and impact. Among the core takeaways:

- funding a national plan (or part of one), rather than developing a parallel program, yields greater country ownership and sustainability;
- systems strengthening is essential—programs can't just pay for outcomes or services;
- while political pressure can add complexity, simple program designs and monitoring schemes are often the easiest to manage and the most effective.

Notably, the governments profiled in the case studies have relatively high state capacity in the health sector and were committed to improving health outcomes. To effectively implement G2G programming, the State Department will need to assess which countries are strong candidates for direct assistance—those with strong financial management systems, independent audit institutions, and an established national health plan. The donor institutions in the case studies benefited from longstanding relationships with country governments, established staffing and management models, and existing assessments of fiduciary and programmatic risk—all of which the State Department will need to build in the wake of USAID's dissolution.

Even with only a few country governments poised to receive direct assistance from the start, the State Department has far fewer staff than USAID to manage health programming. With limited capacity, we hope State can learn from others as it pilots G2G approaches and ensure sufficient resources are made available to evaluate and learn from these partnerships.

The administration's vision, as described in the America First Global Health Strategy, seeks to fundamentally alter how the United States has traditionally programmed health assistance. On paper, this direction—working more closely with partner governments to facilitate transition—has real merit. And operationalizing that vision would be a challenge under any circumstances. These new case studies provide insights we hope the State Department will take on board as it advances its ambitious strategy to help inform any future government-to-government partnership.

Jocilyn Estes
Assistant director of US Development Policy and senior policy analyst, Center for Global Development

Introduction

In September 2025, the US State Department released the America First Global Health Strategy, announcing a major shift in how the United States programs foreign assistance in one of its largest sectors, representing over $13 billion in FY 2024.[1] Global health dollars, the strategy states, will now flow primarily to foreign governments, not to nongovernmental organizations (NGOs), as has been the case in recent decades. The Department has sought to advance this strategy by signing non-binding, multi-year memoranda of understanding (MOUs) with dozens of its largest aid recipients. While officials acknowledge that there will be real challenges to providing direct assistance in the near term, the explicit goal of these MOUs is to transition from donor-driven systems to partner government-led implementation.

Despite having made this transition its guiding principle, the State Department has not yet fully explained how it will approach the delivery of US aid dollars to governments. There are many models of direct assistance, including from multilateral financial institutions, other bilateral donors, and within the US government itself. These models vary in how and to what extent they use country systems, the types of oversight and management structures involved, and the basis for making payments and, therefore, the incentives created.

This paper aims to inform public debate on this topic—and the implementation of the Department's new agreements—by examining three direct donor-to-partner government funding models by three different donors. Though these do not represent the full spectrum of what is feasible, they offer an instructive overview of practices for the various elements the Department needs to consider.

The three approaches were selected for their relevance to the new strategy, focus on the health sector, large funding envelopes that incorporate results-based financing, and programming in countries of strategic interest to the United States. Across the three cases, direct donor-to-government programs benefited from flowing through established national health plans and country systems, paying for performance against a set of clearly defined results, and relying on existing national audit and data institutions for verification. Donor approaches to staffing, risk management, and sustainability varied considerably across the programs, reflecting design choices rather than a singular best model. But in each case, the program's effectiveness relied on early, context-specific judgments about the capacity and comparative advantage of the specific donor, partner country, and broader donor assistance apparatus.

1 U.S. Department of State and U.S. Agency for International Development, *FA.gov*, accessed May 29, 2026, https://foreignassistance.gov/.

Methodology

This paper is based on a desk review of public documents and interviews with experts with direct knowledge of the donor approaches and specific programs described. Primary documents reviewed include donor policies and guidance on grants and loans; specific grant proposals, assessments, and design documents; final grant and loan language, risk management plans, performance frameworks, monitoring plans, and indicator lists; and final reports, donor audits, and evaluations, including third-party evaluations. Donors varied in transparency and information availability, with the World Bank making public dozens of program documents, the Global Fund's website including substantial documentation minus the most recent grant agreements, and USAID and the State Department providing the least amount of information. In some cases, the final grant language was unavailable, so grant proposals or evaluations were used as proxies. For each case, this paper describes programs across a consistent set of design and implementation characteristics: the program's goals and objectives, design, indicator selection, payment basis and disbursement mechanism, funds flow, data and verification arrangements, and results achieved. We compare each program on characteristics that shape management, efficiency, and sustainability— including risk management approaches, donor staffing models, co-financing requirements, and coordination with other donors.

Case study 1: The World Bank and maternal and child health in Ethiopia

Program: Ethiopia Health Sustainable Development Goals Program-for-Results

Amount: $350 million (originally $120 million—primarily IDA Credits complemented by trust fund grants)

Period: 2013–2022 (originally to 2018)

Financing Type: $250 million in zero-interest loans, $100 million in grants

Goal: Improve the delivery and use of a comprehensive package of maternal and child health services

Implementer: Ethiopia Federal Ministry of Health

Key takeaways

- The World Bank invested directly in Ethiopia's national health program and worked through country systems, which contributed to program sustainability and allowed the Bank to rely on existing country management structures, risk management processes, and data systems rather than creating and staffing up their own.
- The Bank worked closely with the government and other donors to ensure those systems were performing effectively—building on the institution's longstanding relationship with the government and its assessments of country systems and fiduciary risk.
- Results-based financing kept the focus on outcomes, especially when top-level indicators were few. Scaling payments to performance kept the government engaged with results even when a target was out of reach.
- Working through a pooled fund harmonized efforts with other donors and reporting requirements for the government of Ethiopia.
- The Bank took a broad look at program sustainability, considering not just its own work and the portion of the country's budget dedicated to health, but also issues of economic growth, domestic resource mobilization, and the effectiveness of the national health plan.

Donor context

The World Bank Group is the world's largest source of multilateral development finance. Through several distinct entities with their own financing terms, balance sheets, and instruments, it provides concessional loans and grants to middle- and lower-income country governments across a broad spectrum of development activities. In 2012, it introduced its first new financing instrument in nearly 30 years: Program-for-Results (PforR). The primary innovation of the PforR instrument was the linking of the disbursement of funds to the achievement of specific program results. It also aimed to incentivize client countries to link their own development programs to tangible results. This new instrument, with performance at the center of its design, was considered an important innovation in the foreign assistance landscape.

In addition to development results, systems strengthening is an explicit objective of the PforR instrument. The World Bank's activities are typically driven by country demand: the bank generally funds a country government's own strategies, systems, and programs, and PforR projects are often designed with capacity strengthening as an essential component for achieving tangible, sustainable results.

The Ethiopia Health Sustainable Development Goals (SDGs) program (also referred to as an "operation") was the first PforR in both the World Bank's Ethiopia portfolio and its Health, Nutrition and Population Global Practice. Given this high visibility, there was strong support within the bank to ensure its success and to generate lessons for scalability.[2] The bank also had other health and economic policy programs in Ethiopia that informed this new work.

Country and program context

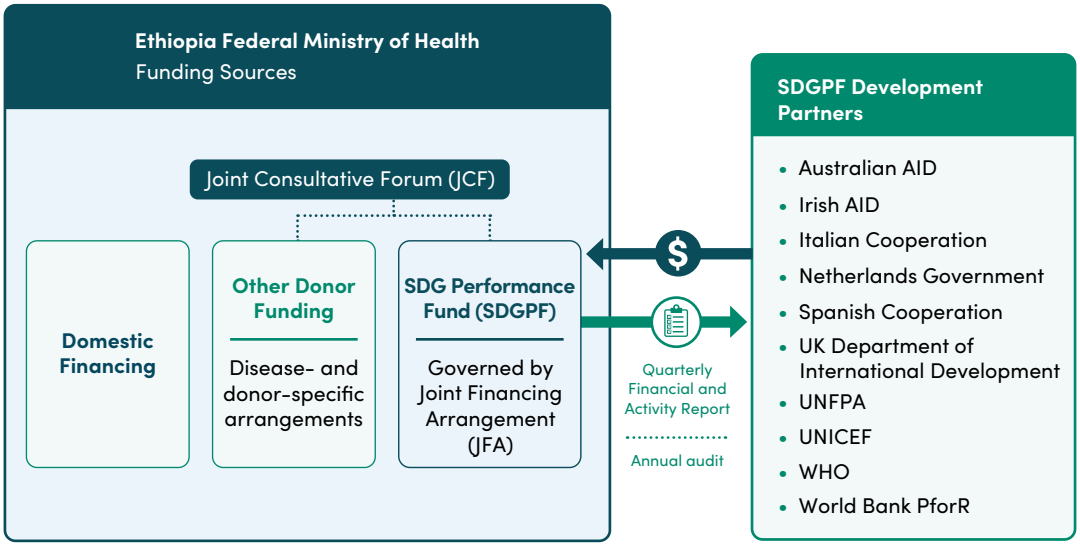
By early 2013, Ethiopia had experienced a decade of strong economic growth, progress on poverty reduction, and significant improvements in human development. Despite these achievements, Ethiopia continued to face lagging health outcomes and persistent gaps and disparities in access and use of quality maternal and child health services, with just 10 percent of women receiving skilled care at birth. There was also growing recognition in the country, including by the prime minister, of the need to shift focus from inputs to results for national health activities.[3]

This provided an opportune context for the World Bank's new PforR instrument. Donors, including the World Bank, already supported Ethiopia's fourth iteration of its national health strategic plan (the Health Sector Development Program, HSDP IV), viewing it as an effective approach using evidence-based interventions. The PforR operation was conceived to support this plan, and to use the implicated country systems for its implementation. The Ethiopia Ministry of Health (MOH) team was heavily engaged in the design and implementation of the new PforR program.[4]

2 World Bank, *Health SDGs Program-for-Results ICR*, 2022, 24.
3 World Bank, *Health SDGs Program-for-Results ICR*, 2022, 6.
4 World Bank, *Health Sustainable Development Goals Program-for-Results: Implementation Completion and Results Report*, ICR00005696 (Washington, DC: World Bank, 2022), 1–14, https://documents1.worldbank.org/curated/en/099620001062330072/pdf/BOSIB000912ba30d80aa3a076cc4128de5a.pdf.

Even before the PforR program, Ethiopia boasted a system of harmonized donor support buttressed by the principles "one plan, one budget, one program," including one set of reporting requirements with common data platforms and mechanisms. This included a well-established institutional arrangement for pooling and managing donor funds: the Millennium (later the Sustainable) Development Goal Performance Fund (SDGPF), managed by the MOH and used to implement the PforR. All donor funding was overseen by a Joint Consultative Forum, headed by the MOH and a rotating development partner; however, only the SDGPF had a unified set of reporting requirements to donors. Despite improved harmonization, unpredictability and donor-specific reporting requirements persisted.

Figure 1. Institutional arrangement for the pooled SDGPF



Beginning in 2016, Ethiopia faced escalating civil conflict and sporadic security incidents, including damage to health facilities and ambulances in affected regions. By 2019, these grew into concerns over instability in significant parts of the country and then internal displacement and looting of health facilities, with some healthcare workers unable to fully perform their duties. The onset of the COVID-19 pandemic also disrupted essential health services. Both the conflict and the onset of the global pandemic led to delays and the program being restructured several times.

Program and approach

1. Goals and objectives

The goal of the PforR operation was to "improve the delivery and use of a comprehensive package of maternal and child health services."[5] The program included health systems activities to support the government's large, complex, devolved health system, focusing initially on introducing new

5 World Bank, *Health SDGs Program-for-Results ICR*, 2022, 1.

tools for monitoring and evaluation (routine data and regular facility assessments) and enhancing transparency of commodity procurement and supply chain management at the Ethiopian Pharmaceutical Fund and Supply Agency (PFSA).

In 2017, building on the program's successful performance and an initial $120 million investment, the World Bank added $230 million in financing to increase targets, introduce intermediate activities informed by program learning to help achieve the overall objectives, and add a focus on nutrition. The program was subsequently restructured multiple times beginning in 2020, in part due to COVID-19 and security issues, but in part to improve data reliability and verification.

2. Design

The program was intended to operate as an integrated part of the government's health system and plan. Since that plan was already endorsed and supported by an established donor coordination mechanism, many aspects of the program design were already settled. The World Bank also had other existing grants and loans in Ethiopia that informed and complemented the PforR operation, for example, support of health extension worker salaries.[6]

The PforR's goals—improving the delivery of maternal and child health services—relied on the availability of critical medicines and other medical supplies at the local level. This fell under the responsibility of the pharmaceutical procurement and supply chain agency, the PFSA, part of the MOH and one of the primary entities that would receive assistance under the PforR. The MOH also received PforR support to strengthen national health data, undertake new facility assessments, and, after the program was expanded, implement nutrition activities.

The initial design included just eight indicators as the primary measures of success for the program. They made up the program's "disbursement-linked indicators" (DLIs), a central component of PforR operations (see Appendix 1). In its final report on the program, the World Bank referred to the design as "simple, focused, and targeted, ambitious in its vision, and yet practical and operational in terms of expected outcomes, allowing the government to test the utility of the instrument and draw lessons for its replicability." Though the PforR comprised many activities and inputs, focusing on these eight indicators was considered an effective way to keep the program results-oriented. However, the number of DLIs rose in 2017 as the scope of the PforR was broadened and financing nearly doubled, generating some implementation challenges.

There was initial concern that the World Bank's contribution was too small to make a difference, as it represented a modest portion of the funding needed to implement the government's national health plan. Ultimately, however, the bank moved forward, believing the PforR reinforced a

6 World Bank, *Health Millennium Development Goals Program-for-Results: Program Appraisal Document*, Report No. 75101-ET (Washington, DC: World Bank, February 1, 2013), accessed June 1, 2026, https://documents1.worldbank.org/curated/en/763541468256147222/pdf/751010PAD0P1230Official0Use0Only090.pdf.

results-oriented culture. Additionally, to counter persistent donor-specific reporting requirements, the World Bank emphasized the use of country reporting processes and encouraged other donors to do the same.[7]

3. Risk management

For PforR operations, the World Bank undertakes assessments in the following areas: technical, fiduciary, and environmental and social. These assessments follow standard guidelines that can be adapted to the program context and institutions being assessed, and they are supported by specialized World Bank staff. They identify risks and appropriate mitigation measures, and their preparation includes extensive dialogue with other donors. These then serve as inputs to a Program Action Plan (PAP)—a limited set of risk mitigation actions to strengthen institutions and improve systems performance—which is included in the main program design document. Relevant government entities, including sections of the MOH, the PFSA, and Ethiopia's supreme audit institution, were the primary responsible parties for the actions, with the bank and the donor coordination mechanism verifying that actions had been completed.

Because the PforR program is an integrated part of a broader country program, its assessments look at the government systems used and the overall government program supported. The technical assessment, for example, includes an expenditure analysis, which assesses the cost-effectiveness and financial sustainability of the government's overall health program. In this way, the World Bank gauges if its investment is part of a sustainable and appropriate set of interventions to achieve the government's—and its own—goals.

The PforR assessments in Ethiopia classified fiduciary risks as "substantial"; it classified technical and environmental and social risks as "moderate." The key risks arose from the performance of the national commodities and supply chain entity (PFSA), which had opaque and anticompetitive procurement processes.[8] Risk mitigation measures were incorporated as both a DLI and actions in the PAP. For one critical PAP action related to clearing a backlog of audits, the World Bank and the government entered into a legally binding covenant. Though many risks were identified and 17 mitigating actions made up the PAP, only the most critical were linked to disbursement of funds or had a signed covenant (see Appendix 2).

Upon completion of the program, the World Bank concluded that funds were used for intended purposes and the program strengthened the government's fiduciary systems, including financial reporting, fraud and corruption reporting, and tracking of procurement activities, despite some delays and variation in select program's performance ratings over the years, which required World Bank follow-up.[9]

7 World Bank, *Health SDGs Program-for-Results ICR*, 2022, 31.
8 World Bank, *Health Millennium Development Goals Program-for-Results*, 2013.
9 World Bank, *Health SDGs Program-for-Results ICR*, 2022.

4. Indicators and disbursements

The central element of the PforR instrument is that all disbursements are linked to indicators. These DLIs can include service delivery and systems indicators, and are generally at the output or outcome level. The World Bank can provide advances of up to 25 percent to facilitate the achievement of DLIs (including activities such as establishing baseline data or setting up monitoring arrangements for the program).

Payment amounts for each DLI are established during the initial program design. PforR design teams assign these values based on consultations with the government, the DLI's relative value to the operation as a whole, and the underlying government program's budget, rather than traditional costing exercises focused on inputs.

The PforR's goal was initially measured by eight DLIs (see Appendix 1). These included four maternal and child health DLIs that were part of the government of Ethiopia's existing monitoring system and considered gold-standard indicators. The targets were established based on global best practices and the government's national health plan (HSDP IV). Systems strengthening activities were captured by four DLIs, designed through stakeholder consultation and aligned with existing frameworks and programs. The addition of subsequent DLIs followed similar approaches.

Once a target—or, in some instances, portion of a target—was reached, funds could be disbursed. Payments against most DLIs were "scalable," meaning disbursement was proportional to progress toward achieving the DLI. This helped provide a more stable basis for disbursements than an all-or-nothing approach. Also, failure to achieve a DLI by the agreed time did not result in immediate loss of the allocated resources; achieving the DLI target (either full or partial) during the project period still permitted payment.

5. Funds flow

The PforR used Ethiopia's Public Financial Management (PFM) systems. Under the Financing Agreements for both the original and follow-on PforR, IDA credits and associated trust-fund grants were made to the Government of Ethiopia with the Ministry of Finance as the borrower's representative. The government then channeled the funds to the MOH. Funds were placed in a pooled donor fund (SDGPF) account at the central bank, which was managed by the MOH and had well-established rules for planning, disbursement, and reporting on the use of funds. The only restriction on the World Bank funds was a cap on the value of contracts issued by the government when using the funds (no contracts over $12 million) due to an internal bank policy. To ensure this limit was maintained, funds were deposited in a sub-account specifically for the PforR operation, where they could be monitored. Advances under the program were large.[10]

10 World Bank, *Health SDGs Program-for-Results ICR*, 2022, 28.

6. Data monitoring, reporting and verification

Each DLI had a specified verification protocol before funds could be disbursed (see Appendix 3). DLIs 1, 3, and 4 used the Demographic and Health Survey (administered every two years in some form), which was conducted by a third party and no additional validation was required. DLI 2 used a household survey implemented by a separate entity within the MOH, with third-party quality checks and technical assistance. The four systems-related indicators relied on reports produced by the government team managing the SDGPF through established processes and were validated by third parties, including universities, technical assistance providers, and individual consultants. The PforR program had a major focus on generating population-based data to facilitate performance monitoring and enhance decision-making.

The PforR used existing SDGPF reporting processes for many of its indicators and other monitoring needs, including quarterly financial and activity reports, an annual review of all audits, and an information management system for technical reporting. The bank conducted an annual Joint Review Mission and an Annual Review Meeting.

7. Sustainability and co-financing

Because the World Bank was funding a portion of the government's national health program (HSDP IV) rather than creating a separate program, it did not ask for co-financing per se, but rather reviewed the effectiveness of the HSDP IV, including the government's own financial contribution, as part of its technical assessment. A critical part of this included an expenditure analysis to determine whether the plan's budget was realistic for achieving the intended results and whether the government's contributions would be sustainable. The government also demonstrated a clear commitment to the health sector by increasing government health spending from $0.3 billion (2011) to $1.2 billion (2020), with its share of total health spending rising from 16 to 32 percent.[11]

More broadly, the World Bank includes a PFM systems analysis as part of the fiduciary assessment described above. This analysis identified risks to sustainable financing of the health system, including in planning, tax collections, and budget execution, among other areas. The bank also had distinct programming in PFM and governance in the country and was able to address some risks through these other programs.

8. Staffing, management, and technical assistance

The World Bank had a core implementation team consisting of a task team leader, deputy leader, and one or two consultants based in-country; these staff sometimes balanced the work with other operations (domestic or regional) in their portfolio. The program also benefited from a support team consisting of staff and consultants based in the region, headquarters, or elsewhere with

11 World Bank, *Health SDGs Program-for-Results ICR*, 2022, 25.

technical expertise in fiduciary, environmental and social, anti-corruption, legal, and other areas. These team members supported the program's design, risk management, and implementation on a part-time basis.

The government of Ethiopia used its existing structures, namely the SDGPF management unit and other units in the MOH, and their existing staff, to manage the program.

Technical assistance was coordinated as part of the "one plan" approach under the SDGPF. Several providers assisted by providing technical assistance for various parts of the PforR, including in health financing and fiduciary systems, public expenditure, nutrition, and monitoring. Providers included the Gates Foundation, UNICEF, WHO, USAID, universities, and the World Bank itself. Some donors, like the World Bank, provided this support through the SDGPF, while others did so via other mechanisms. In the final bank report, stakeholders cited technical support as helpful in achieving program results.

9. Results

Overall, the World Bank and the government judged the PforR as helping to improve the delivery and use of a comprehensive package of maternal and child health services, with virtually all outcome targets surpassed by 2019, and with Ethiopia continuing to make progress in reducing maternal, infant, and under-five mortality. Most notably, progress on expanding deliveries attended by skilled providers rose from 10 percent (2011) to 50 percent (2019), with significant benefits to lower socioeconomic groups and the bottom three performing regions. Similarly, most health systems strengthening DLIs were achieved or surpassed, and the country almost fully achieved those related to institutional strengthening. For example, health centers reporting HMIS data in time rose from 50 percent (2011) to 84 percent (2022; the goal was 86 percent). Some indicators were revised to reflect what was feasible in an increasingly complex country context.[12]

The final World Bank report noted that the PforR was successful in bringing attention and support to maternal and child health and empowering the MOH to manage relevant programming. Given the nature of the World Bank's support—performance-based contributions to a pooled fund supporting a broader national health program—it is difficult to attribute the health gains to the PforR directly. (Drawing links between donor support and development outcomes is always tricky, regardless of the mechanism for providing that support.) However, the World Bank believed that the targeted funding, combined with the pay-for-results approach, were critical drivers of the success. It also noted that while the country made steady progress on all indicators over nearly a decade of support, far more needs to be done to have a major impact on maternal and child health.

12 World Bank, *Health SDGs Program-for-Results ICR*, 2022.

The PforR program had an important impact on strengthening the capacity of government institutions. There were notable improvements in the timely availability of both health outcome and facility data, which helped policymakers track progress on maternal and child health and take remedial action by triangulating data from different sources. The fiduciary reforms of the pharmaceutical procurement and supply chain agency, the PFSA, proved challenging to carry out. Still, the program achieved meaningful progress in improving transparency and competitive procurement practices over the course of implementation.

Case study 2: The Global Fund and results-based financing in Rwanda

Program: Results-Based Financing Grants for HIV/TB and Malaria

Amount: $174 million

Period: 2024–2027 (financing since 2003, results-based since 2015)

Financing Type: Grant

Program Goal: Combat HIV, TB, and malaria

Implementer: Ministry of Finance and Economic Planning (MINECOFIN) and Ministry of Health are the grant co-signatories; the Ministry of Health is the main implementer

Key takeaways

- The government of Rwanda was able to achieve substantial results with less funding in the results-based financing model compared to the prior Global Fund model.
- Disbursements based on a sliding scale for performance indicators allowed for flexibility while preserving essential service delivery.
- 15 percent of the grant was released based on the government providing agreed-upon co-investment amounts.
- Fully aligning to the national strategic plans, using the existing systems, being "on budget," and relying on existing data and reporting systems strengthened ownership and systems.
- Strong, preexisting governance, accountability, and reliable data systems were key for the results-based financing model—strengthening these systems ahead of time or concurrently to financing was needed in places where they were weak.
- Global Fund civil society engagement requirements helped open up space for local stakeholder engagement in design and implementation oversight.
- The Global Fund staffing footprint for Rwanda's program is small and relies on more in-country management by government and multistakeholder teams, as well as a separate auditing and accounting firm.
- Financial sustainability remains a concern despite a high level of country ownership.

Donor context

Since its establishment in 2002, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (the Global Fund) has provided multi-year grants, often to governments directly, to combat HIV, TB, and malaria. A large volume of Global Fund grants are implemented through government systems, typically with one government entity and one civil society entity serving as the principal recipients and both with the responsibility for grant and sub-grant management.

The Global Fund allocates financing to countries based on disease burden and income level, then refines those amounts through qualitative adjustments, a process which incorporates country-specific epidemiological, programmatic, and contextual factors. Global Fund grants include co-financing, under which governments must increase domestic health spending, with 15 percent of total grant funding contingent on meeting these financing commitments.

In most countries, the Global Fund's support is input-based, tied to specific programmatic and project budgets and anticipated expenditures. However, in select countries with strong health systems, the Global Fund has implemented results-based financing, where disbursements depend on verified programmatic performance. Rwanda stands out as an example where this alternate model has been deployed effectively. The Global Fund's Office of the Inspector General noted that there is potential for this approach to expand to other countries in the coming years, as it has proven effective, incentivizes results, and increases country ownership.[13]

Country and program context

The Global Fund has provided support to Rwanda since 2003, committing over $1.9 billion across HIV, TB, malaria, and health systems strengthening.[14]

In the early 2000s, Rwanda faced severe health challenges, including high HIV prevalence, low life expectancy, and elevated child mortality. Over the past two decades, the country has made substantial progress, reducing HIV prevalence to approximately 3 percent and achieving gains in malaria and TB control. These outcomes reflect strong government leadership, deliberate investment in the national system, and sustained donor support (including from the Global Fund and the US government).

As Rwanda's disease burden declined, the Global Fund's allocations—and contributions from other donors—decreased. In response, the government of Rwanda advocated that the Global Fund shift toward full use of national systems and results-based financing, enabling greater country ownership and efficiency.

13 The Global Fund to Fight AIDS, Tuberculosis and Malaria, Office of the Inspector General. "Audit of Global Fund Grants to the Republic of Rwanda." GF-OIG-24-020. 2024. https://www.theglobalfund.org/media/15329/oig_gf-oig-24-020_report_en.pdf.

14 Ibid.

Rwanda's ability to demonstrate strong public financial management, governance, and accountability, and to manage reliable data and reporting systems, bolstered donor confidence in its systems. Rwanda also enacted significant reforms related to cooperation with development partners around 2011. This included a new development cooperation agreement under which development partners aligned their programs with the Rwandan government's priorities and agenda.

While Rwanda scores low on civil society freedom indices and the government has been credibly accused of infringing on citizens' rights,[15] the Global Fund, through its engagement with the government, has over the years expanded civil society's role in the design, oversight, and implementation of Global Fund grants. The government of Rwanda has channeled Global Fund grant support to civil society organizations to deliver services for specific target populations, a concept called "social contracting."

The Global Fund and the government of Rwanda piloted the results-based financing model for the HIV program in 2014, expanding the approach to all Global Fund grants (HIV/TB and malaria) in the country beginning in 2015.

Program and approach

1. Goals and objectives

The 2023–2025 Global Fund grant included seven specific HIV/TB goals and one malaria goal. HIV/TB grant goals and objectives include the reduction in new HIV infections and AIDS-related deaths; expanded prevention (including pre-exposure prophylaxis, PrEP) and prevention of mother-to-child transmission; strengthened integration with broader health services; and scaled-up TB detection and treatment. Among the malaria grant goals were a reduction in morbidity and mortality by 80 percent through expanded vector control and surveillance and transitioning to next-generation prevention tools. Health system strengthening is integrated within the grant and specifically called out within objectives, with a particular emphasis on digital health systems, laboratory and surveillance capacity, and human resources and community systems.

2. Design

The Global Fund grants support Rwanda's national health strategies, including the overall Health Sector Strategic Plan 2024-2029[16] and sector-specific plans for HIV, TB, and Malaria. The grant's performance framework—and specific objectives, budget, and results—flows directly from these national strategic plans. Rwanda is exempt from the typical Global Fund requirement to submit a

15 Freedom House, "Rwanda: Freedom in the World 2025," *Freedom in the World 2025*, 2025, https://freedomhouse.org/country/rwanda/freedom-world/2025.

16 Ministry of Health, Republic of Rwanda, *Health Sector Strategic Plan V (HSSP V): July 2024–June 2029* (Kigali: Ministry of Health, 2024).

detailed grant-specific budget because the Global Fund relies on the national strategic plan and its associated national costed operational plans.

Global Fund proposals in Rwanda are developed through multi-stakeholder consultations involving government, civil society, development partners, and affected communities. The process draws on national strategic plans, midterm reviews, and gap analyses to identify priority interventions.

The Ministry of Finance and Economic Planning (MINECOFIN) and the Ministry of Health are the grant co-signatories. The Ministry of Health is the main implementer, and the Office of the Auditor General provides financial assurance for the grants. The Ministry of Health and the Rwanda Biomedical Center, an MOH-affiliated entity that oversees specific disease programming, directly implement and provide subgrants to government and nongovernmental entities for implementation. The government of Rwanda fully handles the management of any subgrants.

3. Risk management

The Global Fund operationalized a global Risk Appetite Framework[17] in 2018, setting recommended risk appetite levels for key risks affecting Global Fund grants. A standard risk assessment looks at the national health program's technical quality across the three diseases, monitoring and evaluation, governance, and health financing. This risk assessment is done on a regular basis, with the last one completed in Rwanda in 2025 (see Table 1 for scores). Rwanda's results have consistently demonstrated strong and reliable systems across the board. Risk tables with mitigation measures and responsible entities are included in the grant proposals and in grant management, with regular monitoring.

For Rwanda, the overall risk level was assessed as "low." Key risks mentioned in prior assessments included (1) health commodity procurement delays and supply chain management issues; (2) the need to design indicators to better monitor the key population HIV treatment and drug resistant TB; (3) financial risks related to controls at the sub-recipient level; (4) underutilizing the Country Coordinating Mechanism (CCM) for oversight; and (5) concern over the declining donor funding in Rwanda since the country remains highly dependent on external financing. While the 2025 audit rated overall risk as "low," it elevated health financing to a "moderate" risk due to long-term funding concerns.

17 The Global Fund, *Risk Appetite Framework* (Geneva: The Global Fund, 2018), https://www.theglobalfund.org/media/7461/core_riskappetite_framework_en.pdf.

Table 1. Global Fund audit report 2024 risk areas[18]

Audit Area	Risk Category	Secretariat Aggregated Assessed Risk Level	Assessed Residual Risk Based on Audit Results
Programmatic and monitoring and evaluation	HIV: program quality	Low	Low
	TB: program quality	Low	Low
	Malaria: program quality	Low	Low
M&E	M&E	Low	Low
Governance	In-country governance	Low	Low
Health financing	Health financing	Low	Moderate

4. Indicators and disbursements

The performance indicators are all derived and costed based on Rwanda's national strategic plans and associated costed implementation plans. The most recent Global Fund grant—which followed from the pilot program—has 21 performance indicators (two of which are system-strengthening-related indicators) for HIV/TB and eight indicators for malaria. All indicators are tied to disbursements. Additionally, there are "Workplan Tracking Measures," or additional indicators (with no quantifiable targets) that are part of the workplan.

Table 2 includes illustrative indicators from across the three disease proposals. (For a more complete list of indicators for Rwanda's HIV performance-based financing proposal from 2024–2027, see Appendix 4).

Table 2. Illustrative sample performance indicators for Rwanda HIV, TB, Malaria Proposal for 2024–2027[19]

Percentage of people living with HIV currently receiving antiretroviral therapy
Proportion of eligible People Living with HIV initiated on Tuberculosis Preventive Treatment
Confirmed malaria cases (microscopy or RDT): rate per 1000 persons per year
Inpatient malaria deaths per year: rate per 100,000 persons per year

The Global Fund disbursements are based solely on performance against the indicators described above. A disbursement framework is used to calculate disbursements based on the percentage of the performance targets achieved. If 90 percent, on average, across all performance indicators are met, the Global Fund will make full payments. In addition, there is a sliding scale for lower performance, guaranteeing some payment if portions of the targets are achieved. To incentivize results and efficiency, exchange gains and other savings from the grants are reinvested by the country and channeled to the national strategic plans. There are no financial reprogramming requirements. Fifteen percent of Rwanda's grant funding is contingent on increased domestic health spending and

18 The Global Fund to Fight AIDS, Tuberculosis and Malaria, Office of the Inspector General. "Audit of Global Fund Grants to the Republic of Rwanda." GF-OIG-24-020. 2024. https://www.theglobalfund.org/media/15329/oig_gf-oig-24-020_report_en.pdf.

19 Rwanda Ministry of Health. *The Global Fund: Funding Request Form, Allocation Period 2023–2025*. Kigali: Rwanda Biomedical Centre/ Ministry of Health, 2023, https://data.theglobalfund.org/location/RWA/access-to-funding.

meeting co-financing commitments, meaning that even if all performance targets are achieved but Rwanda does not meet health financing targets, only 85 percent of the total grant would be disbursed.

5. Funds flow

Global Fund grants are fully integrated and aligned with domestic funding. The funding flows from the Global Fund to the national treasury. In Rwanda, those funds are transferred from the treasury to the MOH. Global Fund grants are "on budget" and are included in all national budgets and expenditure reports. Historically, across many donors and countries, governments have experienced challenges with absorptive capacity and on-time disbursements with direct funding arrangements; however, in Rwanda, the Global Fund disbursements and expenditures have been on time and close to 100 percent of the agreed amount, demonstrating good absorptive capacity.

Table 3. Global Fund Rwanda grant disbursement performance[20]
Grant Cycle 6 funding and disbursements (July 2021–June 2024)

Component	Principal Recipient	Total Signed (million USD)	Disbursement (million USD)	(%)
HIV/TB	Ministry of Health	222.99	194.68	87.30%
Malaria	Ministry of Health	65.82	65.82	100%
TOTAL		**288.81**	**260.50**	**90.19%**

The national Integrated Financial Management Information System is used across all ministries to support public financial management and is used for the Global Fund grants. Health budgets and expenditures are publicly available, regularly updated, and widely used by the government.

6. Data monitoring, reporting and verification

Rather than using Global Fund-specific reporting tools, the Global Fund uses data and detailed annual progress reports produced by national disease programs and validated by the Country Coordinating Mechanism (CCM), a key multistakeholder oversight body, to assess performance and determine disbursements. All data comes from the health management information system (HMIS). In addition, the model leverages oversight by the Office of the Auditor General to provide assurance not only on financial management, but also on controls related to in-country data management. Rwanda's Auditor General has an independent reporting line to Parliament, enabling transparent accountability to the legislative body and the public on the operations of the MOH. Several additional independent bodies also ensure effective oversight and regulation of the work, including the Rwanda

20 The Global Fund to Fight AIDS, Tuberculosis and Malaria, Office of the Inspector General. "Audit of Global Fund Grants to the Republic of Rwanda." GF-OIG-24-020. 2024. https://www.theglobalfund.org/media/15329/oig_gf-oig-24-020_report_en.pdf.

Governance Board, the Rwanda Public Procurement Authority, the Rwanda National Prosecution Authority, and the Office of the Ombudsman.[21]

The Ministry of Health, with Global Fund participation for independent oversight, also conducts regular data quality assessments and a specific Global Fund Office of Inspector General (OIG) review and report every five years. The Global Fund OIG found data accuracy to be 95 percent in their 2024 report. Monthly data validation processes and nationwide implementation of the District Health Information System supported data quality. The OIG flagged only minor data issues.[22,23]

7. Sustainability and co-financing

Per the Global Fund's co-financing policy,[24] 15 percent of Rwanda's grant funding is contingent on increased domestic health spending and co-financing results–monitored through Rwanda's own financial systems. The current co-financing commitment for Rwanda is $283.5 million to complement the Global Fund grant of $174 million across the three diseases for 2024–2027. In the past, Rwanda has consistently met and exceeded these requirements, with government health financing increasing by 88 percent since 2015. Meanwhile, strong national public financial management systems enable timely, transparent reporting on health expenditures.

While Rwanda is classified as a low-income country, it has made substantial progress in reducing disease burdens. This success has led to reductions in external funding, including from the Global Fund. The government has increased spending and contributes 15.3 percent of its national budget to health but has been unable to offset the reductions fully. The large external financing of the national health program is a major risk for Rwanda.

8. Staffing, management, and technical assistance

Typical Global Fund grants are managed from Geneva by a country team led by a fund portfolio manager, supported by technical and operational staff. While team size varies by portfolio, a typical Global Fund grant is buoyed by a team of around five staff for oversight and management. For the recipient government, day-to-day implementation is usually led by a program management unit within the Ministry of Health. Oversight and accountability are reinforced through two key

21 The Global Fund to Fight AIDS, Tuberculosis and Malaria, Office of the Inspector General, *Audit of Global Fund Grants to the Republic of Rwanda*, GF-OIG-24-020 (Geneva: The Global Fund, 2024), http://oig_gf-oig-24-020_report_en.pdf.

22 Rwanda Ministry of Health. *The Global Fund: Funding Request Form, Allocation Period 2023–2025*. Kigali: Rwanda Biomedical Centre/ Ministry of Health, 2023, https://data.theglobalfund.org/location/RWA/access-to-funding.

23 The Global Fund to Fight AIDS, Tuberculosis and Malaria, Office of the Inspector General, *Audit of Global Fund Grants to the Republic of Rwanda*, GF-OIG-24-020 (Geneva: The Global Fund, 2024), https://www.theglobalfund.org/media/15329/oig_gf-oig-24-020_report_en.pdf.

24 The Global Fund to Fight AIDS, Tuberculosis and Malaria, *Sustainability, Transition and Co-Financing Policy* (Geneva: The Global Fund, 2025), https://www.theglobalfund.org/media/14383/core_sustainability-transition-cofinancing_policy_en.pdf.

Global Fund-enabled or contracted structures: a Local Fund Agent (LFA),[25] an independent firm providing financial and audit assurance to the Geneva team, and a Country Coordinating Mechanism (CCM), a multi-stakeholder body that includes government, civil society, donor, impacted communities, and other partners responsible for grant oversight and strategic alignment.

In Rwanda, the results-based financing model enables a more streamlined management approach with fewer oversight requirements. The Geneva-based country team is small, with just two full-time staff (a fund portfolio manager and a program officer), supported by other technical and operational staff as needed. Implementation management is fully embedded within government systems through the Rwanda Biomedical Center's Single Project Implementation Unit, which coordinates and implements all donor-funded programs. The CCM, chaired by the Permanent Secretary of Health, plays a central role in monitoring performance and ensuring accountability across stakeholders.[26] The LFA—PwC in Rwanda—continues to provide independent verification, with greater emphasis on performance and systems assurance given the country's strong PFM and reporting structures.

9. Results

Global Fund grants under Rwanda's results-based financing model have delivered strong outcomes. Most national strategic plan targets for these programs were met ahead of schedule. Between 2015 and 2022, new HIV infections declined by 56 percent and AIDS-related deaths by 36 percent. Rwanda also surpassed the UNAIDS 95:95:95 targets (reaching 96:98:98, with 99 percent of HIV-exposed infants born HIV-free.[27]) Malaria cases fell by 67 percent over the same period, with national targets to reduce morbidity and mortality achieved.[28] While TB outcomes lag behind some national targets, progress has been made in case detection, diagnostic coverage, and treatment success.[29] While not all achievements can be tied to the Global Fund grant, the Global Fund audit reports that its results-based financing approach has significantly contributed to progress.

25 The Global Fund to Fight AIDS, Tuberculosis and Malaria, "Local Fund Agent," accessed June 5, 2026, https://www.theglobalfund.org/en/lfa/.

26 Rwanda Country Coordinating Mechanism, "Home," accessed June 5, 2026, https://www.ccm.rw/index.php?id=3.

27 Rwanda Biomedical Centre Annual Report (2024–2025) ANNUAL PROGRAMMATIC REPORT FOR HIV -STIs-VIRAL HEPATITIS 2024-2025.pdf.

28 World Health Organization, *World Malaria Report 2023* (Geneva: World Health Organization, 2023), https://www.who.int/publications/i/item/9789240086173.

29 Rwanda Biomedical Centre, TB and Other Respiratory Diseases Division, *Annual Report 2023–2024* (Kigali: Rwanda Biomedical Centre, 2024), https://www.rbc.gov.rw/fileadmin/user_upload/report_2024/TB/TBORD_annual_report_2023-2024.pdf.

Case study 3: USAID and pooled funding for refugee health in Jordan

Program: The Jordan Health Fund for Refugees

Amount: $27 million (USAID contribution), $109 million (pooled amount)

Period: 2018–2024 (extended 2024–2028)

Financing Type: Joint Financing Agreement Grant

Program Goal: To expand access to quality health services for the country's refugee population and to build a more resilient health system for all Jordanians

Implementer: The Ministry of Planning and International Cooperation (MoPIC) manages contributions; the Ministry of Health (MOH) implements

Key takeaways

- Direct government financing can support policy reforms. In this case, funding allowed the government to change its fee structures for refugee healthcare.
- Aligning with the government of Jordan's national strategic plans and priorities facilitated Jordan's own contributions to refugee health programming.
- The US government funding and pooled funding approach leveraged other funding from donors with similar goals.
- Joint financing and one result framework created efficiencies for the government of Jordan—fewer separate donor plans and requirements—and for donors, who were able to build off of assessments and evaluations of others.
- Using Jordan's own systems strengthened them for work beyond the refugee health program.
- Creating a donor coordination unit helped the Jordan Health Fund for Refugees succeed and has also supported other donor coordination beyond this project.

Donor context

As of late 2024, USAID's model of development assistance was dominated by grants and contracts to NGOs. However, the agency had a long history of directly funding governments over its 60 years of operation. In 2024, USAID programmed just 1 percent (or $169 million) of its annual budget directly to government partners, excluding large, congressionally mandated transfers to Jordan—and to Ukraine, albeit indirectly via a World Bank trust fund. USAID's direct government funding was governed by provisions in annual congressional appropriations law and specific USAID government-to-government (G2G) policies. The two most common G2G instruments were Cost Reimbursable Agreements (paid based on incurred costs) and Fixed Amount Reimbursable

Agreements (paid based on achievement of milestones). Beyond these two mechanisms, the agency also had authority to use cash transfers and direct budget support, as well as host country contracting (a mechanism that allowed for government procurement and implementation management with payments made by USAID directly to a contractor), and multi-donor financing agreements (where multiple donors could pool funds).

Country and program context

The US government has provided support for Jordan since the 1950s, and the two countries maintain a close diplomatic relationship. USAID, in more recent years, supported a substantial development program in the country, averaging about $1.9 billion a year.[30] As of the US fiscal year 2024, Jordan received the third-largest direct US economic budgetary aid after Israel and Ukraine.[31] The Jordan portfolio was made up of many G2G agreements along with grants and contracts to NGO partners. A large part of the portfolio consisted of direct government budget support mandated by the US Congress. The other G2G mechanisms covered a range of activities, including education, health, governance, water, and refugee support in Jordan. USAID Jordan also incorporated many types of G2G instruments, including cost reimbursable mechanisms, performance-based mechanisms, host country contracts, general budget support, and a joint donor financing agreement that centered on Syrian refugee health services–the focus of this review.

Jordan has the second-largest number of refugees per capita in the world, with 2025 estimates of 462,282 UN Refugee Agency (UNHCR)-registered Syrian refugees (and 1.3 million unregistered Syrian refugees), as well as other refugees representing 56 nationalities, including approximately 2.39 million registered Palestinian refugees. At the beginning of the civil war in Syria, Jordan provided UNHCR-registered Syrians fleeing conflict with subsidized access to public sector healthcare services. Ultimately, the financial burden of providing adequate health services for the rapidly growing refugee population led the government of Jordan to raise healthcare costs, causing a decline in the number of refugees seeking care. Similarly, as UNHCR-registered non-Syrian refugees were only eligible for very limited levels of assistance, few sought needed health care at public health facilities. The decline in refugees seeking health services led to growing concern for the health of Jordan's broader population.

In response, in 2018, USAID and the government of Jordan established the Jordan Health Fund for Refugees (JHFR), a joint financing arrangement designed to help defray the cost of providing healthcare for refugees and increase donor investments in Jordan's health system.

30 United States Agency for International Development (USAID), *Country Development Cooperation Strategy (CDCS): Jordan, June 30, 2020–July 1, 2025* (Washington, DC: USAID, 2020), https://static1.squarespace.com/static/587fcaeb1b10e3086960b284/t/5fea84d23335c849046a9483/1609204948261/Jordan_CDCS_2020-2025.pdf.

31 *FA.gov*, https://foreignassistance.gov/.

Since 2025, Jordan's health system has faced continued pressure from refugees and increased funding cuts from donors, including USAID.

Program and approach

1. Goals and objectives

The objective of the JHFR is to expand access to quality health services for the country's refugee population and to build a more resilient health system for all Jordanians. It was originally intended to offset the additional costs of providing health services to Syrian refugees through the public health system but was later expanded to cover all UNHCR-registered refugees. The provision of services and improved infrastructure projects supported by the funds have had a secondary impact on improving access and services for the broader population of Jordan.

2. Design

In 2018, USAID offered the government of Jordan funding to offset health care costs for refugees if the government returned to an earlier policy of subsidizing refugee healthcare so that refugees paid no more than 20 percent of the cost of care. This need was deemed urgent, and USAID decided not to use one of its typical G2G instruments to avoid potentially lengthy planning and process requirements. Instead, it used a pooled funding arrangement—in part to allow other donors to contribute—and aimed to launch the fund in six months. Once it was established, other donors joined.

The JHFR was set up as a pooled fund (joint financing arrangement) between the donors and the government of Jordan. The arrangement provides the overall framework for the JHFR, while each donor has its own bilateral agreement. The Ministry of Planning and International Cooperation (MoPIC) is the signatory, while the Ministry of Health (MOH) manages the funding and implements the program. Total funding for the program was $109 million (from 2019–2025), with the largest contributions coming from the World Bank, US, and Canada, and additional funding from Denmark, Qatar, Germany, and Italy. The agreement was renewed in 2024 for the second time, extending it until December 2028.[32]

The pooled funding approach was seen as an effective way to galvanize efforts across donors and have a greater impact on joint policy and program priorities. In that vein, the fund was also used to respond to COVID-19, channeling approximately $40 million of donor funds for the pandemic response.

32 Global Affairs Canada. "Support to Jordan Health Fund for Refugees." Project No. P006740001. Project Browser. Accessed June 3, 2026. https://w05.international.gc.ca/projectbrowser-banqueprojets/project-projet/details/P006740001.

The JHFR aligns with national plans and the national health program. It covers three areas:

- Policy: Refugee access to primary and secondary healthcare facilities at the same user rates as uninsured Jordanians.
- Infrastructure upgrades: Service expansion, infrastructure development, infrastructure refurbishing, and the provision of specialized services and medical equipment at public health facilities located in high-refugee-density areas.
- Capacity building and awareness: Health workforce capacity strengthening through the establishment of a Ministry of Health training center and the distribution of policy manuals and services guidelines.

3. Risk management

USAID did not require a specific risk assessment for joint donor financing mechanisms at the time of the JHFR design; instead, it relied on a recently conducted assessment of the MOH for a separate G2G agreement that used standard USAID policy guidance and tools.[33] Other donors also conducted their own risk assessments. Risks noted from these assessments included the lack of a financial sustainability and transition plan for the JHFR, among others.[34]

While accountability, governance, and fiduciary systems were generally strong, one critical risk for the JHFR program's success emerged: the Ministry of Health lacked a donor coordination unit. At the time, there was no team designated as a counterpart to coordinate, plan, or manage donor financing, despite significant amounts of funding entering the country for health programs. Based on these findings, the Projects Management and International Cooperation Directorate was established within the Ministry of Health.[35]

4. Indicators and disbursements

The JHFR includes about two dozen high-level and intermediate indicators focused on refugee health care access and broader health outcomes. These indicators are updated and revised as needed (see Table 4). However, disbursements are not linked to indicator performance as in the previous two examples. Rather, the JHFR was created—and USAID funding was given—in exchange for the shift in the government's policy on fees charged to refugees. USAID continued to provide additional funding based on annual reporting and financial pipeline information. The JHFR workplan is updated every year with a list of proposed projects for donor funding that is endorsed by its Steering Committee.

33 The guidance and tools used were outlined in the USAID Automated Directive System (ADS) Chapter 220, which is no longer publicly available.

34 Global Affairs Canada, "Summative Evaluation of Canada's Support to Jordan's Health Fund for Refugees II (JHFR)—Executive Summary," Government of Canada, last modified May 29, 2026, https://international.canada.ca/en/global-affairs/corporate/transparency/evaluations/decentralized-evaluations/jordan-executive-summary.

35 Confidential interview, May 5, 2026.

Table 4. Illustrative JHFR indicators[36]
Objective/Outcome: PDO indicators

Indicator Name	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Maintaining number of health services delivered at MOH secondary health care facilities to target populations	1,238,000 31-Dec-2016	1,238,000 31-Dec-2016	1,905,000 24-Jun-2019	2,518,150 01-Mar-2023
Number of health services delivered at MOH secondary health care facilities to poor uninsured Jordanians, male	513,000 31-Dec-2016	513,000 31-Dec-2016	792,000 24-Jun-2019	1,091,910 01-Mar-2023
Number of health services delivered at MOH secondary health care facilities to poor uninsured	556,000 31-Dec-2016	556,000 31-Dec-2016	1,009,000 24-Jun-2019	1,349,430 01-Mar-2023

5. Flow of funds

USAID funds were deposited into a dedicated central bank account and pooled with other donor funds. The Ministry of Health manages the resources using its financial management systems.

6. Data monitoring, reporting, and verification

As an integral part of the country's health system, the JHFR draws on national health data and reporting systems. The national data systems are considered strong and reliable for reporting. Most indicators are drawn from existing, standardized data sources, such as the Demographic and Health Survey. The government and donors also agree upon some JHFR-specific reporting.

A results framework is used to monitor impact. Indicators such as maternal mortality, under-5 mortality, antenatal care visits, and other standard health indicators are used to track progress on the overall health of Jordanians. Refugee-related health indicators are tracked and validated by the UN High Commissioner for Refugees. Some donors conduct regular reviews and evaluations and share findings with partners. The Audit Bureau of Jordan conducts an annual audit and shares the results with donors.[37]

7. Sustainability and co-financing

While there were no required co-financing commitments for the JHFR, the government of Jordan frequently provided additional financial support on its own to complement the programs as needed. Jordan has increased the government's own funding for refugee health services alongside the JHFR.

36 World Bank. *Jordan Emergency Health Project: Implementation Completion and Results Report*. Report No. ICR00006458. Washington, DC: World Bank, April 30, 2024.

37 Global Affairs Canada, "Summative Evaluation of Canada's Support to Jordan's Health Fund for Refugees II."

The JHFR invested in Jordan's public health system and increased the Ministry of Health's institutional capacity, which supported the establishment of permanent systems that could enhance resilience to future crises. However, concerns remain about the sustainability of the fund if donors reduce funding, given other priorities around the world. This risk is somewhat mitigated by engaging multiple donors, but the fund remains vulnerable to donor shifts due to its lack of a concrete, predictable, long-term financial plan.

8. Staffing, management, and technical assistance

The USAID program manager (government agreement technical representative), a health expert based in-country, led technical engagement with the government on the program and was supported by a robust in-country USAID staff consisting of other health team members, financial analysts, monitoring specialists, an agency lawyer, and others.

To manage these funds, the Ministry of Health established a Projects Management and International Cooperation Directorate, which also served to liaise with all donors engaged in the JHFR. This body eventually had 30 permanent government staff supporting coordination and implementation across all donor-funded activities, including those beyond the JHFR. The creation of this Directorate greatly improved coordination and the speed at which the country could implement internationally supported projects in the health sector. There were two committees within the Directorate: the Steering Committee, which met regularly with senior leadership, including the Minister of Health and senior officials from all donors; and the Technical Committee, which met with the working-level program managers and technical staff for implementation. Donor representatives were also part of the Technical Committee. Annual work planning was conducted jointly by the government and donors.

9. Results

The primary goal of the JHFR was for the government of Jordan to institute a policy change that allowed refugees access to health services at the same cost as uninsured Jordanian citizens, which it achieved at the program's outset. As a result, UNHCR-registered refugees in Jordan now have access to public-sector primary, secondary, and preventative healthcare services at more affordable costs. The government has maintained this policy of lower fees, reflecting a major commitment, and it continues to allocate a portion of its own budget to cover refugee-related costs and complement the JHFR funding. The pooled funding arrangement also helped the Ministry of Health advocate and negotiate for other donors to join.

The JHFR also served as a mechanism for responding to health emergencies. It was a readily available mechanism for rapidly implementing its National COVID-19 Response Plan. Through the fund, the government of Jordan procured COVID-19 testing kits, equipment, and medicines. In addition, donor

members helped upgrade health facilities to better respond to the pandemic, including rehabilitating isolation units and constructing new intensive care units at three hospitals. The JHFR's flexible design enabled the Ministry of Health to utilize it for these unexpected health crises.

The JHFR also expanded access to health care by renovating and building better-equipped public sector facilities, benefiting not only refugees but all residents seeking health services. In 2021, the Joint Financing Arrangement supported the renovation of the Specialized Surgical Department at Al Bashir Hospital, the country's largest public health facility. The new facilities enable the Ministry of Health to perform advanced cardiac procedures that previously had to be referred to private hospitals at government expense, resulting in $8 million in annual cost savings for the MOH.[38]

Through pooled donor contributions and the push to change the fee structure, USAID and other donors expanded access to quality health services for the country's most vulnerable residents and built a stronger health system for Jordanians more broadly through renovations and support for facilities that serve all residents. Indicators of maternal mortality, under-5 child mortality, and frequency of antenatal care visits improved in the regions of focus. The country also saw improvements in indicators of access, utilization, capacity, and awareness. While it is difficult to determine the extent to which these improvements can be attributed fully to the JHFR, UNHCR refugee-specific data shows improvements in refugee health access.

38 Confidential interview, May 5, 2026.

Table 5. Case study comparison table

	World Bank Health SDGs Program-for-Results (Maternal & Child Health) *Ethiopia*	Global Fund Results-Based Financing Grants (HIV/TB, Malaria) *Rwanda*	USAID Jordan Joint Donor Financing Agreement (Refugee Health) *Jordan*
National Programs and Systems			
Signatory/ implementer	Ministry of Health	Ministry of Finance + Ministry of Health (MINECOFIN + MOH co-sign; MOH implements)	Ministry of Planning (MoPIC) signs; Ministry of Health manages and implements
Country systems used	National PFM; pooled donor fund managed by MOH; existing reporting	National treasury → MOH; IFMIS for PFM; HMIS for data; national audit	Dedicated central bank account; MOH financial systems
Designing for Results			
Indicator count	8 at launch; rose to 22 after 2017 expansion (World Bank later judged this too complex)	21 HIV/TB + 8 malaria; all indicators tied to disbursement	~24 high-level and intermediate indicators, but not linked to disbursement
What triggers payment	Achievement of disbursement-linked indicators:	Performance against ~21 HIV/TB + 8 malaria indicators	Government policy change
Payment scaling	Scalable: proportional to progress; partial credit allowed	Sliding scale: 90% average performance triggers full payment; partial payment below	Lump-sum/annual; tied to policy compliance, budgets and pipeline
Verification	DHS (3rd party), MOH surveys with 3rd-party QC, universities/consultants for systems indicators	National HMIS, CCM oversight, Office of Auditor General, Local Fund Agent (PwC), OIG review every 5 years	National data + DHS; UNHCR for refugee indicators; Audit Bureau of Jordan annual audit
Management and Risk			
Donor staffing	Small in-country team (Task Team Leader, Deputy, 1–2 consultants) + regional/ HQ specialists	Small. 2 staff in Geneva (Fund Portfolio Manager + program officer) + additional specialists as needed and + 3rd party in-country LFA for compliance	Large in-country USAID footprint (government agreement technical representative + health team, finance, M&E, legal)
Risk approach	Technical, fiduciary, and environmental/ social assessments → Program Action Plan; legally binding covenants on critical items	Risk Appetite Framework + standing assessments of technical, M&E, health financing, governance; Rwanda rated "low" overall (2025)	Relied on prior MOH assessment from another G2G; risk findings led to creating MOH donor-coordination unit
Efficiencies and Sustainability			
Pooled with other donors	Yes. Funds flow through Ethiopia's SDG Performance Fund	No (single-donor grant), but aligned with national plan	Yes. Pooled with other bilateral and multilaterals donors.
Co-financing	None formally required; government increased share of health spending	Up to 15% of grant contingent on domestic spending; current commitment $283.5M	None required; government increased its own refugee-health spending

Findings and looking forward

These case studies offer a number of insights, but we focus on those most relevant for the current foreign assistance landscape and the proposed direction of the US foreign assistance for global health.

1. **National Programs and Systems**
    - **Investing directly in an evidence-based national program and working through country systems increases durability while reducing dependency and donor workload.** In all three case studies, donors channeled funding directly into the existing national health program, including planning and design, implementation, and monitoring systems. In Ethiopia, contributing to an existing government program (HSDP IV) reduced the workload and timeline associated with designing and negotiating an entirely new program, as well as the potential need to create new management structures. The Global Fund in Rwanda waives its typical requirement to develop a detailed grant-specific budget because it relies on the national strategic plan and the associated government-costed operational plans. Not only does this work strengthen country systems, but it increases resilience to shifts in donor funding: If one donor ever chooses to discontinue funding, other donors—or the government itself—can more easily step in to provide continuity. It does, however, make it difficult to attribute results specifically to donor funding.

    - **System strengthening improves program performance.** All the case studies highlight the need to support strong accountability, financial, data, and other systems for success—rather than paying only for outcomes or services. The World Bank views institutional capacity work as integral to the Program-for-Results model and makes it a policy priority, including through incorporating capacity-strengthening goals into disbursement-linked indicators. While the Global Fund emphasized that results-based financing worked in Rwanda because of the country's already strong systems, it still included systems-strengthening activities in its grants. The World Bank PforR in Ethiopia demonstrated that even with weaker systems, results-based models can be successful; strengthening the competitive practices of the Pharmaceutical Fund and Supply Agency was considered a primary driver of improved maternal and child health. Systems strengthening work is most effective when it is seen as a priority not just by the donor but by the partner government as well, making collaboration in program design essential.

    - **Strong and trusted national data systems allow for validation in results-based financing.** Using and strengthening national data and reporting systems can provide donors with the necessary information to validate results-based indicators while strengthening the capacity of the national system. However, given payments are based on the data received, these data systems require assessment, regular monitoring,

and specific support. In Rwanda, the Global Fund's use of a third-party auditor provided checks on the system and additional confidence in the data received. In Ethiopia, the World Bank required data system improvements in order to use the national data system for indicators that triggered payments. This increased donor confidence in the data and was seen as a critical driver of success.

2. **Designing for Results**
    - **Results-based funding approaches keep the focus on outcomes, enable leaner management structures, and allow the government to innovate.** While no counterfactual is available, in Rwanda, the performance-based approach is credited with strong outcomes and with reducing staffing levels below those of most other Global Fund programs. In Ethiopia, the shift to performance-based approaches is credited with raising maternal and child health outcomes, which had previously stagnated. In both cases, the approach provides an incentive for the government to solve problems and find cost savings, and it avoids the high administrative burden associated with input-based funding.

    - **Policy-based funding approaches can also achieve results in the right circumstances.** The example of Jordan and USAID shows that providing funding based on a policy change—in this case, reducing health care co-payments for refugees—can be another useful modality for providing direct government assistance. This was a viable option in part because Jordan and the US had a strong relationship and mutual trust, which facilitated negotiations on policy priorities and funding gaps.

    - **Simple program designs and monitoring schemes are often the most effective.** During its first four years, the Ethiopia PforR used just eight disbursement-linked indicators and achieved significant results; when it expanded, it increased the number of indicators to 22, which the World Bank concluded in hindsight made the program overly complex and difficult to manage.

    - **Scaling payments tied to indicator targets is more effective than all-or-nothing approaches.** Both the World Bank and the Global Fund use a sliding scale for indicator targets linked to disbursements. This maintains incentives to achieve program goals, even if the country is not on track to achieve the full target or to do so on time.

3. **Management and Risk**
    - **Different approaches to donor staffing and management are possible, with larger staffing footprints facilitating greater donor engagement.** The donors profiled in these case studies take different approaches to staffing and management, ranging from minimal staff based at headquarters and outsourcing some oversight functions (Global Fund) to limited in-country staff (World Bank) to a large in-country presence (USAID). This partly reflects the capacity level of the country systems involved but is

also related to how engaged the donor wants to be with the program. More staff allows for greater engagement in coordination, oversight, and systems strengthening, among other activities. It also facilitates relationship-building, which may play distinct roles in bilateral vs. multilateral assistance. Smaller staffing footprints allow for efficiencies in staffing costs and more reliance on the country's own management structures.

- **Civil society engagement and oversight support management and ownership.** The Global Fund's requirement for civil society participation in the Country Coordinating Mechanism provides a clear role for nongovernmental stakeholders in designing Global Fund proposals and applications and monitoring program implementation. This has served as a concrete way to increase the voice and space for civil society and improve relations with recipients of health services. The World Bank and USAID also consider civil society in their pre-award assessments. Engaging nongovernmental stakeholders and ensuring consideration of impacted populations strengthens programming by providing broader perspectives and services that are closer to the populations being served.

- **Effective risk management can help achieve program goals and reinforce country oversight systems.** All the programs described have robust approaches to risk management, including conducting thorough risk assessments and implementing mitigation measures. (In the unique case of USAID and Jordan, the agency took advantage of a prior risk assessment for a different program with the same ministry.) Despite the use of results- and policy-based funding approaches—which avoid some of the intensive oversight work of cost-based funding—the programs still monitored fiduciary and other risks and, in the case of Ethiopia, compelled the government to take action and upgrade relevant systems to achieve program goals. All three relied on the work of the national supreme audit institution and other government audit functions to review program, data, and fiduciary elements. Risk management was not just the donor's role; because the donor invested in the countries' national programs, it was also the responsibility of the country governments, including their systems and staff.

4. **Efficiencies and Sustainability**
    - **Pooling resources with other donors harmonizes aid, leverages funding, and reduces donor duplication.** In Jordan, USAID's pooled fund model encouraged other donors to contribute, increasing the funding available and the impact of the US government contribution. In Ethiopia, working through a common fund (the SDGPF) meant that the World Bank PforR would be harmonized with other donor support and use existing systems for reporting to donors. This approach has the additional benefit of reducing the government burden of managing disparate donor programs and eliminating duplication of donor programming and reporting requirements. The Global Fund tries to mitigate some of the drawbacks of its vertical funding approach by using existing country implementation and reporting systems.

- **Sustainable financing goes beyond government contributions.** All three case studies saw increases in government financing for the implemented programs, yet all three still noted challenges to long-term financial sustainability. Financial durability is a function of both a government's commitment to allocating domestic resources to the health sector and broader dynamics, including economic growth, domestic resource mobilization, allocative efficiency, alternative financing approaches, and others. Both the World Bank and the Global Fund included these considerations in their risk assessments and, in some cases, provided support to address long-term financial sustainability.

The approach taken to giving direct assistance to governments will necessarily reflect a donor's unique needs and circumstances, as well as the recipient country's context and priorities. Ideally, it will also reflect good development practice, including support and use of government systems, harmonization with other donors, and a focus on both immediate achievement of results and the broader dynamics that impact long-term sustainability. As the US State Department advances new direct government funding approaches, it can benefit from the lessons of other donors. Continued dialogue and shared learning will help refine these models and strengthen their effectiveness over time.

Table 6. Findings in brief

National Programs and Systems	Investing directly in an evidence-based national program and working through country systems increases ownership while reducing dependency and donor workload.
	System strengthening improves program performance.
	Strong and trusted national data systems allow for validation in results-based financing
Designing for Results	Results-based funding approaches keep the focus on outcomes, enable leaner management structures, and allow the government to innovate.
	Policy-based funding approaches can also achieve results in the right circumstances.
	Simple program designs and monitoring schemes are often the most effective.
	Scaling payments tied to indicator targets is more effective than all-or-nothing approaches.
Management and Risk	Different approaches to donor staffing and management are possible, with larger staffing footprints facilitating greater donor engagement.
	Civil society engagement and oversight supports management and ownership.
	Effective risk management can help achieve program goals and reinforce country oversight systems.
Efficiencies and Sustainability	Pooling resources with other donors harmonizes aid, leverages funding, and reduces donor duplication.
	Sustainable financing goes beyond government contributions.

References

Introduction

U.S. Department of State and U.S. Agency for International Development. *FA.gov*. Accessed May 29, 2026. https://foreignassistance.gov/.

Case study 1: Ethiopia and the World Bank

Gelb, Alan, Anna Diofasi, and Hannah Postel. *Program for Results: The First 35 Operations - Working Paper 430*. Center for Global Development, 2016. https://www.cgdev.org/publication/program-results-first-35-operations-working-paper-430.

Independent Evaluation Group. *Program for Results: An Early Stage Assessment of the Process and Effects of a New Lending Instrument*. Washington, DC: World Bank Group, 2015. https://ieg.worldbankgroup.org/evaluations/program-for-results.

World Bank. *Bank Policy: Program-for-Results Financing*. Washington, DC: World Bank, 2023. https://thedocs.worldbank.org/en/doc/100b8a625834bdb25526e4a05391927a-0290012023/original/Policy-PforR.pdf.

World Bank. *Ethiopia Program for Results (Hybrid) for Strengthening Primary Health Care Services*. Program Appraisal Document, Report No. PAD4867. Washington, DC: World Bank, November 22, 2022. https://documents1.worldbank.org/curated/en/099315011232241347/pdf/BOSIB16722c1c501e19eeb1d65725e52dc8.pdf.

World Bank. *Health Millennium Development Goals Program-for-Results: Program Appraisal Document*. Report No. 75101-ET. Washington, DC: World Bank, February 1, 2013. https://documents1.worldbank.org/curated/en/763541468256147222/pdf/751010PAD0P1230Official0Use0Only090.pdf.

World Bank. *Health Sustainable Development Goals Program-for-Results: Implementation Completion and Results Report*. Report No. ICR00005696. IDA52090, IDA60900. Washington, DC: World Bank, December 23, 2022. https://documents1.worldbank.org/curated/en/099620001062330072/pdf/BOSIB000912ba30d80aa3a076cc4128de5a.pdf.

World Bank. *Program-for-Results: A New Approach to World Bank Financing*. Washington, DC: World Bank, n.d. https://thedocs.worldbank.org/en/doc/904551435264587829-0290022019/original/PforRbrochure.pdf.

World Bank. *Program-for-Results: Overview*. Washington, DC: World Bank, 2016. https://thedocs.worldbank.org/en/doc/115591467219486922-0290022016/render/PforRTZoverviewpptenglish.pdf.

World Bank Group. "Getting to Know the World Bank Group." July 26, 2012. https://www.worldbank.org/en/news/feature/2012/07/26/getting_to_know_theworldbank.

Case study 2: Rwanda and the Global Fund

Freedom House. "Rwanda: Freedom in the World 2025." 2025. https://freedomhouse.org/country/rwanda/freedom-world/2025.

The Global Fund to Fight AIDS, Tuberculosis and Malaria. "Core Risk Appetite Framework." 2018. https://www.theglobalfund.org/media/7461/core_riskappetite_framework_en.pdf.

The Global Fund to Fight AIDS, Tuberculosis and Malaria. "Local Fund Agent." Accessed June 5, 2026. https://www.theglobalfund.org/en/lfa/.

The Global Fund to Fight AIDS, Tuberculosis and Malaria. "Principal Recipient Reporting Handbook." Accessed June 5, 2026. https://resources.theglobalfund.org/media/z3zamayf/cr_pr-reporting-handbook_guide_en.pdf.

The Global Fund to Fight AIDS, Tuberculosis and Malaria. "Sustainability, Transition and Co-Financing Policy." 2024. https://www.theglobalfund.org/media/14383/core_sustainability-transition-cofinancing_policy_en.pdf.

The Global Fund to Fight AIDS, Tuberculosis and Malaria, Office of the Inspector General. "Audit of Global Fund Grants to the Republic of Rwanda." GF-OIG-24-020. 2024. https://www.theglobalfund.org/media/15329/oig_gf-oig-24-020_report_en.pdf.

Ministry of Health, Republic of Rwanda. *Health Sector Strategic Plan V (HSSP V), July 2024–June 2029*. Kigali: Ministry of Health, 2025.

Rwanda Biomedical Centre, TB and Other Respiratory Diseases Division. *Annual Report 2023–2024*. Kigali: Rwanda Biomedical Centre, 2024. https://www.rbc.gov.rw/fileadmin/user_upload/report_2024/TB/TBORD_annual_report_2023-2024.pdf.

Rwanda Country Coordinating Mechanism. Home page. Accessed June 5, 2026. https://www.ccm.rw/index.php?id=3.

Rwanda Ministry of Health. *The Global Fund: Funding Request Form, Allocation Period 2023–2025*. Kigali: Rwanda Biomedical Centre/Ministry of Health, 2023. https://data.theglobalfund.org/location/RWA/access-to-funding.

World Health Organization. *World Malaria Report 2023*. Geneva: World Health Organization, 2023. https://www.who.int/publications/i/item/9789240086173.

Case study 3: Jordan and USAID

Global Affairs Canada. *Summative Evaluation of Canada's Support to Jordan's Health Fund for Refugees II (JHFR): Executive Summary*. Ottawa: Global Affairs Canada, n.d. https://international.canada.ca/en/global-affairs/corporate/transparency/evaluations/decentralized-evaluations/jordan-executive-summary.

Global Affairs Canada. "Support to the Jordan Health Fund for Refugees — COVID-19." Project No. P006740002. Project Browser. Accessed June 3, 2026. https://w05.international.gc.ca/projectbrowser-banqueprojets/project-projet/details/P006740002.

Global Affairs Canada. "Support to Jordan Health Fund for Refugees." Project No. P006740001. Project Browser. Accessed June 3, 2026. https://w05.international.gc.ca/projectbrowser-banqueprojets/project-projet/details/P006740001.

United States Agency for International Development. "Foreign Assistance." Accessed June 3, 2026. https://foreignassistance.gov/.

United States Agency for International Development. *Jordan Country Development Cooperation Strategy 2020–2025*. Washington, DC: USAID, 2020. https://static1.squarespace.com/static/587fcaeb1b10e3086960b284/t/5fea84d23335c849046a9483/1609204948261/Jordan_CDCS_2020-2025.pdf.

United States Agency for International Development, Office of Inspector General. *Jordan Cash Transfer Program*: *USAID Generally Followed the Grant Agreement and Agency Policy With Some Due Diligence Exceptions*. Report No. 8-278-23-001-P. Washington, DC: USAID, 2022. https://oig.usaid.gov/sites/default/files/2022-11/8-278-23-001-P_0.pdf.

World Bank. *Jordan Emergency Health Project*: *Implementation Completion and Results Report.* Report No. ICR00006458. Washington, DC: World Bank, April 30, 2024. https://documents1.worldbank.org/curated/en/099043024133527895/pdf/BOSIB1bc4c01c90de198821a4e1aeb2a437.pdf.

Appendices

Appendix 1: World Bank disbursement-linked indicators, targets, and disbursement amounts[39]

	Disbursement-Linked Indicators						
DLIs	**2013**	**2014**	**2015**	**2016**	**2017**	***Total Disbursement Amount***	***As % of Total Disbursement Amount***
1. DLI 1: Deliveries attended by skilled birth provider		14%		18%			
Disbursement amount (US$ mil):		10.0		10.0		20.0	16.7
2. DLI 2: Children 12-23 months immunized with Pentavalent 3 vaccine	Baseline Established (65.7%)		70.7%		75.7%		
Disbursement amount (US$ mil):	6.0*		6.5		.6.5	19.0	15.7
3. DLI 3: Pregnant women receiving at least one antenatal care visit		48%		56%			
Disbursement amount (US$ mil):		5.50		8.80		14.3	11.9
4. DLI 4: Contraceptive Prevalence Rate		31%		35%			
Disbursement amount (US$ mil):		9.85		10.65		20.5	17.1
5. DLI 5: Health Centers reporting HMIS data in time	55%	60%	70%	75%	80%		
Disbursement amount (US$ mil):	1.0	1.0	1.0	1.0	1.0	5.0	4.2
6. **DLI 6:** Development and implementation of Balanced Score card approach to assess performance and related institutional incentives	Protocol and roll out plan developed	Implemented in 20 Woredas in 3 regions with appropriate number of controls[24]	Implementation continues in 20 Woredas in 3 regions	Review and decision on national scale-up taken based on the impact evaluation	Scaled up to 200 woredas across the country		
Disbursement amount (US$ mil):	5.0	4.0	4.0	5.0	2.2	20.2	16.8
7. DLI 7 : Development and implementation of Annual Rapid Facility Assessment	Survey protocol developed by EHNRI and agreed with IDA	Survey undertaken and results disclosed with proposed actions to address weaknesses	Survey undertaken and results disclosed with progress in actions addressing weaknesses	Survey undertaken and results disclosed with progress in actions addressing weaknesses	Survey undertaken and results disclosed with progress in actions addressing weaknesses		
Disbursement amount (US$ mil):	4.0*	4.0	2.0	2.0	2.0	14.0	11.7
8. DLI 8: Transparency of PFSA Procurement Processes	Website launched disclosing agreed procurement information	Procurement information on website regularly updated and first open call for prequalification of suppliers made as per the Recipient's law.	Procurement information on web site regularly updated	Procurement information on website regularly updated. PFSA produces price tracking report	Procurement information on website regularly updated		
Disbursement amount (US$ mil):	2.0	2.0	1.0	1.0	1.0	7.0	5.8
Total Credit/Grant disbursed:	18.00	36.35	14.50	38.45	15.50	120.0	100.0%

*Includes payment for prior results

** Values include disbursement from both the Credit and Grant expressed in USD$ equivalent

39 World Bank, *Health Millennium Development Goals Program-for-Results*, 2013, 37–38.

Appendix 2: World Bank program action plan[40]

Action Description	DLI	Covenant	Due Date	Responsible Party	Completion Measurement
1. Developing and implementing balanced score card approach to assess facility performance and related institutional incentives	☒	☐	March, 31,2014	Policy, Plan & Finance General Directorate FMOH with TA from the Gates Foundation and the Bank	Protocol and roll out plan finalized with implementation arrangements in place
2. Implementing annual rapid facility assessments to understand health facility readiness to provide quality maternal and child services	☒	☐	By February each year	Ethiopia Health & Nutrition Research Institute with TA from the Bank	Annual facility survey report available
3. Pharmaceutical Fund and Supply Agency (PFSA) launching/updating its website populated with procurement information including measures to increase competitive bidding	☒	☐	Annual	PFSA	Verification by external consultant engaged by Government
4. PFSA launches an open call for pre-qualifications bidders as per the Recipient's law at least once every three years	☒	☐	Once every three years	PFSA	Open call made
5. PFSA introducing procurement timelines and price tracking system	☐	☐	March 31, 2014	PFSA	Procurement time and price tracking system established
6. Separating the procurement and distribution process for purposes of improving advance settlement & accountability; aging analysis to be prepared every quarter to monitor delays; once the procurement cycle is completed and goods are delivered at PFSA the advances will be liquidated in the books of account. A monitoring mechanism of delivery to ultimate beneficiaries will be developed separately	☐	☐	March 31, 2014	PFSA and FMOH	MOU prepared between PFSA and FMOH and processes separated in practice

40 World Bank, *Health Millennium Development Goals Program-for-Results*, 2013, 84–86.

(Continued)

7. Exchange rate will be applied on the basis of actual rate of transfer while reporting expenditures to minimize reported exchange losses A reconciliation will be completed to adjust actual foreign exchanges losses/gains and accounting losses/gains	☐	☐	March 31, 2014	FMOH and PFSA	MDGPF quarterly activity and financial reports
8. Audit Services Corporation completing the pending audits of PFSA	☐	☒	December 31, 2013	PFSA and Audit Service Corporation	Audit Report available
9. PFSA and FMOH having adequate professionally qualified and trained staff for internal audit	☐	☐	Annual	PFSA and FMOH	Program reports
10. FMOH through appropriate consultation to consider establishing Fiduciary Subcommittee of JCCC to monitor budget performance of MDGPF, advances, reporting, procurement and audit issues	☐	☐	June 30, 2013	JCCC	MDGPF quarterly activity and financial reports
11. FPPA undertaking annual procurement audit and FMOH and Bank team to consult OFAG on the feasibility of undertaking financial and value for money audits for MDGPF	☐	☐	Annual	Policy, Plan & Finance General Directorate FMOH	Annual Audit Reports available
12. PMU, FMOH awarding civil works contracts for construction of the health centers through competitive bidding and FMOH improves tracking and recoding system for procurements undertaken through UN agencies	☐	☐	Continuous	Policy, Plan & Finance General Directorate FMOH	Annual Audit Reports available
13. Federal Ethics and Anti-corruption Agency (FEACC) sharing allegations of fraud and corruption and actions being taken with the Bank	☐	☐	Continuous	FEACC	Reports shared by FEACC

(Continued)

14. All Health facilities establishing and operating infection prevention and patient services committees	☐	☐	Continuous	Pastoralist health and promotion and disease prevention directorate working with Regional Health Bureaus and Woreda Health offices	Annual program reports
15. Availing appropriate temporary storage facilities for collection of hazardous wastes till final disposal is done	☐	☐	Continuous	Same as above	Annual reports
16. Documenting consultations and participatory nature of discussions where communal land is used for construction of health centers and where applicable compensation for land and livelihood paid	☐	☐	Continuous	Infrastructure Directorate, FMOH	Documentation of consultations and compensation
17. Documenting outreach and specific actions focused on providing services to all vulnerable persons	☐	☐	Continuous	Pastoralist health and promotion and disease prevention directorate working with Regional Health Bureaus and Woreda Health offices	Annual reports of the Directorate

Appendix 3: World Bank disbursement-linked indicators data collection and verification methods[41]

DLI	Means of Data Collection	Schedule (Project Year)					Responsible for implementation	Verification Arrangements	Geographic disaggregation
		1	2	3	4	5			
1,3 &4	Household Survey DHS/Interim DHS		X		X		Central Statistical Agency	Not applicable as the survey is undertaken by a third party agency under technical oversight of Measure DHS.	Whole country with robust estimates at Regional level
2	Household Cluster Surveys			X		X	Policy, Plan & Finance General Directorate and EHNRI	Not applicable as the survey will have built in quality assurance.	Whole country with robust estimates at Regional level
5.	Health Management Information System (HMIS) annual report	X	X	X	X	X	Policy, Plan & Finance General Directorate (M&E Directorate)	Semiannual data validation of HMIS by academic institutions and technical partners produced by February for the previous year.	Whole country
6.	Performance of health facilities and woredas as reported by Balanced Score Cards	X	X	X	X	X	Policy, Plan & Finance General Directorate	Impact evaluation to provide evidence on improved performance by health facilities and woredas including effectiveness of implementation arrangements.	Initially in pilot areas and will be expanded to 200 woredas
7.	Rapid Health Facility Assessment	X	X	X	X	X	Policy, Plan & Finance General Directorate	TA provided by IDA for random data quality checks. Report will be available by February each year to align Bank disbursement with budgeting cycle.	Whole country
8.	Review of the PFSA website	X	X	X	X	X	Policy, Plan & Finance General Directorate and PFSA	External consultant with appropriate expertise hired by FMOH under technical assistance.	PFSA

41 World Bank, *Health Millennium Development Goals Program-for-Results*, 2013, 23.

Appendix 4: Global Fund performance-based indicators for 2024–2027: HIV performance indicators and targets[42]

Performance Indicator or Milestone	Target				Rationale for Selection of the Indicator/Milestone	Amount Requested	Expected Outcome	Specify How the Accuracy and Reliability of the Reported Results will be Ensured
	Baseline	Y1	Y2	Y3				
TCS-1(M): Percentage of people living with HIV currently receiving antiretroviral therapy	92.30% 218,255/ 236,518	93.00% 217,734/ 234,123	94.00% 218,488/ 232,434	95.00% 219,059/ 230,588	A high coverage rate of ART is an indicator of better treatment outcomes among PLHV. also contributes to the prevention of HIV transmission		ART coverage and retention in care among all age categories of PLHIV is above **95%**	Ensure that data is collected from reliable and credible sources, such as health information systems (**RHMIS**), **health facility reports, or surveys**. Implement data validation procedures to check for errors, inconsistencies, and outliers in the collected data. This can involve cross-checking with other data sources or conducting regular audits.
Percentage of people living with HIV and on ART, who have a suppressed viral load at 12 months (<1000 copies/ml)	97.7% (annual report 2021–22)	>97%	>97%	>97%	Viral load suppression of people on ART is a proxy for the quality of services provided by the HIV care and treatment program and the adherence to treatment for people on treatment. Furthermore, viral load suppression contributes to the prevention of new HIV infections.		Viral Load suppression among all PLHIV on ART is maintained above 95%.	Employ well-trained healthcare professionals and data collectors who can accurately administer tests, record data, and report results and rectify any potential issues within the **RHMIS** Cross-check data for consistency and accuracy, including comparing with previous records
Number of Medical Male Circumcisions performed according to national standards	307,163 men circumcised. (July 2022–June 2023)	250,000	200,000	200,000	VMMC is one of the priority evidence-based strategies for HIV prevention. The evidence shows that male circumcised are less likely (60% less) to get infected with HIV.		Improving the prevention package for the most at-risk population to include Medical Male Circumcision	Verify that data is complete for all relevant indicators and regions in the **RHMIS and Demographic and Health Survey (DHS)**

42 Rwanda Ministry of Health. *The Global Fund: Funding Request Form, Allocation Period 2023–2025*. Kigali: Rwanda Biomedical Centre/ Ministry of Health, 2023, https://data.theglobalfund.org/location/RWA/access-to-funding.

(Continued)

Performance Indicator or Milestone	Target				Rationale for Selection of the Indicator/Milestone	Amount Requested	Expected Outcome	Specify How the Accuracy and Reliability of the Reported Results will be Ensured
	Baseline	Y1	Y2	Y3				
Percentage of sex workers reporting the use of a condom with their most recent client	81.22% (2022 IBBSS preliminary results)	NA	NA	85.00%	Prevention with Key populations, and particularly with Female sex workers is one of the priority interventions for HIV prevention as they are confirmed drivers of the epidemics. Evidence shows that consistent use of condoms offers an effectiveness of 90%–95% in preventing the transmission of HIV.			Improved timeliness, quality, and completeness of routine (**RHMIS**) and **biological and behavioral surveys** (e.g., **IBBS**, **Stigma Index**) data for evaluation of effectiveness
Percentage of exposed infants who are HIV-free by 24 months	98.6%	>95%	>95%	>95%	Prevention of mother-to-child transmission is a priority intervention to prevent new cases of infections in children of HIV+ mothers. While the country is aiming to apply for the triple elimination of mother to child HIV, Syphilis and Hepatitis transmission. It is important to keep monitoring the vertical transmission.		Proportion of exposed infants who are HIV-free by 24 months above 95%	Utilize proficient healthcare professionals and skilled data collectors who can adeptly conduct tests, record data, report results accurately, and address any potential challenges. We will use the **HIV Annual Report**
Percentage of adults and children with HIV, known to be on treatment 12 months after initiation of antiretroviral therapy	94.60%	95%	95%	95%	High retention of PLHIV on ART is a key indicator to measure the treatment attrition and the reduction of PLHIV on ART who may exit the program due to deaths or being lost to follow-up.		Proportion of adults and children remaining on ART after 12 months to be 95%	Verify that data is complete for all relevant indicators and regions in the **RHMIS and HIV annual report**