COUNTRY PRIORITISATION APPROACH

The Partnership 2016-2018 Business Plan sets out Guiding Principles for approaching countries. A first set of criteria to prioritize the first wave of countries to approach was prepared drawing on these Guiding Principles (see Annex 3) and based on the discussions that took place during the Board Retreat, 1-2 March 2016, Johannesburg. The EC Meeting held on March 23rd 2016 reviewed the c criteria and advised the Secretariat to streamline the process taking into account the following:

- Prioritizing and streamline the approach using clear, evidenced and systematic approach
- Provide a clear matrix matching country to criteria
- Rename the document as "Country Prioritisation Approach"

The Executive Committee's guidance with reference to the criteria was documented and consolidated by the D&F constituency Chair (USAID) and, subsequently encapsulated in a revised criteria and country matrix shared on March 26, 2016. This draft revised version of the Criteria to Approach Focal Countries (Annex1) builds on the Board and EC discussions, as well as the work done by USAID and proposes a revised criteria, and suggests a list of priority countries(Annex 2). .

NEXT STEPS

Once the country selection criteria are agreed, and guidance is received on the proposed priority countries, the Secretariat will work with the Steering Groups for the relevant SOs, the GFF Secretariat (for relevant countries) and the focal points of countries that are already members of the Partnership. . This process should identify if there is a potential niche for Partnership, and assess how this would complement the roles of existing stakeholders and the partnership arrangements already in place in these countries. Additionally, the Secretariat will work with the relevant Steering Group to identify lead partners from the other seven constituencies that are active in the given countries.

ANNEX 1

Criteria to Approach Focal Countries

The Partnership will work in a universal way, reaching for impact in all countries and not only in the focal countries. During the life span of the 2016-2018 Business Plan, the Partnership will build the capacity to focus on four to eight countries at a time. This will allow for balancing ambition for breadth with the realistic capacity to engage in a meaningful way. The following prioritization criteria will be used and the method for weighting these is described in Annex 2. They have been grouped under two broad areas – Country Leadership and Demand" and "Evidence of SRMNCAH Burden and Need".

Country Leadership and Demand

1. **Country commitment and leadership**: As evidenced by political and/or financial commitment to the following: Every Woman Every Child Movement, A Promise Renewed, FP2020. An indicator tracking domestic financing will be added and tracked in subsequent years.

2. **Countries express demand for PMNCH engagement:** In line with good aid effectiveness principles, demand from a country – in particular at Ministerial level - and/or their perceived value add of the Partnership's multi-stakeholder approach is a prerequisite for successful country engagement. Countries in which two or more constituencies, including the partner government (or H6/development partner leads in the case of complex settings), are seeking engagement from the Partnership.

3. **PMNCH membership:** membership of the Partnership is used as an initial proxy filter. This will include countries from which Ministries of Health have applied to become members of the Partnership and have been accepted. Currently the Partnership has the following countries as members: Afghanistan, Bangladesh, Bhutan, Bolivia, Cambodia, Cameroon, Chile, Ethiopia, Georgia, India, Indonesia, Liberia, Mali, Mozambique, Namibia (in process), Nepal, Nigeria, Pakistan, Senegal, South Africa (in process), Uganda and the United Republic of Tanzania.

Evidence of SRMNCAH Burden and Need

High burden, and thus off track to meet all four priority targets[1] identified in the Partnership's Strategic Plan. This set of criteria should include consideration of:

- Maternal Mortality Lifetime risk of greater than 1:250
- Newborn Mortality rate greater than 21 per 1000
- Under Five Mortality Rate greater than 40 per 1000 live births
- Adolescent fertility rate for women ages 15-19 greater than 50/1,000
- Inequality in RMNCH (by economic status): Composite Coverage Index of < 75% in Q1[2 3]

[1] The Partnership Strategic Plan and Business plan priorities:
a. Reduce global maternal mortality to 70 or fewer deaths per 100,000 live births [SDG3.1]
b. Reduce child mortality in every country to 25 or fewer deaths per 1,000 live births [SDG3.2]
c. Reduce newborn mortality in every country to 12 or fewer deaths per 1,000 live births [SDG3.2]
d. Achieve universal access to sexual and reproductive health and reproductive rights [SDG3.7/5.6]; Ensure at least 75% of demand for family planning is satisfied with modern contraceptives

Balance and Diversity

In addition to the above criteria, the following factors should guide us the selection of an appropriately balanced set of focal countries.

- **GFF country:** Currently, one of the four "frontrunner", eight "Wave 2" focal countries for GFF Trust Fund support, as well as "Pipeline" countries that may be identified provide an opportunity for the Partnership to enable a fully inclusive approach in support of harmonised financing.
- **Diversity**: The focal countries should include a range of countries, to ensure that there is balance in terms of humanitarian setting; conflict; federal structure; population size; range of SRMNCAH challenges; weakened health system (e.g. recovering from Ebola); geography.
- **Existing platform:** Multi-stakeholder processes or platforms addressing women's, children's and adolescents' health are existent, under way or planned, allowing the Partnership to complement ongoing efforts and building on existing national structures. Ideally, an existing functional platform would include Ministerial representation, a focal point (typically a senior official of the country MoH), presence of colleagues representing a broad range of stakeholders, and have functional governance arrangements. In addition, the presence of members of the Partnership in-country is essential for engendering successful in-country engagement.

[2] The composite coverage index is a weighted score reflecting coverage of eight reproductive, maternal, newborn and child health interventions along the continuum of care: demand for family planning satisfied; antenatal care coverage (at least one visit); births attended by skilled health personnel; BCG immunization coverage among one year olds; measles immunization coverage among one year olds;DTP3 immunization coverage among one year olds; children aged less than five years with diarrhoea receiving oral rehydration therapy and continued feeding; and children aged less than five years with pneumonia symptoms taken to a health facility. Detailed information about the criteria used to calculate the numerator and denominator values for each indicator is available in the WHO Indicator and Measurement Registry, under the topic "Health Equity Monitor" (www.who.int/gho/indicator_registry/en/)

[3] Dimensions of inequality: Health data were disaggregated by three dimensions of inequality: economic status, education level, and place of residence. Economic status was determined at the household level, using a wealth index.. Within each country the index was used to create quintiles, thereby identifying five equal subgroups that each account for 20% of the population. Q1 refers to the poorest 20% of a population in a country. http://www.who.int/gho/health_equity/services/health_equity_rmnch_composite_coverage_index.pdf

ANNEX 2

PRIORITIZATION OF COUNTRIES FOR THE PARTNERSHIP'S ENGAGEMENT

The secretariat has applied the criteria to a range of countries, including the 20 countries identified at the Board Retreat in March 2016, as well as additional countries who have approach the Partnership requesting engagement. As country-level work marks a new way of working for Partnership, and these country approaches are part of a learning agenda for the Partnership, it is proposed that the selection of focal countries to approach should reflect both diversity and pragmatism, respecting the finite resources available with The Partnership. Given the importance of the GFF to the EWEC Architecture, it is suggested that 50% of the focal countries should be from within the GFF Priority countries

Criteria for ranking of countries

A range of approaches to balance and weight the criteria has been considered. The Country Prioritisation Matrix (Annex 4) shows the details of how each country has been assessed according to the two principal clusters of criteria: Country Leadership and Demand; Evidence of SRMNCAH Burden and Need as well as the Balance and Diversity indicators. Crude scorings have been undertaken and based upon these the following Countries emerge as the first wave for the Partnership to consider:

- Afghanistan
- Angola
- Cameroon
- DRC
- Gambia
- Malawi
- Mozambique
- Nigeria
- Sierra Leone

Methodology to derive ranking for Country Leadership and Demand

1. Countries are assigned points on the basis (see table below) of : 1) EWEC commitment, 2) A Promise Renewed Commitment, 3) Request for / interest in PMNCH engagement, 4)PMNCH membership
2. The points are then used to rank countries {for e.g. Kenya gets 4 points for EWEC (2) + APR (1) + FP2020 (1)}
3. Since Nigeria scores the maximum points of 6, it is ranked #1

Criteria	Max Points
Request for PMNCH engagement	3
Interest expressed in PMNCH engagement	2
PMNCH member	1
EWEC commitment	2
APR commitment	1
FP2020 commitment	1

PMNCH membership: To note the ranking was assigned as follows:

- PMNCH member countries or countries that have made a direct expression of interest in engagement with PMNCH.
- Within the cohort of PMNCH member countries, the country with the greatest burden is the most preferred.

Methodology to derive ranking for Evidence of SRMNCAH Burden and Need

1. All countries are ranked within each burden category (i.e. U5MR, etc.)
2. The rankings are used to assign scores to each country under each category (rank = score; for e.g. Gambia has the 6th highest U5MR under non-GFF countries so gets a score of 6 on U5MR)
3. A weighted score is calculated for each country (assuming equal weight for each burden category; where data is missing, weights are adjusted accordingly)
4. Example for weighted score: Ghana is ranked 10 (U5MR),9 (AFR), 8 (MM Lifetime Risk), 7 (NMR) and 6 (Inequality in RMNCH); Ghana weighted score (8.0) is calculated as: 0.20*10 + 0.20*9 + 0.20*8 + 0.20*7+0.20*6
5. The weighted scores are then used to assign ranks to each country

Countries' ranking based on a combination of burden and demand

The rank for each country under burden and demand is added up to get a combined score (for e.g. Bangladesh was ranked #10 on burden and #2 on demand for GFF countries, and therefore gets a total score of 12). The methodology to rank each country for burden and demand is described separately below.
The combined score is used to get an overall rank for every country.

Diversity

The proposed countries provide considerable diversity in terms of population (large; medium, small); humanitarian setting; weak health system; as well as the existence of multi-stake holder platform in terms of ministerial representation and designated government focal points.

EXTENT OF LIKELY COUNTRY ENGAGEMENT

As a desk-based exercise this assessment cannot address the extent of likely country government engagement with the Partnership and/or the effectiveness of local leadership - perhaps the most important factor in determining success. It is for this reason that the next stage will be ti approach countries to establish their interest in engagement and to ensure that the country specific strategy is genuinely demand driven.

GFF Trust Fund Countries

	Rank by Burden	Rank by Demand	Combined Score	Rank
Nigeria	1	1	2	1
DRC	2	3	5	2
Mozambique	3	4	7	3
Cameroon	4	4	8	4
Liberia	5	4	9	5
Ethiopia	6	4	10	6
Kenya	7	3	10	6
India	9	2	11	7
Senegal	9	2	11	7
Bangladesh	10	2	12	8
Tanzania	8	4	12	8
Uganda	8	4	12	8

"Non-GFF" Countries

	Rank by Burden	Rank by Demand	Combined Score	Rank
Afghanistan	2	2	4	1
Angola	1	5	6	2
Malawi	6	2	8	3
Gambia	5	4	9	4
Sierra Leone	3	6	9	4
Guinea	4	6	10	5
Zambia	8	4	12	6
South Africa	12	1	13	7
Namibia	11	3	14	8
Sudan	7	7	14	8
Ghana	9	6	15	9
Haiti	10	6	16	10

ANNEX 3

Guiding Principles for Country Selection[4]

The Partnership seeks to prioritise and deepen engagement in Partner Countries and has, since 2009, been explicit that it is a Partner-centric organization. The Partnership's role complements the work and accountability processes of its individual members, enabling them to deliver more collectively than alone. The overall focus of the Partnership's work is to achieve results and impact in the countries where the need is greatest.

The Partner-centric approach mobilizes, engages and empowers different implementing partners. It allows them to coordinate their actions and activities, and encourages and promotes mutual accountability. Partners continue to have the capacity and responsibility to implement specific activities; the opportunity to coordinate with others increases the effectiveness and efficiency of these actions. This may be reflected in, for example, inculcating a culture of "one nation one plan", common metrics for all development partners, improved coordination in aid flows, agreement by health-care professionals on common implementation policies, and alignment of messages and practices by the NGO community.

Guiding Principles

During the life span of the 2016-2018 Business Plan, the Partnership will build the capacity to focus on four to eight countries at a time. This will allow for balancing ambition for breadth with the realistic capacity to engage in a meaningful way. Selection of countries, the duration of engagement, and total number of countries selected will be guided by the Board in consideration of the following principles:

- **Commitment to EWEC**: countries that have made a commitment to EWEC **prioritizing countries where the burden is highest[5] and the need greatest,** with consideration of the **added value of Partnership engagement in GFF focal countries;**
- **Added value:** countries where the Partnership's value-add is recognized and is in line with country-identified needs;
- **Partners**: countries in which two or more constituencies, including the government, are seeking engagement from the Partnership;
- **Multi-stakeholder platforms and processes**: countries where multi-stakeholders processes or platforms are existent, under way or planned, allowing the Partnership to complement ongoing efforts and building on existing national structures;
- **Geography**: the Partnership will aim for a balance among the selected countries and regions;
- **Impact on the four priority targets:** the Partnership will aim for a balance across the four targets among the selected countries;
- **Countries that are members** of the Partnership will have priority; at the same time the Partnership will be open to other countries that wish to engage.

[4] The Partnership's 2016-2018 Business Plan.
[5] High burden in at least one of the four priority target areas (maternal, child and newborn health, as well as family planning).