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Report

Innovative Financing Mechanisms for Health : Mapping and Recommendations

Enhancing Impact through Innovative Financing for Health

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ABBREVIATIONS

ATI: Addis Tax Initiative
AMC: Advanced Market Commitment
BMGF: Bill & Melinda Gates Foundation
DFI: Development Financing Institution
DIB: Development Impact Bond
DLI: disbursement linked indicators
DRM: domestic resource mobilization
ESG: environmental, social, and governance
FFT: Financial Transaction Tax
GIIN: Global Impact Investing Network
G7: Group of Seven
G20: Group of Twenty
GFF: Global Financing Facility
GHIT: Global Health Innovative Technology Fund
GIF: Global Innovation Fund
GIIN: Global Impact Investing Network
GFATM: Global Fund for AIDS, TB and Malaria
GPF: GAIN Premix Facility
H20: Health 20 Annual Summit
HIB: Humanitarian Impact Bond
HIC: high-income countries
HRITF: Results Innovation Trust Fund
LBW: low birth weight
IFFIm: International Financing Facility for Immunizations
LMIC: low- and middle-income countries
MCF: Medical Credit Fund
MDB: multilateral banks
MMV: Medicine for Malaria Ventures
MNCH: maternal, newborn, and child health
N3F: Nutritious Foods Financing Facility
ODA: official development assistance
OECD: Organization for Economic Co-operation and Development
PBA: performance-based allocations

RBF: result-based financing
PDP: product development partnership
PPF: pay for performance
PforR: Program for Results
R&D: research and development
SDG: Sustainable Development Goals
SIB: social impact bonds
SME: small and medium enterprises
SRI: Socially Responsible Investing
UN: United Nations

EXECUTIVE SUMMARY

Prior to the COVID-19 pandemic, the annual funding gap to achieve Sustainable Development Goal (SDG) 3—health and well-being—was already estimated at US\$371 billion for low- and middle-income countries (LMIC). This gap may increase in the wake of the pandemic. More than ever, delivering the 2030 Agenda for Sustainable Development will require that all sources of finance—development and commercial—are scaled up and used more effectively.

The pandemic has highlighted the need for a bigger, better toolbox to effectively finance health systems and health services in the short, medium, and long term. All countries—rich, middle income, and poor—need to make health part of their immediate and long-term economic planning. This will bring about the necessary marriage between the wealth and the health of nations.

Fortunately, efforts have been growing over the past decade to improve the deployment of official development assistance (ODA) and to increase domestic revenue generation for development. The global development community has committed to addressing this issue by unlocking new sources of funding through innovative financing mechanisms, as iterated by the Monterrey Consensus, the Doha Declaration, and the Addis Ababa Action Agenda. Innovative finance continues to be prioritized through the Leading Group on Innovative Financing for Development.¹

However, overall progress to date to drive more funding into the SDG agenda has been slow.ⁱ The Development Minister of the Group of Seven (G7) under French presidency in July 2019 highlighted that ODA is only a small proportion of the financial flows needed, and that other public and private, domestic, and international sources need to be urgently considered, including those originating from developing countries.ⁱⁱ The G7 also acknowledged the need to expand the catalytic use of ODA in mobilizing and leveraging private sector financing for SDGs, including impact investors and global private savings.

Summary of the mapping

This report therefore complements the recent calls to develop and deploy more effective innovative financing initiatives for health.

Since the last major review of innovative finance for health in 2011ⁱⁱⁱ there has been a significant increase in the use of innovative finance in the health sector. Here we map 42 major innovative financing initiatives, many of which have been successful in enabling new partnerships and increasing the interest and participation of the private sector in the global health space. For example, catalytic funding initiatives have successfully pooled resources from traditional and non-traditional funders, development impact bonds have begun tapping private capital to help finance the needs of the sector, while impact investing has grown steadily to respond to challenges within health markets.

¹ The Leading Group comprises 66 states and several international and nongovernmental organizations. More about the Leading Group can be found here: <http://www.leadinggroup.org/rubrique173.html>

However, our mapping indicates there is still much to be done. While health is well represented as a sector for results-based and catalytic funding mechanisms, both impact investing and health taxes remain underutilized as financing tools for SDG 3. Consider that between 2013 and 2018, development finance institutions (DFIs) invested less than 3% of their total investments in the health sector.^{iv} Most of that investment has been in infrastructure and pharmaceuticals. Impact investments directed to health care, human capital, ancillary services, and medical devices remain a need. What's more, some of the mechanisms which have demonstrated the most success – including social bonds (via IFFIm), solidarity levies (via the airline ticket solidarity level for UNITAID) and debt funds (via the Medical Credit Fund) – need to be urgently replicated and deployed to meet unmet needs.

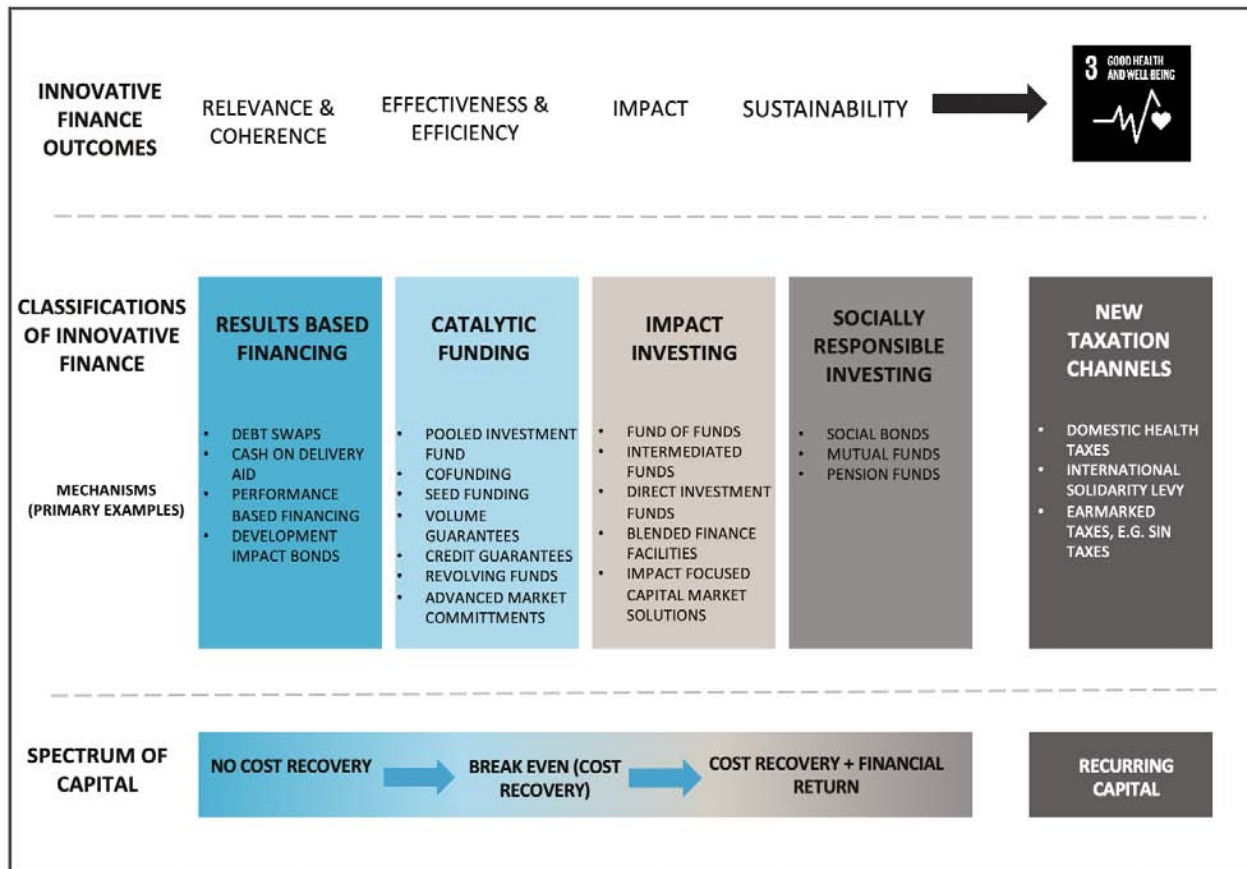
The report maps the initiatives and mechanisms across five classifications of innovative financing outlined in our conceptual framework (Figure A):

- Results-based financing
- Catalytic funding
- Impact investing
- Socially responsible investing
- New channels of international and domestic taxation for development

For the outcomes analysis and to formulate recommendations, we have adapted four criteria from the Organization for Economic Co-operation and Development's (OECD) Development Assistance Committee (DAC): relevance and coherence; effectiveness and efficiency; impact; and sustainability.²

² For assessing the various innovative financing classifications in health, ThinkWell uses an adapted framework from the Organization for Economic Co-operation and Development's Development Assistance Committee.

Figure A: Conceptual framework for innovative finance in health



Adapted from “USAID 2019 Investing for Impact” and “Addis Tax Initiative”

Summary of outcomes analysis and recommendations

1. Innovative financing initiatives must be co-created and designed to be fully compatible with local health markets.

The maturity of local health markets must be considered by donors and DFIs during the design of an innovative financing initiative, and the objectives set appropriately. Each mechanism plays a unique role in the innovative finance ecosystem and across the spectrum of capital flows. Each has relative strengths and weaknesses. For example, if feasibility studies show that market-based innovative financing solutions in LMIC are viable, impact investing and SRI should be considered. However, in contexts with chronic market failures, donors can look to deploy more results-based and catalytic innovative financing. In general, donors should prioritize the growth of domestic resources for health, and for this accelerated effort is needed to consolidate evidence and disseminate good practices on health taxes.

Related, the review also found that mechanisms under impact investing, socially responsible investing, and new channels of taxation demonstrate higher leverage of non-ODA funding, and greater financial effectiveness and sustainability. However, they have not demonstrated as much evidence of impact related to SDG 3 in comparison to results-based and catalytic mechanisms.

This latter grouping has demonstrated more evidence of health impact but remain relatively costly to implement with less leverage of private financing or non-ODA funding.

2. Actionable information unlocks private sector investment and improves impact. For this, more alignment of metrics across all mechanisms is needed.

Capital flows to address SDG 3 are often inhibited due to information failures that arise from several dimensions, notably a lack of meaningful metrics and benchmarks that investors as well as donors can rely on to meet their objectives and fiduciary responsibilities. It is challenging to map comparable data on health impact in innovative finance across mechanisms. Further work is required to ensure innovative investment mechanisms are using common outcome-level indicators. In terms of financial indicators, there have been positive developments to create aligned metrics for private investors which are measurably linked to SDGs, but much needs to be done to improve information flow, metrics, and benchmarks for investments to target the SDG 3.^v

3. ODA should unlock new sources of funding and not displace or discourage natural flows of domestic or external resources.

The interviewees and the literature often referred to the need to “crowd in” private financing or new domestic resources. Equally important is the need to ensure ODA and concessional capital do not “crowd out” existing financing or new private sector investments. It is acknowledged that DFIs and donors conduct due diligence processes to ensure their funding is complementary. However, actual investment performance data held by DFIs and multilateral banks (MDBs) remain proprietary. Private investors are not able to access the same default and return rates experienced by DFIs, and as a result the private sector may be less likely to invest in frontier markets because they cannot compete against DFIs. There should be accelerated efforts by DFIs and MDBs to accelerate their investment performance. This transparency will improve investor understanding and help bring in new private sector financing.

This report outlines several other findings and recommendations for each classification of innovative financing as per the OECD DAC framework in the ‘Way Forward’ section. Table A summarizes this outcomes analysis in aggregate for each innovative financing classification.

Table A: Summary of outcomes analysis by innovative finance classification and OECD DAC criteria

OECD DAC CRITERIA	DEFINITION	RESULTS BASED FINANCING	CATALYTIC FUNDING	IMPACT INVESTING	NEW TAXATION CHANNELS
RELEVANCE & COHERENCE	Were the mechanisms in the respective classification designed appropriately to respond to local priorities in financing health and did they remain relevant over time? Do the mechanisms in the specified classification complement other relevant interventions or do they undermine them? This includes partnerships, harmonization and coordination with others, and the extent to which the mechanisms have added value while avoiding duplication of effort.	MEDIUM	HIGH	MEDIUM TO HIGH	HIGH
EFFECTIVENESS & EFFICIENCY	Did the mechanisms in the specified classification achieve their intended outcomes in a cost-efficient way, especially in relation to aid efficiency and additionality? Has there been timely delivery? How successful have these interventions been in crowding in private sector financing? What has been the public to private funding ratio?	MEDIUM	MEDIUM	MEDIUM TO HIGH	MEDIUM
IMPACT	What difference have the mechanisms in the respective classification made? This includes looking at both positive or negative, intended, or unintended impacts in terms of impacts on financing as well as health.	MEDIUM TO HIGH	HIGH	MEDIUM	MEDIUM
SUSTAINABILITY	Have the mechanisms in the respective classification led to benefits which will last? This includes the sustained net benefits to both the underlying financing of the intervention and health outcomes over time.	MEDIUM	MEDIUM	MEDIUM TO HIGH	HIGH

Conclusion

Delivering the 2030 Agenda for Sustainable Development will require that the many of the innovative finance successes outlined here are improved upon, replicated, and scaled. This report maps 42 major innovative finance initiatives that address SDG 3 summarizing their successes and learnings so that donors and DFIs can enhance the use of innovative finance to achieve better health outcomes. It aims to help address how SDG 3 can be better resourced while considering COVID-19 and the strain it has placed on the global financing infrastructure. Donors, development finance institutions, investors, bankers, and the health and finance ministers from the Group of 20 represent the key group who should play the lead role to take the recommendations from this report forward to improve financing for SDG 3.

INTRODUCTION

In 2015, the UN General Assembly adopted 17 sustainable development goals (SDGs) to end global poverty by improving health, increasing economic growth, and reducing inequality by 2030. However, to achieve all 17 SDGs, there is a funding gap estimated at US\$2.5 trillion a year.^{vi}

SDG 3 aims to “ensure healthy lives and promote well-being for all.” It sets ambitious targets to improve many aspects of health, from reproductive, maternal, newborn, and child health, to communicable and noncommunicable diseases, through to mental health, environmental risks, and health systems strengthening.

The annual funding gap to achieve SDG 3 is estimated at US\$371 billion for low- and middle-income countries (LMICs).^{vii} To date, only 6% of total SDG funding has been devoted to the health sector.^{viii} Further, 81 of 135 (60%) of LMICs have not reached their target spending goals for SDG 3 and will not reach them by 2030 if significant change and progress are not made.^{ix} Achieving SDG 3 will require significantly more financial resources, especially considering the current COVID-19 pandemic, the risk of future pandemics, the growing threat of increasing drug resistance for major communicable diseases, the ongoing burden of neglected diseases, and the increase in noncommunicable diseases.

There are rising opportunity costs in delaying funding for SDG 3. Ongoing delays in funding SDG 3 is leading to higher annual costs and lives lost. The reduced time to secure the funding needed is increasing the amount of funds required every year to meet SDG 3 by 2030. Delays also imply that health pressures continue to mount, compounding the adverse effects.

Ensuring the targets of SDG 3 are met requires that the social determinates of health and related SDGs be considered. While the financing gaps outlined above set a benchmark to encourage additional spending for SDG 3, they do not ensure all health outcomes will be achieved. The financing also needs to be effectively deployed. Related, financing for closely related SDGs is required to ensure SDG 3 is achieved and sustained. For example, suboptimal diets (SDG 2) are now responsible for more deaths than any other risk globally.^x Ensuring more effective financing for the health sector as well as for the determinants of health is critical to achieving SDG 3 targets and sustaining them.

There is therefore an urgent need to generate and deploy more effective official development assistance (ODA) and other financing, including from the private sector, for SDG 3 and related areas. Innovative finance is one critical approach to undertake this. In 2019, total ODA was US\$152 billion, but aid spending through private sector instruments represents only 2.7% of total bilateral ODA.^{xixii} Given the need to mobilize additional sources of funding for the SDGs –and specifically for SDG 3 –channeling aid through private sector instruments represents an important approach to help fill the financing gap.

Innovative finance³ can help accelerate the participation of private investors in health and drive more capital into the health sector. Fortunately, the global development community has committed to this through the 2002 Monterrey Consensus, the Doha Declaration, and the Addis Ababa Action Agenda, all of which highlight the critical role innovative financing can play in

³ The definition used here for innovative finance and the related “blended finance” is outlined in the section Definitions and Conceptual Framework.

funding development and health. In addition, the Development Ministers of the Group of Seven (G7) under French Presidency in July 2019 highlighted that private funding, including impact investments and global private savings, must be catalyzed to support the SDGs and that ODA should be used to create more enabling policy environments.^{xiii} Prioritization of innovative financing for health continues through the Leading Group on Innovative Financing for Development.

From around the time of the 2002 Monterrey Consensus, the diversity and scope of innovative financing initiatives and blended finance tools in health have continued to evolve. These have ranged from: the establishment of pooled investment approaches by Gavi and the Global Fund for AIDS, TB and Malaria (GFATM) (established in 2000 and 2002, respectively) that focus on market failures related to immunizations, and HIV/AIDS, TB, and malaria in LMIC; to the introduction of an “air ticket solidarity levy” to support Unitaid in 2006; to the launch of catalytic funds and initiatives such as IFFIm in 2006; to a number of impact investment funds in LMIC, such as the Medical Credit Fund established in 2009; and finally to several health impact bonds such as Kangaroo Development Impact Bond in 2018.

In this report, we identify mechanisms and initiatives which have demonstrated an ability to generate additional development funds by tapping new funding sources from the public sector, incentivizing the flow of private sector contributions, enhancing the overall efficiency of financial flows, and facilitating more results-oriented expenditure. This report builds on previous efforts to map innovative finance mechanisms used for health through the 2011 study on innovative finance for health, commissioned by the French Ministry of Foreign and European Affairs.^{xiv} Since that 2011 mapping, the field of innovative financing for health has grown rapidly with the introduction of new actors and more interest from the private sector. This report also directly responds to the 2019 Health 20 Annual Summit (H20) recommendation to conduct a high-level review of innovative finance initiatives in health.

This report maps 42 major innovative finance initiatives that address SDG 3. It summarizes their successes and learnings so that donors and development financing institutions (DFIs) can enhance the use of innovative finance moving forward. The report structure is organized by classification and mechanisms as per the adapted conceptual framework outlined below, so all mechanisms and initiatives are categorized as: results-based financing; catalytic financing; impact investing; socially responsible investing or, new channels of taxation. Similarly, the findings and recommendations are structured according to this framework and further framed using the adapted OECD DAC criteria of relevance and coherence; effectiveness and efficiency; impact and sustainability.

OBJECTIVES OF THE REPORT

The objective of this report is to provide an overview of the rapidly evolving field of innovative financing for health—what has worked and what should be improved—to enable decision makers to advance their commitments to new and more efficient innovative finance models to support SDG 3.

Therefore, this report aims to complete the following:

- A mapping of the major innovative financing initiatives in health.
- A review of the relative success of each initiative in achieving results.
- Recommendations on the way forward, using an OECD DAC framework. Specifically, we look at how ODA can be better deployed across the various categories of innovative finance: result-based mechanisms; catalytic mechanisms; impact investing and SRI; and new channels of taxation.

METHODOLOGY AND LIMITATIONS

Methodology

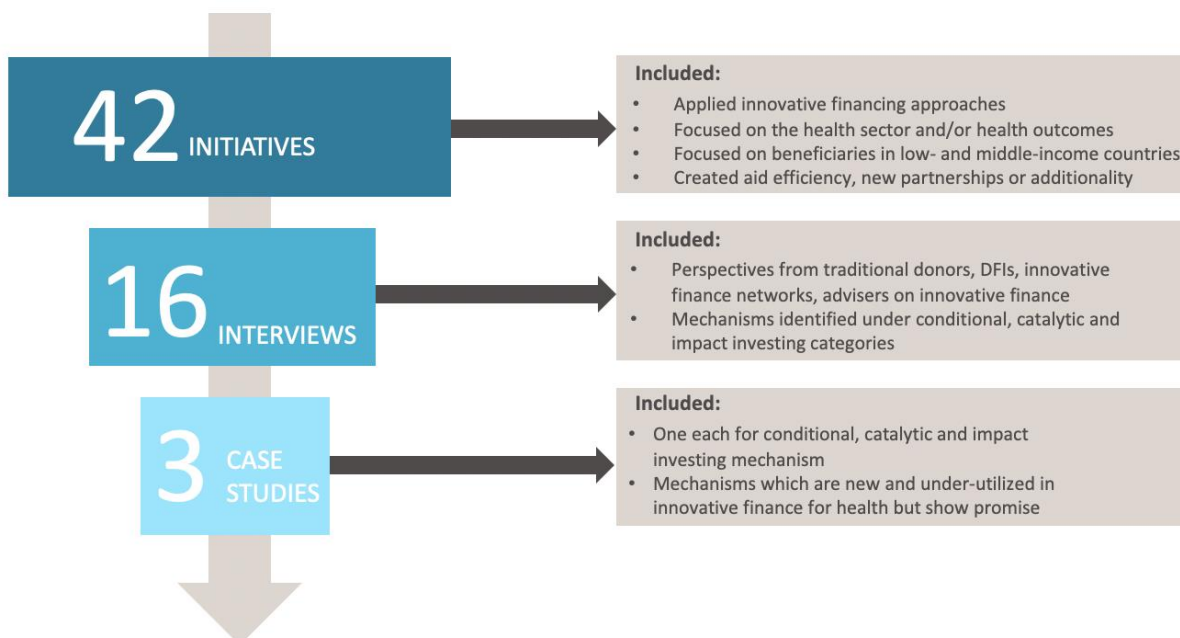
To provide a comprehensive mapping of the rapidly evolving sector of innovative finance for health, including what has worked and what should be improved, ThinkWell applied a seven-step methodology.

First, an analytical framework was adapted to classify the various innovative finance mechanisms. This entailed a review of existing literature of current blended finance and innovative finance reports from various sources, including bilateral and multilateral organizations and specialized organizations and financing actors. A list was compiled with relevant frameworks, and five key classifications were defined based on sources of funds and the financing objectives to present a comprehensive framework for innovative finance mechanisms.

Second, a list of all financing mechanisms was generated, along with inclusion criteria (Figure 1). Financing mechanisms deemed as purely traditional, such as grants and technical assistance with no-cost recovery, were excluded, while purely commercial financial mechanisms, such as debt and equity investments with no social returns, were also excluded, along with mechanisms that do not involve ODA.

Third, only innovative finance mechanisms focused or operational in low- and middle-income countries (LMICs) and targeting health outcomes were included in our research.

Figure 1: Inclusion criteria for source material



Fourth, data collection was undertaken. For this, a list of descriptive data points was developed to capture information from various active and completed innovative financing initiatives in health. The data points include approach, date, brief description, partners, total funding amount, geographic location, results (if any), and impact (intended or achieved). For the mapping, research included a review of both academic and grey literature. To expand the mapping, ThinkWell used a snowball approach through key informant interviews to validate and give detailed information on relevant initiatives not found through the desk research.

Fifth, a list of key informants was generated with input from the French Ministry for Europe and Foreign Affairs. The key informants included managers and recipients of innovative finance projects and global health financing initiatives, think tanks, DFIs, donors, and advisers. (A complete list of key informants interviewed can be found in Annex 1.) Two sets of questionnaires were developed for the interviews; one set was used for donors, DFIs, networks, and advisors, while the second set was employed for interviews with organizations deploying innovative finance projects (Annexes 2 and 3). The OECD-DAC criteria on relevance, coherence, effectiveness, efficiency, impact, and sustainability was used for interviews with innovative finance initiatives to analyze the mechanisms and document recommendations.

Sixth, following the mapping, desk research, and key informant interviews, ThinkWell completed an analysis of the findings using the OECD-DAC criteria (relevance and coherence, effectiveness and efficiency, impact, and sustainability). Within this, reflections and findings on additionality and aid efficiency as well as new partnerships are highlighted.

Finally, ThinkWell analyzed the learnings and compiled a list of cross-cutting recommendations and classification-specific recommendations on the way forward to replicate and scale innovative finance mechanisms for health.

Limitations

Several challenges limited our findings. First, this report maps 42 of the major current innovative finance mechanisms and initiatives in global health. However, it is not a comprehensive list covering all initiatives ever initiated for health in LMIC.

Second, while this report highlights the meaningful perspectives of donors, DFIs, networks, initiatives, implementing agencies, and investors through key informant interviews, the report lacks perspective from local civil society organizations that may have some indirect involvement in some of these initiatives.

In addition, this report was not able to obtain impact data for every initiative reviewed. However, it outlines the limited evidence on impact and calls for more uniform monitoring, evaluation, and reporting, as well as more alignment for innovative financing indicators for health. Further, the comparability of available data across literature is limited because there are varying definitions used for innovative financing.

Finally, in terms of measuring additionality—a mechanisms' ability to mobilize funds that would not otherwise be available for health—it was important to ensure the funds did not displace or replace existing domestic or external resources. This was often not possible to measure because many mechanisms do not have nor provide data on the total present-day value of funds available from the innovative financing mechanism, less the costs it took to create the mechanism and any other funds needed to manage and repay investors or lenders.

CONCEPTUAL FRAMEWORK

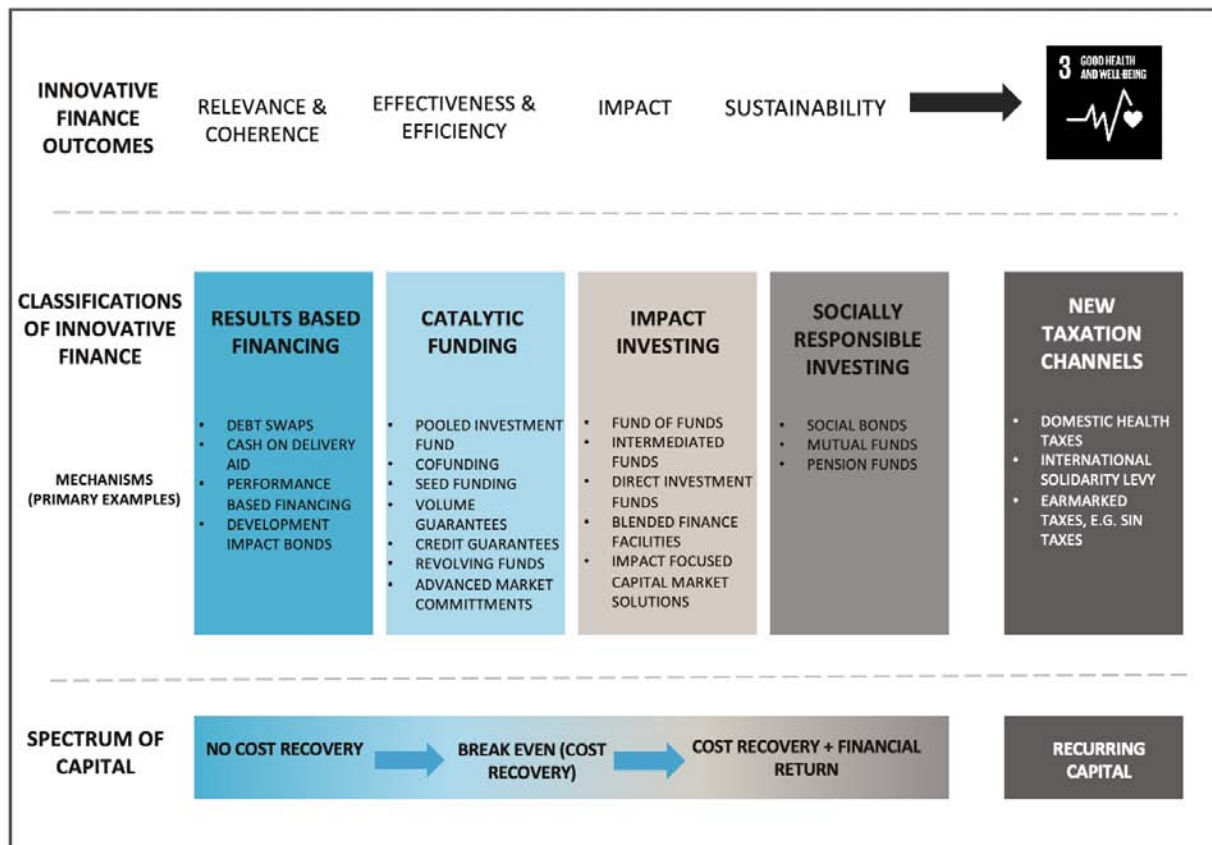
Innovative financing for development is a broad term encompassing both additional sources of nontraditional financing as well as the range of nontraditional mechanisms used to raise and deploy new funds for development aid more efficiently.

Thus, innovative finance comprises both the funding and the mechanisms to deliver those resources. It aims to mobilize global and domestic funds and increase the efficiency and effectiveness of funding used in a wide range of development contexts.

In the literature, the terms “initiative” and “mechanism” are often used interchangeably to refer to various types of financing approaches that may be considered innovative, as well as to the institutions that use innovative financing approaches (e.g., Unitaid, Gavi). For the purposes of this report, ThinkWell uses “mechanism” to refer to specific innovative financing structures and tools—not institutions—that complement more traditional ODA.

In order to structure the 42 innovative financing mechanisms against the backdrop of ODA, cost recovery and capital returns, ThinkWell mapped each across the spectrum of financial capital flows, placing them into one of five categories (Figure 2): results-based financing, catalytic funding, impact investing, socially responsible investing (SRI), and new channels of taxation.

Figure 2: Conceptual framework for innovative finance in health



Adapted from “USAID 2019 Investing for Impact” and “Addis Tax Initiative”

Results-based financing ties funds to specific health outcomes rather than inputs. It enables more accountability among the recipients or implementors as well as a more efficient allocation of donor funds to proven or promising interventions. The mechanisms mapped under the Results-Based financing category are debt swaps and loan buy-downs, development impact bonds (DIBs), and results-based financing.

Catalytic funding aims to leverage external sources of capital or stimulate innovation and market-based solutions that can be delivered at scale in a sustainable way. The mechanisms that ThinkWell has mapped under the catalytic funding category are pooled investment funds, co-funding, credit and volume guarantees, advanced market commitments, revolving funds, and flexible seed funding.

Impact investing represents investments made into companies (including small and medium enterprises or SMEs), organizations, and funds with the intention to generate social and environmental impact first, alongside a financial return.^{xv} While impact investing is sometimes categorized as a subcategory of socially responsible investing (SRI), it is separated here because impact investments give a higher priority to tracking and measuring the societal and environmental impacts than SRI, although SRI by definition does aim for impact. In other words it is *investment for impact* rather than *investment with impact*.

Related, impact investing typically deploys more patient or long-term capital. With patient capital, impact investors are willing to make a financial investment in a business with little expectation of turning a rapid profit. Impact investors often forgo an immediate return in anticipation of more substantial returns in the medium to long term. Impact investments may take the form of equity, debt, loan guarantees, or other financial instruments. The mechanisms mapped under the impact investing category are fund of funds, intermediated funds, direct investment funds, and blended financing facilities.

Box 1. What is blended finance?

Blended finance is defined generally as an approach for leveraging additional resources by combining finance from different sources with varying risk tolerance. It can also refer to blending grants and loans.

For example, additional resources can be raised, and risk can be distributed and mitigated by blending public, concessional funds with commercial, impact-driven funding along with commercial private capital. Many of the mechanisms mapped in this report use variations of blended finance approaches or tools to deploy capital for impact.

Blended finance tools used by DFIs, MDBs, bilateral organizations, and foundations include a wide range of de-risking instruments such as guarantees, first loss capital, technical assistance, and other forms of capital subordination to crowd in capital in emerging and frontier markets and accelerate the achievement of SDGs.

The OECD is currently working on detailed guidance for policymakers to implement a range of OECD DAC Blended Finance Principles. Finally, *Convergence—the Global Network for Blended Finance*—highlights that blended finance currently plays an undersized role in the health sector and should be scaled up.

Socially responsible investing (SRI; also known as sustainable, socially conscious, or ethical investing) is an investment strategy to manage assets using environmental, social, and governance (ESG) investment strategies. It therefore seeks more market-based financial returns along with social and environmental impact. The mechanisms and instruments discussed under this category are pension funds, mutual funds, social impact bonds, disaster-related insurance instruments, and public equity/investment trusts.

New channels of taxation refer to new sources of funds made possible through international and domestic taxes. Mechanisms looked at here include international taxes on air tickets and domestic sin taxes. Through the use of innovative taxation, LMIC can more effectively mobilize their own domestic resources for financing the SDGs.

Using this framework, ThinkWell looked at how ODA can be better deployed against these five categories examining each of these using an adapted OECD DAC framework to frame findings on relevance and coherence; efficiency and effectiveness; impact; and sustainability. Table 1 outlines the criteria and definition which we applied.

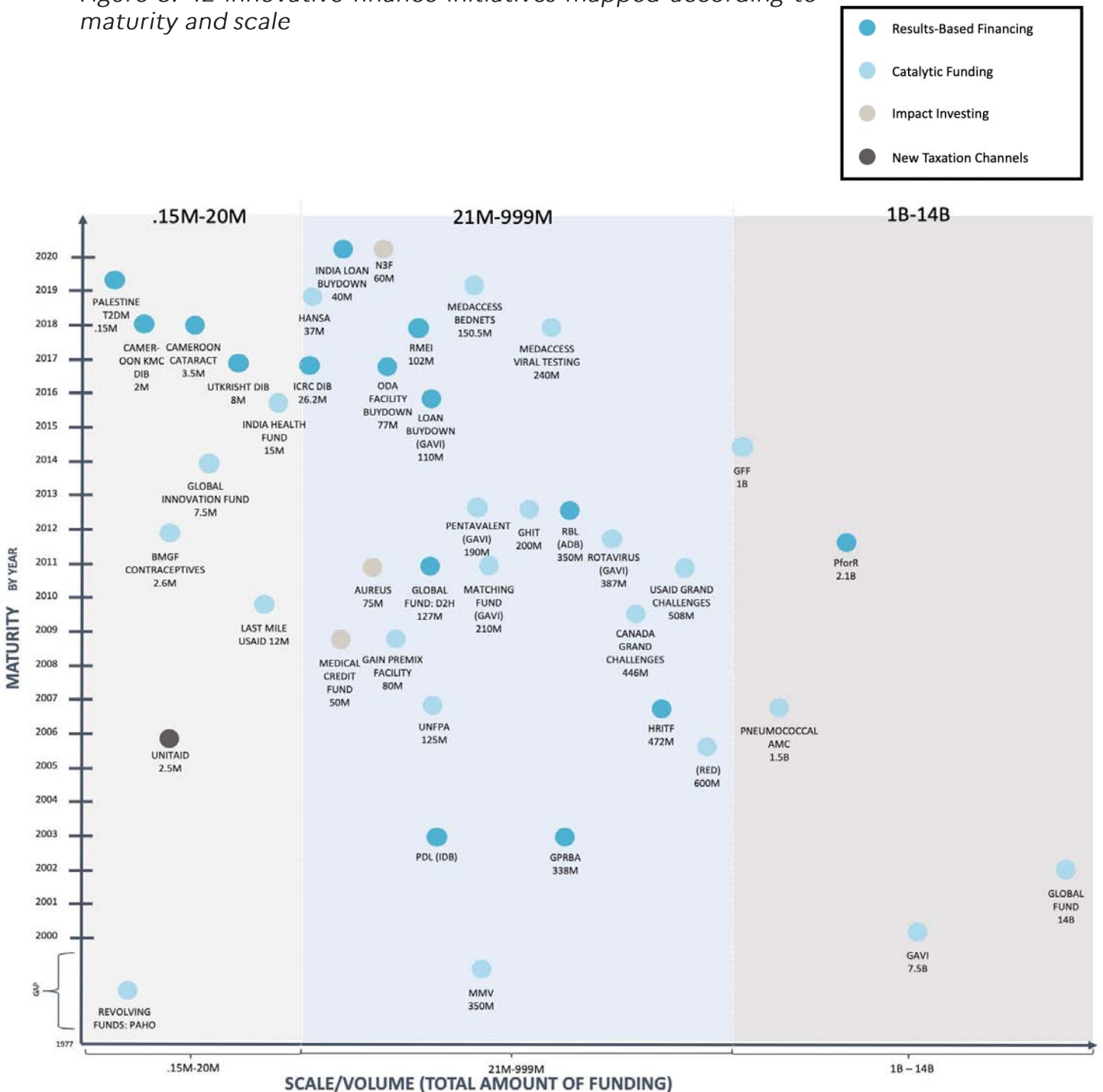
Table 1: OECD DAC criteria and definition adapted for the review

OECD DAC CRITERIA	DEFINITION
RELEVANCE & COHERENCE	Were the mechanisms in the respective classification designed appropriately to respond to local priorities in financing health and did they remain relevant over time? Do the mechanisms in the specified classification complement other relevant interventions or do they undermine them? This includes partnerships, complementarity, harmonization and co-ordination with others, and the extent to which the mechanisms have added value while avoiding duplication of effort.
EFFECTIVENESS & EFFICIENCY	Did the mechanisms in the specified classification achieve their intended outcomes in a cost-efficient way, especially in relation to aid efficiency and additionality? Has there been timely delivery? How successful have these interventions been in crowding in private sector financing? What has been the public to private funding ratio?
IMPACT	What difference have the mechanisms in the respective classification made? This includes looking at both positive or negative, intended or unintended impacts in terms of impacts on financing as well as health.
SUSTAINABILITY	Have the mechanisms in the respective classification led to benefits which will last? This includes the sustained net benefits to both the underlying financing of the intervention and health outcomes over time.

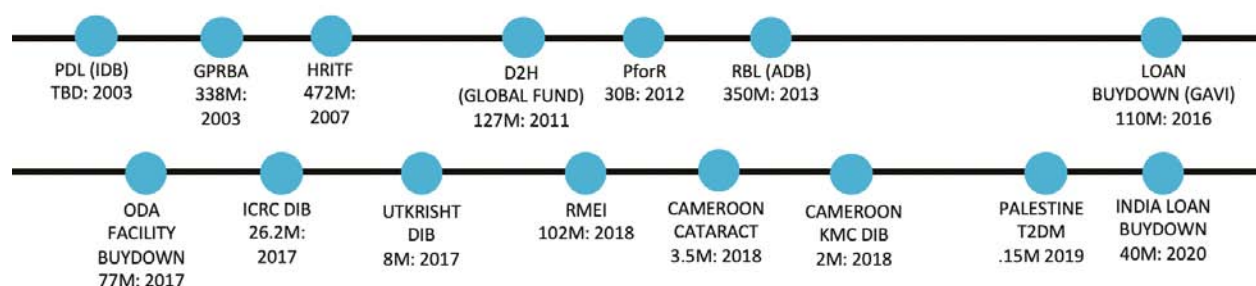
MAPPING AND OUTCOMES ANALYSIS

Innovative finance as an approach to drive forward health outcomes has been rapidly expanding. Figure 3 illustrates where the 42 initiatives which we have mapped are positioned in terms of maturity (based on year of establishment) and scale (total funding available). This figure illustrates that there has been a significant increase especially since 2010. Detailed descriptions of the initiatives can be found in the annex.

Figure 3: 42 innovative finance initiatives mapped according to maturity and scale



RESULTS-BASED FINANCING



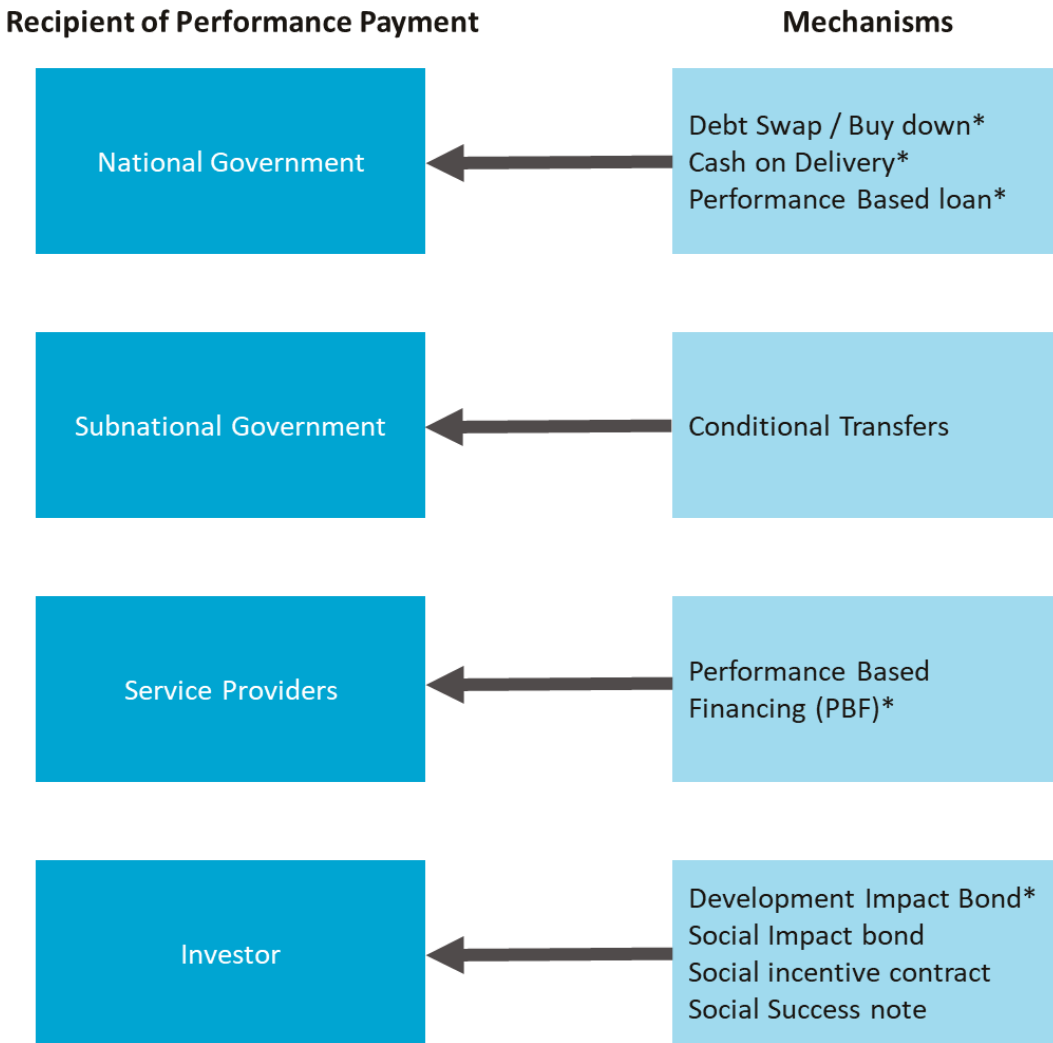
Since the early 2000s, donors have been actively aiming to improve aid effectiveness and ensure maximum impact of their investments. A number of important international agreements reflect these efforts, such as the 2005 Paris Declaration, the 2008 Accra Agenda for Action, the 2011 Busan Outcome document, the 2014 Mexico Commitment, the 2015 Addis Ababa Action Agenda, and the 2019 G7 Ministerial Declaration on Financing for Development.

Result-based financing (RBF) is an umbrella term encompassing various mechanisms using performance-based payment targets. Note that there are many conditions that could be attached to aid transactions, but this report looks primarily at performance conditionality, or RBF. There is no set terminology or definition to classify RBF mechanisms, which are also known as “pay for success,” “outcome-based payments,” or “pay for performance” approaches. Many stakeholders share the World Bank’s standpoint that RBF is an umbrella term referring to any program or intervention that provides rewards upon the credible, independent verification of an achieved result. Figure 4 below, adapted from the Global Partnership on Output Based Aid, provides an overview of the existing mechanisms to date.

The use of result-based mechanisms is increasing across the donor community. The World Bank has been a leader in implementing and testing result-based approaches, with the launch and management of several multi-donor trust funds and the implementation of its Program-for-Results loan mechanism. Bilateral donors are also increasingly looking at integrating results-based principles into their aid portfolio. For example, in 2014, DFID released the Pay by Results guidelines^{xvi} to support the expansion of the approach within its portfolio, and USAID did the same in 2017.^{xvii} Norway has been an early funder of the Health Results Innovation Trust Fund (HRITF), and SIDA has promoted Performance Based Financing in various countries. Development banks including IDB, ADB, and the World Bank have developed result-based loans instruments, and global pools such as Gavi and Global Fund have implemented a vast array of RBF tools. Finally, foundations such as the Bill & Melinda Gates Foundation, Carlos Slim Foundation, and others are also increasingly designing their support using RBF approaches.

There are various forms of RBF mechanisms, which differs in terms of objectives and performance payment recipients. The framework presented in Figure 4 is adapted from the Global Partnership on Output Based Aid. It provides a classification of the RBF mechanisms discussed in this section.

Figure 4: Typology of Result Based Financing Mechanisms



*Mechanisms that can be used with ODA funding, which will be under review in this report.

Debt Swaps

Debt swaps, or “buydowns,” pay down a portion or transfer debt to another entity to make loans more affordable for countries, on the condition that they designate those funds toward a social purpose to make additional investments. A country’s debt is forgiven by the creditor or transferred to another organization with the agreement that they will use funds originally allocated to pay off the debt for an agreed-upon social purpose. In a sense, debt swaps incentivize countries to invest in specific programs or activities.

First established in 2007 by the Global Fund, several new debt swaps have been designed since 2016. There are currently four major debt swaps in use related to health: Global Fund’s Debt to Health; Gavi’s loan buy down facility for immunization; an ODA facility for polio; and the World Bank/Global Fund loan buydown for tuberculosis.

Initially, debt swaps were not seen as successful because they did not create “additional fiscal space” in country budgets or even relieve any significant amount of debt for the country. That is because the amount forgiven was small and the country often preferred to discuss debt relief in the context of international agreements. Furthermore, it was argued that these debt funds—which were public funds—were going towards international, non-country actors, such as the Global Fund.^{xviii} Furthermore, the 2008 global financial crisis affected country governments’ ability to buy into the debt swap exchange. However, enough time has passed since that crisis, and a new round of donors are engaged in debt swaps including development banks. The Global Fund’s Debt2Health relaunched in 2017 with additional technical and legal expertise and a renewed objective to ensure that the capital flows are from within the country itself, making this a self-sustainable option for funding.^{xix} It should be noted however that the effect of the COVID 19-related economic crisis may reduce a country’s appetite for launching new debt swaps.

Debt swaps are best used to address a critical need in a country that does not have enough in-house funding. However, debt swaps are not a long-term, sustainable solution for health financing. While they are extremely beneficial when there are critical health needs that must be invested to save lives, such as immunization for a pandemic, they do not encourage a regular flow of funds for a specific health outcome. (*Initiatives in Annex 4*)

Cash on Delivery Aid & Result Based Loans

First conceptualized by the Center for Global Development, Cash on Delivery Aid offers a fixed payment to recipient governments for each additional unit of progress toward a commonly agreed goal. This approach has been implemented by Gavi in its first rounds of Health System Strengthening grants but has since been discontinued. In Laos, the World Bank and the Global Fund partnered to co-finance a pool fund, the Health and Nutrition Services Access Project (HANSA), with disbursements to the Lao government linked to achievement of 12 Disbursement Linked Indicators DLIs.

**Box 2. Disbursement
Linked Indicators
PforR Mozambique
Mozambique Primary Health Care
Strengthening Program**

DLI 1: Percentage of institutional deliveries in 42 lagging districts, as defined in the IC.

DLI 2: Percentage of secondary schools offering sexual and reproductive health services (information and contraceptive methods), based on visits by health professionals at least monthly.

DLI 3: Couple Years of Protection (CYPs)

DLI 4: Percentage of children between 0-24 months of age receiving the Nutrition Intervention Package (NIP) in the six provinces with the highest prevalence of chronic malnutrition (Cabo Delgado, Manica, Nampula, Niassa, Tete, and Zambézia).

DLI 5: Domestic health expenditures as a percentage of total domestic government expenditures.

DLI 6: Health expenditures made in historically underserved areas (3 provinces and 28 districts).

DLI 7: Number of technical health personnel assigned to the primary health care network.

DLI 8: Percentage of district/rural hospitals that received performance-based allocations (PBA) in accordance with a minimum of two scorecard assessments in the previous fiscal year

DLI 9: Percentage of rural health centers in priority districts that received PBA in accordance with a minimum of two scorecard assessments with community consultations in the previous fiscal year

DLI 10: Number of APEs that are trained and active.

DLI 11: Percentage of deaths certified in health facilities with data on cause of death, coded per ICD 10, reported in SISMA, and sent to the civil registry.

Result-based loans condition their support to the achievement of key indicators. In 2012, the World Bank launched its Program-for-Results (PforR) program, one of the three financing mechanisms for which a country counterpart can apply. As of 30 September 2019, there are 10 health related loans, for a total of \$US2,182M of bank financing. Disbursement of funds under this mechanism is partially made to the government entity based on achievement of Disbursement Linked Indicators (DLI) (see example of DLI used in Mozambique, in the box). After a pilot phase, the ADB Result-Based Lending (RBL) mechanism is now a mainstream tool in the bank financing mechanisms. (*Initiative in Annex 5*)

Performance-Based Financing

Performance-based financing (PBF) is a program where payment of incentives (rewards or penalties) are made to health care providers based on an agreed set of results indicators and targets. Those mechanisms are also known as Pay for Performance (P4P) in high income settings.

The launch of the World Bank administered Results Innovation Trust Fund (HRITF) has catalyzed implementation and learning of Performance Based Financing mechanisms in LMIC. In 2007, in collaboration with Norway and the UK government, the World Bank launched the HRITF to promote and fund Performance-Based Financing (PBF) programs across the globe. The funds sponsored 35 PBF project across 29 countries.^{xx} The majority of the PBF projects or 20 are on the African continent. As of August 2017, the total value of funds committed until 2022 amounted to US\$472.2 million. Since 2015, the fund has evolved into the Global Financing Facility Trust Fund, with the objective of improving maternal and child health through performance-based approaches. Other bilaterals are sponsoring PBF programs, including USAID, SIDA, CDC, and the European Union.

PBF programs have mainly been used at primary health care levels to incentivize use of health care services. Indicators often take the form of a set price per consultation, with the addition of process indicators (training of staff, drugs on stock) as a proxy of quality measures. As incentives are made at provider level, incentivizing outcome rather than output has been challenging. Few PBFs have contracted with the secondary or tertiary level, as contracting and pricing hospital services are more complex. If the majority of PBF schemes contract with public providers, the mechanism does offer the opportunity to better integrate private providers to deliver high-priority services.

The impact of performance-based financing initiatives has been mixed and difficult to measure. PBF programs have been extensively researched, and systematic impact evaluations have been commissioned under the HRITF. These evaluations show mixed evidence on the impact in terms of increase of health care utilization. The evaluations also show that perverse incentives may be created that skew service delivery in the direction of those enlisted for PBF. For example, it was noted in the HRITF midterm review that impact evaluations showed improvement in utilization of RMNCH services, but those improvements are not consistent and vary between and within countries. The PBF community is calling to look beyond quantitative results of the approach to now focus the debate and research around the impact of PBF in the health system overall.^{xxi}

The most common critiques of PBF approaches points include the cost of their implementation, the risk of distorting results, and poor integration into national purchasing systems. More innovation is required to mitigate these risks. For the latter, there is a need to look at more coherent integration of PBF programs withing national purchasing strategies of health care services. For the former, better approaches are needed to decrease the costs of conducting verifications and to ensure there is no negative effect of PBF on non-incentivized services. To reduce the potential risk of fraud, strong verification systems are already in place to control the validity of the information used to validate payment, but this significantly increases implementation costs. Only a handful of studies have looked at the cost-effectiveness of those interventions. (*Initiatives in Annex 6*)

Development Impact Bonds

Impact bonds are a newer form of RBF mechanism, involving a private investor which takes full or part of the performance risk. Impact bonds, created in 2011, were first designed and implemented in the UK as a new way for the government to finance public services. Learning from the early experience and challenges of traditional RBF mechanisms, impact bonds try to overcome these challenges by leveraging the private investment market. In an impact bond, investors cover the up-front capital required for a service provider to set up and deliver its program, while bearing the risk if the provider fails to achieve pre-agreed outcomes. If results are achieved, the investor receives its investment back plus interest. It is important to note that impact bonds are not bonds in the traditional financial term, as there is no bond released on the capital market. Impact bonds encompass both Social Impact Bonds (SIB), where the outcome payer is a government or local authority, and Development Impact Bonds (DIB), where the outcome payer is a donor.^{xxii}

As of today, all sectors included, there are 193 impact bonds in the market active in 33 countries, including 182 SIBs and 11 DIBs.^{xxiii} Development impact bonds for health are slowly increasing in numbers, but the market remains small. The international community started to consider impact bonds in 2013, and one of the first Development Impact bond was launched in Peru in 2015 to protect rainforest in indigenous communities.^{xxiv} In 2017, the first DIB in the health sector, the Utkrisht DIB, was launched, with a US\$8 million commitment made by USAID and Merck for Mothers, a philanthropic initiative of Merck. As of today, the Utkrisht DIB is still the biggest of the five current health DIBs.

After a few years of slow expansion, there is an acceleration of the number of initiatives in the pipeline. Currently, there are five active DIBs in the health sector and nine new DIB initiatives expected to be launched in 2021. SIBs are also expanding in the health sector, with 24 SIBs currently. Overall, Brookings estimates the impact bond market at a total of US\$370 million, which makes it small compared to overall ODA and compared to impact investing (US\$228 billion in impact investing assets, according to the Global Impact Investing Network [GIIN]).

Multi- and bilateral agencies need to learn and adapt their procurement processes to enable broader extension of the approach. As of today, USAID is the outcome payer of the Ukrisht bond, a consortium of European bilaterals (Belgium, Italy, UK, Switzerland) is the outcome payer for the ICRC bond, and GFF funding serves as outcome payer for the Kangaroo DIB in Cameroon. The other two DIBs—one focused on cataracts in Cameroon and the other on diabetes in Palestine—are funded by philanthropic foundations. Overcoming the legal constraints around procurement remains a barrier for further expansion. For example, the legal frameworks in Switzerland and Belgium had no provisions for the Humanitarian Impact Bond (HIB) model.^{xxv} Philanthropic donors have been more active in the space than bilateral donors because foundations are more flexible regarding their procurement processes.

DIBs have a rather short time frame and incentivize practices that can show rapid results. As the cost of capital rapidly increases for long-term investment, DIBs are structured around interventions with rapid impact and where outcomes can be costed. The current interventions sponsored via DIBs (existing and pipeline) are large, from promoting development of service (e.g., incentivizing cataract surgeries in Cameroon, catalyzing health infrastructure development in refugee camps, improving access to menstrual hygiene protection in Niger and Ethiopia), to stimulating quality of care (e.g., ensuring private clinics are accredited in India, promoting Kangaroo care practices in Cameroon) or preventive behavior (e.g., improving diet and physical activity in Palestine or Georgia, improving uptake of family planning services among adolescent girls in Kenya). As per Emily Gustafsson-Wright, from the Brookings Institution: “Impact bonds are better fit for quality improvement and where data can help break the barriers and achieve the outcomes.”

To accelerate the development of development impact bonds, reduce transaction costs, and increase overall ticket size, several outcome funds are currently being designed. An outcome fund is a funding mechanism that pools sources from various contributors and enables the development, in parallel and under a common framework, of several outcome-based contracts.^{xxvi} The first Outcomes Fund, the result of the lessons learned from setting up individual SIBs, was launched in the UK in 2012. To date, the UK government has set up six outcome funds for SIBs, and the model is being replicated in other countries such as France, Germany, Italy, and Portugal. Several outcome funds are now in the making in the development impact bond community. The Education Outcomes Fund in Liberia was the first outcome fund launched in 2018, with US\$35M committed. In the health sector, the Global Fund, in partnership with other donors, is considering launching an outcome fund for malaria for between USD 50 to 100 million. *(Initiatives in Annex 7)*

CASE STUDY : CAMEROON KANGAROO DIB

The Cameroon Kangaroo Development Impact Bond (DIB) is the first DIB to focus on maternal, newborn, and child health (MNCH) in Africa, incentivizing the implementation of Kangaroo Mother Care (KMC) in 10 hospitals in Cameroon.

The Cameroon Kangaroo DIB was launched in 2018, for a total funding of US\$2.8 million, and with the overall objective is to increase access to KMC and improve weight gain for low birth weight or premature babies.

In Cameroon, where low birth weight (LBW) and prematurity are leading risk factors for neonatal mortality. About 20,000 newborn babies die every year due to these issues. Kangaroo Mother Care is a technique where the baby is held skin-to-skin on the mother or caregiver's chest, ideally feeding it only breast milk. It decreases the amount of time in the hospital and increases the follow-up with the mother and child once they return home. Research shows that this approach offers higher protection against infant mortality than incubator care.

DIB structure

In ten selected public and private hospitals across five regions in the country, Kangaroo Foundation Cameroon, the service provider, in collaboration with the Kangaroo Foundation Columbia, supports the clinical team to implement the KMC approach. The first cycle of implementation started in February 2019 and the support will continue for 2.5 years, until the end of 2021. Verification occurs every three months, enabling frequent feedback to the team of their progress towards objectives. It is expected that at the end of the period, care will have been provided to 2,200 newborns, and that the hospitals will become centers of excellence, able to train others to expand the use of the approach.

Upfront funding was provided by Grand Challenge Canada, a philanthropic investor, who will get its capital back at the end of the full period, if outcomes are achieved. US\$800,000 were granted to upgrade health facilities and train health practitioners. The outcome funder who will pay for each unit of outcome achieved is the Cameroon Ministry of Public Health and the Global Financing Facility, who have pledged US\$2 million. Also, Nutrition International has pledged US\$800,000. The evaluator of the project is Institut pour la recherche, le developpement socio-economique et la communication (IRESCO). Finally, Social Finance is the performance manager, whose role is to monitor progress and ensure rapid adaptation of the approach to accelerate results, perform financial management and provide capacity building to partners in the area of adaptive delivery.

Why a DIB?

The KMC approach had been tested in Columbia but there was no evidence that the approach would work in the context of Cameroon. Also, because there was upfront investment required, using an external investor made sense so that the implementers could invest in training and infrastructure for the future success of the approach. Finally, there was significant potential to obtain accelerated results thanks to close monitoring and the possibility to quickly adapt the activities following each evaluation. This made the DIB approach appealing compared to traditional aid support which is often more rigid where budgets and activities are pre-defined.

Early results

Outcome metrics and measurement

- Indicator 1: Number of hospitals with the prerequisites to implement high-quality KMC (including equipment, infrastructure, trained staff; and protocols)— Measurement is undertaken using a checklist.
- Indicator 2: Number of infants who receive good-quality KMC before being discharged from hospital— Measurement is done via a survey to patients selected based on predetermined criteria.
- Indicator 3: Percentage of enrolled infants who come back for their 40-week follow-up with an appropriate weight and having received appropriate nutrition— Measurement is done via a survey to patients selected based on predetermined criteria.

At the end of 2019, 8 of the 10 hospitals are providing Kangaroo Care services, with staff adequacy trained. The project is on track in registering infants into the program, with 500 infants enrolled ahead of the 323 forecasted.

There are good improvements in term of quality measures, including a significant increase in number of hours of skin to skin contact (from 13% during the pilot phase to 36% in 2019).

The adaptive delivery approach requires both the clinical team and the administrative team to work together and quickly adapt implementation to ensure results will be met. This is a cultural shift in the hospitals of interventions and has required time to adapt to this new approach. It is expected that in the following verification cycles, achievements of indicators 2 and 3 will accelerate.

Outcomes Analysis (using adapted OECD DAC Criteria)

Relevance and Coherence—MEDIUM

Result-based financing mechanisms are not always aligned with a country's health financing structures. During design of the initiative, the dialogue is often top-down and imposed on government rather than rooted in priority investment planning and national strategy to achieve the SDG 3 targets. RBF approaches need to ensure that governments have more ownership of the programs, integrating these into country systems and reforms, and focusing on long-term outcomes rather than short-term outputs. The mid-term review of the HRITF showed that several RBF programs have lacked ownership and buy-in from the recipient countries. Coordination among partners has also been challenging in some contexts. Early evaluation of the PforR program showed that while most indicators were well aligned with government priorities, they often lacked a long-term vision of success.

Donors tend to select the RBF mechanism first, then define the results framework. Several mechanisms we reviewed were initiated by the desire of the donor to test a new approach, rather than as the result of an analysis of which mechanisms could yield the most impact. All stakeholders who we interviewed are calling on a revision to the approach, and inviting donors to carefully review their objectives (e.g., increased investment in prevention, better monitoring of performance, catalyzing innovation) as well as the constraints (e.g., need for up-front capital, existence of strong data systems) before selecting the instruments. For example, impact bonds are more interesting and relevant instruments for donors compared to traditional financing if there is a risk element which must be overcome that justifies the cost of private capital.

Result-based financing terminology is not standardized and complex. To enhance dialogue and exchange among all partners, a more streamlined vocabulary aiming at simplicity over complexity is required.

Effectiveness and Efficiency—MEDIUM

The cost advantages of result-based mechanisms over traditional funding mechanisms still need demonstrated because the costs of their design and implementation remain high. RBF mechanisms by design aim to improve aid effectiveness (i.e., aiming to obtain more results for the investment made). As of today, there is little evidence that this has been achieved. Most of the mechanisms appear to be costly in their design and/or in their implementation, due to the heavy investment required to define and verify measurable indicators and to build stakeholders' capacity to operate under this new model. The amount disbursed as conditional in result-based loans still represent only a small part of overall disbursements. Targets appear to be set conservatively to respond to the pressure for disbursement. For DIBs, the time to design a deal can be quite long—two years in the cases of the Cataract Bond and the Utkrisht Impact Bond—leading to high cost in relation to the overall investment. It is expected that as these approaches mature, the operating costs should decline, enhancing their overall cost-effectiveness.

In terms of aid efficiency, additional measures and reforms need to be implemented which go beyond innovative finance. While there is a perception that result-based financing is seen to have had a limited impact on aid effectiveness, there is a widespread sentiment that it has fostered a much-needed debate on how to best to incentivize and pay for health care, and what the expected outcomes and cost of health interventions should be.

Among all RBF mechanisms reviewed, DIBs show the most promise to bring new partners into the aid space, especially private investors. The caveat is that the potential of the market is limited – it is still in its early stages of development, with few initiatives and limited size. Further, the effectiveness of impact bonds to bring in new money is at best indirect because they do not provide additional inflow of money. DIBs are successful in bringing investors onboard for up-front capital when needed, but the outcome payer remains ODA.

Impact: MEDIUM to HIGH

To date, evaluations of result-based approaches have focused on whether more outputs were achieved compared to traditional approaches, showing mixed results in terms of impact. As highlighted in the HRITF mid-term review, there have been some positive results in some contexts, with negligible results in other ones. It is too early to fully evaluate the results of DIBs, but the Utkrisht Impact Bond, the first health DIB in the market, is on track to achieve targets earlier than expected.

The main impact of the RBF mechanisms appears to lie in the systemic change it encourages. Result-based financing is a cultural shift in the aid industry, where donors should offset their focus on how the money is spent for which results are achieved. It implies new internal procedures and different oversight mechanisms, as well as a change in terms of disbursement pressure. For the recipient, those mechanisms accelerate the improvement of data management system and oversight, which can sometimes be challenging in resource-constrained settings.

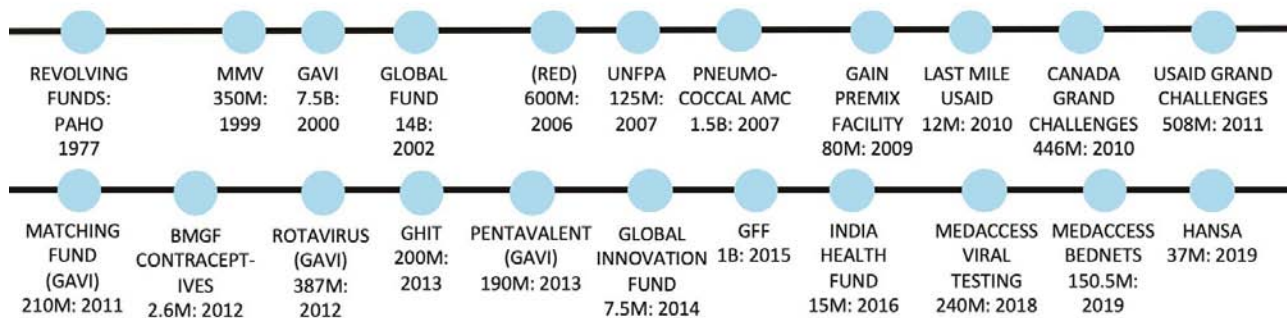
More should be done to incentivize investment in prevention and high-quality health care to ensure more health outcomes. Because identifying and measuring appropriate indicators is difficult, a lot of the RBF mechanisms have focused on output indicators, such as the number of consultations for a set service. If, in some contexts, increasing use of services is important, it is only a partial driver of health outcomes. More remains to be done to ensure conditionalities incentivize quality of care and improve outcomes, rather than short-term output measures.

Sustainability: MEDIUM

RBF has the potential to make lasting and sustainable change, if well integrated into country systems and values. RBF mechanisms could have long-lasting impact in shifting the way we pay for health care, from input-based payments to outcome payments, in countries planning to evolve their health systems in that direction. In countries thinking about how to best contract and purchase health services, PBF can be an important first step towards implementing a national purchasing agency and help to build knowledge and processes. DIBs and debt swaps by design are not meant to be continued for extended periods, but rather aim to catalyze innovation and policy change, to be further picked up by governments. Arguably the greatest contribution of RBF mechanisms is the cultural shift they create to focus on monitoring and planning based on data and performance analysis.

Initiatives in Annex 7

CATALYTIC FUNDING



The goal of catalytic mechanisms is to support market-based solutions by rapidly mobilizing external resources to support a specific objective or mission. Catalytic mechanisms bring together funding from both public and private sector actors to form new partnerships to stimulate innovation and market-based solutions within global health and development. Thus, several of the approaches used by catalytic funding can be considered as “blended finance.” Mechanisms under this classification include pooled investment approaches, co-funding, seed funding, advanced market commitments, volume guarantees, credit guarantees, and revolving funds.

Pooled Investment Approaches

Pooled investment approaches help aggregate funding from multiple donors or partners to achieve a predetermined objective. The predominant use of multi-donor funding over the last 20 years has been targeted at vertical disease programs, immunization, and in some cases broader MNCH service delivery goals. In many instances, pooled funds are established to support a solution to a market-based failure, such as insufficient access to essential health commodities. There have also been some pooled funds that have focused on health systems strengthening approaches.

There are several pooled investment approaches currently deployed, including by Gavi; the Global Fund for AIDS, TB and Malaria; the Global Innovation Fund; the Global Financing Facility (GFF); the Global Health Innovative Technology Fund (GHIT); and Medicines for Malaria Venture

(MMV). These initiatives pool resources as part of public-private partnerships that mobilize and encourage external resources in global health. The exception is the Global Financing Facility which was established as a trust fund under the World Bank.

Gavi and the Global Fund, founded in 2000 and 2002, respectively, are examples of initiatives using pooled investment approaches that focus on market failures related to immunizations, and HIV/AIDS, TB, and malaria, respectively in LMICs. Gavi was established to rapidly improve access and availability of vaccines in LMICs, where it would usually take more than 10 years to bring in new vaccines. The Global Fund was established to address the global burden of HIV/AIDS, TB, and malaria. Both organizations operate on a replenishment cycle, where every three to five years donors commit to financing the organizations for the next three- to five-year cycle. Both organizations have introduced innovative finance initiatives such as Product (Red) and the Gavi Matching (which are discussed below under Public-Private Co-Funding). They both also use catalytic mechanisms such as volume guarantees and advanced market commitments.

Pooled investment approaches have often delivered significant results at a global level. With the introduction of the Global Fund and Gavi, countries across the world have been able to increase their access to affordable medicines and vaccinations, resulting in 198 million children immunized, 18.9 million people on antiretroviral therapies, 5.3 million people treated for TB, and 131 million mosquito nets distributed.^{xxvii xxviii} The products discovered through MMV have resulted in 1.5 million lives saved since 2009, while the GHIT has identified two products for regulatory approval by 2023, and the Global Innovation Fund is forecast to benefit 33 million individuals.^{xxix}
xxx xxxi

A top-down approach is used for pooled funds, where first the mission for engagement is agreed upon and then actors are brought together to mobilize resources for that mission. The Global Fund and Gavi have brought together governmental actors such as France, the UK, USA, and Italy, along with philanthropies such as the Bill & Melinda Gates Foundation (BMGF) and the Rockefeller Foundation. (*Initiatives Annex 8*)

Public-Private Co-Funding

Public-Private Co-Funding builds new partnerships with the private sectors and focuses on efficiency by utilizing private sector approaches to global health projects. Co-funding mechanisms, like pooled funds, bring together the funders based on a specific, predetermined objective or mission. Co-funding mechanisms are applied when “public funding is used to leverage private funding to increase the impact by applying private sector knowledge and approaches to development.”^{xxxii} This mechanism is commonly applied to matching funds, where the private sector matches the public sector funding, with a minimum of a 1:1 ratio, or partnering with private sector actors to drive efficiency. Some examples of co-funding initiatives include the Gavi matching fund, the India Health Fund, Product (RED), and USAID Project Last Mile.

Some of the earliest private-public co-funding mechanisms for health were established in 2010. Project Last Mile, a partnership between the Coca-Cola Company, USAID, and the BMGF, established in 2010, strengthens the supply chain systems in eight African countries by optimizing supply routes and supporting the direct delivery of medicines by using the expertise and networks of the Coca Cola Company.^{xxxiii} This US\$12 million partnership improved the uptake of essential medicines to benefit the communities in Africa. Separately, a year later, Gavi established a matching fund that incentivized the private sector to invest in immunizations. The BMGF and DFID jointly pledged US\$111 million to match investments from corporations and private sector donors, resulting in a total of US\$210 million funding commitments.^{xxxiv}

Some pooled approaches have been highly successful in crowding in private sector funding. For example, the Global Fund, through an innovative financing mechanism called Product (RED), brings together several private sector partners that sell (RED) products to generate financing for

the Global Fund. These partners include American Express, Apple, Nike, Starbucks, Giorgio Armani, among others. This private sector partnership has raised close to US\$600 million for the Global Fund since 2006, representing a success in ethical consumerism and how it can lead to an increase in aid funding.

Public-private co-funding mechanisms allow private sector funding and expertise to drive efficiency and scalability in global health programs. The latest co-funding arrangement for health is the India Health Fund (IHF), formed in 2016 with funding from Tata Trusts and the Global Fund. The IHF is the first platform to aggregate resources to invest philanthropic capital toward the elimination of TB and malaria in India.^{xxxv} (*Initiatives Annex 9*)

Revolving Funds

A revolving fund is a cost recovery financing mechanism often used in health to procure supplies, facilitating better cost and quality of the supplies to participating entities. Revolving funds are designed for health commodities across various disease areas. Products available through revolving funds are usually sold at cost plus markup. This generates the necessary revenue that can be cycled back into the procurement process. The recovered costs usually cover the base cost of the product, the procurement costs, storage, and distribution, and in some cases profit. A consistent availability of liquid funds enables a regular flow of supplies to fulfill customer needs and enables the rapid introduction of new products. Grant funds are sometimes used to provide subsidies or credit for participating entities. Often, multiple products and even competing products are available through a revolving fund to help support cost reductions and to generate revenue (products with fast turnover can produce higher revenue for the fund). Revolving funds currently used in health include the UNFPA Reproductive Health Supplies, the GAIN Premix Facility (GPF) focused on nutrition, and the Pan American Health Organization (PAHO) Revolving Fund.^{xxxvi}

A revolving fund requires its initial capital in the form of seed funding, which can be provided by a donor. In 1977, the first revolving fund was launched, the PAHO Revolving Fund, allowing 41 countries and territories improved access to vaccines and related supplies for a lower price.^{xxxvii} The GPF, founded in 2009, focuses on nutraceuticals for fortified foods that enhance health outcomes. The facility received US\$6 million in seed funding from donors in 2009 (BMGF and the Government of the Netherlands). The GPF has reached approximately 150 million individuals per year since its inception in 2009. A principal tenant of revolving funds is the increase in equity of access to critical supplies or goods.

Revolving funds use economies of scale and aggregate purchasing to ensure a stable supply of health products at a lower price. The PAHO Revolving Fund uses a pooled procurement mechanism that helps lower the market price by pooling demand from 41 countries. The fund procures the vaccines and related supplies at a fraction of the cost and provides a sustainable line of credit for the member countries. The GPF is another example of a revolving fund using economies of scale to improve pricing. It aggregates demand for vitamins and minerals across LMIC and regions. It has achieved 5% to 15% cost reductions on over US\$80 million worth of vitamins and minerals procured since 2009. (*Initiatives in Annex 10*)

Seed Funding and First-loss Capital

Seed funding is a mechanism used by donors to invest in early stage social enterprises or high-impact innovations that can later be scaled and even commercialized at a later stage. Some seed funders deploy a venture capitalist approach but with little or no expectation of repayment. Others take out equity in the project/company as a return. Seed funding often comes via open calls for highly competitive proposals among new actors in development (e.g., social

entrepreneurs), thus bridging not only new ideas but forging new relationships. Award grants for seed funding have helped bring in new players and solutions for SDG 3.

This mechanism has been used to provide funding for a range of health-related domains, including disease prevention, health technology, and health systems. One of the earliest seed funding opportunities in health was Grand Challenges put in place by the Bill and Melinda Gates Foundation in 2007. Later, Canada and the United States replicated this approach in 2010 and 2011, respectively. Some projects that have been funded include the “saving lives at birth” initiative that creates innovative approaches to maternal and child health and “combating ZIKA and future threats,” an initiative that develops solutions for disease outbreaks. Saving Lives at Birth was considered a success because it leveraged a large amount of private investment to grow initial Grand Challenges funding. It has invested US\$83.4 million to support 106 innovations in 21 countries, leveraging another US\$70 million. Most commonly, seed funding is administered by a multilateral/bilateral institution or a philanthropic organization. Other actors involved in the process are investors and innovation organizations.

Seed funding provides the opportunity to invest and scale innovative ideas with the assistance of advisory and incubation/acceleration services. However, it is often a highly competitive process with very few organizations that win funding. Furthermore, this mechanism takes time and resources to help create, incubate, and scale an idea, so it is not best for health outcomes that need an immediate solution. This mechanism is best used when there is a need for diverse perspectives and new ideas to solve a critical problem. It attracts investment for innovation, so additionality, testing, and scaling are key criteria for success. (*Initiatives in Annex 11*)

Box 3. ‘Pull’ Approaches and Initiatives

‘Pull’ approaches are used in global health to address market failures related to R&D for neglected diseases. Pull mechanisms incentivize manufacturers to invest in innovative products that increase access in underserved markets.

In 1999, one of the earliest pooled funds, Medicines for Malaria Ventures (MMV), was established as a pull mechanism to reduce the burden of malaria by incentivizing pharmaceutical companies to invest in R&D through a product development partnership model (PDP). A PDP brings together actors from the public sector, for financing, and the private sector, for R&D expertise to collaborate on product development for neglected diseases. MMV began with US\$4 million in seed funding and has now grown to an investment of US\$100 million per year for the 2019-2023 timeframe. The seed funding was provided by DFID, the Swiss Government, the Dutch Government, the World Bank, and the Rockefeller Foundation. Currently, MMV receives funding from various actors, such as corporate foundations, private donors, and governments, as well as international organizations. Since its inception in 1999, MMV has 19 malaria drug targets validated, including the first child-friendly medicine and the first single-dose cure for relapsing malaria.

Another pull initiative - The Global Health Innovative Technology Fund (GHIT), founded in 2013, and the Global Health Innovation Fund, founded in 2014, both focus on investing in solutions through products that would help achieve the SDGs. The GHIT invests in research and development of medicines for malaria, HIV, TB, and NTDs (neglected tropical diseases) that would be effective and affordable for the countries with the highest disease burden. The newest pooled investment fund is the Global Innovation Fund that includes a US\$7.5 million portfolio of investments in health and nutrition. These investments range from biotech solutions to malaria treatment to increasing availability of essential medicines through a network of digital pharmacies to a distribution system for iron fortified rice to prevent iron deficiency anemia. GHIT and MMV brought together actors such as the government of Japan, BMGF, DFID, Wellcome Trust, global life sciences companies, the Swiss Agency for Development Cooperation (SDC), and the Rockefeller Foundation. More recently, various donors and WHO have collaborated to launch the Access to COVID-19 Tools Accelerator, a pull approach which will focus on the development, production and access to new diagnostics for COVID-19 diagnostics, therapeutics and vaccines.

Advanced Market Commitments

Advanced market commitments (AMCs) serve as a pull mechanism to encourage research and development of new health technologies and affordable products in LMIC while establishing a viable market for the product once it is developed. An AMC incentivizes manufacturers to invest in developing products by guaranteeing the purchase of the product under a predetermined price and demand target. This is particularly beneficial when the risk of investment in R&D would otherwise be too high for the return. The AMC decreases the risk for R&D by providing information for establishing market demand and resolves affordability issues for the end-consumers.

A report, “Making Markets for Vaccines,” published by the Center for Global Development in 2005, introduced the idea of advanced market commitments.^{xxxviii} This report stimulated interest among G7 finance ministers, the World Bank, and various donors, resulting in a project to develop the first AMC. In 2007, the first AMC was launched with a US\$1.5 billion pledge from Italy, UK, Canada, Russia, Norway, and BMGF to incentivize the development of a pneumococcal vaccine.^{xxxix} Since its launch, the AMC has resulted in the introduction of the pneumococcal vaccine in 60 Gavi-eligible countries with 149 million children vaccinated in 2018.^{xl} More recently in June 2020, Gavi launched the COVID Covax AMC aimed at incentivizing vaccine manufacturers to produce sufficient quantities of eventual COVID-19 vaccines, and to ensure access for LMIC.

Volume Guarantees

Volume guarantees usually come in form of long-term fixed-price contract between a purchaser and manufacturers for lower-income countries that result in higher total volumes of a product at lower prices. Typically, a donor or donors is backing the contract helping to make up any shortfall in demand. Even with lower prices, higher volumes can drive more revenue and in some cases profit—a classic win-win for both consumers and producers. Volume guarantees are a pull mechanism that increase visibility into demand for manufactures by establishing demand rates over an extended period of time. For example, vaccine demand can be uncertain, particularly when the product market is small and information asymmetry exists. With greater visibility into needs over time, manufacturers can expand manufacturing capacity and improve the flow of product supply. The benefiting market received better access and lower prices. Volume guarantees can be applied in locations where market prices are not sustainably accessible, but their execution can shape the market in the long term. The effect on the market can be broader and longer lasting than the initial agreement. For example, lower price expectations may continue beyond the scope of the agreement. Other manufacturers may follow suit with their prices to respond to the market.

MedAccess, funded by CDC group, has been creating effective, long term volume guarantees in health. Two volume guarantees which MedAccess recently created include one which helps countries fight malaria through aggregate bed net purchases (2019) and the other through the purchase of diagnostic viral testing products in sub-Saharan Africa (2018). The guarantees come with a price ceiling to ensure affordability. For example, the price ceiling decreases every year for the malaria bed nets as economy of scale are reached. Both guarantees have already achieved price reductions and helped shape markets in sub-Saharan Africa. *(Initiatives in Annex 12)*

Credit Guarantees

Credit guarantees are a funding mechanism that can reduce possible losses of an investment by leveraging donor funding. If an investment is too risky for a private funder, a credit guarantee can help de-risk this and encourage investment by using grant funding to cover part or all of the

capital loss in case of defaults or unsuccessful investments. It is thus a blended finance tool that is also deployed often as part of impact investing (see below under 'impact investing' for details). USAID's Development Credit Authority (DCA) (now part of US Development Finance Corporation) was created in 1999 and made US\$5.5 billion of credit available in over 80 countries between 1999 and 2018^{xli}. While only 3% of these funds were used for health-related opportunities, the number is increasing (ibid).

CASE STUDY: CATALYTIC FUNDING AT THE GLOBAL FUND FOR HIV/AIDS, TB AND MALARIA

The Global Fund was created in 2002 with the goal of defeating three of the deadliest diseases—AIDS, tuberculosis, and malaria—and creating a world with better health for all. Their focus is to increase funding flows and efficiency of investments with the main goal of increasing impact through financing. Government donors comprise 95% of their funds, and 5% are private sector. These funds go directly to support programs run by local experts in over 100 countries that are dedicated to eliminating AIDS, tuberculosis, and malaria, and subsequently build more resilient health systems. The Global Fund has multiple mechanisms to help garner funds, three of the most prevalent of which are highlighted below.

Product (RED), founded in 2006 with the partnership of Bono and Bobby Shriver, works with various iconic brands to develop (RED) products and services. When these products and services are purchased, 50% of the funds are given directly to the Global Fund. This program was designed to kick-start a steady flow of corporate money into the Global Fund, catalyzing engagement from the private sector. Before this initiative, businesses only contributed US\$5 million to the Global Fund, but since the launch of Project (RED), there has been over US\$600 million in contributions. Examples of products include the (RED) iPhone; American Express (RED) card, where 1% of spending is donated to the Global Fund; Gap merchandise; Nike (RED) shoelaces; and Monster cable (RED) Beats by Dr. Dre. Other participants include Bank of America, Belvedere Vodka, Durex, Johnson and Johnson, Starbucks, Primark, Netjets, Salesforce, and Telcel. The proceeds from Product (RED) have benefited over 140 million people. These contributions are invested in HIV/AIDS programs in Africa, with a focus on countries with high prevalence of mother-to-child transmission of HIV. As of July 2019, US\$600 million in contributions have gone to support Global Fund HIV/AIDS grants in Ghana, Kenya, Lesotho, Rwanda, South Africa, Swaziland, Tanzania, and Zambia.

The Lives and Livelihood Foundation approach by the Global Fund changes the financial model of development by blending grants with affordable loans for countries that would not normally be able to access financing. It is a key example of how new financial approaches across different partners can transform health in countries and communities most in need.

This fund pools together Islamic Development Bank lending capital along with donor grant money in a multi-donor trust fund. It finances projects in health, agriculture, and infrastructure in Islamic Development Bank member countries through a combination of grants and concessional loans. It complements existing Global Fund funding and provides resources for governments to meet Global Fund co-financing requirements, increasing country ownership and building program sustainability.

An example is the US\$32 million financing agreement to support the Government of Senegal's mission to eliminate malaria by the end of 2018. The project, designed in collaboration with the Global Fund under the framework of the National Malaria Control Program, will train community workers and contribute to the distribution of one million rapid diagnosis tests and more than 700,000 anti-malaria drug doses, in addition to providing 2.5 million people with mosquito nets. It will support the country to move from the first stage of malaria response, the "control phase," to the "pre-elimination phase."

The Lives and Livelihoods Fund tries to engage new players, such as impact investors, high net-worth individuals, sovereign wealth and pension funds, banks and asset management companies, and development finance institutions. It pools resources from a variety of partners, including the Islamic Solidarity Fund for Development, the Qatar Fund for Development, the King Salman Relief and Humanitarian Aid Center, and the Abu Dhabi Fund for Development. This is an effort to build a broad coalition of fundraising partners, to go beyond government aid agencies, corporate donors, and foundations.

CASE STUDY: CATALYTIC FUNDING AT THE GLOBAL FUND FOR HIV/AIDS, TB AND MALARIA (CONTINUED)

Debt2Health is an innovative finance mechanism that creates a three-way partnership between creditors, grant-recipient countries, and a multilateral institution (the Global Fund), where creditors forgo repayment of a portion of their loan to a poor country so that the country invests a set amount in health-related activities. For example, Germany has cancelled €50 million of Indonesia's debt and €40 million of Pakistan's debt. Australia has cancelled €75 million of Indonesia's debt. Spain has recently cancelled €36 million total of Cameroon, DRC, and Ethiopia's debt. It was created in 2007 and later picked up again in 2018. The creditors so far have been the governments of Australia, Germany, and Spain. The implementing countries where debt have been cancelled are Cameroon, Cote d'Ivoire, DRC, Egypt, Ethiopia, Indonesia, and Pakistan. Through the Debt2Health program, over €127 million in funds have been distributed, and poor countries across the globe have been incentivized to spend more on health. Furthermore, the Global Fund aims to enter more Debt2Health agreements, bringing in additional multilateral development banks and partners. Debt2Health circumnavigates money-to-health causes immediately, allowing for large amounts of funding to go toward saving lives.

Each of these mechanisms is unique and has benefits in terms of sustainability but also challenges in terms of scale. Mechanisms must all create some form of new semi-sustainable funding. Product (RED) is highly replicable as even some of the proceeds from (RED) are being used for COVID-19. This model is sustainable and provides constant funding from the private sector through purchases of (RED) products. The initiative might move toward ethical consumerism where purchasing a product brings social returns. The Lives and Livelihood Fund is a strong source of constant flow of funds from private sector partners and other partners, but it is only applicable to the 50 or so member states. Debt2Health pushes more domestic health resource mobilization and pushes countries to take ownership and direct funds to health, but it is a one-time solution, not a sustainable flow of funds. Partnership building is an inevitable outcome of these mechanisms. Product (RED) can always bring in new partners to introduce new products to the (RED) market, and Debt2Health is creating trusting relationships between poor countries and high-income countries.

The various initiatives described here offer a unique way of disrupting the market. Product (RED) became the largest private sector donor to the Global Fund and showcases how ethical consumerism can benefit SDG goals. Some US\$600 million has been raised as of July 2019 to support global fund grants, impacting 140 million people. The Lives and Livelihood Foundation has used blended finance to help achieve the set targets to bring forth impact and streamlined this impact in sustainable pooled funds. Finally, Debt2Health has focused on helping poor countries become more economically secure and prioritized three of the deadliest diseases, working towards eradicate these while helping bring poor countries out of debt.

Outcomes Analysis (using adapted OECD DAC Criteria)

Relevance and Coherence: HIGH

The catalytic funding initiatives reviewed were designed to target specific market failures in LMIC. The Global Fund and Gavi, funds using pooled investment approaches, were designed to address market failures for immunizations and HIV, TB, and malaria in high-burden countries. Further, volume guarantees, such as the contraceptive guarantee led by the BMGF, addressed both supply and demand side challenges for contraceptives in LMICs, while the PAHO Revolving Fund facilitates access to life-saving vaccines at an affordable price for 41 member states. The GAIN Premix Facility has increased access and lowered costs for essential vitamins and minerals in LMIC valued at US\$80 million.

The catalytic funding mechanisms enhanced coordination among donors in tackling specific health challenges. They forged new and unlikely partnerships that aligned with country priorities vis a vis co-financing policy. The mechanisms have shown enhanced aid efficiency and created new partnerships across multiple actors such as country governments, donors, manufacturers, and the private sector. Although dating back to 1999, catalytic mechanisms remain highly relevant, facilitating new product development partnerships and expanding access to products

and services to benefit the most vulnerable populations around the world. In the case of volume guarantees reviewed, new partnerships have been established between manufacturers, country governments, and donors. This led to virtuous circles with donors de-risking investments and incentivizing manufacturers to introduce the predetermined high-quality product at a lower price. These partnerships have led to new business collaborations between recipient countries and the private sector and thus a high chance for viability of the mechanism.

Effectiveness and Efficiency: MEDIUM

The catalytic initiatives have facilitated strong engagement between private and public sector actors, leading to both additionality and aid efficiency. Improved aid efficiency has been achieved through the co-funding mechanisms that leverage private sector expertise. For example, Project Last Mile learned from the Coca-Cola Company good practice related to resolving supply chain inefficiencies. Improved efficiency was also observed with the pneumococcal advanced market commitment and the MMV product development partnership, where private manufacturers were incentivized to develop vaccines and medicines, resulting in millions of lives saved. These mechanisms also accelerated market entry for new products in places where it would have otherwise taken more than 10 years following introduction in high-income markets. Catalytic mechanisms drive the formation of new partnerships, leading to additionality. The Product (RED) initiative at the Global Fund is an example of how new partnerships can lead to an increase in funding. The (RED) partnerships have scaled up private sector funding for the Global Fund to US\$600 million since 2006. This is a strong example of how innovative finance can transform the way private sector financing is increased through ethical consumerism.

Impact: HIGH

Catalytic funding mechanisms demonstrate a high degree of impact for both new partnerships and aid efficiency. Because the mechanisms have been around for over 20 years, the impact has been well documented and have evolved over time. Some metrics for impact are common across the mechanisms, such as lives saved, deaths averted, and Disability Adjusted Life Years (DALYs) averted. Impact can also be seen with new health commodities developed to target neglected diseases and entering the market at a newly accelerated rate. The mechanisms such as volume guarantees, advanced market commitments, the GHIT, and MMV have facilitated the entry of new medicines and vaccines to enter the market in countries where disease burden is high, especially for neglected diseases. The mechanisms have also shaped the markets where immunization costs are much lower, the price of health commodities is affordable, and barriers to access are reduced. The impact can be largely viewed with the success of the PAHO Revolving Fund, which increased access and reduced the price of vaccines using economies of scale, and helped the region eliminate polio, measles, and rubella.^{xliii}

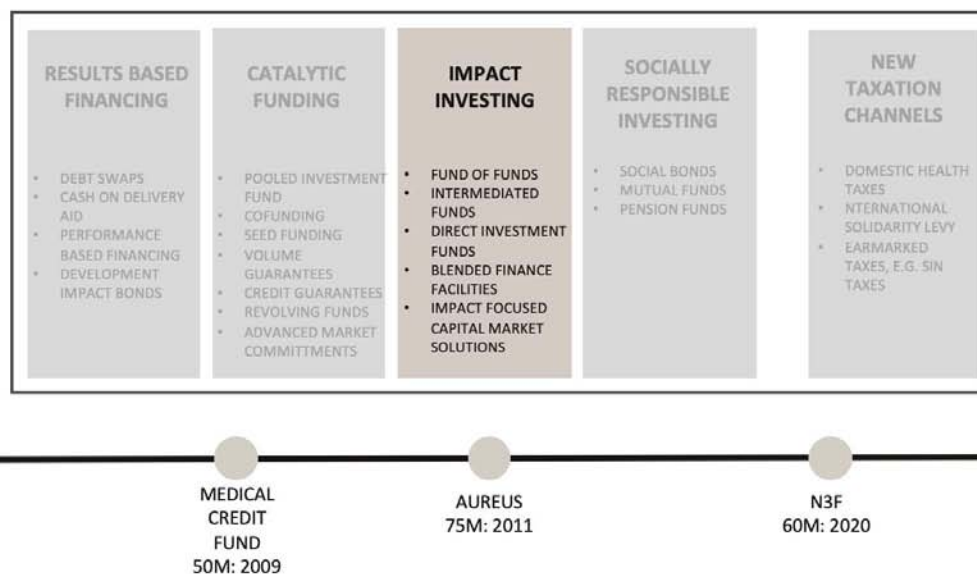
Sustainability: MEDIUM

The success in achieving sustained impact from some of the catalytic funding initiatives is evidenced by the increase in donor financing for these over the last two decades. The Global Fund has successfully increased financing over seven replenishment periods, starting with US\$4.8 billion in 2001 and now at US\$14 billion in the 2020 cycle. However, this reliance on donor financing largely depends on the political economy of donor governments as well as the political will of catalytic philanthropies. This can lead to uncertainty in future commitments and may decrease attention which should be placed on domestic resource mobilization. Further, these mechanisms are largely focused on vertical programming, which can be a roadblock to further health systems strengthening and increase domestic resource mobilization. Both challenges raise questions around sustainability and how recipient country governments will transition to sustain the programs financially once donor funding is scaled back.

A solution to this sustainability challenge includes options like co-financing and transition policies that are structurally embedded in Gavi and the Global Fund. Gavi's co-financing and transition policies require recipient governments to finance part of the costs for immunizations based on the gross national income per capita of the country. As the countries develop and the gross national income per capita increases, the co-funding requirement also increases, eventually to a 100% self-financing model. This policy facilitates domestic resource mobilization and the sustainability of programs. The policy has resulted in 100% of countries sustaining the routine vaccination programs after transitioning out of Gavi financing, although coverage remains uneven.^{xliii}

Some catalytic funding mechanisms, such as volume guarantees and AMCs, are great for positive market disruption but may not be suitable for the long term. These catalytic mechanisms can be used to incentivize private sector players to enter new markets, but they usually provide short- to medium-term agreements rather than a long-term solution. Further, caution should be exercised as volume and price guarantees can have implications on supply shortages for the future or permanently distort the market if volume guarantees are used too often. Similarly, a main challenge with AMCs is long-term price implications. The pneumococcal AMC is a 10-year commitment with a negotiated or subsidized price per unit. Once the AMC expires, it will be important to ensure the supply and demand of the product and to monitor the market for any price changes so that LMICs are able to sustain the pneumococcal vaccination program.

IMPACT INVESTING



Impact investing refers to investments that are made into companies, structured funds or organizations, with the intent of generating a measurable, beneficial social or environmental impact alongside financial returns. Impact investing has gained significant momentum over the past decade as an approach to address the SDGs. Around 2007, the term *impact investing* started to emerge, and investments with the commitment to measure social and environmental performance—with the same rigor applied to financial performance—became increasingly common.^{xliv} In 2009, The Global Impact Investing Network (GIIN) was established as a nonprofit membership organization supporting the impact investing industry. In 2013, the Global Steering Group for Impact Investment (GSG) was created as the successor to the Social Impact Investment Taskforce established under the UK’s presidency of the G8.

In 2019, the GIIN estimated that over 1,300 organizations collectively managed US\$502 billion in impact investing assets worldwide,^{xlv} up from an estimated US\$228 billion under management in 2017.^{xlvi} As per the 2019 GIIN Impact Investor Survey, 35% of impact assets are allocated to real estate, 22% to financials, and 12% to health care, with other sectors trailing these three by some margin.

The goal of impact investing is to generate both a financial return and positive, measurable social and environmental impact. The four core objectives of impact investing, as defined in 2019 by the GIIN are:

- *Intentionality*, which is defined as the investor’s intention to achieve a positive environmental or social impact through his or her investments. Intentionality is central to impact investing.
- *Impact measurement*, which is the process to measure and report the social and environmental performance and progress of underlying investments, ensuring transparency and accountability while building good practice.
- *Investment with return expectations*, or the expectation that the impact investments generate a financial return on capital or, at minimum, a return of capital.

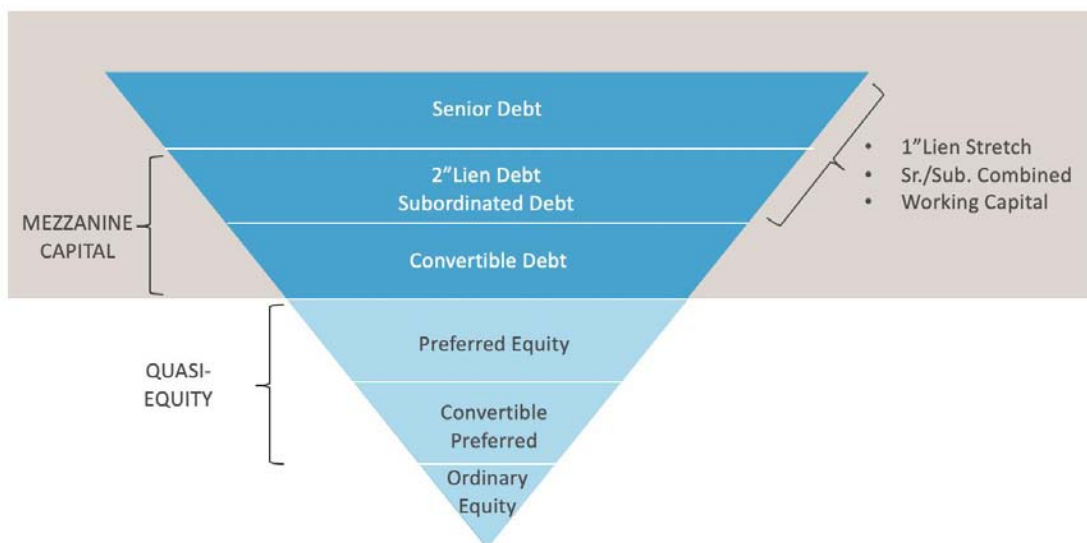
- *Flexible range of asset classes and return expectations.* Impact investments are unusual in that they target financial returns ranging from below market or concessionary rates to risk-adjusted market rates. Impact investments can be made across asset classes.

Several mechanisms and approaches are deployed by impact investors in health and adjacent areas, including:

- *Direct impact investments* made by an investor in an investee.
- *Intermediated funds* whereby capital is intermediated through an asset manager.
- *Fund of funds* approaches where one fund manager holds a portfolio of impact investment funds, usually of similar themes.
- *Blended finance facilities* that leverage grant funds and concessional capital from donors or DFIs as guarantees, subsidy, or free technical assistance to investees. This is blended with investment capital deployed in the form of debt, convertible loans, or equity.

Each of these impact investment mechanisms, if well structured, can mitigate risks and balance financial and impact returns. Impact investment mechanisms are often registered in jurisdictions that maximize capital efficiency and layer targeted returns of investors using a tiered capital structure. Figures 5 and 6 provide an example of a common impact investing fund structure and its instruments. Senior and second lien debt can be provided to qualifying investees seeking capital for tangible, fixed assets that create long-term growth. Mezzanine instruments can be provided to investees seeking to make riskier but potentially higher-return investments in intangible operational improvements that drive high, near-term growth. Equity financing can be used to invest in less established investees.

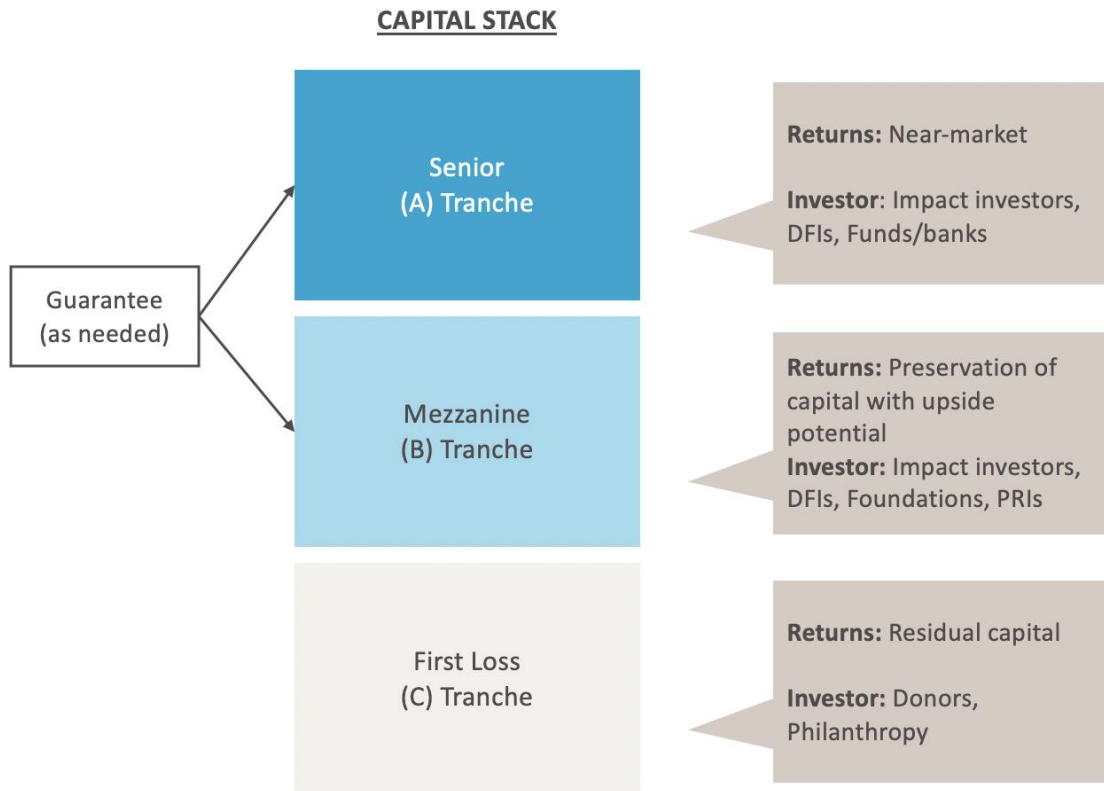
Figure 5: Example of a common impact investing fund structure and instruments



Using tranche-blended structures in impact investment helps to balance financial and impact returns across a diverse investor base, thus crowding in various types of investors and manage risks. All three of the impact investment initiatives reviewed in Annex 13—the Aureos Africa Health Fund, the Medical Credit Fund (MCF) and the Nutritious Foods Financing Facility (N3F)—used variations of blended structures to crowd in private financing and mitigate risk.

Technical assistance—free or subsidized, often funded by ODA and part of impact investing mechanisms—can strengthen investee operations, reduce actual or perceived risk, and provide upstream and downstream investment and business development services to both investees and investors. (*Initiatives in Annex 13*)

Figure 6: Example of a common capital stack used in impact investing



CASE STUDY: MEDICAL CREDIT FUND

The Medical Credit Fund (MCF) is an impact investment fund established in 2009 that provides debt financing to small- and medium-sized enterprises (SMEs) operating in the health sector in Africa.

Overview

SMEs in the private health care sector in Africa often struggle to effectively complement the public health system. A major reason for this is a lack of access to the financing they require to purchase equipment and supplies, improve infrastructure, provide continual training to staff, and invest in overall quality improvements. This barrier accessing financing is due to a range of factors, including a lack of credit history, limited financial performance records, and an inability for health equipment to serve as collateral for loans. Thus, the MCF was founded with the mandate to help address some of these challenges by providing access to capital, which enables health SMEs to improve the efficiency, scale, and quality of their services and products serving low-income patients.

Mechanism and structure

The MCF—a fund using a blended finance facility approach—comprises three components. First, it uses a “multi-layered blended finance” structure with catalytic first-loss capital, allowing it to operate in a financially viable way while ensuring a focus on impact among its target health SMEs. Note that this first-loss tranche—as a total capitalization of the MCF—has declined over time, from 35% in 2012 to roughly 15% today, covering approximately the total credit exposure on the underlying loans (1). Second, the MCF uses financial partners such as local banks to support local currency lending and to leverage existing legal and regulatory set-ups.

Finally, technical assistance (TA) has been used liberally to ensure the feasibility of the financing as well as the improvement in quality. All loans to SMEs made by MCF are linked to pre- and post-investment TA to improve the quality of the health care services, strengthen business sustainability, and reduce MCF’s portfolio risk. TA is delivered by MCF and one of its founding members, PharmAccess, in partnership with local partners. All TA is provided via a dedicated MCF technical assistance financed through grants, including UK’s CDC and IFC, and stood at US\$6.8 million in 2019.

Funding

Debt financing amounting to US\$10.6 million was raised by 2012 from the BMGF, Calvert Impact Capital, Deutsche Bank Americas Foundation, Dutch private investors, Overseas Private Investment Corporation (OPIC), and the Soros Economic Development Fund. By 2019 the debt capital raised amounted to US\$41.5 million. Initially, first loss capital came in the form of grants provided by MCF’s founding members, PharmAccess and Aidsfonds. In 2010, MCF was selected as one of the winners of the G20 SME Finance Challenge. Through the G20 Challenge, USAID provided \$1 million in grant funding to MCF, which was deployed as first-loss. Following this, additional contributions for the first-loss capital tranche came from Calvert Impact Capital, the Dutch Good Growth Fund’s Seed Capital & Business Development (SCBD) program, a Dutch private family office, and the Pfizer Foundation. for a total of US\$17.4 million.

CASE STUDY: MEDICAL CREDIT FUND (CONTINUED)

Impact

As of March 2019, over 1,700 SMEs had received financing from the MCF, nearly 2,500 staff trained, 58% of the patients served were low-income, 18 local banks (MCF financial partners) had been mobilized, and the repayment rate for loans across the portfolio stood at 97% (1).

Sustainability

The MCF aims to reach financial sustainability by the end of 2021 (1). To achieve this, MCF is looking to increase income from loans to high-quality investees while keeping its operating expenses stable. It will look to increase the volume of larger loan proposals executed directly while placing a continued focus on impact (improved the quality of health care services provided by the investee SMEs in Africa).

To enhance the likelihood of sustainability, MCF is developing digital financing solutions (e.g., digital patient revenues) as a means of security for loans and to decrease costs. In an interview with MCF, it was noted that digital technology can play a growing role in making blended finance initiatives more financially efficient and in measuring impact (2). For example, MCF is leveraging mobile money solutions to help develop the scale required to commercialize, while maintaining a strong focus on small-sized health SMEs. For example, MCF launched Cash Advance, a short-term loan facility that uses the digital revenues of health SMEs to secure and repay loans. Following on the success of Cash Advance, MCF launched Mobile Asset Financing, which is based on the same features and technology and can be used for medical equipment assets such as ultrasounds and lab equipment.

Learnings

There have been several learnings from the MCF to date that can be applied more broadly to impact investing for SDG 3:

- The opportunity for impact investing in health is potentially large. Grant funding can help to unlock these opportunities and de-risk investments.
- The first commitment or early-stage funding can go the furthest in a blended finance transaction, thus highlighting the need for donors and DFIs to provide up-front capital, which often results in high impact.
- TA increases both financial returns and development impact.
- Partnering with local financial partners allows for both operational and financial leverage.

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(1) *Convergence 2019: Medical Credit Fund Case Study*. Available from www.convergence.finance. Accessed 23 May 2020.

(2) Key informant interview, Dorien Mulder, Investment Manager, Medical Credit Fund, April 29, 2020.

Outcomes Analysis (using adapted OECD DAC Criteria)

Relevance and Coherence: MEDIUM to HIGH

Each of the impact investing initiatives reviewed completed in-depth sector appraisal processes to understand market needs. This appraisal process was completed during the design phase and focused on the countries and regions in focus.^{xlvii} Each appraisal pointed to an acute

need for addressing the “missing middle” of finance so that health SMEs can access finance, grow, and deliver high-quality services and products. Each initiative was designed with the mandate and intention to meet health and health-related needs and priorities.

In terms of new partnerships, each initiative brought in a range of governmental, nongovernmental, and private sector partners in a complementary way to balance risk. For example, the MCF partnered with local financial partners such as local banks that in turn improved local operational and financial leverage. All three initiatives remained relevant by avoiding duplication and market distortion vis a vis local banks and financiers by not supporting subsidies that inhibit long-term sustainability.

Effectiveness and Efficiency: MEDIUM

While there are a handful of standard indicators for impact investing in health, there is a need to further standardize these and ensure they are used to measure effectiveness, efficiency, and impact of funds. In general, most impact investors use indicators for managing and measuring impact, with 98% reporting that they use a combination of proprietary metrics, qualitative information, IRIS-aligned metrics, or other frameworks.^{xlviii} Note that several industry-wide reporting frameworks exist, including the Global Reporting Initiative (GRI),^{xlix} the International Integrated Reporting Council (IIRC), the World Benchmarking Alliance (WBA) and the Impact Management Project (IMP).^l For impact investing specifically, the Global Impact Investing Network (GIIN) hosts IRIS, a catalogue of generally accepted performance metrics that help investors measure and manage impact. Included in this catalogue are several health-specific indicators. Unfortunately, impact investing indicators for health care and for tracking health outcomes related to investments, relative to other sectors, has been more challenging to streamline and align. More alignment of metrics and strict data guidelines are required for the future.^{li}

Our review found it challenging to obtain health impact data from impact investing initiatives. Accessing impact reports from impact investing funds is challenging because these are often made available only to investors and donors rather than the broader development community. However, the MCF has reported that their investments have led to 18 new local financial partners, 2,400 staff trained, 1,760 SMEs financed, and a 79% improvement in quality of care, with most of the patients in the low-income bracket.^{lii}

The cost of entry in impact investing is often seen as too high by the private sector. To mitigate this, donors and DFIs can help build more investment platforms and pipelines to attract investments. A recurring theme from the literature and from the key informant interviews for impact investing is that a major reason behind the deficit in private finance investments flowing into health in frontier markets stems from a dearth of investable deal flow (e.g., investable/viable investees), based on risk and return constraints.

Despite the fact that the impact investing funds mapped here were impact-first—and therefore financial returns sought were in line with risk- and impact-adjusted expectations in LMIC—building investable pipeline in all three cases led to significant transactional costs. For example, it is important to note that as the Aureos fund entered its final phase of investments, it began focusing on larger ticket sizes, which promised higher financial returns in contrast to the smaller deals with higher transactional costs but arguably higher impact that were made earlier on in the life of that fund.^{liii} In cases such as these, impact and reaching low- and middle-income populations or at-risk populations may take on a secondary focus.

Impact: MEDIUM

Impact investors generally identify transparency in impact performance as a key challenge facing the market.^{liv} One approach to address this challenge is via sector-specific impact performance studies. The GIIN has completed two sectoral impact performance studies to date,

one for clean energy and a second one on housing; two other sector reports are in the planning stage for financial inclusion and agriculture. To date, there has not been a performance study completed across impact investments in health.

Further work is required to ensure impact investment mechanisms are using indicators that are aligned to other more traditionally financed health initiatives. This will ensure comparable impact data in health across more traditional funding mechanisms for health and innovative financing in health.

Sustainability: MEDIUM to HIGH

For impact investing, and especially for impact-first funds, the pathway to financial sustainability is often long but achievable. In the case of the MCF—the only debt financing fund for health in Africa—financial sustainability could be reached by the end of 2021. To achieve this, MCF is looking to increase income from loans to high-quality investees while keeping its operating expenses stable. It is aiming to increase the volume of larger loan proposals executed directly while placing a continued focus on impact (improving the quality of health care services provided by the investee SMEs in Africa).

Digital technology can play a growing role in making blended finance initiatives more financially efficient and in measuring impact. For example, the MCF case study below highlights how this initiative is leveraging mobile money solutions to help develop the scale required to commercialize, while maintaining a strong focus on small-sized health SMEs. MCF launched Cash Advance, a short-term loan facility that uses the digital revenues of health SMEs to secure and repay loans. Following on the success of Cash Advance, MCF launched Mobile Asset Financing, which is based on the same features and technology and can be used for medical equipment assets such as ultrasounds and lab equipment.

To enhance the likelihood of sustainability, funds can look to develop digital financing solutions as a means of security for loans and to decrease costs. Such innovation allows investment funds in health to deploy a very low-cost and low-risk financing solution that in turn can benefit smaller investees in the health sector who are obtaining financing from the fund.

Another effective solution that has been deployed by all three of the initiatives looked at here is targeted technical assistance (TA) to investees. This includes TA provided during the investment period and pre- and post-investment TA. This TA can improve the quality of the health-related services, strengthen business sustainability, and reduce portfolio risk. The TA may be funded separately via ODA or by DFIs. Related, local banks were often used as local financial partners, which, in the case of MCF, led to some of the local banks becoming more comfortable with investing in the health care sector in terms of both risk perception and understanding the market.^{lv}

SOCIALLY RESPONSIBLE INVESTING



IFFM

Socially responsible investing (SRI) –increasingly known as sustainable or responsible investing –is any investment strategy that seeks both financial return and social/environmental good or positive social change.⁴ SRI began to take on momentum in the 1990s, when the term started to refer to investments that use exclusionary screening, and later referred to investments with a best-in-class approach to social investments.^{lv} SRI promotes investments often summarized under the heading of ESG: environment, social justice, and corporate governance.^{lvii} Several mechanisms and products exist for SRI, including fixed-asset bonds, mutual funds and pension funds, disaster-related insurance instruments, public equity/investment trusts, and sovereign wealth funds.

In 2016, US\$1 in every US\$4 under management was allocated for environmental, social, and governance investments, which represents an increase of 25% from two years earlier.^{lviii} This classification therefore represents potentially trillions of dollars, which would be available for addressing the SDGs. Interest seems to be growing as well. For example, UBS’s Investor Watch survey found that 81% of respondents want to align their spending patterns to their values.

Unfortunately, the apparent momentum towards SRI has not translated to a significant growth of investments that are explicitly aimed at addressing the SDGs in LMIC. In 2016, less than 1% of global SRI investment sought to achieve measurable societal outcomes.^{lix} In addition, the number of privately investible, large-scale projects in LMIC with the potential to advance progress toward the SDGs has fallen since 2012 and been flat since 2015.

One SRI mechanism that has delivered impact for SDG 3 are social bonds (including sovereign-backed bonds/secondary market bonds). Most notably, the International Finance Facility for Immunization (IFFIm) has managed to raise large volumes of funds up-front by issuing bonds secured by long-term, legally binding donor pledges. These “vaccine bonds” provide investors with a unique opportunity to realize an attractive, secure rate of return and diversify their portfolios while helping save lives. The bonds are issued by IFFIm’s treasury manager, the

⁴ Under this general definition, impact investing is a ‘impact first’ subcategory of SRI.

World Bank, on the capital markets at low rates, often better than sovereign donors' rates. Government pledges are used to repay IFFIm bonds.

Social bonds like IFFIm's bonds should be designed for other health issues, such as the eradication of neglected diseases or for boosting health systems strengthening. However, to work, these must be designed to raise cash at relatively low rates. This will depend on the ability to maintain a AAA credit rating and make the investment efficient and attractive both to donors and investors. IFFIm has done this by benefiting from its sovereign donors' high credit ratings, therefore enabling it to raise bonds at highly competitive costs.

In terms of financial indicators, there have been positive developments to develop aligned metrics for private investors and to deploy SRI measurably linked to SDGs, but much needs to be done to improve information flow, metrics, and benchmarks.^{ix} The investment performance data held by DFIs and MDBs, who together have a long history of investing in SDG-aligned markets, remains proprietary. There should be accelerated efforts by DFIs, and MDBs to disclose performance to achieve greater transparency and investor understanding. Further, there should be more health bonds designed and deployed that build on the successes of IFFIm. This will help unlock additional private sector financing and ensure comparable impact data in health across the sector.

(The outcomes analysis and recommendations for SRI are integrated into the impact investing section.)

NEW TAXATION CHANNELS



UNITAID
2.5M: 2006

Moving forward, international and domestic taxation can be a rapidly growing source of financing for health. It is crucial to understand how new forms of taxation can expand the fiscal space for health and what has worked to date.

Domestic health taxes

The donor community has long recognized the crucial role of domestic resource mobilization (DRM) to ensure sustainable financing of health and decrease low- and middle-income countries' reliance on foreign aid. With its ambitious targets, the launch of SDG and the Addis Tax Initiative (ATI) has increased donor focus to DRM.

Increasing health taxes yield massive potential to reduce health care costs, avert preventable deaths, and increase revenue. Previously known as sin taxes, and now more often referred to as health taxes, these fiscal instruments are used on harmful products and have the double objectives of positively impacting health outcomes and increasing budgets for health. They generally take the form of excise taxes (selective taxes, confined to a narrow range of goods, the consumption of which governments wish to discourage). Tobacco and alcohol taxes have been implemented for a long time and are in place in 188 and 160 countries, respectively.^{lxi} As the prevalence of non-communicable diseases increase, food-related sin taxes are gaining political momentum, with 33 jurisdictions now implementing them.

As per a recent publication by the Task Force on Fiscal Policy for Health, health taxes represent a significant financing opportunity: If all countries increased their excise taxes to raise prices on tobacco, alcohol, and sugary beverages by 50 percent, over 50 million premature deaths could be averted worldwide over the next 50 years while raising over US\$20 trillion of additional revenues in present discounted value. Raising taxes and prices further in future years would save additional lives and raise even more revenues.^{lxii}

Health taxes are used in many countries, but with vast discrepancies related to level of tax and allocation for health. As noted above, 188 countries tax tobacco and 130 tax alcohol but only two dozen taxing sugar-sweet beverages. WHO estimates that, on average, cigarette excise taxes account for about 32% of price in LMIC, and about 48% of price in high-income countries,

while the recommendation is for taxes to be at a minimum of 70% of the retail price. No recommendation exists for alcohol, although this tax has great potential of resources due to its current low level of taxation and widespread use. There is also debate on whether the taxes collected should be earmarked for health and used overall to increase government fiscal space. Tobacco taxes are implemented in 188 countries but earmarked to health only in 30 of them.

The design and introduction of new taxes must be carefully thought through. Health taxes could be regressive in their financial impact on household budget, and resources need to be allocated to low-income households in priority to counterbalance the negative effect. Also, without strong public finance systems and controls, health taxes risk increasing black-market activity for the relevant products, especially in countries with porous borders. Finally, to be efficient, design and implementation of health taxes should be simple while considering trade issues with neighboring countries.

For efficient design and implementation of health taxes, The Addis Tax Initiative (ATI) calls for the doubling of international technical support by development partner members. Unfortunately, this support for efficient design and implementation of health taxes remains untapped.^{lxiii} ATI brings together more than 40 countries and international organizations in a collective global effort to increase domestic resource mobilization and improve the transparency, fairness, effectiveness, and efficiency of tax systems, with the goal of supporting countries in achieving the SDGs.

International Solidarity Taxes

The solidarity taxes on air tickets is the first mechanism of international taxes for health, but it has not been expanded. Implemented in 2006, the taxes were supposed to be introduced and earmarked for health by 30 countries, but as of today, only 9 countries have them in place (Cameroon, Chili, Democratic Republic of Congo, France, Madagascar, Mali, Mauritius Niger, South Korea). In France, it collects from two to EUR60 per flight, and revenue is allocated to global health initiatives with a cap of EUR10 million per year. Most of the funding is transferred to UNITAID a joint program of the UN aiming at ending HIV-and AIDS-related deaths. With the difficulties experienced by air and travel companies due to COVID-19, the collection of this tax has been postponed for a year.

Several other taxes appear to be a good candidate to support financing of SDGs, including a tax on financial transaction, carbon taxes, or high wealth taxes. Europe has been at the forefront considering a FFT to fund solidarity projects, and the European Commission put forth a proposal in 2013, signed by 11 countries (Germany, France, Italy, Spain, Portugal, Greece, Belgium, Austria, Slovakia, Slovenia, and Estonia). However, discussions to move to its implementation are taking longer than expected, and the tax is facing strong resistance among member countries. As of today, only four countries have implemented the tax: South Africa, Brazil, India, and France. In France, a 0.3% tax is applied on selected financing instruments, generating an estimated EUR1.6 billion per year, of which a portion are earmarked to development. The Tax Policy Center estimates that a 0.01% tax in the United States would raise US\$185 billion over 10 years. Move Humanity estimates that a 1% tax on the income of ultra-high net worth individuals would generate around US\$100 billion per year if successfully levied on all over 2,000 billionaires. Finally, a 2017 World Bank report estimates that worldwide implementation of the carbon tax will generate US\$82 billion in revenue in 2018, part of which could be leveraged to invest in SDG financing. (*Initiatives in Annex 14*)

Outcomes Analysis (using adapted OECD DAC Criteria)

Relevance and Coherence: MEDIUM

In many contexts SDG financing should be covered more by domestic resources – health taxes offer an important approach to increase country fiscal space for health. This assumes that a country tax collection system is efficiently designed and implemented, and that the revenue collected will not be used for other government priorities. This mechanism is relevant in that it addresses both the need for putting in place preventive measures to control health care costs as well as increases new inflows of capital. As consumption of the commodity is reduced, it is to be expected that revenue will decrease as well. Unfortunately, many countries that have implemented health taxes so far are struggling to enforce the tax collection and to earmark the additional revenue to the health sector.

Solidarity international levies can increase financing for SDG 3, but their implementation is complex as they require global leadership and international alignment which is often difficult to achieve. It is important to note that the current international air tax is at risk with the dramatic impact of COVID-19 on the travel industry and may need to be revised in the context of financing UNITAID.

Efficiency and Effectiveness: MEDIUM

Health taxes and international solidarity taxes appear to be effective ways to increase resources for health. Nonetheless, it is important to control for the risk of smuggling and fraud, and to develop a collection system simple enough to avoid cumbersome processes. The level of taxation and its allocation to health are also important criteria to increase the cost efficiency of the system.

Impact: MEDIUM

Only a handful of countries have deployed health taxes resulting in significant resources for health, and there have been only a handful of studies to show their impact. In the Philippines for example, the Department of Health and PhilHealth have almost doubled their budget due to health taxes. Health taxes are also showing a positive impact on prevention. For example, tobacco taxes have had a positive impact on tobacco consumption. Food-related health taxes are also resulting in a decrease in the purchase of products high in salt, fat, or sugar.^{lxiv} Despite the growing body of evidence, only 30 jurisdictions globally are deploying food-related health taxes as a fiscal instrument which to increase revenue for SDG 3 and improve health (ibid).

Sustainability: HIGH

Health taxes represent a major opportunity to increase resources for health. This is both by their potential to reduce incidence of chronic diseases and cost of treatment, as well as collecting additional resources, which could be earmarked to health. In countries where health taxes have been implemented, taxes tend to become a permanent input into government budgets.

The potential of international solidarity taxes is also a significant opportunity because it will unlock recurring and lasting sources of resources for international development. However, it will need to overcome significant operational and political barriers to become a strong complement to traditional ODA.

INNOVATIVE FINANCE, COVID-19 AND HEALTH SYSTEMS

The COVID-19 pandemic has infected millions of people, caused thousands of deaths, and severely impacted the global economy. The novel coronavirus COVID-19 has spread to over 185 countries. As of 14 June 2020, there are 7.8 million cases of COVID-19 across the world with over 430,766 deaths (coronavirus.JHU.edu). Strict stay-at-home and social distancing orders affect many businesses including large economic engines, such as the transportation, tourism, and food industries. The virus has caused major shifts in the economy with stock prices dropping to an all-time low since 1987. Many banks have slashed interest rates and unemployment is at record highs in several countries.

There have been dozens of discussions and several initiatives looking at how innovative finance can help improve the response to the pandemic. These can be categorized broadly into two categories: mechanisms which aim to unlock sustainable financing options for a vaccine and its roll out to high and LMIC; and mechanisms which aim to accelerate the access to capital in frontier markets during the pandemic (in particular by DFIs scaling up investments).

The first issue – sustainable finance for vaccine development and deployment – requires a global effort to support financial solutions that bring a product to market, generate financial returns, and sustainably roll out the vaccine to as many people as possible. It is estimated that developing a vaccine and vaccinating individuals against COVID-19 will cost over US\$20 billion with estimates from experts as high as US\$25 billion (1). Companies across the globe have begun to develop vaccines for the virus with over 130 vaccine candidates at various stages of development and at least six already in testing stage (2). While pharmaceutical products take about 8-10 years to come to market, high demand for a COVID-19 vaccine is incentivizing manufacturers to accelerate and streamline research and development (R&D) to end the pandemic.

As noted above in this report, the pneumococcal AMC was highly successful and arguably represents one of the most promising mechanisms to be leveraged for a COVID-19 vaccine. An AMC could be a strong innovative financing mechanism for vaccine and therapeutic innovation in global health. AMCs contain a purchase commitment and price agreement that helps accelerate the availability and distribution of a new medicines and vaccines in LMICs, where such products would take 10+ years to enter the market. This mechanism is now being proposed by Gavi for a COVID-19 vaccine. A new COVID AMC would allow for accessibility and availability of a new vaccine in LMICs, helping manage the equity and allocation constraints. The AMC would help address the challenges related to supply shortages for LMICs due to high income countries having the economic means to purchase the potential new vaccine. Lastly, the AMC would contain purchase and price commitments for LMICs who would not be able to compete with the prices paid by high income countries for the potential covid-19 vaccine. During the writing of this report, in June 2020, Gavi launched the COVID Covax AMC aimed at incentivizing vaccine manufacturers to produce sufficient eventual COVID-19 vaccines, and to ensure access for LMIC.

The second issue – accelerating access to capital in frontier market – is a much-needed response to the continued, significant exit of external capital from developing countries due to the pandemic. Investors withdrew US\$90 billion from emerging markets in the first 3 months of 2020 which is the largest outflow ever recorded (4). This is eroding already fragile fiscal and balance of payment positions with further devastating consequences for development and growth.

DFIs specifically can play a significant role in thwarting the outflow of capital and playing the lead role in a blended finance approach. They provide much-needed, high-risk-carrying capital and risk mitigation measures that can drive new investments into LMIC and reinvigorate economies. Some of the related initiatives started by DFIs in the wake of COVID include:

- IFC's Board approved \$8 billion in fast-track financing to help companies affected by the outbreak, as part of the \$14 billion from the World Bank Group (5).
 - o Phase I is for direct lending to clients affected by the outbreak. Criteria includes: clients who demonstrate a clear impact on the business due to COVID and IFC ESG requirements; strong emphasis on low income and fragile and conflicted-affected countries; and leverage concessional financing from the IDA Private Sector Window (PSW) and other donor funds where appropriate, particularly to attract foreign direct investment into the more challenging low income and fragile countries.
 - o Phase II: help in the recovery and rebuilding for new and existing clients.
- In early April, the Nordic Investment Bank issued 'Response Bonds' in both euros and Swedish krona (6)
- In April, AfDB launched its Fight Covid-19 Social Bonds denominated in dollars. The bonds pay a 0.2425% coupon and were priced at 14bp over mid-swaps.
- In April, the Council of Europe Development Bank sold a 1 billion-euro Covid-19 Social Inclusion Bond.
- Lastly, the New Development Bank -- which was set up by Brazil, Russia, India, China and South Africa -- issued a 5 billion yuan, three-year RMB Coronavirus Combating Bond in the China Interbank Bond Market. The proceeds will be used to support the Chinese Government in the financing of public health expenditure in Hubei, Guangdong and Henan provinces.

The challenges posed by COVID-19 to the global financing infrastructure force us to examine how innovative finance can best catalyze investments in health and the SDGs at scale, build back better and help health systems prepare for future outbreaks. DFIs have already started to play a lead role in the response by providing much-needed, high-risk-carrying capital and risk mitigation measures that should drive new investments into LMIC and reinvigorate economies. Collectively, all actors in innovative finance need to consider carefully how future investments strengthen overall health systems and their preparedness for future outbreaks.

Innovative finance can play an important role in the medium-to-long term response to the pandemic. It can help to accelerate economic reconstruction, improving pandemic resiliency and responding to the global health crisis (where possible). Guarantees, first-loss protection, and advance market commitments are more important than ever.

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THE WAY FORWARD

Summary of outcomes analyses by classification

Each of the 42 initiatives reviewed—and innovative financing classifications which they represent – play a unique role in the global innovative finance ecosystem and for the local health markets in which they operate. Each has relative strengths and weaknesses. These differences should be considered by donors and DFIs during design and then taken to scale. For example, mechanisms under impact investing, socially responsible investing, and new channels of taxation demonstrate higher leverage of non-ODA funding, and greater financial effectiveness and sustainability. However, they have not demonstrated as much evidence of impact related to SDG 3 in comparison to results-based and catalytic mechanisms. This latter grouping has demonstrated more evidence of health impact but remain relatively costly to implement with less leverage of private financing or non-ODA funding. Below we review the top-line findings for each classification.

Result-Based Financing: The success of the results-based financing initiatives reviewed varied, but all could improve performance across the OECD framework in terms of relevance and coherence, effectiveness and efficiency, impact, and sustainability. While the mechanisms in this category generally promoted a positive shift towards measurable performance management, the promise of improving aid efficiency remains unfulfilled. All the initiatives demonstrated high transaction costs and found measuring impact challenging. Most used output and process indicators as proxies for impact, despite the growing awareness that these are not sufficient to affect quality of care and health outcomes. Furthermore, many mechanisms were not sufficiently embedded into countries' plans.

Catalytic approaches: While initiatives in this category have largely been successful in targeting market failures for vertical disease programming and immunizations, additional measures are needed to strengthen national health systems. The initiatives reviewed enhanced coordination among donors in tackling specific health challenges. They forged new and unlikely partnerships that aligned country priorities vis a vis co-financing policies. They largely facilitated strong engagement between private and public sector actors, leading to both additionality and aid efficiency. The initiatives also demonstrated a high degree of impact. The success and sustainability of some of the catalytic funding initiatives is evidenced by the increase in donor financing over the last two decades. However, most of these mechanisms have been focused on vertical programming, which can be a roadblock to health systems strengthening and increasing domestic resource mobilization. This raises questions around sustainability and how recipient governments will transition to maintain programming once donor funding is scaled back.

Impact investing and SRI: The overarching finding for this category is that ODA and DFI funding should play a much larger role in de-risking, unlocking, and complementing private investments in frontier markets. Our review found that when ODA and DFI funding was used in this way it proved critical for shifting incentives, helping address market barriers, and facilitated an increase in financial viability for impact investments and SRI. However, the opportunity for ODA to initiate and support impact investments and SRI for health is far greater than is currently being addressed by donors and DFIs. For example, there is only one dedicated debt fund for the health sector in Africa targeting SMEs (Medical Credit Fund) and social bonds (e.g. the 'vaccine bonds' issued by IFFIm) could be designed for other health issues, such as the eradication of neglected diseases or for boosting health systems strengthening. More strategic use of ODA can replicate these successes, lower transactional costs in impact investing and SRI, help unlock significantly more

private capital flows, and improve the likelihood of cost efficiency and the effectiveness of investing in health in LMIC.

New channels of taxation: The review found that where effectively implemented, new international and domestic taxes are increasing resources available for SDG 3. However, progress in this area has been slow. At the domestic level, health taxes, are increasingly applied to products which have a proven, adverse impact on health (e.g., tobacco, alcohol, and sugar-sweetened beverages). While the global community, led by WHO, is actively advocating for their scale up, too few jurisdictions use them. More efforts should be made to ensure that these fiscal instruments are properly designed and implemented and contribute to national health budgets. Further, at the international level, examples of international solidarity taxes are scarce. There is also limited literature available to evaluate the success of the existing initiatives. Nonetheless, the limited evidence indicates that if well implemented, those new sources taxes have the potential to significantly increase the resources available to SDG 3 financing.

Recommendations to improve relevance and coherence

Innovative financing initiatives must be co-created and designed to be fully compatible with local health markets.

The maturity of health markets must be considered by donors and DFIs during design of an initiative, and the objectives and ambitions set appropriately. If feasibility studies show that market-based innovative financing solutions in LMIC will be viable, impact investing and SRI should be considered. However, in contexts with chronic market failures, donors should look to deploy more results-based and catalytic innovative financing mechanisms. For RBF in particular, the design phase must consider countries' interest and capacity to move towards outcome-based payments within their health systems. Lastly, donors should increase funding for those initiatives – and in particular those in the catalytic funding classification – which aim strengthen the entire health system, not just vertical programs. This recommendation calls for a much more collaborative approach with local stakeholders during the design and implement phases to ensure innovative financing mechanisms are better tailored to local contexts.

Recommendations to improve effectiveness and efficiency

The cost of entry to invest in SDG 3 in frontier markets is often perceived as too high by the private sector. Donors and DFIs can address this by scaling up funding that builds investment pipeline and 'crowding in' private sector investment.

A recurring theme from the literature and from the key informant interviews – especially for impact investing and SRI – is that the deficit in private finance investments flowing into health in frontier markets is due to a dearth of investable deal flow (e.g., investable/viable investees), based on risk and return constraints. When donors and DFIs have provided grant money to build pipeline, it has attracted investors and helped unlock investments. Related, ODA should finance more technical assistance to complement impact investment funds which will help ensure inherent risk is mitigated and financial sustainability is attained. Unfortunately, sufficient ODA for targeted, complementary technical assistance is lacking.

An important caveat is that ODA must help bring in new private funding while not displacing or discouraging the natural flow of domestic or external resources. This additionality and 'crowding

in' effect was achieved by dozens of the initiatives outlined here, but there remains a need to demonstrate that innovative financing initiatives avoid market distortion and direct competition with other commercial finance providers. In other words, inflows of ODA and concessional capital should not undermine markets. DFIs and donors have in place due diligence processes to ensure their funding complements other private sector investments, but much more can be done to demonstrate the additionality of innovative financing in health. The actual investment performance data held by DFIs and MDBs remain proprietary and yet DFIs and MDBs are the organizations with the longest history of investing in SDG-aligned markets. Private investors are not able to access the same default and return rates experienced by DFIs, and as a result the private sector may not consider investing in frontier markets as they cannot compete against DFIs. There should be accelerated efforts by DFIs and MDBs to accelerate their investment performance. This transparency will improve investor understanding and help bring in new private sector financing.

Lastly, for RBF, donors must proactively monitor transaction costs and implement strategies which reduce those and improve cost efficiencies. They should disseminate this information publicly to facilitate learning and dialogue. RBF initiatives which coordinate and pool government, and donors' resources under similar result frameworks should be encouraged.

Recommendations to improve impact

More transparency and alignment of metrics across all innovative financing mechanisms in health is urgently needed to improve financial and health impact.

Capital flows to address SDG 3 are inhibited due to information failures that arise from several dimensions, notably a dearth of meaningful metrics and benchmarks that investors as well as donors can rely on to meet their objectives and fiduciary responsibilities. Related, it was a challenge to map comparable data on health impact in innovative finance. Further work is required to ensure innovative investment mechanisms are using common health indicators and that these are also aligned to government priorities. More efforts are needed to identify relevant outcome-level indicators. In terms of financial indicators, there have been positive developments to develop aligned metrics for private investors to deploy investments which are measurably linked to SDGs, but much needs to be done to improve information flow, metrics, and benchmarks for private investments to target the SDGs.^{lxv}

Second, impact investors generally identify transparency in impact performance as a key challenge facing the market.^{lxvi} One way that has been used to address this challenge is via sector-specific impact performance studies. The GIIN has completed two impact performance studies to date, one for clean energy and a second one on housing. Two other sector reports are in the planning stage for financial inclusion and agriculture. Unfortunately, there has not yet been a performance study completed across impact investments in health. We recommend donors urgently finance a health sector-wide impact investment performance study, similarly to performance studies done for other sectors.

Third, more work is required to ensure innovative financing mechanisms are using indicators that are aligned to other more traditionally financed health initiatives. This will ensure comparable impact data in health across more traditional funding mechanisms for health and innovative financing in health.

Lastly, we encourage donors to set up more active exchanges among the various actors in innovative financing. This will support further research to identify, define and cost potential outcome measures and indicators, as well as better preventive and quality related indicators.

Recommendations to improve sustainability

Innovative finance offers a significant opportunity to fill the SDG 3 funding gap in a sustainable way, but the differences in the relative strengths and weaknesses of the mechanisms outlined here should be considered by donors and DFIs during design and then taken to scale.

In terms of financial sustainability and sustained impact, more should be done to ensure that innovative financing mechanisms strengthen national and local health systems, processes, and capacity. For example, new social bonds similar to IFFIm's bonds should be designed to boost national health systems strengthening. In terms of health taxes and more sustainable SDG 3 funding and impact, donors should move beyond advocacy for health taxes and finance the operational support to help countries design, implement and enforce health taxes which effectively contribute to financing the health system in the long term. To this end, donors should support an effort to consolidate evidence on health taxes, to disseminate lessons learned from the existing international solidarity levy and promote a global dialogue for its expansion.

Table 2 summarizes the outcomes analysis in aggregate for each innovative financing classification.

Table 2: Summary of outcomes analysis by innovative finance classification and OECD DAC criteria

OECD DAC CRITERIA	DEFINITION	RESULTS BASED FINANCING	CATALYTIC FUNDING	IMPACT INVESTING	NEW TAXATION CHANNELS
RELEVANCE & COHERENCE	Were the mechanisms in the respective classification designed appropriately to respond to local priorities in financing health and did they remain relevant over time? Do the mechanisms in the specified classification complement other relevant interventions or do they undermine them? This includes partnerships, harmonization and coordination with others, and the extent to which the mechanisms have added value while avoiding duplication of effort.	MEDIUM	HIGH	MEDIUM TO HIGH	HIGH
EFFECTIVENESS & EFFICIENCY	Did the mechanisms in the specified classification achieve their intended outcomes in a cost-efficient way, especially in relation to aid efficiency and additionality? Has there been timely delivery? How successful have these interventions been in crowding in private sector financing? What has been the public to private funding ratio?	MEDIUM	MEDIUM	MEDIUM TO HIGH	MEDIUM
IMPACT	What difference have the mechanisms in the respective classification made? This includes looking at both positive or negative, intended, or unintended impacts in terms of impacts on financing as well as health.	MEDIUM TO HIGH	HIGH	MEDIUM	MEDIUM
SUSTAINABILITY	Have the mechanisms in the respective classification led to benefits which will last? This includes the sustained net benefits to both the underlying financing of the intervention and health outcomes over time.	MEDIUM	MEDIUM	MEDIUM TO HIGH	HIGH

CONCLUSION

Delivering the 2030 Agenda for Sustainable Development and addressing the annual funding gap of US\$371 billion in LMIC for SDG 3 will require that the innovative finance successes outlined here are improved upon, replicated, and scaled. We need to enlarge and improve our toolbox to effectively finance health systems and health services in the short, medium, and long term. Innovative financing offers a significant opportunity to fill this gap. All countries—rich, middle income, and poor—need to make innovative financing in health part of their immediate and long-term economic planning.

Our review highlights that there have been significant efforts made over the past decade to scale up and improve the deployment of ODA in more innovative ways for health, complement that with private sector funding, and increase domestic revenue generation for the sector. Innovative financing initiatives have unlocked more capital for SDG 3 and accelerated the participation of private investors. Donors, development finance institutions, investors, bankers, and the Group of 20 health and finance ministers represent the key group who can play the lead role to take the recommendations from this report forward and scale up innovative financing solutions for SDG 3.

ANNEX 1

List of Key Informants Interviewed

Name	Organization	Interview Date
Bérengère Callamand	Proparco	11-June-20
Nafisa Jiwani	US DFC	09-June-20
Lisa Glasgo	GIIN	19-May-20
Gautam Chakraborty	USAID - Utkrisht DIB	7-May-20
Susan De Witt	Bertha Center - MRC Impact Bond	6-May-20
Chris McCahan	IFC	6-May-20
Alan Donnelly	G20 Health and Development Partnerships	1-May-20
Hatice Kucuk	G20 Health and Development Partnerships	1-May-20
Serena Guarnaschelli	KOIS	30-Apr-20
Colin Godborge	KOIS	30-Apr-20
Dorien Mulder	Medical Credit Fund	29-Apr-20
Priya Sharma	USAID - Center for Innovation and Impact	24-Apr-20
Omer Imtiazuddin	USAID - Center for Innovation and Impact	24-Apr-20
Martin Poulsen	Aureus Fund	23-Apr-20
John Fairhurst	Global Fund	22-Apr-20
Michael Borowitz	Global Fund	18- June-20
Emily Gustafsson-Wright	Brookings	22-Apr-20
Zach Levey	Levoca Impact Labs	20-Apr-20
Paola Sison	Gavi	16-Apr-20
Sushila Maharjan	Gavi	16-Apr-20
Rob Kelly	MedAccess	8-Apr-20
Natasha Davie	MedAccess	8-Apr-20
Louise Savel	Social Finance	20-June-20
Marie-Alphie Dallest	Social Finance	20-June-20

ANNEX 2

Questionnaire I : Initiatives

Description and Objectives	Launch date
	What was the rationale for its creation?
	Type of mechanism (RBF, catalytic, impact investment, etc.)
	What is the overall objective of your initiative?
	Can you describe your approach in 1-2 sentences?
	Who are your main financial partners?
	Who are your main “competitors” if any?
OECD DAC Criteria	Relevance (<i>is the intervention doing the right things?</i>)
	How has or can your innovative finance initiative complement current investments in health systems?
	Effectiveness (<i>have outputs led to the achievement of the planned outcome</i>)
	Please comment on the financial feasibility and cost effectiveness of your initiative in relation to outcomes
	Efficiency (<i>outputs in relation to inputs</i>)
	How successful is (was) your mechanism in crowding in private sector financing? What was the public to private funding ratio?
	(Likelihood of) Impact
	<i>(i.e. what results have been achieved)</i>
	How do you define impact? What result metrics are you using?
	What health outcomes, if any, can your initiative report on? E.g. number of vaccines delivered, estimates of lives saved
	What is (was) it about your approach or the context that leads (led) to results?
	Have you had any external evaluations completed and are these available?
	Sustainability (<i>i.e. will the impacts be sustained over time</i>)
	What are the main barriers to scaling your approach, or are there opportunities for expansion and increased impact of your mechanism?
	Have you been able to pass on any activities fully to government, private sector or civil society? Or have you sustainably and positively 'disrupted' the market
Open Questions	In your understanding, what would be useful information this study should tackle which hasn't been yet documented?
	Regarding COVID-19, are you involved in any way or are you aware of any organizations applying innovative finance mechanisms to respond to this outbreak and building systems to respond better next time? If so, could you please provide information regarding the organization and their approach? If not, do you for see any IF mechanisms being utilized for pandemic financing in the future?
	Please comment on existing and or up-and-coming innovative financing models in health

ANNEX 3

Questionnaire II: Donors, Networks and Advisors

The Leading Group on innovative financing, through its permanent Secretariat, the French Ministry for Europe and Foreign Affairs, has contracted ThinkWell to map and review innovative financing mechanisms for health and provide recommendations on the way forward. ThinkWell is looking at different mechanisms under the 4 categories of result-based funding, catalytic funding, impact investing and socially responsible investing.

Overview and Objective

1. Rationale and history of your work in innovative financing for health?
2. In your view, what are the main opportunities for the development of blended finance for health?
3. What are the main barriers for its development, especially in developing countries?
4. Who are the main players active in that field?
 - a. Investors, Donors, Support institutions
5. What are for you the reference documents on this subject?

Impact and Sustainability

1. How do you measure success in this area?
2. What are the main results achieved?
3. What are current discussion and main actors involved in further defining and measure impact?
4. How has or can your innovative finance initiative complement current investments in health innovation?

Lessons Learned

1. What are the main barriers and opportunities for expansion and to increase impact of innovative finance mechanisms?
2. In your view, which are the 2-3 mechanisms / institutions which have made/are making significant impact for the field?

COVID-19

1. How can blended finance play a role in pandemic preparedness?
2. There a lot of innovative finance mechanisms- especially bonds -- which have been issued in response to the COVID 19 crisis, (AfDB fight COVID 19, Council of Europe COVID 19 Social Inclusion bond, European investment Bank Sustainable Awareness Bond, New development Bank bond...), do you know of other ways innovative financing is helping to respond?

Recommendations to G20 countries

3. What could/should be the role of the donor community to support the expansion of innovative financing, especially blended finance, for health?
4. We are looking at providing recommendations to G20 countries as part of our report, for you, how can G20 countries best contribute to the expansion and success of innovative financing for health?

ANNEX 4

Debt Swaps / Loan Buy Down

Initiative	D2H Global Fund	Gavi Loan BuyDown	ODA Facility	Loan BuyDown India
Brief Description	Waive debts owed by LMICs in exchange for investment in domestic health programs supported by global fund	Innovative mechanism where donors provides Gavi with Low-interest loans to help support immunization coverage in African Sahel Region	ODA facility will repay loans in Nigeria so that the loan can go towards polio eradication	Global Fund and World Bank buy down a portion of the principal and make loans more affordable in India.
Objectives	Allow for LMICs to invest in domestic health programs	Help improve new vaccines and renew existing programs in Sahel Region	Help eradicate Polio	Eradicate TB
Year Established	2011 original, picked up again in 2018	2016	2017	2019
Funding				
Partners	Global Fund, Developing nations, multilateral development banks, LMICs	BMGF, Gavi, AFD	BMGF, JICA, Nigeria	Global Fund, World Bank, Indian Government
Results/Outcomes	Encourage poor countries to spend more scarce funds on health but not a long term solution	Protecting 15 million children against vaccine preventable diseases and saving half a million lives	460 million doses procured to vaccinate children, Nigeria saw polio cases drop to 53.	Scaling up of private sector engagement, patient management support, stronger surveillance, management capacity, and diagnostic treatment of TB. GF invested \$41.6 Million – part of a \$400 million buydown from WB

Region/Country	Cameroon, Cote D'Ivoire, Democratic Republic of Congo, Egypt, Ethiopia, Indonesia, and Pakistan	African Sahel Region Burkina Faso, Chad, Mali, Mauritania, Niger and Senegal	Nigeria	India
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ANNEX 5

Result based loans & grants

Mechanisms	Program-for-Results Financing (PforR)	Result Based Lending (ADB)	Performance Driven Loan (IDB)	Regional Malaria Elimination Initiative (RMEI)	Health and Nutrition Services Access Project (HANSA)
Brief Description	Loan mechanism where part of the funding is conditioned to achievement of targets	Loan mechanism where part of the funding is conditioned to achievement of targets		Multi donor funds, managed by the IDB	Co-financing mechanism to support
Objectives	Enhance development effectiveness, building institutional capacity, and tying financing to achievement of results.	Increase accountability to deliver and sustain results. Improve effectiveness and efficiency of programs, promote institutional development and support country ownership, Reduce transaction costs		To eliminate Malaria in central America, the Dominican Republic, Columbia and Mexico by 2022.	Supporting Lao Health Strategy to achieve better health outcomes
Year Established	2012	Pilot in 2013, mainstream in 2019	2003	2018	2019
Funding	US \$2.1 million	USD 350 million		USD 102 million	USD 36 million
Partners	NA	NA	NA	Bill & Melinda Gates Foundation, the Carlos Slim Foundation, the Global Fund and the Ministries of Health of the participating countries.	IDA US\$23M; GF US\$10M; DFAT US\$3M;
Results/Outcomes	Project dependent	Project dependent	Project dependent		NA
Region/Country	10 programs in health	China, India	3 health projects in health in 2014	Central America, the Dominican republic, Columbia	Lao

Tanzania, Nepal,
China, Costa Rica,
Croatia, Ethiopia,
Indonesia,
Moldavia, Morocco,
Mozambique

and Mexico.

ANNEX 6

Performance based financing

Initiative	"Results Innovation Trust Fund (HRITF)"	Global Partnership on Result Based Approaches GPRBA	USAID programs
Brief Description	The trust fund, managed by the World Bank, provide subsidies for performance based financing projects	Housed in World Bank, this Trust Fund provides subsidies to support performance based approaches in poor countries, mainly vouchers scheme in health	Several USAID-funded projects include a component of performance based financing
Objectives	Accelerate health outcome result Learn about the effectiveness of the PBF approach	Explore output-based aid (OBA) approaches	Accelerate health outcome result
Year Established	2007 to 2022	2003	
Funding	472.2 millions as of August 2017	Since 2003, donors have provided a total of US \$338 million in funding, all sector together	
Partners	Norway, DFID, Worldbank	DFID, SIDA, Australian Department of Foreign Affairs and Trade (DFA) Dutch Ministry of Foreign Affairs (DGIS)	
Results/Outcomes	Mixed results, measured in increased utilization of health care services and improved quality, generally at primary health care level	Measured as number of outputs and number of beneficiaries.	

Region/Country	39 countries, including 20 from Africa	1 current active project in Health in Uganda Past projects in Yemen, Uganda, Nigeria, Philippines	Example include: Uganda (ASSIST project) Liberia
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ANNEX 7

Development Impact Bonds

Initiative	Cameroon Cataract DIB	Palestine Type II Diabetes Mellitus DIB	Cameroon Kangaroo Mother Care DIB	Utkrisht DIB for Maternal and Newborn Health	ICRC Programme for Humanitarian Impact Investment
Objectives	Reducing avoidable blindness from cataract	Reducing T2DM incidence	Increasing KMC usage to improve LBW and preterm infant health outcomes.	Reducing maternal and neo-natal mortality rates in Utkrisht	Increasing access to infrastructure and local physical rehabilitation for disabled population.
Year Established	March 2018	2019	2018	2017	2017
Funding	2 million	0.15 million	0.8 million	8 million	19.42 million
Partners	Outcome Payers: Conrad N. Hilton Foundation (80%), Fred Hollows Foundation (10%), Sightsavers (10%)	Outcome Payers Paltel Group Foundation	Outcome Payers GFF (Government of Cameroon) Nutrition international	Outcome Payers USAID, Merck for Mothers	Outcome Payers Belgian Development Cooperation, (SDC), (DFID), Italian Development Cooperation and la Caixa Foundation
Results/Outcomes	18,000 surgery (expected)	Percentage of participants who will successfully reduce their weight by 5% or more	2500 mothers	440 facilities ready to be accredited for quality, targeting 600,000 patients	3600 refugees
Region/Country	Cameroon	Palestine	Cameroon	India	Mali, Nigeria, DRC

ANNEX 8

Pooled Investment Approaches

Initiative	Gavi	Global Fund	Global Financing Facility	Global Innovation Fund	Global Health Innovative Technology Fund (GHIT)	Medicines for Malaria Ventures (MMV)
Brief Description	Created to address the market failure of immunizations. Gavi shares the cost of developing vaccines. Developing countries pay for vaccines.	A partnership designed to accelerate the end of AIDS, tuberculosis and malaria as epidemics.	The GFF Trust Fund acts as a catalyst for financing, with countries to increase their domestic resources.	A non-profit innovation fund that invests in the development, rigorous testing, and scaling of innovations targeted at improving the lives of the world's poorest people.	A public-private partnership fund for global health R&D. The fund is focused on investing in nonprofit product development for HIV/AIDS, malaria, tuberculosis, and NTDs.	A product development partnership in the field of antimalarial drug research and development.
Objectives	Save lives by bringing new vaccines to LMICs where it would typically take 10+ years to reach.	Promote innovative solutions to global health challenges; Harnesses the best possible experience, insights and innovation in the public and private sectors to respond to diseases and build resilient and sustainable systems for health.	Helping governments in low- and lower-middle income countries transform how they prioritize and finance the health and nutrition of their people, with a focus on women, children, and adolescents.	Through grants, loans (including convertible debt) and equity investments, GIF backs innovations with the potential for social impact at a large scale, whether they are new technologies, business models, policy practices, technologies or behavioral insights	Established to solve the challenges associated with drug development for infectious diseases and achieving Universal Health Coverage under the Sustainable Development Goals.	Reduce the burden of malaria in disease-endemic countries by discovering, developing and delivering new, effective and affordable antimalarial drugs.
Year Established	2000	2002	2015	2014	2013	1999

Funding	\$7.5 Billion USD (2015-2020)	\$14 Billion USD	\$1 Billion USD	\$7.5M in health and nutrition	\$100M (2013-2018) \$200M (2018-2022)	\$4M USD in 1999 \$350M (2019-2023)
Partners	BMGF, UNICEF, WHO, World Bank, Governments, Private sector	Governments, civil society, technical agencies, the private sector	World Bank's IDA and IBRD	Department of International Development in the UK, the United States Agency for International Development, the Omidyar Network, the Swedish International Development Cooperation Agency, the Department for Foreign Affairs and Trade in Australia and the Department of Science and Technology in South Africa	Government of Japan, Bill & Melinda Gates Foundation, Wellcome Trust, and global life sciences companies.	BMGF, DFID, USAID, OTA, Wellcome Trust, Swiss Agency for Development Cooperation, Netherlands, The World Bank and Rockefeller Foundation

ANNEX 9

Public Private Co-funding

Initiative	Gavi Matching Fund	Global Fund: India Health Fund	USAID: Project Last Mile
Brief Description	The Gavi Matching Fund is a public-private funding mechanism that doubles private sector partners' impact by doubling their investment in immunization.	The India Health Fund acts as an aggregator of resources from Indian and global foundations, family offices and other private- and public-sector institutions to ensure the efficient review and scale up of innovative solutions, taking them from "lab to last mile."	Project Last Mile collaborates with regional Coca-Cola bottlers and suppliers to strengthen public health systems capacity in supply chain by sharing the expertise and network of the Coca-Cola System with the local Ministry of Health (MoH)
Objectives	Incentivize private sector investments in immunization.	First platform to aggregate and invest philanthropic capital to accelerate the elimination of TB and malaria in India.	Improve uptake of life-saving health services and to enable medicines to go to the "last mile" and benefit communities in Africa.
Year Established	2011	2016	2010
Funding	\$210M	\$15M	\$12M
Partners	BMGF, DFID, Dutch Development Cooperation, Private sector partners	Tata Trusts, Global Fund	The Coca-Cola Company and Foundation, the Bill and Melinda Gates Foundation, The Global Fund, and USAID
Results/Outcomes	\$210M USD pledged for 2011-2015	---	Optimized delivery routes for over 3,500 health facilities in Tanzania and Mozambique, reducing delivery costs and increasing reliability; Developed proactive maintenance and repair systems for over

			392 refrigeration units in Lagos, Nigeria; Supporting direct delivery of medications to almost 2M people with chronic diseases in South Africa
Region/Country	73 Gavi eligible countries	India	Ghana, Liberia, Mozambique, Nigeria, Sierra Leone, South Africa, Swaziland, and Tanzania.

ANNEX 10

Revolving Funds

Initiative	PAHO	UNFPA	GAIN Premix Facility
Brief Description	The Fund helps countries of the Americas protect people against some of the world's worst diseases, including polio, measles, yellow fever, rotavirus, and HPV. Through the fund, Member States pool their national resources to procure high-quality life-saving vaccines and related products at the lowest price.	UNFPA Supplies is structured as a thematic trust fund, a performance-based and flexible mechanism that provides donors the opportunity to target their commitment to a particular thematic priority, allows for pooled multi-year funding and ensures more timely and flexible use of resources to address specific country needs	The GAIN Premix Facility provides credit and procurement services for quality-assured nutraceuticals (vitamins and minerals) for food businesses in LMIC. Donors have subsidized the core costs of the facility while the private sector funds the costs of the vitamins and minerals and the transactions.
Objectives	By buying in bulk, the Fund greatly improves its purchasing power by taking advantage of the economics of scale	To expand access to family planning products	To provide quality-assured, lower cost vitamins and minerals to at-risk populations
Year Established	1977	2007	2009
Funding	---	126M (2019)	\$6M seed capital
Partners	Countries in the Americas	Australia, Belgium, Bill & Melinda Gates Foundation, Canada, Children's Investment Fund Foundation, Denmark, European Union, Finland, France, Friends of UNFPA, Ireland, Regione Lombardia (Italy), Liechtenstein, Luxembourg, Netherlands, Norway, Nutrition International, Portugal, private individuals (online), the RMNCH Trust Fund, Slovenia, Spain, Spain-	Bill & Melinda Gates Foundation, Government of the Netherlands, and various governments of LMIC including Ethiopia, Bangladesh, Kyrgyzstan

		Cataluña, Sweden, Treehouse Investments, United Kingdom and Winslow Foundation	
Results/Outcomes	First WHO region to eliminate polio, measles and rubella. Low infant mortality rate, rapid and equitable introduction of new vaccines.	8M unintended pregnancies averted; 24,000 maternal deaths averted; 152,000 child deaths averted; 2.3M unsafe abortions prevented; Save \$497M in direct health-care costs	US\$80 million in extended credit provided to nutritious food businesses in Africa and Asia while maintaining a 1% default rate. The GAIN Premix Facility has reached roughly 150 million individuals a year since 2009 with more nutritious, fortified foods and decreased costs of the premix by 5-15% (cost reduction depends on product).
Region/Country	41 countries and territories in the Americas	Global	Global- any LMIC

ANNEX 11

Seed Funding / First loss Capital

Initiative	USAID Grand Challenges	Pzifer Foundation	Endowment for Global Health
Brief Description	USAID distributes funds to mobilize governments companies, and foundations around important issues in global health.	1 year 100,000 grants to 15 global health innovators in LMICs	Group of CDC employees and retirees understood challenges in public health and developing countries so they decided to create an endowment to help these areas
Objectives	Expand flexibility and bring to life ideas from LMICs that positively and directly impact LMICs	Expand flexibility and bring to life ideas from LMICs that positively and directly impact LMICs	Provide strong flexible funding to CDC teams working in field to meet critical or emergency needs not easily met through gov channels
Year Established	2011	2014	1999
Total Funds	1.5M	508M grants and technical assistance funds to 450 innovations in 60 countries	
Partners	BMGF, USAID, innovators across the globe	Pzifer, innovators in LMICs	Marcus Foundation matching fund and CDC center for Global Health
Results/Outcomes	Since 2011 USAID and partners have cultivated a pipeline of over 150 innovations and supported them on their path to deliver health impact - MNHC to Ebola and Zika.	Established over 70 new points of care servicing 175 new geographic locations. Over 600 individuals trained to provide evidence-based care.	Provided resources for essential services and equipment such as bullet-proof vests for health workers vaccinating children in war-torn Somalia, ready-to-eat meals for workers in Sudan, satellite phones, incentives for vaccination campaigns in Mexico and India and training in other countries
Region/Country	LMICs across Asia and Africa	60 different countries	India and Somalia

ANNEX 12

Volume Guarantees

Initiative	BMGF Contraceptives	Gavi Rotavirus	Gavi Pentavalent	MedAccess Bednets Malaria	MedAccess Viral Testing
Brief Description	BMGF worked with Merck and Bayer to double supply of contraceptives for half the prices for Sub-Saharan Africa	Gavi worked with partners to establish a new price for rotavirus vaccine to by 132 million doses at 5 dollars per course	Gavi worked with partners to reduce cost of pentavalent vaccine for developing countries. About 40 million doses a year were procured at 1.19 procurement rate per dose.	MedAccess created a volume guarantee to help gain more bednets at a lower cost in sub-Saharan African countries	MedAccess made viral testing more available to help fight HIV/AIDs by creating a volume guarantee that reduces patient test price to 12 dollars.
Objectives	Make contraceptives more accessible to Sub-Saharan African women	Reduce rotavirus cases in over 32 LMICs	Provides protect from Pertussis, Tetanus, Hepatitis B and Hib	Reduce Malaria cases	Reduce deaths from AIDS/HIV
Year Established	2012	2012	2013-2017	2019	2018
Funding					
Partners	BMGF, Merck, Bayer, US, UK, Norway	Supply Partner UNICEF, and GSK, Merck, PATH (supported by BMGF), GAVI	GAVI, BMGF, BioE	BASF, MedAccess, BMGF	MedAccess, Clinton Health Access Initiative, Hologin
Results/Outcomes	400+ million in savings and millions of lives saved	Potential cost savings said to be 650 million	Estimated savings of \$150 M over 4 years and 152.5 million doses distributed globally	35 million bednets have reduced in price hoping to reduce 90% of malaria deaths	40-50% price reduction and over \$50M in savings
Region/Country	Sub-Saharan Africa	32 +LMICs	73 GAVI supported countries	Countries across Sub-Saharan Africa including Burkina Faso, Côte d'Ivoire, Mali	Areas with high prevalence of viral diseases

ANNEX 13

Impact Investing Funds

Initiative	Medical Credit Fund	Aureos Fund	Africa Health	Nutritious Foods Financing Facility (N3F)
Brief Description	The Medical Credit Fund (MCF) is the first and only debt fund dedicated to financing small- and medium-sized enterprises in the health sector ("health SMEs") in Africa	Africa Health Fund provided long term risk capital to private health-related businesses in Africa. The fund had a specific bottom-of-the-pyramid orientation. Classical fund structure investing equity and quasi equity.		The Nutritious Foods Financing Facility (N3F) is a blended finance facility which deploys market-based solutions to increase the consumption of safe, nutritious foods by low income populations. The N3F's investment theme is on improved nutrition outcomes. It provides debt financing as well as technical assistance to medium sized enterprises ("SMEs") throughout Sub-Saharan Africa ("SSA") that scale up production and distribution of locally produced nutritious foods.
Objectives	To build the private healthcare value chain in Sub-Saharan Africa, enabling healthcare companies to increase and improve their quality, scale, and efficiency and serve a wider range of patients better	Africa Health Fund provided long term risk capital to private health-related businesses in Africa. The fund had a specific bottom-of-the-pyramid orientation. The investment period has ended.		Increase the consumption of safe, nutritious foods in Sub-Saharan Africa.
Year Established	2009	2011		2020
Funding and capital	\$50M (as of March 2019)	US\$75M		Raising US\$60M in investment capital in 2020 and additional grant funds for the technical assistance component
Partners	MCF, CDC Group, the International Finance Corporation (IFC), Agence française de développement (AFD), three private impact investors, the European Investment Bank (EIB); PharmAccess Group (fund sponsor)	Norfund. IFC		Rockefeller and Irish Aid (grant funds), DFIs and investors (investment capital), GAIN (technical sponsor), Incofin (fund manager)
Results/Outcomes	18 local Financial Partners, 2,400 staff	Most of the funds were successfully deployed in		The N3F commissioned and competed the first-ever

	trained; 1,760 SMEs financed, 79% improved quality of care; 58% of patients are low income	healthcare projects including hospital infrastructure, pharma and clinics.	financing survey of agri-food SMEs in Sub-Saharan Africa making this report available for all investors and institutions interested in investing in this region ^{lxvii} . Further deal flow development is ongoing in 2020 with the aim to make investments in late 2020 and provide a demonstration effect to the rest of the sector.
Region/Country	Sub-Saharan Africa	All of Africa	Sub-Saharan Africa

ANNEX 14

International Solidarity Taxes

Initiative	UNITAID
Brief Description	A global health initiative to bring about innovations to prevent, diagnose and treat major diseases in low- and middle-income countries, with an emphasis on tuberculosis, malaria, and HIV/AIDS and its deadly co-infections. UNITAID uses airline levies as a funding instrument.
Objectives	Accelerate access to high-quality drugs and diagnostics for HIV/AIDS, malaria, and tuberculosis in countries with a high burden of disease.
Year Established	2006
Funding	\$2.5 Billion USD (since 2006) 63% of funding is from airline levies
Partners	Donors include France, the United Kingdom, Norway, the Bill & Melinda Gates Foundation, Brazil, Spain, the Republic of Korea, and Chile Airline tax is in effect in the following countries: Cameroon, Chile, Congo, France, Guinea, Madagascar, Mali, Mauritius, Niger, and the Republic of Korea
Results/Outcomes	In 2010, Unitaid created and invested in the Medicines Patent Pool (MPP). In 2013, introduction of TBXpert, a TB diagnostic tool, diagnosed 245,000 patients with TB in 21 countries across Africa, Asia, and Eastern Europe.
Region/Country	Global

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