SOLVING THE REPRODUCTIVE, MATERNAL, NEWBORN AND ADOLESCENT HEALTH FINANCING GAP WITH A GLOBAL FINANCING FACILITY: UNDERSTANDING AND BRIDGING HEALTH PRIORITIES BETWEEN COUNTRIES, DONORS AND THE PRIVATE SECTOR

by

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Abstract

This paper will focus on the creation of the Global Financing Facility (GFF) in response to the United Nations’ *Global Strategy* goals towards closing the Reproductive, Maternal, Newborn and Adolescent Health (RMNCAH) financing gap. An annex is introduced on different types of health setting prioritization based on epidemiology, health economics and politics, was created for the GFF to help diverse GFF partners (e.g. national government entities vs. private sector) communicate and collaborate on investment cases. It demonstrates how diverse stakeholders can be a constraint or a benefit dependent on whether they are given the right tools to communicate to ensure the success of the GFF.

Background of the Sustainable Development Goals on RMNCAH Issues

After the Millennium Development Goals (MDG) deadline was met in 2015, the new Sustainable Development Goals (SDG) were created to meet the demands of the new post-MDG world. In the last MDG progress report (United Nations, 2015) the global under-five mortality rate lowered from 90 to 43 deaths per 1,000 live births between 1990-2015 and deaths under-five lowered from 12.7 million (1990) to approximately 6 million in 2015 globally. The maternal mortality ratio has reduced 45 percent since 1990, with most of the decrease happening since 2000. In 2014, there were 71 percent of births attended by skilled health workers which is a 59 percent increase compared to 1990 (United Nations, 2015).

Although there have been successes with the MDGs, there are notable gaps that still need to be addressed. After the MDGs completion, the following areas were determined important towards reaching the world’s most vulnerable people: gender inequality, climate change and environmental degradation hampering progress of development, poverty and lack of access to basic services. Focus on Reproductive, Maternal, Newborn and Adolescent Health (RMNCAH)
issues are a main priority due to maternal morality ratio in low income countries being 14 times
greater than higher income countries, half of pregnant woman in low income countries receiving
the suggested minimum four antenatal visits and the gaping health disparities between rural vs.
urban areas and poorest vs. richest households in low income countries (United Nations, 2015).

The SDG framework that replaced the MDG has certain differences in regards to its goals
and targets to address this focus on RMNCAH issues. The SDGs were created with three aspects
of sustainable development in mind: “economic growth, social inclusion and environmental
protection” (UN SDG site, 2016). As a result, the SDG framework contains 17 goals and 169
total targets compared to the MDG’s eight goals. This is due to the many complex issues that
need to be addressed in order to effectively help eradicate poverty and address the universal need
for sustainable development. A unique function of the SDG framework is that it applies to all
countries, and not only developing countries which were the specific focus of the MDGs.

**RMNCAH Initiative Pre and Post-2015**

Building upon the MDGs progress, and the need to focus on fragile country health
systems’ to provide needed maternal and child health, the UN Secretary General launched the
Global Strategy for Women’s, Children’s and Adolescents’ Health in 2010. The Global Strategy
was created by the UN, but it was intended to be executed by the World Health Organization
(WHO) who would report directly to the UN. This 2010-2015 Global Strategy helped to bring
together political leadership, attract billions of dollars in financial commitments and created the
Every Woman Every Child multi-stakeholder movement. The Every Woman Every Child
movement was launched during the September 2010 UN Millennium Development Goals
Summit to “[mobilize] and [intensify] international and national action by governments,
multilaterals, the private sector and civil society to address the major health challenges facing women, children and adolescents around the world” (Every Woman Every Child, 2016). Since the start of the movement, 40 billion dollars was pledged (in 2010) due to various partners throughout the international community making commitments towards improving the health of women, children and adolescents. There is now a 2016-2030 Global Strategy that is unique in that it focuses on:

- safeguarding women, children and adolescents in humanitarian and fragile settings and
- upholding their human rights to the highest attainable standard of health, even in the most difficult circumstances…[also] by investing in the right policies and programmes for adolescents to realize their potential and their human rights to health, education and full participation in society…[the Strategy also] adopts an integrated and multisector approach, recognizing that health-enhancing factors including nutrition, education, water, clean air, sanitation, hygiene and infrastructure are essential to achieving the SDGs (Global Strategy, 2016).

The greatest achievement that the Global Strategy could achieve is global convergence. The Lancet Commission on Investing in Health (CIH) created a report “Global Health 2035” that reports health outcomes from poor countries could converge to significant levels of richer countries in one generation (Boyle, Levin and others, 2015). This convergence could happen with effective scaling up of health interventions, strengthening existing health systems and sustained, innovative investment in health.

While the developing world’s health statistics have changed significantly since the implementation of the MDGs, so has the landscape of global health financing. Although the financial assistance for health has increased this past decade, its annual rate of growth has slowed
due to the global financial crisis (Leach-Kemon, Chou and others, 2012). There are four trends that have made important impacts on the current global health financing world:

1. shifts in the type of recipients receiving aid and the purpose of the assistance,
2. shift in no longer using bilateral development assistance as main source of aid,
3. stagnation in UN funding which is affecting many health priority areas,
4. presence of new actors (e.g. GAVI Alliance and Global Fund) receiving most aid money.

An example of these changing partnerships is the Global Fund to Fight AIDS, Tuberculosis, and Malaria which stated in 2011 that they would not issue new grants until 2014 due to lack of donations during the global financial crisis. The shift in low-income countries being classified as low-middle income countries is also changing the type of aid being provided. The World Bank adapted to this new shift by changing the way it issues appropriate aid to countries. The major change is how the International Bank for Reconstruction and Development (IBRD) expanded its previous scope and now provides loans to middle-income countries for health and economic improvement. The International Development Association (IDA) which provides grants and interest -free credit to low-income countries has decreased its assistance as a result of the IBRD’s expanded role. Many experts, consistent with what is outlined in the Global Strategy, believe a global financing facility is needed in order to close the gap left by donors dealing with the global financial crisis. As an answer to the RMNCAH gap, the UN recommended in its first Global Strategy that a global financing facility be created to help close the gap through domestic, international donors and the private sector. In support of the Every Woman Every Child movement, the Global Financing Facility (GFF) was created in 2014 with
the partnership of the UN, the World Bank Group and the governments of Canada, Norway and the United States.

**Introduction on the Global Financing Facility (GFF)**

The Global Financing Facility (GFF) is a financing platform meant to be a country-driven financial partnership between national governments and diverse stakeholders in RMNCAH. The GFF’s goal is to end preventable RMNCAH deaths by 2030 and improve the quality of life of women, children and adolescents. The GFF will achieve this goal by providing smart, scaled and sustainable financing to close the financing gap for RMNCAH, estimated as 33.3 billion USD (GFF Business Plan, 2015).

The GFF has a partnership with the International Bank for Reconstruction and Development (IBRD), the part of the World Bank that offers loans to middle-income developing countries, to raise funds for GFF involved countries with RMNCAH financing gaps. This partnership, along with financing commitments from donors (e.g. Government of Canada and Norway, Bill and Melinda Gates Foundation) is meant to encourage private sector investment and encourage domestic financing towards RMNCAH. The main areas of concern that the GFF is meant to improve are civil registration and vital statistics, in order to improve data measurement of “real time”, underfunded health issues (e.g. nutrition, family planning), disadvantaged groups (e.g. adolescents) and to use equity analysis to ensure vulnerable populations are accounted (GFF Business Plan, 2015).

**Need for the Global Financing Facility (GFF)**

The creation of the GFF is meant to be a “key financing platform” in support of the UN Secretary-General’s *Global Strategy*. Due to the changed macroeconomic landscape with the
global financial crisis and the economic upward mobility of low-income countries to middle status, the investment case framework model has shown promise in attracting partners and improving RMNCAH health outcomes. Investment scenarios have shown that, “with current trends…the [GFF] would help prevent a total of 4 million maternal deaths, 107 million child deaths, and 22 million stillbirths between 2015 and 2030 in 74 high-burden countries” (GFF Concept Note, 2015). A major area that the GFF will focus on is on improving civil registration and vital statistics (CRVS) on a universal level to improve health statistics. In most developing countries reliable CRVS can be an impossible task and relying on approximations such as the Global Burden of Disease 2010 Study will not help the international community accurately determine if RMNCAH issues are being adequately addressed.

The GFF Trust Fund, part of the Global Financing Facility, was created in order to provide additional funding for RMNCAH grants to IDA and IBRD projects. The trust fund is established at the World Bank and is meant to mobilize the entire World Bank Group’s expertise around pandemic preparedness. The GFF trust fund will be succeeding the World Bank’s previous Health Results Innovation Trust Fund (HRITF) which provided results-focused financing to countries for RMNCAH needs (GFF Business Plan, 2015). The GFF, as a whole facility, is governed by an investors group (GFF Investors Group) which is made up of the representatives of participating countries, bilateral donors, non-governmental organizations, the private sector, multilateral institutions and private foundations. The main focus of the GFF Investors Group will be to accumulate complementary financing for investment cases and health financing strategies.

The GFF has five main objectives: “1. Finance national RMNCAH scale-up plans and measure results; 2. Support countries in the transition toward sustainable domestic financing of
RMNCAH; 3. Finance the strengthening of civil registration and vital statistics systems; 4. Finance the development and deployment of global public goods essential to scale up; 5. Contribute to a better-coordinated and streamlined RMNCAH financing architecture” (GFF Concept Note, 2014).

What is new about the GFF is it will not focus on providing only development assistance. The GFF model incorporates domestic financing, external donor support and the private sector to encourage a synergistic partnership. A major problem with development assistance and domestic entities (e.g. Ministries of Finance) is that they are very fragmented from each other, which causes high transaction costs. The GFF is a medium to bring these stakeholders under one house where they focus on a country-led (from the bottom up) long-term financing roadmap (refer to Figure 1).

![Figure 1: Harmonization of financing around a country's RMNCAH plans and financial roadmaps (GFF Concept Note, 2014)](image)

This financing roadmap is inclusive by incorporating the respective government, private sector, civil society and GFF development partners. The GFF model is not meant to provide
technical guidance; it is only meant to provide a pathway for financing and build on current resources. Though there is no shortage of partners that are willing to provide technical expertise, there are many organizations (approximately 300) that have made commitments with *Every Woman Every Child*. Domestic financing flows are estimated with the Commission on Investing in Health’s approach which has a conceptual approach containing four key enablers that drive health outcomes “policy, health system, community engagement and innovation” (Stenberg, Axelson and others, 2014). Due to the GFF’s ability to pull in different stakeholders, it can use the comparative advantages of the diverse set of RMNCAH stakeholders and ensure financing for high-impact evidence-based interventions.

The GFF partners use different approaches in order to maximize the comparative advantage they have in unison with the respective governments and existing structures in place. The approaches used are: investment cases for RMNCAH; mobilization of financing for investment cases (e.g. complementary financing of the investment case, increased government investment in RMNCAH); health financing strategies focused on sustainability; investments in global public goods that support RMNCAH results at the country level (GFF Business Plan, 2015).

**Challenges for the Global Financing Facility**

Although there have been many RMNCAH partners supporting the establishment of the GFF, there have been doubts regarding whether the structure of the facility in the World Bank Group will lead to universal health equity for low income countries. According to the Swedish Ambassador for Global Health Anders Nordstrom, the GFF would not lead to simplifying the international system and would prefer to strengthen the current UN agencies currently working
in the field. Mr. Nordstrom’s input is interesting to note because Sweden is a major donor for RMNCAH funds and he was a key person in creating the International Health Partnership which works to streamline donor funding in the health sector. Due to the arrangement of where $1 provided to the GFF will mobilize “$5 of spending on maternal and child health [which will] be [sic] drawn from the bank’s IDA [The World Bank’s International Development Association]...the GFF undermines the governing principles of IDA” (Usher, 2015). The IDA is the World Bank’s main instrument in eliminating extreme poverty through concessional financing and currently 77 countries are eligible to receive assistance. Since the funds from the IDA are not meant to be allocated for a specific purpose, this can be seen as going against the intention of the IDA. Also since the World Bank will act as technical advisor, coordinator and manager of the GFF trust fund, the Swedish Ambassador believed that main implementing agencies would be placed in a subcontracting relationship with the Bank.

It should be noted that the GFF was placed under the World Bank Group’s administration due to the comparative advantages of the IBRD, IDA and the HRITF housed within the Bank. This structure would help reduce the resources and costs to manage a global financing facility. Due to the infancy of the GFF, there will be challenges, but it is believed that the GFF will be a catalyst towards harmonizing funding sources by bringing respective countries, donors and the private sector around one investment case (Jacovella, Evans and others, 2015).

Need for the Annex

Due to the diverse world of stakeholders involved in the creation of the investment case there needs to be tools to help make sure people can understand why a specific health priority is urgent. The politics of health are an example where stakeholders, and individuals within these
stakeholder groups, can differ in mindset. Awareness of the inner politics and economic schools of thought can help GFF partners learn how to speak or interpret the jargon of their peers. As a public health professional in an academic setting, it can be hard to understand why someone would not want to advocate for a high-impact cost effective health intervention unless we acknowledge “health is political” (Bambra, Fox, Samuel, 2005). In Western capitalism health is viewed as a commodity (economic definition) and the absence of disease (biomedical definition), which makes health appear as an individual choice that can be remedied through commodities.

Unfortunately, this can make health inequalities appear as if they are a person’s individual choice and the distribution of health is left up to the health system. In order to bridge this communication gap between GFF partners, there needs to be tools or a framework in place to help create a shared vision for health promotion and practice. An investment case is the best of both worlds by incorporating economic, political, social and health priorities into a conceptual approach. An investment framework contains key enablers with high-impact interventions, health and nutrition gains (e.g. lives saved) and wider societal gains (e.g. improving human capital) (refer to Figure 2).
The investment case framework is made up of problem-solving analysis with quantitative techniques designed to inform decision makers (Soto, La Vincente and others, 2012). The first step is to figure out the problem, which is defined as what is causing the mortality (refer to figure 3). The next part is to analyze what could be done to prevent further mortalities and what is preventing further scale-up efforts. The key interventions regarding causes of death and health system bottleneck constraints are identified. Strategies are then developed “taking into account the local context, policy, and legislative constraints, and the overall structure of the health system”. The details to the scale-up strategies and associated costs are defined at this stage. Finally, the increases in coverage targets that result from the implementation of suggested strategies should be monitored.
The timeline for the investment case can vary according to country and many other factors. In figure 4 above, the image shows how complex a real investment case timeline can become when accounting for institutional, political and socio-economical constraints.

If a country already has a country partnership framework (CPF) in place, they could easily incorporate their investment case within the CPF in order to make sure that their activities and timelines are in line with the political cycle and partnership deadlines (Appendix B). In order to make sure that clinicians, politicians, economists and other involved public health experts can navigate, plan, measure and evaluate their investment plans there should be a primer document on priority setting in health care (Appendix A).
The Development of the Annex

Priority setting in health care is a challenge because demand will always exceed available health resources. Due to this difficulty, consensus over which group’s need is greatest is determined with different health care prioritizations that are intended to provide a fair allocation of resources. Priority setting in health care relies on both qualitative and quantitative data, and depending on the chosen health care priority methodology, can be modified according to the organization’s needs. Based on the research made for the GFF to provide a brief guide on health priorities for GFF partners, six approaches were focused on in regards to RMNCAH needs. The following six approaches were covered with descriptions, strengths and weaknesses and commonly used tools and frameworks:

1. Valuing cost and cost-effective of interventions
2. Using Burden of Disease as benchmark
3. Valuing impact of health technologies
4. Valuing political and financial feasibility
5. Subjective methods, such as interpretive or consensus stakeholder approaches
6. Social determinants and health equity-oriented approaches

The following annex was created through a literature search on available health priorities settings in low-income countries. The purpose is meant to provide a brief background on these six approaches, but also to provide different case studies so GFF partners may see examples of how the tools and frameworks from these different health priority methodologies work.

The annex was created for the Global Financing Facilities diverse partners and in collaboration with Dr. Mickey Chopra, Chief of Health of UNICEF. The annex once completed was meant to be used as a tool to be disseminated to GFF partners, donors (i.e. national
governments, private sectors) in order to ease communication and understanding among clinicians and non-clinicians towards choosing common ground on important health priorities. The case studies serve as practical examples for the GFF partners to draw on in order to understand the different tools and frameworks according to health prioritization methodology.
Annex on Priority Setting in Health Care

Priority setting in health care, at all levels, will always be a challenge because demand will usually exceed available resources. Due to the difficulty of arriving towards consensus over which health need should be urgently addressed, there have been different approaches used to determine the fair allocation of resources (fair allocation decision). Priority setting for health research includes two approaches, technical and interpretive, which show how the diverse interpretation of quantitative and qualitative data is needed in order to determine prioritization. It should be noted that all priority setting methods are to be used and adapted based on the needs of the organization. No method is without its limitations, and pros and cons should be weighed and taken into consideration when choosing a certain methodology (Warren, 2004).

The following approaches to health care prioritization will be covered along with case study examples:
1. Valuing cost and cost-effectiveness of interventions

2. Using Burden of Disease as benchmark

3. Valuing impact of health technologies

4. Valuing political and financial feasibility

5. Subjective methods, such as interpretive or consensus stakeholder approaches

6. Social determinants and health equity-oriented approaches

I. Brief Overview of Prioritization Settings in Health

1. Valuing cost and cost-effectiveness of interventions

   i. Description: These methods allow decision makers to “[know] the financial resources required to implement each effective intervention and how dollars invested compare to outcomes achieved.” (Community Guide, 2005)

   ii. Strengths and Weaknesses: A key strength of this type of prioritization is that interventions are compared and chosen based on how cost effective they are. This methodology is helpful for governments with limited resources that need to wisely allocate resources that are most cost-effective and would advance population health. A main weakness with this methodology is the controversy over whether it addresses health inequality. Cost-effective prioritization does not mean that vulnerable subgroups will receive benefit from the intervention. The main concern with this methodology is on costs, not on which population receives benefit from the interventions.
iii. Commonly Used Tools and Frameworks: Cost analysis, cost-effectiveness analysis, cost-utility analysis, cost-benefit analysis, OneHealth Tool.

2. Using Burden of Disease as benchmark

i. Description: This methodology uses Burden of Disease (BoD) which is a modeling technique that combines epidemiologic measurements as well as combinations of morbidity and mortality to find the assumed need of a population (i.e. disability adjusted life year (DALY), lifetime quality-adjusted life years (QALY)).

ii. Strengths and Weaknesses: Some strengths of this methodology are that the rankings of the different criteria can provide an indicated need for research and leading causes of current burden in subgroups (Warren, 2004). A weakness in using BoD as a methodology is that the data are based on estimates, not measurements. For example, the lack of reliable civil registration in low-income countries, especially in rural areas, makes estimates on death rates and birth statistics less precise.


3. Valuing impact of health technologies

i. Description: The methodology is based on assessing technologies that could have the most potential impact on health needs. Since health technology assessments are based on determining potential lives that can
be saved, these methods are a combination of subjective and objective measurements.

ii. Strengths and Weaknesses: Health technology assessments can identify high-impact technology that can circumvent many obstacles that contribute to poor maternal health (i.e. simpler user requirements for technologies) (Herrick, 2014). One area of difficulty is deciding on what constitutes clinical efficacy and cost-effectiveness of health care technologies. In Hauck (2015), the National Institute for Health and Care Excellence, a government committee focused on evaluating cost-effectiveness of healthcare technology, was criticized for selecting new expensive technology for illnesses that reflect current trends of drug development which as a result could influence NHS spending on drugs for acute illnesses.


4. Valuing political and financial feasibility

i. Description: This methodology is based on prioritizing which intervention has a greater possibility of political and financial support. There are different theories/models that are used to understand how the allocation of health system resources from the simple economic model (i.e. model of
competing interest groups, median voting model, institutional economics and decentralization) (Hauck, 2015).

ii. Strengths and Weaknesses: There are many strengths when analyzing political and financial feasibility of public health interventions. Recognition of interest groups, sensitive political issues and policy windows are examples of strengths due to their importance towards successful implementation of interventions and collaboration with national, local and international stakeholders (Shiffman, 2007). Some weaknesses with these types of methodologies are that they are based on abstract theories and subjective interpretations from different disciplines which can make decision makers wary from choosing these methodologies.

iii. Commonly Used Tools and Frameworks: Process-tracing method, political economy analysis, Inclusive Growth and Development Report, institutional sustainability assessment, various capacity assessments (i.e. health systems research capacity assessment by HEALTH Alliance Schools of Public Health (Jessani, 2014)).

5. Subjective methods, such as interpretive or consensus stakeholder approaches

i. Description: These methodologies focus on the subjective consensus of stakeholders and technical experts as the main basis for setting health priorities. Although these methods are not very objective, or replicable
methodology, they can complement evidence-based approaches and can provide more flexibility to data interpretation than quantitative methods.

ii. Strengths and Weaknesses: A strength of subjective methods, compared to technical analyses, is that they value the judgments of the participants that are capable of detailing various assumptions and value judgments. Technical analyses, or quantitative methodologies, hide value judgements that reflect the stakeholders. A weakness found with subjective methods are that in order to allow stakeholders’ judgments, some objectivity is lost due to the nature of the subjective method.

iii. Commonly Used Tools and Frameworks: Stakeholder analysis guidelines (WHO), PolicyMaker (Schmeer, 2000), systematic reviews of literature.

6. Social determinants and health equity-oriented approaches

i. Description: This type of methodology is based on determining health inequality by measuring and monitoring the observed differences between “subgroups that are disadvantaged as a result of factors, such as economic status, education level, sex, place of residence, race, ethnicity, age, or disability status” (Hosseinpooor, 2015). These approaches can help reduce inequality by tracking progress on health goals and revealing any differences between subgroups that would not appear in greater population averages.

ii. Strengths and Weaknesses: Strengths regarding these types of methodologies are that they focus on a “broad array of health effects and
health determinants, the use of quantitative forecasting tools as well as qualitative evidence, an explicit concern with vulnerable populations and health equity, the engagement of decision makers and stakeholders, and transparency in process and findings” (Bhatia, 2011). However, the same mentioned strengths can be weaknesses, for example there may be opposition from government or the private sector due to different views that may not benefit the population health.

iii. Commonly Used Tools and Frameworks: Health Equity Monitor (WHO), EQUIST platform, Health in All Policies approach (WHO), Health impact assessment
Case Study 1: An ex-ante economic evaluation of the Maternal and Child Health Voucher Scheme as a decision-making tool in Myanmar (Kingkaew 2015)

**Abstract:** Reducing child and maternal mortality in order to meet the health-related Millennium Development Goals (MDGs) 4 and 5 remains a major challenge in Myanmar. Inadequate care during pregnancy and labour plays an important role in the maternal mortality rate in Myanmar. A Maternal and Child Health (MCH) Voucher Scheme comprising a subsidization for pregnant women to receive four antenatal care (ANC), delivery and postnatal care (PNC) free-of-charge was planned to help women overcome financial barriers in addition to raising awareness of ANC and delivery with skilled birth attendants (SBA), which can reduce the rate of maternal and neonatal death. This study is part of an ex-ante evaluation of a feasibility study of the MCH Voucher Scheme. A cost-utility analysis was conducted using a decision tree model to assess the cost per disability-adjusted life years (DALYs) averted from the MCH Voucher Scheme compared with the current situation. Most input parameters were obtained from Myanmar context. From the base-case analysis, where the financial burden on households was fully subsidized, the MCH Voucher Scheme increased utilization for ANC from 73% up to 93% and for delivery from SBAs from 51% up to and 71%, respectively; hence, it is considered to be very cost-effective with an incremental cost-effectiveness ratio of 381,027 kyats per DALY averted (2010, price year). From the probabilistic sensitivity analysis, the MCH Voucher Scheme had a 52% chance of being a cost-effective option at 1 GDP per capita threshold compared to the current situation. Given that the Voucher Scheme is currently being implemented in one township in Myanmar as a result of this study, ongoing evaluation of the effectiveness and cost-effectiveness of this scheme is warranted.

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<th>Approach to Health Prioritization</th>
<th>How it Applies to Case Study</th>
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<td>Valuing cost and economic evaluation methods</td>
<td>A cost-utility analysis and base case analysis were used in this case study to determine if the MCH Voucher Scheme for pregnant women could be cost-effective. Due to the economic evaluation and cost approaches used, it was found that the MCH Voucher Scheme had a 52% chance of being a cost-effective at a 1 GDP per capita threshold compared to current standards. These methods help decision makers determine which priority they can present to policy makers in terms of cost-effectiveness.</td>
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Case Study 2: Global Burden of Disease (GBD) 2010 study of the Institute for Health Metrics and Evaluation (IHME)

The Global Burden of Disease 2010 (GBD-2010) study was completed by The Institute for Health Metrics and Evaluation (IHME) and is one of the largest exercises taken in epidemiological modeling. The estimates use 800 million recorded deaths from 1950 to 2010, which are 30% of global deaths within this period. The goal of the study was to consolidate and represent all “available” data. Available data meaning data that was recorded through vital registration, survey data and sample registration.

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Using Burden of Disease as benchmark

This is a valuable resource to use for estimates. However, due to the lack of civil registration in low and middle-income countries, interpretation of the data can be problematic. “… Rankings for anaemia and diarrhoea vary widely, and sickle cell disorders are ranked substantially higher in the 1980 NHPU estimates than in the GBD-2010 estimates, even though the prevalence of this genetically determined condition in West Africa cannot have changed markedly. These latter examples illustrate the difficulties of translating various estimates into policy, being unsure whether differences reflect changes in methods and data, or real transitions.” (Byass 2013)

Case Study 3: Participatory health system priority setting: Evidence from a budget experiment (Costa-Font 2015)

**Abstract:** Budget experiments can provide additional guidance to health system reform requiring the identification of a subset of programs and services that accrue the highest social value to 'communities'. Such experiments simulate a realistic budget resource allocation assessment among competitive programs, and position citizens as decision makers responsible for making 'collective sacrifices'. This paper explores the use of a participatory budget experiment (with 88 participants clustered in social groups) to model public health care reform, drawing from a set of realistic scenarios for potential health care users. We measure preferences by employing a contingent ranking alongside a budget allocation exercise (termed 'willingness to assign') before and after program cost information is revealed. Evidence suggests that the budget experiment method tested is cognitively feasible and incentive compatible. The main downside is the existence of ex-ante "cost estimation" bias. Additionally, we find that participants appeared to underestimate the net social gain of redistributive programs. Relative social value estimates can serve as a guide to aid priority setting at a health system level.

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<td>Social determinants and health equity-oriented approaches</td>
<td>These budget experiments are demonstrating services that can be the most valuable to specific subgroups. By using these experiments, decision makers can show the feasibility of a program to policy makers and how it can compare to similar programs. The participation of citizens also provides valuable input, in terms of social value.</td>
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Case Study 4: The effect of a multi-component intervention on disrespect and abuse during childbirth in Kenya (Abuya 2015)

**Background:** Disrespect and abuse (D & A) during labor and delivery are important issues correlated with human rights, equity, and public health that also affect women’s decisions to deliver in facilities, which provide appropriate management of maternal and neonatal complications. Little is known about interventions aimed at lowering the frequency of disrespectful and abusive behaviors.

**Methods:** Between 2011 and 2014, a pre-and-post study measured D & A levels in a three-tiered intervention at 13 facilities in Kenya under the *Heshima* project. The intervention involved working with policymakers to encourage greater focus on D & A, training providers on respectful maternity care, and strengthening linkages between the facility and community for accountability and governance. At participating facilities, postpartum women were approached at discharge and asked to participate in the study; those who consented were administered a questionnaire on D & A in general as well as six typologies, including physical and verbal abuse, violations of confidentiality and privacy, detainment for non-payment, and abandonment. Observation of provider-patient interaction during labor was also conducted in the same facilities. In both exit interview and observational studies, multivariate analyses of risk factors for D & A controlled for differences in socio-demographic and facility characteristics between baseline and endline surveys.

**Results:** Overall D & A decreased from 20–13 % ($p < 0.004$) and among four of the six typologies D & A decreased from 40–50 %. Night shift deliveries were associated with greater verbal and physical abuse. Patient and infant detainment declined dramatically from 8.0–0.8 %, though this was partially attributable to the 2013 national free delivery care policy.

**Conclusion:** Although a number of contextual factors may have influenced these findings, the magnitude and consistency of the observed decreases suggest that the multi-component intervention may have the potential to reduce the frequency of D & A. Greater efforts are needed to develop stronger evaluation methods for assessing D & A in other settings.

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<td>Subjective methods for setting priorities</td>
<td>The case study shows that postpartum women, indicated a notable difference between the disrespect and abuse they received at the facilities by their health providers before and after the study. Although this method is subjective, this study would be difficult to gauge through objective measurements which are not able to fully grasp important aspects of the study (i.e. observation of provider-patient interaction).</td>
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<tr>
<td>Valuing political and financial feasibility</td>
<td>The involvement of policymakers and strengthening ties between facilities and the community to improve accountability and governance was instrumental towards providing political and financial support towards the case study’s success. Health providers are a major interest group every country, so it is important that decision makers were cautious of not alienating them during the study to ensure willful participation.</td>
</tr>
</tbody>
</table>
Case Study 5: Prioritizing investments in innovations to protect women from the leading causes of maternal death (Herrick 2014)

**Abstract:** PATH, an international nonprofit organization, assessed nearly 40 technologies for their potential to reduce maternal mortality from postpartum hemorrhage and preeclampsia and eclampsia in low-resource settings. The evaluation used a new Excel-based prioritization tool covering 22 criteria developed by PATH, the Maternal and Neonatal Directed Assessment of Technology (MANDATE) model, and consultations with experts. It identified five innovations with especially high potential: technologies to improve use of oxytocin, a uterine balloon tamponade, simplified dosing of magnesium sulfate, an improved proteinuria test, and better blood pressure measurement devices. Investments are needed to realize the potential of these technologies to reduce mortality.

<table>
<thead>
<tr>
<th>Approach to Health Prioritization</th>
<th>How it Applies to Case Study</th>
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<tbody>
<tr>
<td>Valuing impact of health technologies</td>
<td>The organization in charge of the case study developed a prioritization tool that would capture each technology’s value proposition and potential for impact. This tool is useful because it can provide stakeholders, such as donors or governments officials, information on high-impact technologies that can help them choose the best way to use their resources for maternal health issues.</td>
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</table>
In this Investment Case, the main focus of the development partners was to “support in-country implementation and more equitable outcomes for [MNCH]” in the Asia-Pacific region. The methodologies used for the design of the study are based on social determinants and health equity-oriented approaches such as: problem solving workshops with key stakeholders and a decision-support model that estimates costs and impact. The case study leads used tools that were also used in the also mentioned in the Guidance Note,
the Lives Saved Tool (LiST) and Marginal Budgeting for Bottlenecks (MBB) tool. Some limitations of the study to note are that the models depend on quality of the data used, and since measurements such as distribution of causes of death are usually not available at a sub-national country level then estimates are likely to be affected.

Conclusion

Although the GFF is still new, we can see the results of facility and trust on the RMNCAH financing gap through current investment cases that are underway in low-income countries today. It will take a different array of health setting priorities in order to measure and determine which areas and/or groups are facing urgent health disparities. Due to the diverse expertise of the GFF’s partnership, (e.g. country representatives such as the Ministry of Finance, private sector and GFF partners) investment cases will be more inclusive, adaptable to the changes in the respective country’s political conditions and transparent. Now that we are entering a new era of investment cases and global financing facilities, the annex that was created for the GFF partners to encourage smoother communication and understanding of different types of health priorities, will not be the last type of tool created to help partners undertake the complex road of global health financing.
References:


every woman every child.


   http://doi.org/10.1186/1471-2393-14-10


   http://www.who.int/medicines/areas/priority_medicines/BP3_Approaches.pdf


27. World Bank Group’s Country Partnership Framework to Support Faster Implementation


The Investment Case is a tool that can be used to bring all diverse donors involved in a country’s development together under the same priorities and frameworks. The Global Financing Facility’s country-specific approach is will place all the GFF partners, including the national government entities (e.g. Ministry of Health and Ministry of Finance), on the path to attaining 2030 targets for their respective countries. The figure below shows how the donors can be united under an umbrella, in this case the Investment Case, and use the comparative advantages they have in order to achieve 2030 RMNCAH goals.

In the figure below, the outputs created through the Investment Case process are shown in order to give a common vantage of how a country’s Investment Case will be undertaken. Although donors and countries will be vary according to case, this approach will ensure that investments
will be targeted to high-impact interventions and adaptable to long-term goals. This methodology is also complementary to the Country Partnership Framework (Appendix B), which encompasses not only RMNCAH goals, but other national development priorities with monitoring and evaluation over a span of three to five years.

Figure 6: Progression of Investment Case Implementation (GFF: Country Platform Session, 2015)
**Appendix B: Country Partnership Framework (CPF) in conjunction with the Global Financing Facility**

**Overview:** The World Bank Group’s new approach to country engagement, the Country Partnership Framework (CPF), provides guidance through best practices to World Bank staff on how to support member countries. The new approach, which is replacing the Country Assistance Strategy (CAS), is meant to provide a “country-driven model more systematic, evidence-based, selective and focused on the goals of ending extreme poverty and increasing shared prosperity in a sustainable manner” (The World Bank, Country Strategies, 2015). The CPF works as a complement to the Global Financing Facilities’ Investment Case framework by allowing flexibility and adaptability of reproductive, maternal, newborn and adolescent health priorities within other financing priorities. The CPF will undertake certain tasks for the GFF, which will help to ensure quality assurance and continuing monitoring and evaluation (Figure 1).

The CPF process has four components: 1) the Systematic Country Diagnostic (SCD), 2) Country Partnership Framework (CPF), which draws on the SCD’s analytical work, 3) Performance and Learning Review (PLR) and 4) Completion and Learning Review (CLR). If required, the Country Engagement Note (CEN) is used instead of all four components, when the WBG and a country’s government are not able to develop a medium-term program. The CEN serves as a short-term country strategy. An example of an upcoming CPF program will start in 2016, between The WBG and the government of Bosnia and Herzegovina, where lessons learned and knowledge from the previous CAS will be used for the new CPF (refer to Box 1).

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Description</th>
<th>Contribution to Prioritization of Issues</th>
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<tr>
<td>• A Reference point for client consultation on priorities for WBG country engagement, meant to establish dialogue around high-impact goals and activities directed toward ending absolute poverty in a sustainable manner</td>
<td>• SCD is a diagnostic exercise between WBG staff and stakeholders to identify key challenges and opportunities</td>
<td>• SCD uses available data and analytic methods to identify the most critical constraints, and opportunities to reduce poverty and increase shared sustainable prosperity while considering stakeholders needs.</td>
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<tr>
<td>• SCD is a diagnostic exercise between WBG staff and stakeholders to identify key challenges and opportunities</td>
<td>• SCD will be conducted upstream of the CPF process in order to provide analytical foundation.</td>
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<td>• A SCD for every client country will be undertaken every 4-6 years.</td>
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<td>• The best possible analysis drawing on available evidence and identifying data and knowledge gaps.</td>
<td>• WBG staff will involve partners (private sector, gov’ts, researchers or institutions) in preparation of SCD along with citizen feedback.</td>
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<tr>
<td>• WBG staff will involve partners (private sector, gov’ts, researchers or institutions) in preparation of SCD along with citizen feedback.</td>
<td>• SCD will be prepared by WBG country teams, led by a Task Team Leader</td>
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<td>Purpose</td>
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<td>Contribution to Prioritization of Issues</td>
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<td><strong>Country Partnership Framework</strong></td>
<td>• An analytical report, built on SCD’s systematic and evidence-based analysis, that will provide “an integrated and selective [results] framework for WBG’s partnership with the country” (The World Bank Group, Partnership Framework, 2014).</td>
<td>• In order to prepare the CPF, the WBG uses the member country’s own development goals. Along with consultation from country stakeholders, the WBG uses findings from the SCD and the WBG’s comparative advantage to determine the CPF’s objectives for the country’s engagement program.</td>
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<td><strong>Performance and Learning Reviews</strong></td>
<td>• The PLR “identify and capture lessons; midcourse corrections [and] assist in building WBG’s knowledge base” (The World Bank Group, Country Strategies, 2015).</td>
<td>• The PLR gives the WBG country teams and member countries an opportunity to realign objectives and activities to the current constraints the country may be facing.</td>
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<td><strong>CPF</strong></td>
<td>• CPF is the central tool for the Management and Board in order to review and guide WBG country programs. • Every CPF is tailored according to a member country’s SCD, national development strategy and the WBG’s comparative advantage. • The CPF is prepared every 4-6 years but flexibility is permitted on timing due to country conditions (i.e. political cycle). • The CPF emphasizes on how a specific set of objectives are aligned with the priorities of the country’s national development program, SCD and WBG’s comparative advantages. • Expected lending and possible instruments of engagement are also indicated.</td>
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Completion and Learning Reviews

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<th>Purpose</th>
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<th>Contribution to Prioritization of Issues</th>
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<tr>
<td>• The CLR “identify and capture end-of-cycle learning to contribute to the WBG’s knowledge base” (The World Bank Group, Country Strategies, 2015).</td>
<td>• At the end of the CPF period, the team must complete a CLR which contains their assessment of the CPF program’s performance and the WBG’s performance in regards to the strategy.</td>
<td>• The CLR will be used to provide input for the new CPF, or CEN, in order to ensure lessons from the CPF is carried over to the next CPF.</td>
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<td>• The CLR are validated by the Independent Evaluation Group (IEG) (The World Bank Group, Framework Products, 2014).</td>
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Box 1: Country Partnership Framework (CPF) of Bosnia and Herzegovina for 2015-2020

Due to the past 20 years of violent upheaval, Bosnia and Herzegovina (BiH) has dealt with high unemployment rate of 27% and a poverty rate of 15% that has not changed since 2008. BiH has focused on reform efforts in order to rebuild the infrastructure that was destroyed by the war, establishing an economic framework and fiscal management that would encourage national economic stability, and an environment that would encourage private sector development and create jobs. In order to continue Bosnia and Herzegovina’s progress, the WBG and BiH developed a new CPF based on the previous Country Partnership Strategy (CPS) from 2012-2015 in order to carry over lessons learned and knowledge. The three main focus areas of the CPF were: “increasing public sector efficiency and effectiveness, creating conditions for accelerated private sector growth, and building resilience to natural shocks” (The World Bank Group, 2015).
Figure 7: The Roles the Country Partnership Framework performs within the GFF (GFF: Country Platform Session, 2015)