



## Optimising Global Financing Facility in Support of Every Woman Every Child (GFF) for Sustainable Impact

*We believe in a world where everyone has fair access to health, receiving the right health and reproductive services at the right time, and a future in which health systems develop and maintain their own skills to find solutions, so they can make the best use of finite resources for future generations of women and children. When experience and knowledge is shared, this builds a growing global platform of health expertise in which more countries can become agents for sustainable and scalable change. The International Decision Support Initiative (iDSI, [www.idsihealth.org](http://www.idsihealth.org)) is their partner on that journey.*

### Executive summary

iDSI can support the Foundation in playing a leading role to optimise GFF performance, drive scale, demonstrate impact, and ultimately enhance chances of GFF success. This should be achieved through providing the right kind of technical assistance (TA), beginning with boosting the appetite and capabilities of moderate engagement countries such as **Kenya, Malawi, and Burkina Faso**. iDSI can work with their governments to develop rational and implementable pathways of technology adoption – underpinned by evidence and conscious of budgetary and other constraints – for instance, through co-developing **evidence-informed, cost-effective clinical guidelines**, and **prioritised, measurable quality standards**, and supporting their policy and clinical implementation. These efforts can in term increase the value and impact of strategic purchasing and provider-payment mechanisms, and target HR and infrastructural development efforts at national and subnational levels.

The right kind of TA focuses on long-term sustainability and is plugged into policy and politics. iDSI has a track record of success from providing national governments and payers with **demand-driven** and **context-specific** TA, combining modes of engagement centered around **developing long-lasting in-country relationships and institutions**. Our approach will necessarily be dynamic, responsive to but also pre-empting country partners' changing needs over time as they make progress. We believe that iDSI's model of TA is best placed for strengthening local leadership, local ownership and local capacity, the necessary conditions for achieving sustainable impact.

#### **Box 1. How can iDSI help optimise GFF performance in Kenya?**

Kenya is a GFF frontrunner country with devolved healthcare to its 47 county governments. As part of GFF, Kenya has produced an RMNCH Investment Framework<sup>1</sup> identifying prioritized bottlenecks and a set of smart evidence-based interventions for scale-up, yet substantial gaps remain in implementation. For instance less than half of public providers nationally deliver correct treatment for post-partum haemorrhage. iDSI can help by:

- working in partnership with county governments and other local stakeholders (healthcare providers, hospital and PHC staff, civil society) to develop **quality standards** for key RMCNH interventions: setting out local priorities for implementation based on local datasets (e.g. maternal death registries), developing contextualised, measurable indicators describing high-impact care processes and investment needs.
- conducting **rapid budget impact analyses** based on local cost and disease burden data, from global sources where relevant (e.g. IHME); highlighting 'bad buys' that are cost-ineffective or unaffordable within the county context is as important as identifying best buys.
- aligning with the GFF's PHC strengthening component and national government-led efforts to ramp up UHC – where iDSI has received a direct request from the MOH Cabinet Secretary to support the **review of the Essential Package and the National Health Insurance Fund benefits package**, through embedding transparent and evidence-informed health technology assessment (HTA) processes to support more efficient technology adoption and ultimately sustainable UHC.
- interfacing and coordinating among government and development partners (including BMGF and WHO) in the UHC policy process, and between the national and county levels, ensuring convergence between national and county benefits packages and provider-payment mechanisms (e.g. procurement, pay-for-performance).

We will leverage our strong partnership with **KEMRI**, core-funded by the Wellcome Trust, drawing on KEMRI's local technical and political knowledge, and track record in developing evidence-based RMCNH guidelines for Kenya. We are committed to collaborating with the **National Institute of Public Health, Norway**, drawing on their HTA expertise specifically on GFF country implementation and providing a catalytic multiplier to the Foundation's efforts.

*"We look forward to a fruitful engagement and extend our gratitude to the Gates Foundation and the Department of International Development for their contribution to iDSI's work in Kenya." Mrs Sicily K. Kariuki, Cabinet Secretary, Ministry of Health*

## The need

TA for health systems strengthening is central to the GFF model. In implementing GFF programs, countries need to develop local capabilities to: prioritise best buy interventions including low-cost, high-impact technologies; establish pathways for adoption including cost-effective purchasing mechanisms; and optimise resource allocation accordingly.

In decentralised systems, national governments have a particular need to set standards and establish supportive mechanisms, and build robust M&E and management systems that can drive performance improvement and reduce disparities across states or counties. Local ownership and leadership at all levels is critical for long-term sustainability, and any TA needs to be highly context-specific and centered around strengthening these country-based capacities.

For countries developing a GFF investment case, they need to define a prioritised set of investments to meet pre-defined goals in terms of RMNACH. Prioritisation ensures that the most cost-effective investments are covered, and that resources are used more efficiently than compared to implicit prioritisation. However, the current prioritisation process underpinning investment cases is not standardised across countries, for instance in costing method or consideration of cost-effectiveness. Whilst this has allowed for flexibility on the part of countries and World Bank (WB) country teams, it also makes assessing appropriateness and quality of investment choices as well as fair comparisons between countries more difficult for funders (GFF and upstream funders such as BMGF). More consistency and transparency in how trade-offs are evaluated would better allow GFF funders to make more informed and target investments for maximum scale and impact.

## How iDSI can help

iDSI's will draw on our track record and broad portfolio of country TA work in strengthening health systems and institutions for more evidence-informed, data-driven priority-setting and provider payment mechanisms, in particular to improve the uptake and M&E of best buy interventions in RMNCH through guidelines and standards:

- **India:** we worked with a national health insurance scheme to cost out and introduce evidence-based reimbursement criteria to limit unnecessary hysterectomies<sup>1</sup> (Fig 1).
- **Kerala, India:** our work on WHO-guideline based standards for post-partum haemorrhage and training of healthcare providers to deliver them in practice<sup>2,3</sup> (see also Appendix) seeded further State-led efforts to establish standards for sepsis and reduction of infant mortality.
- **South Africa<sup>4</sup> and Thailand:** we have initiated work on quality standards for maternal health.
- **Myanmar:** we designed an impact evaluation framework to assess cost-effectiveness of the Maternal and Child Health Voucher Scheme<sup>5</sup>.

We also have a track record of working with funders to develop global standards for health economic evaluation underpinned by robust empirical methods and country experience – for instance iDSI has engaged with the Health Results Innovation Trust Fund at the WB (HRITF, the predecessor of GFF) on enhance the HTA process for developing performance indicators, as well as supporting the Foundation in developing the iDSI Reference Case for economic evaluation<sup>6</sup> in LMIC investments, and



The application of quality standards to **India's** national health insurance scheme (RSBY) could improve women's reproductive health; preventing unnecessary and potentially life threatening hysterectomy procedures on **17,500 women**, that will save money to buy almost **3 x the number of natural births**.

Figure 1. iDSI's impact in India

<sup>1</sup> <https://www.idsihealth.org/blog/work-in-india-at-central-level/>

<sup>2</sup> <https://www.idsihealth.org/blog/quality-standards-for-maternal-care/>

<sup>3</sup> Vlad I, Paily V, Sadanandan R *et al*. Improving quality for maternal care - a case study from Kerala, India [version 1; referees: 3 approved]. *F1000Research* 2016, **5**:166 (doi: [10.12688/f1000research.7893.1](https://doi.org/10.12688/f1000research.7893.1))

<sup>4</sup> <http://www.idsihealth.org/wp-content/uploads/2016/04/Maternal-QS-meeting-final-agenda.pdf>

<sup>5</sup> [https://www.gla.ac.uk/media/media\\_484836\\_en.pdf](https://www.gla.ac.uk/media/media_484836_en.pdf)

<sup>6</sup> <http://www.idsihealth.org/resource-items/idsi-reference-case-for-economic-evaluation/>

working directly with LMICs to apply and adapt it in their own health systems.

1. **Optimising GFF in BMGF moderate engagement countries.** In countries such as **Kenya** (Box 1), **Burkina Faso**, and **Malawi**, iDSI can provide context-specific TA to optimise and scale implementation and M&E of investment cases, through co-developing **quality standards for priority RMNCH interventions** with country stakeholders. Quality standards are underpinned by evidence-based clinical guidelines, provide clear and transparent definitions of what high-quality, clinically and cost-effective care looks like (see Appendix), and a means of translating evidence of clinical and economic benefit into the design of cost-effective performance indicators<sup>7</sup>. These can in turn be leveraged to improve coverage and uptake of priority interventions identified in GFF investment cases, and drive and track quality improvement – a major concern for Kenya and many LMICs – with iDSI providing targeted implementation support at the payment and provider levels where necessary (e.g. training of PHC staff) and ultimately drive progress in the GFF core indicators such as maternal mortality and under-5 mortality rates.
2. **Global public goods.** iDSI can work with BMGF and GFF to develop an **enhanced universal framework for the country investment case template** and **decision rules for funders**. This helps to ensure that investments are underpinned by and judged on robust health economics with explicit consideration of trade-offs. Such framework could follow the ‘principles-based’ approach of the iDSI Reference Case setting out the key criteria each with detailed methodological specification; these could then guide countries in collecting and providing the relevant information for the submission and inform downstream M&E. Key criteria will include:
  - *Outcome measures* – in addition to outcomes such as children/mothers’ lives saved that directly inform GFF core programmatic indicators, investment cases should illustrate trade-offs in terms of costs, budget impact, cost-utility (e.g. disability-adjusted life years [DALYs] averted), as well as equity and distributional impacts (such as out-of-pocket costs) where possible. This enables fairer, more meaningful comparisons to be drawn across the broad range of GF interventions within and across RMNCH and nutrition, and more importantly across countries and funders’ broader investments outside of those sub-sectors.
  - *Methods* for considering above economic considerations (cost, cost-effectiveness, budget, and equity impact) in prioritising interventions
  - *Data sources and tools* – relevant global and if possible national data sources. The use of tools such as LiST and Equist could help with understanding the health impacts of new investments or strategically select interventions based on the country context. Such tools have been used in some investment cases, and iDSI could providing guidance on their systematic use.

iDSI will engage closely with stakeholders throughout the process, including consultations with Gates teams, WB and other global partners, and relevant country stakeholders from existing and new GFF countries (including national and subnational policymakers, civil society). To optimise the process and to learn lessons that would inform future scale-up, we also propose to **pilot the new investment case framework with 1-2 countries** that are in the process of submission, identified through discussion with the Foundation and WB.

## How we work and why we believe in its lasting impact

The power of iDSI is in its ability to bring people together, mobilising global and national expertise and building lasting relationships in a country-led priority setting process. We provide demand-driven TA that is sensitive to local contexts, plugged into local policy and politics, and responsive to a country’s changing needs as it makes progress. This needs to go far beyond a fly-in/fly-out approach that characterises traditional consultancies, or only regional TA. There is no one-size-fits-all solution, and a combination of approaches is required including:

- country visits to engage in dialogues with and raise awareness among senior policy champions;
- targeted training workshops and ‘learning by doing’ coaching support to country teams on real policy decisions and policy-informing projects;
- embedding consultants and advisers within, and twinning with, LMIC partner institutions that are well-placed to engage with complex and fluid local relationships and politics;
- providing placements and post-graduate scholarships at iDSI partner institutions to develop LMIC-based capacity
- leveraging the expertise and resources of other development initiatives with aligned goals working in the same geographies to enhance scale of impact;
- convening of regional and global networks and events to foster South-South knowledge sharing and capacity development.

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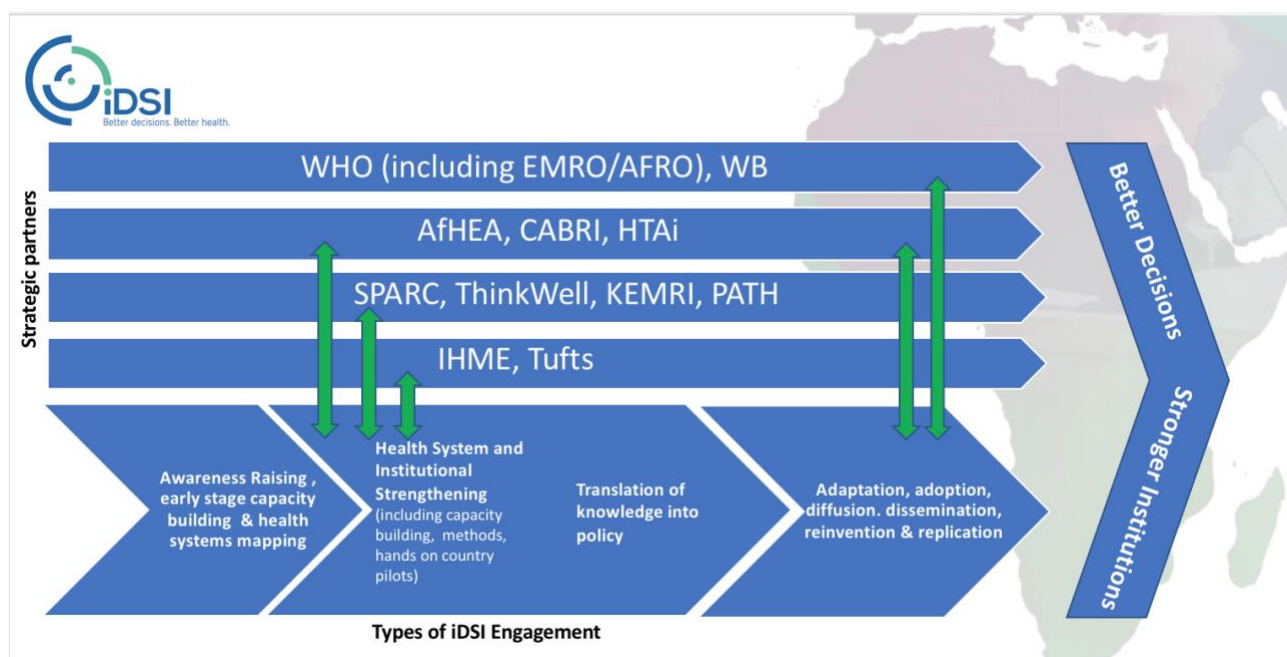
<sup>7</sup> The indicators used in the Quality and Outcomes Framework (QOF), the UK’s pay-for-performance scheme for PHC and the world’s largest, are derived from NICE clinical guidelines and quality standards developed through an evidence-informed process with cost-effectiveness as a central consideration.

We believe that sustainable impact is only possible when there is **local ownership, local leadership, and local capacity** to prioritise and adopt the interventions and technologies that generate the most health for the money. And we believe the best way to build truly country-based capabilities is by being **demand-driven, context-specific,** and through **building lasting relationships** with in-country partners.

### Global and regional strategic collaborations

How we collaborate strategically with global and regional partners particularly across sub-Saharan Africa will be critical to our approach. Key partners will include Gates-funded initiatives such as SPARC, Thinkwell, Joint Learning Network for UHC (JLN) Efficiency stream, WB, IHME, and identified regional intermediaries – to build long-term capacity, diffuse knowledge, and support countries with health systems and institutional strengthening, in particular among GFF countries (Figure 4).

- We have existing collaborations with development partners in the region including: CHAI, PATH, JLN/WB, WHO EMRO/AFRO and country offices
- On procurement, we have strong synergies with and are open to collaborating with SPARC and Thinkwell
- iDSI’s strong links with networks and regional intermediaries such as AfHEA, CABRI, HTAi, etc. create a powerful platform for the diffusion of best practice, both regionally and globally.



On the technical contribution, iDSI will draw on long-standing partnerships with the most renowned academic institutions in health economic methodology such as York University and LSHTM. In addition, we are committed to a new collaboration with the National Institute of Public Health, Norway as part of their NORAD application for core funding; this builds in integral support for GFF and will provide a catalytic multiplier to the Foundation’s efforts.

## Appendix

Example of a quality standard on preventing post-partum haemorrhage. From Vlad I, Paily V, Sadanandan R *et al.* Improving quality for maternal care - a case study from Kerala, India [version 1; referees: 3 approved]. *F1000Research* 2016, **5**:166 (doi: [10.12688/f1000research.7893.1](https://doi.org/10.12688/f1000research.7893.1))

<b>Contextualization of global evidence – Global guidelines and Kerala QS for active management of third stage of labour</b>	
<b>WHO recommendation</b>	<ul style="list-style-type: none"> <li>• The use of uterotonics for the prevention of PPH during the third stage of labour is recommended for all births.</li> <li>• Oxytocin (10 IU, IV/IM) is the recommended uterotonic drug for the prevention of PPH.</li> <li>• If intravenous oxytocin is unavailable, or if the bleeding does not respond to oxytocin, the use of intravenous ergometrine, oxytocin-ergometrine fixed dose, or a prostaglandin drug (including sublingual misoprostol, 800 µg) is recommended.</li> </ul>
<b>Kerala Quality Standard</b>	<b>Quality statement</b>
	Women who have given birth either vaginally or by caesarean are offered a bolus dose of Oxytocin, Ergometrine or Prostaglandin F2 Alfa at the time of delivery of the shoulder or within 1 minute of the delivery of foetus to prevent post-partum haemorrhage and to assist delivery of the placenta.
	<b>Definitions</b>
	Definitions of, e.g., “third stage of labour”, “active management of third stage of labour”, “Oxytocin”.
	<b>Quality Measure</b>
	<b>Structure:</b>
	a) Evidence of agreed guidelines or protocols in the hospital for the active management of the third stage of labour.
	b) Display of flow charts based on agreed guidelines, protocols or clinical pathways in the labour room.
	c) Evidence of availability of Oxytocin, Ergometrine and PG F2 Alfa at the place of delivery.
	d) Evidence of suitable storage facilities (refrigerator) for the drugs.
e) Evidence of equipment for measuring blood loss.	
<b>Example of process measure for vaginal deliveries:</b>	
Proportion of women giving birth vaginally who receive the Oxytocin, Ergometrine or PGF2 Alfa during third stage management of labour during the month (including numerator/denominator indicators).	
<b>Example of outcome measure for vaginal deliveries:</b>	
Proportion of women who experience an estimated blood loss equal to or more than 500 ml during and or following a vaginal delivery (including numerator/denominator indicators).	
<b>Explanations of what the QS means for each audience</b>	
Service providers, healthcare professionals, payers.	
<b>Data Sources</b>	
Data collection needs and procedures for the monitoring of the QS implementation (e.g., labour room register, monthly reporting forms to the NHM).	
<b>Source Guidance</b>	
Sources of global and local evidence used for the development of the statements and of the indicators.	