



Progress in Peril?

THE CHANGING LANDSCAPE OF GLOBAL HEALTH FINANCING

“Our review of the new global health financing landscape suggests that at least 24 countries are likely to face significant changes in their ability to access external funding to priority health areas in the next 5 years, and that unless those changes are proactively managed and coordinated, the human toll could be dramatic. Our ability to maintain the health gains of the MDG era and expand them to all people depends on how global health stakeholders manage this wave of simultaneous transitions”

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Cover Photo caption: Abeni, 4, receives the oral polio vaccine in Ungogo in Kano State, Nigeria.

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DEFINITION OF TERMS

GNI per capita: Gross national income (GNI) is the sum of value added by all resident producers plus any product taxes (less subsidies), not included in the valuation of output plus net receipts of primary income (compensation of employees and property income) from abroad. GNI per capita (p.c.) is GNI divided by the mid-year population. GNI per capita in US dollars is converted using the World Bank Atlas method which smooths exchange rate fluctuations by using a three-year rolling average, price-adjusted conversion factor. GNI per capita is used to determine economic growth and income classification for countries.

Multi-year commitments: Multilateral funding commitment covering the length of a country's comprehensive Multi-Year Plan (cMYP) or health sector plan, provided by a multilateral funder to a country receiving funds.

Health System Strengthening: The process of identifying and implementing the changes in policy and practice in a country's health system, so that the country can respond better to its health and health system challenges; any array of initiatives and strategies that improves one or more of the functions of the health system and that leads to better health through improvements in access, coverage, quality, or efficiency.

Health Financing: How financial resources are generated, allocated, and used in health systems. Health financing policy focuses on how to move closer to universal coverage with issues related to (i) how and from where to raise sufficient funds for health; (ii) how to overcome financial barriers that exclude many poor from accessing health services; or (iii) how to provide an equitable and efficient mix of health services

DTP3: A combined vaccine for Diphtheria, Tetanus, and Pertussis, DTP3 coverage rates are frequently used as indicators for overall access to immunization and access to a health system.

Millennium Development Goals: The eight international development goals for the year 2015 that were established following the Millennium Summit of the United Nations in 2000, and following the adoption of the United Nations Millennium Declaration.

Sustainable Development Goals: Officially known as "Transforming Our World: the 2030 Agenda for Sustainable Development" is a set of 17 "Global Goals" with 169 targets covering a broad range of sustainable development issues.

Bilateral Funder: A donor country that provides assistance directly to a recipient country government or to non-governmental institution operating in the recipient country. This aid is frequently managed by a government agency charged with this task.

Health System and Immunization Strengthening Support (HSIS): A framework developed by Gavi, the Vaccine Alliance, that came into effect in January 2017 that provides governing principles for Gavi investments in health systems strengthening. HSIS includes long-term health system strengthening support (addressing bottlenecks) as well as one-off grants or complementary allocations such as health worker training, which covers part of the operational cost of new vaccine introductions, campaigns and vaccine product switches.

EXECUTIVE SUMMARY

The global health landscape changed dramatically after the adoption of the Millennium Development Goals (MDGs) in 2000. New financing mechanisms were created to channel funding from high-income governments and philanthropists towards the most solvable global health challenges, resulting in dramatically improved health outcomes around the world. That success has made a new level of ambition possible—the Sustainable Development Goals’ (SDGs) commitment to health for all—and new approaches to health finance are possible as well, including scaled-up domestic investments by middle-income countries. Our review of the new global health financing landscape suggests that at least 24 countries are likely to face significant changes in their ability to access external funding to priority health areas in the next 5 years, and that unless those changes are proactively managed and coordinated, the human toll could be dramatic. Our ability to maintain the health gains of the MDG era and expand them to all people depends on how global health stakeholders manage this wave of simultaneous transitions.

The biggest shifts underway are the scaling up of middle-income governments’ investments in health, and the scaling down of external funding to a number of countries as donors refocus their allocations. While these trends could be steered to focus on health equity, if executed poorly they also put recent health progress at great risk.

As economies have grown in many low-income countries, governments increasingly face “transition”—the reduction of external financing typically over a period of two to five years, on the assumption that the government will then fully self-finance the health programs that had been supported by donor funds. This trend takes place within a context of greater competition for aid dollars, and declining interest by some countries in foreign assistance. Country-led, responsible transition can help to maximize health progress and sustainability, and allow scarce external resources to be targeted for greatest efficiency and impact. But transition can also pose serious risks to national budgets, health systems, and ultimately health outcomes. This paper examines risks, in particular, the widely overlooked risk of simultaneous transition, or multiple funders withdrawing from the same country over the same time period. The landscape of development finance is changing, and multilateral institutions and bilateral agencies must adapt.

ACTION, a partnership of locally-rooted organizations around the world that advocate for equitable access to health, is working to ensure that the changing global health landscape is designed and equipped to realize the full ambition of the SDGs. This study is part of our effort to better understand what global health stakeholders need to do to make that vision of health for all a reality. Our findings and recommendations to global health stakeholders are derived from mixed methods research. This included a review of available publications on transition; case studies of three countries based on qualitative interviews and desk research; an examination of published materials from financing agencies on eligibility criteria and transition frameworks; and qualitative interviews with staff from global health financing mechanisms.

SIMULTANEOUS TRANSITION: A THREAT TO ENSURING HEALTH FOR ALL

Using projections from the largest multilateral global health funders, Gavi, the Vaccine Alliance (Gavi), the Global Fund to Fight AIDS, Tuberculosis (TB), and Malaria (Global Fund), the Global Polio Eradication Initiative (GPEI), and the World Bank’s International Development Association (IDA), we found simultaneous transition is a major upcoming challenge in global health. Our report projects that 36 countries will likely transition from two or more multilateral health financing mechanisms in the next decade—24 in the next five years alone. Of these, seven countries are projected to transition out of three or more multilateral mechanisms in the next five years. None of the projections are definitive, as economic and policy changes, or fragility and instability, could change the timelines. Still, it is clear that the scale and immediacy of this trend demands more attention than the global health community has so far given to simultaneous transition. Notably, these projections exclude the compounding impact of transition from bilateral funders, who fund health programs in countries identified as high priority but without clearly and publicly defined eligibility criteria. Thus, we anticipate that the actual impacts of the shifting global health financing landscape on country budgets and health systems may actually surpass what we have been able to project from published data.

LESSONS FROM THREE COUNTRIES

We selected three countries in various stages of transition to conduct case studies that highlight the different realities and challenges of the transition process.

- **Côte d'Ivoire** has yet to transition from any multilateral mechanisms but anticipates increased co-financing payments and the beginning of the process in 2020. So far, discussions on transition in Côte d'Ivoire are only superficial, with the exception of the stakeholders working with Gavi on a daily basis. The fragility of the health system and the low prioritization of health in the national budget have been clearly identified as weaknesses, posing additional risks during transition. For Côte d'Ivoire, it will be essential to have a strong, harmonized, and costed plan created by a partnership of all relevant stakeholders to address transition.
- **Nigeria** currently faces accelerated transition from Gavi, as well as from the GPEI, although polio eradication efforts in Nigeria are ongoing; these transitions will take place roughly in the next five years. With low rates of DPT3 coverage already, immunization systems are especially at risk, as are surveillance and emergency response systems. In order to even maintain the current low levels of health coverage, a dramatic increase in financing at both the federal and state level must occur in the next 5-10 years to replace reduced external support.
- **Vietnam**, which is further along in transitioning, is poised to undertake simultaneous transition effectively, having achieved middle-income status, having reduced income poverty significantly, and improved overall population health standards. Nonetheless, limitations in health service delivery and governance could cause problems during transition, notably in protecting access for key populations served by donor-financed health programs.

While the realities of these three countries differ, we were able to draw some overarching conclusions. Our case studies found a significant lack of coordination and planning across funding mechanisms, and inadequate engagement with other critical stakeholders, including government and civil society. In fact, the research found that while multilateral institutions are already beginning to plan for transition, some stakeholders in civil society and government were either not aware or did not believe the transition process would move forward.

FINDINGS

With continuing unmet need and inequality in access to health, the overall pool of resources supporting health services for all people, especially those living in poverty and from marginalized groups, needs to continue to grow to meet the promise of the SDGs. This increased financing needs to come through significantly expanded domestic investments in health in low- and middle-income countries, but also through a continued commitment from high-income country governments and multilateral institutions to “leave no one behind.” World leaders have committed to “ensure healthy lives and promote well-being for all at all ages,” and this is the bottom line against which changes to the financial structures supporting health should be considered. The following findings and recommendations summarize how the changing global health financing landscape can best put people at the center, promote health equity, and avoid undermining recent health progress:

- **Strong Health Systems.** Successful sustainable transitions have demonstrated the critical importance of strong health systems, while the features of weak systems, including a lack of budgeting capacity, human resource shortages, and supply chain or infrastructure gaps, exacerbate transitions' risks. Solutions suggested by the literature and experiences in case study countries include ensuring greater investment in key elements of health systems, such as human resources, community and civil society engagement, and supply chains before a financing transition begins.
- **Strong Coordination at Country and Global Levels.** In our three case studies and across the available literature, we consistently found the need for strong, cross-sectoral stakeholder awareness, engagement, and planning in the transition process which takes into account the interrelated timelines, processes, and impacts of all donors planning to withdraw over a similar time period.

Where coordination has begun in an ad hoc fashion, it has improved transition planning; at both the country and global levels, however, stakeholders identified a need for more deliberate and formal coordination to take place.

- **Transparency and Predictability.** There is a growing consensus among global health stakeholders, based on the experience of countries that have already transitioned, that predictability and a long and sequenced timeline lead to more successful and sustainable transitions. Best practices for transparency include clear eligibility criteria, which most multilateral funders have but most bilateral agencies lack. Predictability ideally includes making projections of transition timelines available to all stakeholders well in advance.
- **Political Will and a Country-Driven Process.** The literature points to a lesson from past transitions: the most successful transitions have been driven by country ownership and proactive national government leadership. Stakeholders in the case study countries also saw a need for political will to guide the process. Unfortunately, we also found significant variations in knowledge among the government stakeholders interviewed and some instances of exclusion of government stakeholders from transition planning processes.
- **Post-transition Support and Safeguarding Health for Vulnerable Groups.** We found that while many stakeholders identified a need for post-transition support, such as funding for civil society or continued technical assistance, policies and processes have not yet been articulated by many funders, and donors themselves described this question as a “missing piece of the puzzle.” Particularly important during and after transition is ensuring the health of key populations, who have in some cases experienced rebounding rates of disease after transition has taken place.

RECOMMENDATIONS

All Global Health Stakeholders

- **Ensure High-level Political Alignment and Oversight at the Global Level.** All actors within the global health financing landscape have a responsibility to work toward the shared global goals of ending infectious disease epidemics, preventable child deaths, and other measures of achieving healthy lives for all. Mutual accountability among all stakeholders will only be possible if, at the highest political levels, the specific responsibilities around transition are articulated, monitored, and regularly reviewed. Governments in countries that will experience transition can and should be engaged up to the highest political levels in transition planning and ensuring that health service delivery is sustained. Political statements must be clear and visible, demonstrating governments’ commitments to protect and expand recent health gains. Civil society and community leaders must also be clear about their contributions to sustainable health financing. Similarly, high-income country governments must show leadership to ensure that political pressures to reduce aid do not result in catastrophic changes to health financing structures. Existing global platforms should be used to discuss the new landscape of global health financing, monitor the risks of simultaneous transition, and mobilize all stakeholders to respond to challenges as they arise.
- **Create Political Accountability for Protecting and Expanding Recent Health Gains.** The world has made tremendous health gains over the last twenty years, but these gains are directly threatened by the risks of uncoordinated or unsustainable simultaneous transition. Therefore, for the new global health financing landscape to succeed, there must be political rewards for investing in health for all, and political consequences if poor and marginalized people lose access to life-saving health services. Cross-party parliamentary caucuses, engaged media, and regional platforms like the African Union are all platforms that have provided such accountability for specific health priorities like HIV/AIDS and malaria, and could be used to bolster more sustainable approaches to transition. Civil society, in particular, should raise awareness and generate demand for sustainable health financing in addition to holding governments accountable for the commitments made at global and regional levels.

- Mitigate the Risks of Simultaneous Transition Through Comprehensive, Cross-mechanism Planning.** The importance of coordinated transition planning across funding mechanisms cannot be overstated, especially in the 24 countries we project could face simultaneous transitions in the next five years. With the bulk of these countries experiencing transition from Gavi and GPEI, there are particular risks to immunization programs, which draw support from both mechanisms. Funders need to work closely not only with the transitioning country governments and other critical stakeholders like UNICEF, the WHO, and civil society, but also with each other to ensure the full impacts of transition out of all mechanisms are understood, that adequate preparations are taken, and that transition planning and support is not duplicative or run in parallel. Even though the timing and duration of each funder’s budget and planning cycles do not align with each other, there is no reason why multi-year comprehensive transition planning cannot take multiple funders into account. Multilateral funders must participate in or establish, in close coordination with bilateral funders and governments, global and country level coordination mechanisms to facilitate this process across mechanisms, with the central goal of producing a comprehensive, costed transition plan cutting across all mechanisms.
- Safeguard the Health of Key Populations.** Stakeholders in Vietnam raised specific concerns on the sustainability of health programs for key populations, many of whom experience discrimination; evidence of past transitions, such as Romania’s loss of Global Fund HIV funding, demonstrate the risk to key populations posed by transition. We recommend that a specific strategy around safeguarding the health of key populations be developed as part of a comprehensive, costed transition plan developed at the country level. Specific strategies could include tactics such as joint cross-border/regional programming, including representatives of key populations on decision making and advisory bodies at global, regional, and country levels, and helping non-governmental stakeholders diversify their sources of funding to directly provide services to key populations.
- Create Space for Civil Society.** Civil society has a critical role to play in holding governments accountable for sustaining health gains, in reaching key populations, in mobilizing resources for health, and in service delivery. These roles are even more important through transition periods, and the full global health financing community should prioritize making space for civil society at decision making tables, and work actively to ensure that civil society remains strong and capable during transition periods, including through dedicated funding for nongovernmental stakeholders.
- Fill the Research Gap.** As the global health financing landscape continues to evolve, several areas of additional research and learning are particularly important to inform the transition process. This includes a comprehensive mapping of health financing at the national level in low- and middle-income countries—including sources and volumes separated by disease components and types of spending—to better inform transition timelines and activities as well as allocation decisions; research on the role of the private sector and innovative financing arrangements in transition; further analysis of the financial and programmatic impacts of losing preferential pricing and/or pooled procurement for health commodities; and reviews of the experiences of countries after simultaneous transition takes place.

Global Health Funders

- Change Eligibility and Transition Policies to Fully Incorporate Health and Sustainability Indicators.** Transition must not take place at the expense of human health, and this is why it is critical to factor health outcomes into decision making. ACTION recommends that funders currently using only economic criteria more fully incorporate key health indicators such as disease burden and disease risk into their eligibility policies. In the same vein, we recommend including sustainability benchmarks in the transition implementation process. Benchmarks can be fiscal, such as fulfilling co-financing obligations, or managerial, such as the development of a costed, comprehensive, cross-mechanisms transition plan. If a country fails to meet these benchmarks, the speed at which a country transitions must be slowed, or the targeted transition assistance it receives increased, until the benchmark is met. Benchmarks must be designed carefully to avoid creating perverse incentives for governments to under-invest in health systems.

- **Provide Targeted, Equity-Focused Post-Transition Support and Feedback Mechanisms.** Multilateral and bilateral funders should play a continuing role after transition. This can include targeted support such as negotiating continued access to preferential pricing and joint procurement, providing assistance for key populations, including through non-governmental service providers, and continuing to provide technical assistance for health systems strengthening. Monitoring of and learning from the transition experience should be institutionalized within and across global health financing mechanisms to ensure that health outcomes are not sliding backward and to influence how the global health financing landscape continues to evolve.

High-Income Country Governments

- **Improve the Transparency and Predictability of Bilateral Aid Programs.** High-income countries' aid agencies should create transparent eligibility policies, robust communication about transition, prolonged timelines for transition and clear guidelines for managing transition which take into account the plans of multilateral institutions and other bilateral donors. Lack of clarity around bilateral aid programs was one of the key findings of our analysis, and one that needs to be urgently rectified.
- **Use Roles on Multilateral Funding Mechanism Boards to Improve Policies.** Board representatives from high-income countries should push to modify eligibility and transition implementation policies and practices to prioritize sustainability and maintained health outcomes, including at the operational level of robust policy guidance and planning procedures. At all levels of policy and procedural guidance, boards should push for greater awareness of and coordination around simultaneous transition.

Low- and Middle-Income Country Governments

- **Lead the Coordination of Transition Efforts at National Level.** Governments should elevate or create a national coordination mechanism with the mandate, competence, and authority to manage and oversee simultaneous transition processes. It will be important to ensure that this mechanism—whatever form it takes—includes all relevant stakeholder groups: all relevant government agencies (including not only health ministries but also ministries of finance, planning, or local government agencies), representatives of funding agencies, nongovernmental technical partners, parliamentarians, civil society and affected communities. National-level coordination mechanisms should look at transition holistically, to ensure the impact of simultaneous donor withdrawal on the entire health system is assessed in context with all stakeholders.
- **Make Clear Commitments to Increase National Funding to Meet Priority Health Needs.** Particularly for health priorities where the government has drawn on external support for a significant proportion of funding, it is critical to make specific, time-bound, public commitments to increasing domestic funding. Additional ways to demonstrate movement toward sustainable domestic financing of health include meeting co-financing obligations, meeting the agreed-upon targets of the Abuja Declaration, and beginning the process early of identifying what additional revenue can be made available for meeting the health needs of the population.
- **Strengthen Health Systems and Improve Budgeting Practices to Begin the Process of Transition Preparedness.** Countries must begin the work of developing stronger health systems before the transition process begins. This should include filling vacant health worker positions, strengthening management capacity in the health system, and strengthening supply chains. Equally important are steps to strengthen the transparency and clarity of budget lines. The capacity of health stakeholders to project and articulate funding needs is particularly important to long-term sustainable financing.

INTRODUCTION: INVESTING IN GLOBAL HEALTH

During the Millennium Development Goals (MDGs) era, global cooperation produced impressive results: under-five mortality rates were cut in half; 37 million lives were saved by the global response to tuberculosis (TB) from 2000 to 2013; the number of people living on less than \$1.25 per day dropped from 1.9 billion in 1990 to 836 million in 2015.ⁱⁱⁱ This was a result of ambitious target-setting, economic growth, political prioritization, and smart investment in proven health interventions. Unprecedented investments flowed through global institutions including the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund), Gavi, the Vaccine Alliance (Gavi), the World Bank, product development partnerships, and other financing mechanisms.

Despite that progress, the launch of the 2016-2030 Sustainable Development Goals (SDGs) highlighted that far more must be done. Location, gender, religion, ethnicity, family income, and other demographic factors still determine who has a chance at a healthy life, and who does not, to an unconscionable degree. The SDGs reflect the shift in global focus from achieving broad improvements to health in aggregate to ensuring that everyone—no matter who or where they are—has equitable access to health. That commitment to “leave no one behind” demands the same level of transformative cooperation and investment as the MDGs were able to catalyze, sustaining and building upon past success. What can transformative global cooperation and investment look like today, with a focus on equity?

This paper seeks to understand the shifts already happening around financing for global health, assess the current and potential impacts of these trends, and recommend steps that governments, civil society, and global institutions can take to ensure even faster progress on health equity rather than abandoning or undermining progress made. We have examined a major threat to progress: the withdrawal of donor funding, which could derail even the best-laid plans.

Terminology and the Power of Framing

Transition: As used throughout this report, the term “transition” refers to the process of withdrawing donor funding from a certain country, with the expectation of replacement by domestic resources. Donors themselves have framed the process in this way, after in some cases originally describing the process as a graduation from assistance. While “transition” as a term implies a smooth and natural process whereby one source of financing replaces another, the withdrawal of key development funds is not necessarily either smooth or natural. Therefore, though we use the term transition, we point out that this framing masks the significant risks to global health associated with donor withdrawal..

Simultaneous Transition: As used throughout this report, “simultaneous transition” refers to the process of multiple donors that have supported global development programs withdrawing those funds from the same country within the same time frame. A country undergoing simultaneous transition is losing access to grants or highly concessional loan terms from two or more of the sources it has drawn on to finance the expansion of core public services, such as health, to all people. The term’s focus only on the timing of transition masks the fact that the funds being withdrawn are not merely concurrent, but often programmatically intertwined, meaning that withdrawal by multiple sources can have a negative multiplier effect on health systems.

GLOBAL HEALTH FUNDING IN TRANSITION

Governments that invest in global health are now trying to balance between conflicting goals: the principle of “leave no one behind” on the one hand, and the pressure to cut budgets or advance political or economic interests on the other. For almost all stakeholders in the global health financing landscape, political priorities, rationales for investment, and/or specific criteria have been developed to address that inherent tension. Many different rationales have all led to the same criterion being central to determining in which countries a variety of external global health funders will invest in health and development: a country’s GNI per capita. This means that as low-income countries experience economic growth, they will cross global health funders’ eligibility thresholds, triggering a transition from donor to domestic financing for health interventions.

Though plans for donor funding transitions and eligibility policies themselves are not new, in the last few years several global health funders have designed and driven more aggressive timelines and processes for withdrawal. New narratives around impact, sustainability and the ability to pay have also been used to justify donor withdrawal from middle income countries. That shift has been driven by several factors, including an important focus on sustainability and value for money, the growing pressures of climate change, population growth, conflict, and urbanization on other development priorities like health, as well as by aid fatigue in high-income countries.

This shift and its impact on the global health financing landscape are particularly clear when reading high-income countries’ aid strategies. For example, between 2011 and 2015, the United Kingdom (UK) government’s position was that the greatest impact and value for money could be achieved by focusing on a smaller group of low-income countries, which was one of the factors leading to a phasing out or change in the UK’s development partnerships with 18 countries.^{iv} In the same vein, the European Union’s (EU) development policy for 2014-2020, Agenda for Change, called for differentiated development partnerships in the context of “difficult economic and budgetary times.” This means focusing aid in partner countries where “it can have the greatest impact,” and removing grant-based aid from “more advanced developing countries already on sustained growth paths and/or able to generate their own resources.”^v

This trend illustrates that decisions are really about operating from a mindset of scarcity: even the dramatic scale-up of global health funding in the MDG era was not enough to fully meet global needs. Two interviewees from multilateral funders highlighted that eligibility and transition policies are linked to each replenishment and highly depend on the level of funding raised. Another interviewee agreed, stating that “thresholds are being developed because there’s not enough to go around.” This is a fundamental challenge: when the financing that is made available from domestic and external sources is insufficient to address the reality of health needs in low- and middle-income countries, what is the responsibility of the global community?

Evolution of Eligibility and Transition Policies: Gavi, the Vaccine Alliance

Since the launch of the initiative, Gavi has embraced the concepts of sustainability and transition alongside the priorities of equity and access. Gavi’s approach to sustainability and transition has evolved to respond to changing conditions. Beginning in 2011, Gavi’s establishment of \$1500 GNI per capita eligibility threshold, to be updated annually for inflation, resulted in a rapid increase in the numbers of countries entering a formal transition process: 16 countries started the process in January 2012, compared to only 4 total that transitioned from Gavi support between 2000 and 2010.^{vi} Recognizing a greater need for a large number of countries to appropriately prepare for and adjust to gradually increasing self-financing, the Gavi Board reviewed and updated its approach to transition, adopting a new Eligibility and Transition Policy in June 2015.^{vii} The updated policy focused on making transition smoother and giving countries more guidance and clarity about when and how financing will change.

The revised approach uses a 3-year average of GNI per capita for the eligibility threshold, rather than single-year measures; initiates transition preparedness support as early as possible, before a country reaches the eligibility threshold; and recognizes that sustainability is programmatic as well as financial.^{viii} An exception to the hard economic eligibility threshold was also added: countries whose 3-year average GNI per capita is above the threshold, but whose growth has not translated into Penta3 coverage above 90 percent can remain eligible for two additional years of support.^{ix}

PROGRESS IN PERIL?

One of the reasons transition puts progress at risk is the interdependence of health systems on the programming and financing of multiple external funders. This use of multiple funding sources to advance a country's health and development agenda has made it possible to expand access to health, particularly to traditionally marginalized and excluded people. However, this also compounds the potential for transition to disrupt the delivery of health services and derail future health progress. Since many of the funding streams are governed by similar eligibility criteria, low-income countries' growth can trigger a succession of multiple multilateral and bilateral donors withdrawing funds over a short period of time, creating major threats to sustained health gains.^x Even if each mechanism is approaching transition in a careful and well-justified way, without awareness of the potentially compounding impacts and close coordination to mitigate them, simultaneous transition poses a significantly higher risk to health progress than many stakeholders yet realize.

In some cases, middle-income country governments are genuinely in a position to support universal health coverage with reduced external support, and are guiding sustainable transitions. But it is also essential for bilateral and multilateral funding agencies to adopt policies which assess relevant economic and social factors and institute processes which facilitate—rather than undermine—the maintenance or improvement of services for all people. All stakeholders in the global health financing landscape must recognize that transition is not inevitable; it is political. Indeed, political pressure on high-income country governments to reduce or reallocate aid often drives the decision to withdraw global health financing from places and people who still do not have access to the same basic health services as their neighbors around the world.

In our examination of transition, we therefore start from the more fundamental questions about what the roles of low-, middle-, and high-income country governments, multilateral institutions, and other stakeholders, including civil society, should be in the changing global health financing landscape. We ask how global health financing could be reframed to put health equity and universal access to health at the core of political decisions about development finance. We identify the risks posed by simultaneous transition in its current form, and recommend a different path forward. The recommendations distilled from that analysis are intended to help policymakers navigate the changing health financing landscape.

METHODOLOGY

The analysis presented here is based on a mixed methods research design, to give us the fullest possible picture of the risks and challenges of simultaneous transition. We relied on two main methods: qualitative analysis (interviews and desk research) in three countries to produce case studies illustrating the complexity of transition, and a literature review to synthesize best practices and lessons learned about transition as documented in academic literature and materials produced by multilateral institutions, NGOs, journalists, or other sources. Additionally, in the Structure and Scope of Simultaneous Transition section, we examined what documentation exists on the processes by which Gavi, the Global Fund, the Global Polio Eradication Initiative (GPEI), and the World Bank Group's International Development Association (IDA) plan to withdraw funding from the countries where they currently fund programs. Each of these methods is described briefly below, and explained in full in the Methodology Annex.

Review of Transition Frameworks: To compare the different eligibility and transition frameworks determining which countries receive donor funding, we reviewed the eligibility criteria published by multilateral funding institutions themselves. We then used each funder's publicly available guidance on eligibility and transition to chart when different funding mechanisms are projected to withdraw from countries that are currently funded. We chose to analyze multilateral funding institutions because they have publicly available data on projections of country transitions, and clear eligibility and transition policies; bilateral funding programs have not been included in the analysis of the scope of simultaneous transition because of the closed nature of their funding decisions. We selected Gavi, the Global Fund, GPEI, and IDA for review because they are the four largest multilateral institution funders of global health programs. While our analysis builds this review of currently available projections from the institutions themselves, we recognize that with economic and disease burden changes happening continuously, this is only a projection and subject to change.

Qualitative Interviews with Funders: We interviewed 12 stakeholders working for global health funding organizations for perspectives on the differences between policies, processes, institutional structure and implementation.

Case Studies: For the country case studies, we first used a selection methodology to identify three countries that would best inform our analysis. We focused on selecting countries that represented different stages of transition, different geographic regions, and differing challenges. This process identified Côte d'Ivoire, Nigeria, and Vietnam for our case studies. Interviews were conducted with 10-15 stakeholders in each country, representing civil society, policymaker, technical agency leadership, and donor perspectives. All case study interviews were semi-structured, guided by a standard questionnaire developed by ACTION. The case studies were further supported by desk research into each country's political and economic situation.

Literature Review: The literature review was conducted between February and April 2017 and relied on searches from a variety of databases and journals. An array of search terms related to the changing global health financing landscape, including "transition" and "graduation," along with the names of multilateral institutions are included in this analysis, as well as vertical intervention areas, such as "vaccines" or "HIV." We focused on literature that drew out potential implications of transition on health systems, budgets, and programs. The literature review primarily informed the findings and recommendations sections of this paper.

STRUCTURE AND SCOPE OF SIMULTANEOUS TRANSITION

Multilateral global health funders have developed policies on transition, which govern the gradual phase out of funding from countries that no longer meet the donor’s definition of eligibility. Drawing from the current policy documents available publicly, and from interviews with officials from targeted institutions, this section compares the policies of the largest global health financing initiatives. In a context where 24 countries may face simultaneous transition in the next five years, the following analysis highlights some of the different frameworks governing transition, how the processes around transition have shifted over time, and what risks and opportunities this new landscape presents.

One of the central risks which receives little attention among global health financiers currently is how simultaneous transition may undermine each financing institution’s individual assumptions about how health services will be maintained after its funds are withdrawn. While transitioning country governments should and must plan for how to replace multiple streams of funding, the funders themselves should also prepare for transition with a global view on the overall impacts to health financing, ensuring the sustainability of service delivery. More support from and coordination among funders will be needed for countries facing simultaneous transition than if transition were solely a process between one funder and a country receiving support. Financing institutions will need to manage transition support and coordination across many countries at the same time – the number of countries transitioning over the next decade being much larger than in the last 20 years. There are significant risks to health posed by transition if it is not country-driven and sustainable: the level of risk and potential impact is higher in countries facing simultaneous transition. The additional burden of simultaneity and the acute need for strong coordination at the country level is often overlooked.

RATIONALES FOR TRANSITION

The rationale for transition helps to explain the structures that are created to implement it. The withdrawal of external support from a government’s efforts to expand health access is an inherently political decision, generally resulting from an effort to make the biggest impact on health equity and promote sustainability within a set—and often limited—pool of resources. Though transition may be justified in many ways and some agencies may not see budget constraints as driving decision-making, in all cases transition is taking place against a backdrop of scarcity: the resources currently devoted to providing equitable access to health and ending the burden of preventable and treatable infectious diseases remain insufficient globally.

Rationales for transition include:

- **An Initiative Has Achieved its Goal:** One logical reason for withdrawing funding is the closure of a program that has reached its objective. For instance, when polio is eradicated, GPEI will cease to exist as a channel for funding and technical support. In Afghanistan, Nigeria, and Pakistan, the remaining endemic countries, GPEI is planning progressive withdrawal of resources, with a more rapid draw down planned in the other countries where GPEI currently operates.^{xi} Based on that rationale, the structure of transition for GPEI is focused largely on winding down programming and transferring relevant program assets to other health programs, especially in the 16 GPEI priority countries.
- **An Organization is Established to Serve a Particular Group of Countries:** Institutions or donor agencies may also leave a country because they have a specific mission that determines country eligibility for funding. This is the case with IDA, “the part of the World Bank that helps the world’s poorest countries. Overseen by 173 shareholder nations, IDA aims to reduce poverty by providing loans (called ‘credits’) and grants for programs that boost economic growth, reduce inequalities, and improve people’s living conditions.”^{xii} As countries’ GNI per capita increases, they cease to fit the focus on “the world’s poorest countries” and therefore lose their eligibility to the concessional window of IDA and instead transition to borrowing as needed from the World Bank Group’s International Bank for Reconstruction and Development (IBRD), a lending mechanism with less concessional terms.

- Funding that is viewed as “catalytic,” or intended to fill a gap in health services until a government builds the fiscal space and health system infrastructure to sustain progress, is typically focused on the greatest need. This is the case with funders like Gavi and the Global Fund, whose eligibility and transition frameworks seek to target their available funds to countries that have a high burden of disease, low income, or both, while incentivizing partner governments to invest more domestically.

MULTILATERAL FUNDERS’ TRANSITION FRAMEWORKS

Eligibility

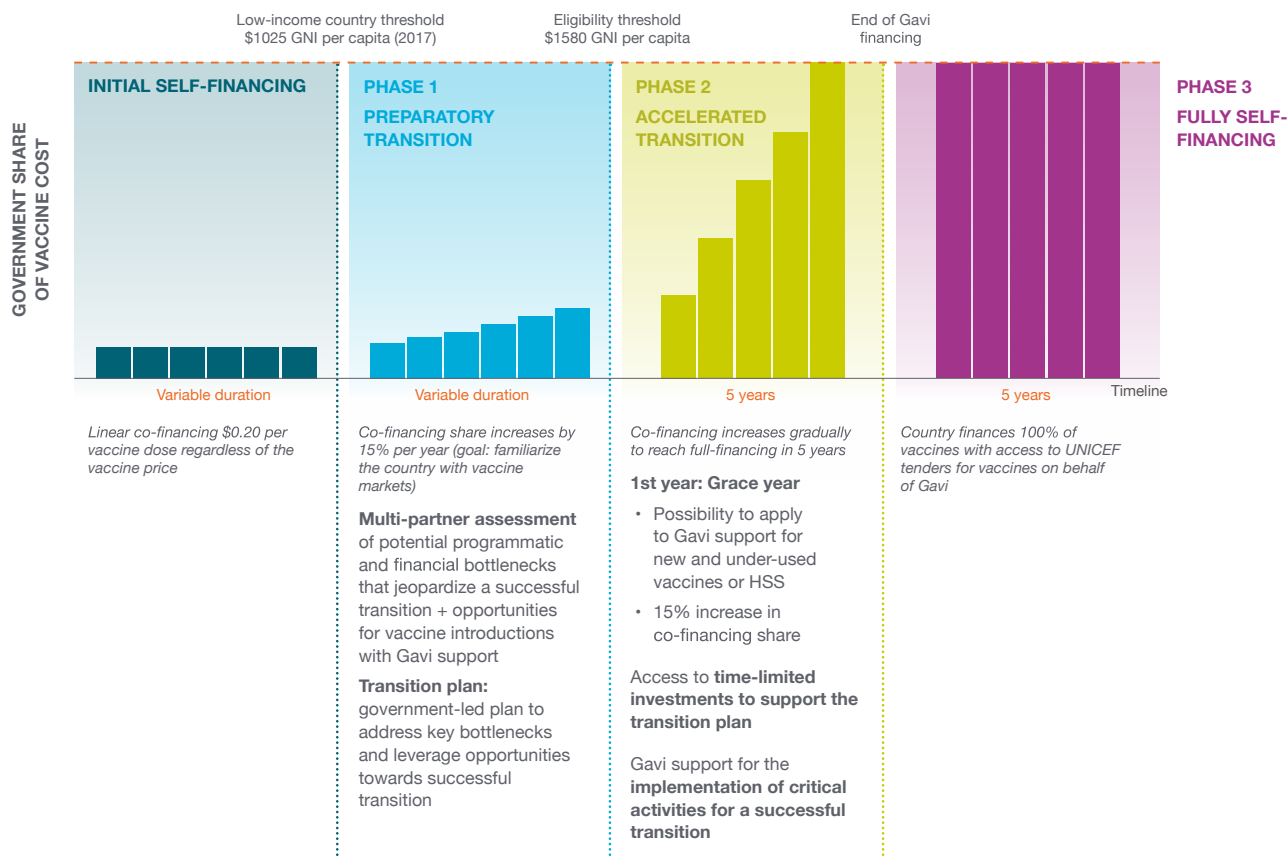
The major multilateral funding institutions investing in global health have specific, published eligibility criteria. In countries that meet these criteria, governments, and in some cases non-governmental partners, are able to apply for and access funding support. The majority of criteria are similar and heavily based on country income. With narrow exceptions, Gavi and IDA use GNI per capita as their primary eligibility criteria, with thresholds of \$1,580 and \$1,165, respectively.^{xiii,xiv} The Global Fund’s economic thresholds are further along the development continuum: reaching \$2,480.50 triggers the beginning of transition preparation and reaching \$3,946 GNI per capita means that a country is only eligible for a transition grant, which exclusively funds transition activities for a period of three years.^{xv} Though the eligibility criteria of the major multilateral global health funders use GNI per capita as an indicator of a government’s readiness to fully fund health services for its population, multilateral institution representatives we interviewed indicated that they recognize that the use of this indicator is problematic and does not capture the complexity of each country’s situation.

To varying extents, disease burden is also used to determine eligibility, most significantly for the Global Fund and GPEI. This can result in countries with higher GNI per capita continuing to receive funds, or in grant amounts decreasing significantly before a country crosses a GNI threshold. Interviewees from two multilateral organizations insisted that eligibility thresholds determined by Gavi and the Global Fund are very different from one another and that few countries would experience withdrawal from both at the same time, with Gavi expected to withdraw funding first. While Gavi’s thresholds are indeed much lower, funding reductions from Gavi and Global Fund during similar timeframes are possible because Global Fund allocations respond to disease burden as well.

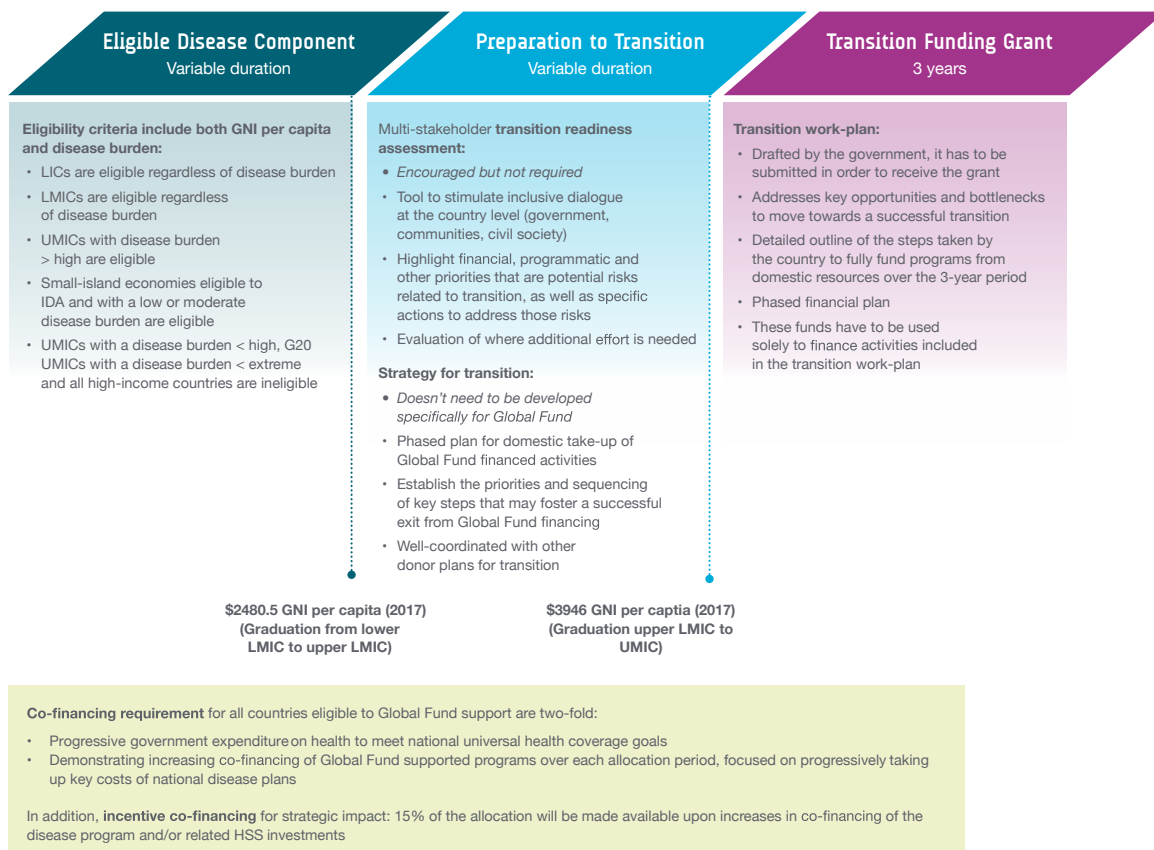
The following charts and text boxes set out the key features of each institution’s eligibility policies, and show how these policies can overlap.



Gavi, the Vaccine Alliance



Global Fund

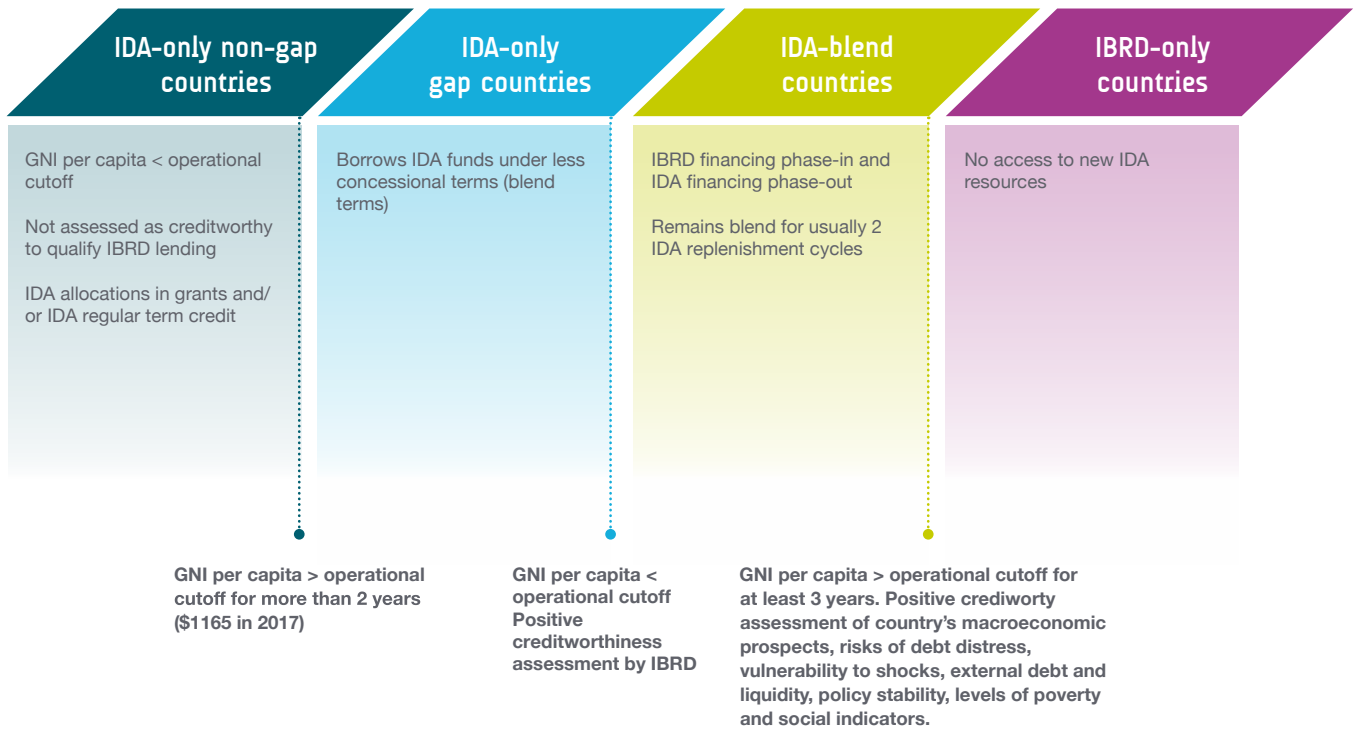


Transition After Eradication: GPEI

GPEI is unique among multilateral global health institutions, designed as much as a program delivery mechanism as a means of pooling funds. With a mandate to eradicate polio, the location and budget of GPEI's programs are determined by disease burden and response protocols, rather than by countries' GNI per capita. Polio remains endemic in three countries: Afghanistan, Nigeria, and Pakistan; GPEI also currently assists surveillance and immunization programs in 13 countries that have recently eliminated wild polio transmission, and supports regional immunization systems work in far more countries. When polio is eradicated—which will be certified by the World Health Organization (WHO) after three years pass without the detection of wild polio virus transmission anywhere in world—GPEI's mission will be complete, and its programming as currently managed will conclude. GPEI is developing a Post-Certification Strategy (PCS) with programmatic and technical standards for polio-related activities at least 10 years after certification. Based on the PCS, decisions will be made about any post-GPEI governance and monitoring structures to oversee ongoing polio essential functions.

If current projections for polio eradication hold, GPEI's programming will conclude in the next three to four years. The impact of GPEI wind-down will be significant: currently, GPEI channels about 90% of its US\$1 billion per year budget into the health systems of 16 priority countries and the partners, including WHO and UNICEF, who deliver services. GPEI is housed at WHO and GPEI funding makes up 27 percent of the WHO's overall budget.^{xvi} Additionally, polio funding supports 14 percent of all WHO staff positions, and in some WHO country offices, up to 70 percent of staff.^{xvii,xviii} Those human resources—individuals skilled in community outreach, communications, disease surveillance, program management, logistics and supply chain management, and more—currently make and could continue to make significant contributions to other areas of health after polio eradication, but their future is uncertain. There is a risk that GPEI's scale down will decimate staff capacity at WHO, unless funding currently routed through GPEI is instead invested by donors into scaling up other WHO functions.^{xix} There are significant risks to the sustainability of routine immunization programs in countries that will experience transition from both GPEI and Gavi. There are additional risks that emergency management capacity will be depleted or that disease surveillance programs currently supported 'in kind' by GPEI, such as measles, neonatal tetanus and yellow fever, could cease to function in some countries. A 2017 World Health Assembly report on polio transition planning found that "of the 146 polio laboratories, 122 (84 percent) are accredited in the measles and rubella network and are at risk of being dismantled when polio resources decline... At the present time, 2500 polio-funded individuals are supporting measles and rubella surveillance."^{xx}

Because GPEI's transition is expected to take place rapidly and include both funding and programming, its impact will look different from other donor withdrawals. The impact could be particularly acute in countries like Nigeria and Pakistan, where GPEI's withdrawal may fall at the same time as other transitions, especially Gavi. GPEI has already begun transition planning, including through the PCS and through 16 country-specific plans, and this is a critical first step. However, more needs to be done to coordinate this transition with governments, with other multilateral funders, and with other stakeholders including civil society to ensure that the incredible success of polio eradication is not marred by a downturn in routine immunization, surveillance, and health service delivery



Transitional Support

- IDA17 graduating countries (Bolivia, Sri Lanka and Vietnam) will receive exceptional support during IDA18 on IBRD leading terms in the amount of 2/3 of the resources that these countries received in IDA17.
- The Accelerated Payment Clause was also suspended.
- A longer-term transitional support policy will be discussed during IDA18's Mid-Term review.

Flexibility and Predictability

Beyond eligibility criteria, multilateral institutions need policies—formal or informal—to guide the transition process itself. Current transition frameworks differ in how they approach two key factors of transition implementation: how clear and predictable the timelines and stages are, and how much flexibility or adaptability is built into the process. Strong predictability allows governments and civil society in transitioning countries to have greater knowledge of the expectations and risks and a clear timeline for transition planning. Flexibility in the application of eligibility thresholds or in the forms of transition support provided can allow for the pace and timeline of transition to change in response to unforeseen challenges while avoiding the moral hazard dilemma that more lenient eligibility thresholds might create. A policy with too much flexibility might remove the incentives for low and middle income country governments to increase domestic investments in health, since they could lean on external funders to continue their funding; a policy with too little flexibility could punish citizens whose government does increase health spending but then faces an unforeseen budget crunch. In some instances, for example, countries have been exempted from starting transition due to special circumstances, such as conflict or fragility.

Summary of Multilateral Transition Frameworks

We have compared the different major multilateral funding mechanisms' transition frameworks here:

	Gavi, the Vaccine Alliance	The Global Fund	GPEI	IDA ^{xvi}
RATIONALE FOR TRANSITION	Mission to support immunization, especially introduction of new and underutilized vaccines, in low-income countries.	Rationing based on amount of donor funding and increase of economic growth in countries with high burdens of HIV, TB, and malaria.	End of program – eradication of polio.	Mission to only support low-income countries.
ELIGIBILITY CRITERIA	Economic = GNI per capita < \$1,580 on average over the past three years (2015). ^{xxii}	(1) Economic = GNI per capita as determined by the World Bank, and (2) Disease burden classification ^{xxiii} Allocations are made every 3 years. ^{xxiv}	Eradication status will determine when to begin conversations about transition. For endemic countries, dialogue around transition is encouraged, but should not distract from eradication efforts. ^{xxv}	Economic = (1) absence of creditworthiness, and (2) concept of relative poverty, measured by GNI per capita < \$1,215 for FY16.
FLEXIBILITY	Countries experiencing a rapid single-year increase in their GNI per capita and with a Penta3 coverage estimate below 90% will remain in phase 1 for two additional years. Possibility to Regain Gavi-eligible status if subsequent to entry into Phase 2 a country's 3-year average GNI per capita falls below the threshold amount. ^{xxvi}	Flexibility for Challenging Operating Environment countries and for ineligible countries where the political context is identified as a barrier to service provisions for HIV/AIDS (NGO rule). Possibility to regain Global Fund-eligible status if drop in GNI per capita or disease burden for 2 consecutive years. ^{xxvii}	Difference of ramp-down pace spending on epidemiological and programmatic risks.	Possibility to regain IDA-eligible status. Graduation to IBRD-only is also assessed by a country's "macroeconomic prospects, risk of debt distress, vulnerability to shocks, external debt and liquidity, political stability, levels of poverty, and social indicators," giving the Bank additional flexibility in IDA to IBRD transition.
PREDICTABILITY	The World Bank's Low-Income Country threshold, set at < \$1,005 for FY18, helps distinguish between the classification of initial self-financing and preparatory transition, which alerts Gave to countries that are on their way to passing its eligibility criteria for transition. A 3-year average of GNI per capita as a threshold is used to avoid sudden changes in eligibility status. Transition projections are provided publicly and annually. ^{xxviii}	A 3-year average of GNI per capita as a threshold is used to avoid sudden changes in eligibility status. Transition projections, based solely on income are updated annually based on available data. ^{xxix}	As all countries will be transitioning due to the expected eradication of polio, transition planning will be country-led with support from GPEI and should be in line with national priorities for health. GPEI will support transition plans by providing technical assistance, guidelines for asset mapping, simulations, business case development, and may provide funding to execute the national transition plans. ^{xxx}	GNI per capita and creditworthiness need to be able the threshold for IDA for 3 consecutive years before graduation to IBRD. ^{xxxi}
TIMELINE	Long timeframe of variable duration for initial self-financing and preparation phases, 5 years of accelerated transition phase, and 5 years of access to UNICEF tenders. ^{xxxi}	Short timeframe: 3 years, i.e., one replenishment period. Co-financing requirements are based on a country's income status. Once a country maintains its income status for 3 years, transition funding is available for up to one allocated period as soon as a country reaches ineligibility. ^{xxxiii}	Short timeframe, 2-5 years, although eradication status determines the length and intensity of the transition plan. GPEI recommends preparing for transition at least 12 months prior to execution of the national transition plan, and having transition plans ready to execute no later than 12 months from the date of last detectable wild polio-virus case. ^{xxxiv,xxxv}	Variable timetable: Countries typically move from IDA-only non-gap to IDA-only gap, to IDA-blend, and then graduate to IBRD-only status. On average, countries remain in blend status for approximately 2 IDA replenishment cycles with graduation at the end of replenishment cycle.



BILATERAL FUNDERS' TRANSITION FRAMEWORKS

Bilateral funding agencies operate significantly differently than multilateral funding mechanisms. These global health funders either do not have eligibility, transition, and/or sustainability policies or their policies exist but are not made public.^{xxxvi} For example, although DFID does not have a publicly articulated policy governing transition, it has transitioned out of certain countries and developed a strategy to ensure that it is delivering greater “value for money” in the context of transition. The “value for money” approach is based on case studies of live or recently completed transitions’ value for money considerations (staffing, estate planning for infrastructure, exit plans, etc.), and desk reviews of country exit plans, when available, for value for money data.^{xxxvii} This analysis of transition activities and expenditures is conducted to determine what is driving costs to obtain the desired quality at the lowest price while improving poor people’s lives.^{xxxviii} DFID implemented this approach when it transitioned aid funding entirely from Burundi between 2010 and 2012.

Other bilateral funders have stronger methods of ensuring sustainable transition out of their programs even without eligibility policies. The President’s Emergency Plan for AIDS Relief (PEPFAR), for instance, creates five-year sustainability plans with each partner country, and refers back to its own country-specific Sustainability Indices and Dashboards to help inform investment decisions.^{xxxix} This helps to ensure sustainability around programming. Unfortunately the continuity of PEPFAR funding levels and timeline for transition are not entirely predictable, as funding is awarded annually through the Country Operating Plan (COP) process.^{xi}

Overall, receiving funds from bilateral donors is less transparent and less predictable for low- and middle-income country governments than partnering with a multilateral funding institution. For instance, when the Australian Government reduced overall official development assistance (ODA) by \$AUD1 billion, or 19.5 percent, in the 2015-2016 fiscal year, the Department of Foreign Affairs and Trade (DFAT) had only six months to implement and negotiate reductions in country programs, which were severe for some regions; in Southeast Asia, the average annual cut in country allocations was 38 percent.^{xii}

SCOPE OF SIMULTANEOUS TRANSITION

Using transition projections included in public documents, we found that 24 countries will likely face simultaneous transition, defined as the withdrawal of funding from more than one of the four most significant health financing mechanisms in the next five years—and another 12 countries within ten years. While the available projections are all subject to change, the conservative assumptions in our estimate make this more likely an under- than overestimate of the scale of the shifts we will see in global health financing in the next decade. If nothing changes, seven countries could simultaneously transition from three or more mechanisms, including Nigeria and Pakistan. The most common simultaneous transition scenario is the gradual withdrawal of support from both Gavi and GPEI; the transition from IDA concessional loans to IBRD funding is the most common additional shift. This is an astonishing number of countries at immediate risk of losing their ability to maintain and expand health access: of the 79 countries receiving aid from at least two of the four multilateral financing mechanisms we studied, 30 percent face simultaneous transition.

Despite this scale, senior officials from multilateral institutions who were interviewed varied in their opinions on the seriousness of simultaneity as a challenge. This issue is also a gap in the transition literature: we found no studies that examined simultaneous transition in depth. This gap is likely due to the fact that simultaneous transition has so far been rare, and because the overriding approach to transition is siloed, with each funder focusing on itself. The majority of interviewees at the global level, as well as the majority of those aware of transition at the country level, identified the need for a comprehensive mapping of health financing—including sources and volumes separated by disease components and types of spending—to better inform transition timelines and activities as well as allocation decisions.

As elaborated above, bilateral financing institutions generally offer less transparency and predictability around transition. Because of the lack of clarity around eligibility and transition from these mechanisms, we were unable to include bilateral funding mechanisms in our mapping of simultaneous transition. The findings below, drawn entirely from the major multilateral funding institutions, thus are an under-estimate: it is extremely likely

that more countries will actually experience simultaneous transition, and it is likely that some of the countries listed below will actually experience transition from more mechanisms than represented. For each individual country, this mapping is more illustrative than definitive; it represents a snapshot in time, based on currently available projections, which will certainly continue to change as economic and political conditions fluctuate. However, in aggregate it provides a valuable—and striking—sense of the massive scale of simultaneous transition. With 24 countries at risk of simultaneous transition in the next five years, the global health financing landscape is at a critical turning point.

Methodology for Simultaneous Transition Projections

The following chart shows the 24 countries we project are at risk of simultaneous transition in the next five years, with yellow and red stamps indicating countries our methodology identified as at risk of transition and green stamps indicating continued eligibility. We recognize that uncertainties in economic growth, potential policy changes, instability or fragility, and flexibility within transition frameworks make definitive projections impossible, and have had to make assumptions in order to construct an overall picture: for example, we have elected to use IDA’s “blend country” status as a criteria for inclusion in the table below, but recognize that some of these countries will transition out of “blend country” status over a longer timeframe. Additional information about the chart below, and the policy documents and assumptions on which it is based, can be found in the Methodology Annex.

Using the same methodology, we would project an additional 12 countries to face simultaneous transition within the next 10 years: Bangladesh, Bhutan, Djibouti, Egypt, Ghana, Guyana, Honduras, Kosovo, Lesotho, Mauritania, Nicaragua, and Zambia.



Credit : Tom Maguire

Countries Likely to Face Simultaneous Transition in the Next 5 Years

This table lists the 24 countries our analysis indicated are likely to transition from at least two of the four financing mechanisms represented here in the next five years; for more information on specific country designations please refer to the Methodology Annex.

● Eligible for funding, not yet transitioning
 ● Projected to begin transitioning; In early stages of transition
 ● Transition already underway or close to completion

Country	Region	Gavi Transition Status (2017)	Global Fund Transition Status	IDA Transition Status	GPEI
ANGOLA	Africa	PHASE 2	ELIGIBLE *	not eligible	PRIORITY
ARMENIA	Europe and Central Asia	PHASE 2	ELIGIBLE	not eligible	not eligible
BOLIVIA	Latin America and Caribbean	PHASE 2	ELIGIBLE	CURRENTLY TRANSITIONING	not eligible
CAMEROON	Africa	PHASE 1	ELIGIBLE	BLENDED FINANCING	PRIORITY
CONGO, REPUBLIC OF	Africa	PHASE 2	ELIGIBLE	BLENDED FINANCING	BY 2020
COTE D'IVOIRE	Africa	PHASE 1	ELIGIBLE	ELIGIBLE	BY 2020
CUBA	Latin America and Caribbean	PHASE 2	CURRENTLY TRANSITIONING	not eligible	not eligible
INDIA	South Asia	PHASE 2	ELIGIBLE	CURRENTLY TRANSITIONING	PRIORITY
INDONESIA	South Asia	PHASE 3	ELIGIBLE	not eligible	PRIORITY
KENYA	Africa	PHASE 1	ELIGIBLE	BLENDED FINANCING	BY 2020
LAOS	East Asia	PHASE 2	ELIGIBLE	ELIGIBLE	BY 2020
MOLDOVA	Europe and Central Asia	PHASE 3	ELIGIBLE	BLENDED FINANCING	not eligible
MONGOLIA	East Asia	PHASE 3	ELIGIBLE *	BLENDED FINANCING	not eligible
MYANMAR	East Asia	PHASE 1	ELIGIBLE	ELIGIBLE	PRIORITY
NIGERIA	Africa	PHASE 2	ELIGIBLE	BLENDED FINANCING	PRIORITY

Country	Region	Gavi Transition Status (2017)	Global Fund Transition Status	IDA Transition Status	GPEI
PAKISTAN	South Asia	PHASE 1	ELIGIBLE	BLENDED FINANCING	PRIORITY
PAPAU NEW GUINEA	East Asia	PHASE 2	ELIGIBLE	BLENDED FINANCING	not eligible
SRI LANKA	South Asia	PHASE 3	CURRENTLY TRANSITIONING	CURRENTLY TRANSITIONING	not eligible
SUDAN	Africa	PHASE 1	ELIGIBLE *	Inactive country: no active IDA financing due to protracted non-accrual status.	PRIORITY
TIMOR LESTE	East Asia	PHASE 2	ELIGIBLE *	BLENDED FINANCING	not eligible
UKRAINE	Europe	PHASE 3	ELIGIBLE	not eligible	BY 2020
UZBEKISTAN	Europe and Central Asia	PHASE 2	ELIGIBLE *	BLENDED FINANCING	not eligible
VIETNAM	East Asia	PHASE 2	ELIGIBLE	CURRENTLY TRANSITIONING	not eligible
YEMEN	Middle East	PHASE 1	ELIGIBLE *	ELIGIBLE	BY 2020

* These countries have been identified as priorities for sustainability and transition planning by the Global Fund due to their income level and/or disease burden.

Risks

The risks of simultaneous transition are more varied than they initially appear: it is not merely the quantity of funding but the nature of the support that could impact health systems' capacity to provide universal access to basic services. GPEI funding, for instance, pays for WHO regional staff, whose work focuses on polio but also supports a wide range of other health programs supported by other funders. As another example, the flexibility in grants and concessional lending terms provided by IDA can create the budget space required for countries to meet their co-financing share of health programs to other external funders. However, under simultaneous transition, the increasing expectation for co-financing from other external funders could coincide with a reduction in financing volume and flexibility when World Bank lending terms tighten under transition from IDA to IBRD.

One of the key risks highlighted in the case studies and findings below is the inability of countries where health outcomes are already poor to catch up with global progress. For example, low vaccine coverage and low performing programs persist in Côte D'Ivoire, Nigeria, and Papua New Guinea despite their access to external funding; they and other countries like them will be deeply challenged to translate rapid economic growth into the government funding and programming that would be necessary to maintain recent health gains, let alone fill the significant remaining gaps. If alternative financing is not smoothly phased in and sustained, weak health



services are likely to persist, and any quality health services are at risk of being cut, with all the resulting health impacts. Far beyond the financial impacts on national budgets, though they are significant, the true risk in transition is that people suffer from conditions that could be prevented or treated.

Another key risk in the new global health financing landscape is the potential impact of transition on marginalized groups, who are denied basic human rights and discriminated against by receiving fewer services than needed from government-run programs in some countries. A review of programs transitioning from external HIV funding noted risks that service delivery to key populations—such as men who have sex with men (MSM), sex workers, people who inject drugs, and the incarcerated—would decline or cease altogether during and after transition.^{xiii} As noted in the findings below, prioritization of these key populations within programs may not be taken forward in the absence of external funding. Most acute is the risk for HIV resurgence and with it, TB resurgence, if programs bringing critical health services to key populations are eliminated.

Transition also poses significant risks to people living in poverty. While economic growth lifts countries into higher World Bank income categories, it frequently widens the gap between the top and bottom wealth quintiles in a population. In many countries, the lowest wealth quintile already experiences reduced access to health services. For example, in Nigeria, only an abysmal 13.7 percent of children in the lowest wealth quintile receive a basic package of immunizations, while in the richest quintile, 63 percent have been immunized.^{xiiii} Access is certain to decline even further for poor or marginalized groups if funding is reduced or unstable, should government leaders and civil society fail to take the necessary precautions and make the necessary adjustments that promote equity and reaching the poorest.

Coordination Across Donors

While coordination mechanisms between donors are not at the forefront of their policies, all of the interview respondents identified coordination as a high priority. Many platforms seem to exist for coordination among health financing donors at both the global policy and country levels, although the latter are mostly put in place in an ad-hoc manner. Several respondents underlined the fact that coordination at both levels is highly influenced by personal relations and personal interest on the issue.

At the global policy level, donors coordinate and communicate through several different working groups, such as the newly created UHC2030 Working Group on Transition, which gathers representatives from the WHO, World Bank, Global Fund, Gavi, donor governments, and others. One interviewee from a multilateral funder specified that key global health funders also coordinate bilaterally: the Global Fund and PEPFAR closely align and communicate; Gavi and Global Fund senior officials meet about once every two weeks. However, there is no primary platform for decision-making among funders about simultaneous transition at a high level. A platform with oversight and advisory authority like the Polio Transition Independent Monitoring Board, but across multiple funders, could bring great value in ensuring simultaneous transitions are managed effectively. One reason that more formal cross-funder coordination is difficult is budget and programmatic cycles not being aligned, causing strategies and policies to be developed in a non-harmonized way. Such harmonization and coordination at the policy level would require a high-level commitment from all donors that so far is lacking. An interviewee highlighted that despite current coordination efforts, transition was described as “its own little industry,” with consulting firms and donors doing their own separate assessments in an uncoordinated manner.

In comparison with coordination at the global level, country-level coordination is even less formalized and happens mainly on an ad hoc basis. For instance, a respondent from a multilateral institution noted the World Bank, Gavi and the Global Fund coordinate in Ghana, Kyrgyzstan, Indonesia and Vietnam. In Côte d’Ivoire, donors created a technical working group on health financing gathering health donors every two months (Gavi, the Global Fund, the World Bank, USAID, UNAIDS, UNICEF, WHO, the French Development Agency, the Japan International Cooperation Agency) but did not invite the government to all of its meetings, and in Nigeria separate groups which include different, and rarely overlapping, partners and organizations oversee the transition plans for Gavi and GPEI. Budget cycle misalignment was also cited as a challenge at the country level where joint planning can be made difficult when external funders allocate resources and draft country strategies that overlap but are not coordinated.

CASE STUDY: CÔTE D'IVOIRE

The year 2020 will be pivotal for addressing health challenges in Côte d'Ivoire. From 2016-2020, Côte d'Ivoire adopted a new National Development Plan, with the goal of transforming the country into an emerging economy by 2020 and substantially reducing poverty. If its economy grows as planned, it will be met by a decrease in external financing. The country would enter the accelerated transition phase from Gavi support in 2020, and it may also begin the transition process from Global Fund support. The Cotonou Agreement,^{xliv} which governs relations between the European Union and 79 Africa, Caribbean, and Pacific (ACP) countries and has a specific pillar on development cooperation and aid, will also come to an end, with negotiations for a follow on agreement not yet started.^{xlv} Finally, 2020 will mark the end of President Alassane Ouattara's second term, leading to new presidential elections in a country that is still recovering from the aftermath of the 2010-2011 political crisis.^{xlvi} The potential for simultaneous transition of health financing to be compounded by an overall decrease in external development funding needs to be addressed and prepared for as early as possible, while also considering the uncertainty around economic and political factors.

ECONOMIC AND HEALTH BACKGROUND

Strong economic growth but persistent inequality

According to World Bank classification, Côte d'Ivoire is a low-middle-income country with a GNI per capita of \$1,520.^{xlvii} After the 2010-2011 political crisis, Côte d'Ivoire experienced impressive economic growth, averaging nine percent from 2012-2015. The country is still highly dependent on cocoa and to a lesser extent crude oil, which comprises around 60 percent of exports and 25 percent of its GDP.^{xlviii} The Ivorian economy is vulnerable to commodity price shocks and has been hit by the dramatic drop in oil prices since 2015 when it was around US\$100 per barrel to a low point of almost US\$25 in January 2016.^{xlix} For part of that time, high cocoa prices compensated for the loss, but in mid-2016 cocoa prices plummeted just as oil prices started to recover. Cocoa has since lost 35 percent of its value, putting Côte d'Ivoire's economy and public finances under pressure. The shock is not expected to last,ⁱ and the International Monetary Fund has lowered its prediction of 2017's economic growth from 8.5 percent to a respectable 6.9 percent.ⁱⁱ

However, the rapid economic growth has not translated into improved well-being of the population. Côte d'Ivoire ranked 171 out of 188 countries on the Human Development Index in 2015.ⁱⁱⁱ Vast disparities remain between urban and rural regions, with 77 percent of the urban population but only 10 percent of the rural population falling within the two wealthiest quintiles.ⁱⁱⁱⁱ According to the 2015 Gender Development Index, Côte d'Ivoire has one of the lowest gender equality scores, and 75 percent of women live under the poverty line.^{liv,lv}

Weak and inequitable health system governance and financing

Côte d'Ivoire has historically under-invested in health. To this day, the annual government budget allocated to health remains low. In 2016 it was closer to 5 percent, far from the 15 percent allocation target of annual budget to health set in the 2001 Abuja Declaration by African Union countries.^{lvi,lvii} The burden of health expenditure largely falls on low income households, as 48 percent of total health expenditure comes from out-of-pocket payments.^{lviii} Health resources are not equitably distributed: although a majority of Ivoirians access care through primary health care centers, more funds support tertiary care; 60 percent of health staff are concentrated in Abidjan, where only 19 percent of the population resides.^{lix} Thus, despite the country's improved economic outlook, its maternal mortality rate remains one of the highest in the world with 645 deaths per 100,000

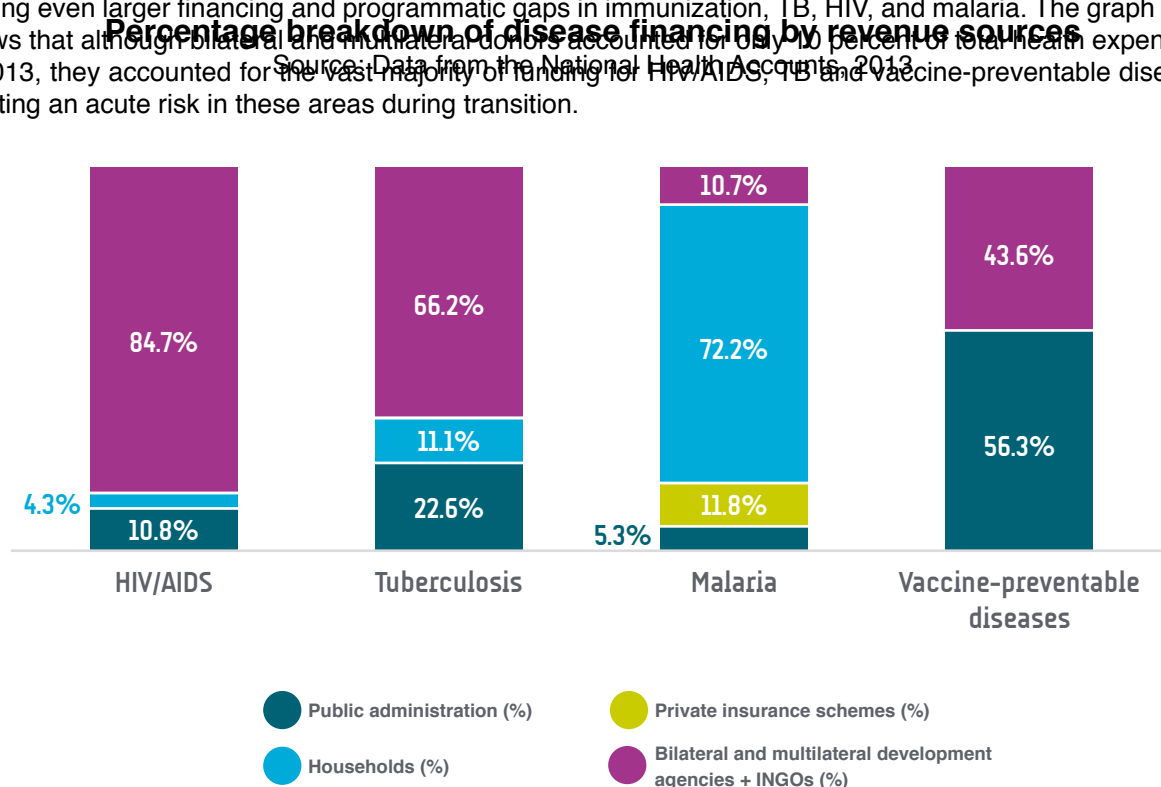


Credit: EC/ECHO/Anouk Delafortrie

live births in 2015, well above the average for sub-Saharan Africa of 547.^{ix} According to an interviewee, the government recently launched a series of structural reforms on the hospital sector and the public health code, and committed to create the first pharmaceutical market regulatory authority in West Africa. However, strengthening health systems and improving health outcomes will be a challenge without increased financing and reinforced capacity in the sector.

External financing plays a significant role in underpinning Côte d'Ivoire's health budget. The heavy use of donor funds in the health sector was identified by all Ivoirian civil society interviewees as a challenge for priority-setting and addressing real health needs. Civil society interviewees noted that the government of Côte d'Ivoire has aligned much of its own health spending to the priorities identified by donors, rather than the health needs identified in the National Health Development Plan (PNDS). There is concern from civil society that during and after transition, the government will reallocate funding towards other areas receiving donor funds,

leaving even larger financing and programmatic gaps in immunization, TB, HIV, and malaria. The graph below shows that although bilateral and multilateral donors accounted for only 15 percent of total health expenditure in 2013, they accounted for the vast majority of funding for HIV/AIDS, TB and vaccine-preventable diseases, creating an acute risk in these areas during transition.



TRANSITION

Status: still time to prepare for simultaneous transition

Côte d'Ivoire is currently in the preparatory transition phase for Gavi support and is expected to move into accelerated transition in 2020. Gavi support would therefore end in 2025, and access to UNICEF vaccine procurement, including preferential vaccine pricing, would end in 2030. The Gavi Côte d'Ivoire co-financing factsheet projects an increase of co-financing obligations for the first two years of accelerated transition by 314 percent, meaning the country's cost for providing vaccines will quadruple between 2020 and 2022.

Though Côte d'Ivoire does not appear in the Global Fund's list of countries projected to transition by 2025, interviewees at the global level and in Côte d'Ivoire noted that it is likely to start transition in 2020 due to the country's increasing capacity to finance its health investment needs from its own revenues and the need for the country to develop a realistic and sustainable long-term investment strategy for health. Interviewees additionally highlighted the fact that this prediction is highly dependent on what the Global Fund's sustainability, transition, and co-financing policy looks like in 2018-2019 and that the allocation will be determined by funding available from the next replenishment round and the evolving specific health context in the country. This suggests Côte d'Ivoire has little visibility or predictability for when a substantial draw down of funding from the Global Fund will take place. Despite the fact that Côte d'Ivoire is not yet transitioning, it has experienced a €10 million decrease between the new funding cycle (€190 million for 2018-2020) and the previous one (€200 million for 2014-2017). This decrease is particularly steep for the HIV grant, which will be €66 million, compared to about €110 million for the last period, a 40 percent decrease.

President Ouattara and Vice-President Kablan Duncan have committed to increasing domestic investments for the HIV response by 407 percent in 2017 to pay for antiretroviral (ARV) and HIV/AIDS related supplies.^{lxvi} This is a strong political signal towards more country ownership and sustainability of the HIV/AIDS response, especially in a context where PEPFAR and the Global Fund supported 45 percent each of the country's total HIV drug supply in 2016.^{lxvii} Civil society interviewees added that despite the Minister of Health confirming that the commitment would be honored, there are concerns about the disbursement of this funding due to reduced revenue. This is particularly worrying as the announcement led to a reallocation of PEPFAR and Global Fund financing away from ARVs and first-line antiretroviral therapies (ARTs).^{lxviii} This demonstrates that even with political will at the highest level the government, the health budget is vulnerable to economic shocks. Because of this volatility, donors must create an iterative, flexible approach to transition that responds to the country's situation throughout the transition process, including economic changes.

Several stakeholders from civil society, the French government and the World Bank agreed and emphasized the need for a stronger health system in Côte d'Ivoire before transition takes place. They also spoke to the importance of capacity building in the Ministry of Health and Public Hygiene (MoH), including public management, budgeting, surveillance and data, and decentralization in order to strengthen the health system. The lack of efficiency and quality of health spending, as well as the budget's lack of alignment with the country's health needs all pose challenges for successful transition. A stakeholder from a development agency indicated that these systems-level challenges would actually be more difficult to tackle than a decrease in financing volumes. The lack of regulation and absorptive capacity of the MoH was cited as an obstacle to additional allocation from the Ministry of Budget and State Portfolio. While threats to the continuation of health systems strengthening currently exist from Gavi transition, other donors such as the AFD and the World Bank are focusing their efforts on health system strengthening and have confirmed they will not transition that funding in the near future.

Stakeholder awareness: increasing due to high-level advocacy

All stakeholders interviewed were aware of the upcoming transition from Gavi and or the Global Fund, but with varying degrees of understanding. Both Gavi and the Global Fund held Board meetings in Abidjan recently, which participated in raising the issue at the highest governmental level. Other opportunities for this kind of engagement exist, and should be used to build political will and connect across stakeholders.

Civil society stakeholders were aware of the link between Côte d'Ivoire's economic growth and the anticipated start of transition from Gavi and possibly the Global Fund in 2020, but were quite skeptical about an actual exit. While current economic projections predict Côte d'Ivoire's economy will grow enough to trigger transition in 2020, most interviewees did not believe this will be the case. On the contrary, they assumed more time will be available before external sources of funding begin to transition out of the country. Furthermore, most interviews revealed a general doubt of the forecasted economic growth as well as disbelief of donor support coming to an end. Transition, they suspect, would more likely result in a change to the nature of partnerships, through increased private sector engagement and more ad hoc cooperation, rather than a direct shift from external aid to domestic resources.

When it comes to transition, there is a discrepancy in awareness between stakeholders working in immunization and stakeholders working in the fight against HIV/AIDS, TB, and malaria. Since Gavi transition will happen first, there is more evidence of Gavi communicating about and preparing for its exit at all levels. Co-financing projections are available through 2020, and regular meetings are being held with the government and civil society. The timeline for Global Fund transition is not clear, and interviewees each had a different estimate of when funding will end.

Consequently, the extent to which the Gavi and Global Fund transitions may be simultaneous is not well known by government officials or civil society. Several civil society stakeholders expressed extreme concern about the actual willingness of the government to take over the funding and fill the gap made by transition from both multilaterals. They fear an abrupt cut in their own health service delivery programs following donor withdrawal as they are mainly funded by external resources. The population will experience an overall decrease in access to health services if the government is not willing or able to step in immediately.

Various financial and technical partners interviewed were very aware of the planned transitions. The AFD, Global Fund, and World Bank recently created a technical working group on health financing as part of their coordination on the health sector. As described by an interviewee, the group's 2017 goal is to contribute to strengthening domestic resource mobilization, and the efficient and equitable allocation of budget for the health sector by including other activities, and drafting a harmonized multi-donor health financing strategy

towards sustainability which would eventually feed into an inclusive transition plan across donors.

Coordination around health financing is welcomed in a time when Côte d'Ivoire is projected to experience a change in its external financing landscape after 2020. Although the government is part of the multi-stakeholder health cluster where financing discussions are raised, it is not a member of this technical working group, and will only be invited for some sessions. Considering low awareness from the government side and the extent to which political will is needed for successful transitions, success of the outcomes of the working group can only be ensured if the government is involved and consulted at every step, especially to ensure ownership of a potential future transition plan. Efforts at coordination and planning across mechanisms, such as this one, are clearly necessary, but to be effective should include all critical stakeholder groups, including government, civil society and representatives from all relevant funders.

Transition experience: coordination challenges abound

Projected donor withdrawal will have large impacts to government budgets, and much work needs to be done to prepare the health system. According to those interviewed, some of this preparatory work has begun, but is currently done in an uncoordinated way. In the immunization space, the Expanded Program on Immunization (EPI) has jointly developed a co-financing plan with Gavi until 2020 and a specific budget line for immunization was created in February 2017. While this helps the government prepare to take over the purchase of Gavi-financed vaccines, this transition preparation is only within one narrow focus area. Additionally, according to global-level interviewees, Gavi, the U.S. government, and the Global Fund are creating an oversight coordination unit under the MoH focused on bottlenecks in the MoH and designed to reduce them. A stakeholder from civil society shared that both PEPFAR and the AFD have their own project coordinating units. The MoH is planning to put in place a project management unit to improve the coordination and Global Fund grant management of the national programs on HIV, TB and malaria, but the numerous separate units demonstrate the lack of coordination of donor funding within Côte d'Ivoire currently.

Despite ongoing discussions, information sharing and meetings, harmonization among donors is very difficult at the operational level, especially because of differing grant management and budgeting procedures. Civil society stakeholders stressed that donors have different modalities and budget cycles for awarding funding, which result in inherent difficulties to align planning and provide long-term common and predictable financial projections. A stakeholder from the Global Fund Country Coordinating Mechanism (CCM) described coordination issues in terms of planning and financial decisions caused by PEPFAR's and the Global Fund's difference in allocation periods. Donors are aware of this challenge: PEPFAR and the Global Fund signed a Memorandum of Understanding during the COP17 conference in Johannesburg in which they agreed to not drastically change their strategy for the next three years. This additional challenge makes it even more necessary for strong coordination to exist at the country level when transition starts in earnest.

CONCLUSIONS

The fact that donors will exit the country at some point is quite well known, but there is limited recognition of a true timeline for transition or of the specific policies that will govern donor withdrawal. So far, the discussions on transition in Côte d'Ivoire are only superficial, with the exception of the stakeholders working with Gavi on a daily basis. The fragility of the health system and the low prioritization of health in the national budget have been clearly identified as weaknesses posing additional risks during transition. For Côte d'Ivoire it will be essential to have a strong, harmonized, and costed plan created by a partnership of all relevant stakeholders to address transition. Engaging government stakeholders and building political will are critical components of this work which need to be prioritized from the start of this process.



CASE STUDY: NIGERIA

As a large, lower middle-income country facing political and economic instability as well as significant health inequity, Nigeria illustrates the crucial role global health resources from donors and multilateral institutions play in maintaining and expanding basic health services, even in a country with a relatively high GNI per capita. Furthermore, it exemplifies how removing donor financing without a full sustainability plan is likely to cause serious problems for an already fragile health system.

ECONOMIC AND HEALTH BACKGROUND

Rapid but unequal growth exacerbates risks of simultaneous transition

Nigeria, Africa's most populous nation, has one of the largest economies in the continent. The country's GNI grew from US\$350 billion in 2010 to US\$549 billion in 2014; a growth of approximately 57 percent in 4 years.^{lxiv} This increase was mainly due to two factors - the rebasing of the economy, which confirmed that Nigeria was a lower middle-income country for the first time, and global commodity prices.^{lxv} Since this rebasing, however, Nigeria's GNI has contracted to US\$396 billion in 2016, attributed to commodity price changes.^{lxvi} Nigeria's economy remains largely reliant upon the price of natural resources, and while the economy has since begun to grow slowly, the World Bank only predicts a growth rate of one percent in 2017.^{lxvii}

Nigeria's tax base has not grown alongside its economy. In 2013, the latest year for which data is available, tax revenue as a percentage of GDP was only 1.5 percent. This is low compared to over 10 percent in other countries with similar GDPs.^{lxviii} In addition to this challenge, as of 2009, 85.2 million people—53 percent of the population—live on less than \$1.90 a day.^{lxix} Using the most recent figures available, the richest 20 percent of the population represent almost 50 percent of national income with the poorest 20 percent accounting for only 5 percent of income. These figures have largely remained unchanged since the 1990s.^{lxx} It is evident that while there has been significant economic growth over the past ten years, this has yet to translate into gains for the populace. With a population growth rate of 2.6 percent^{lxxi} representing a growing cohort of children requiring health services each year, the government budget will undergo increasing constraints while economic gains remain stagnant.

Weak health infrastructure and lack of domestic investment lead to underperforming health system

The Nigerian health system has many governance levels, all with their own separate budgets and responsibilities. While the federal budget for health focuses on procurement, state and local government area (LGA) health budgets focus on service delivery and human resources. This distinction in responsibilities means that managing a comprehensive national health financing strategy, which ensures equitable access to health care, is complex.

Nigerian government health spending has been inconsistent from a high of 9 percent of the government budget in 2007 to between 5-8 percent over the last decade – far from the 15 percent agreed by African leaders at the Abuja Conference, a target Nigeria has not ever met since it hosted the conference.^{lxxii}

Yet the consequences of continued low levels of investment in health are self-evident. The maternal mortality rate is 840 per 100,000 live births.^{lxxiii} Nationally, there are less than two health workers for every 1,000 people, with only 35 percent of births attended by a skilled health worker.^{lxxiv} Only 49 percent of children are immunized, one of the most basic child health interventions a health system should provide.^{lxxv} Fifty-five percent of the national TB budget remains unfunded, resulting in only 15 percent TB treatment coverage.^{lxxvi} In addition, there are large disparities in health outcomes within and between states and regional zones. For example, infant mortality rates range from 90 per 1,000 live births in the South West states to 185 per 1,000 live births in the North West and DTP coverage rates range from as low as 14 percent in the North West to 44 percent in North Central, and 80 percent in the South East.^{lxxvii, lxxviii}

Insufficient investment at both national and state levels has left the health system fragile, underperforming, and facing extreme human resources, data, and logistical challenges, especially in areas with ongoing political instability and fragility. Increased restrictions in financing for health are also due to a lack of political will at all levels of government, a growing population, and the continuing low levels of tax revenue.

TRANSITION

Status: immunization coverage most at risk from simultaneous changes in donor financing

In 2016, Nigeria had the largest number of unimmunized children in the world, surpassing India. For the third year in a row, Nigeria's DTP3 coverage rate was 49 percent, falling into the same grouping as South Sudan, Syria, and Equatorial Guinea.^{lxxxix} Measles coverage was also just 51 percent.^{lxxx} Low immunization coverage rates have led to frequent outbreaks of measles and meningitis; Nigeria is one of the three remaining polio endemic countries in the world. With plans to introduce a number of new, and more expensive vaccines before 2020, and a growing birth cohort of around seven million a year, the immunization budget will need to grow significantly regardless of changes to donor support.^{lxxxi} The recently finalized Comprehensive Expanded Programme on Immunization Multi Year Plan sets out a substantial funding gap of \$1.45 billion, or 53 percent of the total resource requirements, for the 2016-2020 period.^{lxxxii}

In 2017, Nigeria officially entered Gavi's accelerated transition stage, requiring an increase in co-financing payments every year until 2022, when the country's routine immunization program is expected to be fully financed by domestic resources.^{lxxxiii} Nigeria's co-financing obligation in 2017 was just over \$42 million, which will increase to a projected \$138 million by 2022.^{lxxxiv} However, in 2016, only 29 percent of immunization expenditures came from government funds with the remainder flowing primarily from external sources.^{lxxxv}



Credit: Tom Maguire

¹ It is important to note that due to the unexpected rebasing in 2013, Gavi postponed Nigeria's entry into the accelerated transition phase for two years to allow more time for preparation.

At the same time, Nigeria's immunization program will be under further pressure as polio eradication nears and external support from GPEI winds down in the next few years. According to various stakeholders, funding from GPEI has had a direct and indirect impact on routine immunization systems. For example, in addition to health infrastructure such as human resources and cold chain equipment, GPEI currently funds two WHO-accredited laboratories that support disease control beyond polio. Measles, rubella, and yellow fever control will all be at risk as GPEI winds down unless resources can be found to support the labs' continued work.^{lxxxvi}

It is also worth noting that while Nigeria is currently still eligible for IDA support, it has passed the operational threshold of IDA and is already accessing loans from IBRD. While it is not presently clear when the transition to IBRD-only may be triggered, it is clear that the hardened future terms, which could apply within the next few years, will have an impact on the availability of government resources for health.^{lxxxvii} However, other large bilateral and multilateral donors such as USAID, PEPFAR, and the Global Fund are not expected to reduce funding for many years to come because of the continued high burden of HIV, TB and malaria.

Stakeholder awareness: limited recognition of the risks of simultaneous transition

Gavi, GPEI and bilateral donors are aware of the challenges transition brings to Nigeria, but an interviewee from civil society highlighted there is a need for donors themselves to increase their engagement in the issue, and make more people aware that a change is fast approaching. Similarly, several interviewees noted a need for more practical guidance on transition using the experience of countries that have successfully navigated this process, turning theoretical challenges into practical solutions. The challenge in Nigeria, however, is that no organization or partnership the size of GPEI has ever withdrawn funds and support on this scale from the country, especially a program that devotes significant resources to funding staff positions, and no country the size of Nigeria has ever transitioned from Gavi support. Planning, preparation, and coordination are crucial.

The interconnectedness of changing donor relationships requires careful management by government officials and multilateral institutions alike. At the moment, immunization and polio stakeholders are focused almost exclusively in planning separately and while most of the technical staff involved are beginning to take into account and consider each other's processes, there does not appear to be a full understanding of what the impact will be. Beyond technical partner and government transition teams, awareness of simultaneous transition is low, with parliamentarians and civil society we interviewed almost completely unaware of GPEI wind down.

In an interview it was noted that the National Primary Health Care Development Agency (NPHCDA) is taking the issue of Gavi transition seriously and is working to raise this issue across the government, with parliamentarians and the media, through dedicated advocacy activities being undertaken by the National Immunisation Financing Task Team (NIFT).^{lxxxviii} Various members of the NIFT, including civil society, parliamentarians and NPHCDA staff, highlighted that their core focus is the financing gap left by Gavi transition, but there is almost no awareness of the financial or programmatic implications of GPEI wind down and how this might additionally affect routine immunization.

There is little evidence of concrete actions being taken to increase domestic financing or technical capacity to fill the remaining gaps once GPEI and Gavi support ends. According to multiple interviewees from civil society and government, the focus on current outbreaks of polio, measles, and meningitis A, challenges with health budget approvals, and economic instability are some of the main obstacles for immunization financing. Less than a quarter of interviewees showed awareness of the wider impact on the health system beyond the finances. The impact of changing financing on human resources, laboratories and surveillance capacity with the reduction of current support from GPEI was hardly mentioned.

Transition experience: lack of preparation and other challenges undermine progress

During Nigeria's first year in the accelerated transition phase from Gavi, the existing gap between domestic funding and what is required in co-financing over the next five years is worrying. The response to transition so far has been described by the Chairman of the NIFT as "tepid" and there is currently no government transition plan for immunization that considers Gavi alone nor simultaneously with GPEI. Even with immunization being declared a national emergency by the new director of the NPHCDA, and growing political support for tackling transition, all but one interviewee told us that transition is not possible in the current timeframe. Without a

plan in place before the transition process begins, countries like Nigeria will struggle to implement long-term, sustainable resource mobilization.^{lxxxix}

It is important to note that in previous years Nigeria's Gavi co-financing requirements have been heavily financially supported by the World Bank. Around 80 percent in 2015 and 100 percent in 2016 of the co-financing for the Penta and Pneumococcal vaccines came from World Bank loans.^{xcii} Per interviews conducted, Nigeria is also currently considering a further five-year loan from the World Bank to support immunization activities. The Chairman of the NIFT highlighted that Nigeria "cannot continue to borrow" to finance its routine immunization program.^{xcii}

Planning for the wind down of GPEI began before Nigeria became a polio endemic country once again in 2016. The Polio Transition Technical Task Team (PT4) stated in an interview that they are currently balancing the need for increased resources to interrupt polio transmission while preparing for what could be an imminent reduction in technical staff and partner support. One interviewee added that the planning done by the PT4 so far has acknowledged the financial impact of Gavi transition, but has not yet included a joint analysis of Gavi and GPEI simultaneous transition's impact on the immunization and health system. Multiple stakeholders, often from the same organization but different teams, are working with the federal government to produce comprehensive independent financial transition plans; the plans contradicting each other is a latent risk. Domestic and donor financing must be utilized holistically to benefit the full immunization system, reducing fragmentation between donors and parts of EPI to ensure more children are reached with all recommended vaccines.

Interviews conducted also revealed current analysis being done by government officials focused almost exclusively on financing in terms of both direct program funding and personnel costs and procurement gaps when Gavi and GPEI retreat. The NPHCDA is intending to undertake a comprehensive analysis of technical and financial implications of the polio transition. This will be essential as Nigeria moves towards finalizing its transition plan as currently the impact and costs for the loss of GPEI funding to the immunization and health delivery system is largely unknown, especially with non-polio stakeholders at a state and LGA level. Current advocacy strategies in Nigeria calling for individual transition plans do not consider the potential gaps in human resources nor the impact on health service delivery.

Transition from many other donors such as Global Fund and PEPFAR is distant, so how Nigeria manages this first test of donor withdrawal will provide them useful lessons for the future. Without a costed, multi-stakeholder transition plan that sets out reliable and increasing sources of sustainable domestic resources, the risk of large funding holes when GPEI and Gavi funding stop is a pressing and imminent reality. The government of Nigeria must urgently acknowledge the scale of the challenges—both financially and programmatically—and take steps towards increased country ownership of immunization at all levels of government.

CONCLUSIONS

It is worrisome that in order even to maintain the current low levels of health coverage, a dramatic increase in health financing at both the federal and state level must occur in the next 5-10 years to replace reduced external support. All of this is compounded by Nigeria facing its first economic contraction in 25 years due to a drop in oil exports and foreign currency shortages. As a result of the drop in oil exports inflation has reached a decade high, which continues to exacerbate many of the existing challenges.^{xciii} Furthermore, the polio outbreak in Borno State in 2016, measles and meningitis epidemics, as well as ongoing conflict, instability and drought, create additional financial demands to deliver essential humanitarian and emergency services. As noted by several interviewees the competition for external and domestic resources is extremely high. Nigeria's context is complex and the far-ranging impacts on health services that transition is likely to have could be irreversible. Additionally, if transition goes poorly, there remains a risk for polio resurgence in Nigeria and the surrounding Lake Chad region. It is thus critical to look beyond the country's GNI levels when assessing transition.

CASE STUDY: VIETNAM

Vietnam is a country already experiencing transition from several significant external funding sources, having entered Gavi's accelerated transition phase, moving to IBRD-only support from the World Bank Group, and experiencing reduced or refocused support from bilateral donors. Vietnam has made significant progress in improving many of its health and social outcomes in recent years, and its experience of going through and preparing for pending reductions in external support illustrates both important lessons in successful country ownership and several challenges. These include responsibly managing transition, especially how to involve the people who will be most affected by reduced support, and ensuring key populations are not left behind.



Credit: The Global Fund / Ryan Quinn Mattingly

ECONOMIC AND HEALTH BACKGROUND

Sustained growth with a focus on poverty alleviation

Over the past 25 years, Vietnam has made remarkable progress in poverty reduction and socio-economic development. Market-oriented reforms to the previously socialist economy, known as 'Doi Moi,' from the late 1980s resulted in industrialization, private sector expansion, and trade liberalization, and led to the country progressing from low- to lower-middle-income status.^{xciii}

The proportion of people living below the national poverty line has declined from nearly 60 percent in 1993 to 13.5 percent in 2015.^{xciv} This reflects strong economic growth over a sustained period. From 2005 to 2015, real growth in Vietnam's GDP averaged 6.1 percent per year.^{xcv} A young and relatively well-educated workforce, proximity to China, and openness to private investment have underpinned this GDP growth. As Vietnam's living standards have increased, both bilateral and multilateral assistance have declined as a proportion of GDP, and in absolute terms.

Both domestic investments and donor funding have contributed to progress

Total health spending is equal to 6.6 percent of GDP, of which 42 percent is government health expenditure, 9 percent is privately insured costs and 49 percent is out of pocket costs to individuals.^{xcvi} The proportion of out of pocket costs is below average for lower-middle-income countries, but still leaves lower income people vulnerable to catastrophic health costs.² The Government of Vietnam has a goal of reducing out of pocket costs to 40 percent of total health spending by 2020.^{xcvii} The government aims to achieve this reduction in out of pocket costs through increased coverage of the population by Social Health Insurance, with a goal of increasing coverage from 71 percent in 2014 to 80 percent in 2020. The government is also planning the development of a basic health services package, which would include basic and specialist treatment, medication, and preventive and primary healthcare.^{xcviii}

Most of the government's health spending in Vietnam is from domestic resources, with development assistance for health constituting about 10 percent of the government's health budget.³ The bilateral donors to Vietnam, in decreasing order of annual assistance, are Japan, Korea, France, Germany, Australia, the U.S., and the EU.^{xcix} Vietnam is more reliant on external funding for specific health programs: 78 percent of Vietnam's HIV funding comes from external sources, including 95 percent of funding for ART coming from PEPFAR and the Global Fund.^c Therefore, continued support by international donors is crucial for diseases that affect vulnerable populations such as HIV and TB, which may not be a high priority for the national government.

TRANSITION

Status: Simultaneous transition underway

As Vietnam has moved from low- to lower-middle-income status, global health funders, including Gavi, the Global Fund and the multilateral development banks, which use per capita income as the primary criterion for support have either stopped or reduced support, or have announced plans to do so soon.

Concessional loan assistance, mostly from multilateral development banks, has also declined from 4.6 percent of Vietnam's GDP in 2010 to 2.7 percent of its GDP in 2015.^{ci} In the coming years, Vietnam is also transitioning from the highly-concessional to non-concessional facilities of both the World Bank and the Asian Development Bank (ADB). To be eligible for concessional funding from the Asian Development Fund (ADF), a country must have a per capita GNI below \$1,065 (2006 dollars) and low debt repayment capacity. The transition from IDA to IBRD funding became effective in July 2017, and transition from ADF to ADB funding is due in 2019.

Vietnam's economic and social progress has also led to reductions and changes in the focus of bilateral and regional funding. In 2010, the UK decided to phase out bilateral support to Vietnam by 2016, due to a focus of the UK's development assistance on Africa and South Asia. Similarly, Australia cut many country programs, including Vietnam, by 40 percent in the 2015-16 aid program, and is only providing AUD 58.4 million in bilateral support to the country in 2017-18.^{cii}

The biggest changes to Vietnam's level of external financing will result from Gavi transition and the move from highly concessional to less concessional loan support from the World Bank and ADB. Changes in Global Fund support will be less dramatic, but will also have an impact. The Global Fund has allocated \$US 121.5 million to Vietnam for 2017-2019, compared with \$US 158.4 million in 2014-2016.^{ciii} While the level of funding for 2017-2019 has declined, the Global Fund remains a significant source of funding for HIV, TB and malaria programs for Vietnam.

2 Households without full health insurance coverage face a risk of incurring large medical care expenditures should they fall ill. This uninsured risk reduces welfare. Further, should a household member fall ill, the out-of-pocket purchase of medical care would disrupt the material living standards of the household. If the health care expenses are large relative to the resources available to the household, this disruption to living standards may be considered catastrophic.

3 Calculated from figures in Health Policy Project, Health Financing Profile Vietnam, 2016.

Stakeholder awareness: extensive awareness has not guaranteed preparation or coordination

Stakeholders in both government and civil society are aware of donors departing, but have noted that this did not lead to consultation or a strategy from government on how to manage implications of the departure.

As one respondent from civil society said: “I think everybody is aware that the donors are leaving...I think the policy makers are aware and community members are aware but I don’t think everybody is prepared for transition. There are some people who only think of transition in terms of funding. They don’t usually think of transition in terms of providing quality health care or taking care of the vulnerable population. I don’t see community involved in transition. It is a conversation between the donor and the government. For HIV, there have been some discussions relating to transition. And the community are more actively involved in preparing for transition including identifying the challenges and working on making sure health insurance covers people living with HIV. For other parts of the health sector there’s very little communication between donors and civil society.” Other interviews conducted with civil society representatives also reinforced that the Government of Vietnam, non-government stakeholders and members of the public are aware of reduced donor support, but the limited capacities of CSOs and their restricted opportunities to make the case for change to the government reduces public involvement in the transition process.

Both bilateral and multilateral donors, such as Gavi and the multilateral development banks, deal directly with government, and do not have mechanisms for consulting or negotiating with civil society directly. Two exceptions identified by an interviewee from civil society where community-based organizations have some input are on changes to PEPFAR support and Global Fund programs, through the CCM. This limits civil society involvement in preparing for transition, except where the government actively seeks to involve civil society in the process.

Transition experience: despite Strong preparation, numerous threats to health progress

Since 2010, Vietnam has experienced a reduction in donor assistance, but the peak period for simultaneous transition will be in the next five years. Although Vietnam has made impressive progress in health outcomes, measured at the national level, inequalities in service access and health standards between regions and ethnic groups are significant. For example, ethnic minority groups have a much higher rate of infant mortality (44 per 1000 live births) than the majority Kinh and Hoa ethnic groups (10 per 1000 live births).^{civ} Stunting rates among children also vary widely, with rates among ethnic minorities in 2010 reaching as high as 55 percent compared with the national average of 29.3 percent.^{cv} Such gaps indicate that national progress is not being reflected in all regions nor all groups in the community. There are real concerns about the impact of transition on vulnerable and marginalized groups in Vietnam.

Vietnam has already seen a decrease in overall funds, and a change in the form of assistance. Between 2000 and 2010, for example, international donors concentrated on strengthening the health system, including both hospitals and primary care. According to a civil society stakeholder, the focus of more recent external support has been on specific diseases, notably HIV/AIDS and malaria, and on health financing reform. In the case of the PEPFAR, the focus of its support for Vietnam is moving from service delivery to technical assistance.

An additional concern is the curse of success—that Vietnam’s success in improving overall health standards will directly lead to a reduction in donor support. In order for countries to prevent a malaria resurgence after reaching low disease burden, the Global Fund bases country eligibility on malaria data from 2000 to determine the disease burden of a country rather than current levels, but only until a country reaches elimination status.^{cvi} Given the dramatic reduction in malaria cases and deaths in Vietnam, it is therefore more likely that the Global Fund will reduce support within the next five years as Vietnam achieves malaria-free status. For the 2017-2019 period, the Global Fund has reduced support to Vietnam by 23 percent in comparison to the 2014-2016 period, primarily due to a reduction in HIV support.

To provide services for some diseases such as TB, Vietnam relies primarily on external funding. The WHO’s Vietnam country profile indicates that in 2016, only 9 percent of the estimated TB requirements were funded

domestically, 22 percent were funded by external sources, and 69 percent of the TB programs went unfunded.^{cvii} Domestic funding for these programs must be increased significantly to improve services provided and to close the funding gap.

Vietnam's experience of simultaneous shifts in external funding highlights the need for international donors to establish integrated and coordinated approaches when reorienting their priorities and implementing exit strategies. As several interviewees noted, the remaining donors are more likely to fund stand-alone health facility projects than improvements to the health system, which risks distorting health system priorities.

Vietnam's primary health and immunization systems require further investment and skills development, and according to a stakeholder from civil society, Vietnam's upcoming transitions pose a risk of increased failures of the health system to deliver services—with potentially devastating impacts on people's health. For example, a temporary drop in Pentavalent immunizations in 2013 due to spoilage of vaccine stocks resulted in vaccination coverage rates falling from more than 90 percent to 60 percent. This exemplifies the danger that a lapse may pose during transition. An analysis by WHO researchers suggests that, without a catch-up vaccination campaign for children born in 2013, this one-year drop in vaccination rates could lead to 90,000 additional cases of hepatitis B and 17,000 future deaths.^{cviii}

CONCLUSIONS

The findings of published reports and interviews held with stakeholders emphasize that Vietnam is poised to undertake simultaneous transition effectively, having achieved middle-income status, having reduced income poverty significantly, and achieving improvements in overall population health standards. Nonetheless, limitations in health service delivery and governance could cause problems in the transition process. As the following quote from a civil society stakeholder notes, donors have a role in engaging with civil society to determine the country's readiness for transition:

“... it should not only be about the income level it should also be about the political and policy environment in the country. In terms of taking care of the vulnerable and marginalized populations, the donors should not only look at the income level but other factors and matters and have a consultation with civil society and other stakeholders.”

With increasing health insurance coverage which covers part of the cost of treatment, rather than preventive measures, and the departure of donors, Vietnam needs to ensure its expenditure on prevention does not decline. This is especially relevant for groups at high risk for HIV, such as injecting drug users. Declines in Gavi and Global Fund grants also mean reduced funding for health system strengthening investments.

Vietnam may be well positioned for transition, but reductions and changes in external support still pose risks for continued improvement in its health system and overall health outcomes. A decrease in global or domestic health financing could reduce access to health services for the most vulnerable and marginalized populations, reversing or delaying progress. Dialogue and engagement with civil society will be important when processes such as the Global Fund's CCM eventually cease to exist, and PEPFAR completes its transition in Vietnam.

FINDINGS

Our review of the new global health financing landscape suggests that at least 24 countries are likely to face significant changes in their ability to access external funding to priority health areas in the next 5 years, and that unless those changes are proactively managed and coordinated, the human toll could be dramatic. Our ability to maintain the health gains of the MDG era and expand them to all people depends on how global health stakeholders manage this wave of simultaneous transitions.

Based on our survey of transition frameworks, the lessons learned from the experience of Côte d'Ivoire, Nigeria, and Vietnam, and our review of relevant literature, we have found five key areas in which a new approach to simultaneous transition is necessary to avoid undermining recent health progress: the need for stronger health systems, stronger coordination across stakeholders, improved transparency and predictability, increased political commitment within transitioning country governments, and more targeted and deliberate support during and post transition to ensure health services do not suffer when donor funding is withdrawn. This section summarizes the risks and opportunities in each area, while the final section recommends a new way forward.

The clearest and most easily measurable impact of transition is financial. Indeed, taken together, the five key findings below point to an overarching lesson: that more and better financing is needed to address the continuing unmet need and inequity in access to health. In the new global health financing landscape, much of that increase in funding will come from low and middle income country governments and other domestic resources, but external funding will also need to be maintained, coordinated, and targeted for maximum sustainability in addition to maximum short-term impact. One can analyze the amount of funding a country receives from multilateral and bilateral funders, and compare it with current health expenditures from the national budget to understand the significance and impact on the budgeting process that transition will have. In Côte d'Ivoire, for instance, the co-financing requirements for Gavi alone will result in a 314% increase of the immunization budget line between 2020 and 2022.

Another significant financial impact to countries experiencing transition will be the loss of preferential pricing, and/or pooled procurement, for essential health commodities. Beyond simply filling the funding gap that will be left by funders through transition, countries will also have to contend with health programs costing more overall, as they will eventually have to purchase commodities at the same prices as high-income countries. But the impacts of transition, and what is needed to make transition successful, are far more than financial, critical though this may be.

The lessons below remind us that behind the financing structures are real programs delivering health services to real people. If we as a global health community are truly committed to “leave no one behind,” we must be equally committed to prioritizing health equity in the design and management of transition.

STRONG HEALTH SYSTEMS

There was agreement among all donors interviewed that the goal of the global health financing landscape should be sustainability, or the ability of national health systems to provide all services in the long term. Strong health systems will, therefore, be a “make or break” condition for a successful transition, with weak systems exacerbating the risk that removing external funding would undermine health progress. A stakeholder from a donor agency pointed out that the features of weak systems, including a lack of budgeting capacity, human resource shortages, and supply chain or infrastructure gaps, are more likely to be barriers to sustainability than insufficient domestic resources. Strong health systems, which have the capacity to take on full management of integrated, aligned programming after externally funded programs cease, were consistently recognized as key to a successful transition, including in interviews in Côte d'Ivoire, Nigeria, and Vietnam as well as in the existing literature that has assessed the impact of full or partial transition in countries where it has taken place. In Serbia, for example, Global Fund support enabled the government to scale up HIV prevention and harm reduction services between 2006 and 2014, but the government did not have the capacity to fill the funding gap after programming ended in 2015.^{[x] cix}

Building strong health systems is a lengthy process. As such, it is essential for sustainability policies to be developed and implemented well before a transition period, regardless of a country's economic position. According to multilateral interviewees, the transition process itself should be envisioned using the whole health system as a lens. Indeed, a more limited focus on disease-specific sustainability within a weak health system could have disastrous consequences for other health programs if domestic budget allocations are forced to shift to replace disease-specific external funding at the expense of other critical health services.

Changes in health financing have impacted the health system's ability to deliver services in some instances. For example, in the Democratic Republic of the Congo DTP3 coverage nearly doubled from 2002 (38 percent) to 2007 (72 percent), but was not sustained, and regressed to 63 percent by 2010 because of a failure to invest in health systems. The funding for vaccine supply increased dramatically from US \$5.4 million in 2006 to US \$30.5 million in 2010, mostly from Gavi support for new vaccines. However, during the same period, the funding (from all sources) for all other aspects of routine immunization services decreased from US \$36.4 million to US \$24.4 million. This 33 percent drop in funding primarily affected basic health system capacity – surveillance, transport, and cold chain equipment. The resulting drop in vaccination coverage rates took place even while continuing to receive funding from Gavi; a further drop in funding would have only compounded the health impacts. This highlights the importance of thorough policies and investment plans to ensure strong supply chains for vaccine delivery, trained personnel at all levels of the health system, and a good community understanding of the need for immunization and health services.

Since GNI per capita does not reflect the state of a health system, countries will enter transition at different levels of preparedness, needing more or less support and time to build strong health systems. However, there is little flexibility in most timelines to address the readiness of the health system. Both Gavi and the Global Fund have put in place transition readiness assessments to identify potential bottlenecks and gaps to a successful transition, which are meant to inform transition planning and which areas to focus on. However, the extent to which they may inform flexibility if a country's health system proves to be weak, or the extent to which these assessments take simultaneous transition into account is unclear. What is clear is that they currently happen in parallel, rather than in a coordinated way.

Recommended in addition to or as part of transition readiness assessments was the use of sustainability benchmarks to ensure that countries are actually prepared for transition, not just that the economy has grown to a point where in theory the government should be able to fund its own health programs. Concerns have been raised, however, that such benchmarks could create perverse incentives for governments by rewarding poor performance of a health system with additional access to funding, while withdrawing funding from a high-performing system. The Gavi Board, while examining its Health System and Immunisation Strengthening Support (HSIS) policy, has carefully considered how to tailor this kind of support to avoid the moral hazard risk.^{ox} This has included caution in some forms of health systems support, such as minimizing support for human resources for health, while investing more fully in other kinds of support. The same care and approach can be taken with the establishment of sustainability benchmarks, to minimize the risk of governments failing to invest sufficiently in health systems through the transition process.

Perhaps because of this moral hazard risk, it is also unclear where the threshold is: the level of health system sustainability needed before transition is not well defined. Gavi, for instance, will look to the coverage rates of Penta3, but only for countries that have experienced exceptionally fast economic growth.^{oxi} But it is critical that the capacity and performance of the health system overall be incorporated into decision-making around transition—when it occurs, at what pace, and with what kinds of targeted transition support activities. Health system strengthening activities need to be incorporated in all health and disease-specific activities from the very beginning of projects and grants, with the end goal of ensuring that all funds and activities bring a government closer to sustainably ensuring access to health, without duplication, gaps, or parallel systems.

STRONG COORDINATION AT COUNTRY AND GLOBAL LEVELS

In all three of the case studies, we found an urgent need for stronger coordination, especially at the country level. While some transition planning mechanisms exist, such as the management unit organized within the Director-General for Health's office in Côte d'Ivoire, we consistently found the need for strong, cross-sectoral stakeholder awareness, engagement, and planning in the transition process which takes into account all donors planning to withdraw over a similar time period, through both our case study research and in the literature review.

At the global level, some coordination efforts take place, such as the Transition Independent Monitoring Board of the GPEI, which closely monitors GPEI transition efforts. In our interviews, we found evidence of staff and leadership of multilateral funding mechanisms speaking to each other about global trends and policies around transition, although frequently only bilaterally. There is no overarching coordination mechanism cutting across all funding agencies, despite the ongoing challenge of funders' differing—but overlapping—budget and allocation decision-making cycles and the ongoing evolution of transition policies and planning.

Government stakeholders, civil society, donors, officials from Ministries of Health and Finance, and communities should all be engaged in transition planning. In a review of lessons learned from PEPFAR transitions in the Eastern Caribbean, stakeholder consultations are described as “a vital component of any successful transition planning process ... [because it] increases the likelihood that counterparts at all levels buy into the plan, understand its intentions, and accept stakeholder responsibilities.”^{cxii} Our case studies revealed different coordination mechanisms acting at the country level created by the different multilateral funders, but no overarching authority or coordination mechanism working across funding mechanisms. It is critical for success that stronger coordination across mechanisms takes place at the country level and that transition plans do not solely focus on one health intervention and consider the impact on the whole health system.

Building on stronger country coordination mechanisms, a finding echoed in various sources in the literature review is the recommendation for a comprehensive, costed, cross-mechanism country transition plan in place before the actual withdrawal of funds begins. A review of PEPFAR transitions in China, Guyana, Botswana and Bangladesh called for a “transition plan with a realistic timeline and sufficient resources to reach sustainability benchmarks.”^{cxiii} Essentially, it is necessary for country transition plans to allow for adequate time to transition, include full costing information, and have measures of readiness included. Our analysis suggests that these plans must not be donor-specific, but instead address all relevant external funders and facilitate coordination.

TRANSPARENCY AND PREDICTABILITY

Given the challenges faced by countries that have already transitioned out of some mechanisms, there is a growing consensus that predictability and a long and sequenced timeline are paramount to ensure successful and sustainable transitions. In an effort to allow countries to plan ahead as much in advance as possible for the transition process, donors have added some predictability measures into their transition policies. These include the use of a 3-year-average GNI per capita, the publication of transition projections, and the creation of multi-year transition plans. There are some challenges to predictability, however: funders' budget cycles can be misaligned, and eligibility policies themselves continue to evolve, changing the timelines for transition. For some countries, GDP rebasing has also affected transition predictability.⁴ Nigeria (2013) and Ghana (2010) respectively experienced an 89 percent and 60 percent increase in GDP after rebasing. This has a significant impact on the timeline towards transition, which is closely linked to economic growth.

Transparency and predictability are an even greater challenge when it comes to bilateral funders, many of whom invest ODA based on unclear, and likely political, criteria. Without clear benchmarks for eligibility, countries cannot know when they will lose funding from these mechanisms. Bilateral funding agencies could increase predictability by developing clear eligibility criteria that include health indicators as well as economic status. The literature on transition is consistent: clearer communication and longer periods of time for transition planning from bilateral donors would increase the sustainability of health and development programs.

4 The rebasing of GDP is the revision of the methods and base data used to calculate GDP in order to provide for a clearer picture of an economy's size and structure. For instance, Nigeria's GDP was rebased from a 1990 base year to 2010. Since the size and structure of the economy had evolved significantly over that 20-year period, the new estimation captured significantly more economic activity.

POLITICAL WILL AND A COUNTRY-DRIVEN PROCESS

Among countries that have already transitioned from donor financing for health there have been both successes and failures. The successes share the common thread of proactive political leadership. Estonia, Croatia, and Thailand in particular have been hailed as examples of government-led transition from Global Fund support. Croatia “succeeded in not only sustaining the status quo of the national HIV response... but in expanding many of its components and in transforming NGO dependences on external sources into productive contract relationships through a variety of domestic financing mechanisms.”^{cxiv} Thailand has elected to transition out of Global Fund resources more rapidly than required by Global Fund transition policy, moving to fully self-fund programming previously supported by the Global Fund in a two year time period.^{cxv} Brazil’s transition away from external sources of financing for its HIV programs is another example of strong country leadership driving a sustainable transition.^{cxvi} The success of these transitions is characterized by increasing government investment in health, and specifically the health programming supported by external funds, from before transition begins, and by strong political will at all levels of government.

We found consensus among the donor agency representatives interviewed on the fact that transition should be a country-driven process. Several stakeholders from multilateral institutions highlighted that only country ownership and country leadership of the process would ensure true sustainability, otherwise “we might get the [short-term health] results, but it won’t be sustainable.” This is clearly reflected in Gavi’s strategy documents around co-financing, but is not as explicitly mentioned by other funding mechanisms. While there was agreement among the various stakeholder groups concerning the principle, there was less consensus on who is responsible and accountable for the monitoring and evaluation of the transition process or for coordinating between donors transitioning simultaneously. In the cases where it happens, for example, what would a sudden drop in service coverage and surge in disease burden mean for both the government and the withdrawing donor or donors?

According to an interviewee, external donors are “a necessary but not sufficient condition” to sustainability, and real success is at the country level. The lack of evaluation makes it hard to determine if the responsibility for success or failure comes from the policy itself, or from the way it was implemented. Full country responsibility assumes that countries have full ownership and thus, lead the process. However, this was not evident in our analysis of the experience in Côte d’Ivoire, Nigeria, or Vietnam. Lack of awareness and access to the same level of information, lack of government leadership, and lack of inclusive planning are all obstacles that have been detailed in the case studies. As the process of drafting policies and strategies has largely been donor-driven, concerns around this are legitimate and will need to be addressed.

Transition is a highly political process, both at the global level, where political, financial and strategic concerns intertwine and influence eligibility and transition policies, and at the country level as well. External funding has been channeled through different groups at the country level who all have different interests in maintaining funding—power, positions, jobs—but limited incentive in talking to each other, said two stakeholders in multilateral institutions. According to a senior multilateral institution official, the impact of the political economy both at the international and country levels is largely ignored in discussions of transition, and needs to be acknowledged and addressed at both global and country levels. To tackle these challenges and especially address the highly political agenda surrounding global health financing, a high-level political discussion is imperative and should include high-level representatives of multilateral institutions, bilateral funding agencies, implementing governments, and other stakeholders such as civil society. Such discussion should formalize the guiding principles that are underpinning the processes of drafting and implementing policies, with sustainability of health systems, health financing and health results as the ultimate goal.

POST TRANSITION SUPPORT AND SAFEGUARDING HEALTH FOR VULNERABLE GROUPS

Our case studies and literature review raised two unresolved questions about post-transition support. The first is a fundamental question about the accountability of donors after leaving the country, or to what extent they are responsible for the success—or failure—of the process. The second is a tactical question about which kinds of engagement donors might support after financial withdrawal, including technical assistance, preferential pricing and procurement, or other models of cooperation. Current publicly available transition policies are largely silent on these issues, and stakeholders we interviewed identified this as a missing piece of the puzzle. This raises several questions, including that of the “end” of the transition process, and at which point transition is really considered finished: is it when the last dollar is disbursed? Does continued technical assistance mean transition has not fully concluded?

While some middle-income countries are genuinely ready for transition and need limited support post-transition, there are also countries who have experienced significant reductions in health progress after transition has taken place, where better post-transition support might have saved lives. This is exemplified by Romania, where no plan for transition from external funding to domestic resources was put in place for the HIV sector at the culmination of the last Global Fund HIV grant in 2010.^{cxvii} The dramatic resurgence of HIV transmission among people who inject drugs (PWID) in Romania after Global Fund transition was a result of a gap in programming that could have been avoided with better planning or more targeted post-transition support to provide services to key populations: “a specific HIV outbreak among drug users (around 2011) has been directly linked to the significant decline in harm reduction services following the Global Fund transition.”^{cxviii} This lack of funding coincided with a dramatic increase in HIV among PWID especially in the capital, Bucharest, from 1.1 percent prior to the end of Global Fund support in 2009, to 6.9 percent in 2012 after the grant ended.^{cxix} Even though some needle and syringe exchange programs were reestablished after the exit of the Global Fund, the damage had been done: prevalence of HIV among PWID aged 25-29 years and 30-34 years continued to climb, reaching 28 and 27 percent, respectively, in 2015. And the impacts went beyond HIV: viral hepatitis C (HCV) was rampant in the PWID community with prevalence in 2011 at 79 percent, the highest rate in Europe, compared to 3.2 percent among the general population.

Although post-transition support policies and implementation are identified by stakeholders in country as critical, they have not yet been articulated by many donors. In Vietnam, for example, stakeholders’ optimism about a sustainable country-led process was tempered by concerns over a lack of clear plans or discussion with funders of how to protect key populations after transition. In Côte d’Ivoire, many interviewees indicated that they would still require support and partnership, potentially through assistance structured differently from current development partnerships. All interview respondents acknowledged the lack of evaluation of the post-transition period and the need to generate knowledge on this issue. This appears to be one of the major gaps in the literature around transition. Without systems to monitor and evaluate the process it will be difficult to create evidence-based policies and guidelines informed by country experiences. It will be important in the upcoming wave of simultaneous transitions to avoid the unfortunate outcome after smallpox eradication, where many of the lessons learned and best practices were lost. GPEI in particular has made a specific effort to ensure that lessons learned from polio eradication are well documented, and other global health stakeholders should follow suit.^{cxx}



RECOMMENDATIONS

ALL GLOBAL HEALTH STAKEHOLDERS

Ensure High-Level Political Alignment and Oversight at the Global Level. All actors within the global health financing landscape have a responsibility to work toward the shared global goals of ending infectious disease epidemics, preventable child deaths, and other measures of achieving healthy lives for all. Mutual accountability among all stakeholders will only be possible if, at the highest political levels, the specific responsibilities around transition are articulated, monitored, and regularly reviewed. Governments in countries that will experience transition can and should be engaged up to the highest political levels in transition planning and ensuring that health service delivery is sustained. Political statements must be clear and visible, demonstrating governments' commitments to protect and expand recent health gains. Civil society and community leaders must also be clear about their contributions to sustainable health financing. Similarly, high-income country governments must show leadership to ensure that political pressures to reduce aid do not result in catastrophic changes to health financing structures. Existing global platforms should be used to discuss the new landscape of global health financing, monitor the risks of simultaneous transition, and mobilize all stakeholders to respond to challenges as they arise.

Create Political Accountability for Protecting and Expanding Recent Health Gains. The world has made tremendous health gains over the last twenty years, but these gains are directly threatened by the risks of uncoordinated or unsustainable simultaneous transition. Therefore, for the new global health financing landscape to succeed, there must be political rewards for investing in health for all, and political consequences if poor and marginalized people lose access to life-saving health services. Cross-party parliamentary caucuses, engaged media, and regional platforms like the African Union are all platforms that have provided such accountability for specific health priorities like HIV/AIDS and malaria, and could be used to bolster more sustainable approaches to transition. Civil society, in particular, should raise awareness and generate demand for sustainable health financing in addition to holding governments accountable for the commitments made at global and regional levels.

Mitigate the Risks of Simultaneous Transition Through Comprehensive, Cross-Mechanism Planning. The importance of coordinated transition planning across funding mechanisms cannot be overstated, especially in the 24 countries we project could face simultaneous transitions in the next five years. With the bulk of these countries experiencing transition from Gavi and GPEI, there are particular risks to immunization programs, which draw support from both mechanisms. Funders need to work closely not only with the transitioning country governments and other critical stakeholders like UNICEF, the WHO, and civil society, but also with each other to ensure the full impacts of transition out of all mechanisms are understood, that adequate preparations are taken, and that transition planning and support is not duplicative or run in parallel. Even though the timing and duration of each funder's budget and planning cycles do not align with each other, there is no reason why multi-year comprehensive transition planning cannot take multiple funders into account. Multilateral funders must participate in or establish, in close coordination with bilateral funders and governments, global and country level coordination mechanisms to facilitate this process across mechanisms, with the central goal of producing a comprehensive, costed transition plan cutting across all mechanisms.

Safeguard the Health of Key Populations. Stakeholders in Vietnam raised specific concerns on the sustainability of health programs for key populations, many of whom experience discrimination; evidence of past transitions, such as Romania's loss of Global Fund HIV funding, demonstrate the risk to key populations posed by transition. We recommend that a specific strategy around safeguarding the health of key populations be developed as part of a comprehensive, costed transition plan developed at the country level. Specific strategies could include tactics such as joint cross-border/regional programming, including representatives of key populations on decision making and advisory bodies at global, regional, and country levels, and helping non-governmental stakeholders diversify their sources of funding to directly provide services to key populations.

Create Space for Civil Society. Civil society has a critical role to play in holding governments accountable for sustaining health gains, in reaching key populations, in mobilizing resources for health, and in service delivery. These roles are even more important through transition periods, and the full global health financing community should prioritize making space for civil society at decision making tables, and work actively to ensure that civil society remains strong and capable during transition periods, including through dedicated funding for nongovernmental stakeholders.

Fill the Research Gap. As the global health financing landscape continues to evolve, several areas of additional research and learning are particularly important to inform the transition process. This includes a comprehensive mapping of health financing at the national level in low- and middle-income countries—including sources and volumes separated by disease components and types of spending—to better inform transition timelines and activities as well as allocation decisions; research on the role of the private sector and innovative financing arrangements in transition; further analysis of the financial and programmatic impacts of losing preferential pricing and/or pooled procurement for health commodities; and reviews of the experiences of countries after simultaneous transition takes place.

GLOBAL HEALTH FUNDERS

Change Eligibility and Transition Policies to Fully Incorporate Health and Sustainability Indicators. Transition must not take place at the expense of human health, and this is why it is critical to factor health outcomes into decision making. ACTION recommends that funders using only economic criteria more fully incorporate key health indicators such as disease burden and disease risk into their eligibility policies. In the same vein, we also recommend including sustainability benchmarks in the transition implementation process. Benchmarks can be fiscal, such as fulfilling co-financing obligations, or managerial, such as the development of a costed, comprehensive, cross-mechanisms transition plan. If a country fails to meet these benchmarks, the speed at which a country transitions must be slowed, or the targeted transition assistance it receives increased, until the benchmark is met. Benchmarks must be designed carefully to avoid creating perverse incentives for governments to under-invest in health systems.

Provide Targeted, Equity-Focused Post-Transition Support and Feedback Mechanisms. Multilateral and bilateral funders should play a continuing role in promoting health equity in countries after transition. This can include targeted support such as negotiating continued access to preferential pricing and joint procurement, providing assistance for key populations, including through non-governmental service providers, and continuing to provide technical assistance for health systems strengthening. Monitoring of and learning from the transition experience should be institutionalized within and across global health financing mechanisms to ensure that health outcomes are not sliding backward and to influence how the global health financing landscape continues to evolve.

HIGH-INCOME COUNTRY GOVERNMENTS

Improve the Transparency and Predictability of Bilateral Aid Programs. High-income countries' aid agencies should create transparent eligibility policies, robust communication about transition, prolonged timelines for transition and clear guidelines for managing transition which take into account the plans of multilateral institutions and other bilateral donors. Lack of clarity around bilateral aid programs was one of the key findings of our analysis, and one that needs to be urgently rectified.

Use Roles on Multilateral Funding Mechanism Boards to Improve Policies. Board representatives from high-income countries should push to modify eligibility and transition implementation policies and practices to prioritize sustainability and maintained health outcomes, including at the operational level of robust policy guidance and planning procedures. At all levels of policy and procedural guidance, boards should push for greater awareness of and coordination around simultaneous transition from multiple sources.

LOW- AND MIDDLE -INCOME COUNTRY GOVERNMENTS

Lead the Coordination of Transition Efforts at National Level. Governments should elevate or create a national coordination mechanism with the mandate, competence, and authority to manage and oversee simultaneous transition processes.^{cxvi} It will be important to ensure that this mechanism—whatever form it takes—includes all relevant stakeholder groups: all relevant government agencies (including not only health ministries but also ministries of finance, planning, or local government agencies), representatives of funding agencies, nongovernmental technical partners, parliamentarians, civil society and affected communities. National-level coordination mechanisms should look at transition holistically, to ensure the impact of simultaneous donor withdrawal on the entire health system is assessed in context with all stakeholders.

Make Clear Commitments to Increase National Funding to Meet Priority Health Needs. Particularly for health priorities where the government has drawn on external support for a significant proportion of funding, it is critical to make specific, time-bound, public commitments to increasing domestic funding. Additional ways to demonstrate movement toward sustainable domestic financing of health include meeting co-financing obligations, meeting the agreed-upon targets of the Abuja Declaration, and beginning the process early of identifying what additional revenue can be made available for meeting the health needs of the population.

Strengthen Health Systems and Improve Budgeting Practices to Begin the Process of Transition Preparedness. Countries must begin the work of developing stronger health systems before the transition process begins. This should include filling vacant health worker positions, strengthening management capacity in the health system, and strengthening supply chains. Equally important are steps to strengthen the transparency and clarity of budget lines. The capacity of health stakeholders to project and articulate funding needs is particularly important to long-term sustainable financing.

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