Navigating aid transition in the health sector

An issues paper of priority areas and practical recommendations for donors, countries and the provision of technical assistance

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Contents

List of abbreviations and acronyms

ADB	Asian Development Bank
AfDB	African Development Bank
BMGF	Bill and Melinda Gates Foundation
Gavi	Gavi, the Vaccine Alliance (formerly the Global Alliance on Vaccine and Immunization)
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GFF	Global Financing Facility
GNI	Gross National Income
GPEI	Global Polio Eradication Initiative
IATI	Independent Aid Transparency Initiative
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
ODA	Official Development Assistance
PEPFAR	President's Emergency Plan for AIDS Relief
UHC	Universal Health Coverage
WHO	World Health Organization

Executive summary

Key messages

- Aid transition is already happening, but we need to frame it differently to avoid a funding 'cliff edge'.
- Transition presents an opportunity to strengthen the resilience of health systems and to sustain improvements in health outcomes.
- An effective approach to transition requires joint planning, donor–recipient coordination and data transparency.
- Successful transition requires a whole-country approach, where health plans are integrated into and aligned with overall economic and fiscal policies.
- A Global Observatory on Transition could provide technical assistance to donors and countries to help them plan for and execute transition, monitor progress and ensure data availability and accuracy.

Transition requires a new approach

'Transition' describes the change in the relationship between a donor and a recipient that occurs when the donor reduces the level of support it provides to the recipient. The changes that have been seen in practice have been widely discussed, but how those changes should occur has received less attention. Transition in the health sector is often thought of as the handover of programmes and activities to national governments, rather than in terms of sustaining improvements in health outcomes. This mindset needs to change, because if transition is not well planned and integrated into the country's overall path towards universal health coverage (UHC), it can jeopardise the health system's ability to provide essential services.

Transition is happening: the level of overseas development assistance for health is stagnating and its form is changing. Donors are reducing the amount of support they provide, increasing their co-financing requirements and focusing on a reduced number of priority countries. Aid relationships are changing, based on recipients' economic growth and their graduation between income brackets.

Transition is also happening in a context of increasing need. We are not making enough progress to meet global commitments to reduce maternal and child mortality rates, and at the same time we are seeing the prevalence of chronic and more expensive-to-treat diseases increase. Countries need additional resources, but external support is diminishing. The lack of a unified response to transition means that progress towards UHC will be slower and even more challenging than it needs to be.

Donors have the opportunity to reframe transition according to recipient countries' particular contexts. By collaborating with recipients on how to phase out their financial support, the possibility of a funding cliff edge can be avoided.

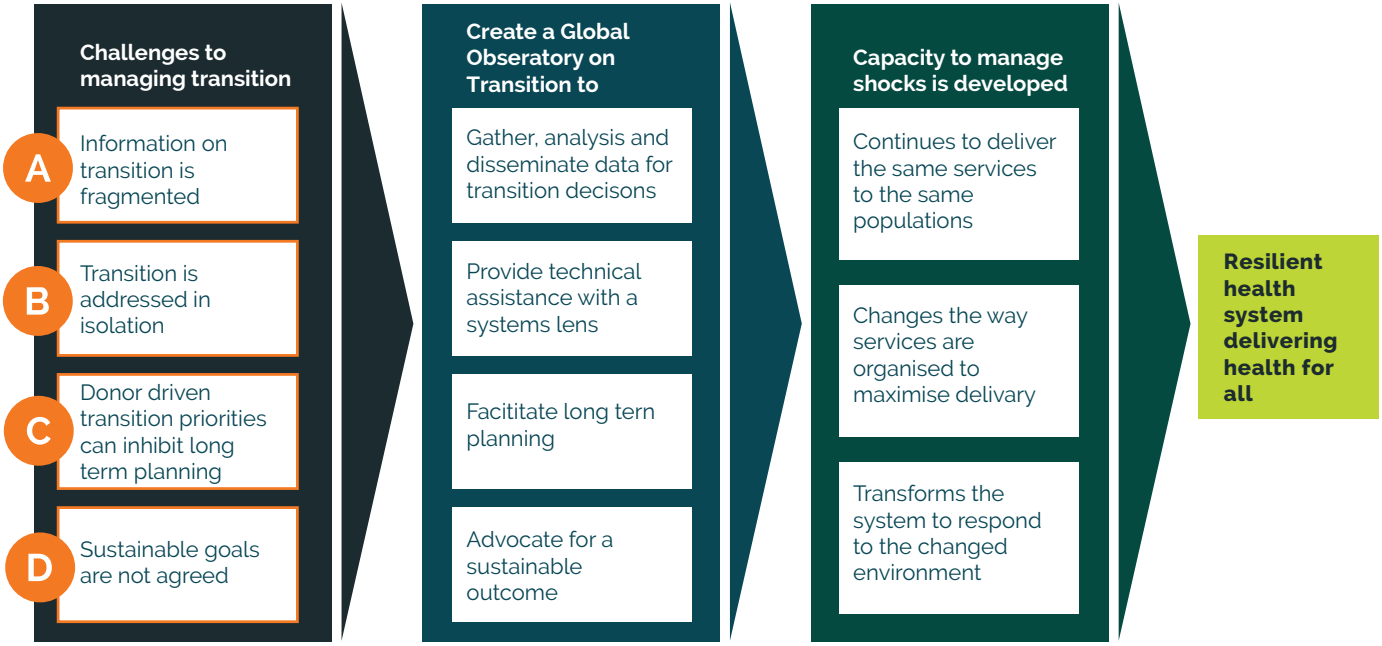
This report highlights critical issues with transition processes. It then suggests a new approach to transition, one which can enable donors to reduce their financial commitments while at the same time allowing countries to achieve their health goals.

Transition is an opportunity to strengthen the resilience of health systems

Changes in the aid relationship between a recipient and a donor can be a shock to the health system. Just as a country might face the 'shock' of a pandemic or a recession, it can also face the 'shock' of transition. To cope with this new shock, a health system must be resilient – it must have the 'capacity to absorb, adapt, and transform when exposed to a shock, and still retain the same control over its structure and functions'. We used Blanchet et al.'s resilience framework to propose a new way of thinking about transition and to define what roles donors and recipient governments can play in a successful transition process. The framework helped us to classify those elements of transition that can hinder progress towards UHC and to generate recommendations for donors and governments.

Figure 1 summarises the current challenges involved in managing transition, the solution proposed to mitigate them and the expected outcomes. These are described in the following paragraphs.

Figure 1 Dimensions of resilience for transition; adapted from Blanchet et al., 2017[67]



Challenges to managing transition: critical issues to address

If donors and countries plan together, transition to a domestically funded health system becomes a unique opportunity to mobilise resources and expertise and to build a health system that can manage shocks and be more sustainable. This will require donors, countries and technical partners to agree to address a number of issues together.

Information on transition is fragmented

Donors and national government should agree on the meaning of transition; on a shared goal, and commit to data transparency and accessibility. Transition is a 'change in aid relationship', but there are no clear and universally applicable parameters to identify and measure what that change will look like or how it will be reached. To create a clear and shared understanding of what a country and its donors mean by transition, and develop a concrete plan, it is essential to have accurate, recognised and up-to-date financial and epidemiological data. Generally, the data required for donors and the government to make sense of transition are not readily available or accessible to all stakeholders. Costing analyses, fiscal space projections and information about donor resources are not accessible.

Without clear data, transition planning will become guesswork focused on specific activities. Health financing strategies for transition are often conceived in isolation and do not align with the country's overall financial and economic strategy. A shared understanding of the transition process and its goals means the government and donors make their respective assumptions explicit, outline expected changes and define joint planning criteria. Availing financial and epidemiological data will enable government, donors and partners to use it to plan realistically and effectively, make better decisions and adapt, as well as monitor progress towards domestically funded systems and sustained health outcomes.

Transition is addressed in isolation

Transition planning should involve all relevant donors, with financial decisions aligned to the country's overall economic framework, under the stewardship of the national government. Transitions tend to be analysed from an individual donor's or programme's perspective, not in relation to the health systems they affect. This results in fragmented or uncoordinated management of transitions at country level. Transition activities that focus on a specific issue or disease might not align with the health system's overall strategic direction and can skew government priorities and allocations. Transition planning and allocative decisions should be based on a whole-system view – one that takes account of national priorities and has a goal of sustaining better outcomes. A country can experience multiple transitions at the same time, but in the absence of an overarching national plan and governance system for managing the overall transition and shocks, the government can find itself with unrealistic financial plans, unmet commitments and a poorer performing health system.

Donor-driven transition priorities can inhibit long-term planning

Donors should adhere to a transition process that aligns with the government's long-term plans. If individual transitions are driven by donors in separate processes, countries will struggle to make effective long-term plans. Donors are likely to push for transition according to their own priorities and timelines. In the absence of a unified transition process, governments risk juggling multiple, standalone commitments with different stakeholders, which are difficult to monitor and implement. These can have conflicting timelines and unexpected crunch times; for example, multiple co-financing commitments in the health sector might coincide with a major national investment in another sector. The inability to integrate all transitions to an overarching national framework and plan has implications beyond the health sector, affecting economic development and finance. If transitions are not well integrated, governments and donors cannot plan for the long term, they will not know what is expected of them at each stage, and negotiations might not include the relevant institutions (e.g. ministry of finance).

Uncertainty about the transition process can lead to last-minute solutions (e.g. to avoid a drug stockout). Integrating transition decisions into discussions on progressive universalism and benefit packages would enable governments to plan for the long term, including which services are to be delivered, what populations will be covered and how outcomes will be achieved, thus increasing the likelihood of transition being a success.

Sustainable goals are not agreed

Sustainability should be framed in terms of continuously improving health outcomes, and aid effectiveness principles should be applied to transition processes. To achieve sustainability, one should focus on outcomes, not activities. Like transition, the concept of sustainability has different meanings for donors and countries, resulting in different ways of trying to design, plan for and achieve it. Sustainability is often considered as the 'handover' of activities and inputs from donors to governments. This view of sustainability delegitimises the role of governments in the process of transition, and diverts attention away from the goal of sustained improvements in health outcomes.

A transition that is able to sustain improved health outcomes through new ways of financing requires continuous commitment from both the donors and the government to the principles of aid effectiveness (ownership, alignment, harmonisation, results and mutual accountability). Maintaining the focus on health outcomes is essential to ensure that the pressure for transition does not lead to short-term, ineffective solutions, rather than long-term reforms. Country ownership and stewardship of these long-term reforms will only be achieved if donors' interventions are anchored in national plans and strategies and there is a shift in the balance of power from donors to governments.

Facilitating successful transitions through a Global Observatory on Transition

We propose that a Global Observatory on Transition is set up to support donors and governments in planning for and implementing effective transitions. The role of the Global Observatory on Transition would be to develop a shared framework for transition, and to coordinate and provide tailored technical assistance to donors and countries, to help them prepare for, plan, implement and monitor transitions. The Global Observatory would respond to the critical issues identified above in the following ways:

Gather, analyse and disseminate data for transition decisions

The Global Observatory would identify, collect and analyse data relevant to transition and ensure that they are made available. The methods, sources, results, and analyses would be transparent, allowing for data to be combined, critiqued and used for decision-making. The Observatory would create a framework for increased data transparency at the global level and collect and promote the transparent use of financial and evaluation data from donors, as well as health, programmatic and financial information from countries. The Observatory would support countries, donors and civil society in their use of these data to monitor the effects of transition on citizens and hold countries to account on their delivery of UHC, despite the changing context.

Provide technical assistance through a systems lens

The Global Observatory would lead the development, dissemination and coordination of new approaches to technical assistance. It would coordinate a network of technical assistance providers that are able to apply systems thinking and can support transition processes in an integrated way. The transition pathway provides a framework for planning the activities, analysis, and support required. Technical assistance provided during this period would adopt a systems approach: it would bring together experts from outside the health sector to ensure that the right institutions are engaged in decision-making, and focus on the medium to long-term ability of the

system to respond and continue to sustain health outcomes. This would ensure that donor transition timing and sequencing will fit within a country's broader plans, including progressive universalism.

Facilitate long-term planning
Through the provision of technical assistance, the Global Observatory would help countries to adopt a transition pathway (a draft of this nonlinear pathway is presented in this report). It would provide guidance on tools to implement, questions to ask and negotiations to hold, to ensure an effective transition. The transition pathway would be adapted over time, to integrate learnings from the unified approach to transition planning and implementation. The observatory would ensure that any donor or country embarking on a transition process adopts a context-specific approach that will result in health outcomes being sustained or improved.

Advocate for a sustainable outcome
The Global Observatory would be an independent body aiming to increase the capacity of countries to manage transition and achieve sustained progress in health outcomes. The observatory would use its voice to advocate for the principles of aid effectiveness to be implemented and for outcomes, rather than inputs, to be sustained. As a provider of support to recipients and donors, it would ensure these principles are integrated into its own work and would use any evidence generated by its activities to demonstrate the importance of these principles to others.

Conclusion

Transition in the health sector is successful when a government continues to make sustained progress on improving health outcomes by increasing access to, quality, and equity of care in a dynamic, forward-thinking policy and planning environment. A Global Observatory on Transition would address the key transition-related issues that risk undermining the ability of a health system to sustain health outcomes. It would provide a unified response to the challenges encountered during transition and help countries to improve the capacity of their health systems to manage transition and achieve better health for all.

Section 1

Why do we need to rethink and act on transition now?

This issues paper was commissioned to provide a framework for discussion on the transition to lower levels of external funding to low- and middle-income countries. Literature on transition from aid, and its consequences for both donors and recipient countries, remains limited. No universal agenda or agreed set of best practices that would result in a smooth transition has been identified for the cohort of countries approaching, or undergoing transition right now.

Our work focuses on the health sector, building on and complementing that of others, in particular the UHC2030 technical working group on transition and sustainability, analyses of the projected impact of transition,[1,2] and evaluations of previous transition processes, such as USAID family planning programme graduation.[3-5] This analysis contributes to the debate on transition by highlighting priority areas and identifying practical recommendations on how countries, donors and technical advisors can address transition for the health sector, both programmatically and financially, in a sustainable way.

The countries now approaching transition are concentrated in Africa, whereas the available literature tends to document best practices and learnings from South America, India or the Western Pacific,[6-8.] These contexts are vastly different to those for countries currently experiencing transition, as shown in Silverman's study comparing transition cohorts.[1] Lessons based on what has worked in a small economy in the South Pacific or in Europe cannot be applied to Africa. There is also limited literature on how governments can approach transition from the systems perspective, or how they can deal with multiple transitions.

In recent years, more countries have reached middle-income country status, but they have also become home to two-thirds of the world's poorest people.[10] Inequality and limited fiscal space are the backdrop to many transition processes, the consequences of which are already visible in increasing drug stockouts, reprioritisation of available resources (towards meet donors' co-financing requirements) or defaults on co-financing payments. It is important that, as national income levels increase, progress towards development outcomes are not undermined by transition.

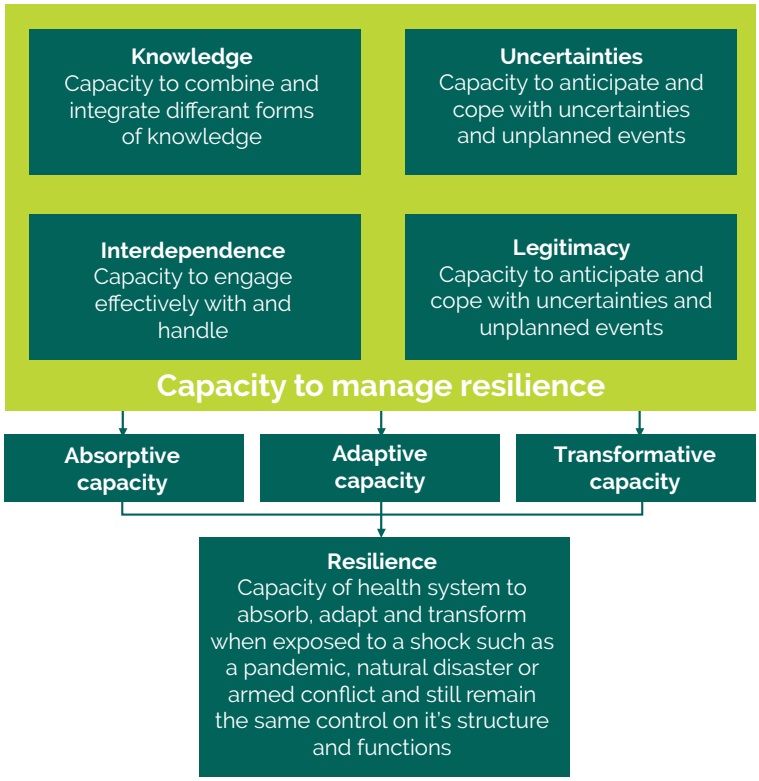
As donors define strategies for complete transition, some countries are already facing non-explicit transitions ('stealth transitions'), whereby external funding is conditional on meeting co-financing requirements, absorbing procurement and financing responsibilities for drugs and human resources, or prioritisation of specific programmes and activities within domestic resource envelopes. Current technical assistance models tend, for the most part, to be sector specific, vertical, and based on previous experiences, rather than taking a holistic view of the current development needs of a country or multisectoral approaches.

We argue that transition can be an opportunity for middle-income countries to accelerate progress towards UHC and reduce their health systems' dependence on donors. To navigate this will require a shift in mindset and approach among both donors and countries,[11] and new principles of technical assistance to mediate the process will be needed. Technical assistance providers will need to develop multi-sectoral models and methods able to respond to the new challenges that transition is presenting for health systems and beyond. For transition to be an opportunity, it requires donors and countries to adopt a shared approach that has an agreed and realistic timeline.

Section 2
Conceptual framework

Our approach is informed by the literature on systems thinking[12,13] and resilience theory[14,] and considers transition as one of the many 'shocks' that health systems have to adapt and respond to along their path towards UHC, rather than an isolated or discrete event. We built our analysis on Blanchet et al.'s conceptual framework for resilience (Figure 1)[14] in order to embed transition discussions within the broader system it interacts with, and frame it as an opportunity for health systems' to strengthen and test their resilience management capacity, and prepare them for the multiple upcoming challenges, or changes, from migration to the increasing prevalence of non-communicable and chronic diseases. An effective transition will in fact depend on the stakeholder's ability to combine and integrate different forms of knowledge (and have access to relevant data), and their legitimacy to make decisions. This will enable them to put in place systems to effectively engage with interdependence and ultimately cope with the inevitable uncertainties, thus maximising the capacity of the health systems to manage transition.

Figure 1 The dimensions of resilient governance: a conceptual framework; from Blanchet et al. (2017)[14]



This issue paper aims to kickstart a dialogue on transition, bringing together donors, recipient countries, civil society and practitioners to design and agree upon a way forwards. It is only the first step in a longer process that will require further research, validation and testing at country level.

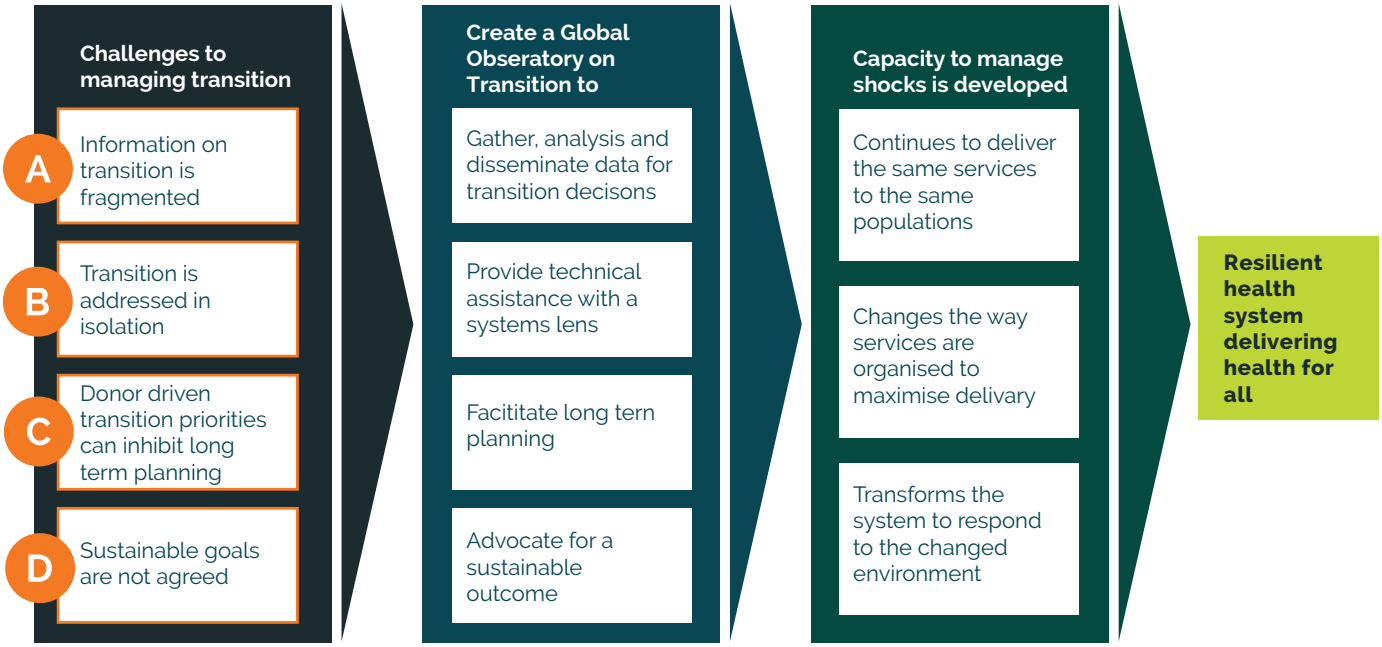
We looked at transition from both a country and a donor perspective, with a focus on what this could mean for technical assistance. We conducted a desk review of literature on transition, research on the transition policies of thirteen multilateral organisation and interviews with key informants already working on the transition agenda in low and middle income countries, especially in Sub-Saharan Africa.* We have combined these findings with our own experience as technical assistance providers.

Building on existing work on transition, we want to shift the attention to implementation. We used the dimensions of Blanchet's resilience governance framework to reframe transition (figure 2), highlighting 4 main challenges, and opportunities for transition, and propose a possible first step to move towards more resilient health systems.

* These thirteen multilateral organisations are: Gavi, Global Fund, PEPFAR, BMGF, GPEI, WHO, ADB, AsDB, GFF, IDA, IBRD, OECD, EBRD

Section 3
Issues and recommendations

Figure 2 Dimensions of resilience for transition; adapted from Blanchet et al., 2017[67]



A Information on transition is fragmented

There is no common agreement on what transition is

In the international development context, transition can mean many things and is perceived differently by donors and recipients. The word 'transition' can be used to describe a country's progress towards democracy (political); across national income brackets (economic); changes in a country's population patterns (demographic); and/or disease burdens (epidemiological). We can also use the word to describe the change in aid or funding that a country receives over time (financial), along with the terms 'graduation', 'increased ownership' and 'sustainability'.

When talking about donor transition and the reduction in external health funding to low- and middle-income countries, there is no agreed definition or approach regarding what is meant and how it should be managed. This leaves individual departments within ministries of health to negotiate independently with donors, often without a national transition plan or financing strategy that considers contextual transitions, broader investment plans and service delivery needs. Several attempts have been made to create joint definitions, such as efforts by the UHC2030 technical working group on transition and sustainability, and a recent report by ACTION, RESULTS UK and the UN Foundation.[15]

Figure 3 Word cloud generated from donor's definitions of transition

For recipient countries, transition can be defined as the significant reduction of funding received from donors, or a change in the cost of receiving external financial support, through a process almost always driven by donors. It represents a change in both the quantity and the type of financial resources received, and often a reduction or ending of technical assistance (in some cases, preceded by a spike in technical assistance).[16] For countries, transition does not usually apply to only one programme; more often it involves a reduction of funding for multiple programmes or disease areas, and it may also be simultaneous with transitions across other sectors.

From the donor perspective, we looked at the definitions used by thirteen donors. Ten of the

donors used the term 'transition' and three used the term 'graduation'. Four of the donors used other terms interchangeably, such as 'ownership' and 'sustainability'. Across all the donors, transition was defined as an incremental process, rather than a target. The key differences in the definitions of transition related to what the transition was from and to, and what the transition process included. Transition was used as a label for both a reduction of support and a change in funding type.

Each donor defined transition in relation to their own programme of funding. The common words emerging from these definitions are illustrated in figure 3. Donors based their eligibility criteria and processes on their expected funding levels and timelines, and then adjusted them based on the expected needs of the recipient country and disease area priorities.

Development banks typically use the term 'graduation' rather than 'transition', and explain it as the change in the types of credit a country can access as it achieves higher levels of income.[17-23] Global initiatives such as Gavi, the Vaccine Alliance (Gavi),[24,25] the Global Polio Eradication Initiative (GPEI)[26-27] and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)[28-30]) use the term 'transition' to indicate the ending of funding that supports a specific programme. Other donors do not have a standard term or definition to describe the ending of their financial support, such as the Bill and Melinda Gates Foundation (BMGF),[31] the President's Emergency Plan for AIDS Relief (PEPFAR)[32, 33] and the World Health Organization (WHO).[7,11]

Some donors are refocusing or concentrating their support on specific groups of countries (thus indirectly transitioning from others), such as PEPFAR and BMGF. PEPFAR, for example, has selected [13] countries that will receive 'accelerated support', but it has not issued explicit guidance to existing recipients who are not included within this group.

Why is this important? The lack of a common definition reflects the different agendas and concerns that donors and recipient governments have in regard to transition. It prevents systematic transition planning, both in the health sector and beyond – planning that takes a whole-country perspective.

Robust planning for transition would take a shared perspective (donor and recipient), and would cover the whole health system, not just a single disease area or programme. It would mean working out how to use a country's financial resources in the most efficient manner to achieve its goals, including progress towards UHC, and how to change the revenue mix over time in a way that does not restrain health outcome improvements and is financially sustainable for the country.

When transition is framed as 'how can we sustain effective coverage of priority interventions?', rather than 'how can we sustain the donor-supported programme?', the perspective (country-wide) and sequencing of transition, including co-financing requirements, and joint transition planning, become essential steps in the dialogue between donors and recipient countries.

Data are not available for evidence-based decision-making

The transparent communication of data, particularly financing data, is the foundation for reinforcing trust and improving coordination with partners, as required to achieve effective aid delivery. The availability of data is a core part of the aid effectiveness agenda and, following the 2005 Paris Declaration, received a broad coalition of support. The open-data standard was endorsed at the 2008 meeting in Accra and subsequently the Independent Aid Transparency Initiative (IATI) was set up. Today, 800 organisations are publishing data on IATI, covering more than one million activities, marking a significant step forward for the transparency agenda.[34]

IATI was created to be accessible to all and to incentivise donors to buy into the initiative. However, IATI is not particularly intuitive, and it does not work as a tool to help recipient governments understand exactly what funding they are (or are likely to be) getting, in what areas and from whom. It is not used by all donors, and the data that are there are not always complete.[35] IATI, like any data platform, requires countries to receive long-term support in how to use its data and plan around it.

Several initiatives have tried to capture data on the following three key questions at the core of transition planning:

1. How much funding and technical assistance is being provided? Despite initiatives such as IATI, the level of funding that donors provide generally remains opaque. [4] Those working for donors are often unaware of the overall package of support being provided to government, and other donors choose not to share this information outside their organisation.[36] Governments also face a lack of information regarding their own available funding, co-financing requirements, and aid conditionalities. Inefficiencies, a lack of prioritisation or a lack of capacity can result in inaccurate estimates of resource availability or a lack of data on planned future revenue and expenditure.

2. Where is the support allocated? Donors may inform governments on the levels of funding they have provided, but governments also require information on exactly how that support was distributed, in terms of geography, target population, partners and timing. One practical way in which donors demonstrate harmonisation as part of the aid effectiveness agenda has been to split geographic regions between donors.[37] Within regions, donors may have supported specific segments of the population (such as key vulnerable and marginalised populations) or certain facilities or districts. Some donors will have supported non-governmental organisations, and others, specific ministries.

3. What did it achieve? In our analysis we observed that none of the donors assessed had transitioned out of any country completely. Rather, they had pushed back deadlines for transition multiple times, sending mixed messages to governments. If we take transition to mean sustaining and enhancing outcomes, rather than activities, then it is crucial that governments and donors generate and share information regarding what outcomes were achieved, at what cost and where, so they can plan effectively and deliver successful transitions. Donors might not know what the real priorities are, or how much funding a country has; and governments might not know exactly what they are being asked to transition, or by when.

Why is this important? Not all donors have policies on transition, and where they do, they can be complex. Governments are not involved in creating these policies and have limited opportunities to influence them. Meanwhile, governments and donors are both trying to implement transition without having information on what is being transitioned, or information on the funding available or required to implement the transition. This makes it impossible to plan, implement or monitor transitions successfully. Governments must understand how funding or support has been distributed if they are to identify where the financial need will be and which areas are at risk of having funds diverted as a result.

GPEI extension

Instead of winding down in 2019, as previously planned, GPEI has been extended for another five years. Uncertain timelines and the expectation that donor support will continue (regardless of the dialogue around transition) have contributed to countries developing unrealistic transition plans for polio eradication.[38]

Gavi uncertainty

Despite indications suggesting that Gavi transitions might not be successful, the Gavi board has concluded that there is not sufficient evidence to change their timelines. It remains to be seen whether Gavi does continue with transitions as planned, and whether countries take this commitment to the original timelines seriously.[39]

Recommendation: Gather, analyse, and disseminate data for transition decisions

Frame transition and set metrics to monitor it. We cannot engage in discussions about transition without agreeing on what we are talking about. In each context, governments, donors, providers of technical assistance and other stakeholders need to agree on what a 'successful transition' would look like, who it involves and how we would know that it has been successful. Successful transition should be understood as a spectrum, with clear indicators of progress attached to it. The goal and approaches of transition should be discussed and agreed from both donor and recipient perspectives (multi-stakeholder, multi-donor) in each country, and take into consideration the broader country context in terms of both financing and health needs.

Insist on data transparency and accessibility. A major factor in the success of a transition process will be the availability of financing data and information on programmatic resource allocation at all levels. Government, donors and technical assistance providers alike need access to the same information so that transition processes are integrated and not project specific. Governments require visibility on external funding flows into their countries, both across and within sectors, and donors require up-to-date and disaggregated budgeting and spending data. It needs agreement between donors and governments from the outset and governance mechanisms able to monitor data quality and hold all parties accountable. This could be achieved through a 'global observatory on transition' that is tasked with collecting and analysing data relevant for transition, sharing methods and tools to support transition planning, and providing targeted technical assistance for transition implementation.

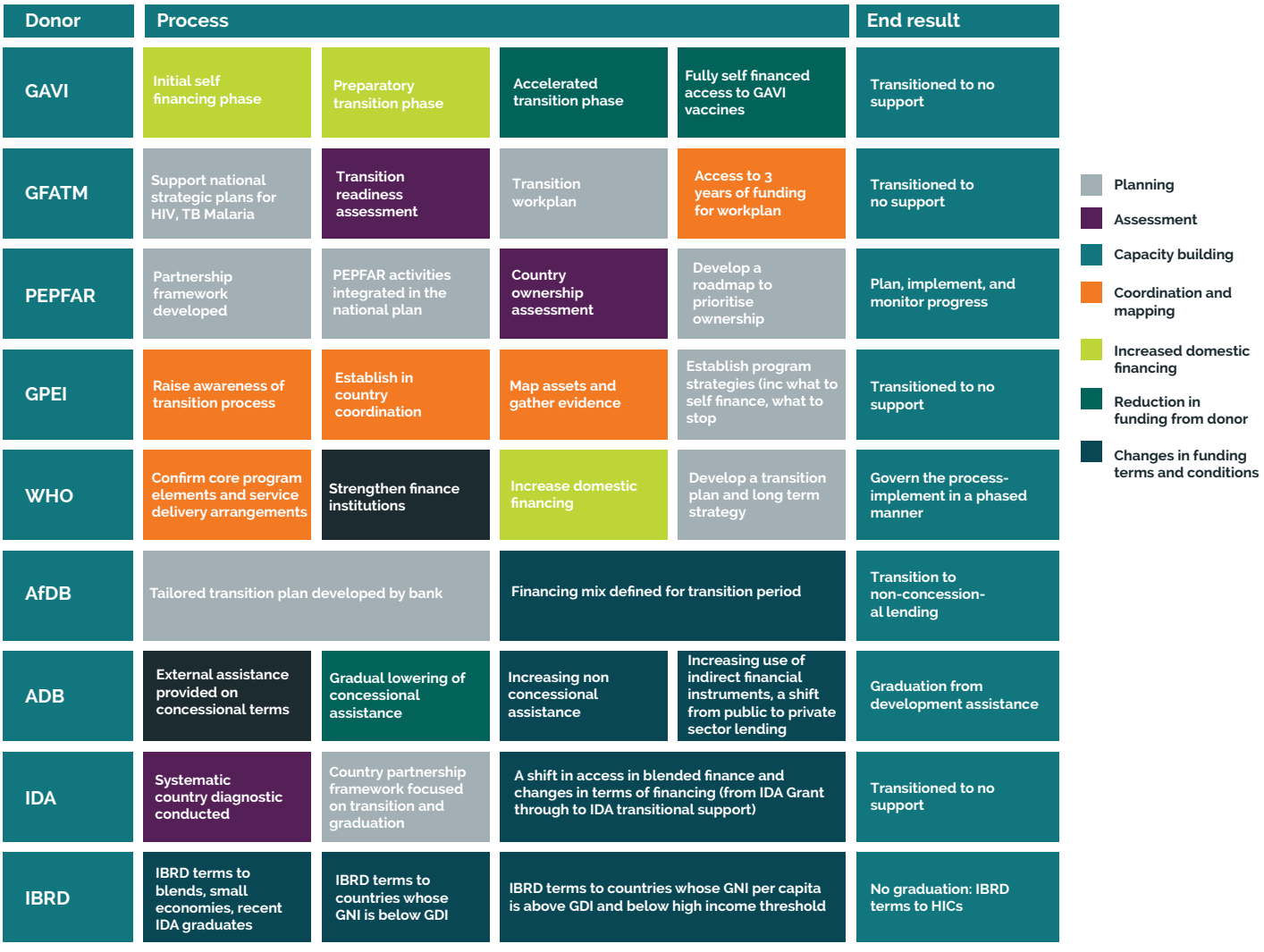
B Transition is addressed in isolation

Each donor implements transition in its own way

Different definitions and priorities for transition result in different approaches to its implementation, both in terms of requirements for countries and timing. Those donors that have documented their approach and processes for transition have focused on different agents, actions and specificity of instructions. Some processes describe the type of support that is on offer to the country at different stages of transition, and others focus on the actions or conditions that must be met by a country during the different stages of transition.

Figure 4 shows the transition process as documented by each donor we assessed and highlights how each one places the onus of transition on different actors. Under Gavi, for example, recipient governments are responsible for increasing co-financing, while AfDB creates its own tailored transition plan for implementation.[23,40] Across these processes, there is little room for countries to participate, lead, or change, the course of action, and there is no unified approach to coping with the transitions of different donors. Therefore, each time a donor signals the wish to transition out of a country or sector or to change the support that it offers; recipient countries must familiarise themselves with a new process. Looking at the diversity of transition processes followed by different donors, three key areas stand out as main causes of fragmentation, duplication and confusion regarding who is responsible and how an activity should take place during transition.

Figure 4 Transition process mapping (GFF and EBRD not included due to lack of information on transition process)



• **Planning:** Gavi, GFATM, GPEI, PEPFAR and the WHO include the development of a plan as part of the transition process. However, this can mean that countries are themselves required to develop a plan for the transition, or to incorporate donor activities into a long-term strategic plan. Analyses of transitions suggest that these multiple requests create an incentive to develop unrealistic plans.

• **Assessment:** Some donors include an assessment or diagnostic as part of the transition process, to identify key challenges, gaps and opportunities. The assessments focus on different domains, including governance, domestic resource mobilisation, planning and coordination, and inclusiveness. However, they tend to be conducted in an ad hoc manner and driven by donors. A country transitioning from multiple donors will have multiple assessments, looking at different domains and measures. As a result, countries do not have clear guidance on, or ability to plan and forecast, how, what and when they should be achieving indicators to meet the transition requirements.

• **Coordination:** Transition processes led by different donors require different agencies or coordination bodies. For example, GPEI requires the establishment of an in-country coordination mechanism specifically for the transition of the polio initiative. The coordination of the transition process often neglects to take a multi-stakeholder approach, instead maintaining the status quo, i.e. liaison with a single ministry (health or finance), and often with a single department within the ministry.

Why is this important? Lack of clarity on transition processes and expectations reduces both donors' and countries' accountability for health outcomes and targets. The range of different processes being used and the lack of in-depth guidance or relevant technical assistance result in countries being unable to plan adequately. Uncertainty acts like noise, reducing a country's ability to invest time and resources in prioritising the interventions to be transitioned and evaluating their impact and alignment with national priorities. Poor communication regarding the planning and coordination of transition creates a high risk of a 'cliff-edge' transition, where resources required to sustain health service provision and gains in health outcomes are not committed.

Economic growth does not necessarily result in improved health outcomes or ability to fund and deliver health services

Income status is one of the main eligibility criteria donors use to identify countries that are 'ready' to start the transition process. The use of gross national income (GNI) as the key eligibility criterion is based on the assumption that increased national income will be reflected in government budgets and allocations, and thus a country's ability to sustain improvements in health outcomes.[39] While income status is simple to understand, and a quantifiable measure, it does not take into account the complexity of health systems, equity issues[41] or the diversity of conditions and readiness across countries.

Income status is based on World Bank estimates, which are revised on an annual basis. Therefore, this trigger for transition eligibility is independent of any discussions between countries and partners or their preferred timeline. Different donors have different thresholds for the level of income that must be reached, and the number of years for which it must be sustained, before transition will start taking place. The International Bank for Reconstruction and Development (IBRD) is the only donor that does not set income as a key criterion, but instead uses income as a prompt to begin discussions.[19]

Figure 5 maps the eligibility criteria used in donor transition planning. Generally, income is not the only determinant of funding and technical assistance from a donor, but it is typically the primary eligibility criterion (i.e. IF income exceeds threshold THEN criterion X). Where other eligibility criteria are

Figure 5 Eligibility criteria by donor

Income per capita	GAVI	GFATM	AfDB	ABD	IBRD	GFF
Pace of economic growth	GAVI	AfDB	ADB	IDA		
Socio-economic indicators	AfDB	IBRD	EBRD	IDA		
Credit worthiness	AfDB	ABD	IBRD	IDA		
Governance and ownership	PEPFAR	ABD	IBRD	EBRD		
Disease burden	GFATM	PEPFAR	GPEI			
Service delivery Indicators	GAVI					

considered, they are usually used to determine the speed of transition, or how transition will be implemented, rather than whether transition should go ahead. Only three of the donors investigated document disease burden as a consideration when assessing the eligibility of a country for support or transition, and only one considers service delivery.

Unlike countries that have previously transitioned from low to lower-middle income status, countries currently experiencing transition are more likely to have experienced very rapid income growth, and fluctuations in income, over previous years.[1] Alongside this, projections of GNI over time are typically unpredictable and cannot accurately be used to plan or forecast the future. Therefore, graduation or transition can occur sooner than expected, before the government has put systems in place to ensure that increased income is reflected in the health system.[39]

Economic growth can lead to improved health outcomes, but it is not a standalone catalyst.[42] For example, governments will also be required to: strongly prioritise health, and then continuously prioritise high-impact services and interventions within the health sector [43] improve efficiencies in spending and service delivery; have the political will and power needed to allocate sufficient funding to the health sector; and have systems in place to protect health outcomes from external shocks.

Even if it is assumed that higher income status is translated into higher government spending, other sectors would be competing for increased funding, and if funding did increase within the health sector, it would take time to yield results.[44] In fact, there is a significant time lag ('health financing transition') between an increase in overall public spending and an increase in health spending, and then again between the increase in health spending and the reduction in out-of-pocket expenditure.[45] During these periods, vulnerable and marginalised population groups are at risk of declining health outcomes,[41] and countries in transition are at risk of regressing against UHC.

Finally, the pressure of transition and new trends in global financing mechanisms can lead countries to fund health expenditure through debt. This has implications for the overall financial health of these countries, decisions on which services are to be provided and how (purchasing arrangements), and the equity of access to health services.

Why is this important? Donors have started to recognise that income on its own is not a good enough indicator of whether health outcomes will be sustained or improved. This is demonstrated by donors' inclusion of additional eligibility criteria, to improve the flexibility of transition policies. It will be important for transition plans to: incorporate rigorous assessments of the political economy conditions, identify the willingness for resource allocation to occur in the health sector through the different stages of transition, and integrate transition planning into broader development policies[46] and health financing strategies.

Governance structures are too fragmented for smooth transition

Successful transition will require strong coordination and a shared vision between government departments to navigate and govern the process. Countries that receive official development assistance (ODA) often have multiple funding streams, each carrying a different set of conditions and requirements, channelled through multiple actors, both within and outside government, at national and subnational levels. Weak national ownership and transition processes exacerbate problems of fragmented governance.

Mali: Decentralisation and transition planning

Transition in family planning has been particularly difficult in Mali. Family planning has been adopted at the national level, but not at the local level. Without understanding the relationships and social norms at both national and subnational levels, it will be impossible to successfully transition health outcomes.[47]

Governance is considered fragmented if the systems or shared procedures put in place to make decisions or to translate such decisions into action, are inadequate, and if the relevant actors cannot participate in the process. For example, a donor may have worked with a ministry of health on primary health care, but, for transition, this responsibility (and the budget allocated towards it) will be shared between the ministry of local government and the ministry of health. Furthermore, neither of these ministries will be able to fulfil any of the commitments to transition without the backing of the ministry of finance. As transition activities are implemented, decentralised governance structures also need to be considered, to ensure that the commitment to sustain health outcomes extends beyond the national level.[47]

Fragmented governance makes it impossible to plan and implement transitions in a way that considers their impacts on the whole health system ('systems

perspective'). While an individual donor may transition from a single programme, the entire country's health system, and financial planning, will be affected. Therefore, transition plans must take into account how the whole system works, rather than just the governance of a single issue or area of support.

Multilateral donors recently interviewed about the transition process observed that political economy conditions were not given enough consideration during transition.[48] Donors tend to want a straightforward roadmap for transition to national ownership and resourcing. Having to consider prevailing governance constraints and resource allocation processes can be an inconvenient hindrance to such plans. Political economy conditions change constantly and progressive change to national ownership is 'cumulative, unpredictable, highly political, and needs to be locally led',[49] meaning that flexible and unconventional ways of working will be needed, not transition blueprints to be uniformly applied in different contexts.

Why is this important? Specific circumstances of governance, and power relations in each context, mean that the political economy needs to be assessed on a country-by-country basis and the findings used when drawing up transition plans. The power mapping that forms part of this assessment helps to identify with whom donors should liaise during the process of transition and which parties will influence the success of transition. It will help stakeholders to understand any impacts that the donor has had on a country that need a response (e.g. systemic gaps caused by the ending of a vertical programme), as well as the potential barriers to national ownership and funding of specific interventions.

Kenya: Identifying who the decision makers are

In Kenya, the Global Financing Facility has worked with the ministry of health to develop an investment case for reproductive, maternal, newborn, child and adolescent health. Funding provided by the International Development Agency (IDA) should be used to implement this. The priority in the investment case was to focus on high-burden counties. However, as IDA funding is negotiated with the ministry of finance (and documented in the project appraisal document), the choice of priorities was taken over by alternative incentives within the ministry of finance, which chose to spread the funding across all counties. This highlights the need to work beyond the health sector, and understand other stakeholder incentives, before it is possible to ensure commitment to transition.[50]

Recommendation: Provide technical assistance with a systems lens

Transition should be led from a country perspective. Governments and providers of technical assistance need to be brought 'on board' with the transition process as early as possible, and implementation processes should be agreed under the stewardship of governments. This way, the timelines, interactions, responsibilities, gaps and priorities are clear and agreed. Technical assistance has a role in ensuring transition plans are realistic and rational, and in bringing together assessments and diagnostic requirements into a unified approach in which governments take the lead. Government leadership will be particularly helpful in bringing together different donors who are starting transition processes at different times

Use transition as an opportunity to build systems that can respond to shocks. As donor support to health programmes diminishes, so too will support to governance structures (financial and technical). This should be taken as an opportunity to reform governance within the health system; reform that supports the system's ability to adapt and respond to shocks while maintaining service coverage, quality and availability. This would require explicit commitment by governments and donors, supported by tailored technical assistance, assessments, targeted methods and tools to strengthen health systems' resilience to transition and other shocks.

C Donors drive transition priorities that can inhibit long term planning

The aid effectiveness agenda has not shifted the balance of power between donors and recipients

As mentioned in the previous section, for transitioning countries, their ability to set priorities and drive the sequencing of transition relies on them having the power to do so. The 2005 Paris Declaration set out principles of aid effectiveness to improve the quality of development assistance. The principles of ownership, alignment, harmonisation, results and mutual accountability were agreed to by donors and recipient countries alike, and then furthered through the 2008 Accra Agenda for Action.[51] The aid effectiveness agenda gained traction, yet it was unable to change the way development was delivered.

Mali: Too many plans for a strategy

Mali has three strategy documents and a joint assistance strategy, written by donors; and a multitude of sector-specific strategic plans. The large number of plans has resulted in incoherence and a lack of prioritisation, which undermines their content and, thus, the very concept of government ownership. Without a clear roadmap, donors cannot be held to account for not aligning with national priorities, and government cannot manage donors to align with their priorities.[47]

Transition is often framed and planned in the context of the aid effectiveness agenda, either assuming that aid already encompasses the aid effectiveness principles, or that it will be possible to achieve these principles through the transition process. National ownership, meaning 'the effective exercise of a government's authority over development policies and activities',[52] requires that donors align their programmes with government priorities and plans, and that the government articulates its development agenda and related priorities.

Ghana: The impact of hardening loan terms

Increased income in Ghana has resulted in a rise in the proportion of external funding it receives as loans, rather than grants, and a reduction in the concessionality of those loans. This has created an even stronger incentive for government to seek as much aid as possible and to accept all assistance being offered, irrespective of whether it aligns with national priorities.[47]

In practice, the donor–recipient power dynamics skew the application of those principles and create a parallel set of incentives. Donors are accountable to boards, agencies or their own country's citizens; they are expected to adhere to their own reporting, procurement and funding requirements and priorities, which are often influenced by foreign policy and geopolitical factors. With donors being able to independently decide how much external support is provided to each, recipient countries have lacked the resources and power (whether perceived or real) to exercise ownership.[53]

Countries have an incentive to request and follow what donors will fund, as a means of maintaining or gaining access to aid.[47] Under these skewed and implicit power dynamics, the exercise of ownership becomes a 'rubber stamp' of perceived priorities and expectations.

Why is this important? Proceeding with transition planning without challenging the assumptions of the aid effectiveness agenda will result in gaps in the process. There is a need to take into account the challenges of phasing out external support to countries that do not yet have strong national systems. For transition to be a gradual process, rather than a cliff edge, the donor–recipient relationship must move towards being a mutual partnership.

Donor spending skews national resource allocation

One of the consequences of donors setting their funding agendas while national ownership of programmes is still limited is that recipient countries often allocate domestic resources in response to the donors' priorities, funding the gaps left by external support, rather than according to their own national priorities. Therefore, government funding may not entirely reflect government priorities. For example, if a donor funds all HIV/AIDS drugs, the government will direct its resources to other areas.
Aid and technical assistance approaches, where external resources and skills substitute for domestic ones, have contributed to and fostered perverse incentives against financial planning for transition. Co-financing requirements for Global Fund grants, for example, resulted in Cameroon experiencing prolonged antiretroviral stockouts following a reduction in Global Fund contributions in 2013, leading to thousands of patients being unable to continue with first-line HIV treatment.

Programme areas that typically receive little attention from donors during implementation are at risk during transition. Donors focus on the transition of their programmes, putting pressure on governments to commit funding for them. However, transition planning to date has taken little account of the opportunity costs associated with this approach. As governments reallocate or mobilise funding to absorb transitioning health programmes, are other activities or outcomes being cut or delayed as a result? As health receives increased funding to manage transition, what are the consequences beyond the health sector?[54]

Why is this important? During transition processes, governments can be put under pressure to change which programmes they prioritise and how they allocate funding. Keeping donors happy by meeting co-financing arrangements can result in failing to meet the needs of a changing population (as in the case of non-communicable disease burden). Specific inputs and immediate commitments of the health budget, such as infrastructure and human resources, are likely to be prioritised if a government is struggling to finance a gap left by transitioning donors.[56] Meanwhile, services for marginalised groups, quality improvements, system strengthening interventions and emerging priorities are more likely to be defunded or scaled back.

Zambia: Hidden costs of transition

The district basket was a funding mechanism in Zambia funded by several major donors to support the delivery and management of primary health care at the district level. When donors withdrew from the basket due to a corruption event, the government was expected to take on the additional funding requirements. While the additional funding requirements appeared to have been met in line with a 'successful' transition, the proportions of the allocation were skewed towards human resources, and no longer included funding to support service delivery or quality of care interventions.[55]

Recommendation: Facilitate long term planning

Integrate transition into benefit package decisions. Taking a 'systems perspective' means assessing the content and timing of transition within broader decisions on the benefit package.[57] The success of transition will depend on whether sustained improvements in health outcomes are taken into account as countries define their health system (in terms of which services are to be provided, to whom, in which facilities and at what cost), whether explicitly, through a formal benefit package design process, or implicitly, through public health system guidelines. Technical assistance models should use and adapt existing tools for priority setting in order to sustain gains, map the hidden costs and identify the areas at risk of being underfunded in transition. Transition planning and benefit package design will also have to address the risk of implicit rationing and delays to coverage expansion. This will need sufficient time, planning and capacity for transition to be in place, so governments can look beyond their immediate commitments and annual budget cycles.

Allocative decisions must be realistic and driven by countries. There is no evidence to support the assumption that increases in national income will directly translate to increased availability of funding for health. Technical assistance to guide assessments of political economy conditions, fiscal space and benefit package prioritisation will be required to ensure funds can be made available to deliver the needed health services. Political economy assessments will help to evaluate political willingness, incentives, institutional capacity of the health system to plan, manage and drive the transition within the path towards UHC. Financial and fiscal space analyses will inform country-wide prioritisation of resources and inform timelines for and sequencing of affordable service provision packages. Finally, prioritisation assessments of health services will guide decisions on coverage expansion, benefit package design and transition implementation. This will help to ensure that transition plans fit within realistic and country-wide health financing strategies, new revenue streams are affordable and align to the country's fiscal policies, and the key factors influencing resource allocation are understood.

D Sustainable goals are not agreed

Transition involves complex prioritisation in health sector spending: no country can afford everything

Changing economic circumstances have led to a decline in traditional ODA, and new challenges have emerged, such as an increased burden in non-communicable diseases and emerging global health security threats. New political priorities have had an impact on levels of commitments to aid in the health sector and beyond. As discussed, income remains the key eligibility criterion for transition. This means that countries often face multiple donors simultaneously exiting or changing the type of support they provide, often quite abruptly.[58] The consequences of this 'cliff edge' effect can be dangerous, with recipient countries being required to coordinate multiple transitions with multiple donors while ensuring that improvements in health outcomes are sustained.

Malawi: The cliff edge effect in Malawi's agricultural sector

A joint review of the donor exits of Norway, Denmark, Sweden and the Netherlands highlighted the consequences of Denmark withdrawing from Malawi with six months' notice. The result was a 40% drop in Malawi's agricultural budget and a long-term impact on its agricultural sector. The review also highlighted a lack of donor coordination regarding transition, resulting in countries being subjected to a wide variety of exit justifications, contexts and types of transition.[59]

The financial gap left by donors can be a significant proportion of a country's gross domestic product (GDP), especially when multiple sectors or donors are transitioning. For example, in Liberia, ODA accounts for 39% of GDP, while in Malawi it is 23% and in Afghanistan it is 21%[60,61] Recipient countries have to find the fiscal space to fund interventions included in a donor's transition plan or look for alternative sources of external support. Borrowing is one mechanism that can be used to increase public investment, but this would mean transition leading to greater debt, especially as interest rates increase as a country's income status improves. As their economies grow, countries must balance the loss of external resources, the increased need to borrow, and the higher cost of doing so.[18,47]

The integration of donor-funded services, commodities or staff into domestically funded schemes requires time and resources. It also needs the skills and systems required to perform robust assessments of what is affordable and when, given the available funding for health. As priorities change, technical assistance models aimed at building up the capacity of government to perform health technology assessment (HTA) and implement robust procedures for designing and prioritising benefit packages,[57] and how to continuously fund them, become paramount.

Nigeria: Simultaneous transition

Nigeria received US$ 247 million from GPEI in 2016 and is projected to require US$ 138 million per year by 2022 to fill a finance gap left by Gavi. PEPFAR, which did not include Nigeria as a country of focus in its 2017 strategy, cut its funding by 30% over the previous two years. Projecting Nigeria's 2022 health budget, taking into account the transitions by Gavi, PEPFAR and GPEI, would mean that 49% of the 2022 national health budget would have to be reallocated to take up the costs of these programmes alone. In reality, these costs are being met by credit. In 2016, 100% of co-financing requirements for Gavi came from loans.[62]

Why is this important? If funding becomes insufficient to maintain the coverage, quality and availability of health services, the result can be a decline in health outcomes. During transition, this risk is particularly high for hard-to-reach populations and marginalised or minority groups, because the targeted programmes from which they have benefitted are not always prioritised or continued by government. Failing to maintain services for these populations can cause re-emergence of epidemic diseases and undermine progress made in strengthening health systems, improving health outcomes and achieving UHC.[48, 63]

Sustainability means different things to donors and countries

Ensuring sustainability of funding for service delivery is critical to successful transition processes. However, like transition, the concept of sustainability has different meanings to donors and countries, resulting in different approaches throughout the design and implementation of transition.

From the donor perspective, sustainability is often linked to, or measured by, the continuation of activities after the end of their support. The implications of this assumption for transition, and

development assistance more broadly, affect both the type of support and the scope of investments donors are willing to make, and their expectations of recipient countries.

Donors tend to think that the continuation of a project's activities will continue to lead to improved health outcomes. However, health systems need to adapt continuously and respond to the changing needs and circumstances to ensure that improvements in health outcomes continue, which may mean changing or discontinuing previously effective activities. Reaching a common understanding of what sustainability will mean in each country is an essential step in transition planning.

Sustainability has become increasingly integrated into donor programme design and implementation, leading to a move away from vertical programming and towards systems approaches.[64] Funding and technical assistance are allocated to strengthen governance, planning and budgeting, and many donors attempt to work through the health system rather than in parallel ways. Placing the focus on the health system, rather than on individual building blocks, aims to achieve sustainable, long-lasting outcomes that impact across the health sector.[12]

These are positive developments; however, to date, governments and donors have not directly addressed the implications of removing a single programme or funding stream on the wider health system or the national economic strategy. For example, donor funding for HIV services, such as provided by PEPFAR, enables a government to focus other sources of funding in different areas [65]. PEPFAR may see the sustainability of its investment as related to HIV outcomes, but for the government, sustainability may also include the other health outcomes previously achieved by focusing their resources.

At the programme level, sustainability is broadly defined as 'the ability of a project to function effectively, for the foreseeable future, with high treatment coverage, integrated into available health care services, with strong community ownership using resources mobilised by the community and government. Yet, a donor's support to a programme often acts as an ongoing subsidy to the wider health system.

Why is this important? This shift towards 'systems thinking' needs to be adopted in the dialogue around sustainability and transition. If successful transition is about sustaining improvements in health outcomes, then efforts at sustainability must incorporate an approach that considers the whole health system. In this context, sustainability should mean 'the ability of a health system to function effectively for the foreseeable future, with high coverage and strong community ownership, and using resources mobilised by the community and government'.

Recommendation: Advocate for a sustainable outcome

Frame sustainability in terms of continuously improving health outcomes. Given that donors and governments have different (and sometimes conflicting) motivations for transition and different understandings of sustainability; they will have to build a consensus on what the common desired outcomes are. Understanding the pressure points will be an essential step towards achieving transparency in negotiations and planning; for example, understanding that governments might resist engaging in transition processes due to the perceived risk of accelerating funding reductions, and that donors feel under pressure to demonstrate impact and legacy of investments. The concept of country ownership can be complex, covering more than just funding allocations, and can only be achieved if donors' interventions are anchored in national plans and strategies. Careful analyses are required to ensure that time pressures from the transition process do not lead to short-term solutions (e.g. increased borrowing), rather than long-term reforms.

E. Cross cutting recommendations

The issues and recommendations set out above give rise to two cross cutting recommendations, that must be adopted for transition to be a success: accountability and partnership.

Accountability

Observe and use global governance mechanisms to increase mutual accountability. When individuals or organisations are held accountable it means they uphold their obligation to answer questions regarding their decisions or actions. In the context of a transition in the health system these questions may relate to: (a) the monitoring of information about what has been done or spent; and (b) explanations and justifications of why those actions (or spending) were performed.[68 67] The literature on transition notes a persistent problem in lack of accountability. While weak accountability is commonly recognised as a contributory reason for health system failures, and strengthening it is expected to improve health system functioning, recommendations to do so need to be informed by local contextual factors.

As in other parts of the health sector, efforts to improve accountability in the transition process relate to strengthening decision-making, in order to maximise quality – and access, availability, and equitable distribution – of health services, and minimise risks relating to abuses of power, financial mismanagement, corruption, and unresponsiveness.[67]

The issue in the transition process is that the actors involved are more diverse and have vaguer lines of duty and accountability to one another.

Partnership

Successful transition is aided by strong partnerships from the start. Transition should not start once eligibility has been reached; rather, planning for transition should commence at the initiation of a donor's support to a country. The recognition that donor funding will stop, and that the government will be required to sustain the results achieved, needs to be built into the design of donor programmes. The aid effectiveness agenda provides a set of already agreed principles that, if adhered to, could facilitate the process of a smooth transition.

Donors and governments need to tackle transition through partnership, rather than within the power dynamic of a donor–recipient relationship. Before, during and after support, donors should align their priorities to those of the partner country. Donors and governments must have a long-term vision for the support being provided, and what transition would look like in the future. The starting point for reaching this shared vision is a recognition of the expectations and objectives of both parties. Because the donors' and governments' incentives tend to be misaligned, we believe technical assistance providers, as third parties, could play a facilitator and mediator role that would be critical to the success of transition.

Section 4
Facilitating successful transition

A. A Global Observatory on Transition

In the current global health architecture, transition governance is fragmented, and technical assistance approaches and tools are developed independently by different providers and used and evaluated in different ways, while impact and risk are measured and monitored on a case-by-case basis. Key aspects of the nine issues we have outlined in this paper could begin to be addressed by the establishment of a Global Observatory on Transition.

The Global Observatory would build on and learn from existing technical working groups (such as the UHC2030 technical working group on sustainability and transition) and initiatives such as the International Initiative for Impact Evaluations (3IE) and the IATI.

The Global Observatory would have dedicated resources, staff, and a mandate to perform three key functions:

1. Produce robust and agreed principles and methods, tools and case studies on transition.
2. Support transition processes by providing specialised technical assistance, either directly or through member organisations
3. Monitor ongoing transition processes and host an open-data repository.

The Global Observatory would comprise: a permanent core team of technical experts; a targeted discussion forum, including representatives from low- and middle-income countries, philanthropic, bilateral and multilateral donors, academic institutions and other technical agencies; and a membership base consisting of organisations involved in transition and technical assistance, who are committed to applying approaches and methods developed through or adopted by the Observatory. The Observatory would amplify opportunities for south–south collaboration and cross-country learning.

Low- or middle-income countries would identify a focal point for transition, who would coordinate the country's interactions with the Observatory, represent its interests in the discussion forum convened by the Observatory, and lead the governance arrangements in country when the transition process has begun.

B. The transition pathway

The recommendations outlined above are part of what could be a dynamic pathway for transition planning and implementation. The pathway shown in Figure 6 is a simplified representation of a transition process. The pathway outlines a hypothetical scenario that includes all the main components of transition (represented by yellow and orange boxes in the figure). The pathway will need to be tailored to each country context and type of transition.

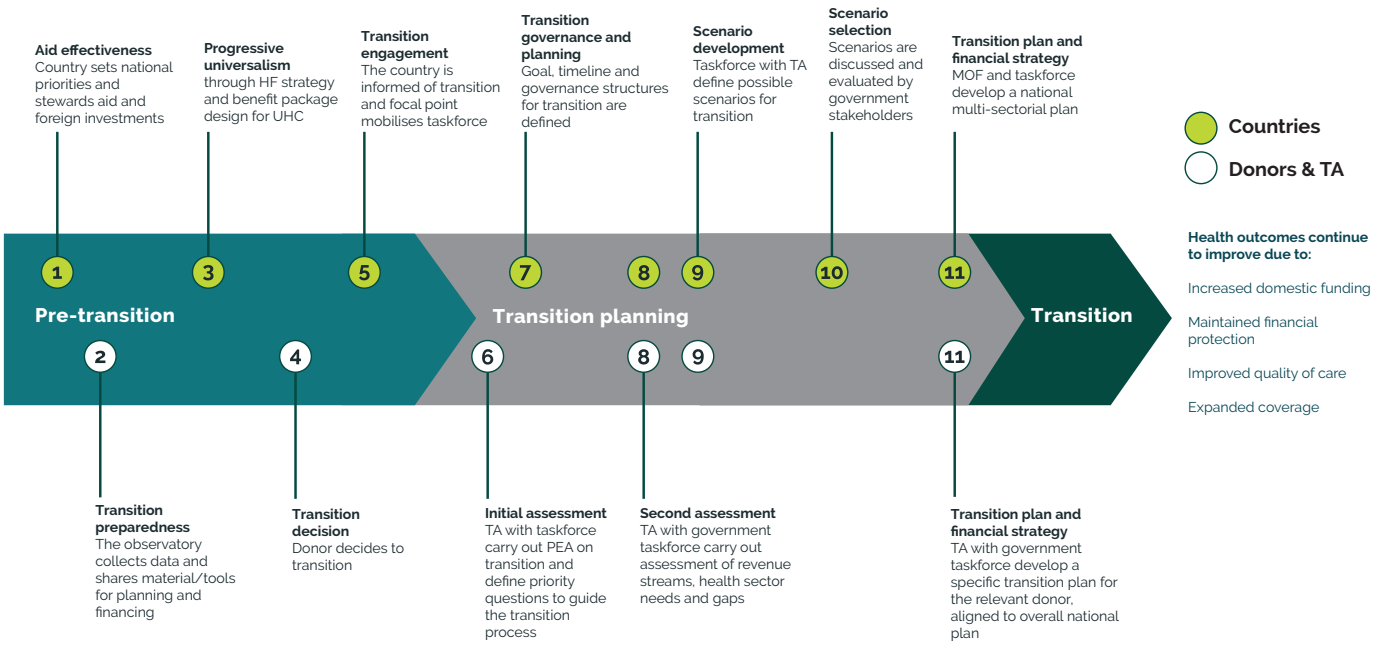
It is a dynamic tool, subject to many and different iterations; it can start at any point, for example when multiple donors are transitioning at different times and go through multiple iterations and directions; and the progression might not include all components. The pathway is aimed at providing an overarching structure for use in navigating the complexity of any transition process; it must be framed in the broader context of health reforms, national economic strategies and complex multi-stakeholder (including multi-donor) negotiations. It is not a linear or step-by-step process that must be followed in sequence, nor a comprehensive list of activities to be carried out each time.

The pathway can serve as a starting point where donors, recipients and technical assistance providers can come together and plan for transition, so that transition can be integrated into a country's strategies and processes. A transparent, evidence-based process will enable countries to manage and sequence multiple donors' transitions based on their health systems' needs and fiscal space and allow synergies and risks to be identified before they affect service delivery.

The transition pathway breaks the transition process down into three phases (pre-transition, transition planning and transition), and at the end of the pathway are key outcome measures for a successful transition. These measures are the continuation of positive trends in health outcomes; sustained financial protection, especially for vulnerable populations; the gradual expansion of coverage; the maintenance of quality of care; and progression towards domestically funded health systems. We outline the steps that countries, donors and technical assistance providers can take to prepare for, plan and execute transition (depicted by the yellow and orange boxes in the figure).

Figure 6 describes the entire pathway using the numbers as reference points, to provide an overview, and discuss its application.

Figure 6 Overview of the transition pathway



1. Pre-transition (ongoing activities)

All countries that are receiving donor funds are in a state of pre-transition. In theory, aid relationships should be based on the principles of the Paris Declaration and Accra Agenda for Action **(1: aid effectiveness),** although we acknowledge these are rarely fully achieved. As countries plan their path towards UHC and leverage domestic and external funding to provide or purchase health services **(2: transition preparedness)**, they should also prepare for the inevitable shift in the donor–recipient relationship. The Global Observatory on Transition would play a supportive role, by working with the country focal points, providing targeted training and sharing key tools and materials **(3: progressive universalism).** Country focal points would be key individuals working in the ministry of health or finance, who are tasked with guiding the transition process and liaising with the Observatory. In other words, the focal points would be playing a role of social brokers, defined in Blanchet et al. as individuals who 'help coordinate actors in times of crisis or shock and build bridges between different groups within the system and beyond it'.[14] The Observatory would leverage the country focal points as social brokers, and target technical assistance to support their ability to combine and integrate different forms of knowledge, as a critical function for resilience of the health system.

2. Transition decision

Transition decisions have tended to be donor-led **(4: transition decision);** it is essential that countries respond to this by taking the lead in planning what happens next. Ideally, at this stage data would be widely available, so that analysis of the impacts and options can commence, including a pre-assessment of prevailing political economy conditions and revenue streams. Similarly, donors would be able to share with the Observatory and the country their initial thinking and the evidence they have used in making their transition decisions, and also their proposed timelines. What that transition will look like will be defined through a joint and evidence-based process, where the Observatory can mediate negotiations, but ultimately it is the country's decision to choose what to integrate, close or fund. It is important to note that a donor may choose to 'hand over' to government either a specific programme or the whole of its portfolio.

Different types of transition will affect the magnitude of the 'change' or 'shock' the country's health system needs to adapt to, but the key questions to be answered, preparatory analyses and methods remain the same. Focusing on key questions, transparent processes and third-party facilitation can mitigate the risks of asymmetric power dynamics and short-term incentives. The Observatory, and the technical assistance offered through it, can play a critical role in ensuring both parties remain focused on sustaining health outcomes.

3. Transition engagement

Once a decision has been made, the Observatory and country focal point would be informed and begin to engage with the government and the donors **(5: transition engagement).** The focal point would lead the country's mobilisation process, while the Observatory could share again the transition preparedness material and links with technical assistance providers and members of the Observatory, and support a pre-assessment of the type of transition, the health system's situation, and the transition planning needs. It is at this stage that a transition task force, or other governance arrangement, would be established, if one does not already exist. The inclusion of key officials from the ministry of finance and other relevant institutions (e.g. a national development board, ministry for economic planning, national insurance agency or social security board) in the task force would be essential to ensure any transition decision fits within the country's overall financial strategy **(9: transition plan and financial strategy),** and could be implemented without jeopardising other publicly funded interventions, within and beyond health.

4. Initial assessment

To inform transition planning and facilitate evidence-based negotiations and decisions, an initial assessment **(6: initial assessment)** will be carried out (in collaboration with the country focal point) by technical assistance providers, which are either directly engaged by the Observatory or are contracted members applying agreed methods and approaches. The assessment, which serves to set the context for transition planning, will identify key actors, the status of each donor, interdependent processes and competing priorities; assess financial and other resources availability; flag data and analysis gaps; and ultimately define a set of priority questions that donors and the country need to answer during the transition planning phase for it to be successful and mutually acceptable.

Depending on the type and size of the transition, the assessment may involve several different analyses and use a range of existing information, including: a political economy analysis, an analysis of key decision-making processes and governance structures, an assessment of the complexity of the donor environment, a needs assessment for both financial and service delivery data, a review of current health strategies and medium-term plans, mapping of funding flows for domestic and external sources allocated to both health and the country overall, and an analysis of health care services in terms of utilisation, unmet needs and coverage.

5. Transition governance and planning

Transition planning requires a clear set of responsibilities and processes, and a governance arrangement that is recognised by both parties and aligned to the country's system **(7: transition governance and planning).** Agreeing on the governance arrangement can require a few iterations and discussions, but it is essential if transition planning is to take place in an effective and transparent manner, and if the relevant actors are to participate in the different stages of transition planning, including representatives from government and technical teams, donors in the sector, internal technocrat(s) and external technical assistance providers.

The main objectives of this phase are as follows:

- Agree on and define a national task force (or other governance structure) to lead the transition planning, with agreed roles and responsibilities and clearly defined scope and procedures.
- Discuss and agree on a mutually acceptable goal for the transition.
- Outline what information is needed to agree on a transition timeline, which must both reflect donor preferences and be viable for the country.
- Define the need for further analyses and the sequencing of activities.

It is at this stage that the pathway can be further tailored according to the country context and agreed transition objectives, in order to identify specific technical assistance needs and mobilise support. Support could include discrete analyses, embedded technical assistance (to strengthen the task force or a specific process), cross-country learning and inter-ministerial collaboration.

6. Second assessment

At the core of transition planning is the integration of outcomes from transition interventions into the country's health plans and budgets. Integration in this case means looking at service delivery channels, the inputs required to sustain quality of care, and the sequencing of the roll-out and costs of interventions, both direct costs and opportunity costs. Making trade-offs and opportunity costs explicit will both strengthen the prioritisation and decision-making process and improve transparency. No country is able to afford everything, and each has the ability to choose what or who to prioritise, based on its own values and objectives. Making decisions on transition without referring to detailed analyses will result in implicit rationing, with the associated unintended effects on health outcomes (8: second assessment).

The Global Observatory can facilitate the provision of technical assistance, where needed, to support the task force with the assessment components.

Variables and analyses that can influence transition decisions include the following:

- Assessments of transitioning programmes' impact, alignment to national health plans and the benefit package, costs and strategies for implementation.
- Analysis of revenue streams, projected availability and gaps in resources.
- Revision of the benefit package's coverage, planned expansion, and estimated cost.
- Purchasing arrangements, and the impact of the transition on out-of-pocket payments and other equity measures.

7. Scenario development

The output of the second assessment will be a series of scenarios used to model the costs and impacts of different options, where transition planning is a component of the overall health strategy for the country **(9: scenario development).** The scenarios will help to outline clearly the assumptions, trade-offs and key variables for decision-makers. For this process to remain realistic and acceptable for all parties, it will have to recognise that countries will need to make choices68 in terms of rate of progress in health outcomes, increases in service coverage and features of the benefit package, and that donors have control over the speed at which withdrawal occurs. Scenario development in one country could trigger multi-donor discussions at the global level regarding broader transition sequencing, for example if multiple donors are planning to transition from the same country over a short period and in a way that would undermine the health improvements made to date. In this case, the Observatory can identify opportunities for synergies, facilitate global discussions and help bring country issues into high-level fora.

8. Scenario selection

The final scenario selection (10: scenario selection) is led by the task force and decisions made by the country leadership, including the ministry of finance. The final scenario, which needs to align with the country's overall financial strategy (11: transition plan and financial strategy), can then be translated into annualised plans and budgets.

9.Transition plan and financial strategy

The financial strategy refers to the country's overall national plan for public spending, which balances all the different sector priorities against the projected revenues. It is important that any transition plan affecting the health sector (or any other sector) aligns with this strategy. This will ensure that the ministry of finance can buy into the transition plan, and that the transition is part of a longer-term view, and thus outside of the limitations imposed by annual budget cycles and is anchored to the country's goals.

Once the country has an overall transition plan, individual transition plans are developed for each of the donors involved. Each donor transition plan **(11: transition plan and financial strategy)** fits within the broader framework of the country's health goals and financial strategy. The drafting of the individual plans takes into consideration the agreed goals and timelines of the selected scenario and includes the assignment of roles and responsibilities necessary to implement and monitor the transition.

Transition can involve making many changes to funding arrangements, including increasing how much the government contributes to the cost of donor programmes (co-financing), changing how finance is provided (such as raising the cost of borrowing from banks) or moving from donor support to no donor support (expecting that all funding will come from domestic sources). It may also mean the loss of access to technical expertise or membership of purchasing clubs (e.g. Gavi or UNICEF for vaccines). For many governments, there will be a combination of these, thus keeping a systems perspective throughout the process is critical for ensuring that the coverage and availability of intended services are not disrupted, either directly or unintentionally.
This requires multiple iterations, and continuous updating may be needed as more donors transition or priorities shift. The transition pathway is not linear. However, while different donors may start the process at different times, the principles remain the same: the pathway ensures that the overarching country strategy is the anchor for multiple donor transitions, branching across budget and project cycles, guiding the various line ministries and donors towards a rational and explicit prioritisation of funding and interventions.

Implementing, monitoring and evaluating transition

Finally, the Global Observatory would contribute to ensuring that data are made available to relevant stakeholders, that methods and sources are transparent, and that analyses and results are accessible. It will also be able to monitor progress across different countries, link to technical assistance, where needed, and share lessons.

Section 5
Conclusion

Successful transition means that a government can meet the health needs of its citizens. Citizens should be able to access the promotive, preventive, curative, rehabilitative and palliative health services they need, and which are of sufficiently high quality to be effective, without suffering financial hardship. When transition is successful, the government leads the country towards, and is fully accountable for, UHC.

Governments should be able to do this as they see fit, using cost-effective interventions, financing these interventions how they choose, and providing additional services in line with their own priorities. Donors will need to relinquish their influence over governments so that governments can take full control of meeting the needs of their citizens. This requires a change in mindset; it means choosing to accept that a donor's programme might not continue, and that the way health services are planned, managed and financed might be different from that which a donor would choose.

The transition process might not result in inputs being transferred, but it should mean that results continue to be sustained and improved by the government, moving the country towards UHC. The path to UHC is long and the goalposts will keep moving, but this should not detract from the ambition to reach the goal. Donors and governments need to know what a successful transition looks like, to align incentives, and move towards a shared goal. Agreeing on a shared vision will allow donors, governments and researchers to track the progress of transition, to learn lessons that can be shared with others, and to hold each other to account throughout the transition process.

Annex 1

Examples of tools to support transition

Tool	Function
Multi-stakeholder meeting facilitation guide	To identify the goal of successful transition, who the transition will involve and its guiding principles.
Political economy analysis Process mapping Actor network analysis	To identify: a. key stakeholders and levels of participation, influence, willingness to participate b. Who should be engaged when, how and what for c. Key governance mechanisms and framework (how things work) d. Opportunities and constraints related to (a), (b) and (c), and set up an effective task force.
Fiscal space analysis Financial gap analysis Financial forecasting Funding flow analysis	To identify available resources over time and how funding reaches all levels of the health system, to identify bottlenecks and opportunities for efficiencies, and to quantify the funding gap between available resources and costed health targets.
Costed scenarios of different levels of coverage and services package	To identify a set of options to achieve different health outcomes within different funding envelopes.

References

1 Silverman, R. Projected Health Financing Transitions: Timeline and Magnitude. CGD working paper 488, 2018. Available here.

2 Yamey, G. et al. Transitioning from Foreign Aid: Is the Next Cohort of Graduating Countries Ready? Working paper, 2018. Available here.

3 Cromer, C. et al. The Family Planning Graduation Experience: Lessons for the Future. 2004.

4 Vogus, A. and Graff, K. 'PEPFAR transitions to country ownership: review of past donor transitions and application of lessons learned to the Eastern Caribbean', Global Health: Science and Practice, 2015, 3(2):274-286. Available here.

5 Sgaier, S.K. et al. 'How the Avahan HIV prevention program transitioned from the Gates Foundation to the Government of India', Health Affairs, 2013, 32(7):1265-1273.

6 Shen, A. et al. 'Applying lessons learned from the USAID family planning graduation experience to the GAVI graduation process', Health Policy and Planning, 2014, 30:687-695.

7 World Health Organization Western Pacific Region. Draft Regional Framework for Action on Transitioning to Integrated Financing of Priority Public Health Services, 2018. Available here.

8 Bennett, S. et al. 'Management practices to support donor transition: lessons from Avahan, the India AIDS Initiative', BMC Health Services Research, 2015, 15(232).

9 Blanchet, K. et al. 'Can international health programmes be sustained after the end of international funding: the case of eye care interventions in Ghana', BMC Health Service Research, 2014, 14:77.

10 Cernuschi, T. et al. 'Challenges to sustainable immunization systems in GAVI transitioning countries', Vaccine, 2018, 36(45):6855-6866.

11 Kutzin, J. et al. 'From silos to sustainability: transition through a UHC lens', The Lancet, 2018, 392(10157):1513-1514.

12 de Savigny, D. and Adam, T. (eds). Systems Thinking for Health Systems Strengthening, 2009. Available here

13 de Savigny, D. et al. Applied Systems Thinking for Health Systems Research: A Methodological Handbook. McGraw-Hill Education, 2017

14 Blanchet, K. et al. 'Governance and capacity to manage resilience of health systems: towards a new conceptual framework', International Journal of Health Policy Management, 2017, 6(8): 431-435. Available here.

15 RESULTS UK. 'Leaving no one behind? Considering the impact of donor transition', 2017. Available here.

16 UHC2030 Technical Working Group. UHC2030 Technical Working Group on Sustainability, Transition from Aid and Health System Strengthening. No 2 Report, 2017. Available here.

17 International Development Association. IDA Eligibility, Terms and Graduation Policies, 2001. Available here.

18 International Development Association. IDA18 Mid Term Review: Transitioning Out of IDA Financing: A Review of Graduation Policy and Transition Process, 2018. Available here.

19 International Bank for Reconstruction and Development. IBRD Articles of Agreement, 1989. Available here.

20 European Bank for Reconstruction and Development. The EBRD and Transition, 2018. Available here.

21 Asian Development Bank. A Graduation Policy for the Bank's DMCs, 1998. Available here.

22 Prizzon, A. et al. Graduation from ADB Regular Assistance: A Critical Analysis and Policy Options. ODI background paper, 2016. Available here.

23 African Development Bank. Transition Framework for Graduating and Reversing Countries, 2011.

24 Gavi. Eligibility and Transition Policy, 2018. Available here.

25 Gavi. Co-financing Policy, 2018. Available here.

26 Global Polio Eradication Initiative. Polio Legacy Planning: Guidelines for Preparing a Transition Plan, 2015. Available here.

27 Global Polio Eradication Initiative. Transition Planning, 2018. Available here.
28 The Global Fund. Sustainability, Transition and Co-financing. Guidance Note, 2017. Available here.
29 The Global Fund. The Global Fund Sustainability, Transition and Co-financing Policy, 2016. Available here.
30 The Global Fund. Global Fund Transition Management Processes. Audit Report, 2018. Available here.
31 Bill and Melinda Gates Foundation. What We Do, 2018. Available here.
32 Hecht, R. et al. Donor Transitions from HIV Programs: What is the Impact on Vulnerable Populations?, 2018. Available here.
33 Palen, J. et al. 'PEPFAR, health system strengthening, and promoting sustainability and country ownership', Journal of Acquired Immune Deficiency Syndromes, 2012, 60(3):S113-119. Available here.
34 Barder, O. and Foster, G. 'Ten years of aid transparency – fulfilling the dream of Accra'. Center for Global Development, 2018. Available here.
35 International Aid Transparency Initiative. 'Using IATI data', 2019. Available here.
36 Moon, S. and Williamson, T. Greater Aid Transparency: Crucial for Aid Effectiveness. ODI Project Briefing, 2010. Available here.
37 OECD. Harmonising Donor Practices for Effective Aid Delivery. DAC reference document, 2003. Available here.
38 Rutter, P. et al. Transition planning for after polio eradication. The journal of infectious diseases, 2017. Available here
39 Kallenberg, J. et al. 'Gavi's transition policy: moving from development assistance to domestic financing of immunisation programs', Health Affairs, 2016, 35(2):250-258.
40 Humphrey, C. The African Development Bank: Ready to Face the Challenges of a Changing Africa?, 2014. Available here.
41 The WHO Consultative Group on Equity and Universal Health Coverage. Making Fair Choices on the Path to Universal Health Coverage, 2014.
42 Doherty, J. et al. 'Does expanding fiscal space lead to improved funding for the health sector in developing countries?', Global Health Action, 2018, 11(1):1461338.
43 Norheim, O. et al. 'Avoiding 40% of the premature deaths in each country 2010–30: review of national mortality trends to help quantify the UN Sustainable Development Goal for health', The Lancet, 2015, 385:239-252. Available here.
44 Fan, V. and Savedoff, W. 'The health financing transition: a conceptual framework and empirical evidence', Social Science and Medicine, 2014, 105:112-121. Available here.
45 Wagstaff, A. et al. 'Progress on catastrophic health spending in 133 countries', The Lancet Global Health, 2017, 6(2):e169-179.
46 Ly, C. et al. 'The economic transition of health in Africa: a call for progressive pragmatism to shape the future of health financing', Health Systems Reforms, 2017, 3(4):290-300.
47 Brown, S. 'Foreign Aid and National Ownership in Mali and Ghana', Forum for Development Studies, 2017, 44(3):335-356. Available here.
48 ACTION. Progress in Peril? The Changing Landscape of Global Health Financing, 2017. Available here.
49 Unsworth, S. 'Is political economy analysis too challenging for aid donors?', 2014. Available here.
50 World Bank. Kenya Project Appraisal Document: Transforming Health Systems for Universal Care Project, 2016. Available here.
51 OECD. 'Paris Declaration and Accra Agenda for Action'. Available here.
52 OECD. 'National ownership', 2007. Available here.
53 Besson, P. 'Country ownership and aid effectiveness: why we all talk about it and mean different things', Politorbis, 2009, 46(1):34-39.
54 Maher, A. and Sridhar, D. 'Political priority in the global fight against non-communicable diseases', Journal of Global Health, 2012, 2(2):0204032012. Available here
55 Jackson, A., et al. Responding to aid volatility: government spending on district health care in Zambia 2006-2017. Global Health Action. 2020. Available here.
56 Transition Independent Monitoring Board. The End of the Beginning: First Report of the Transition

Independent Monitoring Board of the Polio Programme, 2017.
57 Glassman, A. et al, What's In, What's Out: Designing Benefits for Universal Health Coverage. Center for Global Development, 2017. Available here.
58 Cracknell, B.E. Evaluating Development Aid: Issues, Problems and Solutions, 2000. Available here.
59 Van der Meer, E., et al. Managing Aid Exist and Transformation Malawi Country Case Study, 2008. Available here.
60 World Bank. 'Net ODA provided, total (current US$), 2019. Available here.
61 World Bank. 'GDP (current US$), 2019. Available here.
62 RESULTS UK, A balancing act: risks and opportunities as polio and its funding disappears, 2017. Available here
63 Glassman, A. and Kenny, C. 'In health spending, middle-income countries face a priorities ditch, not a financing ditch – but that still merits aid'. Center for Global Development, 2015. Available here.
64 Department for International Development. Women's Integrated Sexual Health (WISH): Terms of Reference, 2017. Available here.
65 Heldgaar, J. Managing Aid Exit and Transformation: Summary of a Joint Donor Evaluation, 2008.
66 Gruen, R. et al. 'Sustainability science: an integrated approach for health programme planning', The Lancet, 2008, 372(9649):1579-1589. Available here.
67 Brinkerhoff, D. Accountability and Health Systems: Overview, Framework, and Strategies. Partners for Health Reformplus Project, Abt Associates Inc, 2003.
68 Glassman, A. and Chalkidou, K. Priority Setting in Health: Building Institutions for Smarter Public Spending. Center for Global Development, 2012.

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