TECHNICAL REPORT

Transition from External Aid: Challenges and Opportunities

A Country Consultation Paper for the UHC2030 Working Group on Sustainability, Transition from Aid and Health Systems Strengthening

February 2018

BREAKING NEW GROUND

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Acknowledgements:

This consultation paper was commissioned by the UHC2030 Secretariat for the UHC2030 Working Group on Sustainability, Transition from Aid and Health Systems Strengthening.

The authors would like to thank the 35 government officials and development partner experts from Kyrgyzstan, Myanmar, Nepal, Panama, Papua New Guinea, Sri Lanka and Zambia who generously shared their knowledge and perspectives on transition in key informant interviews. The support of WHO and World Bank country offices in facilitating access to country stakeholders and information is gratefully acknowledged. The authors would also like to express its appreciation of feedback provided by UHC2030 WG on an earlier version of this paper.

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This report was produced by ThinkWell.

ABBREVIATIONS

3MDG	Three Millennium Development Goal Trust Fund
ADB	Asian Development Bank
BBP	Basic benefit package
CCM	Country Coordination Mechanism, GFATM
CSO	Civil society organization
DAC	Development Assistance Committee, OECD
DFAT	Department of Foreign Affairs and Trade, Australia
DFID	Department for International Development, United Kingdom
EPI	Expanded Programme on Immunization
GDP	Gross domestic product
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GFF	Global financing facility
GGE	General government expenditure
HIV	Human Immunodeficiency Virus
HRH	Human resources for health
HSS	Health systems strengthening
IBRD	International Bank for Reconstruction and Development, World Bank
ICC	Inter-agency Coordinating Committee, Gavi Alliance
IDA	International Development Association, World Bank
IDB	Inter-American Development Bank
IHP+	International Health Partnership
IMF	International Monetary Fund
JFA	Joint financing arrangement
JICA	Japan International Cooperation Agency
JLN	Joint Learning Network
KfW	KfW Development Bank, Germany
KOICA	Korean International Cooperation Agency
LIC	Low-income country
LMIC	Lower-middle income country
MA	Mutual accountability
MDG	Millennium Development Goal
MHIF	Mandatory Health Insurance Fund, Kyrgyzstan
MOH	Ministry of Health
MOF	Ministry of Finance
MTEF	Medium-term expenditure framework
NCD	Noncommunicable disease
NDH	National Department of Health
NGO	Nongovernmental organization
NHA	National health accounts
NRA	National regulatory authority
OECD	Organization for Economic Co-operation and Development

OOP	Out-of-pocket expenditure
PAHO	Pan-American Health Organization
PHC	Primary health care
PPP	Public-private partnership
RMNCH	Reproductive, maternal, newborn and child health
SWAp	Sector-wide Approach
TB	Tuberculosis
THE	Total health expenditure
UHC	Universal health coverage
UMIC	Upper-middle income country
UNFPA	United Nations Populations Fund
UNOPS	United Nations Office for Project Services
USAID	Unites States Agency for International Development
VII	Vaccine Independence Initiative
WG	UHC2030 Working Group on Sustainability, Transition from Aid and Health Systems Strengthening
WHO	World Health Organization

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I INTRODUCTION

As a successor to the former International Health Partnership (IHP+), UHC2030 seeks to provide a multi-stakeholder platform to promote collaborative work at the country and global levels on health systems strengthening for universal health coverage (UHC). UHC2030 has established a Working Group (WG) on Sustainability, Transition from Aid and Health Systems Strengthening "to explore roles, responsibilities and opportunities for collaboration among countries, development partners and expert networks to enhance efforts to sustain increased effective coverage of priority health interventions with financial protection, in countries transitioning from aid." The WG is supported by the UHC2030 Secretariat co-hosted by WHO and the World Bank.

One of the recommendations of the first meeting of the WG in March 2017 was to collect and synthesize country perspectives on key health system challenges and opportunities presented by the transition process to inform the technical agenda and policy dialogue on transition support.[1] To take these recommendations forward, the UHC2030 Secretariat commissioned ThinkWell to prepare two distinct but interrelated and complementary products: a country consultation paper to compile lessons learned and challenges due to transition in countries and a global mapping tool to provide an overview of the countries where WG members are active, are in the process of transitioning, or are expected to transition away from support soon. This report presents the findings of the country consultations. An earlier version of this paper was presented at the second meeting of the WG in November 2017.

II RATIONALE

An increasing number of countries are currently or will soon be transitioning to reduced external funding due to changes in the income status of countries according to economic development, improved health outcomes, and shifting priorities of donors. As countries strive to achieve UHC, a central concern during this transition is how to sustain or increase coverage of priority interventions, especially for vulnerable populations. Health systems strengthening (HSS) efforts are at the core of the response to transition. Transition provides an opportunity to examine how domestic financial resources for health can be increased, as well as how efficiency can be maximized to sustain coverage of priority interventions and reach targeted health outcomes.

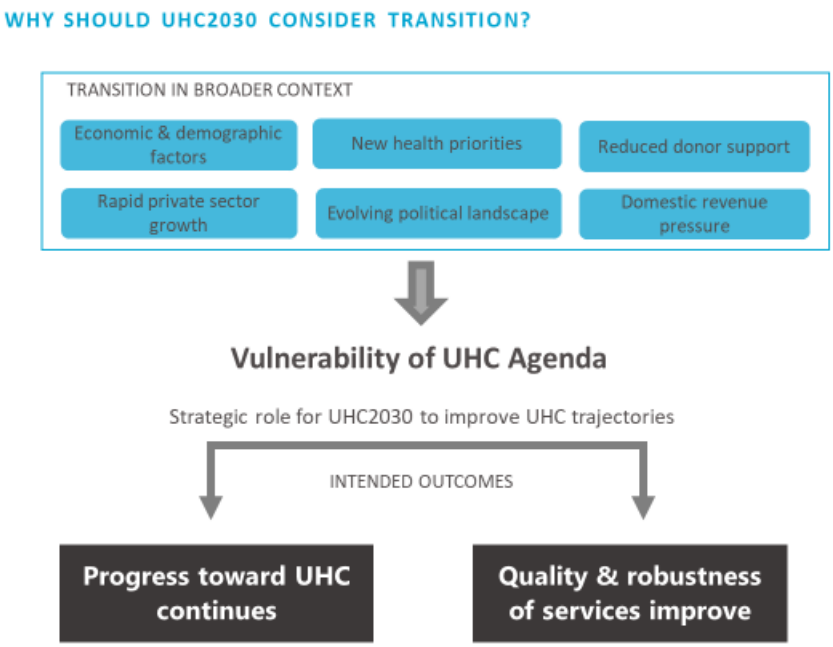
Transition is one of many factors that affect progress on the three core dimensions of UHC, as outlined in the UHC framework of the 2010 World Health Report and the WHO/World Bank UHC monitoring framework: population coverage, service coverage, and financial protection.[2,3] These factors also affect the way in which the transition takes place and may compromise the advancement of the UHC agenda as described below (Figure 1).

- **Economic and demographic factors:** The level and pace of economic development are key factors influencing fiscal space and the degree to which governments can meet financing gaps due to decreases in donor funding. Population growth and aging as well as increased income inequalities also mean that, to move toward UHC, many countries must cover national health services for larger poor or marginalized populations.

- **Rapid private sector growth:** The share of health services provided by the private sector is increasing rapidly in most lower-middle income countries. This expansion often takes place within a context of weak regulation and limited strategic engagement to leverage the potential of non-state actors to contribute to public health objectives. Instead, private providers tend to focus on curative care for better-off populations, which exacerbates inequities and leaves the poorest and most vulnerable population groups underprotected.
- **New health priorities:** The increasing costs of health care driven by new technologies, aging populations, and economic growth demand new ways to organize the health care system. There are also new and emerging health threats, such as global health pandemics, antimicrobial resistance, the increased dominance of noncommunicable diseases (NCD), and increased trend in chronic multi-morbidity patterns. These factors require new models of care and of financing and delivery of services that strengthen prevention and promote a people-centered approach.
- **Evolving political landscape:** The growing focus on social accountability and participation requires that national governments evolve and be open to dialogue and collaboration with civil society organizations (CSOs) while playing a robust stewardship role.
- **Domestic revenue pressure:** Globally, health expenditure is growing faster than the overall economy. Although government health expenditure is slowly increasing over time, recent global analysis suggests that the increase in fiscal government capacity has not translated into an expected increase in government health spending, and there is increased pressure from all sectors for national budget allocations.[4]

The UHC2030 WG has a strategic role to play in bringing countries and development partners together to collectively advance the agenda of support for countries managing their transition process. This will in turn contribute to improved UHC trajectories so that progress toward UHC is sustained and the quality and robustness of services improve (Figure 1).

Figure 1: Transition and other factors influencing the UHC agenda



To inform the WG's efforts to support countries during the transition process, this country consultation paper has the following objective: To broadly articulate and classify the major health system and programmatic pressure points and enablers of the transition process as seen by key informants from the seven countries consulted. This paper presents the results of the country consultations and recommendations to the WG.

III METHODS

The methods are summarized in Annex 1. Seven countries were selected for the consultation: Kyrgyzstan, Myanmar, Nepal, Panama, Papua New Guinea, Sri Lanka, and Zambia.

Annex 2 explains the country selection criteria such as income status, transition status, progress on UHC (service coverage and financial protection), government finance indicators, health expenditure, and geographic region.

A desk review was conducted to build an understanding of the country context and inform data collection and analysis. Key informant interviews were conducted with 35 experts from Ministries of Health (MOH) and in-country development partners to seek their perspectives on health system challenges and opportunities presented by transition. Because of the limited number of consultations by country, the perspective from each country might not be comprehensive. While attempts were made to contact ministries of finance and civil society organizations (CSOs), it was not possible to schedule interviews with these actors.

Annex 3 presents the interview guide questions, and Annex 4 contains the list of key informants.

IV SUMMARY OF COUNTRY CONSULTATIONS

The complete perspectives and insights on transition shared by key informants are presented by country in a separate report, which is available upon request. Information from the interviews was complemented by data collected during the desk review. The following table (Table 1) presents a summary of the key findings by country.

Table 1: Key findings of country consultations

Country	Income level	Key statistics (2014 data) [a, b]	Transition status	Key health system issues and opportunities related to transition of external aid
Kyrgyzstan	Lower-middle income country (LMIC)	General government health expenditure (GGHE) as % of total health expenditure (THE): 56% External resources on health as % of THE: 9% Projected GDP growth (2017-2022): 4.6%	*Active:* Gavi, Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), World Bank (IDA) *In transition:* USAID *Transitioned*: DFID, JICA, UNFPA	– Sustained service delivery of such donor-funded programs as immunization, tuberculosis, and HIV/AIDS services is at risk. – Country is exploring ways of reducing health care costs, e.g. by strengthening primary health care (PHC) and increasing focus on prevention including for NCDs. – Increasing domestic revenues and efficiency to cover financing gap is a challenge
Myanmar	LMIC	GGHE as % of THE: 46% External resources on health as % of THE: 22% Projected GDP growth (2017-2022): 7.5%	*Active:* Gavi, GFATM, 3MDG Trust Fund, World Bank (IDA)	– Coverage of vulnerable populations is at risk. – Most external assistance, both financial and programmatic is 'off-budget' and 'off-system', i.e. managed outside the MoH. – MOH has capacity constraints to take on activities funded by donors. – Increasing domestic revenues to cover financing gap is a challenge.
Nepal	Low-income country	GGHE as % of THE:	*Active:*	– Not expected to start transition planning in the next

	(LIC)	40% External resources on health as % of THE: 13% Projected GDP growth (2017-2022): 4.6%	Gavi, GFATM, JICA, KfW, World Bank (IDA) *Transitioned:* DFAT	few years. – Both funding and programmatic coverage could be problematic following transition. – Limited participation of the private sector beyond serving the wealthy
Panama	Upper-middle income country (UMIC)	GGHE as % of THE: 73% External resources on health as % of THE: 1% High economic growth for past years. Projected GDP growth (2017-2022): 5.6%	*Active:* IDB Loan, World Bank (IBRD) *Started dialogue:* GFATM (HIV) *In transition:* GFATM (TB)	– Coverage of vulnerable populations is at risk when Inter-American Development Bank (IDB) loan ends. – Sustainability of CS donor-funded activities for HIV and TB risk populations is a concern. – Biggest MOH challenge, as donors phase out, is how to integrate donor-funded activities including CS with the public health sector.
Papua New Guinea	LMIC	GGHE as % of THE: 81% External resources on health as % of THE: 21% Economic growth volatile and closely linked with commodity prices. Projected GDP growth (2017-2022): 3.0%	*Active:* DFAT, GFATM, World Bank (Blend) *In transition:* Gavi (with potential delay)	– Coverage of health services for HIV, TB, and malaria is at risk when donors phase out. Activities are currently carried out by donor-funded NGOs. – Limited participation of the private sector beyond serving the wealthy. – Partners state that country is not ready for transition. – Increasing domestic revenues to cover financing gap is a challenge.
Sri Lanka	LMIC	GGHE as % of THE: 56% External resources on health as % of THE: 1%	*Active:* JICA, KfW, World Bank (IBRD) *Started dialogue:* GFATM (HIV	– Technical support is still important to maintain robust results after donors have phased out. – Transition challenges related to interphase of public financial management systems and transition.

		Robust annual growth 5-6% in past several years. Projected GDP growth (2017-2022): 5.0%	and TB) *In transition:* GFATM (Malaria) *Transitioned:* Gavi	– It would be better that all the development assistance for health interacts with the MOH planning unit for better coordination. – Limited participation of the private sector beyond serving the wealthy.
Zambia	LMIC	GGHE as % of THE: 55% External resources on health as % of THE: 38% Projected GDP growth (2017-2022): 4.4%	*Active:* GFATM, JICA, DFID, USAID, World Bank (IDA) *Started dialogue:* Gavi (with potential delays)	– Service delivery of donor-supported health programs is at risk if donors phase out. – Partners state that country is not ready for transition.

[a] Other key statistics, references, and details of sources of funding can be found in Annex 2.

[b] Data on projected GDP growth (2017-2022) obtained from the 'Global mapping tool' on transition developed together with this country consultation paper.

V CORE THEMES

This section presents six core themes that emerged from the country consultation data collection and analysis. The themes address transition-specific issues but also include more general health systems challenges raised by key informants that are not necessarily directly related to the transition process. The six themes are:

- **Coverage of vulnerable populations:** Countries have two main concerns about vulnerable groups post-transition: maintaining coverage of health services and providing financial protection against the costs of accessing those services.
- **Governance of donor-funded programs:** Countries expressed the need for support to increase domestic capacity to manage central public health programs within a context of integration and evolving financing arrangements.
- **Generation of domestic revenues:** Countries felt they are not well equipped to effectively mobilize more resources for the health sector and to get more out of existing resources by improving efficiency.

- **Participation of private sector:** Countries highlighted that there is need for engaging private providers to sustain and advance UHC progress by aligning incentives and developing an enabling environment.
- **Mutual accountability:** Countries and donors share responsibility for transition. Countries expressed a need for more effective platforms for joint planning for transition and called for more clarity and consistent messaging from donors.
- **Capacity of development partners:** Countries expressed the need to strengthen their ability to manage the transition. They noted that development partners, including donors, technical agencies, NGOs, and civil society, need to be adequately prepared to provide support.

Each of the six themes includes an overview of the key points of each thematic area and a summary box with the following information:

- **Status quo**: The current situation of the thematic area as expressed by key informants.
- **Future scenario:** What the status quo will lead to if nothing is done to address the issue.
- **Role of the WG:** Suggestions for what the WG could do to shift the thematic area trajectory.
- **Alternative future scenario**: What the future scenario may look like with WG engagement.

5.1. COVERAGE OF VULNERABLE POPULATIONS

In most of the countries consulted, donors are financing a considerable share of certain health services for vulnerable population groups, such as the poor, the hard-to-reach, and groups affected by HIV and TB. Countries are concerned that they will not be able to ensure that vulnerable population groups have access to high-quality health services if donors reduce their funding. Non-state providers—usually funded by donors—are delivering a considerable share of health services for vulnerable populations in most of the countries. In addition, many of such health service might only focus on donor-funded disease programs, while the full range of healthcare services would need to be provided.

In their own words…

"Conflict areas and specific ethnic groups are being serviced by civil society organizations funded by donors. These populations are not covered by the government. We are talking about millions of people at risk." (Myanmar)

In addition to concerns about meeting the financing gap left by donors, several countries suggested that they do not have the technical capacity to manage non-state providers and that they need to strengthen their governance systems and purchasing arrangements. As a policy response to reduced external support, some governments are considering two options: contracting non-state providers to continue providing the services or taking over delivery through the public sector. The first option would capitalize on the experience of CSOs in providing services to vulnerable population groups through their service delivery networks at the community level. In order to manage this, governments expressed a need for capacity building on (1) how to agree with non-state actors through contracting-out mechanisms, and (2) how to put in place effective processes to govern such purchasing arrangements.

Key informants from lower-middle income countries expressed concern about how to cover the costs of providing the full range of health services to vulnerable population groups. Donors have provided financial and technical resources to non-state providers to cover some health services for these groups. This has been an effective arrangement because vulnerable populations are covered, governments are able to use resources for other priorities, and non-state providers receive financing and capacity building.

In their own words…

"Population and service coverage will inevitably decrease, if not collapse, if donors phase out." (Zambia)

Several key informants also suggested that political considerations may constrain the willingness and ability of governments to absorb the costs of activities targeted at vulnerable populations, such as refugees and populations that border neighboring countries.

Status quo

Health services for vulnerable populations, such as poor, hard-to-reach, and indigenous groups, are provided by non-state providers, which are often funded by donors.

Future scenario

If donors phase out, non-state providers may lack funding to continue their activities and there is a risk that vulnerable population groups will lose access to currently donor funded services and suffer increased financial hardship.

What the UHC2030 WG can do to shift the trajectory

1 Support focused advocacy campaigns to maintain and scale up services for coverage for vulnerable populations, in collaboration with civil society. Vulnerable populations require the full range of health services beyond those supported only by donors.

2 Include vulnerable population groups through CSOs explicitly in any transition dialogue. In addition to the contribution these groups can make to the technical discussion, inclusive transition dialogue will act as an incentive to governments to take these groups into account and implement policies to cover them.

Alternative future scenario with UHC2030 WG engagement

Sustained and scaled-up access to a full range of high-quality services and financial protection for vulnerable population groups.

5.2. GOVERNANCE OF DONOR-FUNDED PROGRAMS

Many current donor-supported health programs face evolving governance structures. Historically, public health programs have been vertically financed, managed, and implemented. Donor

In their own words…

"Most external funding is managed outside of the government. All budgetary decisions are made at the technical program level, and therefore the Ministry of Finance is not involved at all." (Myanmar)

financing mandated strong centralized planning and management structures for national programs delivering such essential public health interventions as family planning, immunization, HIV/AIDS, TB, and malaria.

As donors exit and national financing structures evolve, the question of how these central programs delivering important public health interventions are governed and financed becomes paramount. If donor support and funding on maintaining these public health programs is removed, the financing and governance structures of these programs may need rethinking in terms of how to integrate them into the wider health system while maintaining results. For example, one key area of concern among countries is the procurement of medicines, vaccines, and diagnostics. Some donor-supported programs have had access to preferential prices, so as donors exit, one question is whether countries will continue to have access to commodities at preferential prices. In addition, countries might not have the capacity to follow international procurement practices.

Health financing mechanisms in many countries are evolving and maturing. New strategic purchasing arrangements may lead to a de-prioritization of important donor-supported interventions. Countries have expressed concern about being unable to maintain coverage of services, fearing that they lack the capacity to take over processes such as procurement or to integrate currently donor-funded interventions into the basic benefits package. Countries embarking on strategic purchasing arrangements therefore need to carefully consider how they can "protect" achievements made through robust governance and coordination mechanisms, especially those that are managed and financed outside the MOH.[5]

In their own words…

"Financing the activities carried out by civil society organizations is not a problem for the government. The issue is how to transfer those activities logistically to the Ministry of Health, [which] implies many changes." (Panama)

Status quo

Programs delivering key public health interventions are vertically financed by donors and vertically managed by national programs, often with considerable autonomy from the MOH.

Future scenario

If donors withdraw their funding and the health financing systems of countries evolve toward strategic purchasing arrangements without careful consideration of these public health interventions, there is a risk that they become de-prioritized or mismanaged, leading to reduced coverage.

What the UHC2030 WG can do to shift the trajectory

Potential UHC2030 engagement may involve creating a transition workstream focused on governance and financing of central programs, which could focus on the following:

3 Developing a toolkit based on best practices and country experiences on strategies to protect the financing, delivery, and governance of essential public health interventions in a context of transition, integration pressures, and evolving financing arrangements.

4 Providing focused technical assistance to countries on program governance, social contracting, and access to medicines.

Alternative future scenario with UHC2030 WG engagement

(Re)configured robust policy responses to ensure service delivery models, governance, and financing to sustain effective coverage of priority interventions, including those currently supported by external finance.

5.3. GENERATION OF DOMESTIC REVENUES

Evidence shows that public health financing is essential to make progress toward UHC.[6] Low levels of public health financing have been associated with reduced overall financial protection. LICs face stagnation of public expenditures from domestic sources to finance health care. Recent analysis suggests that in LMICs the level of external aid to the health sector reduces the degree of budget priority, so higher external health aid is not necessarily associated with higher public health expenditures.[6]

As donors phase out of financing the health sector, almost all countries consulted would face a funding gap that the government is expected to cover with domestic resources. Given competing priorities and fiscal space constraints, the political dimension of raising domestic revenues becomes a central concern.

Countries say that they do not feel well equipped to effectively advocate for increased resources. Mobilization of domestic revenues is inherently a political process involving a range of actors with different incentives, yet most countries and their development partners approach this important task as a technical exercise. While developing investment cases to demonstrate the health impact and economic and social returns on investing in health can be useful, such evidence must be complemented by strategic advocacy based on a solid understanding of the political economy.

In their own words…

"The MOH is exploring different ways to optimize resources to reduce costs. We want to extend prevention services because they have been shown to reduce costs in the long run." (Kyrgyzstan)

Countries expressed a need to learn from other countries about how to approach resource mobilization. The introduction of the Philippines sin tax offers an example of effective advocacy for health reforms. It was based not only on a technical perspective but also on robust understanding of the political economy. It also involved the creation of a

movement with aligned incentives, the identification of champions, and intense lobbying tailored to different target audiences.[7]

In addition to raising additional revenues, other opportunities mentioned by countries include getting more out of current and future resources by making systematic and sustained efforts to reduce inefficiencies in the health system such as, for example, reducing duplicative activities across programs and misalignments.[8]

Countries said that they would like to learn more from other countries about how they have implemented innovative financing mechanisms. There may also be opportunities to further expand the use of innovative financing instruments that have been applied successfully in health and other sectors. For example, Zimbabwe's AIDS Trust Fund, which is a tax/levy-based instrument; Botswana's "buy-down" design; and Côte d'Ivoire's SWAp Agreement are mechanisms that have facilitated access to additional financial resources.[9,10]

Status quo

Some government officials in low-income and lower-middle income countries expressed concern that they are not well equipped to effectively mobilize additional domestic resources to meet financing gaps left by donor transition.

Future scenario

If the capacity of the health sector to catalyze and nurture strategic advocacy is low, countries will not be able to reallocate or mobilize sufficient public domestic resources to sustain interventions that are currently donor supported.

What the UHC2030 WG or its members can do to shift the trajectory

UHC2030 can play a catalytic role to generate and support a broad-based movement for resource mobilization for UHC, by doing the following:

1 Supporting countries to develop a high-level advocacy strategy for the health sector grounded in the political context of the country.

2 Identifying country champions and aligning incentives of key stakeholders, including civil society, to build one strong movement to increase pressure in the political sphere.

3 Supporting countries to optimize the use of current resources by identifying cross-programmatic and other health system inefficiencies and by building capacity to analyse and identify inefficiencies on a routine basis.

Alternative future scenario with UHC2030 WG engagement

Strategic and tailored advocacy for UHC will contribute to increased domestic revenue generation and more efficient use of current resources.

5.4. PARTICIPATION OF PRIVATE SECTOR

Country informants noted that there is untapped potential to engage with the private sector. Private providers should be offered incentives to serve the full population with a broader set of services, including preventive care. In many low- and middle-income countries there is a lack of a strategic vision for private sector engagement, weak regulation, and limited investment opportunities, leading to missed opportunities. In many transitioning countries, the private sector is growing rapidly in an unregulated environment, which means they are

In their own words…

"There are real opportunities for the private sector to play a significant role in supporting the Ministry of Health in delivering health services, but there's limited regulation of the private sector, and limited capacity of the MOH to contract private provider for service delivery within a government-led system." (Nepal)

not guided toward supporting the achievement of UHC objectives. In most settings, the private sector focuses on "low-hanging fruit" by delivering curative care for the wealthy, which exacerbates inequities in access to health services.

There are three main reasons for this. First, private providers have limited knowledge about remunerated opportunities for service delivery that extend beyond the wealthy. Second, even when private providers are interested in expanding service delivery to additional population groups, they often lack funds for required investments due to gaps between private providers and private investors. Third, there is a lack of a strategic sector-wide vision that enables an optimal role for private sector providers to move together with the public sector toward UHC within an appropriate regulatory environment.

Country representatives noted that they are not well equipped to leverage the potential of the private sector. They explained that they need a better understanding of opportunities and options for engaging private providers, and that their capacity to design, implement, and monitor such policy interventions as regulation and contracting needs to be strengthened.

Status quo

The share of health services provided by the private sector in low- and middle-income countries is expanding rapidly. Private sector growth is often taking place in contexts with weak regulatory frameworks and without a strategic vision for engagement and alignment with UHC objectives.

Future scenario

Unregulated growth of the private sector and lack of strategic engagement will result in missed opportunities as well as a continued focus of private providers on curative services for those who are better off, which will have negative consequences for equity in health service delivery for UHC.

What the UHC2030 WG can do to shift the trajectory

UHC2030 has a role to support and catalyze strategic engagement with the private sector, by doing the following:

1 Documenting countries' best practices and experiences in leveraging the private sector and aligning their incentives with such UHC objectives as increased access to high-quality health services through regulation, contracting, and other mechanisms.

2 Supporting the development of opportunities for the private sector to help achieve UHC goals through market-shaping activities to address gaps between the objectives of private providers, investors, and government, and creating an environment that is conducive to effective private sector engagement for UHC.

Alternative future scenario with UHC2030 WG engagement

Optimized government engagement that leads to a market for strategic private sector participation to support UHC objectives.

5.5. MUTUAL ACCOUNTABILITY

Key informants emphasized that transition is a shared responsibility among donors and governments. Currently, most transition processes do not empower countries to hold partners accountable if they provide insufficient support throughout the process, delay disbursements of transition grants, or provide confusing or incorrect information on what is expected of the country. There are no clear implications if the roles and responsibilities established in a transition process are not respected. Countries also noted that donors do not always consider whether the health system is ready to manage the transition process.

In their own words…

"Donors shouldn't push a country toward transition if it clearly does not have the financial or the programmatic capacity to take it over." (Papua New Guinea)

Country representatives expressed the need for alignment of transition messages from donors and more clarity on transition timelines and country-specific implications. They also called for better coordination among donors and development partners, both in general and specifically related to transition, as well as a platform for joint planning and implementation of transition.

In their own words…

"We might have transitioned, but we still need support to maintain the targets reached; donors cannot just leave." (Sri Lanka)

Country representatives also expressed interest in increasing mutual accountability (MA) for outcomes post-transition, for example, through transition agreements or compacts between countries and donors and development partners. MA should be about sustaining or increasing coverage for priority UHC interventions with financial coverage, including interventions currently supported by donors. These agreements should contain provisions for fair financing and make explicit what amount will be provided and the program or health system areas funded. It is essential that agreements also specify the mechanism through which donors and governments can hold each other accountable for their commitments.

Six key features of country/donor agreements have been identified in a review of compact agreements:[11]

- The duration of agreements should be more than two years, ideally five years.
- All actors involved in the transition should be included and should sign the agreement, since these agreements lay out important responsibilities and expectations.
- The agreement should specify domestic and external financing commitments (not just estimates) for the short term and include projected financial plans for the next five years.
- Inputs and tools for setting financing targets should be grounded within the country context, such as financing ability and country strategies.

- The agreement can provide mechanisms to promote greater transparency and trust between donors and countries and to evaluate whether both are meeting their commitments.
- The agreement should specify the consequences of not meeting the conditions of the agreement

Status quo

A disproportionate share of accountability for the transition process is placed on countries rather than donors and other development partners. Moreover, there is limited transparency and lack of coordination among development partners. MA should be about a shared responsibility to sustain or increase coverage for priority UHC interventions, including priorities currently supported by donors.

Future scenario

If nothing is done to address the lack of MA arrangements, joint planning, and coordination platforms, governments and their development partners will not feel a collective responsibility for the transition process, which may in turn affect success.

What the UHC2030 WG can do to shift the trajectory

UHC2030 has a role to support and catalyze MA, by doing the following:

1 Promoting the understanding and accomplishment that MA is about sustaining or increasing coverage for priority UHC interventions with financial coverage, including priorities currently supported by donors.

2 Promoting the use of transition compacts and consider the six components mentioned above, including a mechanism for enforcing accountability of all parties.

3 Contributing to an environment for MA through support to or participation in inclusive country platforms to stimulate dialogue as well as joint planning and execution of transition processes.

Alternative future scenario with UHC2030 WG engagement

Effective mutual accountability agreements and platforms used for transition processes that ensure sustainable progress toward UHC.

5.6. CAPACITY OF DEVELOPMENT PARTNERS

As reflected in the country summaries and the discussion of core themes, countries expressed the need for capacity building in such areas as planning, financial gap and fiscal space analysis, advocacy, and safeguarding the delivery of donor-supported public health interventions, to be better prepared for transition. However, although much focus has been put on strengthening the capacity of government staff, this can only be effectively done if donors and other development partners strengthen their own capacity to be able to effectively support the transition process. Adequate development partner capacity is required to (1) enable responsive and appropriate technical assistance to governments that is grounded in a robust understanding of the country's political capacity for UHC, and (2) fulfill commitments to such transition agreements as country compacts. Building capacity for transition

support is relevant not only to donors but to all development partners, including civil society. It is also important to work with CSOs to build an understanding of key concepts related to sustainability, transition, and UHC; of the implications of transition; and of what CSOs can do to plan for and respond to anticipated reductions in donor financing.

Many development partners have invested heavily in strengthening their own capacity to assess development results. Increasingly, donors are focusing on institutional and individual capacity for evaluation in partner countries, with the aims of strengthening domestic accountability, facilitating collaboration with partners, and improving development effectiveness at the country level.[12] Guidelines on capacity development issued by the Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development provide a set of commonly accepted definitions, as well as an agreed-upon analytical framework that focuses on the individual, the organization, and the enabling environment.[13] Partners can also consider exploring models of joint technical assistance funds at the global and country levels to ensure that each development partner's comparative advantage is utilized to its fullest potential, and to facilitate a coordinated response to transition support needs.

VI RECOMMENDATIONS FOR THE UHC2030 WORKING GROUP

The country consultations with key informants from Kyrgyzstan, Myanmar, Nepal, Panama, Papua New Guinea, Sri Lanka, and Zambia, as well as a complementary desk review, identified six core themes related to transition: coverage of vulnerable populations, governance of donor-funded programs, generation of domestic revenues, participation of the private sector, mutual accountability and capacity of development partners.

As described in the core themes section, the UHC2030 Working Group on Sustainability, Transition from Aid and Health Systems Strengthening has a strategic role to play in supporting countries for more effective planning and management of the transition process and related health system challenges.

Country specific recommendations to the UHC2030 Working Group are summarized in the next table 2.

Table 2: Summary of country recommendations to the UHC2030 WG

1 Design and operationalize a platform to share experiences from other countries on what has worked, where, and why. Specific topics mentioned include:

- Improve planning, budgeting, and budget execution
- Develop social contracting with CSOs
- Work with the private sector, including learning how to contract services from the private sector
- Cope with a shock (such as a conflict or a massive earthquake) while transitioning away from donor funding
- Build the capacity of human resources

- Address transition in a decentralized context

2 Develop a toolkit on how to carry out long-term financial analysis.

3 Share guidance on systems optimization of resources from the overall sector perspective (including procurement and access to lower commodity prices).

4 Build capacity on how to raise awareness of domestic resources needed for the health sector, and lobby the central government to increase health budgets.

5 Advise countries on how to integrate national vertical programs into the health system while protecting the financing and governance of essential public health interventions.

6 Map the different conditions for transition, requirements, and processes from different development partners.

7 Provide technical support on how to estimate financing gaps after transition by walking governments through options on various technical decisions and reforms, or on unique programmatic issues.

8 Provide advice on how to integrate the donor-funded activities into the MOH.

9 Build capacity on how to raise awareness of lack of funding to the health sector and how to lobby the government.

10 Provide guidance on the required contents of a transition agreement to ensure mutual accountability between donors and governments during transition processes.

11 Provide technical support on public financial management, financial analysis, and budget allocation.

Based on the feedback from countries and the analysis in the core themes, two general recommendations emerge for how the WG could take country suggestions forward and shift the trajectory for better transition process:

- **Support learning and knowledge sharing.** Almost all key informants highlighted the need for a common platform to stimulate sharing of best practices, toolkits, and lessons learned by other countries that have undergone transition. Different models exist, and specific options tailored to the transition agenda are available to be considered. A brief options paper based on a review of existing models could provide an entry point to taking this recommendation forward.

- **Drive the transition agenda forward through thematic sub-groups.** While the UHC2030 WG has a key role in providing overall coordination and guidance to the transition agenda, thematic sub-groups could facilitate a more targeted approach to addressing key technical issues related to transition. The sub-groups could commission analytical work to build a more nuanced technical understanding in, for example, the areas of transition planning and coordination; advocacy for resource mobilization, revenue raising, and efficiency to address financing gaps; social contracting to cover vulnerable populations; creation of an enabling environment for strategic private sector engagement; and access to affordable commodity prices post-transition. The experience of technical working groups set up by the Economic Reference Group could inform thinking. Setting up these sub-groups would require identifying thematic areas, developing scopes of work, and determining membership composition.

ANNEX 1 - METHODS

Seven countries were selected for the consultation: Kyrgyzstan, Myanmar, Nepal, Panama, Papua New Guinea, Sri Lanka, and Zambia. The team conducted a desk review to build an understanding of the country context and inform data collection and analysis. Key informant interviews were conducted with 35 experts from governments and development partners to seek their perspectives on key health system challenges and opportunities presented by transition.

Country selection

Countries were selected in consultation with the UHC2030 Secretariat. Country selection was informed by criteria related to income level, UHC progress (service coverage and financial protection), government finances, government health expenditure, status of transition from donors, and geographical region. The specific indicators used to inform country selection are presented in Table 3.

Table 3: Criteria and indicators used for the selection of countries

Criteria	Indicator
Income level	– Low income, lower-middle income, or upper-middle income
UHC progress	– Service coverage: composite coverage index for selected interventions in reproductive, maternal, newborn, and child health[14] – Financial protection: out-of-pocket expenditure as a proportion of total health expenditure (THE) (proxy indicator given limited data on catastrophic and impoverishing expenditure)[15]
Government finances	– Tax revenue as proportion of GDP[16] – General government final consumption expenditure as proportion of GDP[17] – Real GDP growth[18]
Health expenditure[15]	– THE per capita – General government health expenditure (GGHE) as a proportion of GDP – GGHE as a proportion of THE – External resources on health as a proportion of THE – GGHE as a proportion of general government expenditure (GGE)
Transition status	– Financial transition status for Gavi[19] – Financial transition status for the Global Fund[20]
Geographical region	– At least one country from each WHO region

Drawing on an initial set of 38 countries, the ThinkWell team worked to ensure diversity in income levels, stages of transition, and geographical balance as it narrowed the list. Therefore, the team decided to include the following: (1) only one low-income country, because the WG prefers to focus on

countries already undergoing transition, (2) middle-income countries at the end of transition, with at least one having transitioned already, and (3) representative countries from all geographical regions. This narrowing process led to a final list of seven countries: Kyrgyzstan, Myanmar, Nepal, Panama, Papua New Guinea, Sri Lanka, and Zambia.

Key informant interviews

The team selected key informant interviews as the main data collection tool to seek stakeholder perspectives on key transition-related health system challenges, opportunities, policy responses, and recommendations to the WG.

Key informant selection

Key informants were selected to include representatives of the ministries of health, the ministries of finance, WHO, the World Bank, development partners, and civil society. Attempts were made to interview two representatives from the MOH: a senior staff member who could speak to the broader planning and budgeting process (e.g., from a planning department or similar), and staff members with a program implementation perspective (e.g., from a national disease program). An initial list of WHO contacts and World Bank contacts was provided by the UHC2030 Secretariat. During interviews, key informants were asked to suggest other names from among government or development partners.

Key informant guide

A key informant guide supports the interview process and serves as a checklist to ensure that key topics were explored. Table 4 displays the topics covered by the guide.

Table 4: Topics covered during the consultations

Topics covered by the guide	
Defining transition from external aid to government financing and status of transition	Preparing for transition in the health sector
Transition, health systems, and UHC: challenges and opportunities	Process and dialogue around transitioning
Lessons learned and recommendations for the working group	Documentation and suggestions for other key informants

In some cases, not all questions were asked, but additional questions and topics may have been discussed, depending on the country context, answers from key informants, and the flow of the discussion. Whenever possible, interviews were audio recorded. All answers were entered in an Excel table to inform the country consultation summaries, synthesis of common themes, and recommendations for how the WG can support countries during the transition process.

Interview statistics

A total of 51 key informants were invited to participate in an interview. A total of 23 interviews were conducted with 35 individuals. Most interviews were conducted on a one-to-one basis, but in some cases more than one person participated. More than two interviews were conducted in six countries. From each country, the team interviewed one or two persons from the MOH, one or two persons from the country office of WHO (except Myanmar), one person from the World Bank, and one or two persons from among development partners.

Desk review

Key documents related to sustainability and transition from external financing in a UHC and health systems context were reviewed to build an understanding of each country context, to inform data collection, and to complement information from the interviews. These are included in the references list at the end of this document.

ANNEX 2 – HEALTH EXPENDITURE DATA OF SELECTED COUNTRIES

Part 1: Government finances and health expenditure (2014 data)

	Government finances			Health expenditure[15]				
Country	Tax revenue as % of GDP[16]	Government consumption expenditure as % of GDP[17]	Real GDP growth (%)[18]	Total health expenditure (THE) per capita (USD)	General government health expenditure (GGHE) as % of GDP	GGHE as % of THE	External resources on health as % of THE	GGHE as % of general govt expenditure
Kyrgyzstan	18	17	4.0	82	3.6	56	9	12
Myanmar	na	na	8.0	20	1.0	46	22	4
Nepal	16	10	6.0	40	2.3	40	13	6
Panama	na	10	6.1	959	5.9	73	1	15
Papua New Guinea	na	na	7.4	92	3.5	81	21	10
Sri Lanka	10	8	4.9	127	2.0	56	1	11
Zambia	16	15	4.7	86	2.8	55	38	6

Part 2: Income level, UHC progress (2014 data), transition status, and region

Country	Income level	UHC-service coverage: Composite coverage index (%)[a, 14]	UHC-financial protection: Out-of-pocket expenditure as % of THE (2014) [b, 15]	Transition status		WHO Region
				Gavi [c, 19]	GFATM[20]	
Kyrgyzstan	LMIC	77	39	Prep	Active	EUR
Myanmar	LMIC	na	51	Prep	Active	SEAR
Nepal	LIC	69	48	ISelfF	Active	SEAR
Panama	UMIC	80	22	na	Active	AMR
Papua New Guinea	LMIC	na	10	Acc	Active	WPR
Sri Lanka	LMIC	na	42	FSelfF	Active	SEAR
Zambia	LMIC	76	30	Prep	Active	AFR

Notes:

na = not available

a. Composite coverage index: National average, all country studies, DH & MICS 2005-2014. World median is 71.5%. Eight service delivery areas are covered: antenatal care, BCG immunization among one-year-olds, births attended by skilled personnel, demand for family planning, DTP3 immunization, measles immunization, children <5 years with diarrhea receiving oral rehydration, children <5 years with pneumonia symptoms taken to health facility.

b. Due to lack of data on catastrophic health expenditure (WHO/World Bank recommended measure of financial protection), out-of-pocket expenditure (OOP) as a share of THE was used as a proxy measure.
c. Gavi transition phases: Acc = Accelerated transition phase; FSelfF = Fully self-financing; ISelfF = Initial self-financing; Prep = Preparatory transition phase.

ANNEX 3 - INTERVIEW GUIDE

This annex contains an excerpt from the interview guide, presenting the questions used for semi-structured interviews with key informants from the seven countries. The full interview guide includes such standard interview information as purpose, voluntary participation, and more.

Defining transition from external aid to government financing

1 How are you defining transition from external funding in the health sector? (Prompt: financial transition, programmatic transition, changes in lending conditions, changing aid relationships, etc.)

2 What might a successful transition from external funding in the health sector look like in your context? (Prompt: any national goals, what are the perspectives at the end of the transition)

Status of transition

3 What is the status of transition in your country? (Prompt: major donors supporting the health sector, stage of donor transition: starting, underway, completing/completed; trajectory of donor transition/s; any dates; etc.)

Preparing for transition in the health sector

4 In the context of UHC, how is (a) the country preparing for transition from external funding, and (b) the donor supporting the preparation and planning of transition? (Prompt: what's in place to sustain and scale up coverage of priority services; any transitional planning in place; financial gap analysis undertaken; efficiency studies, coordinated donor transition planning, and processes, etc.)

Transition, Health Systems, and UHC: Challenges and Opportunities

5 In the context of UHC, what health system challenges are presented by transition? (Prompt: specific pressure points related to WHO building blocks; health system capacity challenges, financing of the health system, variability in objectives/concepts, linking transition to UHC/political commitment, development partner transition policies focused on economic growth, social contracting capacity, incentives for integrating previously donor-funded activities [e.g., TB or immunization] to basic benefit package [BBP] etc., strengthening prioritization/strategic purchasing processes, capacity for efficient procurement, systems for evidence-informed policy, HRH, etc.)

6 What opportunities does transition present for the health system and for progress in UHC? (Prompt: priority setting, potential reconfiguration of services, introduction of efficiencies, integration of specific interventions into national health insurance schemes, etc.)

Process and Dialogue

7 Who is leading the planning of transition from external aid in your country? (Prompt: MOH? MOF? Donors? Who else is involved? Are some key actors missing from this process? What is working well? What can be improved?)

8 Is the dialogue driven by the budget process or by technical departments and program? (Prompt: how are the different service delivery programs involved?)

9 How was the country informed about the transition? Was the country informed in a timely manner?

Transitioning

10 How does the country monitor the external aid transition?

11 What challenges did the country face after external finance had ended? (Prompt: what kind of challenges the country experienced post transition, in terms of sustaining and scaling up priority interventions to achieve UHC [how did it solve some of its pressure points?])

Lessons learned, documentation and further country support

12 What are the lessons learned from the transition process and what are their implications for UHC? What has worked well? What would you do/have done differently?

13 Would you have any key documents or presentations that can be shared?

14 How could the UHC2030 WG support the country in the transition process?

Other key informants

15 Could you recommend other key informants (governments and development partners) we could speak with?

ANNEX 4 - KEY INFORMANTS CONTACTED

Country	Name	Organization
Kyrgyzstan	Mederbek Ismailov	MOH
	Marat Kaliev	MHIF
	Jarno Habicht	WHO
	Ha Thi Hong Nguyen	World Bank
	Jamilya Sherova	Gavi
Myanmar	Thandar Lwin	MOH
	Htar Htar Lin	MOH
	Oren Ginsburg	3MDG Trust Fund
	Wai Yee Khine	3MDG Trust Fund
	Kyaw Nyunt Sein	3MDG Trust Fund
Nepal	Sri Krishna Giri	MOH
	Khurshid Alam Hyder	WHO
	Susheel Lekhak	WHO
	Manav Bhattarai	World Bank
	Nichola Cadge	DFID
Panama	Itza Barahona	MOH
	Natasha Dormoi Eluf	MOH
	Hilda Leal	WHO
Papua New Guinea	Elva Lionel	NDH
	Ken Wai	NDH
	Navy Mulou	NDH
	Roderick Salenga	WHO
	Deki	WHO
	Luo Dapeng	WHO
	Aneesa Arura	World Bank
	Nicolas Rosemberg	World Bank
	Riin Teoh	DFAT

Country	Name	Organization
	Chris Sturrock	DFAT
Sri Lanka	Susie Perera	MOH
	Padmal Da Silva	MOH
Zambia	Solomon Kagulura	WHO
	Collins Chansa	World Bank
	Uzo Gilpin	DFID

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