Graduating from global health programme financing

Lessons and future challenges in the Asia Pacific region

Mark Pearson and Jackie Mundy

November 2015

The sustainability of activities supported by the major global health programmes (GHPs) such as Gavi, the Vaccine Alliance, and the Global Fund to Fight AIDS, TB and Malaria is an increasingly important issue as recipient countries graduate from this assistance or see their funding seriously curtailed by changes in the ways resources are allocated.

Despite interest in the question of how best to plan and implement the transition to local ownership, there is limited evidence of strategies that effectively support graduation, or of countries actively involved in 'sustainability planning'.

The purpose of this paper is to review, analyse and synthesise the findings of the existing literature on graduation as relevant to the GHPs. It attempts to bring together emerging issues, lessons learned, and evidence gaps, drawing on global experiences, but placing particular attention on countries from the Asia Pacific region. The paper looks only at questions of financial sustainability (or countries' ability to finance services) and not on wider but equally important questions of programme or institutional sustainability. It also attempts to identify where the most pressing financial sustainability challenges will be faced.

This paper is based on a presentation given at the annual Australasian Aid Conference (Canberra, 12-13 February 2015) and is therefore focused in the Asia Pacific region. However many of the findings will be of more general relevance.

Mott MacDonald

Mott MacDonald
10 Fleet Place | London EC4M 7RB | United Kingdom
T +44 (0) 20 7651 0302 | E health@mottmac.com | W www.mottmac.com/health

1. Introduction

The sustainability of activities supported by the major global health programmes (GHPs) such as Gavi, the Vaccine Alliance (Gavi) and the Global Fund to Fight AIDS, TB and Malaria (the Fund) is an increasingly important issue as recipient countries graduate from this assistance or see their funding seriously curtailed by changes in the ways the GHPs allocate their resources. This is especially important in parts of the Asia Pacific region where some countries remain heavily dependent on GHP financing, have few alternative external funding sources and yet still have weak health systems or lack the capacity to plan and fund programmes independently of this source of financing.

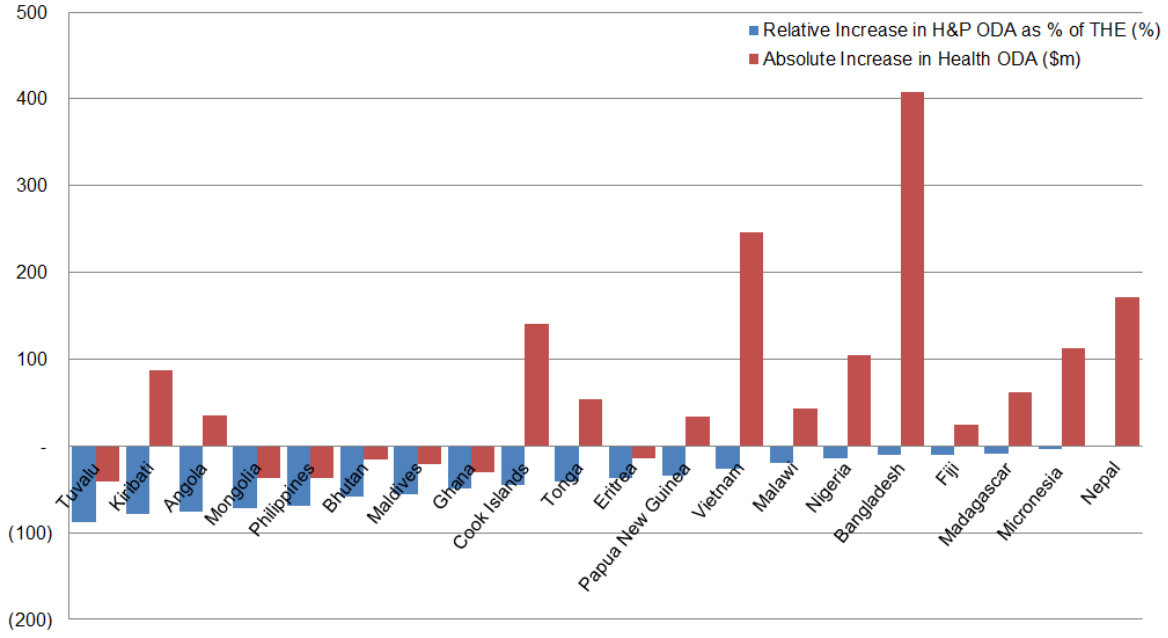
As a result of increases in per capita income and reductions in the burden of disease, factors which largely determine eligibility for funding, Gavi and the Fund are already 'graduating' some countries from their lists of eligible aid recipients, including in the region. Despite interest in the question of how best to plan and implement the transition to local ownership, there is limited evidence of strategies that effectively support graduation, or of countries actively involved in 'sustainability planning'.

Few would argue against the principle that countries which are more able to pay for their own health care needs should do so. This is especially relevant given recent constraints on aid budgets and the growing wealth of many countries in the Asia Pacific region. The question is whether this is being done in ways which are fair and do not compromise the delivery of important health programmes. Sustained investment in quality communicable disease programmes is essential in the Asia Pacific region to avoid health security threats and manage emerging drug resistance, including artemisinin resistance – a growing threat to successful malaria control and elimination. Equally important are routine immunisation programmes to protect populations against vaccine preventable diseases.

A real concern is that countries become victims of their own success, with higher incomes and healthier populations leading to reduced GHP funding. This would likely then be reinforced by rapid declines in support from bilateral donors, who tend to have similar eligibility criteria, at the same time as countries face higher costs of delivering the services they are expected to take over when they are no longer classified as a low income country.

Analysis of WHO National Health Accounts (NHA) data shows that countries in the region have already had some success in reducing aid dependence over time.

Figure 1: Trends in dependence on external assistance for health and population between 2002 and 2012 (%)

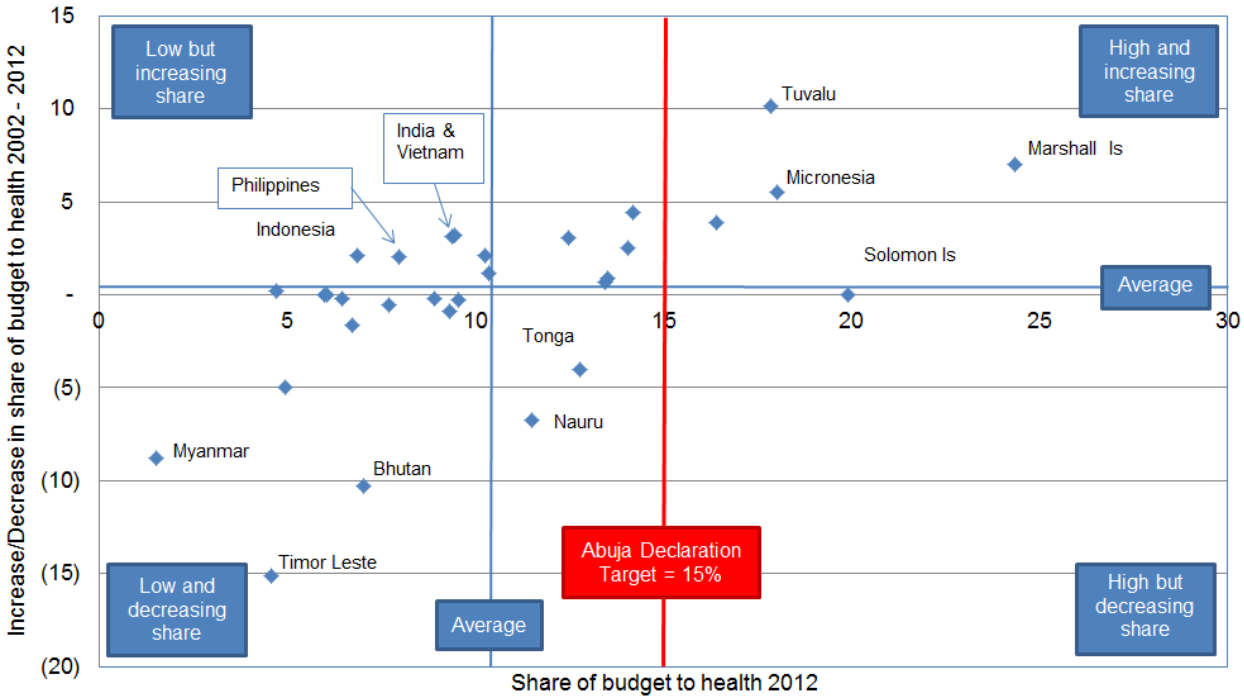


Legend: H&P: Health and population; THE: Total Health Expenditure

Figure 1 shows a number of aid recipients who have reduced the *relative* role of external support in their overall health spending over the last decade or so (Tuvalu and Kiribati have seen the biggest reductions). The Asia Pacific is clearly well represented in this group. That this trend is associated with *absolute* increases in aid in some countries (e.g. in Kiribati, Vietnam and Bangladesh) reflects strong growth in domestic expenditure. As such although financial sustainability challenges undoubtedly remain, they are less daunting than they would have been had dependence on aid not already declined.

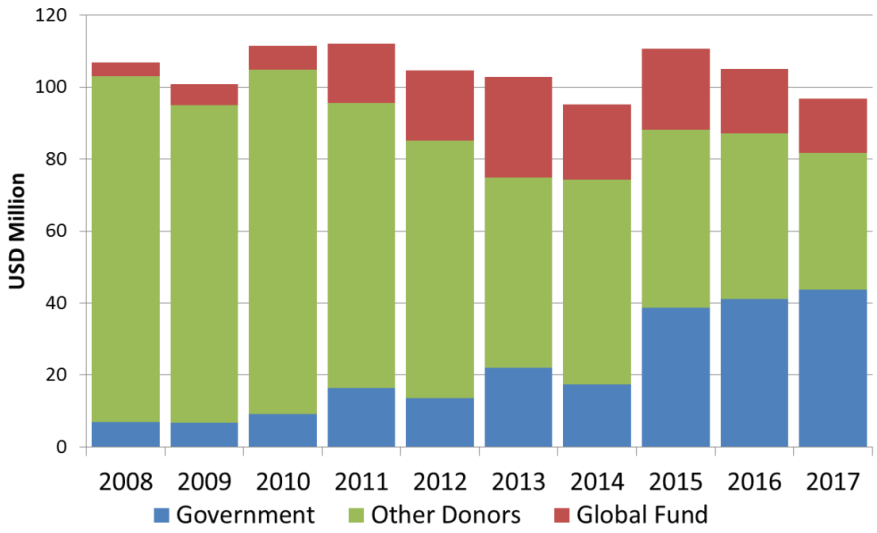
The problem is not necessarily a lack of political commitment. As Figure 2 shows many countries in the region (notably the Pacific Islands) have devoted a large, and increasing share of their budgets to health, to levels far in excess of the 15% target set out in the Abuja Declaration[1].

Figure 2: Association between current share of the budget to health and past trends in share



There are clear exceptions. Bhutan, Myanmar and Timor-Leste are the most prominent: in these countries allocations have declined from already low shares. Some countries have rapidly scaled up domestic financing yet still face declines in overall spending. Vietnam for example (as shown in Figure 3) has rapidly increased domestic funding for AIDS, TB and malaria in recent years but this has been more than offset by reductions in flows from GHPs and other donors (especially PEPFAR).

Figure 3: Financing of the HIV/AIDS response in Vietnam



Source: Global Fund

[1] A useful rule of thumb though the agreement relates to Africa.

Concerns have also been raised that graduation may weaken some funding priorities and activities, such as support to civil society organisations and funding targeted at specific groups such as drug users, men who have sex with men and sex workers at risk of HIV. The key populations at highest risk of malaria infection also include those least able to access services. For example, in Myanmar those most at risk are migrant workers and individuals living in villages in or near forests. Many of the migrants in the region are unregistered or illegal, or represent a minority ethnic group, and actively avoid contact with any authorities. Particular attention is needed to ensure services for these groups are maintained – as such attention needs to be paid to the allocation of funds, not just to the overall level of available funding.

2. What do we mean by sustainability?

A commonly used definition of sustainability in the health sector refers to "the capacity to maintain service coverage at a level that will provide continuing control of a health problem" (Claquin, 1989)[2]. Alongside there is the implicit assumption that this also contributes to broader concepts of sustainability.[3]

In health, there are a number of dimensions to sustainability, for example:

- **Fiscal sustainability**: the ability of governments to finance a programme without compromising the long term solvency of the government and its abilities to service its debt.
- **Organisational sustainability**, made up of both:
  - **financial sustainability**: the ability of an individual institution to meet the ongoing financial needs of its programmes and respond to future opportunities and threats; and
  - **institutional sustainability** – the integration of externally supported activities into existing structures and the ability of a programme to maintain benefits once external funding stops or declines.

Box 1 presents an example of how these have been combined into an explicit statement on what sustainability might mean post-graduation.[4]

Box 1: Criteria for successful graduation: USAID Family Planning Programme

- A sustained or increasing modern contraceptive prevalence rate (CPR);
- In-country technical, administrative and programmatic capacity capable of maintaining family planning service delivery and adapting to changes as appropriate;
- On-going financing of essential aspects of family planning service delivery and products, including contraceptives; and
- Services directed to remaining pockets of unmet need.

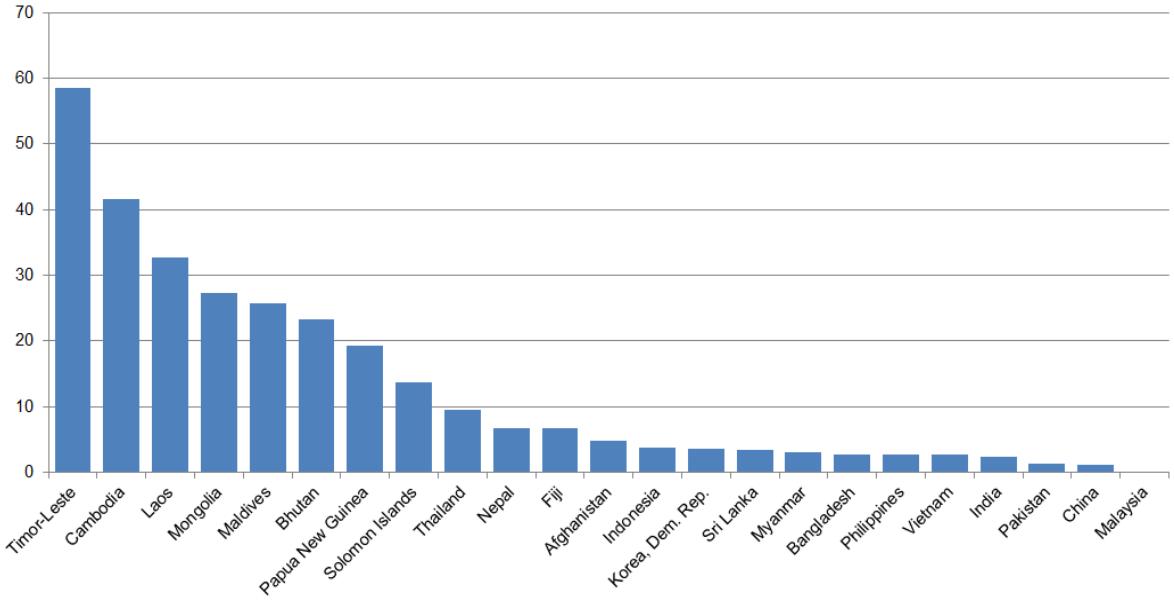
Source: Bennett, 2011

[2] Claquin, P. "Sustainability of EPI: Utopia or sine qua non condition of child survival." *Resources for Child Health Project* (1989).
[3] For example "Sustainable development is development that meets the needs of the present without compromising the ability of future generations to meet their own needs" Bruntland Commission, 1987.
[4] As noted in the introduction the focus of this paper is on issues of financial sustainability.

3. What is the role of GHPs in the region?

The GHPs play a major role in financing health care in the region. Figure 4 shows average annual per capita disbursements by the Fund in the region over the last decade.

Figure 4: Per capita disbursements by Global Fund 2002 – 2012 (US$ per head)



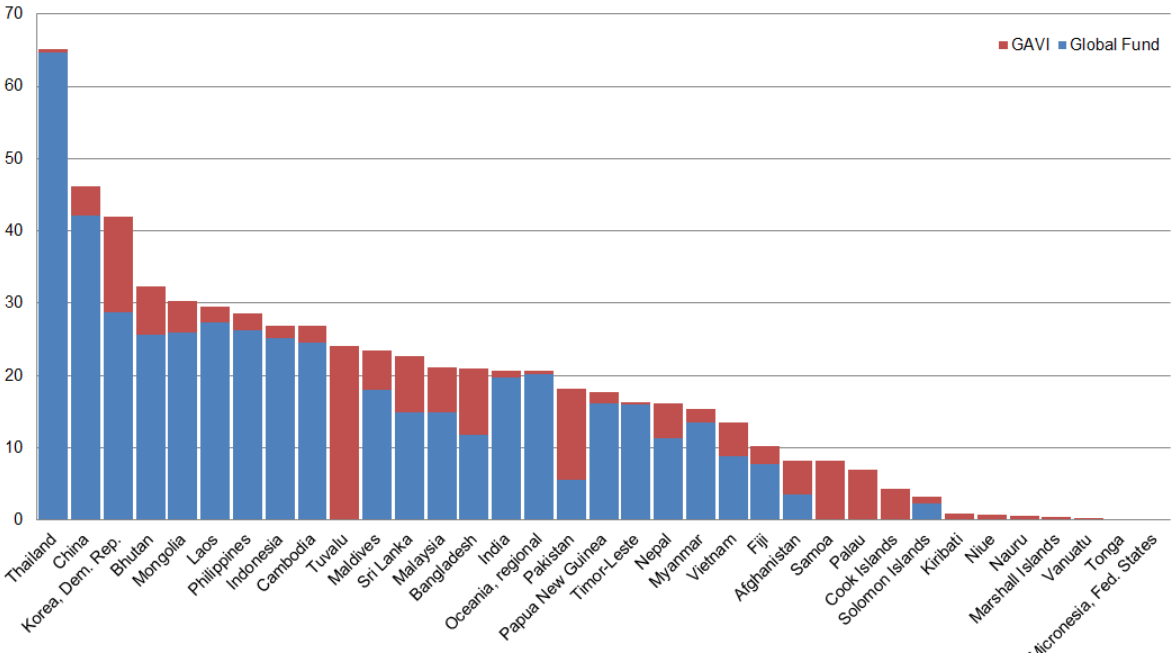
Source: Global Fund.

There is wide variation – disbursements exceed $30 per head over the period in Timor-Leste, Cambodia and Laos but are below $5 per head in half of the countries listed (Source: Global Fund).

Figures 5 and 6 help identify the countries which are both aid dependent and heavily reliant on the GHPs for financing health services as an indication of where graduation and transition from the GHPs might pose major challenges.

Figure 5 shows the relative role of the GHPs in overall donor support to the health and population sector. The GHP share is above 40% in better off countries such as China and Thailand (reflecting the Fund's relatively heavy current emphasis on middle income countries) but is above 20% for a large number of poorer countries in the region.

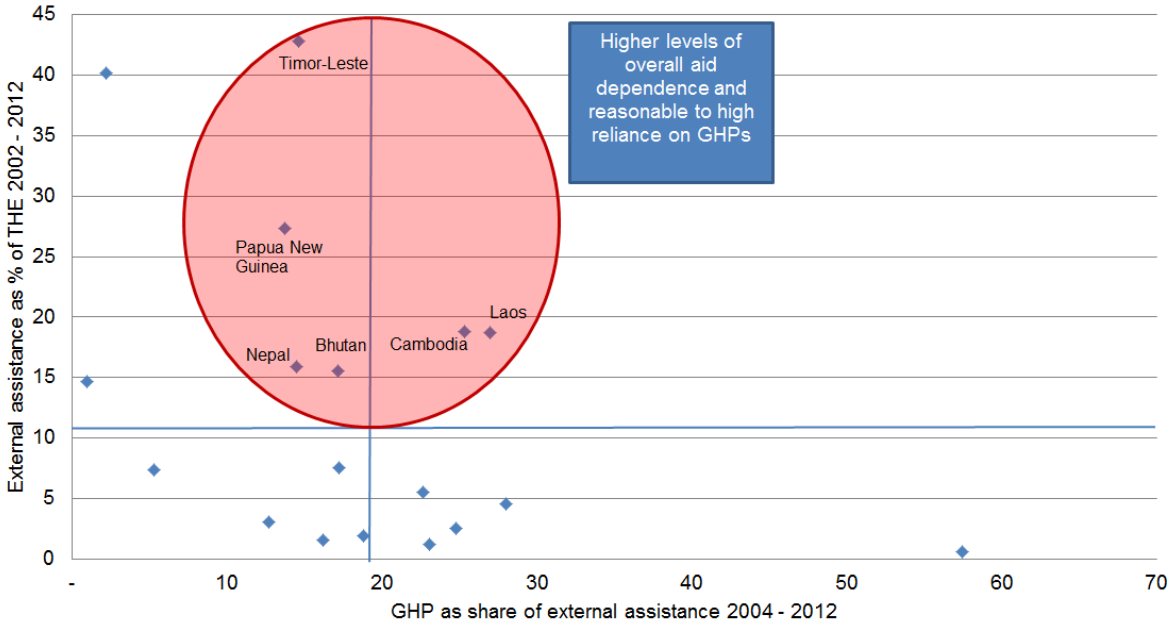
Figure 5: Reliance on Global Fund and Gavi



Data source: DAC Creditor Reporting System.

Figure 6 tries to identify the countries which are both aid dependent and, within this category, heavily dependent on the GHPs. The likely high risk countries include Bhutan, Cambodia, Laos, Nepal, Papua New Guinea, and Timor-Leste.

Figure 6: Association between overall aid dependence and dependence on GHPs for health and population ODA



Data source: DAC Creditor Reporting System and WHO NHA database. The horizontal and vertical lines show the averages for the region.

4. GHP graduation policies

This section maps out the eligibility thresholds for GHP assistance, the co-financing approaches used while countries are still eligible (which aim to improve the chances of long term financial sustainability) and the processes by which graduation and transition take place. In the case of the Global Fund we also describe the New Funding Model which has, and will have, a considerable effect on the allocation of Fund resources. A reliance on per capita income as a means of defining eligibility is common to Gavi and the Fund (as it is for many other donors). The key shortcomings of per capita income as a measure have been well rehearsed elsewhere, especially in relation to small economies and fragile states with large mineral wealth and weak health systems, a failure to consider inequality in income and in access to health services between different populations. Compounding this, the measure is also subject to sudden readjustment (see Box 2).

Box 2: Vulnerability to changes in eligibility

"On Tuesday, September 30, 2014 Kenya became a middle income country, following a review and rebasing of the National accounts statistics for 2006–2013. The rebasing indicated that Kenya's gross domestic product (GDP) is 25% larger than previously thought this. This classifies Kenya as a middle-income country".

Source: UNAIDS, 2014.

4.1 Gavi

Eligibility for Gavi support (under the new graduation policy effective from July 2015) is based on a per capita income threshold (currently set at $1,500 to be adjusted over time in line with inflation[5]); countries that exceed this threshold enter a graduation process, while countries falling below the threshold automatically become eligible again for support.

In terms of co-financing, since 2007 all countries applying for new vaccine support have been required to meet part of the cost domestically.[6] Currently, countries with a per capita income of $1,035 (the World Bank low income country threshold) pay $0.20 per dose. This increases by 15% per annum for countries within higher per capita incomes but still within the Gavi threshold. For graduating countries, the policy is for the country to meet the full costs over a five year period.[7] The policy is being amended slightly with effect from January 2016.

4.2 Global Fund

Eligibility for Global Fund support is rather more complex. All low and middle income countries are eligible for Global Fund support. Upper middle income countries (UMICs) are only eligible for funding for diseases where the burden is rated high, severe or extreme. UMICs with severe or extreme (but not high[8]) disease burdens can apply for health system strengthening (HSS) funding. All the grants to UMICs must be allocated to special groups and/or interventions. Lower middle income countries (LMICs) are eligible for all types of grant irrespective of disease burden (except where malaria has been declared eliminated) but 50% of funds must be allocated to special groups and/or interventions.

In terms of the allocation of resources the New Funding Model replaces the earlier 'first come first served approach' to the allocation of resources. The model allocates resources according to objective criteria[9] that are based primarily on per capita income levels and the burden of disease, but there are some exceptions, for example for small islands. Eligibility for higher income groups also comes with more stringent conditions on what the funds can be used for (and more specifically who is being targeted by the funds).

Co-financing requirements increase with income. At least 5% of the overall national effort is to be domestically funded for low income countries (LICs). The figure increases to 20% for lower LMICs, 40% for upper LMICs, and 60% for UMICs.[10] Countries are also expected to increase their contributions in absolute terms over time and to improve the availability of expenditure data in the sector (to show that co-financing is not displacing other key interventions). Many countries comfortably exceed these minimum financing arrangements. For example the counterpart financing share in the Philippines is 64% and is expected to increase to 87% in the coming years against its minimum of 20% as an LMIC.

The New Funding Model will have a large impact on the overall allocation of Global Fund resources. Effectively the new model concentrates resources on low income countries, which may be a good thing, but it raises sustainability challenges, increasing the level of dependency on external assistance in countries least able to cover such costs. This is mitigated, in part, by the fact that this approach improves predictability over the size of the challenge the countries will face. Figure 7 compares the allocations under NFM with past disbursement shares.

---

[5] Countries with higher incomes can still apply for support for the pneumococcal vaccine under the Advances Market Commitment initiative.

[6] Exceptions to this are vaccines for measles second dose, meningitis A, yellow fever preventive campaigns and measles-rubella catch-up campaign where there is no co-financing requirement.

[7] This is to be achieved in a linear fashion with the difference between the initial price and the full market price i.e. the Gavi subsidy reducing by 20% per year.

[8] "Recognizing the diversity of country situations, eligible UMICs with a 'high' disease burden and eligible 'Small Island Economy' exception countries to the International Development Association lending eligibility requirements with a 'low' or 'moderate' disease burden will only be eligible to receive a pre-defined maximum amount of funding"

[9] "The allocation formula is based on disease burden, income level, external financing and Minimum Required Level (to ensure that a country that has been over-allocated in the past is gradually adjusted to a fairer allocation over time). The Global Fund will then use qualitative factors to adjust the indicative funding amount for each country; these qualitative factors include previous grant performance, impact, increasing rates of infection, absorptive capacity, and risk".

[10] When transitions are made the new threshold levels are applied to new grants (but not existing ones). The Fund plans to develop an early warning system identifying countries likely to transition in the coming three years.

Figure 7: Allocated funding for 2014–2015 compared to actual disbursements 2011–2013 (% inc)

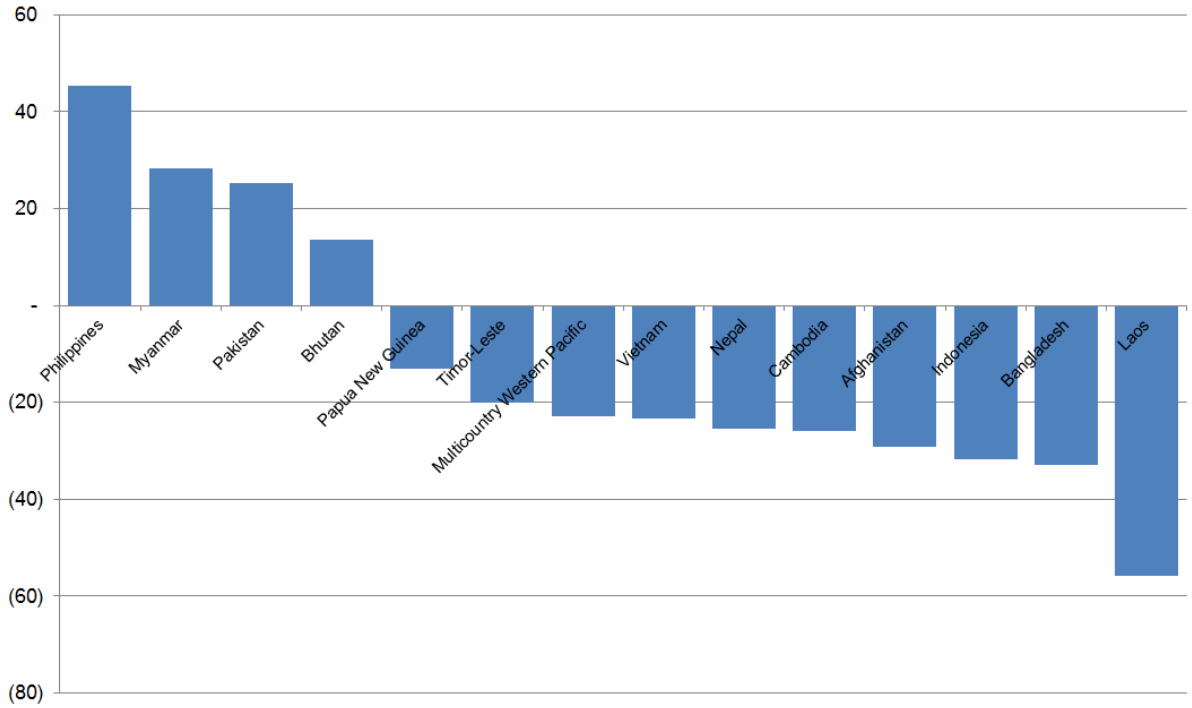
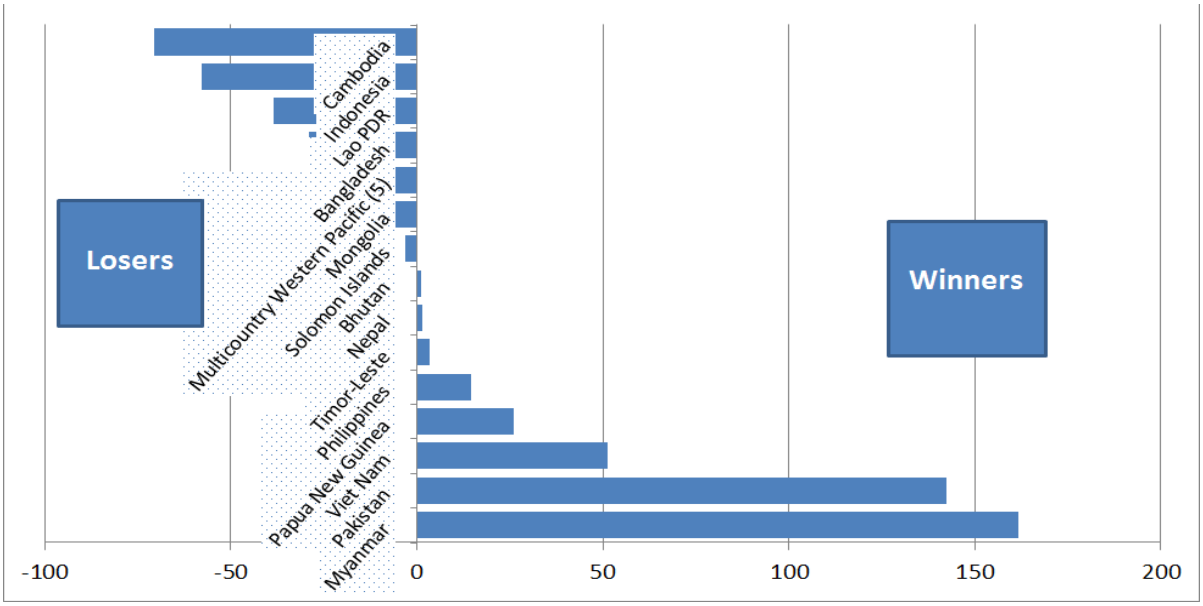


Figure 8 shows the winners and losers under the NFM, comparing what countries will actually get with what they would have got had the old system been retained.

Figure 8: Relative gain or loss by country through introduction of the New Funding Model (US$m)



Overall, the Asia Pacific region loses out to the tune of some $871m (what it gets under the new formula compared to what it would have got had past spending trends continued). However, once the declines of India and China are excluded the region sees a net gain. Within this, Vietnam and Myanmar are the largest net gainers and Cambodia and Laos are the biggest losers. In relative terms Pakistan and Myanmar see a more than a doubling in their share of the overall Fund pot. As a result, one could argue that those seeing immediate rapid declines in the Fund support will face transition pressures much earlier, and for those with relative gains the sustainability challenge will be larger but it will be delayed and faced later.

Whilst this data sheds light on what we would call macro-level (i.e. overall GHP funding) the picture will differ at the micro-level (i.e. individual programmes) as there will also be changes in allocations between

the different components, including different diseases or activities. For example the Asia Pacific Malaria Elimination Network (APMEN) argue that Indonesia will see reductions in support for malaria despite a 43% increase in cases between 2000 and 2012.[11]

5. Implications for future eligibility

Looking forward, we considered a range of potential per capita income growth trajectories for countries in the region[12] to identify countries likely to graduate or transition between eligibility income categories in the near future. We focused on the transition between low income and middle income status as this threshold is also used by many bilateral donors to guide the allocation of resources and makes countries vulnerable to a multiple withdrawal of funding. Table 1 shows likely graduates and timing of the graduation assuming a conservative 3% annual increase in per capita income. In practice real growth in per capita income[13] has averaged around 4% in the region over the last decade (although it varies widely between countries).

We also looked at the extent to which countries were close to disease burden thresholds (relevant for UMICs under the Fund). If we assume trends between 2010 and 2013 continue there are likely to be very few changes in eligibility in the region. Thailand may move from the moderate to low category (prevalence of 0.5%). All four countries currently rated extreme for TB (Kiribati, Papua New Guinea, Timor-Leste and Democratic People's Republic of Korea) are likely to remain so. Vietnam and Bangladesh are rated severe but are close to the high category whilst Afghanistan, India and Thailand are rated high but are close to the severe border.

For Gavi the Asia Pacific region is over represented in terms of the currently graduating countries, with no less than seven of the 20 countries from the region graduating (Bhutan, Sri Lanka, Mongolia, Indonesia, Kiribati, Papua New Guinea and Timor-Leste). Others are expected to graduate in the coming years as set out in Table 1.

Table 1: Countries likely to transition between GHP eligibility categories (assuming 3% growth in GNI per capita and 2010 to 2013 trends in health indicators)

Transition	Transition expected	Countries likely to transition	Implications
Per capita Income	Above UMIC	Long Term: Malaysia, China, Thailand	No further Global Fund support (macro sustainability issue)
	From LMIC to UMIC	Short Term: Mongolia, Indonesia, Timor-Leste, Micronesia, Samoa Medium Term: Philippines, Sri Lanka, Vanuatu, Kiribati, Bhutan Long Term: Vietnam, Pakistan India	Greater conditions on use of funds (micro sustainability issue). Higher co-financing requirement
	From LIC to LMIC	Short Term: Cambodia, Bangladesh Medium Term: Nepal, Afghanistan	Greater conditions on use of funds (micro sustainability issue) Higher co-financing requirement under Gavi
	Above Gavi threshold	Short Term: Laos, Pakistan Medium Term: Myanmar, Bangladesh, Cambodia Long Term: Afghanistan	No further Gavi funds (except possibly AMC (macro sustainability issue) Higher co-financing for Gavi when above LIC threshold (see above)

Short Term 2015 to 2020, Medium Term 2020 to 2030, Long Term 2030 to 2050. Assumes thresholds remain constant in real terms.

[11] The impact of the Global Fund's new funding model on Asia Pacific malaria elimination network countries. A briefing prepared by the Global Health Group at the University of California, San Francisco, May 2014.
[12] Our approach is based on a number of potential growth scenarios. We look at IMF projections for economic growth (GDP per capita) and applying these to current GHI per capita figures. We also extrapolate figures based on GDP per capita growth over the last 10 years. We extrapolate according to World Bank estimates for GNI per capita over the last 3.5 and 10 years and finally look at the implications of GNI per capita growth from 0% to 5% in 0.5% increments.
[13] GNI per capita World Bank atlas deflated by the GDP deflator.

It is important that the GHP approaches are not seen in isolation and an understanding of their effect is not confined simply to financial flows from the GHPs. Other factors to consider include:

- **The response of other donors:** A major risk is that the GHP graduations when countries hit certain per capita income thresholds will also be repeated for other donors resulting, for example, in countries 'falling off a cliff' when they hit middle income country (MIC) status.
- **Effects on the cost of inputs:** new MIC status is likely to have implications for the sustainability of the HIV response as it is not immediately clear if countries will continue to benefit from the special arrangements currently offered by pharmaceutical companies to low income countries. These include, for example, price discounts and voluntary licenses to use their patents. In the case of Gavi, voluntary agreement has been reached with some companies to afford some countries some protection during graduation (see Box 3). It is less clear that such arrangements will provide protection against the higher costs of antiretrovirals for those living with HIV.

Box 3: Providing countries with financial protection after graduation

"GlaxoSmithKline (is) committed to supporting developing countries that have growing economies by offering a five year freeze on vaccines prices for countries who graduate away from GAVI Alliance support. Sir Andrew Witty, CEO of GSK, told the GAVI Alliance […] that the company is taking a 'pragmatic' approach to vaccine pricing for countries that have growing economies to avoid creating a 'strange economic dynamic' where national resources are over-stretched as countries graduate. He added: "We want not just to help people when they are on their knees but to continue to help them when they stand up and move forward."

Source: Gavi, News 20 May 2014

6. Evidence base on graduation and transition

There is very little specific evidence on the experience of countries graduating from GHP support.

A recent review of Gavi's early experience with graduating countries[14] found wide variation in countries' ability to assume responsibilities for their programme. This is due in part to their ability to raise funds domestically but also the size of the investments made (see Box 4). It found key areas of weakness included budgeting for vaccine purchase, national procurement practices, performance of national regulatory agencies, and technical capacity for vaccine planning and advocacy, suggesting that lack of funding is certainly not the only constraint. The review confirmed the value of transition planning which Gavi has now decided to continue.

A five country review of exit strategies by bilateral donors commissioned by SIDA[15] found that "exit strategies and good exit practices do not receive sufficient attention and are a neglected part of donor cooperation – yet the number of exits is increasing and will continue as donors concentrate their aid programmes in fewer countries and sectors". The paper distinguished between cases where withdrawal is due to force majeure (e.g. a major governance failure), where it is a planned withdrawal and where the country is no longer aid dependent and advised that "each exit has its own features, and must be planned and implemented accordingly".

It found few cases of comprehensive exit plans – in terms

Box 4: Identifying the key challenges

"One can foresee challenges in the Republic of Congo, which has relatively low government spending on health per capita (US$59) and is adopting the largest number of new vaccines. In contrast, even though Sri Lanka has lower government spending on health per capita (US$43), it has only one new vaccine adoption to incorporate into its budget."

Source: Saxenian et al, 2014.

[14] Overcoming challenges to sustainable immunisation financing: early experiences from Gavi graduating countries, H Saxenian, R Hecht, M Kaddar, S Schmitt, T Ryckman and So Cornejo, Health Policy and Planning 2014:1–9.
[15] Managing Aid Exit and Transformation Lessons from Botswana, Eritrea, India, Malawi and South Africa. Synthesis Reports, Anneke Slob, Alf Morten Jerve Joint Evaluation 2008:1.

of a clear timeframe, guidelines on communication, indicators on monitoring, and a step-by-step approach. The Danish exit plan from India was presented as a good example of such a plan especially in the ways it attempted to mitigate adverse consequences and carefully consult with all stakeholders. In contrast, precipitous, unplanned exits can cause major problems (see Box 5). 'Natural phasing out' was typically the default mode whereby ongoing commitments were simply honoured until they came to completion.

The positive Danish experience in India highlighted the need for a more proactive approach including adjustments in existing agreements, and even temporary increases in support in the run up to withdrawal. Institutional capacity on the part of the recipient was seen as crucial and, although the Indian Government was able to take on most of the key responsibilities easily, components with a more innovative focus proved more challenging. The lack of donor capacity was also seen as a constraint, with a lack of internal lesson learning on how to manage aid exit and a series of negative incentives which do not reward successful phase out (exit is seen as failure and offices which are closing are usually not sought after by the best staff).

A DFID evaluation[16] found that successful exits typically involved a mix of realistic timeframes, careful and mutual planning, consultation, and flexibility to set up arrangements for handing over or finding alternative ways of financing. Exits from aid-dependent countries were generally found to be less successful, but in a few cases results at the level of recipient institutions and beneficiaries could be sustained. General guidance was "to communicate graduation plans to recipient governments as far in advance as possible so that they can prepare for reduced aid flows and changes in the nature of engagement". Nonetheless referring to India, the review cautioned that DFID's future strategy remained "unclear, making partners' planning difficult". It further found that "DFID has yet to define a clear exit strategy for the technical assistance or how the state will replace the capacity it provides after 2015".

Box 5: Impact of unplanned withdrawal

"The Danish exit from Malawi with six months' notice created a 40% shortfall in the agriculture sector budget, a major setback in agriculture sector programme development, and affected long-term agricultural research negatively."

Source: Slob and Jerve, 2008.

Recent work by Shen et al[17] which considers lessons learned from the USAID Family Planning graduation experience for Gavi graduation processes, emphasises the fact that plans "helped focus on strategic needs and highlighted the importance of pre-determined financial and technical benchmarks, that sequencing is important (phasing out of contraceptive donations first before phasing out from technical assistance) and in maintaining political support during the process". It also stressed the need for a sound process "involving transparent country-level partners well in advance of graduation".

A review of USAID's experience with graduation from family planning support[18] found that whilst no systematic analysis had been undertaken of the impact of graduation on service delivery, in most cases graduated countries were able to maintain or increase their levels of modern contraceptive prevalence in the years following the phase-out of assistance. It did, however, note Indonesia as a possible exception (partly due to the fact that the process coincided with a period of health sector reform including a major decentralisation effort) and referred to anecdotal evidence of stock outs of oral contraceptives and condoms in the public sector in Peru for a period of time. Another area of possible concern related to apparent increases in adolescent fertility rates among the poor in some graduated countries, potentially reflecting that governments prioritise such groups less than donors.

[16] Country Programme Evaluations Synthesis of 2006/07 Evaluations, Julian Barr and Charlotte Vaillant, ITAD, January 2008.
[17] Shen et al Applying lessons learned from the USAID family planning graduation experience to the GAVI graduation process. Health Policy and Planning 2014:1–9.
[18] USAID Graduation from Family Planning Assistance: Implications for Latin America Bertrand J Tulane University, October 2011.

7. Lessons and conclusions

Many countries in the Asia Pacific region have already made significant progress in reducing their dependence on external support. Nonetheless, the challenges of sustaining GHPs remain, although the timing and size of the challenge will vary widely between countries. This paper focused largely on financial sustainability which is only one constraint and may not be the most pressing one.

Key messages, many of which are already features of GHP approaches or have been taken on board, include:

- Many countries in the region have already made considerable strides in reducing relative reliance on external partners. Although aid may have gone up in absolute terms, this has often been more than offset by large increases in domestic financing. Further fiscal space for more domestic financing is limited, especially in the Pacific Islands, by the fact that the share of the budget allocated to health is already very high and economic prospects relatively low.
- Sustainability needs to be built into country planning processes from the outset. Initial levels of investment need to consider likely future affordability; this might include not over-investing at the outset.
- Funding models need to ensure there are no perverse incentives to overstretch in the run up to graduation (e.g. taking on too many new vaccines). It should also consider the types of investment. Some may be more likely to be taken over and sustained financially by countries (e.g. drugs and commodities rather than prevention and community based activities) so it may make sense to withdraw from these earlier. However this needs to be balanced against the effectiveness of targeting services, including prevention efforts, at populations at highest risk of new communicable disease infections.
- Graduation requires a clear rationale. Ability to pay is usually a clear and sound rationale but is difficult to operationalise – per capita income is a readily available indicator but has severe shortcomings and may be particularly inappropriate in certain settings e.g. small island states. Convergence of GHP allocation and graduation approaches increases the risks of major cuts in programme funding at the country level.
- Efforts should be made to identify challenges in advance so steps can be taken in good time to help countries prepare and to allow them to mitigate potential adverse consequences. We identify a series of possible risk factors in Box 6.
- Graduation runs the risk of undermining activities – such as support to CSOs and funding targeted at specific groups e.g. adolescents, migrants, key populations most at risk of HIV – and particular attention is needed to ensure such vital roles and services are maintained. Where graduation is to take place:
    - It should be predictable giving countries a chance to adapt to any new resource environment. Smoothing will be needed and will be essential to cushion the impact of changes in eligibility whether expected or unexpected;
    - The usual approach to transition is one of benign neglect. More proactive approaches may well be needed – this may mean a change in the focus of investments in the end stages and may actually require additional support in the run up to graduation rather than a gradual tapering off;
    - The process needs to be well managed. There should be good communication including two way exchange of information, close consultation and close monitoring of results; and
    - Particular attention may need to be placed on ensuring marginalised groups are not further disadvantaged and also on how to sustain the innovative aspects of existing programmes during and after the graduation process.
- Countries with higher institutional capacity and stronger health systems tend to fare better, yet donors sometimes underestimate the capacity of recipients, or do not pay it enough attention.
- Donors and GHPs need to coordinate around supporting countries to build sustainability into country-led planning processes. In particular they should consider any components of their funded programmes that could be better integrated with country budgets, systems and planning frameworks. Technical assistance and other types of support may well be required to support the transition

process, including around sustainable financing and transition strategies and plans, and the strengthening of health systems to take on the costs and roles of externally funded programmes (e.g. logistics, supply chain management, human resources and monitoring and evaluation). It will also be important to ensure that any existing technical assistance supports a coordinated sustainability approach working with national systems, planning processes and capacity.

- Donors and GHPs could do more to share lessons and best practice on graduation. At present there tends to be little learning within and between organisations (in part because graduation is seen in negative terms – as a failure rather than as a success). Attention needs to be paid to ensure institutional incentives do not compromise effective exit.
- The GHPs need to think carefully about their roles post-graduation, especially in terms of ongoing access to commodities at reasonable prices.
- Graduation is not one way traffic. Some counties – especially where there is ongoing fragility – may reverse and become eligible for support again.

Box 6: Sustainability: possible key risk factors

We can, to a degree, predict where challenges are the greatest. We would suggest the following as a starting point:

Countries likely to face the biggest challenges sustaining programmes (during transition) are those:

- Which have taken a lot of donor support (they have high levels of aid dependence both from GHPs and aid as a whole).
- Where support is focused in areas governments are typically reluctant to fund (e.g. prevention/community action which have few alternative funding options).
- Where other donors in country are not those with growing programmes.
- Where current support is already skewed to the three diseases and there is little prospect of reorienting existing resources towards them.
- Where the overall health budget share is already high and there is little scope for further increases.
- Where the fiscal situation is difficult so there is little scope for increase in future.
- Which face major governance issues making them vulnerable to donor withdrawal arising from e.g. financial mismanagement.
- Where the disease burden remains high and/or where new challenges are emerging (e.g. non communicable diseases).
- With ageing populations which affect the tax base, place greater demands on health services and the increasing dependency ratios effects economic growth; and
- With poor economic prospects resulting in unhealthier populations and poorer revenue prospects.