uhc2030
International Health Partnership

PERSPECTIVES FROM HEALTH PROGRAMMES

May 2019

on sustainability and transition from external funding

Report of a meeting held at
Chateau de Penthes Geneva, Switzerland

Contents

1. Executive summary

UHC2030 is working to build consensus on the sustainability objective when used in relation to transition from external funding to mean sustained or increased effective coverage of priority interventions and associated outcomes towards UHC, and develop a collaborative agenda taken forward by different actors in support of this. In 2018 the working group developed the UHC2030 statement on sustainability and transition that includes a set of 10 recommendations directed at governments of countries experiencing transition from external funding and the broad range of development actors working in such contexts.

The objective of the meeting was twofold: firstly to present and discuss some of the key HS challenges related to transition from external funding as seen by priority programmes, and secondly to discuss and map out priority areas for improved outcomes and collaboration in contexts of transition from external funding.

Key messages from programmes

In facilitating joint work across the system, we should be careful with wording and concepts. We all work on the health system; we have different specializations but we belong to the same system. We cannot only speak of scaling up coverage of interventions; programmes need to be there but we should think about improvements that help us address better the cross-cutting elements that prevent us from jointly moving towards UHC.

Table 1 summarizes the top concerns highlighted by disease programme representatives related to transition from external funding. Table 2 summarizes key issues raised by programmes less reliant on external funding together with some general points.

Table 1 Programme perspectives – priorities and threats related to transition from external funds

TB	For transition from external funding the biggest threat we perceive relates to **drug supply systems**. MSF wrote an open letter to GF in 2016 highlighting the threats posed by transitions particularly related to the quality of and the supply chain for TB drugs. Once countries transition to domestic funds for TB, will governments continue to purchase quality drugs – how will the balance play out in relation to incentives to buy locally produced drugs, sometimes with weaker quality control standards? This can have huge implications on resistance development – **threatening advancement of multi-drug resistant TB (MDR-TB)**.
HIV	Transition can and has led to **resurgence in concentrated HIV epidemics** where key populations served by NGOs have a key role. In many countries there is **weak or no capacity for social contracting and priority in national resource allocation and policies is insufficient**. The major challenge will be the financing of community-based services that are often at a lower cost and effective. There are many different initiatives at community level – home-based care workers for HIV, community-based DOT workers, malaria extension workers, and PLHIV treatment supporters, to mention a few. **When funds become scarcer such structures are vulnerable. Prevention and community outreach is an area where resources are often cut first and there is the real threat that we may lose those community-based and outreach services needed to reach the vulnerable populations that are essential to reach UHC.**

Table 1 (cont.) Programme perspectives – priorities and threats related to transition from external funds	
Malaria	**While securing funding continues to be an issue, the efficient use of resources is even more important.** Currently we have parallel systems for planning and budgeting such as the CCMs while there is a clear need for better comprehensive sector planning for consistent ways to, for example, improve delivery models and data availability and use. Eroding the political commitment to eliminate malaria in the Asia-Pacific region. Many countries are well equipped to take over the current donor-supported programmes, but certain elements like **replacing the current DAH-supported procurement mechanisms** can be problematic particularly in small countries procuring small commodity orders. The malaria programmes share the concerns raised by other programmes about **difficulties in sustaining the current outreach for hard-to-reach populations being provided by civil society**. **There is a risk that political commitment to maintain vector control through effective coverage of indoor residual spraying (IRS) and LLIN will not be sustained at regional level.**
EPI	According to the Global Vaccine Action Plan (GVAP) 2018 report, the **global expenditures on routine immunization per live birth grew by 35% between 2010 and 2017**. In addition to **increased advocacy for additional domestic resources, it is a priority to improve efficiency**, through building institutional and human resource capacity, and strengthening management skills and ways of enforcing accountability. We have established collaboration, for example, on national health accounts (NHA) and have worked on tools to demonstrate the return on investments for immunization. We would like **broader collaboration on positioning immunization priorities and work within an overall framework on UHC**.
Polio	The Vaccine Preventable Disease (VPD) surveillance system is crucial for provision of reliable epidemiological data, immunization impact monitoring, outbreak prevention and informed decision-making on new vaccines. In many LICs and MICs, the current VPD surveillance system was built on the polio surveillance system with funding provided by the Global Polio Eradication Initiative (GPEI). **With polio approaching eradication, the GPEI funds will gradually dry up worldwide. This raises a sustainability challenge for countries. We are particularly concerned about sustaining the surveillance system and how this can be successfully integrated.**
NTDs	Barriers include the generally low profile and priority of NTDs both in countries and internationally despite them causing huge morbidity, challenges in effectively collaborating across sectors and sustaining community engagement, and having weak infrastructure and health systems including reliance on drug donations for several of the diseases. **In general, work on NTDs is reliant on interest from a selection of international partners and reduction in those would impact achievements substantially as work on NTDs is often not prioritized in countries.**

Table 2 Perspectives of health programmes that are less reliant on DAH	
NCDs	**The NCD agenda is huge, but has not received much attention from donors. The programmes are therefore fully reliant on domestic resources and systems.** **There are many HS barriers. Information systems are weak. Prevalence and coverage data is frequently absent – contrary to some other conditions where efforts have gone into strengthening surveillance and data systems. Budgets are also often skewed and NCDs are not prioritized proportional to the disease burden, perhaps in part as a result from an information bias.** **In order to respond to the high NCD burden, major investments are needed in both public health measures and models of service delivery – in particular, primary health care but also regional services as well as tertiary care – for example, for cancers.** NCDs are often chronic and alignment between PHC and other levels of service is important as is building services in a people-centric manner. Decentralization adds a layer of complexity and often partners like WHO are not always well geared to address this. Mechanisms to strengthen intersector work are essential to address commercial determinants of major NCDs. In many countries people are paying for services at the point of delivery and private sector providers are poorly regulated. The latter is an issue but priority must be given first to improving public sector data availability and use.
RMNCAH	The reproductive, mother, newborn, child and adolescent health (RMNCAH) area is a good indicator of the performance of the health system overall. The area benefits from external funding within the area of immunization (Gavi) and more recently the GFF is active. Overall, however, this area is one that relies mainly on domestic resources and systems. **For the future it is important to increase focus on equity in service access as well as advocating for and supporting more implementation research, through strengthened policy analysis capacity in countries. More focus is needed on innovations in service delivery including better integration of outreach and community services.**

Key messages from GHI and partnerships

The focus on UHC triggers a change in dynamics both at country and global level. There is need for different ways of working and coordinating in countries and globally. **There should be work across the boards of GF, Gavi and WB to better synchronize approaches, align co-financing requirements and move away from the current approach of agreeing co-financing policies institution by institution.** Similarly in countries, there is need to move away from coordinating disease by disease and to redefine the balance between vertical and horizontal efforts.

Some of the global disease elimination targets are ambitious and highly vertical, and as such they can run counter to working together in countries towards UHC targets. Eighty per cent of new HIV infections outside Africa occur in key populations that the general health system is typically not good at reaching. When donors like GF leave we have seen resurgence in infections. The issue is political commitment and it seems unlikely, despite everyone's best efforts, that domestic resources will be earmarked for the key populations in the short and medium term in many middle-income countries.

This necessitates engaging in efforts to design basic benefit packages and working hard to ensure HIV is included in pooling efforts under UHC reforms. This can be challenging as often the resources have been used to set up parallel systems that have masked the weaknesses in the health system and – no less important – are often very expensive. For example, the cost of taking

over the HIV treatment scheme in one country recently visited was around six times the cost of running the national hospital.

TB services should be part and parcel of the basic benefit packages and provide payment systems, as well as work to strengthen PHC and effective community outreach. This should all come together and help incentivize the increased coverage of TB services.

In the case of malaria, transition from external funding risks eroding the political commitment to eliminate malaria in the Asia-Pacific region. Many countries are well equipped to take over the current donor-supported programmes, but certain elements like replacing the current DAH-supported procurement mechanisms can be problematic. Also, the malaria programmes share the concerns that other programmes have raised about difficulties in sustaining the current outreach for hard-to-reach populations being provided by civil society. There is also the risk related to transition from external funding that political commitment to maintain vector control through effective coverage of indoor residual spraying (IRS) and LLIN will not be sustained at regional level.

Transitions from Gavi funding will only be successful if positioned within the wider macroeconomic context of countries. We are working with our board towards a comprehensive approach to transition that ensures the challenges to sustaining coverage are addressed upfront – but there is need to work on harmonizing the overall position and voice for best results.

General

Issues raised can broadly be divided into two categories. Firstly, issues related to health system barriers raised by programmes in relation to transition, outlining a "*cross programmatic health system/efficiency*" agenda (see Table 3). Secondly, issues that relate to how planning on transition happens in countries and ways of strengthening effective development coordination; issues related to an "*coordination agenda*" (see Table 4).

Table 3 Cross-programmatic health system/efficiency agenda

Priority area	Programmes identifying barrier	Related global coordination efforts/ platforms
Procurement and supply systems	TB, malaria, VPI, HIV	CGD Working Group on the Future Of Global Health Procurement* Inter-Agency Pharmaceutical Coordination Group, Interagency Supply Chain Coordination Group * Does not cover immunization.
Multisector ways of working	• NCDs: determinants of tobacco, alcohol and dietary policies • TB/HIV: work in prisons/other • Malaria: Vector control • NTDs: Vector control • All: migrants/cross border	SDG action plan determinants of health accelerator

Table 3 Cross-programmatic health system/efficiency agenda (cont.)		
Priority area	**Programmes identifying barrier**	**Related global coordination efforts/ platforms**
Strengthen service delivery models/ PHC	All	Global Service Delivery Network (GSDN) Primary Health Care Performance Initiative (PHCPI) SDG action plan PHC accelerator, SDG community and CS accelerator (WHO and UNICEF)
Integration of community services	Polio, HIV	
Data and HMIS	All	Health Data Collaborative SDG action plan data and digital health accelerators
Social contracting	HIV, TB, malaria, polio, VPI, NTDs	UNDP/GF/OSF/UNAIDS/USAID coordination on social contracting
Prioritization	All	SDG action plan health finance accelerator – (P4H secretariat) There are two main categories: firstly *what* to fund, focusing on questions about benefit design; and secondly *how* to purchase health services in a strategic way (strategic purchasing, including coherent provider payment methods and contracting). Health technology assessment (HTA) helps inform the decisions on the first part regarding benefit design. With respect to "what" to purchase (benefits design), numerous networks on HTA exist*, along with donor-funded networking activities**, representing different constituents such as professional agencies, individuals, industry and academia. MOHs have anecdotally reported confusion with regard to the contribution that the different networks have to support their advancement and avoiding duplication. In response, WHO will launch the Decide Health Decision Hub to provide a space for all networks to communicate and align to support country processes for resource allocation decisions. * Health Technology Assessment International (HTAi), International Network of Agencies for Health Technology Assessment (INAHTA), Health Technology Assessment Network of the Americas (RedETSA), EuroScan, EUnetHTA, HTAsiaLink, International Society for Pharmaceutical Outcomes Research (ISPOR). ** International Decision Support Initiative (iDSI), Disease Control Priorities (DCP).

Table 3 Cross-programmatic health system/efficiency agenda (cont.)		
Priority area	**Programmes identifying barrier**	**Related global coordination efforts/ platforms**
Human resources for health	All	Global Health Workforce Network (GHWN) The five-year action plan for health employment and inclusive economic growth (ILO, WHO and OECD) Health worker mobility/migration: the health worker labour mobility platform established to coordinate efforts to maximize benefits from health worker mobility between source, destination countries and migrant health workers
Health financing	VPI, TB, HIV, malaria	P4H, WHO Montreux agenda, WB Multi-Donor Trust Fund SDG action plan health finance accelerator (WB and GF led P4H with secretariat)

Table 4 Donor-related issues – a coordination agenda	
Fragmented approaches by DPs	There is need for different ways of working and coordinating in countries and globally. There should be work across the boards of GF, Gavi and WB to better synchronize approaches, align co-financing requirements and move away from the current approach of agreeing co-financing policies institution by institution. Similarly in countries there is need to move away from coordinating disease by disease and redefine the balance between vertical and horizontal efforts.
An assumption when transitions started that it would be an easy process	There is need for: • Better understanding the local context to engage on UHC • A new skill set • Adjusting the appetite for risk • New ways of demonstrating results • Revised timelines • Eligibility criteria.

In countries and globally there is need to address misalignment of incentives to support a move to UHC. We should define ways of improving the coherence in incentives created by external support, how these are aligned with domestic policies and incentives within an overall direction of the country moving towards UHC. Discussions highlighted the need for a more holistic approach to health financing discussions that embeds donor transition issues within the frame of overall health financing.

Work should address cross-cutting health system strengthening or efficiency issues on HS subareas to improve outcomes. For many of these, there are coordination bodies that work to coordinate, share good practice and as appropriate harmonize efforts. Notably, the cross-cutting

HS issues/barriers are to some extent similar for donor-supported programmes (for example, HIV and TB) and for those programmes less reliant on external funds (for example, NCDs), underlining that work on transition is in essence a UHC/health system strengthening agenda.

Work on transition should address issues related to how planning on transition happens in countries – coordination – that also relate to effective development coordination. The current donor-by-donor piecemeal approach is not effective as systemic issues will need better addressing.

Notably, there can be **tension between an eradication/elimination agenda and moving towards UHC. There is also need for better optics/frameworks that consider the progression of change in a spectrum from fragile to highly sophisticated complex health systems.**

We should define a transition investment and reform agenda that would allow us to jointly work on addressing selected cross-cutting elements that are hampering the scale-up of priority interventions in countries. This should extend to cross-cutting issues both inside and outside the sector.

Innovations are happening in health financing – perhaps too many innovations in health financing and too few in service delivery. We should work on coming together on innovations and a vision for reform of service delivery. There is no magic bullet, only good and bad ways of implementing.

2. Concepts and frameworks: Transition from external funding through a UHC lens

Kara Hanson, London School of Hygiene and Tropical Medicine

All countries face a number of critical pressures on their health system. There are some that are particularly salient in countries that are currently or will soon be "transitioning" to much lower external funding.

While responses to transitions must be specifically adapted to each country's context, a guiding principle is to maintain and increase the effective coverage of quality priority interventions and associated outcomes towards UHC.

This does not simply mean channelling government revenues to pay for previously donor-funded programmes. Rather, transition provides the opportunity to assess how governance service delivery and financing are configured to ensure the sustainability of effective coverage of priority interventions. By placing the focus in this way it ensures donors and policy-makers alike are working together towards sustainable solutions to the problems presented by transition.

UHC2030 is working to build consensus on the sustainability objective when used in relation to transition from external funding to mean sustained or increased effective coverage of priority interventions and associated outcomes towards UHC, and develop a collaborative agenda taken forward by different actors in support of this.

In support of this, UHC2030 in early 2017 set up a working group. The membership of the group brings together country representatives, WB/WHO health system and disease experts, bilateral partners, global health initiatives, GFF, OECD, BMGF, academia think tanks and civil society. Country interest and participation in the group has been strong, with 15 countries actively engaging in the group, either through direct participation or country consultation.

In 2018 the working group developed the UHC2030 statement on sustainability and transition that includes a set of 10 recommendations directed at governments of countries experiencing transition from external funding and the broad range of development actors working in such contexts. The purpose of the statement is to contribute to consensus among countries and development partners on a set of common principles to guide the actions of all actors working in contexts of transition from external funding.

The principles place work on sustainability and transition within the context of UHC. While all the principles are relevant for the discussion today there are some that are particularly so, including principle number three that refers to the need to have clarity on "what" we aim to sustain or increase in a transition process – being the effective coverage of priority interventions and associated outcomes towards UHC – and principle number eight that refers to the need for disease experts and those working on other parts of the HS to work together to identify barriers and actions needed in response to transition from external funding. Finally, sustaining or increasing coverage of quality priority interventions and associated outcomes towards UHC will require additional resources and the case should be made for adequate resources for the health sector as a whole.

In line with this, the objective of the meeting is twofold: firstly to present and discuss some of the key HS challenges related to transition from external funding as seen by priority programmes, and secondly to discuss and map out priority areas for improved outcomes and collaboration in contexts of transition from external funding.

Joe Kutzin, Coordinator, WHO Health Financing Policy

Transition from external funding has brought a flurry of interest in "financial sustainability". Many programmes and donors have contacted us, requesting to discuss new funding innovations or investment cases. In countries, MOFs are being approached with funding requests from different programmes concerned about the impact that transition from external funding will have.

However, not every disease or health priority should have its own tax or revenue stream. We often have a tendency to focus too much on the revenue side, and too little on the efficiency side. "We cannot spend our way to UHC." It is important to aim for a comprehensive rather than piecemeal engagement between MOH and MOF.

Budget dialogue makes most sense at the sector level rather than by disease programme. We should analyse the impact at the population level, not by programme beneficiaries or participants in a particular health-financing scheme. Discussions and plans on sustainability in relation to **transition from external funding should take into consideration the context of countries moving towards UHC and efforts should aim to sustain or increase the effective coverage of quality priority interventions towards UHC.** For this a system-wide analysis is needed.

Hence the question should not be "how can we make the HIV programme sustainable?" but rather "how can we sustain increased effective coverage with intervention to prevent and treat/ manage HIV?". Programmes may be well run internally but there may be efficiency opportunities when looking across at the sector level. We should seek to identify those and the targeted actions needed to improve the use of resources.

However, as always, "where you stand depends on where you sit". How do the issues and challenges related to sustainability and transition look from your perspective? What are the priority areas for coming together? What can be usefully consolidated without loss of accountability?

3. Programme perspectives on priority outcomes transition and health system challenges

Diana Weil, Coordinator, WHO Global TB Programme

In facilitating joint work across the system, we should be careful with wording and concepts. We all work on the health system; we have different specializations but we belong to the same system. The Global TB Programme has spent the last two years working hard on preparation for a UN high-level meeting on TB and a political declaration on TB. This was certainly not focused on a vertical programme but rather on a system response to TB that very much emphasized the importance of financing mechanisms, governance and the active voice and engagement of civil society.

The aims go beyond sustaining the gains: our ambition is to find and treat those that we are not reaching today. In this we come up against the thorny and complex issues of service delivery models.

Regional and country contexts are different. In Eastern Europe the situation is very complex but a system-wide response is critical if we are to make progress to control TB – not least MDR-TB. In Latin America we have seen things go backwards regarding TB; weak financing and access to new technologies are some of the issues. In East Asia, WPRO has done very interesting work across the system including in decentralized contexts. Indonesia is an example of a decentralized country, where much has been done to embed TB budgets within the provincial structures. We are collaborating with the health finance team on payment systems for TB, thinking about both public and private providers – the latter being very prominent in many countries in Asia. In some countries, public funding for TB has been incorporated into health insurance funds but there are issues of capacity and making full use of the potential this brings.

When it comes to transition from external funding, the biggest threat we perceive relates to drug supply systems. MSF wrote an open letter to GF 2016 highlighting this issue. Once countries transition to domestic funds for TB, will governments continue to purchase quality drugs? And how will the balance play out in relation to incentives to buy locally produced drugs, sometimes with weaker quality control standards? This can have huge implications – not least on resistance development threatening advancement of multi-drug resistant TB.

New technologies are in the pipeline, but an important priority is to ensure that the poor who currently do not access to TB services are prioritized in efforts. We are working to build new tools

into health technology assessments. We are also keen to engage and support development of social security programmes that we see as key to UHC, not least the equity part.

Taskeen Khan, WHO, Management of Noncommunicable Diseases programme

The NCD programme works to reduce the premature mortality and morbidity from major NCDs including but not limited to CVD, cancers, diabetes mellitus, and COPD. The programme also includes mental health as well as road safety, disabilities, food safety and others.

Core interventions are many and include both population and individual service interventions through primary and secondary prevention. At the population level this includes work on determinants of major risk factors like tobacco use (for example, legislation, taxation, marketing and advertising polices) and policies to reduce the harmful use of alcohol, and dietary and lifestyle policies. For individual services this can include work to increase the detection and management of risk factors like hypertension, high blood sugar, hyperlipidaemia as well as tertiary prevention to reduce morbidity from the various conditions.

Many countries have a complex disease burden – with a large and rising noncommunicable disease burden – while an unfinished agenda on communicable disease remains. **The NCD agenda is huge but has not received much attention from donors. The programmes are therefore fully reliant on domestic resources and systems. Information systems are weak and prevalence and coverage data is frequently absent or reliant on STEPS surveys undertaken only intermittently – contrary to some other conditions where efforts have gone into strengthening surveillance and data systems. Budgets are also often skewed and NCDs are not prioritized proportional to the disease burden, perhaps in part as a result from an information bias.**

In order to respond to the high NCD burden, major investment is needed in models of service delivery – in particular primary health care but also regional services as well as tertiary care (for example, for cancers). NCDs are often chronic and alignment between PHC and other levels of service is important, as is building services in a people-centric manner. Decentralization adds a layer of complexity and often partners like WHO are not always well geared to address this. Mechanisms to strengthen intersector work are essential to address commercial determinants of major NCDs.

In many countries people are paying for services at the point of delivery and private sector providers are poorly regulated. The latter is an issue but priority must be given first to improving public sector data availability and use.

Discussion

How donor priorities affect the distribution of domestic resources is important. Data have shown in LICs that DAH focused on TB, HIV immunization and malaria while NCDs were funded from domestic resources.

In some countries, requests to MOH related to co-financing requirements are taking up large parts of MOH discretionary budgets.

Jeanette de Putter, Coordinator, WHO HIV programme

Historically elements of "*verticalization*" originate from a desire to deliver impact quickly. We have seen waves of efforts to work in a more integrated manner – for example, the sector-wide approaches (swaps) come and go. In many countries the organizational structures related to health services and communicable diseases are vertical at national level, but become more integrated at district level.

In WHO we still have separate programmes in HQ; these become more integrated at regional level. At country level, in less-high burden countries we have communicable national professional officers (NPOs) and in high burden countries we have specialised HIV, TB and Malaria NPOs. Prevention remains a priority to avoid higher treatment and care cost. The major challenge will be the financing of community-based services that are often at a lower cost and effective. There are many different initiatives at community level – home-based care workers for HIV, community-based DOT workers, malaria extension workers, and PLHIV treatment supporters, to mention a few.

When funds become scarcer such structures are vulnerable. Prevention and community outreach are areas where resources are often cut first and there is a real threat of losing those community-based and outreach services which reach vulnerable populations that are essential to achieving UHC. Procurement is another important area where considerable savings can be made in many countries – but this requires investments in building stronger cross-cutting capacities on supply and procurement.

Finally on domestic funding, sometimes the MOH budget is allocated based on the expenditures in the previous year and the budget was prepared two years in advance. In Namibia where I used to work, there was never a separate budget line on HIV but the scale-up on ART was done through existing emergency mechanisms.

Discussion

Breakdown of outreach to key populations in countries with concentrated HIV epidemics is a real scare, and has already resulted in donors like GF having to return to countries where transition had been planned.

We should examine the political economy of the SDGs and how this differs from the MDG era. For some donors this has not changed; for example, the USG still directs funds quite vertically driven by the objective to maximize short-term impact.

Many high-income countries already have very integrated service delivery; lessons should be drawn from these. There is an important balancing act between short-term impact and the time it takes to strengthen systems for more durable impact. This requires nuance and typically bureaucracies do not handle this very well.

A critical element for sustainability of impact is citizen voice for health/priority areas. It took many years to strengthen this but capacity has grown. We should identify critical system areas like this and procurement and place them upfront in our work, rather than facing them only when external support is phasing out.

Alastair Robb, Adviser, WHO Malaria programme

From a sustainability perspective, transition does not begin when external funding starts to reduce, but should rather be part of the design of interventions from the onset. However, the balance may shift in contexts where eradication/elimination becomes an option and additional efforts may be needed to secure the global good that this presents.

Looking back some 20 years, efforts to control malaria were seriously off track with limited funding, and using mostly old tools and technologies. The MDGs brought focus on malaria and we saw the setup of the Roll Back Malaria (RBM) partnership and additional resources through the GF, which was initially set up for HIV but broadened to include also malaria and TB following requests from African Ministers of Health. The efforts brought great progress with 60% reduction in malaria mortality worldwide as well as reduced morbidity from malaria. The past years have, however, seen a plateauing of progress especially in high burden countries. Sustaining efforts is important. Despite progress, less than half of children presenting with fever are taken to a trained provider and only one in five of those who do seek care, receive antimalarial medicine. The poor are least likely to seek care.

While securing funding continues to be an issue, the efficient use of resources is even more important. Currently we have parallel systems for planning and budgeting, such as the CCMs, while there is a clear need for better comprehensive sector planning for consistent ways to, for example, improve delivery models, and data availability and use. The SDGs and the new action plan both call for better aligned and integrated ways of working to identify and address the common system barriers and engage better with subnational and decentralized parts of the systems. **Threats related to transition from external funds include the tendency to be politically expedient at the risk of under-focusing on the long-term issues.** The work that NCD teams are doing to address commercial determinants of health are an example of the longer-term thinking that is needed overall.

Discussion

It is important to consider the demand side of services. We need patient-centred service delivery models that correspond to the increased co-morbidity seen in many countries. We should build systems through their use rather than shortcutting and building parallel systems.

There is also need for better optics/frameworks that consider the progression of change in a spectrum from fragile to highly sophisticated complex health systems. The contexts also vary by burden of malaria; in high burden countries HS issues are quite different from those of elimination countries. Climate change is making it more difficult to project when countries will move to an elimination phase and, as a vector-borne disease, malaria has a strong multisector element. **We need coherent pragmatic guidance/approaches across diseases and health priorities on how to address multisector dimensions. Cross-border issues also need consideration unpacking the political economy of this.**

Xiao Xian Huang, Expanded Programme on Immunization

The Vaccine Preventable Disease (VPD) surveillance system is crucial for provision of reliable epidemiological data, immunization impact monitoring, outbreak prevention and informed decision-making on new vaccines. In many LICs and MICs, the current VPD surveillance system was built on the polio surveillance system with funding provided by the Global Polio Eradication Initiative (GPEI). **With polio approaching eradication, the GPEI funds will gradually dry up worldwide. This raises a sustainability challenge for countries that are reliant on GPEI funding.** Preparation for GPEI transition has become an urgent priority issue that WHO and partners are working to address.

The decade 2010–2020 has been called the Decade of Vaccines. Great progress has been made in increasing immunization coverage in an equitable manner, as well as promoting the use of new and underused vaccines in LICs and LMICs. New vaccines are, however, much more expensive than traditional ones. The introduction of new vaccines has substantially increased the cost of vaccines for many countries. In addition, with the increase in variety and volumes of vaccines in the routine immunization schedule, the vaccine delivery and operational cost has increased accordingly. **Hence according to the Global Vaccine Action Plan (GVAP) 2018 report, the global expenditures on routine immunization per live birth grew by 35% between 2010 and 2017.**

The Gavi alliance has been a major source of external funding for the national immunization programmes in 72 LICs and MICs. However, the Gavi model has an inbuilt transition period where the higher-income countries must prepare for transition out of Gavi funding within five years. The timeline is quite short and the challenges faced in countries often substantial.

Gavi does not only provide funding support, but also access to beneficial vaccine prices for eligible countries. For instance, the pneumococcal pneumonia vaccine is available at 3.8 USD/dose for Gavi countries vs. 33 USD/dose for non-Gavi countries. The alliance partners are closely monitoring the sustainability risk and discussing possible solutions. **In addition to increased advocacy for additional domestic resources, it is a priority to improve efficiency, through building institutional and human resource capacity, strengthening management skills and ways of enforcing accountability.**

We have established collaboration, for example, on national health accounts (NHA) and have worked on tools to demonstrate the return on investments for immunization. We would like broader collaboration on positioning immunization priorities and work within an overall framework on UHC.

Discussion

Immunization work has been very dependent on external funding in many countries. As we transition away from external funds, the question arises if the same level of investment will continue to be needed. The surveillance system is strong and works very well, but can the same be achieved with fewer resources while still maintaining the quality?

Brian Tisdall, Team Leader, WHO Polio Transition team

In terms of outcomes, polio transition works towards achieving and sustaining three key outcomes:

a. Sustaining a polio-free world after eradication of polio virus;

b. Strengthening immunization systems, including surveillance for vaccine-preventable diseases;

c. Strengthening emergency preparedness, detection and response capacity in countries to fully implement the International Health Regulations (2005).

Key interventions of the polio programme are many, but include the established systems for door-to-door outreach. Many of the countries where the polio programmes work are fragile and/or conflict affected like Somalia and Yemen. The polio outreach is often almost the only public health service systematically provided. Meanwhile, the platform makes an important contribution to UHC as it supports other public health services, including routine immunization.

From a sustainability perspective, it is important to look at ways of integrating this better within a framework on UHC. There are many programmes doing outreach for different things. **The focus should be on supporting one strong outreach system with multiple purposes, linked also to wider issues like nutrition and water and sanitation.**

While we are very close to polio eradication, regrettably this year we see more cases of wild polio virus in Afghanistan and Pakistan compared to the same point in time last year. The main challenges are inaccessibility due to security reasons and issues related to vaccine acceptance.

We should use our resources more efficiently – several of the polio priority countries are also in transition from Gavi. In reality, many programmes are having the same dialogue with the Ministry of Finance. We would like to see more collaboration on health financing. For efficient use of resources we need a UHC lens. Currently there are few countries that have set aside domestic resources to maintain the work on polio and capacities are weak in many countries, sometimes related to fragility. **We are particularly concerned about sustaining the surveillance system and how this can be successfully integrated.**

Dr Daniel Dagne, LOP Coordinator, Innovative and Intensified Disease Management NTD, WHO

Neglected tropical diseases are a group of 21 parasitic bacterial and viral diseases that prevail among the world's poorest populations and affect more than one billion people each year. Unlike some of the other communicable diseases, this group of diseases has to date not benefited from a global partnership or fund but there is nonetheless interest from some donors as well as support from pharmaceutical companies.

Key interventions to improve access to case management and break the transmission include: preventive chemotherapy and disease management, vector control, veterinary public health measures, and improvements in water and sanitation. Eradication is a realistic goal for some diseases where upfront investment can save a lot of costs.

Barriers include the generally low profile and priority both in countries and internationally despite these conditions causing huge morbidity, challenges in effectively collaborating across sectors and sustaining community engagement, weak infrastructure and health systems including reliance on drug donations for several of the diseases. **In general, work on NTDs is reliant on interest from a selection of international partners and reduction in those would impact achievements substantially as work on NTDs is often not prioritized in countries.**

Blerta Maliqi, Technical Officer, WHO RMNCAH

The reproductive, maternal, newborn, child and adolescent health (RMNCAH) area is a good indicator of the performance of the health system overall. The area benefits from external funding within the area of immunization (Gavi) and more recently the GFF are active. However, this area is one that relies mainly on domestic resources and systems.

The MDG era was nonetheless a good time particularly related to initiatives such as the Commission for Information and Accountability for Women's and Children's Health (CoIA) and the UN Commission on Life-Saving Commodities for Women and Children in addition to the MDG target itself. Lately there has been focus on health financing strategies and how this can benefit RMNCAH and subsequently the GFF was established, but this is still fairly new and concrete benefits are still to be seen.

For the future it is important to increase focus on equity in service access as well as advocating and supporting for more implementation research, through strengthened policy analysis capacity in countries. More focus is needed on innovations in service delivery including better integration of outreach and community services.

Discussion

In many countries, frontline facility staffing is stretched, but this is increasingly also the case for community workers for whom new duties are continuously added. We should work towards more integration in community outreach services.

Traditionally, WHO programmes are heavily reliant on DAH, with areas not prioritized within DAH funds being often chronically underfunded.

4. Reflections on country context

There is a disconnect between high-level policy commitments – including on development effectiveness – and what plays out in practice in countries.

WHO recently did analytical work in Ghana to support the government in identifying and engaging in a dialogue to address specific areas of duplication or overlap across functions of the HIV, TB, malaria and MNCH programmes. The aim was to improve the efficient use of available resources to meet programme and system objectives. This analysis was timely given transition dynamics in the country, with Ghana recently being classified as a middle-income country. The transition discussions are happening across donor agencies, including GF and Gavi, but also including bilateral

aid organizations. Despite the positive overall economic classification, fiscal space for health is constrained in Ghana and there is very limited discretionary budget available after salaries and fixed costs have been allocated. There are strong indications that the health sector can do much better with available resources given low budget execution rates and persistent inefficiencies.

Donor transition discussions are taking place in the context of the National Health Insurance Fund (NHIF) experiencing long delays in paying providers and high rates of out-of-pocket spending. The donor discussions, particularly related to GF and Gavi, focus heavily on co-financing obligations and less on system-related issues to improve efficiency and better align resources to need.

Several issues emerged from the analysis. For example, issues related to how TB and HIV services were being paid for – GF pays the premiums for HIV and TB-positive individuals to enrol in the NHIF, but those services are explicitly excluded from the NHIF benefit package. The consequence of this is that HIV and TB services are often provided in a vertical manner, without treatment for co-morbidities, because those units cannot be reimbursed by NHIF for the provision of services. Similarly, the supply chains for TB and HIV drugs were run separately from other medicines and despite funds being available to purchase drugs, stock-outs were occurring due to transport issues arising from having to make multiple runs to pick up the different medicines. The budget execution rate for domestic health funds was only 70% in 2017. The analysis highlighted the need for a more holistic approach to health financing discussions that embeds donor transition issues within the frame of overall health financing. The current donor-by-donor piecemeal approach is not effective as systemic issues will need to be addressed. **There is need to define actions and steps that can improve the alignment and coherence in incentives created by external support, and how these are aligned with domestic policies and incentives within an overall direction of the country moving towards UHC.**

There are many small and big issues. Can we start with identifying feasible steps for collaboration to address the inconsistencies we currently see? We could start with mapping the common issues across the government, as well as across donor partners. These financing-related discussions will need to take place within the context of governance-related discussions as well. WHO should play a strategic role in coordinating this dialogue.

Multiple requirements on co-financing increase fragmentation and open the door for gaming. Under the UHC banner we should jointly rethink ways to design and channel DAH to improve accountability for results, coherence in payment systems, and how information systems can better facilitate accountability for results.

Different disease/health priorities should be integrated within the overall direction of UHC rather than the other way around. What are the functions provided by each programme that can usefully be consolidated? Information systems, for example, where the reporting goes to, the system of supervision, the design of the financing system. Are there structures that we can use more efficiently? Based on the discussions above, could the polio programme merge into or become the backbone of the surveillance system in some countries? What issues need unpacking?

5. Partner perspectives

Luca Occhini, Global Fund

Building on examples of work in countries, we can look at Lao – a country that is not a transition country but where GF is reducing funding by almost half so in reality is not very different from a transition context. There we have tried to think of incentives for continued engagement by government on prevention work with key populations; but low buy-in by authorities continues to be an issue thus jeopardizing achievement of set targets. Collaboration with HS efforts is helping address some of this. We are collaborating with the WB in Lao on the Multi-Donor Trust Fund that incorporates some HIV indicators – thereby placing some of the work within a wider HS effort.

The focus on UHC triggers a change in dynamics both at country and global level. There is need for different ways of working and coordinating in countries and globally. There should be work across the boards of GF, Gavi and WB to better synchronize approaches, align co-financing requirements and move away from the current approach of agreeing co-financing policies institution by institution. Similarly in countries there is need to move away from coordinating disease by disease and redefine the balance between vertical and horizontal efforts.

When transition started there was an assumption that it would be an easy process. It quickly became apparent that the contrary was true – that to effectively engage on UHC there was need to understand local systems and context much better and this required a new skill set, rethinking of the appetite for risk and revising the timelines for results.

Lucia Mardale, Stop TB Partnership

For TB control, work on UHC is essential. The GF remains the main external donor for TB unlike HIV where more donors are active. We have worked to mobilize civil society for TB services and new drugs are also on the horizon. These are important achievements but it is absolutely critical to increase the coverage. TB services should be part and parcel of the basic benefit packages and provider payment systems, as well as work to strengthen PHC and effective community outreach. This should all come together and help incentivize the increased coverage of TB services.

It is challenging to ensure the allocation and flow of resources to the different levels and services but single payer systems – where these exist – can be very conducive to optimize and prioritize effectively. WHO still faces many challenges; for example, with data systems and defining the baselines important progress has been made in defining country-specific targets on multi-drug resistant (MDR) TB but we still need to unpack the baseline data for countries more broadly.

Nertila Tavanexhi, UNAIDS

If the processes of target setting for quality service coverage and patient health outcomes in single diseases is not done in coordination with the broader target-setting processes for moving towards UHC, it could pull countries in different directions.

Eighty per cent of new HIV infections outside Africa occur in key populations that the general health system is typically not good at reaching. When donors like GF leave we have seen resurgence in

infections. The issue is political commitment and frankly it seems unlikely, despite everyone's best efforts, that domestic resources will be earmarked for these key populations in the short and medium term in many middle-income countries.

This necessitates engaging in efforts to design basic benefit packages and working hard to ensure HIV is not only included in pooling efforts under UHC reforms but also incentives are provided to make this service accessible to all those that need them. This can be challenging, as for example in Kenya, where UHC has the highest level of political commitment and resources for HIV for the largest part (70%) have come from external donors and in most part are off budget. The size of the ARV programme in Kenya is considerable and the related cost was recently estimated to be six times higher than that of the entire budget for the National Hospital Insurance Scheme. Therefore, providing HIV treatment services as part of a national basic benefits package might necessitate some channelling of donor funding in the country's financing schemes. This might prove problematic due to weak public financial management systems in countries in terms of both efficient and timely money flows to transparency in accounting and reporting.

This makes it near impossible to track donor resources fully, something that is unacceptable to some donors like PEPFAR who in turn continue to use vertical parallel systems.

Joshua Levens, RBM Partnership to End Malaria

By 2030 the Americas and Asia-Pacific region are set to eliminate malaria, leaving only the African region with endemic malaria. There are, however, threats to the achievement of this goal.

One challenge relates to transition from external funding potentially eroding the political commitment to eliminate malaria in the Asia-Pacific region. Many countries are well equipped to take over the current donor-supported programmes, but certain elements like replacing the current DAH-supported procurement mechanisms can be problematic – particularly in small countries procuring small commodity orders, including long-lasting insecticide-treated bednets (LLINs), Malaria Rapid Diagnostic Tests (mRDTs), and Artemisinin Combination Therapy (ACT). Ensuring adequate supplies and keeping prices competitive will therefore be difficult. In such settings regional procurement mechanisms may need to replace current DAH support to procurement and partners need to take an active role in helping develop those. A failure in the supply chain and consequent failure in service delivery can potentially lead to the development of resistance and eventually resurgence in transmission.

Also, **the malaria programmes share the concerns raised by other programmes about difficulties in sustaining the current outreach for hard-to-reach populations being provided by civil society.** The systems for taking over and supporting this work from national sources are not in place. More importantly, there needs to be more innovative thinking – exploring outsourcing of the procurement role, starting with allowing countries to channel domestic resources through some of the current GF-supported pooled mechanisms as a first step towards building greater demand for social contracting.

There is another risk related to transition from external funding – that political commitment to maintain vector control through effective coverage of indoor residual spraying (IRS) and LLIN coverage will not be sustained at regional level. From the country perspective, there are competing demands for domestic resources and maintaining adequate funding while the case burden drops is challenging. The next generation of LLINs will also remain more expensive than the current pyrethroid LLINs, even after market shaping has reduced prices below their current levels. A more effective deployment of tools will therefore be needed to achieve the needed impact. Also, sustaining the involvement of the private sector to spend money on developing new tools as the market shrinks represents a challenge.

The RBM Partnership strategy has identified three strategic objectives. The first, to keep malaria high on the political agenda, recognizes that national health and budgets are part of a political process and that political engagements require tailored approaches to different political contexts. This can include parliamentary engagement, support for civil society in lobbying government, or working to establish national End Malaria Councils comprising national influencers who can push the malaria elimination agenda.

Second, we work with regional economic communities to address common challenges facing groups of countries, explore opportunities to leverage joint support, and address cross-border malaria transmission. Third, we support innovative ways to increase the global financing envelope for ending malaria, working with core donors, new donors, the private sector, and with endemic countries in the area of domestic resource mobilization. This can include working with governments to develop multisectoral investment cases for malaria. In some countries, the domestic resource agenda focuses on the health sector overall; in other cases the focus is on leveraging resources from other sectors for malaria elimination. The relevant sectoral linkages span across energy, mining, agriculture, water and sanitation, lands and environment, education, finance, and even tourism.

Jhoney Barcarolo, Gavi

Several countries have already transitioned from Gavi support. The main challenges coming up in relation to transition from external funding do not pertain to financing but are programmatic in nature. It is essential to address these; for example, issues around capacities of supply and procurement systems, which need to be upfront, at the start rather than late in the process when countries are about to transition to domestic funding. **Transitions from Gavi funding will only be successful if positioned within the wider macroeconomic context of countries. We are working with our board towards a comprehensive approach to transition that ensures the challenges to sustaining coverage are addressed upfront – but there is need to work on harmonizing the overall position and voice for best results.**

The level of integration varies by country context; for example, in Honduras immunizations are fully integrated while in other countries the programmes are quite vertical, so tailored approaches are needed.

Discussion

Immunizations will always be vertical in part; the question is more about the balance. **We cannot only speak of scaling up coverage of interventions – programmes need to be there; but we should think about improvements that better help address the cross-cutting elements that prevent us from jointly moving towards UHC.**

There are cross-cutting issues inside the sector that affect individual services like HMIS and service delivery models, and also outside the sector there are issues like PFM and intersector work like vector control. We should be careful with wording – this is not about "deconstructing programmes" but improving the efficiency in resource use for better outcomes and UHC.

For transition we have discussed the "efficiency agenda" and some emerging steps to work jointly on this. Examples include doing joint work on a selection of cross-cutting HS challenges. There is less clarity on how to proceed with the transition "coordination agenda"; for example, how planning on transition happens – more work is needed unpacking, with less harmonizing in some areas (such as eligibility criteria), while in others more (such as approaches to co-financing). This relates more to the agenda on effective development cooperation.

It would be useful to document two or three country experiences on UHC – for example, for UNGA in September countries that have made impressive progress on UHC – and use this for inspiration and learning. Analyse the incentives that helped countries move, and think of ways of systematizing best practices and principles. We should also separate out the technical agenda vs the political agenda and how country and partners were involved, including civil society. Perhaps we could also think of a list of priority global goods that supported countries in progress on UHC.

6. Conclusions

In countries and globally there is need to address misalignment of incentives to support a move to UHC. We should define ways of improving the coherence in incentives created by external support, how these are aligned with domestic policies and incentives within an overall direction of the country moving towards UHC. Discussions highlighted the need for a more holistic approach to health financing discussions that embeds donor transition issues within the frame of overall health financing.

Work should address cross-cutting health system strengthening or efficiency issues on health system subareas to improve outcomes. For many of these there are coordination bodies that work to coordinate, share good practice and, as appropriate, harmonize efforts. Notably, the cross-cutting HS issues/barriers are to some extent similar for donor-supported programmes (for example, HIV and TB) and for those programmes less reliant on external funds (for example, NCDs), underlining that work on transition is in essence a UHC/health system strengthening agenda.

Work on transition should address issues related to how planning on transition happens in countries – coordination – that also relates to effective development coordination. The current, donor-by-donor piecemeal approach is not effective to address key health system issues.

Notably, there can be **tension between an eradication/elimination agenda and moving towards UHC. There is also need for better optics/frameworks that consider the progression of change in a spectrum from fragile to highly sophisticated complex health systems.**

We should define a transition investment and reform agenda that would allow us to jointly work on addressing selected cross-cutting elements that are hampering the scale-up of priority interventions in countries. This should extend to cross-cutting issues both inside and outside the sector.

Innovations are happening in health financing – perhaps too many innovations in health financing and too few in service delivery. We should work on coming together on innovations and a vision for reform of service delivery. There is no magic bullet, only good and bad ways of implementing.

Annex one: Programme perspectives on sustainability and transition

10 December 2018

Chateau de Penthes Geneva, Switzerland

08:45–09:00	Welcome coffee and registration
1. Work on transition from a UHC perspective	
09:00–09:20	Background to the work of the UHC2030 on sustainability and transition from external funds • Kara Hanson, Professor of Health System Economics, LSHTM, co-chair of the UHC2030 WG on sustainability and transition from external funding
09:20–09:35	**Concepts and frameworks. Transition from external funding through a UHC lens** • Joe Kutzin, Health Finance Coordinator, WHO
09:35–09.45	Discussion
09:45–10:00	COFFEE/TEA BREAK
2. Programme perspectives on transition from external funds and HS challenges to progress on outcomes	
10:15–11:45	**Moderator:** Ke Xu WHO HF **Panel: Programme perspectives on priority outcomes, transition and health system challenges Priority outcomes and top 3 HS challenges related to transition from external funds and how cross-programmatic approaches for UHC could help – 10 minutes each:** • TB: Diana Weil, WHO TB Coordinator, PSI/WHO Global TB Programme • NCD: Dr Taskeen Khan, NCD management, WHO • HIV: Jeanette de Putter, WHO HIV programme • Malaria: Alastair Robb, WHO GMP • Polio: Brian Tisdall, Team Leader, Polio transition • WHO VPI/EPI: Xiao Xian Huang • NTD: Dr Daniel Dagne, Coordinator IDM • RMNCAH: Blerta Maliqi, WHO
11.45–12.00	Discussion
12:00–13:00	LUNCH

3. Country context	
13:00–13:30	**Moderator:** Lucica Ditiu, ED Stop TB Partnership **Reflections on country contexts – Ghana and Vietnam** Opportunities for cross-programmatic work on HS barriers to priority outcomes • Ke Xu, WHO HF team – Vietnam • Susan Sparkes, WHO HF and Mark Saalfeld GF – Ghana
13.30–14.30	Commentary: Service delivery/Joint working team, Hernan Montenegro, Joe Kuzin WHO HF
14:30–15.20	**Moderator:** Richard Gregory, Senior Health Advisor UHC2030 **Partner perspectives – Working with a UHC lens: What are the operational implications for partners?** • GF: Luca Occhini • STB: Lucica Ditiu • UNAIDS: Nertila Tavanexhi • RBM: Joshua Levins • Gavi: Jhoney Barcarolo
15:20–15.35	COFFEE/TEA BREAK
4. Feedback and implications for action	
15.35–16.00	**Moderators:** Joe Kutzin and Kara Hanson **Panel discussion – feedback and implications for next steps**

Annex two: Participants at the third face-to-face meeting of the UHC2030 Technical Working Group on Sustainability and Transition from External Funding

10 December 2018

Pavillon Fontana, Chateau de Penthes, Geneva

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