The Global Fund

Guidance Note

Sustainability, Transition and Co-financing of programs supported by the Global Fund

13 January 2017

Background

With its focus on achieving impact, the Global Fund's 2017-2022 Strategy[1] recognizes that ending the HIV and TB epidemics and eliminating malaria will require sustainable systems for health and national responses to the three diseases. As such, the Global Fund strongly encourages all countries to build sustainability planning into program and grant design regardless of where they are on the development continuum. The Global Fund defines **sustainability** as *the ability of a health program or country to both maintain and scale up service coverage to a level, in line with epidemiological context, that will provide for continuing control of a public health problem and support efforts for elimination of the three diseases, even after the removal of funding by the Global Fund and other major external donors*.[2] Many countries begin discussions around planning for sustainability of programs while elaborating National Strategic Plans, and should continue them during the development of Global Fund funding requests and implementation of grant programs.

The Global Fund determines a country's eligibility for funding according to the World Bank's income classification[3] and disease burden indicators for HIV, tuberculosis and malaria as defined in the Eligibility Policy.[4] As countries move upwards in income classification and/or experience improvements in disease burden, questions around the sustainability of Global Fund financed programs and the overall national disease response become increasingly pertinent. To minimize the risk of programmatic disruption and to mitigate potential negative impacts that could result as Global Fund financing decreases and eventually ends, countries are strongly encouraged to conduct detailed sustainability planning – with the support of the Global Fund as necessary – and to prepare in advance for transition from Global Fund financing.

Before Global Fund financing ends, countries should proactively plan how programs will continue when Global Fund resources are no longer available. The Global Fund defines **transition** as *the mechanism by which a country, or a country-component*[5]*, moves towards fully funding and implementing its health programs independent of Global Fund support while continuing to sustain*

[1] As set forth in GF/B35/02 – Revision 1 and approved by the Board in April 2016 under decision point GF/B35/DP04.

[2] Sustainability, Transition and Co-financing policy.

[3] The World Bank income classifications are based on Gross National Income per capita, Atlas method. The data are from: http://databank.worldbank.org/data/home.aspx

[4] Annex 2 to GF/B35/06 – Revision 1 and approved by the Board in April 2016 under decision point GF/B35/DP07.

[5] This refers to any disease component (HIV, TB, malaria, HSS) that receives funding from the Global Fund.

the gains and scaling up as appropriate.[6] In line with this definition, the Global Fund considers a transition to have been successful where national health programs are able to at least maintain and preferably improve equitable coverage and uptake of services through resilient and sustainable systems for health even after Global Fund support has ended.

This document is intended to guide countries in planning and developing Global Fund funding requests and implementing grants towards sustainability and transition, in accordance with the Global Fund's Sustainability, Transition and Co-financing (STC) Policy.[7] This document describes the requirements of the STC policy and also provides guidance that can be used at the discretion of country stakeholders to determine how best to plan for sustainability and prepare for transition within their specific country, epidemiological, and financial context.

What this guidance note covers:

- Definitions and principles of sustainability and transition within the Global Fund context, as well other terms related to the implementation of the STC policy
- Guidance on **what is recommended** for all countries to embed sustainability considerations into planning and program design
- Guidance on **what is recommended** for countries to prepare for transition, including assessing transition readiness and having in place a strategy for transition
- An overview of **what is required** for applicants to align with the STC policy:
    - Co-financing requirements – for all countries
    - Focus of application requirements – for middle income countries
    - A transition work-plan to submit with the funding request – for components applying for "transition funding"

[6] Sustainability, Transition and Co-financing policy.
[7] As set forth in Annex 1 to GF/B35/04 – Revision 1 and approved by the Board in April 2016 under decision point GF/B35/DP08.

Overview

The guidance note elaborates upon the following aspects of sustainability and transition planning:

A) **Embedding sustainability considerations into program design:** This applies to all countries, and begins with a robust and costed National Strategic Plans, developed with the meaningful engagement of all stakeholders (including the communities most impacted and civil society). A sustainable approach to program planning and implementation should consider how to implement the latest guidance from technical partners, not only with the view of financing available today through donor support but also with the view of what the government will need to take up in the future. This also includes investing in the appropriate systems for health and implementing Global Fund activities through national systems, as well as implementing health financing strategies to progressively increase domestic financing for health and for the three diseases.

B) **Preparing for transition**: While the timeframe for receiving Global Fund financing and the total amount of financing will vary by country, all Upper Middle Income (UMI) countries (regardless of disease burden) and Lower Middle Income (LMI) countries with low or moderate disease burden are encouraged to design, develop and implement Global Fund funding requests and grants with the aim of eventual and full integration into domestically funded responses. For these disease components, the Global Fund encourages countries to have or strengthen a strategy for transition (ideally informed by a transition readiness assessment developed through a multi-stakeholder process), which should be an integral part of the Country Dialogue and Funding Requests.

C) **The transition funding grant:** As per the Eligibility policy, once a country disease component funded under an existing grant becomes ineligible, the component may receive up to one allocation period of transition funding following their change in eligibility.[8] The funding request for a transition funding grant must be informed by a detailed transition work-plan. It will be subject to tailored review by the Technical Review Panel (TRP).

D) **Co-financing:** Increasing domestic investments for the national disease response is an integral aspect of each country's work towards sustainability and eventual transition. To enhance sustainability and preparedness for transition, the Global Fund has implemented new co-financing requirements, designed as a strategic tool to stimulate increased domestic financing for health and the three disease programs. Requirements of the co-financing policy are differentiated by income classification and disease burden.[9]

[8] The amount of transition funding as well as the period for funding may vary. The Eligibility Policy provides circumstances when transition funding may not be awarded. Specifically, countries not eligible for transition funding are those that a) move to high income, b) become G-20 UMI with less than an 'extreme' disease burden, or c) become members of the Organisation for Economic Co-operation and Development's Development Assistance Committee.

[9] Sustainability, Transition and Co-financing policy. See also the Co-financing Operational Policy Note.

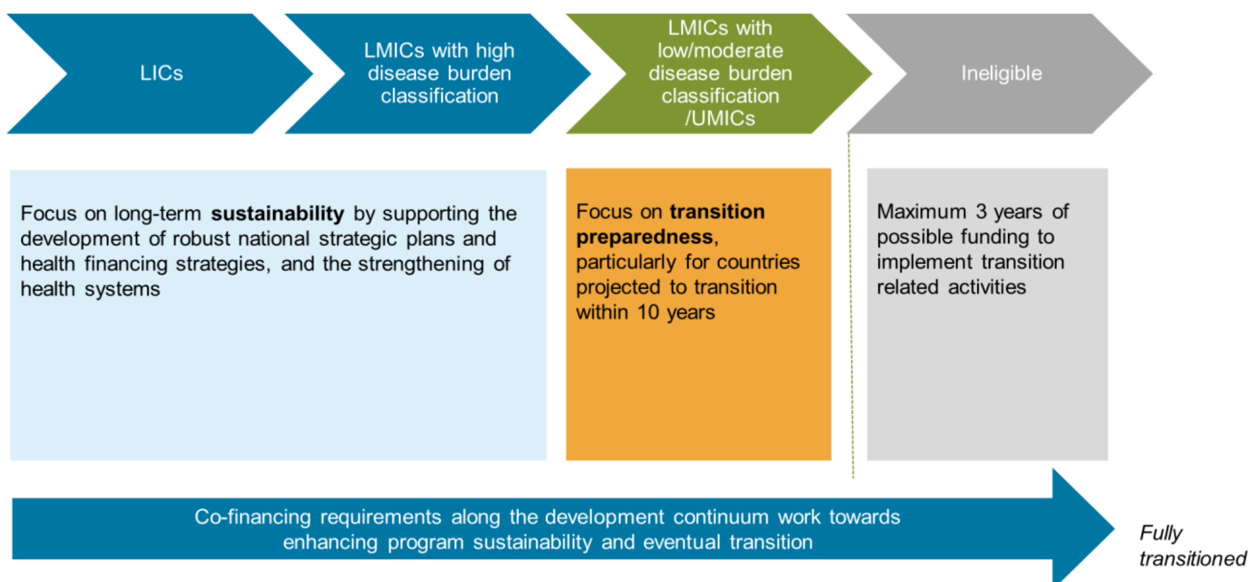

FIGURE 1: STC AND THE DEVELOPMENT CONTINUUM

A) Embedding Sustainability Considerations into Program Design

Sustainability considerations should be inherent in program planning and implementation **for all countries**, regardless of where they are along the development continuum.

Sustainable and effective responses to the three diseases require the engagement and commitment of multiple stakeholders across all levels of policy and program development and implementation. As part of the Global Fund's commitment to country ownership and participatory decision-making, planning for the funding request to the Global Fund should be conducted through inclusive, country-led processes that involve governments, multilateral and bilateral agencies, local civil society organizations, the private sector, representatives of key and vulnerable populations, and people living with the diseases. Communities most impacted by the three diseases (including key and vulnerable populations) bring to these processes critical expertise to develop and implement programs appropriate for and accessible to marginalized groups, activities to reduce human rights and gender related barriers to services, and support to systems for health in monitoring and reporting on issues of access and quality.

There are several activities that the Global Fund recommends all countries undertake to enhance the sustainability of HIV, TB, and malaria programs as well as the overall health sector. These activities can inform the development of the funding request or the reprogramming of funds during grant implementation as relevant. They include the following:

1. **Development of a robust, costed and prioritized National Strategic Plan (NSP):** The Global Fund encourages applicants to base their funding requests on robust and costed NSPs for the health sector and specific disease. If the country does not have an up-to-date NSP, the funding request can be based on an investment case. While the country dialogue planning process is country-specific, the following are key considerations recommended for countries to embed sustainability into the iterative planning process:

    a. **Planning:** Program goals for the NSP period should be defined through a multi-stakeholder process. Because NSPs provide the overall strategic direction for a country's health sector or disease program, the process of creating the NSP encourages decision-making among stakeholders on how to sustain impact on a

detailed level. To implement the latest guidance from technical partners, including on new technologies, countries are encouraged to plan not only with the view of financing available today through donor support but also with the view of what the government will need to take over in the future. Effective planning should consider all activities that contribute to the disease response, including private sector and civil society organizations.

b. **Costing:** The interventions and systems to achieve program goals should be costed to define the full funding need over the NSP period to achieve those program goals.

c. **Financing:** It is important that the disease-specific NSPs include or are accompanied by plans detailing the financing of these programs. A key aspect of sustainability planning is increasing domestic financing of the national disease response, including interventions funded by the Global Fund. Resources from all funders should be mapped against the funding need to provide a financial gap analysis. This gap analysis is a key input to determining by how much domestic investments need to increase so that governments can progressively take up key program costs.

d. **Priority setting**: Program planners should maximize the use of available funds by allocating resources to the most cost-effective interventions, providing them with quality at minimum cost. In the event of declining funds from major donors, including reduced allocations from the Global Fund, cost-impact analysis can help policy makers identify the potential for efficiency savings or prioritize which interventions must be funded at minimum to achieve impact. By linking investments to health and economic gains, cost-impact analysis can also support advocacy efforts towards the Ministries of Health and Ministries of Finance for mobilizing increased domestic financing for health and the three diseases. It is important that resource allocation discussions include interventions that cannot be easily quantified in a cost-impact analysis (such as health systems strengthening activities or human rights interventions) and take into account the challenges of conducting accurate priority setting for interventions with limited reliable data (such as key population size estimates).

Some countries may not have a national strategic plan that is sufficiently robust, inclusive (including key and vulnerable populations), evidence-informed or accurately costed to form the basis of Global Fund financing. In these circumstances, the Global Fund may, in coordination with relevant partners, support countries through existing grants to strengthen the development of the NSP to ensure that it provides the appropriate strategic direction for the disease programs. Relevant activities may be funded through Global Fund grants, as appropriate. For example, countries may seek technical assistance to apply available tools for costing and priority setting. Annex 1 provides a table of the costing and resource allocation tools that countries have previously implemented to inform the development of NSPs and funding requests.

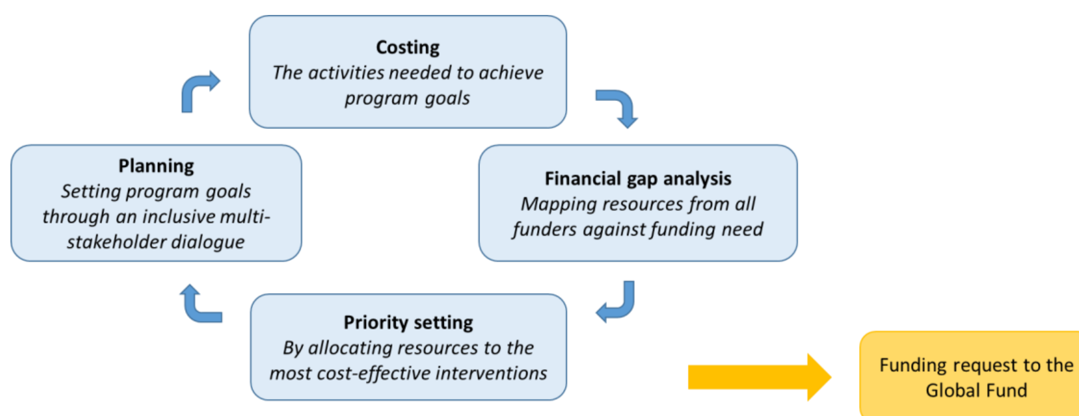

FIGURE 2: THE ITERATIVE PLANNING PROCESS FOR NATIONAL STRATEGIC PLANS

2. **Development of a Health Financing Strategy:** Countries are encouraged to engage in dialogue on long term strategies to sustain program financing with increased domestic investments. As a measure to progressively raise domestic revenues to finance the health sector and the three disease programs, the Global Fund encourages countries to have in place Health Financing Strategies, which provide a framework for developing and advancing *health financing* towards Universal Health Coverage. These strategies should provide a detailed overview of how health care will be financed in the country, including sources of financing (e.g. external, domestic public, domestic private) and revenue type (e.g. unmarked public spending, earmarked public spending, tax subsidies, voluntary prepayment, out-of-pocket spending).[10] They should consider the government's fiscal situation as well as the allocation and execution of the national budget. They may also provide a framework for increasing domestic public funding for health and alleviating the health financing burden on households. In order to remain useful, it is important that health financing strategies be frequently reviewed and updated.

   The Global Fund will engage with countries, where appropriate, by working with partners at all levels to support the development of health financing strategies**.** Where a health financing strategy exists, the Global Fund may provide support to operationalize this strategy. While all countries are encouraged to have health financing strategies, the Global Fund will provide support in particular in countries where government health spending is low by collaborating with partners and global platforms (such as the Global Financing Facility[11]) to contribute towards the development and implementation of robust health financing strategies. These countries will be identified by the following criteria: a) have a high, severe or extreme disease burden[12] for two or more disease components, and b) where health accounts for less than 8% of government expenditure and/or tax revenues are lower than 15% of the GDP.

3. **Tracking health and disease program spending**: To inform NSPs and health financing strategies, it is essential to have relevant and updated data on health and disease program spending in the country. Where possible, the Global Fund encourages countries to have institutionalized national health accounts processes to track domestic expenditure on health, so that data on past spending can be used regularly to inform health sector policy-making.[13] It is recommended that programs have processes in place to track spending, ideally by intervention and major sources of funding, to inform program planning, costing and

[10] WHO guidance on developing Health Financing Strategies: http://www.who.int/health_financing/tools/developing-health-financing-strategy/en/
[11] http://globalfinancingfacility.org/
[12] As defined in Annex 1 of the Global Fund Eligibility Policy.
[13] See http://www.who.int/health-accounts/en/ for more information on health accounts and the standard methodology for tracking health spending recommended by WHO.

budgeting. Countries can request that grant funds are used to invest in resource tracking efforts.

4. **Implementing through national systems:** Resilient and sustainable systems for health (RSSH) are necessary to effectively implement HIV, tuberculosis and malaria interventions.[14] To improve their sustainability, Global Fund financed programs should be implemented through country systems, including national health information systems, national procurement and supply chain systems and public financial management systems. It should be noted that "national systems" are not necessarily government systems. National systems may also include instances where the government contracts with non-governmental organizations (NGOs), for example to provide prevention services including the procurement of prevention commodities. Funding for RSSH activities should be aligned with national health sector (or sub-sector) plans, such as M&E plans and pharmaceutical plans. Applicants are encouraged to include systems strengthening measures in their funding requests so that national systems can be used to implement interventions. Where grants are currently implemented through parallel structures, countries should articulate plans for eventually integrating the implementation of donor-financed programs through country systems.

   There are a number of systems-related needs that are common across the three diseases, including community systems, primary care infrastructure, human resources, procurement and supply chain systems, health information systems and financial management systems. Such needs should be assessed across the three disease programs, and where appropriate, included in funding requests – either as standalone RSSH funding requests or built into the disease funding requests – to improve the efficiency of investments and to integrate into national systems where parallel systems have been set up. Building national capacity is an important stepping stone to ensure the sustainability of programs. When integrating into national systems, countries should also ensure that existing local capacities are not lost.

B) Preparing for Transition

As countries move along the development continuum, it's essential that they increasingly focus on planning for eventual transition from Global Fund support. As described in the overview, disease components transition from Global Fund support when they are no longer eligible for funding as per the Global Fund's eligibility policy.[15] However, preparations for transition may also be affected by changes in the size of the Global Fund allocation. Given the potential in reductions to the allocation, countries may need to progressively assume key parts of the national disease response even multiple allocation cycles prior to becoming ineligible.

As highlighted in the Global Fund's STC Policy, there is ample evidence to suggest that successful transitions take time, and therefore early and proactive planning is a key part of enhancing transition preparedness. All UMI countries regardless of disease burden and all LMI countries with low or moderate disease burden are encouraged to prepare as early as possible for eventual transition from Global Fund support. These components are listed in the table below.

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[14] For more information, see the Information Note: Building resilient and sustainable systems for health through Global Fund investments.

[15] www.theglobalfund.org/documents/core/eligibility/Core_ProjectedTransitions2016_List_en/

Transition priorities: Components with existing grants and classified as LMI with low or moderate disease burden or UMI

UMI countries	Albania (HIV, TB), Algeria (HIV, TB), Angola (HIV, TB, malaria), Azerbaijan (HIV, TB), Belarus (HIV, TB), Belize (HIV, TB), Botswana (HIV, TB, malaria), Bulgaria (TB), Colombia (HIV), Costa Rica (HIV), Cuba (HIV), Dominica* (HIV, TB), Dominican Republic (HIV, TB), Ecuador (HIV), Gabon (HIV, TB, malaria), Georgia (HIV, TB), Grenada* (HIV, TB), Iran (HIV), Iraq (TB)***, Jamaica (HIV), Kazakhstan (HIV, TB), Malaysia (HIV), , Marshall Islands* (HIV, TB), Mauritius (HIV), Mongolia (HIV, TB)**, Namibia (HIV, TB, malaria), Panama (HIV, TB), Paraguay (HIV, TB, malaria), Peru (HIV, TB), Romania (TB), Saint Lucia* (HIV, TB), Saint Vincent and the Grenadines* (HIV, TB), Serbia (HIV), South Africa (HIV, TB), Suriname (HIV, TB, malaria), Thailand (HIV, TB, malaria), Tonga* (HIV, TB), Tunisia** (HIV), Turkmenistan (TB), Tuvalu* (HIV, TB)
LMI countries with low or moderate disease burden classification	Armenia (HIV, TB), Bangladesh (HIV), Bhutan (HIV, malaria), Bolivia (malaria), Cabo Verde* (malaria), Egypt (TB), El Salvador (TB, malaria), Guatemala (TB, malaria), Honduras (TB, malaria), Kiribati* (HIV), Kosovo (HIV, TB), Lao PDR (HIV), Micronesia, Fed. Sts. (HIV), Nicaragua (TB, malaria), Philippines (malaria), Samoa* (HIV, TB), São Tomé and Principe* (HIV), Solomon Islands* (HIV), Sri Lanka (HIV, TB, malaria), Sudan*** (HIV, TB), Swaziland (malaria), Syrian Arab Republic*** (HIV, TB), Timor-Leste (HIV), Uzbekistan (malaria), Vanuatu* (HIV), Palestine*** (HIV, TB), Yemen, Rep. (TB)***

Source: Global Fund 2017 Eligibility List, which is the basis for the 2017-2019 allocations. Includes countries that have recently become ineligible and may be eligible to receive up to three years of funding for priority transition needs in 2017-2019. G20 countries and components that did not receive an allocation in 2014-2016 are excluded.

*Small island economies. These countries are encouraged to plan for transition even though UMI countries in this group are eligible for all components regardless of disease burden as per the Global Fund's Eligibility Policy.

**The World Bank reclassified Tunisia and Mongolia as LMI in 2016. However, the Global Fund determines income classification using a three-year average of GNI per capita over the latest three-year period; as such, Tunisia and Mongolia remain classified as UMI in the 2017 eligibility list.

*** Classified as a Challenging Operating Environment (COE) by the Global Fund for the 2017-2019 period, and thereby eligible to access the flexibilities provided under the COE Policy (Annex 1 to GF/B35/03).

While the timeframe for receiving Global Fund financing and the total amount of financing will vary by country, planning for eventual transition should be a priority for all countries listed above. These countries are encouraged to build considerations for transition into co-financing commitments, program design and grant design.

To that end, the Global Fund has published a list of the disease components *projected to transition* from Global Fund support by 2025 due to predicted income classification changes.[16] These transition projections are estimates based on latest available information, and will be updated annually as an additional resource to support countries in long-term planning.[17] For disease components where the timelines are particularly short, working with the Global Fund Country Team to evaluate how current grants can be used to strengthen transition preparedness in the immediate short term, potentially through reprogramming of non-essential activities, will be key.

Comprehensive transition planning across all eligible components is encouraged. While some countries may transition for components over different timeframes (due to differences in the disease burden classification), it is nonetheless important that these countries consider transition in a holistic manner to the extent possible.

1) Assessing Readiness for Transition:

As a first step in preparing for transition, countries are encouraged to conduct transition readiness assessments, particularly where and when sufficient detailed and high quality analysis on sustainability and transition challenges is not already available. The transition readiness assessment should highlight financial, programmatic, and other priorities that are potential risks related to

[16] www.theglobalfund.org/documents/core/eligibility/Core_ProjectedTransitions2016_List_en/

[17] These projections are not a statement of Global Fund policy or eligibility; moreover they will not influence country allocations.

transition from donor financing, as well as (and most importantly) specific actions to address those risks. Whether the assessment is carried out by country stakeholders or independent teams, it is crucial that the process involves inclusive dialogue among key country stakeholders, so that the outcomes of the assessment reflects the inputs of a variety of stakeholders and is country owned.

Transition readiness assessments will differ based on country context. Countries may use as guidance the thematic areas below to consider key factors that affect health outcomes as well as the future sustainability and transition readiness of the health system and disease program:

- **Epidemiological context**: the drivers of infection and any key and vulnerable populations that might be disproportionately affected as well as age and gender related disparities and vulnerabilities.
- **Economic situation:** the country's macroeconomic outlook and the fiscal capacity of the government to increase public sector financing.
- **Political context:** the government's commitment to program and finance the disease response, including specific components such as prevention for key and vulnerable population groups. This includes not only national level authorities but also sub-national authorities, particularly in cases where health systems rely on sub-national authorities for planning and implementing key parts of the national disease response.
- **Policy and legal environment**: the policy and legal issues that may impact transition.
- **Human rights and gender**: the human rights related barriers in access to services including, for example, stigma and discrimination against people living with the diseases and key and vulnerable populations, policy and legislative environment, sensitivity and capacity of the health system to meet the needs of these communities. The effects of gender and age inequalities and the situation of access to services including, for example, gender based violence, low levels of health seeking behavior amongst men, availability and accessibility of youth friendly services.
- **Program:** the current interventions being implemented, service delivery coverage by gender and age, and including for key and vulnerable populations, and an analysis of where scale-up is needed to achieve policy objectives; the key services needed and for which population groups and geographical areas; how services are delivered, including the ability for civil society organizations to continue providing services; the capacity needs, the enabling environment to support program implementation, the most pressing issues to address these needs and the issues that may need longer to address.
- **Health systems:** the capacity and quality of health systems elements that are critical for transition, including data systems, human resources, labs; the current capacity for health systems planning, monitoring and evaluation; procurement and supply chain management including aspects such as national procurement system flexibility (e.g. could a country continue to access international – pooled -- mechanisms such as the Global Drug Facility for tuberculosis, UNICEF, and the Global Fund's Pooled Procurement Mechanism, the regulatory environment (e.g. whether products procured with government resources need to be registered, what happens if the products registered are not optimal), and the supply system (e.g. can governments supply prevention materials to NGOs)); what reforms are happening in the health sector and their potential relevance for the sustainability of the disease program; the enabling factors required for transition and what systems components present roadblocks to transition.
- **Financing:** the major funders, how the public financial management system is structured, whether key services of the disease program are included in the national health insurance. The financing impact of the reduction in donor funds, as well as the potential for including services in benefits packages, mobilizing domestic resources and strengthening innovative financing.

- **Support:** Needs for technical assistance and resources available to conduct transition planning.

Findings from the transition readiness assessment should inform a country's strategy for transition and/or a transition work-plan (as described in Section C) and be used to evaluate where additional effort and investment is needed to enable a successful transition from Global Fund support. It is important to note that some countries may be able to draw from ongoing exercises carried out by partners on related sustainability and transition activities to inform the assessment. Annex 1 provides a brief description of these exercises. The Global Fund has also supported the development of tools that apply to various contexts, building on past experiences of transition. These tools are also provided in Annex 1. Please note again that transition readiness assessments are encouraged but not required, particularly in cases where there already exists sufficient, detailed analysis of the sustainability and transition challenges at the country level.

2) Develop and/or Strengthen a Strategy for Transition:

The Global Fund strongly recommends that all countries preparing for transition have in place an overall strategy for transition to provide the overall pathway to transition, including a phased plan for domestic take-up of Global Fund financed activities. A solid strategy for transition establishes early the priorities and sequencing of key steps that may foster a successful exit from Global Fund (and other donor) financing. Ideally, a strategy for transition considers the future of all donor financing. It may take many forms depending on country circumstance; it does not need to be a separate plan or document nor does it need to be developed specifically for the Global Fund. However, transition planning should be part of the national planning process, therefore where possible any transition strategy should be aligned with the NSP and well-coordinated with other donor plans for transition. Moreover, it should be developed through a rigorous and inclusive process. As countries prepare to move away from Global Fund support, the full engagement of community and civil society actors in transitions will be critical to ensuring an effective transition approach. High-level political and financial commitment to the strategy is also important to enable the success of the transition process.

A strategy for transition should provide an overview of the policy priorities of the program, the related programmatic components that must be sustained in order to realize those policy priorities, and the financing needed to implement the programmatic components over the term of the plan. It should also define the responsibilities for those entities implementing the strategy. While this will vary by country, guidance is provided below on the general elements that may be included when countries think through their strategy for transition:

- **Outline the policy priorities and national coverage targets** of the disease response as stated in the NSP
- **Define the essential program components** that need to be sustained without Global Fund support in order to achieve these priorities and targets
- **Estimate what financing is needed** to implement the key program components over the course of the strategy, and where this financing will come from
- **Describe what services will need to be financed**, how approaches of delivering services may need to change compared to current implementation arrangements, and how the proposed package of service delivery modalities would minimise costs and create efficiencies, while maintaining quality of care and service coverage
- **Provide a financial analysis** to take into account existing donor funding for the disease program, highlight gaps in funding, and indicate potential sources of funding, including innovative financing mechanisms such as loan buy-downs

- If possible, **provide an estimated timeframe** for full transition from donor support, based on discussion among in-country stakeholders
- **Provide a high level plan** covering this timeframe, outlining the phased scale-up of financing that the government will undertake towards full transition, in line with the co-financing requirements, and the responsibilities of each key stakeholder in implementing the plan
- **Include a monitoring plan** with clear benchmarks and indicators to assess regularly the effectiveness of the strategy for transition and flag risks/bottlenecks along the way
- **Ensure that there will be a review of the strategy and monitoring plan,** and allow for revisions based on new epidemiological or financial data, economic indicators or political changes

The Country Coordinating Mechanism (CCM) can play an important role in convening key stakeholders for transition planning. Once developed, the strategy for transition must be communicated with in-country stakeholders so that the transition process is transparent and predictable.

3) Consider Enabling Factors for Transition:

Although preparing for transition depends on specific country context, the level of reliance on donor funding, and the national disease strategy, there are a number of enabling factors that countries should consider in order to progressively strengthen country ownership of all key interventions and integrate donor-financed activities into national systems. Many of these factors take significant time to be put in place. These factors could influence a country's ability to maintain service provision beyond transition, and ideally would be in place by the signing of the last Global Fund grant. Enabling factors for transition include (but are not limited to):

- **Providing an enabling environment to continue programs for key and vulnerable populations:** When programs financed by the Global Fund transition to domestic funding, evidence indicates that the continuation and scale up of effective, evidence informed, rights-based and gender-responsive programs for key and vulnerable populations are the most at risk of cessation or interruption. Programming that serves marginalized and/or criminalized communities such as people who inject drugs, men who have sex with men, transgender persons, sex workers, prisoners and migrants, including critical interventions to remove human rights and gender-related barriers to access, often lack adequate domestic political commitment. In order to safeguard against disruptions to these critical interventions when disease components transition from Global Fund support, key and vulnerable populations must be central in all transition processes, not only as recipients and implementers of services but also as advocates for well-planned, data-driven transitions that maintain and expand effective evidence informed and human rights based interventions, including harm reduction and peer based outreach.

- **Strengthening the capacity of non-state actors:** In many Global Fund grants, non-state actors play an essential role in the implementation of key activities. In addition, the Global Fund has encouraged the use of dual track financing to maximize the effectiveness and impact of programs it supports and to ensure the necessary development and inclusion of non-state actors in national responses. While this approach has been successful in elevating the role of non-state actors (such as NGOs, community groups and the private sector) and increasing their capacity to perform a variety of roles within the national disease response, the experience of countries that have already transitioned from Global Fund support suggests that there are challenges to maintaining non-state actors as implementers and to sustaining prevention activities, especially those targeting key populations. As such, national governments should prioritize activities that enable or facilitate working with civil society organizations and non-state implementers to ensure strengthened capacity in program design and service delivery.

a. *Social contracting*: A critical factor in sustaining effective responses following transition is the capacity of governments to continue funding non-state actors financed by donor support. A number of factors – including fiscal, legal, and political – may make it difficult to maintain comparable funding for these organizations to continue their role in national disease responses. One way to mitigate this is to set up appropriate "social contracting[18]" mechanisms prior to transition (such as accreditation of NGOs), so that government funds can flow directly to civil society organizations to implement specific activities. It is important to note that this type of system change often takes significant time to put in place. Even where social contracting is possible within the country's legal framework, if the health sector is not actively contracting civil society and community organizations, putting the necessary mechanisms in place can be a lengthy process. For those countries with existing platforms for contracting of non-state entities, the dialogue around this issue should include identification of specific strategies for adequate levels of financing of those non-state entities through consistent, annual budgeted mechanisms, and ensuring fairness and efficiency of the procurement process by government of services provided through social contracting.
b. *Enhanced capacity for advocacy and resource mobilization*: In order to ensure civil society and community participation in decision-making and implementation of interventions for key and vulnerable populations, capacity building of these entities for advocacy is essential – including advocacy as part of the budget development process – as well as on-going policy dialogue to secure future financing of advocacy activities. Another mechanism to enable civil society organizations to continue providing services is to support strengthening their own ability to develop and implement strategies for resource mobilization. Where governments may not fund these types of activities, other stakeholders could support them, such as the private sector or national / international philanthropy focused on advocacy.

- **Implementers for Global Fund grants**: In preparing for successful transitions, the Global Fund encourages CCMs to consider which entity is the most appropriate to manage the transition process, and should carefully consider the selection of local entities and government entities as Principal Recipients (PRs). While country context matters, this may help ensure national ownership of the key interventions financed by external donors, while building national capacity for implementation of specific donor-financed activities. Where and when it is not possible or appropriate to select either a local entity or a government entity to implement Global Fund grants, CCMs are encouraged to include in their funding requests specific details as to how international NGOs or other entities will ensure that capacities are transferred to local institutions. It is not recommended that a CCM wait until the transition funding grant to shift essential functions of the disease response to local institutions. This process should start as early as possible in order to strengthen the possibility of success.

- **Aligning with national salaries and institutionalizing trainings**: As a general rule and as per the Global Fund's budgeting guidelines, salaries supported by the Global Fund should be in line with national human resources procedures and salary scales.[19] Budget requests that include human resources costs should be able to provide plans for the sustainability of human resource costs beyond Global Fund support.[20] Government workforce trainings supported by the Global Fund (including prevention, advocacy, sensitization, gender and human rights trainings) should be progressively institutionalized

[18] Social contracting may be known by other terms in certain countries and regions.
[19] For more information on salaries and other human resource investments, see the Briefing Note for Global Fund applicants on Strategic Support for Human Resources for Health.
[20] Global Fund Guidelines for Grant Budgeting and Annual Financial Reporting 2014

into the national health curriculum and capacity development programs, with specific domestic funding included in appropriate budgets.

- **Developing strong monitoring and evaluation (M&E) systems:** Country level data systems should be robust enough to generate reliable surveillance data related to the epidemiology of the three diseases. Having the right information and institutionalizing the appropriate research processes to obtain this data is imperative to ensuring that a disease program is appropriately tailored to the epidemic. As such, investing in surveillance, surveys, and population size estimates at national and subnational levels on a routine basis is necessary to ensure that the disease program is structured in a way that ensures that the right populations are being targeted. In particular, these systems should capture data inputs such as disease incidence and disease prevalence, disaggregated by gender and age, and amongst specific key populations. Having transparent data on program performance is also essential, to enhance civil society participation in program planning and ensuring accountability. Countries preparing for transition should specifically consider the following:

    a. *Investing in key data systems* such as Health Management Information Systems (HMIS), surveillance systems, population-based surveys, administrative and financial data sources, while making sure that data and service quality assurance and improvement are integrated into their routine processes
    b. *Including in funding requests priority interventions for improving in-country monitoring and evaluation systems*. The Global Fund recommends that grants allocate between five and ten percent of their budget to monitoring and evaluation activities to address any gaps in M&E
    c. *Mitigating challenges and bottlenecks in developing and using national M&E systems*, engaging with the Global Fund and other partners and mobilizing support

- **Developing reliable and efficient systems for procurement and supply chain management:** Where parallel procurement and supply chain management systems (PSM) are being used, these should be transferred to national systems in a step-wise fashion well before a country stops receiving Global Fund support.[21] Technical support, provided by partners or funded through grants, should align with national strategies/plans as well as identified needs and timelines to ensure that gaps in capacity within the national procurement systems, national supply systems, and/or the supportive pharmaceutical policy and regulatory environment are addressed in time to enable continued access to quality assured health products at affordable prices. With respect to procurement, this may include proactive planning to ensure continued access to affordable pricing for quality assured medicines and other health products needed to fight the three diseases after transition for countries that have benefitted from international procurement mechanisms (e.g. GDF, UNICEF), and pooled pricing options (such as the Global Fund Pooled Procurement Mechanism). It may also take into consideration aspects such as registration where waivers have traditionally been used and/or the use of TRIPS flexibilities, in compliance with national laws and international obligations, as a strategy for sustained access to medicines.[22]

[21] Procurement and supply management refers to all procurement, supply and distribution activities required to ensure the continuous and reliable availability of sufficient quantities of quality-assured, effective products to end-users, procured at the lowest possible prices in accordance with national and international laws. It includes aspects such as selection, financing, pricing/affordability, quantification, procurement, storage, distribution, rational use, and monitoring.
[22] Guide to Global Fund Policies on Procurement and Supply Management (2012).

- **Adapting governance during and after transition:**
  a. *The role of CCMs during the transition process*: Country Coordinating Mechanisms (CCMs) can play a key role leading the transition preparedness process and overseeing the transition away from Global Fund support and toward full domestic financing. With their links to the external and internal environment, CCMs are encouraged to coordinate the country dialogue to assess transition readiness and develop a strategy for transition as early as possible. As a country prepares for transition in at least one of its components, the role of the CCM should be appropriately adapted to enable a successful transition process. This may include but is not limited to: 1) modifying the composition of the CCM, such as by inviting the Ministry of Finance or Planning, the World Bank, the Private Sector, and or other key stakeholders who may play a role in the transition process to become CCM members and 2) using CCM funding to help drive the transition planning process, implement or oversee aspects of transition work-plans, or enhance capacity of CCM members around transition related topics.
  b. *Governance after transition*: Countries preparing for transition in all eligible components should envisage the evolution or replacement of the role of the CCM after transition, particularly with respect to the key principles of inclusion and participatory decision-making. Options to consider include maintaining the CCM, in which case resources will need to be mobilized to continue CCM functions after transition, or merging the CCM with other governing entities while ensuring that the core CCM principles of inclusivity and participatory decision-making are maintained.

C) The Transition Funding Grant

Once a country disease component becomes ineligible for funding, it *may be eligible* to receive up to 3 years of transition funding before Global Fund financing ends.[23]

For components in this “transition funding” category, the funding request should focus almost exclusively on activities essential to achieving, by the end of the grant, full domestic funding and implementation of activities currently funded by the Global Fund. The funding request for “transition funding” components will be subject to a tailored review by the Technical Review Panel (TRP).

Applicants for transition funding are required to submit a **transition work-plan** along with their funding request. The transition work-plan would ideally be derived from the program’s strategy for transition and/or transition readiness assessment (or equivalent). In all cases, the work-plan must be aligned with the NSP.

While there is no prescribed format, the transition work-plan should be practical, measurable, costed and include a detailed outline of the steps that the country will take to transition to fully funding programs from domestic resources over the three-year transition funding period. The work-plan should provide the following:

- Overview of activities currently financed by the Global Fund, and the activities that require financing to enable a successful transition

[23] The Secretariat, based on country context and existing portfolio considerations, will determine the appropriate period and amount of funding for priority transition needs. The Eligibility Policy provides circumstances when transition funding may not be awarded. Specifically, countries not eligible for transition funding are those that a) move to high income, b) become G-20 UMI with less than an ‘extreme’ disease burden, or c) become members of the Organisation for Economic Co-operation and Development’s Development Assistance Committee.

- A phased financing plan towards full government uptake of all activities by the end of the final grant (with the exception of transition-specific activities)
- Description of how these activities (with the exception of transition-specific activities) will continue to be financed beyond the grant period to sustain the gains and scale up as set out by the NSP
- Description of which activities are specific to the transition process (such as technical assistance) and would therefore cease by the end of the grant implementation period
- Where applicable, options and strategies for reprogramming existing funds and/or seeking additional funds from new sources to fill the gaps
- Description and budget of any activities essential for enabling a successful transition that are not financed in the current grant

Funding requests for transition funding grants should focus on providing support to the transition process as described in the transition work-plan and as prioritized during the country dialogue process. While country context will influence the content of what a transition funding request includes, in general transition funding requests should address as relevant the enabling factors described in section B3. Therefore, transition funding grants **are encouraged to include** but are not limited to:

1) Activities that enhance the sustainability and support the transition of effective and evidence-informed services for key and vulnerable populations
2) Activities, as relevant depending upon the health and public financial management systems, needed to ensure solid linkages between the government and non-state actors, including enabling government financing of civil society organizations
3) Activities to secure the availability of robust programmatic and financial data for program planning and monitoring (e.g.: building capacity for data collection and analysis, strengthening national HMIS and surveillance systems)
4) Activities to ensure adequate procurement processes and to address access to affordable prices beyond transition
5) Activities to ensure the financial sustainability of supported programs (e.g. integrating service provision into national health insurance schemes, activities to strengthen budget advocacy for service provision to key and vulnerable populations, activities to strengthen resource mobilization for non-state actors and civil society, etc.).

Transition funding is *not expected* to be used to maintain the status quo of current grants or to extend for additional time the activities currently financed by the Global Fund. While different country contexts will affect the prioritization of activities and speed at which national authorities can absorb interventions currently financed by the Global Fund, the aim of transition funding is to help facilitate the process to full domestic financing of the national disease response. Therefore, any activity expected to be continued after the end of Global Fund support, if included in transition funding requests, should be accompanied by specific, time-bound plans to phase out Global Fund financing as well as complementary activities to secure funding from alternative sources. This may include, for example, co-financing commitments that specifically require increased domestic financing of these activities at the early stages of transition funding grant implementation. These activities include (but are not limited to):

1) **Service delivery**: It is expected that a significant portion of service delivery activities be fully domestically funded by the time that a country receives transition funding, regardless of the type of implementing entity. That said, given that countries will be inevitably at different stages of preparedness when beginning a transition grant, transition funding requests that include the provision of essential services should also include a clear plan to shift the source of funding to one of domestic origin during the life of the grant, as well as

specific complementary activities designed to achieve the full absorption of the service provision during the life of the grant.

2) **Procurement of health products:** It is expected that all or a significant proportion of procurement of medicines or other health products and supplies for treatment, diagnostic and prevention activities be fully funded domestically by the time a country reaches the transition grant stage. However, where funding for the procurement of health products has not yet been secured, the inclusion of health product procurement should also be subject to a clear plan to absorb them over the life of the grant. Specific, costed, time-bound government commitments to take up all necessary procurement to maintain coverage in line with national strategic plans and the complementary activities necessary to achieve this goal should be included along with the funding request.
3) **Human resources and other recurrent operational costs**: It is also expected that recurrent costs for the management of the disease programs of all implementing entities involved (including salaries, travel related costs for supervision visits, office costs, fuel, maintenance and insurance of vehicles, etc.) be fully funded domestically by the time of the transition funding grant. This reflects the Global Funds' overall approach of integrating into grants sustainability considerations regarding human resources for health.[24] Where specific country context has prevented essential human resources or program operational costs from being absorbed, requests for these activities as part of transition funding should include time-bound and specific commitments to transfer them to national authorities during the life of the grant request.

Countries, in discussion with the Global Fund country team, should evaluate how best to use transition funding, and agree on a reasonable performance framework for the transition funding grant with the adequate choice of indicators vs. work-plan tracking measures.

D) Co-financing

A critical enabler for sustainability is increasing domestic financing of key parts of the disease response and health systems. As countries expand their fiscal capacity, they are expected to take on greater ownership of the national response to the three diseases by contributing increasingly to disease programs and health systems.

The STC policy includes co-financing requirements aimed at incentivizing greater domestic resources for health and Global Fund-supported disease programs. The requirements are differentiated by income to encourage the additional domestic investments to be progressively focused along the development continuum as a country prepares for transition.[25]

Together with the application focus requirements, the co-financing requirements aim to encourage progressive domestic uptake of key program costs to move towards complete domestic financing of all aspects of a country's disease program as countries approach transition.

[24] Briefing Note for Global Fund applicants on Strategic Support for Human Resources for Health
[25] Sustainability, Transition and Co-financing policy.

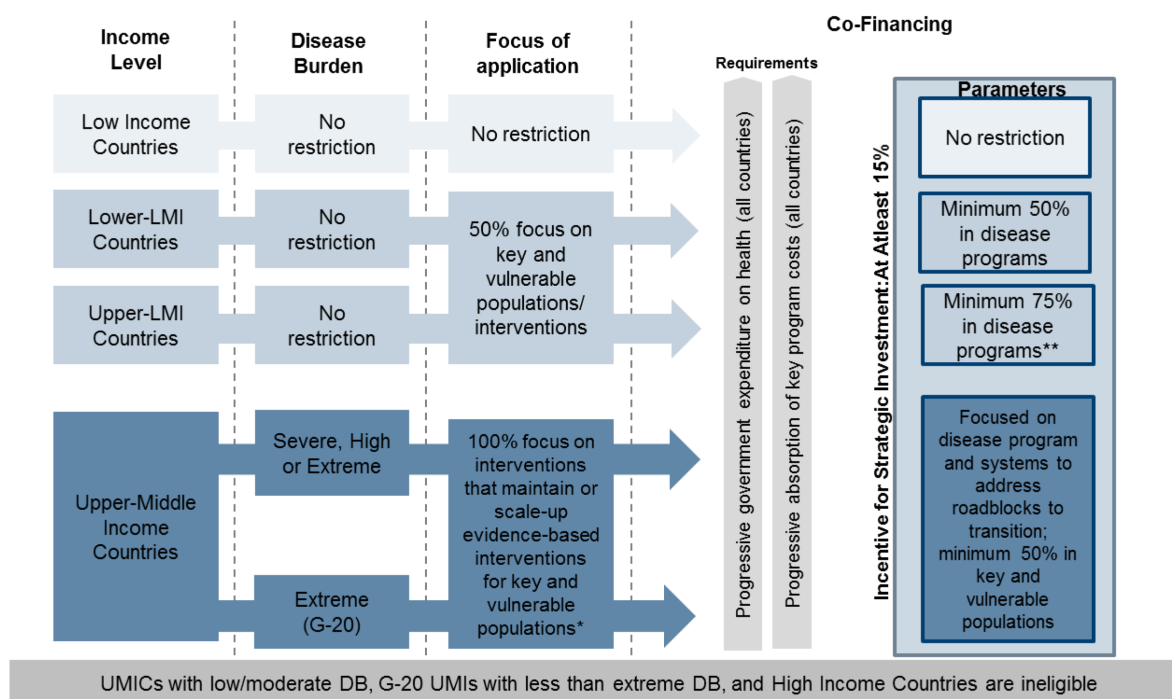

FIGURE 3: THE APPLICATION FOCUS AND CO-FINANCING FRAMEWORK

*As per the STC policy, UMI countries can include investments for RSSH interventions that are critical for ensuring transition readiness as identified through a transition readiness assessment. UMI countries may also include technologies or innovations that represent global best practice. For additional details on the focus of application requirements, please see the STC policy.

The co-financing requirements are two-fold. First, in order to access the allocation, all countries need to demonstrate that over the implementation period, government spending on health and co-financing of Global Fund supported programs will increase.

Second, to further encourage domestic investment, ***at least*** 15% of a country's allocation is a **co-financing incentive** made available if countries make – and realize – additional domestic commitments over the implementation period (relative to expenditures over the previous implementation period). These additional investments need to be as follows:

- For low income countries, additional domestic investments need to amount to at least 50% of the total co-financing incentive;
- For middle income countries, additional domestic investments need to amount to at least 100% of the total co-financing incentive.[26]

As per the STC Policy, the co-financing incentive is ***at least*** 15%. Factors that may influence co-financing incentives to be greater than 15% include, but are not limited to: if the share of government spending on health is less than 8%, if the country is a UMI (regardless of disease burden) or LMI with low/moderate disease burden and will need to proactively plan for transition, or other country specific contextual factors. For more details on the co-financing incentive, countries should consult the Co-Financing Operational Policy Note.

In addition, the co-financing requirements for these commitments are differentiated by income to incentivize countries to progressively take up key program costs as they move along the development continuum (see Figure 3).

[26] See the Co-financing Operational Policy Note for more details. For country income classifications see the World Bank's website: http://databank.worldbank.org/data/home.aspx.

- **For low income countries**, the co-financing incentive focuses on increasing domestic commitments for health and the three diseases. Low income countries have the flexibility to commit to investing in disease programs and/or in strengthening national systems by including commitments that contribute to RSSH.

- As countries move along the income spectrum, they are encouraged to use their additional commitments to access the co-financing incentive to invest increasingly in disease programs and absorb key program costs, such as human resources,[27] procurement of essential medicines and other health products, and programs for key and vulnerable populations. As described in Figure 3, **for Lower-LMI countries,** a minimum 50% of co-financing contributions should be in line with identified priority areas within the disease program. **For Upper-LMI countries with a 'high', 'severe' or 'extreme' disease burden,** a minimum 75% of co-financing contributions should be in line with identified priority areas within the disease program. **In Upper-LMI countries with a 'low' or 'moderate' disease burden,** applicants are also encouraged to invest a greater share of domestic contributions to address systemic bottlenecks for transition and sustainability.

- To strengthen transition preparedness, 100 % of the additional commitments in order to access the co-financing incentive in UMI countries (regardless of disease burden) must focus on the disease program and RSSH activities that specifically address roadblocks to transition. Within this, a minimum of 50% should be invested in specific activities targeting key and vulnerable populations, as relevant to the country context. Applicants for transition funding are also required to meet the co-financing commitments.

Co-Financing Incentive Example:
Country A is a UMI and is eligible for HIV only. It receives an allocation of $10 million for 2017-2019, of which 20% is a co-financing incentive. To access its full allocation, Country A must commit additional investments over the three-year implementation period that are at least $2 million more than what it spent over the past three years. Of the $2 million, at least $1 million must be committed to activities for key and vulnerable populations.

Countries will need to show evidence of having met their previous co-financing commitments from the 2014-2016 allocation (formerly known as "Willingness-to-Pay"). The realization of commitments made during both the 2014-2016 and the 2017-2019 periods will be verified throughout the funding cycle. Further details can be found in the Co-Financing Operational Policy Note.

[27] For examples of countries that have absorbed human resource costs, see the Briefing Note for Global Fund applicants on Strategic Support for Human Resources for Health.

Annex 1: Resources for sustainability and preparing for transition

Note: the lists of resources provided in this Annex are not comprehensive.

A. Overview of cost-impact tools to inform resource allocation:

Name	Function	Disease Area	Countries where this has been applied	Web links for more information
AIM	Epidemiological impact (linked to OneHealth for costing)	HIV	Used by UNAIDS to produce HIV estimates for over 150 countries	AIM (AIDS Impact Model)
Goals	Epidemiological impact (linked to OneHealth for costing)	HIV	Used to support national and international planning for HIV programs in over 40 countries	Goals
AEM	Epidemiological impact; costing	HIV	Bangladesh, Cambodia, China, Dominican Republic, India, Indonesia, Laos, Malaysia, Myanmar, Nepal, Pakistan, Peru, Philippines, Thailand, Ukraine, Vietnam, Guatemala, Nicaragua	
Optima	Optimization of resource allocation; epidemiological impact	HIV	Armenia, Argentina, Barbados, Belarus, Brazil, Botswana, Cambodia, China, Colombia, Cote d'Ivoire, Georsgia, Ghana, India, Indonesia, Kazakhstan, Kenya, Kyrgyzstan, Macedonia, Malawi, Mexico, Moldova, Myanmar, Nepal, Niger, Nigeria, Papua New Guinea, Peru, Philippines, Russia, South Africa, Sudan, Swaziland, Tajikistan, Tanzania, Thailand, Uganda, Ukraine, Uzbekistan, Vietnam, Zambia	Optima HIV
TIME	Epidemiological impact (linked to OneHealth for costing)	TB	Afghanistan, Bangladesh, Bolivia, Botswana, Brazil, Belarus, China, DR Congo, Dominique Republic, Ghana, Guatemala, Lesotho, India, Indonesia, Kazakhstan, Nicaragua, Nigeria, Sudan, South Africa, Vietnam	TIME (TB Impact Model and Estimates)
AuTuMN	Epidemiological impact	TB	Fiji, The Philippines, Bulgaria	AuTuMN (Australian Tuberculosis Modelling Network)
OpenMalaria	Epidemiological impact; Costing	Malaria	Bangladesh, Madagascar, Mozambique, Ethiopia, The Philippines, Tanzania	OpenMalaria
Malaria Tools Package (Elimination Scenario planning - ESP)	Epidemiological impact	Malaria	Hispaniola region, Rwanda, Gambia, Senegal, Papua New Guinea	Malaria Tools Package (Elimination Scenario Planning)
OneHealth	Costing (linked to Goals and TIME for epidemiological impact)	Health, with modules for HIV, TB, malaria and more	Angola, Bangladesh, Benin, Botswana, Burkina Faso, Cape Verde, DRC, Ethiopia, Ghana, Kenya, Lesotho, Liberia, Malawi, Morocco, Mongolia, Mozambique, Nigeria, Papua New Guinea, Paraguay, Rwanda, Senegal, Sierra Leone, Sri Lanka, South Africa, Sudan, Tajikistan, Tanzania, Turkmenistan, Viet Nam, Zambia	OneHealth
STAR (Socio-Technical Resource Allocation)	Cost effectiveness analysis	Health	Bangladesh, Sudan, Mozambique	STAR

B. Partner resources that can be used to inform transition readiness assessments:

	PEPFAR: Sustainability Index and Dashboard (SID)	World Bank: checklist for transition planning of national HIV responses	USAID and PEPFAR Health Policy Project: Readiness assessment – moving towards a country-led and –financed HIV response for key populations
What is it?	A tool used to assess the sustainability of national HIV programs where PEPFAR has investments, for monitoring progress over time. Based on a colour-coded dashboard. It has been applied in all countries where PEPFAR invests.	A checklist to provide an analytical framework to support countries in undertaking transition planning to ensure programmatic sustainability of their national HIV responses. This checklist is in the process of being integrated into a comprehensive Health Financing System Assessment.	A guide to assess the ability of a country's stakeholders to lead and sustain HIV epidemic control among key populations as donors transition to different levels and types of funding.
What components does it include?	15 elements of sustainability grouped into 4 domains: governance, leadership and accountability, national health system and service delivery, strategic investments, efficiency and sustainable financing, and strategic information.	Key considerations to understand, assess and plan across the following areas: contextual factors, service delivery, institutional and financial issues.	Assessment questions focused on key populations, grouped under the same four domains as PEPFAR's SID: governance, leadership and accountability; national health system and service delivery; strategic investments, efficiency and sustainable financing; strategic information.
For more information:	http://www.pepfar.gov/countries/cop/c71524.htm	http://documents.worldbank.org/curated/en/645871473879098475/pdf/108266-NEWS-WBChecklistforTransitionPlanning-PUBLIC.pdf	http://www.healthpolicyproject.com/index.cfm?id=publications&get=pubID&pubId=462

C. Tools for transition readiness assessments developed for the Global Fund context:

	Curatio: Transition preparedness framework	Aceso Global/APMG: Guidance for Stakeholder analysis, Discussions and Decision-Making for Global Fund Transition Planning	APMG: Social Contracting Diagnostic tool
What is it?	A tool to support the transition planning process by identifying strategic and operational issues that will assure the sustainability of programs currently supported by the Global Fund and other donors.	A tool to help countries identify: financial, programmatic and governance gaps, bottlenecks and risks that need to be addressed to promote a smooth transition; and options for solutions to be incorporated in a strategy for transition.	A tool to examine the ability of civil society organizations to register, receive funds from government, use those funds for key populations and other HIV, TB and malaria efforts, and their ability to be involved in planning and implementing HIV, TB and malaria responses among key populations.
What components does it include?	External environment: political and economic; internal environment: financing, human resources, health information systems, governance, accountability, service delivery, organization capacity, and transition preparedness	Modules include Global Fund support; epidemiological situation and disease response; institutional and enabling environment; health care financing and fiscal space issues; delivery system; role of civil society and social contracting.	Social contracting (an abbreviated version of this is incorporated into the Aceso tool)
Where has it been applied?	Ukraine, Belarus, Georgia, Bulgaria, Jamaica, Philippines, Morocco. In progress – Moldova, Armenia, Kyrgyzstan, and Uzbekistan.	In process of finalization. Will be piloted in 3 countries in the Latin America and Caribbean region.	In process of finalization. Will be piloted in 3 countries in the Latin America and Caribbean region together with the Acesco tool.

For more information: Contact the Global Fund

D. Other resources:

European Harm Reduction Network *Transition and sustainability of HIV and TB responses in Eastern Europe and Central Asia: A regional consultation report and draft transition framework*: http://www.harm-reduction.org/library/transition-and-sustainability-hiv-and-tb-responses-eastern-europe-and-central-asia
WHO *Health Financing Country Diagnostic*: http://www.who.int/health_financing/tools/diagnostic/en/
World Bank *Health Financing System Assessment (HFSA) transition protocol* (forthcoming)