



Transitioning away from donor funding for health: a cross-cutting examination of donor approaches to transition

AUTHORS

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Working Paper • April 2020

SUMMARY

Many donors are reconsidering their approach to providing health aid to countries that are viewed as becoming increasingly capable of self-financing their own development. To better understand this phenomenon, we analyzed the transition approaches adopted by six key global health donors, three multilateral and three bilateral, who provided nearly 75% of all disbursed official development assistance for health in 2016. We conducted a desk-based review and triangulated our findings with semi-structured key informant interviews.

We found:

1. there is no consensus on the terminology used to describe the transition process;
2. donors vary in terms of the formality of their policies, the indicators used to allocate resources and/or trigger transition, and the timeline/duration of transition;
3. some donors view the unit of transition at the sector or program level rather than the country level; and
4. donors provide varying degrees of support before, during, and after transition.

Our findings suggest that more explicit transition approaches and greater definitional clarity are needed. Donors should avoid a “one size fits all” approach—a lack of flexibility puts countries at risk. Evidence should be generated and shared on which transition modalities work best and under which circumstances. Donors should communicate with each other and avoid transitioning at the same time. As more low-income countries transition to middle-income status, transitions away from donor support for health will become an increasingly important phenomenon to understand.

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SUGGESTED CITATION

McDade KK, Schäferhoff M, Ogbuoji O, Bharali I, Dixit S, Mao W, Bandara S, Yamey G. *Transitioning away from donor funding for health: a cross-cutting examination of donor approaches to transition*. The Center for Policy Impact in Global Health. Duke Global Working Paper Series: number 21, April 2020. Available at: <http://centerforpolicyimpact.org/transitioning-away-from-donor-funding-for-health-cross-cutting/>.

KEY WORDS

Transition, graduation, foreign aid, health aid, development assistance for health, aid for health, multilateral donor, bilateral donor, Gavi, the Vaccine Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank, the United States Agency for International Development (USAID), the President's Emergency Plan for AIDS Relief (PEPFAR), the United Kingdom Department for International Development (DFID), Japan International Cooperation Agency (JICA).

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● ACRONYMS

CPIA	Country Policy and Institutional Assessment
CRS	Creditor Reporting System
DAC	Development Assistance Committee
DFID	Department for International Development
GNI p.c.	Gross national income per capita
GPEI	Global Polio Eradication Initiative
HIV	Human immunodeficiency virus
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
JICA	Japan International Cooperation Agency
LIC	Low-income country
LMIC	Lower-middle income country
MIC	Middle-income country
ODA	Official development assistance
OECD	Organization for Economic Cooperation and Development
PEPFAR	President’s Emergency Plan for AIDS Relief
SDG	Sustainable Development Goal
SID	Sustainability Index and Dashboard
TB	Tuberculosis
TRA	Transition readiness assessment
UK	United Kingdom
UMIC	Upper-middle income country
US	United States
USAID	United States Agency for International Development

● GLOSSARY

- Accelerated transition** A term used by Gavi, the Vaccine Alliance (Gavi) to categorize a phase a country reaches when its average gross national income per capita (GNI p.c.) over the previous three years crosses Gavi’s eligibility threshold. This phase typically lasts five years, at which point a country reaches the “fully self-financing” phase.
- IDA-only non-gap** A term used by the World Bank to classify one of the interim periods between being eligible for International Development Association (IDA) funding but not yet fully eligible for International Bank for Reconstruction and Development (IBRD) funding.
- IDA-only gap** A term used by the World Bank IDA to classify one of the interim periods between being eligible for IDA funding but not yet fully eligible for IBRD funding. In this phase, a country’s GNI p.c. remains above the operational cutoff for IDA funds but a country does not have sufficient creditworthiness to access IBRD funds.
- IDA-blend** A term used by the World Bank to classify one of the interim periods between being eligible for IDA funding but not yet fully eligible for IBRD funding. In this phase, a country is considered creditworthy and therefore is eligible for IBRD funds. As an IDA-blend country, IDA funds gradually reduce while some IBRD funds become accessible.
- Transition** In this study, transition refers to the changing of instruments, finances, and programming with the intention of shifting more responsibility to a recipient country in its preparation for an era beyond aid.

1 INTRODUCTION

A major shift is underway in the health financing landscape. Many donors are reconsidering their approach to providing health aid in countries that are viewed as becoming increasingly capable of self-financing their own development. Such donors are focusing their health funding on the lowest-income countries. Some donors have begun to end support to countries when health or economic milestones are reached, whereas others are becoming increasingly interested in building self-reliance to prepare countries for an eventual era beyond aid.(1,2) Some countries, such as Ghana, have declared their intention to self-finance and plan to operate “beyond aid.”(3)

A particular group of countries, those that have recently moved from low-income to middle-income (according to the World Bank’s classification system), may be particularly vulnerable during this transition.(4) Although a country’s economic transition from low- to middle-income reflects advancement in economic development, many lower-middle income countries (LMICs) are unprepared to finance and manage their health systems with only domestic resources.(5) A forthcoming study found that donor transitions, if mismanaged, could present significant challenges to sustaining investments necessary for global health progress.(6) Lack of political will, poor coordination at the leadership level, improper planning or mismanagement of health financing have a domino effect on the entire health system.(6,7) These effects were seen in Romania and Serbia where lack of political will affected harm reduction programs, in South Africa where poor planning by the President’s Emergency Plan for AIDS Relief (PEPFAR) affected service delivery, and in Albania where lack of funding commitments led to disruptions in HIV/AIDS care continuation.(8,9,10,11)

One difficulty that countries face in meeting the challenges of donor exits is that while many donors have established eligibility criteria (i.e., what requirements a country must meet to be considered for aid), it is often unclear when exactly a country becomes ineligible for health aid.(12) Some donors do not have clear eligibility criteria but do have ways of prioritizing countries, often based on a combination of metrics deemed relevant to donors’ aid programming. But priorities can change, which can often leave de-prioritized countries in a vulnerable position. Some donors are pioneering transition policies that put countries on a clear trajectory to end support, but little evidence exists on how effective these policies are in preserving sustainability.

At its heart, the transition of middle-income countries away from health aid presents both a threat and an opportunity to achieving sustainability. The Sustainable Development Goal (SDG) era is about achieving a sustainable future for all where no one is left behind.(13) The SDGs can only be achieved through a massive mobilization of domestic flows and enhanced national capacity building for development. Sustainably shifting financing and programmatic responsibility away from donors to domestic partners is a critically important underpinning of success in reaching the health SDGs. This shift requires strong transition policy and planning that address the ever-changing health needs of the population. Donors are interested in program sustainability to sustain gains and ensure their investments are safeguarded. Countries are navigating calls for increased domestic resource mobilization for health against a rapidly evolving aid landscape.(14)

It is against this backdrop that we sought to understand the transition process across several major health donors. We conducted a policy analysis that compared how six donors are approaching transitions in the health sector. In this paper, we begin by describing our overall analytic approach (Section 2). We then summarize the key cross-cutting findings (Section 3), and finally we put forward a set of policy implications emerging from our findings (Section 4). This analysis can help donors understand the transition landscape

and learn how other actors are approaching this phenomenon. It can also help countries understand donor strategies for transition, allowing for better planning for sustainability.

Most of the existing literature on donor approaches to transitions is specific to a particular donor, type of donor, or focused on a particular region (Appendix 1). We look across both bilateral and multilateral donors specifically on transition in the health sector. Where a donor has no health-specific approach to transition, we highlight broader agency-wide phenomena that may relate to health. To the best of our knowledge, our analysis is the first attempt to analyze health transition approaches in a cross-cutting way across both bilateral and multilateral health donors.

2 METHODS

2.1 How we defined transition

From our literature review we determined that there is no agreed definition of what constitutes a transition (or graduation) of a country out of donor support for health (Appendix 1: overview of key transition studies). There are a variety of terms used, sometimes interchangeably, to describe this phenomenon. Transitions are most commonly described in the literature as being linked with a country's income level—that is, when a country's gross national income per capita (GNI p.c.) rises to a certain threshold level, this triggers the transition process (Appendix 1).

In this study, we use the term transition more broadly to include any major shift in policy, funding, or programming with the intention of giving more responsibility to a country in its preparation for an era beyond aid. Our focus in this paper is the *transition process*. Our intention was to gain a better understanding of a donor's transition approach even in the absence of a clear transition policy (some donors have not published their policies on transition).

2.2 Selection of donors

This analysis was conducted as part of a broader project called “Driving health progress during disease, demographic, domestic finance, and donor transitions,” which is examining the interplay of these four types of transitions in six middle-income countries (MICs) that are at different stages in their transition: Ghana, India, Kenya, Myanmar, Nigeria, and Sri Lanka.^(15,16) A key component of this project is understanding how the major health donors to these countries are approaching transition.

We identified the major donors using the Organization for Economic Development's (OECD's) Creditor Reporting System (CRS) database,⁽¹⁷⁾ which provides aid funding data by year, donor, recipient country, and sector. Out of the official donors who report to the OECD, we identified the top three bilateral donors and top three multilateral donors across our six focus countries: the World Bank's International Development Association (IDA); the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund); Gavi, the Vaccine Alliance (Gavi); the United States (US) government; the United Kingdom (UK) government; and the government of Japan. These six donors provide most of the total health aid to our six focus countries (Table 1). Across all official development assistance (ODA) recipients worldwide, these donors provided about 75% of all disbursed ODA for health in 2016. We calculated ODA for health using the sum of CRS sector codes 120 (health), 130 (population policies/programs and reproductive health), and 16040 (social mitigation of HIV/AIDS), as is common practice in other research that tracks health aid.⁽¹⁸⁾ Additionally, this selection ensured variation in policies based on (i) the type of donor (bilateral versus multilateral) and (ii) whether a donor was focused on health (“health-centric donors” versus those that have health portfolios as one of a broad range of portfolios across multiple sectors) (Table 2).

Given that bilateral donors tend to have a multitude of aid-disbursing agencies, we identified the primary agency responsible for health aid and analyzed its agency-specific policies (e.g., in the UK this agency is the UK Department for International Development [DFID] and in Japan, this agency is the Japan International Cooperation Agency [JICA]). Given that the US is the largest bilateral donor for health, we included the two agencies responsible for most of its health aid: PEPFAR and the US Agency for International Development (USAID).⁽¹⁹⁾

Table 1: Share of donor contribution to each focus country, 2016

Donor	Ghana	India	Kenya	Myanmar	Nigeria	Sri Lanka
<i>Multilateral</i>						
Global Fund	26%	24%	13%	40%	18%	10%
Gavi	8%	24%	4%	7%	12%	0%
World Bank, IDA	5%	24%	3%	6%	12%	46%
<i>Bilateral</i>						
United States	31%	14%	65%	10%	37%	0%
United Kingdom	10%	3%	4%	13%	11%	0%
Japan	3%	2%	3%	8%	0%	15%
<i>Total share</i>	<i>84%</i>	<i>91%</i>	<i>92%</i>	<i>84%</i>	<i>90%</i>	<i>70%</i>

2.3 Our approach

To understand how these donors approach transitions, we conducted a desk-based review that included donor websites, strategy documents, grey literature, and academic literature. To reflect up to date approaches and thinking, we triangulated our findings from the desk review with findings from a series of semi-structured key informant interviews. A sample interview guide can be found in Appendix 2. Interviews were conducted with personnel within each of the donor agencies. All research was performed according to a study protocol approved by the Duke University Institutional Review Board (Campus IRB #2019-0366). Each donor was analyzed individually in a series of profiles (20); this report pulls together cross-cutting findings from the individual donor analyses.

Table 2: Overview of donors selected for our analysis

Donor	Share of total DAH across six focus countries, 2016	Ranked contribution to ODA for health for all countries, 2016	Agency highlighted	Health-centric
<i>Multilateral</i>				
Global Fund	20%	#1 multilateral	N/A	Yes
Gavi	11%	#2 multilateral	N/A	Yes
World Bank, IDA	11%	#3 multilateral	N/A	No
<i>Bilateral</i>				
United States	37%	#1 donor government	PEPFAR, USAID	Yes (PEPFAR), No (USAID)
United Kingdom	8%	#2 donor government	DFID	No
Japan	2%	#4 donor government	JICA	No

3 FINDINGS

Overall, each of the six donors we studied are currently reviewing how they structure their support to smooth the path to a health system that is country owned and domestically financed. However, the philosophies, policies, and mechanisms adopted by these donors vary greatly (see Appendix 3 for overview). Taking a cross-cutting approach, our analysis had four key findings.

3.1 The terminology used to describe transition is imprecise

There is no consensus on the terminology used to describe the transition process. While several donors have clearly defined the terms that they use, others are reluctant to even use the word “transition,” believing it to be too sensitive or political. A summary of terminology donors themselves explicitly use to describe this phenomenon, or a particular aspect of this phenomenon, is presented in Table 3. Some terms are used to describe a process while others describe a particular phase or phenomenon. We have included only those terms found specifically in policy documentation.

Table 3: Examples of terminology used to describe the transition process

	World Bank IDA	Gavi	Global Fund	USAID	PEPFAR	Japan	DFID
Transition		✓	✓	✓			✓
Graduation	✓			✓		✓	✓
Phase-out				✓			
Self-reliance				✓			
Exit							✓
Country-ownership					✓		

Transition

Gavi has an Eligibility and Transition Policy that outlines its approach to transition. According to Gavi, transition is embedded throughout a country’s time as a recipient. A country can be in one of four phases: initial self-financing, preparatory transition, accelerated transition, and fully self-financing.(21) Countries in the accelerated transition phase are said to be preparing for an imminent end to funds for Gavi-supported vaccines. Fully self-financing countries are those that have transitioned out of Gavi support. However, even a fully self-financing country can receive some support from Gavi for certain vaccines and post-transition support.

The **Global Fund** has a formal transition policy that outlines when a country should transition from support for particular disease components. The policy defines transition as “the mechanism by which a country, or a country disease component, moves towards fully funding and implementing its health programs independent of Global Fund support, while continuing to sustain gains and scaling up as appropriate.”(22)

USAID’s Global Health Bureau refers to transition as the time between a decision to end support and a full exit. Specifically, “this period is one during which gains made under past programs should be consolidated, ongoing activities that are not contributing to program goals are removed from the strategy, and new activities are introduced only if they are necessary for successful graduation or phase-out.”(23)

DFID uses the term transition to refer to the phasing out of bilateral aid or financial aid in favor of new forms of development cooperation.(24) Transition applies to “emerging powers” such as India, China, and South Africa. During this process traditional partnerships are phased out in whole or in part in favor of building development partnerships with new objectives.

Graduation

The **World Bank** uses the term graduation to refer to the shift in eligibility from IDA to International Bank for Reconstruction and Development (IBRD) funding. However, IDA has a transition continuum built into the graduation process with various stages for a country to pass through prior to fully graduating from IDA: IDA-only non-gap, IDA-only gap, IDA-blend.(25)

According to the **USAID Bureau for Global Health**, graduation occurs “once certain thresholds of development or intended results have been attained” (i.e., some programmatic target has been achieved).(23)

Japan uses the term graduation to refer to countries losing their eligibility to receive ODA from the OECD Development Assistance Committee (DAC) donors (i.e. countries “graduate” when they have been removed from the OECD DAC list of eligible recipients).(26) However, even these countries may be granted exempted status by Japan so that technical cooperation can continue.

Exit

DFID uses the term exit when referring to the phasing out of its bilateral aid relationship with a country. DFID has exited countries based on the country reaching middle income status, GNI p.c., a shift in UK government priorities, or after determining that other donors are better placed to assist.(24) DFID may exit a country, but it may also then transition to a new type of development partnership.

Phase-out

Phase-outs, according to **USAID’s Global Health Bureau**, occur when support is reduced over a finite period, “often as a consequence of resource constraints, instability, and economic or political considerations (i.e. a circumstance presented to a country partner).”(23) During phase-out, an intermediate step, usually called “phasing down,” occurs when donors begin to transfer activities to local partners and reduce the funding amount. Although phase-outs are still planned and sometimes guided by a similar rationale as that for USAID graduation (e.g., a mission achieves its goals), there is not necessarily a comprehensive strategy governing the process. Phase-outs can also occur when a graduation is likely overdue and there is no need for assistance anymore.(23)

Self-reliance

USAID focuses on “self-reliance,” or “ending the need for foreign assistance.”(27) Self-reliance is not considered synonymous with donor exit; self-reliance encourages both a change in the way USAID programs operate and a shift in the relationship that USAID has with the host country.

Country-ownership

PEPFAR does not have clear terminology to describe transition. However, PEPFAR has reoriented its approach to move towards country-ownership and sustainability. In its PEPFAR 3.0 strategy it outlined a “Sustainability Action Agenda,” calling for more country responsibility for financing, management, and implementation.(28)

3.2 There is no one-size-fits all approach to transition

Across the donors in our study, transitions were understood, and therefore approached, in very different ways. A transition may or may not result in a donor exit from a country—for example, a donor may continue to provide technical assistance to a country even after it withdraws financial support. An exit may be carefully planned and scheduled, or it could be unplanned and abrupt. A transition may also result in a decline, but not total withdrawal, of donor resources—while a decline may not be as drastic as ending all aid, it can still have significant implications on a country’s health system. Transitions may lead to new types of partnership engagement (e.g., technical assistance or scientific exchange) or funding arrangements (e.g., a shift from grants to loans).

Despite these differences, there are several dimensions of transition that can be analyzed across donors. In particular, we assessed the level of formality of a donor’s transition approach, the indicators used to trigger transition considerations, and the pace of transition.

Formality of Transition Policies¹

We found that although all donors have increased their attention towards transitions and sustainability planning in recent years, there are varying degrees of formality in donors’ transition policies and planning approaches (Figure 1). There is a clear difference in such formality between multilateral donors and bilateral donors.

Figure 1: Summary of types of transition approaches¹

Formal policy	Ad-hoc approach	No formal approach
Formal, explicit policy for future transition decisions, published in easily accessible online documents	No formal policy, but has used published criteria to inform previous transition decisions	Focused on sustainability planning, but does not have a formal, published approach to transition
<ul style="list-style-type: none"> • Gavi • The Global Fund • World Bank IDA 	<ul style="list-style-type: none"> • DFID • USAID 	<ul style="list-style-type: none"> • JICA • PEPFAR

Multilateral donors

All multilateral donors in our study have a formal, centralized, and explicit approach to transitioning countries out of their support and this approach is published in easily accessible online documents.(21,22,25) The boards of both **Gavi** and the **Global Fund** have developed and published transition policies and provide oversight on their enforcement. These transition policies outline the criteria used to make transition determinations and the process of transition. **IDA** has clear guidance on its

¹ Another study by the Overseas Development Institute (ODI) [analyzed](#) the formality of transition policies of bilateral donors. However, this study was not health-focused in nature. We adapted the categories ODI identified for our study. Where our studies have overlapping donors, we came to similar conclusions, with the exception of PEPFAR. ODI classified PEPFAR as having a formal transition approach due to its use of the severity of disease burden as a criterion. However, our definition of formality is a formal, explicit policy for future transition decisions, which PEPFAR does not have.

graduation approach from IDA to IBRD, although it does not have a standalone health-focused policy. For all of the multilateral donors in our study, transition is inextricably linked with eligibility; in general, a transition process is triggered once the maximum eligibility threshold has been reached.

Bilateral donors

All of the bilateral donors in our study lack explicit or publicly available policies to govern transitions. Despite the general lack of formality in transition approaches, bilateral donors are modifying their support to shift responsibility to domestic partners and monitor for program sustainability (Box 1).

Some bilateral donors have published policies and metrics that guide transition *thinking*, although these tend to be governed at the sector, rather than central level, or are applied in an ad-hoc nature. For example, both **USAID** and **DFID** underwent prioritization exercises in which they refocused their efforts on a smaller number of “needier” countries. While these exercises were informed by metrics that were explicit and published, they were not part of a broader, long-term transition approach. Most of the information currently available for both donors is related to past transitions rather than the implementation of potential future transitions.

Although both **JICA** and **PEPFAR** are focused on sustainability planning, our document review suggests that these agencies have even less of a formal approach than the approaches adopted by DFID or USAID. PEPFAR has yet to fully depart a country, and therefore planning for an exit is not considered a top policy priority. However, reductions in funds and programmatic shifts are underway. JICA has transitioned out of countries, and has made its decisions on a case-by-case basis.

Box 1: Examples of bilateral donor responses to economic growth or health improvement in recipient countries

All bilateral donors, whether or not they are explicit about their transition plans or approach, identify ways to shift responsibility to domestic governments. While complete country exits are less common among bilateral than multilateral donors, bilateral donors are making use of different modalities and mechanisms to shift responsibility to domestic leaders and partners.

Japan, the OECD donor with the highest ratio of loans to grants, tailors its loan assistance to recipient country capacity. Japan tends to reserve grant assistance for low-income countries (LICs), since these countries have the greatest perceived need. As countries develop, Japan shifts its support towards more loan assistance. In general, upper middle-income countries (UMICs) tend to receive primarily technical cooperation support (although this comes in the form of a grant.)

PEPFAR uses a combination of mechanisms to sustainably shift support for programs to domestic partners. For example, in 2018 PEPFAR established local partner funding targets to ensure that local partners, rather than international partners, are the primary recipients of awarded funds. The goal of the targets is to build capacity among local implementation partners. By the end of fiscal year 2020, PEPFAR aims to channel 70% of its funds locally. PEPFAR also recently adopted the responsibility matrix, an instrument that outlines the various activities required of an effective HIV response and supports facilitated discussions on which key actors are responsible for which pieces of the response (the actors are typically PEPFAR, the Global Fund, and the government). This tool also can help support conversations on how to best transfer responsibilities currently managed or funded by external partners.

For certain countries where **DFID** has chosen to “exit,” the UK continues to provide some financial support. The UK refers to these types of countries that continue to receive support but have exited from aid as “development partnerships.” When a country changes status to a development partnership, responsibility for the partnership can transfer to other departments that also disburse UK aid.

Indicators used to allocate resources and/or trigger transition

There is a wide variety of indicators that trigger a transition, either out of an aid relationship completely (i.e., an exit) or towards a new type of support (i.e., away from financial support towards technical cooperation). Box 2 gives examples of the two predominant criteria.

Often these criteria are used to determine whether a country still has sufficient “need” for aid (e.g., based on disease burden) and whether or not it has the capacity to address remaining needs if a donor were to change or end a program (e.g., based on the country’s income level). “Need” is often used as a catchall phrase to combine various metrics of interest to donors. Individual donors may include additional metrics to understanding a country’s need, such as fragility (used by **DFID**) or creditworthiness (used by **IDA**).

Box 2: Commonly used criteria to guide transition decisions

Income: Donors commonly use a change in a country’s GNI p.c. to signal the need for a new type of support. This threshold is often below the threshold for eligibility for receiving ODA; to receive ODA, countries must be classified as low- or middle-income (based on their GNI p.c. as published by the World Bank). All LICs and MICs are eligible for ODA, except for “G8 members, EU members, and countries with a firm date for entry into the EU.”(26) Donors such as **Gavi** and the **World Bank** establish GNI p.c. thresholds below the ODA eligibility threshold to trigger a transition. Other donors, such as **DFID** and **USAID**, have reprioritized their focus primarily on LICs over MICs, a designation that reflects GNI p.c.

Disease burden/coverage: Health-specific donors, or health-specific programs within a development agency, often use disease burden or intervention coverage levels as a milestone to trigger transition considerations. For example, **USAID’s family planning program** transitions out of a country based on the country’s total fertility rate and prevalence of modern-method contraceptives for married women of reproductive age.(23) The **Global Fund** pairs disease burden with income level; while LICs and LMICs are eligible for allocations, upper middle-income countries (UMICs) may no longer be eligible to access funds if their disease burden for a particular disease component is not classified as high.(28)

The indicators mentioned above may be examined as part of a broader assessment of a country’s performance, or used in addition to other factors measured by a donor. Several donors have developed indices or frameworks to evaluate country performance to help support sustainability planning and/or transition decision making. Some donors make their evaluation criteria publicly available (see examples in Box 3). However, the extent to which these assessments are used to inform transition decision-making is often unclear. For example, **USAID** states that its new self-reliance metrics *may* be used to trigger transitions, but what type of “score” might trigger such a change remains unclear. Tools, while useful, do not necessarily provide a clear indication of whether or not a country will transition once a particular threshold is reached.

Box 3: Assessment frameworks used to assess country performance

USAID’s self-reliance indicators: USAID measures a country’s “self-reliance” at a high level based on two factors: country commitment and country capacity. Country commitment is defined as “the degree to which a country’s laws, policies, actions, and informal governance mechanisms — such as cultures and norms — support progress towards self-reliance.” Country capacity is defined as “how far a country has come in its ability to manage its own development journey across the dimensions of political, social, and economic development, including the ability to work across these sectors.”(29) USAID selected 17 publicly available indicators for routine monitoring to inform a country’s self-reliance status. Commitment indicators relate to governance, inclusive development, and economic policy, while capacity indicators focus on the capacity of stakeholders such as the government, civil society, citizens, and the economy.

The self-reliance metrics will not be the only determinants of transition decision-making, but they will help to “inform strategic decisions,” such as country strategies, and “to signal when USAID might consider a strategic transition.” USAID’s strategic transitions are not necessarily synonymous with complete donor exit; they are, however, indicative of a need to change the relationship between the two partner countries (the U.S. and the host country), perhaps towards greater private sector engagement or away from financial towards technical assistance.(29)

PEPFAR’s Sustainability Index and Dashboard (SID): PEPFAR’s SID is completed annually “with the aim of providing new data to inform annual PEPFAR investments and an opportunity for a dedicated sustainability dialogue with national stakeholders.”(30) For PEPFAR, sustainability refers to the ability of a country to domestically fund, manage, and monitor its HIV response. The SID assesses indicators across four broad themes: 1) governance, leadership, and accountability; 2) national health system and service delivery; 3) strategic investments, efficiency, and sustainable financing, and 4) strategic information. PEPFAR measures where a country is situated on the “sustainability spectrum” by producing a score, between zero and ten, for each indicator. Higher scores reflect sustainability strengths, likely requiring little or no additional investment, whereas lower scores reflect sustainability vulnerabilities, which require some or significant additional investment.(30)

IDA’s Country Policy and Institutional Assessment (CPIA): The CPIA rates a country according to 16 criteria grouped into four equally weighted categories: economic management, structural policies, policies for social inclusion and equity, public sector management and institutions. A country is given a score from 1-6 in each category, 1 being the lowest and 6 being the highest. Once the country has passed IDA’s eligibility criteria of GNI p.c. and lack of creditworthiness, the annual CPIA ratings for the recipient countries are used to determine the allocation of IDA resources. These CPIA ratings help IDA understand the country’s performance in implementing poverty reduction and economic growth policies.(31)

DFID’s Aid Allocation Model: As part of DFID’s 2016 bilateral aid review, several tools, including the Aid Allocation Model, were developed to inform DFID’s approach to supporting countries. The model looks across four key areas: present need (defined as extreme poverty), aid effectiveness (the degree to which aid can translate into poverty reduction), future need (the permanent effect of aid on future levels of poverty), and ability to self-finance (countries that cannot self-finance poverty should be prioritized). When a country is deemed able to ‘self-finance’, DFID states this can serve as an “implicit graduation criterion.”(32)

Timeline of transitions

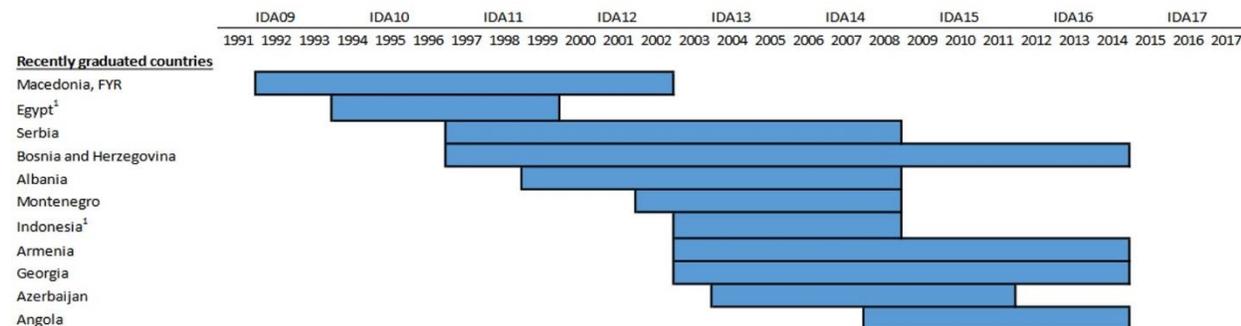
The timeline of transition varies across donors. Some donors have long-term arrangements with fixed end dates, while others have very flexible timelines or no timelines at all. We found no obvious correlation between the pace of transition and whether or not a transition policy is in place.

IDA has a clear policy but countries that have transitioned to IBRD-only funding have spent very different amounts of time transitioning to IBRD-only funding (Figure 2). **DFID's** approach has been equally variable. When DFID exited several countries as a result of its 2011 bilateral aid review, some countries had merely nine months (Burundi) whereas others had six years (Vietnam).(24)

Some donors, such as **Gavi**, push for transitions as soon as a minimum threshold of capacity is perceived, while others are unwilling to define a set timeframe until a country is more or less outside the risk of backsliding. Gavi does have some built in standard grace periods to ensure sudden economic growth does not jeopardize the vaccine program due to premature transition, but it has shown that under exceptional circumstances, it will be flexible with the transition timeframe. Specifically, Gavi extended Nigeria's "accelerated transition phase" from 2021 to 2028, since the country still has one of the lowest childhood vaccination rates in the world and was unprepared to fully finance vaccination.(33)

One factor that might influence the timeline of transition is the level of integration of donor-funded programs into the national health system. If a donor has set up a parallel non-integrated system—for example, a separate HIV supply chain or distinct HIV clinics—then transition to country financing of these same health services is likely to take longer.

Figure 2: Graduation period for recent IDA transitions: from first year above IDA operational income cutoff to year of graduation (25)



Note: This figure includes two "reverse graduates" that have since graduated again (Egypt and Indonesia).

3.3 Some donors view the unit of transition at the sector or program level rather than the country level

The literature often focuses on countries that will graduate from a specific donor's aid, but in some cases, the unit of transition for a donor is not necessarily the country. In some cases, it can be a specific sector (e.g., health) or program (e.g., family planning). For example, as described below, while it is typical for a country as a whole (i.e. all sectors and programs) to transition out of **IDA** support, when it comes to **USAID** support, transition may occur out of a specific health program (e.g., family planning).

The **World Bank** has clear thresholds and criteria for moving countries from IDA-only to IBRD-only. While there are several phases between these two funding scenarios, and there are some types of support that

could help ease the shift to IBRD only (e.g., loan buy downs, transitional support), a country as a whole faces an eligibility ceiling that leads to graduation across all programs. However, among some donors with broad development portfolios, health-specific transitions can be unique from other sectors and therefore the unit of transition is not always at the country level.

The **Global Fund** transitions occur at the “disease component” level. Country programs as a whole do not necessarily transition—instead, the unit of transition is a particular disease component. For example, a country can transition out of support for its TB control program but remain eligible for funding for its HIV control program.

Within **USAID**, the Bureau for Global Health has historically used a transition process for some of its programs, such as family planning. Although USAID does graduate countries out of its support (i.e., “strategic transitions”), the Bureau for Global Health began to transition particular programs in countries out of their support earlier than these broader mission closures. Over 65 health programs have been closed out by USAID, some of which have been guided by publicly shared thresholds and criteria for graduation (Table 4).⁽²³⁾ The evidence base for selection of USAID’s thresholds for transitions out of family planning programs is unclear. In addition, external assistance for family planning remains critical for achieving global reproductive maternal, newborn, and child health goals.

USAID’s transition from family planning, for example, is based on thresholds related to total fertility rate (TFR) and modern contraceptive prevalence (Table 4). Since 1965, when USAID began its support for family planning, 24 countries have graduated from family planning assistance.⁽³⁴⁾ Across these 24 countries, TFR ranges from 2.3 to 3.1 children per woman and the prevalence of modern contraception use ranges from 51-71%. However, it is unclear the extent to which these thresholds remain relevant for transition and programmatic decisions.

Table 4: USAID family planning graduation thresholds⁽²³⁾

Indicator	Imminent graduation threshold	Near-term graduation threshold
<i>Primary thresholds to trigger graduation process</i>		
Total fertility rate	Less than 3.0	Between 3.0 and 3.4
Modern-method contraceptive prevalence for married women of reproductive age	Greater than 55 %	Between 48–55 %
<i>Achievement of the above thresholds will prompt an assessment of the below thresholds</i>		
% of population who can access at least three family planning methods within a reasonable distance	At least 80%	At least 70%
Maximum share of family planning products, services, and programs subsidized by USAID	No more than 20%	No more than 30%
Major service providers (public sector, NGO, and private commercial sector) meet and maintain standards of informed choice and quality of care	Meet and maintain	Generally meet and maintain

3.4 Donors provide varying degrees of support before, during, and after transition

Pre-transition support

Regardless of the unit of transition (i.e., country, sector, or program level), many donors take steps to prepare for transition. Several donors conduct readiness and planning assessments, and then ensure that remaining funding and programming is targeted at areas of concern or bottlenecks.

Gavi, the **Global Fund**, and **USAID** all conduct transition readiness assessments (TRAs) to inform transition work planning and identify needs, gaps, and possible bottlenecks:

- **Gavi** conducts TRAs two to three years prior to when a country is expected to move from the preparatory transition to the accelerated transition phase.
- The TRA process at the **Global Fund** is led by the Country Coordinating Mechanism or another multi-stakeholder body. The assessment is typically done at least three funding cycles in advance of transition.
- **USAID** family planning and maternal and child health programs have previously provided transition planning and preparation, through TRAs, for countries facing graduations or phase-downs.

Donors without clear transition criteria and procedures are still shifting their support to better manage a sustainable program in the future. While this support is not necessarily tied to a transition policy, it is preparing countries for an era without, or with a reduced amount of, external aid and support.

- **Japan** targets grant aid to LICs, more funding as loans than as grant aid to LMICs, and technical cooperation (typically in the form of a grant with co-financing) to UMICs.
- **PEPFAR** uses the Sustainability Index and Dashboard to monitor progress against specific indicators required for a sustainable HIV program. PEPFAR's Country Operational Plans lay out in detail the gaps and areas where enhanced focus is required, as well as any required shifts from a management point of view (e.g., responsibility matrix, local partner funding targets).
- **USAID** uses the self-reliance metrics across the whole agency to assess country capacity and commitment over time.
- **DFID** uses diagnostic tools to assess country needs, with particular emphasis on a country's capacity to self-finance their own poverty reduction.

Support during and after transition

Some donors, particularly those with explicit transition policies, have transition grants available to support transitioning countries during their final phase of partnership. These grants are specific funds set aside for countries experiencing transition—these funds are separate from using up remaining or existing programmatic funds.

The **Global Fund** has a special transition funding grant that countries can receive for one additional allocation cycle (i.e., three-year period) after becoming ineligible. During the 2017- 2019 allocation cycle, the Global Fund provided \$34.8 million in transition grants to 11 countries for 12 disease components.²

Gavi provides transition grants, previously known as graduation grants, to fund the implementation of transition plans. As of 2017, 16 countries had received transition grants amounting to US\$13.6 million. Gavi has been a pioneer in finding innovative ways to continue supporting countries after they transition out of Gavi support:

- post-transition engagement support to individual countries is available to eligible countries,

² Albania received transition support for two disease components: HIV and TB.

- a Learning Network for Countries in Transition was established for peer-to-peer sharing on navigating Gavi transition,
- recently transitioned countries can access the Vaccine Procurement Practitioners Network for expert insights and guidance, and
- Gavi negotiated with several vaccines suppliers to continue access to Gavi agreed prices for selected vaccines for recently transitioned countries for up to 5 years post-transition.(35)

Beginning during the IDA 17 replenishment, the **World Bank** began providing transitional support to certain eligible countries. This funding is available to countries for the first three years after graduating from IDA. The goal of the transitional support is to minimize negative effects from the reduction in concessional funding. However, not all graduating countries receive this support. Only certain countries deemed at risk according to several key indicators are eligible. The World Bank also offers innovative financing approaches to ease the burden of moving to IBRD-only funding. For example, the loan buy-down mechanism can help reduce the loan burden on newly IBRD countries by arranging another development funder to pay a portion of the principal or the interest of the loan. This in turn reduces the cost of the loan for the recipient country (the borrower) and incentivizes the recipient country to invest more resources in a development project that it might not have otherwise invested in due to interest rate terms.(27)

Across all donors, even though a transition occurs, that does not necessarily mean that there is a funding cliff or that funding fully or immediately stops. Several donors have clear examples of continued support even after a fundamental change in the relationship has occurred (Box 4).

Box 4: Examples of continued donor support to countries post-transition

Gavi: a vaccine that was introduced during accelerated transition is not required to graduate. Gavi also can continue to provide health systems strengthening support to post-transition countries.

Global Fund: all committed funds can continue to be used throughout the remainder of any three-year allocation period.

IDA: countries can continue to spend down existing allocated IDA funds available even when they have graduated to IBRD-only status.

DFID: support to countries where DFID has exited or is planning to exit from bilateral aid can continue through centrally managed funds, such as the Conflict Stability and Security Fund or the Prosperity Fund.(36) Although not solely a DFID enterprise, these cross-governmental funds continue to provide financing channels focused on global development issues.

Japan: continues to engage with countries that have graduated from the OECD DAC list of ODA eligible recipients. According to its Development Cooperation Charter, Japan can continue to provide support to countries they deem as “developing areas,” or those countries facing particular vulnerabilities, such as small island economies, despite having achieved a high level of per capita income.(37)

4 POLICY RECOMMENDATIONS

Our new cross-cutting analysis of the policies of seven major health donors found that there is no agreed, standardized definition of what constitutes a transition of a country out of donor support for health. Indeed, there is a wide variety of terms used to describe the phenomenon, each of which may mean different things to different donors—these terms include graduation, transition, phase-out, self-reliance, exit, and country ownership.

This variation in terminology is matched by major differences among donors in the transition process itself. Donors use a variety of different indicators to trigger the transition process, they vary greatly in how explicit and formal they make their transition policies, and they adopt very different transition timelines (from long-term arrangements with fixed end dates to flexible timelines or even no timelines at all). Some donors may exit from a single health program (e.g. **USAID** from a family planning program or the **Global Fund** from a malaria control program) while still supporting other health programs or other development sectors, while other donors, such as **IDA**, exit from the country as a whole.

In shifting greater responsibility to countries for financing their own health programs, donors use a variety of different support modalities (including grants, concessional loans, technical assistance, and development partnerships). They also provide varying degrees of support to countries before, during, and after transition.

Based on these findings, we propose four key policy recommendations that we believe could help strengthen the transition process and reduce the risk of setbacks in the health sector or disease resurgence when ODA for health is withdrawn.

1. Greater definitional clarity and explicit transition approaches are needed

One challenge in examining donor policies towards transition and the factors that support transition success is that transition means different things to different donors. Some donors even avoid the word altogether, arguing that they *never* stop supporting a partner country (even when, objectively, that donor has reduced its funding support to the country). When donors' transition policies are not made explicit, or they are only for internal purposes, it becomes much harder for countries to adequately prepare for and be true partners in the transition process.

We have previously pointed out that donors are not fulfilling their commitments to the aid effectiveness agenda in the SDGs era.(38) For MICs facing transition away from aid we argued that it is critical to reiterate the aid effectiveness principle of providing predictable financing. We made the case that *“donors should as a matter of principle jointly develop transition plans with their host countries to ensure that progress towards achieving the SDGs are not stalled or reversed as a result of donor exits.”* Donors' clarity and transparency surrounding transition—including its timelines, planning, processes, and use of monitoring and assessment tools—are a critical foundation for such joint planning.

2. Donors should avoid a “one size fits all” approach—a lack of flexibility puts countries at risk

We have argued above that donors must have clear and transparent transition plans, which allow countries to adequately prepare for an increasing domestic role in health financing. Some donors, for example, have made it clear that the transition process will be triggered by a country reaching a particular income threshold. Nevertheless, while having clear policies is helpful for transition planning, at the same time we believe that donors should avoid being too rigid, as a “one size fits all” policy could end up being harmful to countries that are clearly not ready for full transition.

There is some merit to flexibility and allowing for context-specific transition approaches. A good example is **Gavi's** agreement to extend support to Nigeria from 2021 to 2028, based on exceptional circumstances. At the time that the extension was granted, Seth Berkley, Gavi's Chief Executive Officer, said: "With 4.3 million under-immunized children, Nigeria has the highest number of children in the world who are not fully protected against deadly vaccine-preventable diseases. This has also contributed to major recent outbreaks of diseases such as yellow fever, meningitis and cholera."⁽³³⁾ If Nigeria had been forced to transition under these circumstances, there would have been a high risk of back-sliding on vaccination coverage and of disease resurgence. Similarly, while **IDA** has several clear indicators prompting transition, it prides itself on taking a flexible approach.

3. Evidence should be generated and shared on which transition modalities work best and under which circumstances

Several donors have taken great strides to define a clear approach to transition and have developed transition specific mechanisms, such as grants, learning networks, or TRAs. However, given the relatively recent nature of transitions, there is little empirical evidence available on what makes for a "successful" transition. We believe that it would be enormously valuable for all health donors to evaluate their practices and share lessons learned. Innovations in transition support, such as **Gavi's** Learning Network for Countries in Transition, should also be evaluated to assess whether these should be widely replicated.

We recently conducted a scoping review on the health systems impacts of transition, and we found very few high quality, empirical studies on the phenomenon of aid transition.⁽⁶⁾ The state of the scientific evidence on what works best remains remarkably weak. Given that transition is now firmly under way, in multiple settings involving multiple donors and countries, there is clearly an urgent need for evidence to guide the transition process. In particular, donors are using a variety of different support modalities in the transition and post-transition period, and there is almost no evidence indicating which works best under which circumstances.

4. Donors should communicate with each other and avoid transitioning at the same time

Our analysis found that those donors that have explicit policies all use income level as one of the key indicators for a country's transition readiness. However, there is a risk that if common indicators are used across multiple donors, simultaneous transitions are possible, leaving a country even more vulnerable. Our interviews with key informants suggested that donors do not take a country's overall levels of donor support into account when making their transition decisions. We found that there is little communication between donors when it comes to transition planning.

This risk of multiple, simultaneous transitions was illustrated starkly in a July 2018 analysis by Rachel Silverman at the Center for Global Development called *Projected Health Financing Transitions—Timeline and Magnitude*.⁽³⁹⁾ Silverman projected country transitions to 2040 from **Gavi**, **IDA**, the **Global Fund**, **PEPFAR**, and the **Global Polio Eradication Initiative**. She found that "a handful of countries face many major transitions within a very narrow time frame—and the cumulative fiscal effect may be substantial, even if each individual transition should be manageable." We agree with Silverman's recommendation that "instead of focusing narrowly on managing their own disease-specific transitions, global health funders should work cooperatively with countries to better understand the sequencing and magnitude of transitions, drawing on country-specific fiscal and programmatic context." An overarching coordination mechanism for donors could be valuable to promote simultaneous transitions. Such a mechanism would not of course dictate individual donor approaches to transition, but rather coordinate and cooperate in transition countries and in transition planning. The Global Action Plan for Healthy Lives and Well-being for All, especially its financing accelerator, could potentially play this role.

5 CONCLUSIONS

As more low-income countries transition to middle-income status, transitions away from donor support for health will become an increasingly important phenomenon to understand. This study helps fill a research gap on health-focused donor transition processes and policies. These findings have important policy implications for both donors and countries who are beginning to navigate this increasingly important yet understudied phenomenon.

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● APPENDIX 1. OVERVIEW OF KEY DONOR TRANSITION STUDIES

Study	Focus	Definition of transition	Relevant findings
Exit from aid: an analysis of donor experiences (40)	Donors: bilateral Sector: Cross-cutting/agency-wide	Exit: 1) when a country no longer meets eligibility criteria, or 2) when programs are no longer in place/assistance no longer demanded Transition: the period when financial and programmatic instruments evolve	Three categories of donors in relation to transition policies: 1) No policy; 2) Informal; and 3) Formal.
Progress in Peril? The Changing Landscape of Global Health Financing (41)	Donors: Multilateral Sector: Health Country case studies: Côte d'Ivoire, Nigeria, Vietnam	"Transition" was referred to in two ways. 1) the reduction of external financing typically over a period of two to five years 2) When countries are likely to face "significant changes in their ability to access external funding to priority health areas" in the next 5 years.	Requirements for a successful transition: strong health systems; strong coordination at country and global levels; transparency and predictability; political will and a country-driven process; post-transition support and safeguarding for vulnerable populations. For funders: change eligibility and transition policies to fully incorporate health and sustainability indicators; provide targeted, equity-focused post-transition support and feedback mechanisms.
Projected Health Financing Transitions: Timeline and Magnitude (39)	Donors: Multilateral (Gavi, Global Fund, IDA, GPEI), one bilateral (PEPFAR) Sector: Health	None provided, but language implies significant financial shifts from donors. Uses each organization's self-defined transition approach/process.	There appears to be a clear sequencing of transition: GPEI tends to transition first, Gavi and IDA overlap, then PEPFAR, then Global Fund tends to come last given it tends to transition later in a country's economic development phase.

<p>Sustainable Transition From Donor Grant Financing: What Could It Look Like? (12)</p>	<p>Donors: Multilateral (Global Fund, Gavi, IDA), one bilateral (USAID family planning)</p> <p>Sector: Health</p> <p>Region: Asia Pacific</p>	<p>None provided, but language emphasizes financial shifts: <i>“Donor transition is an important aspect of sustaining the impact of donor investments after financial support has ceased.”</i></p>	<p>Eligibility and transition are often conflated. In theory, eligibility policy is a starting point for understanding transition policy. However, having an eligibility policy in place is not the same as a transition policy – an eligibility policy does not outline how to manage ineligibility.</p> <p>Policy recommendations: future sources of health financing need to be identified following donor exit; explicit and transparent transition policies are needed; a clear timeline for transition, with flexibility, is critical; donors should coordinate on transition; transition policy should be equitable both in terms of income and burden of disease; evaluate long-term impact of earlier grants; ensure flexibility.</p>
<p>Transitioning from External Aid and Ensuring Sustainability of UHC (42)</p>	<p>Perspective: Country</p> <p>Sector: Health</p> <p>Countries included: Kyrgyzstan, Myanmar, Nepal, Panama, Papua New Guinea, Sri Lanka, and Zambia.</p>	<p>No clear definition of transition provided. However, language used in introduction provides some context: <i>“An increasing number of countries are currently or will soon be transitioning to reduced external funding due to changes in the income status of countries according to economic development, improved health outcomes, and shifting priorities of donors.”</i></p>	<p>Transition can be due to income, health indicators, or shifting donor priorities.</p> <p>Several factors can lead to a donor exit: capacity/self-reliance, unilateral decision, and/or fewer priority countries.</p> <p>Core transition challenges: coverage of vulnerable populations, governance of donor-funded programs, generation of domestic revenues, participation of private sector, mutual accountability, capacity of development partners.</p>

● APPENDIX 2. SAMPLE INTERVIEW GUIDE

1. How does your organization think about country transitions away from aid? How has this approach changed over time?
2. What terms are used to describe this phenomenon? (i.e. graduation, exit, phase out, etc.)
3. What influences transition decision-making? Who determines the criteria used? Are these criteria weighted?
4. How do transitions relate to country eligibility? For example, if a country no longer meets the fundamental eligibility criteria, does support for this country by default end?
5. If your organization provides support beyond health specific support, do health sector transitions differ from transitions for other sectors?
6. At what level do graduations occur (i.e. by country, by program, subnational)?
7. Do you take into consideration the transition policies of other donors when making funding allocation and/or transition decisions? If so, does it matter if it is a multilateral or bilateral donor?
8. Are there tools used to aid in transition decisions? If so, are these publicly available?
9. What is the timeline of “transitions”? Is it agreed upon in advance with the country?
10. Does your organization produce country transition projections? Are these made publicly available? If not, could you explain the type of factors used to make these projections?
11. Is there any specific transition funding channel/mechanism? Is there any transition/sustainability funding available embedded within the grant/loan?
12. Is there a comprehensive list of countries who have graduated/transitioned away from your organization’s support? Is it possible to share this with us?
13. How have these exits/transitions influenced the way you think about transitions?
14. What comes after a donor exit from a country? What options are available to countries?
15. After a transition, how does your organization think about the funds that are “freed-up”? How will these funds be reallocated?
16. Do you anticipate any major changes related to your approach to transitions in the next couple of years?
17. How has your approach to health support shifted in light of other major changes in global health like disease shifts, demography changes, and increasing domestic resource mobilization?
18. Is there anyone else from your organization you suggest we speak with?

● APPENDIX 3. SUMMARY OF DONOR TRANSITION APPROACHES

For full profiles of each donor, visit <http://centerforpolicyimpact.org/our-work/the-4ds/4ds-donors/>.(20)

Donor	Short description of transition approach
<i>Multilateral</i>	
Gavi	Gavi has a clear transition policy and approach for countries based on their GNI p.c. Transition is approached through four distinct ‘phases’, each of which has clear corresponding criteria that must be met. When a GNI p.c. threshold is met, Gavi begins to shift financial responsibility over a fixed time duration to the government. Although explicit, Gavi’s transition policy makes exceptions for countries that experience rapid spurts in economic growth within a short time frame to ease the responsibility of their co-financing obligations.
The Global Fund	The Global Fund also has a clear and explicit policy. However, its policy is contingent on both the income level of a country, based on GNI p.c. measures, and the burden of disease for its three disease components (HIV, TB, and malaria). Transitions can happen at either the country level when an income threshold is reached (e.g., high-income) or at the disease component level (e.g., malaria).
The World Bank, IDA	The World Bank has a clear policy for when countries are no longer eligible for IDA financing and should become eligible for International Bank for Reconstruction and Development (IBRD) funding. There are several interim stages a country can move through once it meets the thresholds for IDA financing that smooth the transition process. These interim steps are not time contingent and vary based on a variety of other indicators that the World Bank takes into consideration. Although the policy is explicit, there are several flexibilities that take into consideration country context. IDA also allows for ‘reverse graduations,’ so that a country that has moved to IBRD only and experiences backsliding can regain IDA eligibility.
<i>Bilateral</i>	
DFID	DFID has transitioned out of several countries in recent years, guided by evidence generated for its 2011 and 2016 bilateral aid reviews. However, these transitions were conducted in an ad-hoc way, rather than being guided by an institutionalized policy. DFID does not treat health sector transitions separately from an overall country transition.
Japan	Japan views the ODA eligibility list as the primary governing mechanism for country exits. However, Japan uses different instruments to respond to the changing needs and capacity of countries, primarily based on their income level. In general, LICs and LMICs receive a greater share of Japan’s ODA grants whereas UMICs are often provided with loan-based support or technical assistance.
PEPFAR	PEPFAR has never fully left a country and has not designed an approach to govern country exits. However, PEPFAR has begun to lay the groundwork for sustainably shifting responsibility to the government and local partners through mechanisms such as the Sustainability Index and Dashboard and the responsibility matrix. PEPFAR has three different types of country support: long-term strategy, targeted assistance, and technical cooperation. Each of these support types are tailored to country needs based primarily on the status of the country’s epidemic and its national capacity to manage the epidemic.
USAID	Among the bilateral agencies we studied, USAID is the only bilateral donor that has a formal policy for transitioning health programs in a standalone way. Within health, most transitions have occurred among the family planning program. The broader agency has experienced “strategic transitions” at the country level, although these have been on an ad-hoc basis given that there is no explicit agency-wide approach to govern these types of decisions. Health program transitions, thus far, have pre-dated such country-wide approaches. However, given the recent redesign of USAID policy around “self-reliance” it is unclear if these health program-specific transitions will continue as they have in the past.