Sustainability Planning for HIV/AIDS, Tuberculosis, and Malaria Programs in High Impact Africa Countries

Guidance for the Global Fund on How to Support a Successful Transition to Domestic Financing

Acknowledgments

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Key Terms

absorb/incorporate. In the health context, the process by which a donor-funded program or components of such a program become the responsibility of a domestic government agency, through merging into existing health system arrangements. Program components may include service delivery, health workforce, information systems, procurement, and/or data reporting and monitoring.

basis for entitlement. In health financing, the constitutional, legal, or operational foundation on which an individual has the right to receive health benefits. Basis for entitlement takes two main forms: 1) *contributory-based entitlement*, in which a person's right to benefit from a health coverage program derives from a contribution made by or on behalf of that person (an insurance contribution) and 2) *noncontributory-based entitlement*, in which the entitlement to health services or benefits does not derive from a specific contribution but rather on another basis such as citizenship, residency, poverty status, age, or a particular health condition or intervention.

benefit package. The specified package of services that will be covered using government funding (through any health financing arrangement, not only national health insurance) and made available to all or to a defined subset of the population for free or with a copayment for a portion of the cost.

efficiency. In the health context, getting more or better results from existing health spending as a result of improved resource allocation (more of overall spending going to the right things) and/or better use of resources that are already allocated. *Results* in this context can mean improvements in effective coverage[1] of interventions for any or all diseases targeted by the given level of health spending.[2]

fiscal/budgetary space. Room in a government's budget that allows the government to allocate resources for a desired purpose without jeopardizing the sustainability of its financial position or the stability of the economy.[3]

[1] Increase in the probability that someone who needs a health intervention will get it and will see their health improved (maintained, palliated, etc.) as a result. The concept combines quality with equity relative to need. See Shengelia B, Tandon A, Adams OB, Murray CJL. Access, utilization, quality, and effective coverage: an integrated conceptual framework and measurement strategy. *Social Science & Medicine*. 2005;61(1):97–109. https://doi.org/10.1016/j.socscimed.2004.11.055.

[2] Spending and health improvement should be assessed at the system level (for expenditures) and the population level (for health improvement) rather than simply within programs and defined beneficiary groups. Thus, the concept of efficiency must incorporate spillover effects (e.g., whether the emphasis on one particular disease may have negative implications for other interventions such as immunization or attended deliveries) and cross-program considerations (e.g., embedding particular program elements within the overall system to capture whether the health system is running separate information systems for each program).

[3] Barroy H, Gupta S. Fifteen years later: moving forward Heller's heritage on fiscal space for health. *Health Policy and Planning*. 2021;36(8):1239–1245. https://doi.org/10.1093/heapol/czab033.

general revenue. Money that a government raises through personal income taxes, taxes on corporate income and profits, value-added and sales taxes, duties and import taxes, property and inheritance taxes, payroll taxes, and/or taxes on profits from the sale of natural resources. These revenues are typically pooled into a consolidated fund and appropriated toward payment of public expenses through regular budgeting and planning cycles.

government co-financing. The government share of expenditure on or investment in health and the cost of key health programs, including those supported by donors such as the Global Fund. The Global Fund requires progressive government co-financing, with the amount and focus based on the country's income classification and context.

national health insurance (NHI). A label that countries attach to their health reform strategy or a particular health agency. While there is no standard definition of NHI, it typically involves a separate agency under the ministry of health or other ministry, a dedicated funding stream tied to a defined package of services (benefit package) through output-based health provider payment (payment linked to the delivery of services rather than input-based line-item budgets), and conditions of entitlement for coverage, such as payment of a premium by or on behalf of an individual.

public financial management (PFM) system. A system in which financial resources are planned, allocated, and controlled to enable and influence delivery of public services. PFM includes all phases of the budget cycle, including budget preparation, internal controls and auditing, procurement, monitoring and reporting, and external auditing.

purchaser-provider split. An institutional arrangement in health financing under which the responsibility for allocating prepaid resources to providers on behalf of all or on behalf of specific groups within the population is assigned explicitly to one or more agencies. The purchasing agency or agencies contract with (public and/or private) providers, and the providers have a degree of flexibility with respect to the internal management of their revenues. Thus, provider payment methods are related to service delivery outputs rather than rigid input-based line-item budgets.

social health insurance. A health financing arrangement that is a subset of NHI and in which coverage is mandatory for the entire population or a subset of the population, entitlement to covered services is linked to a contribution made by or on behalf of an individual (typically through a payroll tax or premium payment), and the pooling of these funds and purchasing of health services is carried out by a government or government-regulated body or bodies. In countries marked by high levels of informal employment, social health insurance coverage is generally low, arising from the contributory-based nature of entitlement.

strategic health purchasing. Using evidence and information about population health needs and health provider performance to make decisions about which health services should have priority for public funding, from which providers those services should be accessible, and how and how much providers should be paid to deliver these services.

sustainability. In the health context, the ability of a health system to both maintain and scale up effective service coverage to a level in line with the epidemiological context and to assess and analyze it on a systemwide basis. This provides for continuing control of public health problems and supports efforts to eliminate the three diseases targeted by the Global Fund, even after removal of external funding from the Global Fund and other major external donors.

transition. In the health context, the process by which a country or part of a country moves toward fully funding and implementing its health programs independent of support from the Global Fund and other external donors while sustaining gains and scaling up as appropriate.

universal health coverage (UHC). Ensured access to essential health services for an entire population without risk of financial hardship or impoverishment.

Introduction

Many low- and middle-income countries are in the midst of multiple health sector transitions—epidemiological and demographic transitions, transitions away from donor financing of health programs, and transitions in how health services are financed and delivered. All of these transitions can pose challenges as well as provide opportunities for sustaining and improving the coverage, quality, and efficiency of priority programs such as those that address HIV/AIDS, tuberculosis (TB), and malaria (together referred to as *HTM*).

The major global health agencies—including the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)—have put sustainability at the forefront of their strategies and investment policies, with *sustainability* referring to the maintenance of national responses to major health threats as donor funding declines or ends.[4,5,6] While each global health agency has its own definition of sustainability for its programs and its sustainability planning (Box 1), the dialogue on sustainability at the country level should be grounded in a systemwide view of domestic health financing and service delivery.

[4] Global Fund. Guidance Note: Sustainability, Transition and Co-financing. Allocation Period 2023–2025. Geneva: Global Fund; 2022. https://www.theglobalfund.org/media/5648/core_sustainabilityandtransition_guidancenote_en.pdf.

[5] Gavi, the Vaccine Alliance website. The sustainability goal (phase 5) page. https://www.gavi.org/our-alliance/strategy/phase-5-2021-2025/sustainability-goal. Accessed October 21, 2023.

[6] US Department of State website. The US PEPFAR Five-year Strategy 2022 page. https://www.state.gov/pepfar-five-year-strategy-2022/. Accessed October 21, 2023.

While sustainability must address both financing and programmatic aspects of national HTM efforts, dialogue around domestic financing has often been treated as simply an issue of identifying potential sources of fiscal space to fund HTM programs. However, domestic health financing arrangements are often complex and rapidly evolving. Where a country is in this evolution will determine the kinds of opportunities it has to strengthen domestic systems so they can absorb and efficiently implement donor-funded programs and sustain improvements in health outcomes.

Best practice calls for countries to plan and implement improvements in effective coverage based on how they can most efficiently and equitably finance and deliver priority services regardless of support from the Global Fund or any other external partner. Seeking efficiencies within and across programs as early as possible and well before transition can increase the likelihood of sustained coverage improvements. This involves:

Box 1. The Global Fund's Sustainability, Transition, and Co-Financing Policy

The Global Fund works to help countries achieve long-term sustainability of their national HTM efforts after Global Fund support ends. The Global Fund partnership aims to take a holistic approach to sustainability, at both the program and financing levels. The Global Fund's Sustainability, Transition, and Co-Financing (STC) Policy formalized the Global Fund's approach to strengthening sustainability, enhancing domestic financing and co-financing, and supporting countries in preparing for transition away from Global Fund financing.[4] The purpose of the STC Policy is to help countries better invest external financing and mobilize domestic resources to strengthen health systems and address critical sustainability and transition challenges.

The STC Policy recognizes that comprehensive approaches to strengthening health system financing are needed to achieve sustainability—that is, to "maintain and scale up coverage to a level - in line with epidemiological context - that will provide for continuing control of a public health problem and will support efforts for elimination of the three diseases, even after funding from the Global Fund or other major external donors comes to an end."[4]

- Exploring opportunities to consolidate elements of HTM interventions within the broader health system where it is feasible and cost-effective to do so
- Strengthening procurement, supply chain, and service delivery models at the level of the entire health system rather than solely by program
- Updating public financial management systems to allow the use of strategic health financing policy tools (such as benefits specification, health technology assessment, contracting, provider payment, and performance monitoring) and adapting them to incorporate donor-funded services and program components

All of this demands a holistic approach to sustainability planning across the health sector and across donor-funded programs, as well as careful planning for incorporating each program component into domestic systems. However, vertical approaches to sustainability remain the norm, and sustainability planning by the Global Fund and other donors is often fragmented and independent of a country's broader health sector sustainability planning and health service delivery and financing reforms. When donor agencies are coordinated in their approach to sustainability in support of government plans and priorities, their

funding and technical assistance can align behind these priorities and be directed toward strengthening these domestic systems.

This guide offers suggestions on how dialogue and supporting analytics can help identify and strengthen sustainability pathways grounded in domestic health financing arrangements. While the Global Fund is not in a position to lead health financing dialogue in a country, its sustainability planning process and investment approaches should clearly contribute to and align with sector-wide dialogue and planning processes grounded in the country's domestic health financing arrangements and reform plans.

Purpose of This Guide

This guide provides suggested approaches and analytical tools for implementing the Global Fund's Sustainability, Transition, and Co-Financing (STC) Policy in High Impact Africa countries (Box 2).[7] It is meant to support structured dialogue to inform policy decisions that can help sustain progress on programs that address HIV/AIDS, tuberculosis, and malaria as donor funding declines or ends, given the context of a country's health financing system and reform plans. The dialogue will be most useful if it is embedded in ongoing health financing and service delivery reform processes.

Box 2. High Impact Africa Countries

High Impact Africa 1	High Impact Africa 2
Burkina Faso	Ethiopia
Côte d'Ivoire	Kenya
Democratic Republic of the Congo (DRC)	Mozambique
Ghana	South Africa
Mali	Tanzania
Nigeria	Uganda
	Zambia
	Zanzibar
	Zimbabwe

Although the target audience is Global Fund staff and consultants, the dialogue should be led by and engage domestic actors—such as a country's ministry of health, ministry of finance, health agencies and other stakeholders, national health insurance and other health funding agencies, civil society organizations, and other global health initiatives and implementing partners active in the country.

The specific goals of the guide include:

- Providing guidance to the Global Fund on implementing its STC Policy in High Impact Africa countries
- Encouraging and guiding a more holistic approach to sustainability planning that embeds health programs in overall domestic current and planned health financing and service delivery arrangements as countries transition from donor support for a range of HTM programs

[7] Note that sources treat semiautonomous Zanzibar differently; "United Republic of Tanzania" refers to Tanzania and Zanzibar.

- Supporting policy dialogue and analytics that can inform country-led decisions about sustaining increased coverage of the services supported through the Global Fund and other donors by incorporating them effectively and efficiently into domestic health financing arrangements—including decisions about which domestic health financing arrangement should absorb which programs and program components, as well as how to design specific health financing policy tools to incorporate donor-funded services and program components
- Providing guidance to the Global Fund on where to focus future grants to ensure that they align with current and planned domestic health financing arrangements and broader health system reforms

The guide's approach is grounded in the dynamics of country health financing and service delivery systems and includes several key elements:

- **Country-led dialogue.** The approach supports structured dialogue in High Impact Africa countries to facilitate stakeholder consensus and buy-in on how to continue improving the coverage, quality, and efficiency of HTM and other donor-funded programs in the context of the country's health service delivery system and domestic health financing arrangements.
- **A systemwide perspective.** The approach calls for absorbing all priority programs, whether funded domestically or by donors, into the health system rather than maintaining individual vertical programs.
- **Support for informed decision-making in mixed health financing systems on the following issues:**
    - Which agency will have primary responsibility for financing and purchasing specific commodities and services when donor funding declines, based on ability to ensure sustainable financing, universal access to services, efficiency gains, and quality improvements
    - Which program elements (e.g., procurement, service delivery, information systems, performance monitoring) should be consolidated across programs and/or within the broader health system
    - How PFM and health financing arrangements can effectively and efficiently incorporate program components and how these components can be strengthened, better integrated, and made more efficient regardless of the main source of financing.
- **Donor investments that support health systems strengthening.** The approach calls for Global Fund grants and investments to support health systems in achieving greater efficiency and therefore greater ability to sustain increased coverage.

This document was developed using a mix of methods, including a review of existing tools and guidance on sustainability and transition planning; targeted stakeholder interviews with global partners, technical experts, and country stakeholders; and development of

country case studies on relevant topics. Annex A provides more detail on the development of the guide.

The issues addressed in this guide are relevant to sustainability planning for priority health programs in many low- and middle-income countries with mixed health financing systems, but the guide was developed with special attention to High Impact Africa countries.

How This Guide Is Organized

The guide has three main parts.

Part 1: Conducting a Situational Analysis provides guidance on understanding where the country is in terms of both the magnitude of its sustainability challenge and the evolution of its health financing system in order to identify possible entry points for the sustainability dialogue.

Part 2: Determining How to Absorb Donor-Funded Programs into Domestic Financing Arrangements provides a set of key issues and questions to explore through country-level stakeholder dialogue and supporting analysis. These issues and questions concern which financing arrangements will absorb which programs and program components and how to strengthen those financing arrangements.

Part 3: Recommendations to the Global Fund on Supporting System Strengthening for Sustainability offers options for how the Global Fund could direct future investments based on the decisions and plans made for absorbing programs and program components into domestic financing systems.

Mixed Health Financing Systems: Challenges and Opportunities

All countries need to plan for the sustainability of donor-funded programs—including HTM programs—as donor funding decreases, not only in terms of making sufficient domestic resources available for these efforts but also to ensure that funding can be used efficiently for commodity procurement and service delivery. Incorporating donor-funded programs into domestic financing arrangements involves clearly allocating responsibility for all program components among domestic agencies—including determining which agencies will be responsible for forecasting, budgeting, financing, procuring commodities, and paying for and delivering community-based services—so no parts are left behind during the transition.

Many High Impact Africa countries have mixed health financing arrangements in which government budget financing of health facilities co-exists with other financing arrangements, such as a national health insurance (NHI) scheme or results-based financing (RBF) programs. Many of the countries have implemented or are planning to introduce an NHI scheme as part of the government's universal health coverage (UHC)

commitments, although evidence on the effectiveness of this approach is mixed (Box 3).[8] The existence of diverse revenue sources, purchasing agencies, and entitlement mechanisms can provide opportunities for sustainably financing the services currently provided through donor-funded programs. They can sometimes enable innovation in areas such as provider payment, private-sector engagement, and channeling of budget or donor funding through NHI.

Box 3. NHI Systems and Sustainability Planning for HTM Programs

Low- and middle-income countries are increasingly introducing NHI systems as a way to make progress toward UHC. Nine of the 15 High Impact Africa countries have either implemented an NHI system (Burkina Faso, Côte d'Ivoire, Ethiopia, Ghana, Nigeria, Tanzania, and Zambia) or have draft legislation to establish one (Uganda and South Africa). NHI has no standard definition—rather, it is a label that countries attach to their health reform strategy or a particular agency. What is common across the countries using the NHI label is the existence of (or a plan for) an agency that has responsibility for purchasing health services on behalf of the covered population. The purchasing agency is institutionally distinct from the providers (in what is known as a *purchaser-provider split*), requiring a contract between them. The channeling of some (and sometimes all) general budget revenues into the scheme conveys an intent to include the entire population in the program, hence making it "national" in nature.

In practice, NHI schemes look quite different across countries. For example, NHI in Ghana is mainly a contributory-based entitlement, funded from a mix of mainly general tax revenues and individual insurance contributions. In contrast, the basis for entitlement in the proposed NHI program in South Africa would be fully noncontributory, funded from general tax revenues.

Many low- and middle-income countries with national health insurance see these systems as a way to absorb donor-funded programs into domestic financing arrangements as donor funding declines. As is the case with all mixed health financing arrangements, absorbing HIV, TB, malaria, and other donor-funded programs into NHI systems presents both opportunities and challenges that warrant careful exploration and assessment based on the country context before responsibility for any or all program components is shifted to NHI agencies and budgets. This guide can help inform and guide that decision-making process.

On the other hand, mixed health financing systems can also present risks to access to and delivery of these services. One area of risk is when access to priority services is channeled through a financing scheme, such as NHI, when coverage has not reached the entire population. This can create a challenge in reaching the unenrolled population with services—even if the government has committed to making those services free for everyone. Another area of risk is when roles and responsibilities across different financing agencies and other key actors are not clearly defined and some key functions of the programs fall through the cracks or are duplicated.

Historically, approaches to sustainability and transition planning by the Global Fund and other major donor agencies have paid insufficient attention to the structure and mechanisms of health systems, particularly those with mixed financing arrangements.

[8] Cashin C, Dossou JP. Can national health insurance pave the way to universal health coverage in sub-Saharan Africa? *Health Systems & Reform*. 2021;7(1):e2006122. https://doi.org/10.1080/23288604.2021.2006122.

Furthermore, sustainability planning has generally focused on how to make a specific program sustainable, with a focus on estimated resource requirements to replace donor funds for that program and broad fiscal space analysis to identify potential sources of domestic funds. This approach sometimes neglects to take into account current and evolving health financing arrangements and the opportunities and challenges of incorporating aspects of disease programs into different financing schemes. The disease-specific focus has also led in many cases to calls for disease-specific revenue sources, which may bring in modest additional resources at best while adding to fragmentation and inefficiency in health financing.[9]

Rather than focusing on the simplistic goal of replacing Global Fund revenue for disease programs, the sustainability planning process can address issues holistically through sector-wide dialogue and planning that considers how programs will be absorbed into domestic health financing systems, identifies potential efficiency gains, and possibly leads to broader structural reforms.

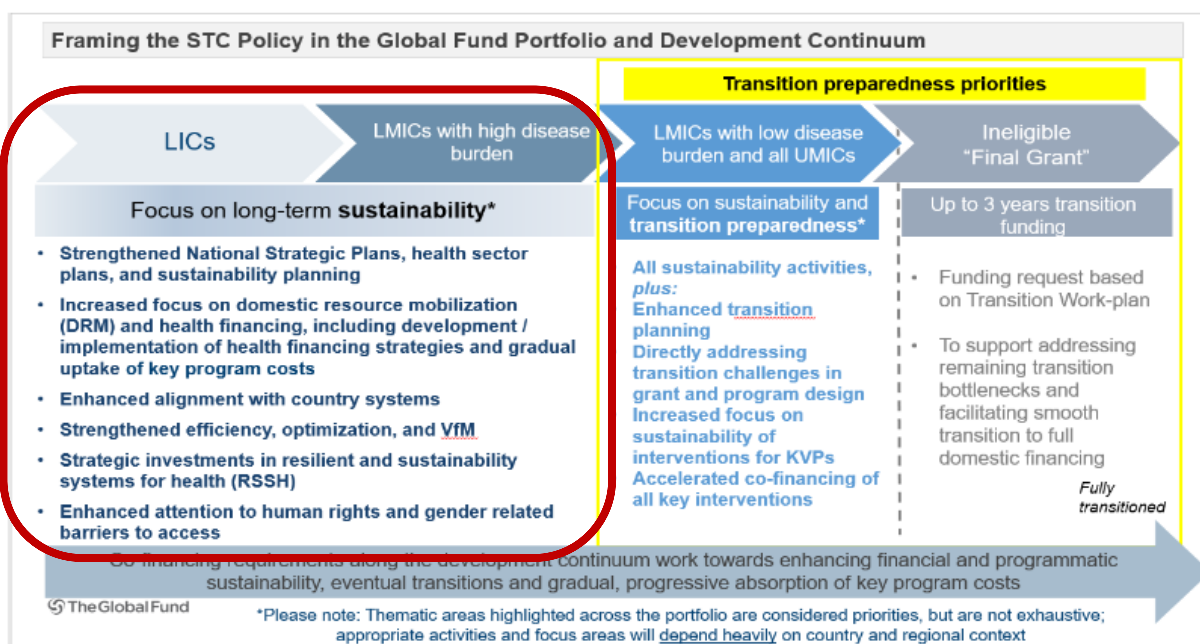
Health Financing Landscape in High Impact Africa Countries

In 2012, the Global Fund organized three new departments (High Impact Africa 1, High Impact Africa 2, and High Impact Asia) to manage its grants to countries with the highest HTM disease burden and where Global Fund investments could produce the greatest results despite significant risks. This reorganization was intended to enable more targeted Global Fund contributions to reduce morbidity and mortality in these three groups of countries.

Most High Impact Africa countries are still years away from the end of Global Fund support, but sustainability planning well ahead of transition can prevent ill-considered last-minute decisions about incorporating financing and service delivery into domestic systems. The Global Fund's STC Policy provides guidance on areas of focus to prepare for long-term sustainability in low-income countries and lower-middle-income countries with a high disease burden (Figure 1). All High Impact Africa Countries fall into this category.

[9] Atun R, Silva S, Ncube M, Vassall A. Innovative financing for HIV response in sub-Saharan Africa. *Journal of Global Health.* 2016;6(1):010407. https://doi.org/10.7189/jogh.06.010407.

Figure 1. Guidance from the Global Fund's STC Policy on Areas of Focus for Long-Term Sustainability Planning



Adapted from Global Fund Guidance Note: Sustainability, Transition and Co-financing, 2022. See [www.theglobalfund.org/media/5648/core_sustainabilityandtransition_guidancenote_en.pdf.](www.theglobalfund.org/media/5648/core_sustainabilityandtransition_guidancenote_en.pdf)

Of the 15 countries in the combined High Impact Africa regions, eight are classified as lower-middle-income, six are low-income, and South Africa is the only upper-middle-income country. Table 1 shows the countries by income group and disease classification for HIV, TB, and malaria. Every country has a high burden of each of the three diseases except Burkina Faso (not high for TB) and South Africa (not high for malaria).

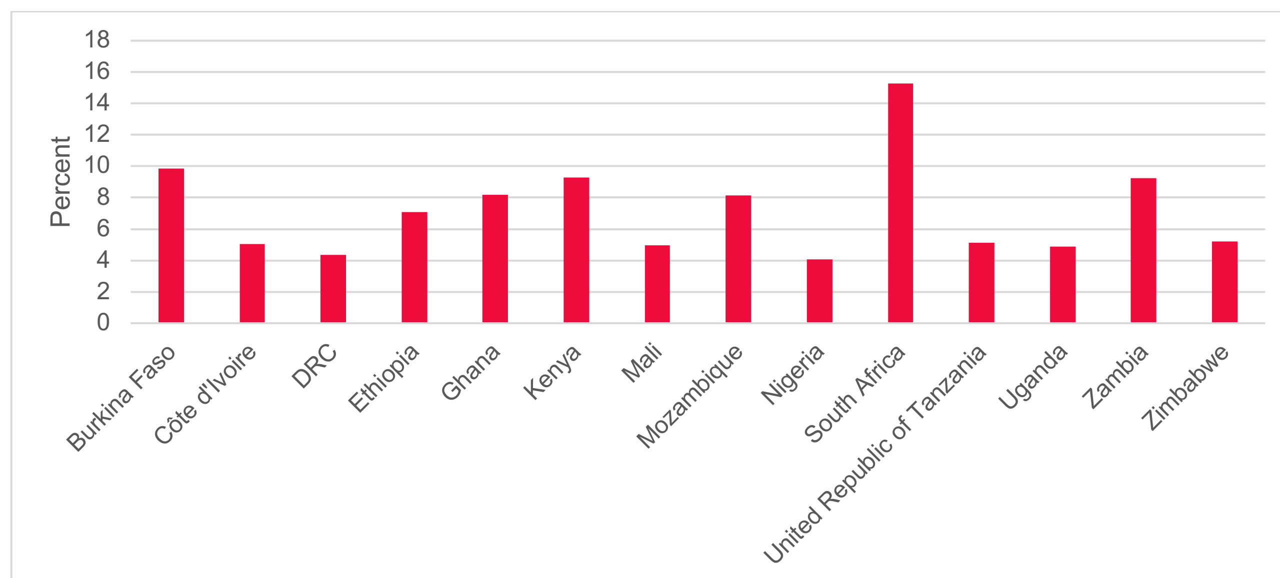
Table 1. Income and Disease Classification

Country	Income Group	HIV	TB	Malaria
Burkina Faso	Low	High	Not high	High
Côte d'Ivoire	Lower-middle	High	High	High
Democratic Republic of the Congo	Low	High	High	High
Ethiopia	Low	High	High	High
Ghana	Lower-middle	High	High	High
Kenya	Lower-middle	High	High	High
Mali	Low	High	High	High
Mozambique	Low	High	High	High
Nigeria	Lower-middle	High	High	High
South Africa	Upper-middle	High	High	Not high*
Tanzania	Lower-middle	High	High	High
Uganda	Low	High	High	High
Zambia	Lower-middle	High	High	High
Zanzibar	Lower-middle	High	High	High
Zimbabwe	Lower-middle	High	High	High

*South Africa is not eligible for malaria grants

General government expenditure on health is low throughout the High Impact Africa region, as shown in Figure 2. South Africa is the only country in the region with more than 10% of its government expenditure going to health, estimated at 15.3% in 2021. Burkina Faso, Kenya, and Zambia each spend close to 10%. DRC and Nigeria have the lowest spending as a percentage of general government expenditure, at 4.3% and 4.1%, respectively.

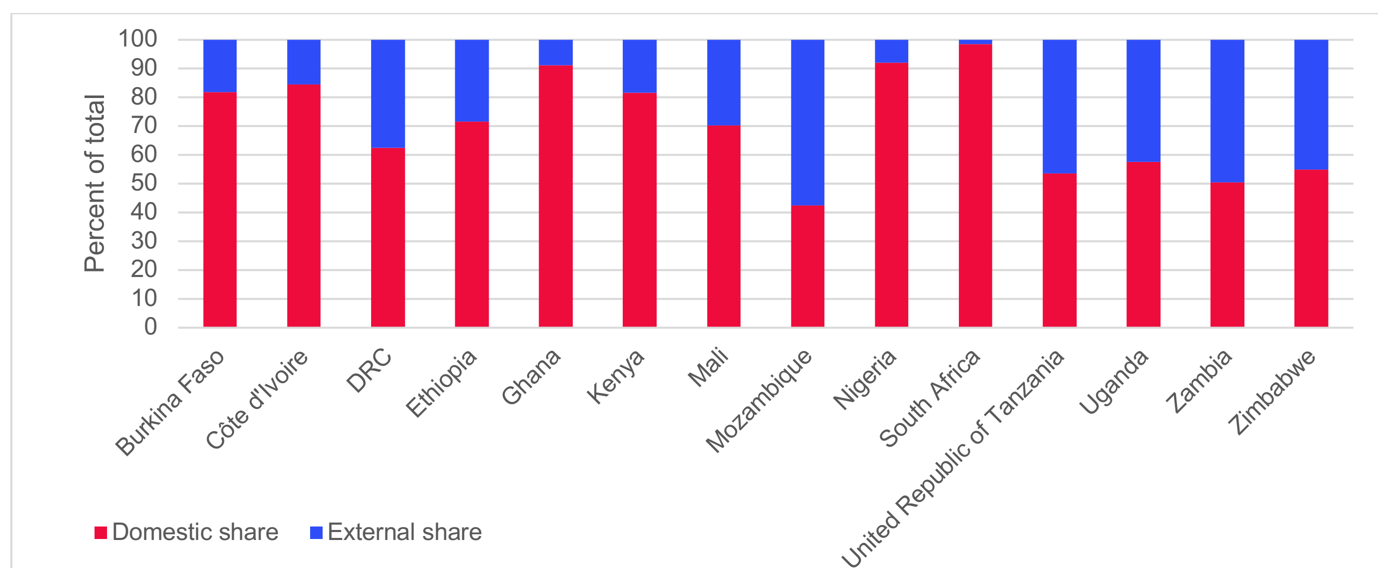
Figure 2. Domestic Public Health Expenditure as a Percentage of General Government Expenditure (2021)



Source: WHO Global Health Expenditure Database (accessed December 19, 2023)

External financing for health constitutes a major portion of health expenditure in High Impact Africa countries, as shown in Figure 3. Notably, Mozambique relies on external funding for well over half of its current health expenditure, at 58% in 2021. Tanzania, Uganda, Zambia, and Zimbabwe all come close to half, at 46%, 42%, 49%, and 45%, respectively.

Figure 3. External vs. Domestic Shares of Current Health Expenditure (2021)



Source: WHO Global Health Expenditure Database (accessed December 19, 2023)

TB Funding

High Impact Africa countries are especially dependent on donor support for TB (Table 2). Dependence on external funding for TB is highest in Zimbabwe and Mali, with 96% and 93% donor funding, respectively. Ethiopia, Ghana, Burkina Faso, and DR Congo also receive 90% or more of their TB funding from donors. On the other end of the spectrum, the donor share of TB funding in Côte d'Ivoire, Kenya, and Zambia is 39%, 51%, and 54%, respectively.

Table 2. Estimated TB Funding: Total, Domestic, and External (2021, as Reported by Countries)

Country	TB Funding (US$ millions)	% Domestic	% External
Burkina Faso	$2	8%	92%
Côte d'Ivoire	$12	61%	39%
DR Congo	$26	8%	92%
Ethiopia	$68	10%	90%
Ghana	$8	9%	91%
Kenya	$30	49%	51%
Mali	$10	7%	93%
Mozambique	$30	12%	88%
Nigeria	N/A		
South Africa	N/A		
Tanzania (United Republic)	$29	14%	86%
Uganda	$26	13%	87%
Zambia	$37	46%	54%
Zimbabwe	$21	4%	96%

Source: WHO Global Tuberculosis Report 2022, Annex 4

Malaria Funding

High Impact Africa countries generally receive a high percentage of external funding for malaria control (Table 3). Tanzania and South Africa are the least donor-dependent for malaria response, receiving 4% and 20%, respectively. DR Congo (99%), Mozambique, Nigeria, and Zimbabwe (all 97%) remain almost fully reliant on external funding for malaria control.

Table 3. Estimated Malaria Funding: Total, Domestic, and External (2021, as Reported by Countries)

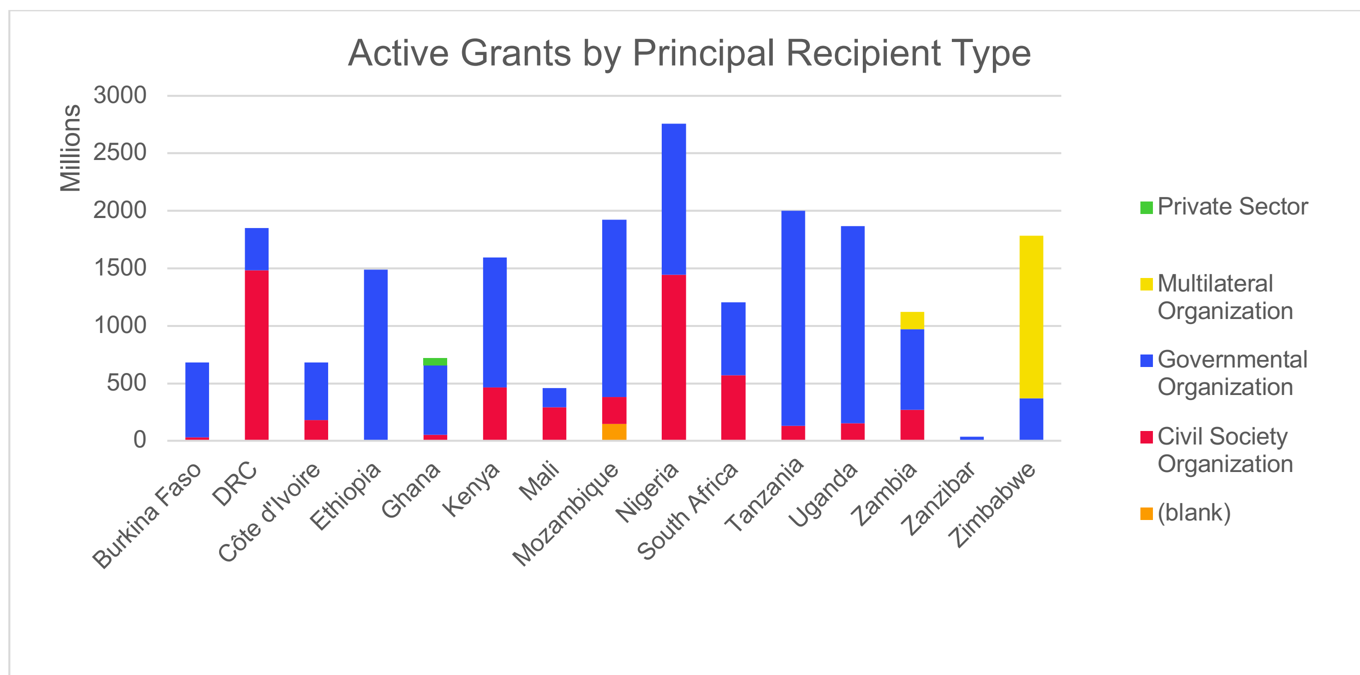
Country	Malaria Funding (US$ millions)	% Domestic	% External
Burkina Faso	92.3	51%	49%
Côte d'Ivoire	66.1	21%	79%
DR Congo	208.4	1%	99%
Ethiopia	84.9	32%	68%
Ghana	75.9	16%	84%
Kenya*	88.9	7%	93%
Mali	49.0	13%	87%
Mozambique	50.0	3%	97%
Nigeria*	193.1	3%	97%
South Africa	27.1	80%	20%
Tanzania (United Republic)	85.0	96%	4%
Uganda*	123.5	6%	94%
Zambia	73.8	19%	81%
Zimbabwe	55.4	3%	97%

Source: WHO Global Malaria Report 2022, Annex 4
*2020 data (2021 data unavailable or incomplete)

Global Fund Investments

Across all High Impact Africa countries except DR Congo, Mali, and Nigeria, government organizations receive a greater share of Global Fund grants than civil society organizations (CSOs) (Figure 4). Global Fund grants to private-sector entities are uncommon; when they do happen, they account for a minority of the funding.

Figure 4. Global Fund Grant Recipients by Sector (May 2023)



Donor Transition Status of High Impact Africa Countries

Countries need to plan and prepare for transitioning from not only Global Fund support but also funding from Gavi, the International Development Association (IDA), and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), depending on their stage of eligibility with each. This can mean multiple distinct sustainability planning efforts unless donors harmonize their efforts. Table 4 shows the countries' most recent Global Fund and PEPFAR allocations, Gavi eligibility and co-financing status, and IDA eligibility. None of the High Impact Africa countries are on the Global Fund's latest list of projected transitions,[10] but Côte d'Ivoire, Ghana, Kenya, and Nigeria are within the eight-year accelerated transition phase with Gavi financing, after which they will fully self-finance vaccines.

[10] https://www.theglobalfund.org/media/9017/core_projectedtransitionsby2028_list_en.pdf

Table 4. Global Fund, Gavi, IDA, and PEPFAR Eligibility in 2023–2024

Country	Global Fund Allocations for 2023–2025 (US$)	PEPFAR Allocations (US$)	Gavi Eligibility and Co-Financing Status as of 2024	IDA Eligibility as of July 2023
Burkina Faso	HIV: 45,753,994 TB: 11,892,816 Malaria: 184,847,661 Total: 242,494,471	FY24 planned allocation: 9,950,000	Eligible; initial self-financing phase	Eligible
DR Congo	HIV: 189,997,416 TB: 100,844,218 Malaria: 409,812,233 Total: 700,653,867	FY24/FY25 planned allocation: 229,379,063	Eligible; initial self-financing phase	Eligible
Côte d'Ivoire	HIV: 81,898,854 TB: 16,827,783 Malaria: 130,372,338 Total: 229,098,975	FY24/FY25 planned allocation: 227,546,000	Eligible; accelerated transition phase. Expected to be fully self-financing in 2030.	Eligible and also creditworthy for some IBRD support ("blend" credit terms)
Ethiopia	HIV: 256,910,005 TB: 54,362,193 Malaria: 116,298,685 Total: 427,570,883	FY24/FY25 planned allocation: 222,900,000	Eligible; initial self-financing phase	Eligible
Ghana	HIV: 95,049,043 TB: 18,217,425 Malaria: 120,781,507 Total: 234,047,975	FY24 planned allocation: 12,860,000	Eligible; accelerated transition phase. Expected to be fully self-financing in 2030.	Eligible; borrowing on blend credit terms
Kenya	HIV: 252,843,015 TB: 61,567,466 Malaria: 78,578,587 Total: 392,989,068	FY24/FY25 planned allocation: 674,167,500	Eligible; accelerated transition phase. Expected to be fully self-financing in 2030.	Eligible borrowing on blend credit terms
Mali	HIV: 72,025,244 TB: 8,395,751 Malaria: 99,205,796 Total: 179,628,791	FY24 planned allocation: 9,360,000	Eligible; initial self-financing phase	Eligible

Country	Global Fund Allocations for 2023–2025 (US$)	PEPFAR Allocations (US$)	Gavi Eligibility and Co-Financing Status as of 2024	IDA Eligibility as of July 2023
Mozambique	HIV: 506,987,373 TB: 55,556,657 Malaria: 207,998,460 Total: 770,542,490	FY24/FY25 planned allocation: 831,550,000	Eligible; initial self-financing phase	Eligible
Nigeria	HIV: 361,689,416 TB: 153,771,804 Malaria: 417,695,711 Total: 933,156,931	FY24/FY25 planned allocation: 782,186,330	Eligible; accelerated transition phase. Expected to be fully self-financing in 2029.	Eligible; borrowing on blend credit terms
South Africa	HIV: 463,598,573 TB: 72,441,924 Total: 536,040,497	FY24/FY25 planned allocation: 902,146,360	Never eligible	Not eligible
Tanzania	HIV: 370,004,151 TB: 49,963,120 Malaria: 182,910,065 Total: 602,877,336	FY24/FY25 planned allocation: 827,801,250	Eligible; preparatory self-financing phase	Eligible
Uganda	HIV: 288,484,740 TB: 31,392,046 Malaria: 267,250,747 Total: 587,127,533	FY24/FY25 planned allocation: 750,370,500	Eligible; initial self-financing phase	Eligible
Zambia	HIV: 251,027,914 TB: 21,508,410 Malaria: 77,243,020 Total: 349,779,344	FY24/FY25 planned allocation: 761,517,900	Eligible; preparatory self-financing phase	Eligible; borrowing on blend credit terms
Zanzibar	HIV: 4,209,668 TB: 1,377,491 Malaria: 5,229,004 Total: 10,816,163	(see Tanzania)	(see Tanzania)	(see Tanzania)
Zimbabwe	HIV: 432,970,984 TB: 23,797,805 Malaria: 47,975,037 Total: 504,743,826	FY24/FY25 planned allocation: 409,700,000	Eligible; preparatory transition phase	Inactive; no active IDA financing due to protracted nonaccrual status.

Part 1. Conducting a Situational Analysis

Key Messages

- Dialogue about sustainability can begin with a situational analysis to identify critical risks in attempting to sustain and improve HTM service coverage as well as opportunities and entry points for a country's transition and sustainability planning.
- Many aspects of the sustainability of donor-funded programs warrant examination to understand entry points for system strengthening and sustainability, including institutional responsibilities/accountability, PFM systems, health financing arrangements, commodity procurement systems, and service delivery.
- The stage of evolution of a country's health financing system will determine what opportunities are available to strengthen domestic financing arrangements so programs and program components can be absorbed and efficiently implemented, leading to sustained improvements in health outcomes.
- Analytical tools such as institutional mapping, cross-programmatic efficiency analysis, and PFM assessment can help identify potential areas for efficiency gains and answer questions about institutional politics, resource requirements, and program mechanics.

A situational analysis can identify critical risks in attempting to sustain and improve HTM service coverage as well as opportunities and entry points for a country's transition and sustainability planning dialogue in light of current and planned health financing arrangements. Countries at different stages of transition and health financing reforms will have different opportunities and require different approaches to prepare or strengthen systems to absorb donor-funded programs efficiently and effectively. A situational analysis also documents current and planned service delivery arrangements and commodity procurement systems for donor-funded programs to align financing decisions with service delivery objectives.

Expected Output of a Situational Analysis

The expected output of a situational analysis is a document summarizing:

- **The current state of transition and sustainability planning.** This includes:
  - Current epidemiological trends and program performance in each of the three disease areas, to quantify the results that need to be sustained and improved
  - Current institutional responsibilities and relationships for managing the programs
  - The magnitude of the transition and sustainability challenge
  - Major opportunities to improve efficiency
  - Key risks in attempting to sustain and improve HTM service coverage
  - Which solutions should have priority within the planning process
- **Current and planned health financing arrangements.** This includes:
  - Where the country is in improving or reforming its health financing arrangements, to help identify entry points for the sustainability dialogue
  - Possible options for absorbing donor-funded programs and program components, based on institutional mandates, capacity, and politics; sustainable and efficient resources; universal entitlement and access; and potential for efficiency gains and quality improvement)
  - Appropriate steps for strengthening health financing arrangements (including the PFM system) and addressing potential political, institutional, or capacity issues in the sustainability planning process
- **Current and planned service delivery arrangements.** This includes:
  - Potential service delivery gaps when donor funds decline (especially related to community health workers and civil society and nongovernmental providers), to help ensure that financing aligns with service delivery objectives and supports the continuity of and ongoing improvements to service delivery as program financing is incorporated into domestic systems
  - Key service providers and delivery arrangements that will need to be financed through domestic financing arrangements to deliver HTM services, and how financing should align with service delivery objectives
  - Critical service delivery subsectors and providers of HTM services (and the populations they serve) that may be particularly vulnerable to the decline in donor funding
  - Key areas that will need to be addressed to maintain access to these providers, including regulatory requirements, higher cost structures associated with harder-to-reach populations, stigma, and overall trust and communication between nonstate providers and public agencies
- **Current and planned procurement arrangements for HTM commodities.** This includes:
  - Potential risks as the government takes over procurement of HTM medicines and diagnostic products; this can help point to solutions that will ensure the continuity of and ongoing improvements to procurement as financing is incorporated into domestic systems.

The next sections provide guidance on key issues to explore and specific questions to address for each step of the situational analysis.

Step 1. Assessing the Current State of Transition and Sustainability Planning

The first step in the situational analysis is to assess the current state of transition and sustainability planning and the institutional landscape governing HTM and other donor-funded programs. This step also looks at how dependent the country is on donor funding for HTM and other priority programs, as well as which programs or program components may be particularly vulnerable as donor funding declines.

> **What this step involves:** From the descriptive data on epidemiological trends, program performance, and the magnitude of the sustainability challenge, identifying the key risks to sustaining and improving HTM service coverage and which solutions should take priority within the planning process; key issues related to institutional politics that will need to be managed; and several feasible options to address efficiency improvements.

Understanding Current Epidemiological Trends and HTM Program Performance

This set of questions covers current epidemiological trends and program performance in each of the three disease areas, in order to quantify the results that need to be sustained and improved. A clear understanding of the current epidemiological and programmatic context is the starting point for developing specific options to absorb HTM programs and program components into domestic financing arrangements and to project financing requirements.[11] It involves identifying key epidemiological indicators (including HTM incidence, prevalence, and mortality), the latest data available, and recent trends.

- What are the rates of new infections by sex, age, geography, and socioeconomic group, and what are the modes of transmission?
- What is the disease prevalence among key populations?
- What are projections of new infections and associated morbidity and mortality given various assumptions?
- What are the estimates of burden of disease as measured by illness, deaths, and disability-adjusted life years?
- How has coverage of specific services changed in recent years as measured by Global Fund performance frameworks and indicators and by other widely accepted key indicators of national response that are reported by countries?

[11] The Global Fund. Guidance for Sustainability and Transition Assessments and Planning for National HIV and TB Responses. Prepared by Pharos Global Health Advisors. Geneva: The Global Fund; 2021.

- What are the data on service delivery coverage by population group covered, including general population, key and vulnerable populations, and hard-to-reach groups?
- Which types of providers are responsible for service delivery (government, civil society or nongovernmental organizations, private sector), and at what levels (hospital, health center, community based, etc.)?

Understanding Institutional Responsibilities, Accountability, and Politics

This set of questions aims to identify current institutional responsibilities for HTM programs and program components, lines of accountability, and the political issues that may affect options for domestic financing.

- Which institutions currently carry out which functions in HTM programs and at which administrative levels?
- How do these institutions relate to one another, and what are the power dynamics?
- What mechanisms are in place for accountability for outcomes?
- Are there any institutions, agencies, or departments that have been created or largely funded by donors, and how do they relate to other government institutions?
- Which groups may be threatened by sustainability discussions and why?
- Which groups have an interest in retaining, obtaining, or reallocating various program functions and why? (An important focus of the "why" is potential changes in control over resources that may arise in the sustainability discussions.)
- In decentralized settings, what is the distribution of responsibility and accountability between national and subnational agencies?
- Are there any major political issues that need to be considered or addressed in further discussions about future absorption of donor-funded programs into domestic financing arrangements?

Quantifying the Magnitude of the Sustainability Challenge

This set of questions aims to quantify the magnitude of the sustainability challenge in terms of current dependence on the Global Fund or other donors to fund specific programs and program components and to identify program components that are particularly vulnerable to a decline in donor funds.

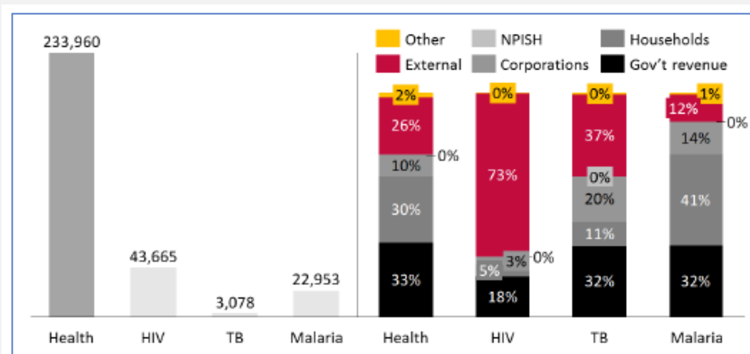
- What is current expenditure on donor-funded programs, by revenue source and program component?
- What is the estimated funding needed for each program and the projected funding gap over the next three to five years?
- Which program components will be particularly vulnerable when donor funding ends?

Box 4 shows a sample analysis of the magnitude of the sustainability challenge from a Global Fund situational analysis in Kenya in 2017.[12]

Box 4. Sample Analysis of the Magnitude of the Sustainability Challenge in Kenya

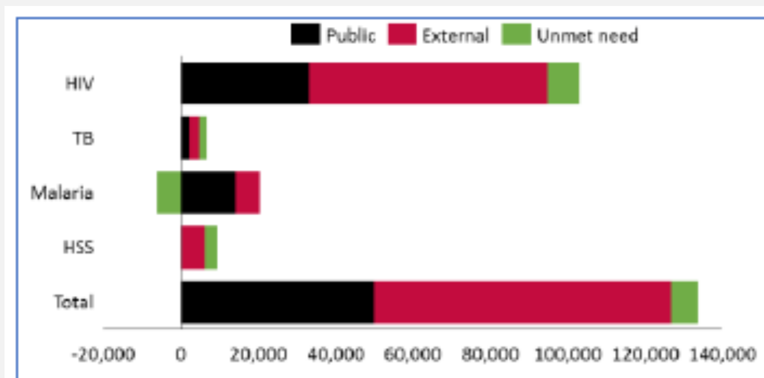
The following tables from a 2017 Global Fund situational analysis in Kenya highlight the high share of funding from donors for the country's HIV and TB programs. The HIV program was particularly vulnerable, with an estimated 73% of funding coming from external sources. Within the HIV program, several components (e.g., community-based care and treatment support and prevention among priority populations) were entirely funded by donors, with no current funding from the Kenyan government.

Overall Health and HTM Expenditure by Revenue Source, FY2012–2013 (KES Millions)



NPISH = Nonprofit institutions serving households
Source: National Health Accounts for FY2012/13 (Ministry of Health, 2015b)

Estimated Annual Funding Availability and Unmet Need, 2018–2020 (KES Millions)



HSS = health system strengthening
Source: Funding landscape analyses in Kenya's Global Fund funding requests (Kenya Coordinating Mechanism 2017a, 2017b)

[12] Chaitkin, M., O'Connell, M., and Githinji, J. (2017). Sustaining Effective Coverage for HIV, Tuberculosis, and Malaria in the Context of Transition in Kenya. Washington, DC: Results for Development.

Box 4. Sample Analysis of the Magnitude of the Sustainability Challenge in Kenya *(continued)*

Annual Funding by Program Component, FY2015–2016

Program component	Total spending ($US)	PEPFAR	Global Fund	Government of Kenya	Other donors
Clinical care, treatment and support	370	58%	8%	34%	0%
Community-based care, treatment and support	13	100%	0%	0%	0%
Prevention of mother-to-child transmission (PMTCT)	46	50%	0%	48%	2%
HIV testing services	71	60%	1%	39%	0%
Voluntary medical male circucision	15	100%	0%	0%	0%
Priority population preventions	12	96%	4%	0%	0%
Key populations	12	70%	28%	0%	1%
Orphan and vulnerable children care	82	48%	0%	0%	51%
Laboratory	42	61%	17%	22%	0%
Surveillance	25	54%	46%	0%	0%
Total	688				

Source: PEPFAR. 2017. "Kenya Country Operational Plan (COP17): Strategic Direction Summary." President's Emergency Plan for AIDS Relief. https://copsdata.amfar.org/SDS/2017/Kenya.pdf.

Identifying Major Opportunities to Improve Efficiency

This set of questions helps identify the major inefficiencies due to fragmentation, duplication, and overlap among priority programs that could be addressed to improve the efficiency in how funds are channeled and used to improve outcomes. The cross-programmatic efficiency analysis (CPEA) diagnostic approach, developed by the World Health Organization (WHO), can be a useful tool to guide this part of the situational analysis (Box 5).

- Is there fragmentation, duplication, or overlap in planning and budgeting processes that could be integrated or streamlined?
- Is there fragmentation, duplication, or overlap in financial flows that could be integrated or streamlined?
- Is there fragmentation, duplication, or overlap in human resources deployment processes that could be integrated or streamlined?
- Is there fragmentation, duplication, or overlap in procurement processes that could be integrated or streamlined?
- Is there fragmentation, duplication, or overlap in data reporting and monitoring that could be integrated or streamlined?

Box 6 shows some results of a CPEA analysis in South Africa in 2021.[13]

Box 5. Cross-Programmatic Efficiency Analysis

WHO's CPEA diagnostic approach detects inefficiencies resulting from how health programs and related services are implemented within the context of the overall health system. This systemwide approach is designed to identify and address duplications, misalignments, and overlaps in functions across specific health programs: service delivery, financing, input generation, and stewardship/governance.

In more than 13 countries in Africa and Asia, the CPEA approach has supported evidence-based dialogue on improving alignment, integration, and coordination to improve efficiency and overall coverage.

[13] World Health Organization. South Africa: cross-programmatic efficiency analysis. Policy brief (Health financing case study, no. 23). Geneva: World Health Organization; 2021.

Box 6. Sample CPEA Findings in South Africa

A cross-programmatic efficiency analysis was conducted in one province in South Africa in 2021 to identify critical areas of overlap, misalignment, or duplication across the country's HTM and maternal, newborn, and child health programs. Funds flowed from the national government to provinces via two primary channels: About 80% came as general health sector allocations from national and provincial treasuries, and about 20% came through conditional grants from the National Treasury to the National Department of Health, the largest of which was earmarked for HIV/AIDS and TB. The CPEA identified several inefficiencies related to fragmented funding flows, including challenges with coordinating activities across funding sources, which resulted in duplication among plans and budgeting within the HIV/AIDS and TB programs and constraints on adapting resources to actual patient needs. Due in part to the differentiated funding flows, health workers treating HIV-related illnesses were separated from those in the rest of the system, which was contrary to government policies calling for integrated service delivery. Separate information systems were used for TB, HIV, and the overall health system, with no coordination between systems. Investments were heavily focused on disease-specific systems (e.g., TIER.Net for HIV) rather than on building a strong underlying system.

Analytical Tools and Approaches and Potential Data Sources to Identify Opportunities for Efficiency

- Institutional and stakeholder mapping
- Political economy analysis
- Government budget documents
- National health accounts
- Public expenditure reviews
- Global Fund funding requests
- Planning documents and assessments of other donor agencies
- Cross-programmatic efficiency analysis

Step 2. Assessing Current and Planned Health Financing Arrangements

Step 2 of the situational analysis identifies current and planned health financing arrangements to understand how financing is currently organized for the health sector. This information can support dialogue on absorbing donor-funded programs into domestic financing arrangements and appropriate steps to take to strengthen these arrangements. Key features of health financing arrangements that will affect their suitability for absorbing donor-funded programs include institutional mandate, capacity, and politics; sustainable and efficient resources; universal entitlement and access; and potential for efficiency gains and quality improvement.

This step also examines how well the PFM system is functioning and whether it allows flexibility for more advanced health financing functions for funds that flow through the PFM system (in particular, strategic purchasing approaches such as contracting with public and private providers and strategic provider payment systems) and what changes may be needed to improve PFM systems for these purposes. Finally, this step documents any planned health financing reforms so they can be part of the sustainability planning dialogue as appropriate.

This step may draw on health financing assessments, strategies, or descriptive reports that have already been completed by country stakeholders or other partners.

> **What this step involves:** From the mapping of current and planned health financing arrangements, identifying possible options for absorbing donor-funded programs and program components based on institutional mandate, capacity, and politics; sustainable and efficient resources; universal entitlement and access; and potential for efficiency gains and quality improvement. It also involves identifying and prioritizing steps to strengthen these health financing arrangements (including the PFM system) and how to address any political, institutional, or capacity issues during the sustainability planning process.

Mapping Health Financing Sources and Funding Flows

This set of questions helps identify significant health financing arrangements in the country, quantify their coverage in terms of share of funding and population, and document the key features that will affect decisions about their suitability to absorb donor-funded programs and program components.

- What are the current health financing arrangements, how are the different functions (revenue raising, pooling, and purchasing) organized, and what agencies are involved in each and how?
- What are the revenue sources for each health financing arrangement, and how stable are the funding streams?
- What is the likelihood that overall levels and share of budget for health could increase based on macroeconomic projections?
- How much flexibility does the country’s health ministry (or equivalent decision-making authority for resource allocation within the health sector) have to reprioritize and reallocate budgets within a year and from year to year, given how the budget process works?
- What key institutions are involved in each health financing arrangement, and what are their mandates and capacity?

- What are the key political issues and challenges related to the health financing agencies and between multiple health financing agencies?
- Which populations are "covered" by each health financing arrangement? What is the total share of population coverage under each health financing arrangement?
- What are the policies on entitlements and obligations of the covered population (e.g., user fees, referral requirements) for each financing arrangement?
- What services are covered by each financing arrangement? Are preventive, diagnostic, and curative services covered?
- What strategic purchasing policies are used by each financing arrangement (e.g., strategic contracting and provider payment), and what is the potential to use strategic purchasing to improve the efficiency and quality of service delivery?
- Which aspects of HTM and other donor-funded programs are included in each financing arrangement and how?

Box 7 shows results from a mapping of health financing arrangements in Burkina Faso in 2021, which used the Strategic Purchasing Progress Tracking Framework.[14] Box 8 highlights some of the recent momentum in Ghana on mapping the benefits and financing sources of various benefit packages.[15]

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[14] Strategic Purchasing Africa Resource Center (SPARC). Strategic Health Purchasing in Burkina Faso: A Summary of Progress, Challenges, and Opportunities. Nairobi: SPARC; 2021.

[15] Results for Development (R4D). Sustainability Planning in Ghana: Mapping Benefits in Ghana's National Health Insurance Scheme, Essential Health Service Package, and Priority Programs. Accra: R4D; 2023.

Box 7. Mapping Health Financing Arrangements in Burkina Faso

The government of Burkina Faso is accelerating progress toward UHC through the *Gratuité* program, which provides free health care for women and children under age 5. In addition to *Gratuité*, the main coverage scheme, the government provides direct supply-side financing through grants to public facilities and municipalities. Burkina Faso also has voluntary coverage schemes, and the government is in the advanced stages of establishing a national health insurance scheme called *Régime d'Assurance Maladie Universelle.* A 2021 mapping exercise used the Strategic Purchasing Progress Tracking Framework to identify the country's main health financing schemes:

- ***Gratuité.*** Tax-financed subsidies cover all user fees for primary and hospital care for women and children under age 5 at public health facilities and some accredited private facilities.
- ***Crédits Délégués*** (Delegated Credits). Tax-financed grants are provided to public facilities to guarantee access to health services for the general population.
- ***Crédits Transférés*** (Transfers to Municipalities). These are tax-financed grants to municipalities for public facilities within their jurisdiction. Funds are used for infrastructure improvements and equipment.
- ***Mutuelles Communautaires*** (Community-Based Health Insurance). These voluntary schemes provide health coverage to informal-sector workers and organized communities. Membership fees are pooled to meet the cost of health services for beneficiaries.
- **Occupation-Based Health Insurance.** Voluntary, nonprofit associations of workers from public or private companies pool membership fees to meet the cost of health services for beneficiaries.
- ***Régime D'assurance Maladie Universelle.*** This planned mandatory national health insurance scheme is intended to be the future vehicle for UHC for all Burkinabe.

The table below shows the institutional arrangements, financing, coverage, and purchasing functions of each scheme.

	Gratuité	*Crédits Délégués*	*Crédits Transférés*	CBHI Schemes	OBHI Schemes
% of Current Health Expenditure (2015)*	56%			2%	
Main Purchaser(s)	Ministry of Health (MOH) Technical Secretariat in Charge of UHC (ST/CSU)	MOH Directorate of Administration and Finance (DAF)	MOH DAF	CBHI executive boards	OBHI executive boards
Governance	Funds are transferred by the Treasury to MOH DAF, which has the purchasing mandate. Providers have limited autonomy to allocate funds according to guidelines for the use of public funds.	Funds are transferred by the Treasury to MOH DAF, which has the purchasing mandate. Providers have limited autonomy to allocate funds, according to guidelines for the use of public funds.	Funds are transferred by the Treasury to MOH DAF, which has the purchasing mandate. Providers have limited autonomy to allocate funds, according to guidelines for the use of public funds.	Membership fees are pooled by each CBHI scheme, which has the purchasing mandate. A general assembly of members provides oversight. Providers have autonomy to allocate funds received from CBHI schemes. CBHI receives financial and technical support from umbrella organizations (e.g., *Le Réseaux d'Appui aux Mutuelles de Santé au Burkina Faso* and *Association Songui Manegré / Aide au Développement Endogène*).	Membership fees are pooled by each OBHI scheme, which has the purchasing mandate. A general assembly of members provides oversight. Providers have autonomy to allocate funds received from OBHI schemes.
Financial Management	The annual budget is based on the budget circular that guides budget formulation and is approved by the National Assembly as the annual Finance Act. Budget deficits occur and are corrected through amendments to the annual budget and to the Finance Act. Deficits at the end of the year are carried over to the next year.	The annual budget is based on the budget circular that guides budget formulation and is approved by the National Assembly as the annual Finance Act. Budget deficits occur and are corrected through amendments to the annual budget and to the Finance Act. Deficits at the end of the year are carried over to the next year.	The annual budget is based on the budget circular that guides budget formulation and is approved by the National Assembly as the annual Finance Act. Budget deficits occur and are corrected through amendments to the annual budget and to the Finance Act. Deficits at the end of the year are carried over to the next year.	The annual budget is based on projected member contributions. Budget overruns occur and are covered by increasing membership fees and by financial support from the umbrella organization.	The annual budget is based on projected member contributions. Budget overruns occur and are covered by increasing membership fees or using the previous year's surplus.
Benefits Specification	Care during pregnancy, childbirth care and obstetric interventions, care for children under age 5 (except basic treatment for chronic diseases), screening for precancerous cervical lesions, medical evacuations within the country	Detailed list of input items to support health facility operations	Detailed list of input items for infrastructure and equipment	Different for each CBHI scheme; broad categories include consultations, diagnostics, medicines, referrals, and hospitalization	Different for each OBHI scheme; broad categories include outpatient consultations, hospitalization, diagnostics, medicines, and referrals
Contracting Arrangements	Loose agreements with all public providers for services, but selective contracting with private facilities	No specific contracting; loose agreements with all public facilities	No contracting; loose agreements with municipalities	Selective contracting with public and private facilities	Selective contracting with public and private facilities, including pharmacies and laboratories
Provider Payment	Fee-for-service	Line-item budgets	Line-item budgets	Fee-for-service	Fee-for-service
Performance Monitoring	Monthly facility activity reporting on DHIS2; e-Gratuité platform built on DHIS2 for claims monitoring, external auditing by national and international nongovernmental organizations, and internal monitoring and auditing by ST/CSU	Monthly facility activity reporting on DHIS2; internal auditing and controls by MOH DAF	Monthly facility activity reporting on DHIS2; internal auditing and controls by MOH DAF	Internal auditing, customer complaints	Internal auditing, customer complaints; sanctions for noncompliance with contractual terms

Box 8. Mapping Ghana's NHIS Benefit Package to Its Essential Health Services Package

Ghana established the National Health Insurance Authority (NHIA) in 2003 to minimize the impact of catastrophic health expenditures, particularly on poor and vulnerable populations, by offering health insurance to workers through the National Health Insurance Scheme (NHIS). Since then, the NHIA has served as the country's main health purchasing agency and the NHIS has significantly improved access to quality health services and contributed to reducing out-of-pocket payments at the point of care, particularly for poor and vulnerable populations. However, the benefit package skews heavily toward treatment and curative services, with minimal or no coverage of preventive and promotive services.

Ghana's UHC Roadmap, developed in 2019, laid out a plan for the country to achieve UHC by 2030. The roadmap has since guided health sector priorities, including the development of a nationally integrated Essential Health Services Package (EHSP), which defines the essential services and interventions that should be universally accessible to all people living in Ghana. These are high-impact, cost-effective services and interventions that can contribute to a strong health system, reduced morbidity and mortality, and more equitable access to quality health services at all levels of health care. The EHSP takes a life-course approach, with attention to promotive, preventive, curative, palliative, and rehabilitative interventions.

Development of the Health Prevention and Promotion Benefits Package (HPPBP)

A mapping exercise comparing the NHIS benefit package to the EHSP showed that the NHIS does not cover about 50% of the essential services enumerated in the EHSP—mostly preventive and promotive services. To address this major gap, the Ghana Health Service (GHS) convened a series of workshops to collaboratively define a Health Prevention and Promotion Benefits Package (HPPBP). The workshops first identified preventive and promotive services within the EHSP thematic areas and then prioritized that list based on health impact criteria.

The mapping exercise included identifying the financing source of each preventive and promotive service. While many of the services not covered by the NHIS are funded by external donors, there was also a set of "orphan" services—those without any specific funding from domestic or external sources. Once the HPPBP has been validated by government stakeholders, the Ministry of Health, GHS, and NHIA will need to devise a plan for financing these services as part of planning for any pilot or rollout. Development partners are exploring options for piloting financing mechanisms, including channeling funding for the HPPBP services through the NHIA, which would in turn pay providers, thus strengthening domestic financing pathways and systems.

Mapping and Absorbing Vertical Programs

Another mapping exercise, conducted in late 2023, compared traditionally vertically financed programs (for HIV, TB, malaria, immunization, and nutrition) against the NHIS benefit package and identified the sources of funding for the priority services throughout the regions. This exercise revealed major funding fragmentation: It identified over 30 different funding sources (e.g., development partners, NGOs, and projects) for the selected prevention and promotion services in various regions or districts over different periods of time. Together with planning for HPPBP financing and rollout, this mapping will enable decision-makers to plan for the future of these services, including how long they should continue to be delivered and financed vertically and how best they could be absorbed into the NHIS or other benefit package and scaled up sustainably.

Assessing the Performance of the PFM System

This set of questions helps identify how well the PFM system is functioning and whether it allows flexibility for more advanced health financing functions, such as strategic purchasing to contract with public and private providers and implement more sophisticated provider payment systems.

- Are health sector policies and priorities, including for HTM services and program components, reflected in the budget, and are health budget allocations sufficient and stable enough to meet health sector objectives and commitments?
- Are program-based budgets used in health? If so, what are the key budget programs?
- Can funds (in general and for HTM services and program components) be pooled, allocated, and disbursed across populations, geographic areas, and time to respond to health needs and ensure equity and financial protection for target populations?
- How much flexibility do budget holders have to reallocate budgets within a year?
- Are there any major challenges with budgets being fully allocated and disbursed in a timely manner?
- Can health providers receive funds through output-based provider payment, and can funds be used effectively and efficiently by providers to deliver high-quality services? Or are budgets formulated and disbursed using input-based line items?
- Can private-sector actors be contracted using public funds?
- What accountability measures are in place to ensure that the ministry of health (MOH), ministry of finance (MOF), providers, and other actors can make the most effective use of public funds?

Documenting Planned Health Financing Reforms

This set of questions helps identify planned health financing reforms, how advanced the planning is, and the likelihood of implementation, to inform the sustainability planning dialogue as appropriate.

- Are any new health financing schemes being planned, such as national health insurance or a user fee removal program? If so, what stage have the plans reached (proposal, approval, design, early implementation)?
- Will a new agency be established, or does one already exist (e.g., an agency under the MOH or other ministry or government body)?
- Will there be a dedicated funding stream tied to a defined package of services (benefit package)? If so, will it be on budget or off budget? And will any new PFM flexibilities be introduced for use of funds in the scheme?
- Will entitlement be universal or based on an insurance contribution (e.g., premium payment or payroll tax)?

- Will general budget revenues be combined (pooled) with any insurance contributions?
- Will health providers be paid through output-based provider payment to deliver the benefit package?
- Are there any plans to unify, harmonize, or defragment existing schemes? If so, how will this be done?

Analytical Tools and Approaches and Potential Data Sources to Assess PFM Systems and Document Planned Health Financing Reforms

- Resource mapping (using national health accounts, budget data, and public expenditure reviews) to understand the sources, flows, and uses of funds, the extent of dependence on out-of-pocket spending, and so forth.
- World Health Organization (WHO) Health Financing Progress Matrix. Stage 1 of the matrix yields a picture of the health financing landscape across the health system, providing an initial picture of the extent of fragmentation and misalignment. Expenditure data from the Global Health Expenditure Database (or, where available, from country health accounts studies) are then mapped onto the individual coverage programs, providing a picture of the relative financial weight or importance of each coverage scheme.
- Strategic Purchasing Progress Tracking Framework. This framework guides the documentation and assessment of health financing arrangements through the lens of health purchasing functions (benefits specification, contracting, provider payment, and performance monitoring).
- PFM assessment (to understand budget formation, execution, and reporting).
- *Aligning Public Financial Management and Health Financing.* This guide lays out a process for assessing how aligned the PFM system and health financing system are in support of UHC, including for donor-funded programs.
- Health financing strategy documents.
- Government health reform plans, legislation, and other documents.

Step 3. Identifying Current and Planned Service Delivery Arrangements

The third step of the situational analysis identifies current and planned service delivery arrangements for HTM services to ensure that financing aligns with service delivery objectives (e.g., flexible, population-based payment for preventive services or new contracting units that include community health providers) and supports the continuity of and ongoing improvements to service delivery as program financing is incorporated into domestic systems. Key issues include the role of community health workers and nonstate providers (particularly civil society and nongovernmental organizations) that can be critical to covering hard-to-reach populations and are currently funded directly by donors and excluded from public financing arrangements. These providers may also be subject to different regulatory requirements and have other reservations about being contracted through government agencies. For example, they may be concerned about the reliability of

government budgets and receiving timely payment. They may also rely on technical assistance from donors and have challenges operating once that technical assistance ends. Governments may perceive that civil society organizations (CSOs) and nongovernmental organizations (NGOs) have high unit costs in covering vulnerable and hard-to-reach populations. That said, there can be valid reasons why unit costs are higher for reaching those groups that need to be understood.

What this step involves: From the mapping of current and planned service delivery arrangements, identifying key service providers and delivery arrangements that will need to be financed through domestic financing arrangements to deliver HTM services and how that financing should align with service delivery objectives (e.g., flexible, population-based payment for preventive services or new contracting units that include community health providers). This step also involves identifying critical service delivery subsectors and providers of HTM services (and the populations they serve) that may be particularly vulnerable to declines in donor funding and identifying key areas that will need to be addressed to maintain access to these providers—including regulatory requirements, higher cost structures associated with harder-to-reach populations, stigma, and overall trust and communication between nonstate providers and public agencies.

Documenting Current Delivery Arrangements for Preventive, Diagnostic, and Curative HTM Services

This set of questions helps identify current and planned service delivery arrangements for delivering preventive, diagnostic, and curative HTM services to patients, including through donor-funded programs. The questions also help identify potential challenges related to bringing community health workers and nonstate providers into government health financing arrangements.

- What services are delivered at what levels of the public health service delivery system?
- What public agencies at which administrative levels manage service delivery, quality, and other regulatory issues?
- Do donor-funded programs include any vertical service delivery systems?
- What is the role of community health workers in providing each type of HTM service—preventive, diagnostic, and curative?
  - Which populations do they serve?
  - Do they receive regular payment or other financial resources?
  - What is the source of financing?
  - Are they reliant on donor-provided technical assistance for their operations?
  - What regulations govern community health workers?

- Does the PFM system currently have any mechanisms for public financing agencies to contract with community health workers?
  - Do any government agencies, donors, NGOs, or other funders currently have any contracts with community health workers to deliver preventive, diagnostic, and/or curative HTM services? What are the major characteristics of those contracts?
  - What are the key considerations in financing service delivery by community health workers?
  - Do community health workers have concerns about engaging in contracts with government agencies?
  - What additional information would be needed to begin a dialogue about community health workers contracting with government agencies?
- What is the role of CSOs/NGOs in providing each type of HTM service—preventive, diagnostic, and curative?
  - Which populations do they serve?
  - Do they receive regular payment or other financial resources?
  - What are the sources of financing?
  - Are CSOs/NGOs reliant on donor-provided technical assistance for their operations?
  - What regulations govern CSOs/NGOs?
  - Does the PFM system currently have any mechanisms for public financing agencies to contract with them?
  - Are there existing contracts with CSOs/NGOs through a government agency or funders to deliver preventive, diagnostic, and/or curative HTM services? What are the major characteristics of those contracts?
  - What are key considerations in financing service delivery through CSOs/NGOs?
  - Are they reliant on donor-provided technical assistance for their operation?
  - Do they have concerns about engaging in contracts with government agencies?
  - What additional information would be needed to begin a dialogue about contracting with government agencies?
- What is the role of other nonstate providers in providing each type of HTM service—preventive, diagnostic, and curative?
  - What populations do they serve?
  - Do they receive regular payment or other financial resources?
  - What is the source of financing?

- Are they reliant on donor-provided technical assistance for their operations?
  - What regulations govern them?
  - Do any government agencies, donors, CSOs/NGOs, or other funders currently contract with them to deliver preventive, diagnostic, and/or curative HTM services? What are the major characteristics of those contracts?
  - Does the PFM system currently have any mechanisms for public financing agencies to contract with them?
  - What are key considerations in financing service delivery through them?
  - Do they have concerns about engaging in contracts with government agencies?
  - What additional information would be needed to begin a dialogue with them about contracting with government agencies?
- Are any new service delivery arrangements for preventive, diagnostic, or curative HTM care being planned or piloted?

Documenting Current and Planned Arrangements for Delivering Population-Based HTM Services to Communities

This set of questions helps identify current and planned service delivery arrangements for population-based HTM services to communities, including through donor-funded programs. It also helps identify potential challenges related to bringing community health workers and nonstate providers into government health financing arrangements.

- What services are delivered at which levels of the public health service delivery system?
- Which public agencies manage population-based HTM services, and at which administrative levels?
- Do donor-funded programs include any vertical service delivery systems?
- What is the role of community health workers in delivering population-based HTM services?
  - Which populations do they serve?
  - Do they receive regular payment or other financial resources?
  - What is the source of financing?
  - Do any government agencies, donors, NGOs, or other funders currently contract with community health workers to deliver population-based HTM services? What are the major characteristics of those contracts?

- What is the role of NGOs/CSOs in delivering population-based HTM services?
    - Which populations do they serve?
    - Do they receive regular payment or other financial resources?
    - What is the source of financing?
    - Do any government agencies, donors, NGOs, or other funders currently contract with NGOs/CSOs to deliver population-based HTM services? What are the major characteristics of those contracts? Are NGOs/CSOs reliant on donor-provided technical assistance for their operations?
- What is the role of other nonstate providers in delivering population-based HTM services?
    - Which populations do they serve?
    - Do they receive regular payment or other financial resources?
    - What is the source of financing?
    - Do any government agencies, donors, NGOs, or other funders currently contract with other nonstate providers to deliver population-based HTM services? What are the major characteristics of those contracts?
- Are any new service delivery arrangements for preventive, diagnostic, or curative HTM care being planned or piloted?

Step 4. Assessing Current and Planned Procurement Systems

This step helps identify potential risks as the government takes over the procurement of HTM medicines and diagnostic products. It can help point to solutions that will ensure the continuity of and ongoing improvements to procurement as financing is incorporated into domestic systems.

> **What this step involves:** From the mapping of current and planned procurement systems for HTM medicines and diagnostic products, identifying key risks as the government takes over procurement and identifies potential policy solutions related to regulatory measures, issues of tax and trade policy for essential medicines and products, and strengthening the procurement system itself.

- Which HTM drugs are on the country's essential medicines list? Are any WHO-recommended first- or second-line medicines missing?
- Which agency/actors are responsible for HTM-related procurement, and at which administrative levels?

- Are there any parallel procurement systems for HTM commodities? If so, are they run by domestic agencies or by donors?
- How is procurement currently carried out? Does procurement happen only at the national level, or are pooled procurement mechanisms such as the Global Fund's online procurement platform (wambo.org) or the Stop TB Partnership's Global Drug Facility (for TB diagnostics and treatment) also used?
- If pooled procurement mechanisms are not used, are there obstacles to using pooled procurement mechanisms given government procurement regulations?
- Do regulations related to domestic procurement create barriers to accessing international pooled procurement mechanisms, including requirements related to national procurement or requirements for nationally run competitive tenders?
- Do national product registration processes create barriers to manufacturers registering new drugs or diagnostics, potentially reducing local availability?
- Are HTM products procured through domestic systems subject to value-added taxes, import duties, or other taxes? Are the policies different for products procured by donors?

Part 2. Determining How to Absorb Donor-Funded Programs into Domestic Financing Arrangements

Key Messages

- Planning for how donor-funded programs will be absorbed into domestic health financing arrangements is most effective when it takes a systemwide view and involves a variety of stakeholders from key institutions in the health sector.
- The planning process is likely to be iterative, with a subset of programs and program components addressed in each iteration. Different components of one program (e.g., population-based actions, individual services, procurement) may be absorbed by different financing arrangements.
- To identify entry points for sustainability dialogue, it can be helpful to use a decision guide that locates a country along a continuum based on robustness of public funding for health and the maturity of its health financing systems.
- Countries with mixed health financing systems will need to determine which health domestic financing arrangements will absorb which donor-funded programs and program components. The potential benefits and risks of all institutional options for absorbing each program and program component should be considered carefully. *NHI should not be assumed to be the best option for sustainability.*

  Key considerations include institutional mandate, capacity, and politics; sustainable and efficient resources; universal entitlement and access; and potential for efficiency gains and quality improvement.
- In planning for absorption of donor-funded programs into domestic health financing arrangements, decision-makers may need to design, adapt, and/or strengthen a number of health financing functions to incorporate HTM and other donor-funded programs and all program components:
  - PFM and procurement and supply chain systems
  - Benefit packages
  - Service delivery and contracting arrangements (with public and private providers)
  - Provider payment systems
  - Health information systems and performance monitoring systems
- Special consideration should be given to procurement and public health elements of donor-funded programs, including institutional responsibility and processes.
- The process of designing or strengthening financing functions offers an opportunity to ensure that all program components are designed in a way to increase access, quality, and efficiency and reduce or mitigate the consequences of fragmentation.

The process of determining how donor-funded programs will be absorbed into domestic health financing arrangements and identifying priorities for sustainability planning should include a stakeholder dialogue process that takes a systemwide view to accomplish the following:

- **Identify how PFM and procurement systems need to be strengthened overall**, and specifically to allow for more strategic health financing tools and approaches (e.g., benefits specification to strategically determine covered services, contracting with public and private providers, strategic provider payment, and financial and service delivery performance monitoring).
- **Identify which financing arrangements and institutions will assume primary responsibility** for financing, procurement, and/or service delivery for key components of all currently donor-funded programs (short, medium, and long term) as donor funding declines. The process will also help identify which program elements (e.g., procurement, service delivery, information systems, monitoring) should be consolidated across programs and/or within the wider health system.
- **Inform the design or strengthening of strategic health financing tools and approaches** (benefit package, contracting arrangements, provider payment, information systems and performance monitoring, PFM system, and procurement systems) to incorporate the components of HTM and other donor-funded programs.

The process is likely to be iterative, with a subset of programs and program components addressed in each iteration. The government should determine which programs and program components to address in each iteration based on the needs of the population and the readiness of the system to absorb a specific donor-funded program or program elements. This may be driven in part by the funding trajectory and sustainability, transition, and co-financing requirements of different donors.

Expected Outputs

The outputs of this step will be:

- **A plan or roadmap** for transitioning financing, procurement, information systems, and/or service delivery for each program and program component to designated institutions
- **System design documents with supporting policies and implementation tools** for each program and program component addressed in the current iteration of the process.

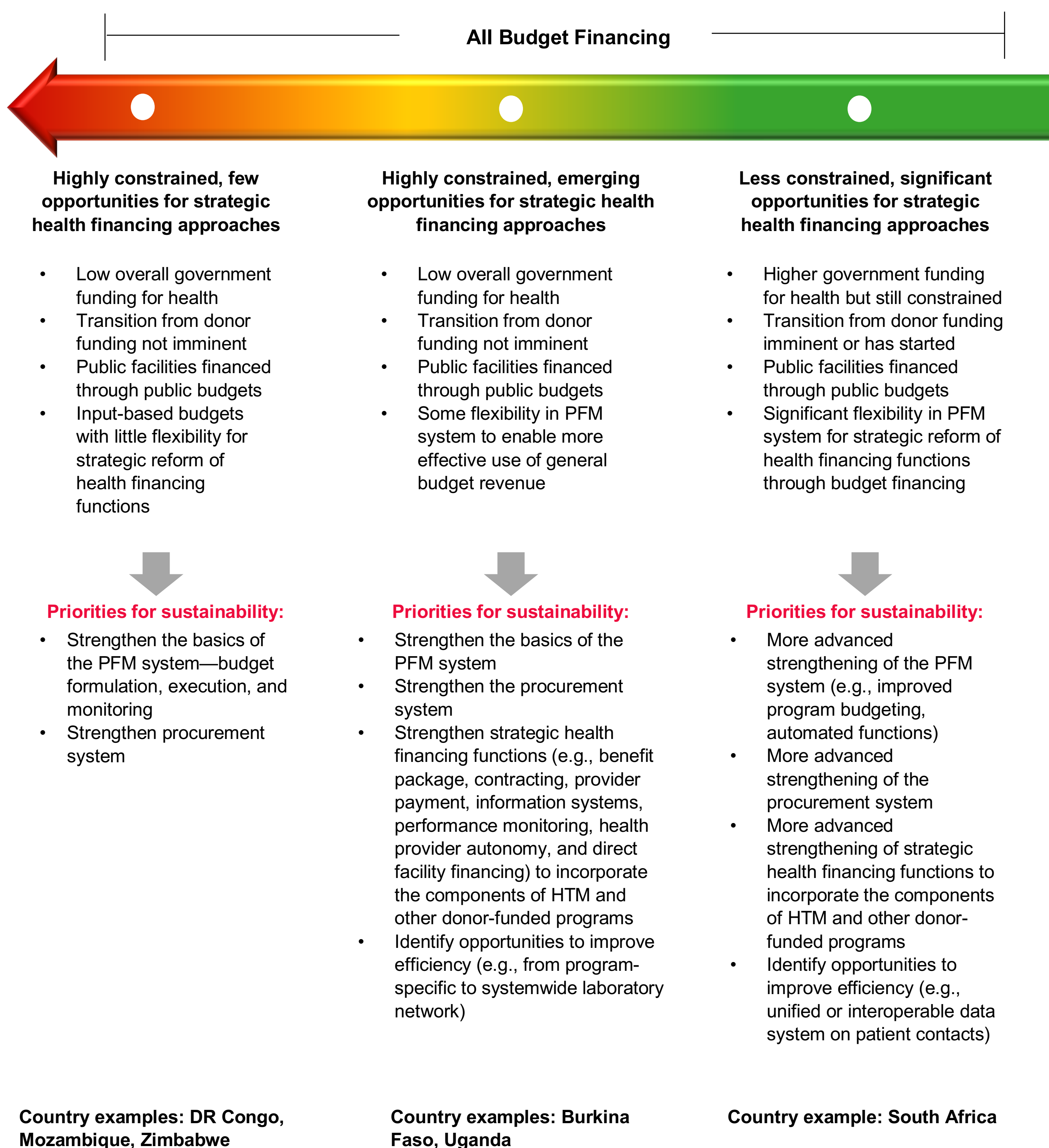
Entry Points for Sustainability Planning

Sustainability planning and health financing reform are systemwide endeavors and not disease-specific, so the process should be led by the government and supported by funders. Together, they can identify the best entry points for sustainability planning, which depend on a number of factors, including the overall level of health financing and the country's stage of transition from donor financing for some or all priority programs, the maturity and complexity of health financing arrangements, and the opportunity to introduce

strategic health financing approaches (benefits specification, contracting, provider payment, and performance monitoring) either through the budget or other health financing arrangements.

Figure 5 is a decision guide for identifying potential entry points for sustainability dialogue and action based on a country's stage of transition and planned health financing reforms. Countries are grouped by the organization of their health financing system (all budget financing or a mixed health financing system) and the overall level of government health spending. A country can be placed on the continuum of opportunity for strategic health financing tools and approaches, with the greatest opportunity in the center (green sections) and the least opportunity at the far left and far right (red sections). Countries in the center green portion of the graph are the least constrained and have the most opportunities for strategic health financing tools and approaches because of more advanced PFM systems or more flexibility and capacity in another health financing arrangements (such as NHI, which covers a significant share of the population). The yellow and red areas of the graphic are more constrained due to a lower level of government health spending and more rigidities in the PFM system or fragmentation in health financing arrangements, which limit opportunities to introduce strategic health financing tools and approaches.

Figure 5. Decision Guide for Identifying Entry Points and Priorities for Sustainability Planning Dialogue



Mixed Health Financing System

Less constrained, significant opportunities for strategic health financing approaches, and some mixed financing

- Higher government funding for health but still constrained
- Transition from donor funding imminent or has started
- Public facilities financed through public budgets and other health financing arrangements, at least one with significant population coverage
- Some flexibility in PFM system for reform of strategic health financing functions through budget financing

Priorities for sustainability:

- More advanced strengthening of the PFM system
- More advanced strengthening of the procurement system
- Decisions about which financing arrangements will absorb which donor-funded programs and program components
- Strengthen strategic health financing functions to incorporate the components of HTM and other donor-funded programs
- Identify opportunities to improve efficiency

Country examples: Côte d'Ivoire, Ghana, Tanzania, Zambia

Highly constrained, emerging opportunities for strategic health financing approaches, and fragmented mixed financing

- Low overall government funding for health
- Transition from donor funding not imminent
- Public facilities financed through public budgets and multiple other health financing arrangements, at least one with significant population coverage
- Some flexibility in PFM system for reform of strategic health financing functions through budget financing

Priorities for sustainability:

- Strengthen the basics of the PFM system
- Strengthen the procurement system
- Decisions about which financing arrangements will absorb which donor-funded programs and program components
- Strengthen strategic health financing functions to incorporate the components of HTM and other donor-funded programs
- Identify opportunities to improve efficiency, especially through defragmentation

Country examples: Ethiopia, Mali, Nigeria

All Budget Financing for Publicly Funded Health Services

In these countries, the sustainability dialogue should focus on strengthening the fundamentals of the PFM system and introducing strategic health financing approaches to incorporate the components of HTM and other priority programs and make the best use of budget funds. This may involve dialogue on introducing health sector–specific flexibilities in the PFM system, such as health provider autonomy and output-based provider payment.[16]

- **Highly constrained, few opportunities for strategic health financing approaches.** In these countries, health service delivery is carried out largely or entirely by public providers, which are funded by the MOH through input-based line-item budgets. The financial sustainability dialogue is constrained by a low level of government resources and little opportunity for strategic health financing actions in a relatively rigid budget system. The entry point for dialogue is how to strengthen the PFM and procurement systems at a basic level to ensure that budget allocations align with needs as donor-funded programs are absorbed, budget execution bottlenecks are reduced and funds are used more efficiently, and fragmentation is reduced or avoided. High Impact Africa countries in this group include DR Congo, Malawi, Mozambique, and Zimbabwe.
- **Highly constrained, emerging opportunities for strategic health financing approaches.** In these countries, health service delivery is carried out largely or entirely by public providers, which are funded by the MOH through input-based line-item budgets, but some improvements in the PFM and procurement systems have been initiated. The entry point for dialogue is how to continue strengthening the PFM and procurement systems and integrate more sophisticated health financing tools to incorporate the components of HTM and other donor-funded programs (e.g., benefit packages, contracting arrangements with both public and private providers, and improved information and performance monitoring systems). Possible steps include improving budget priority-setting processes, moving toward program-based budgeting, making budget execution more flexible to allow for output-based payment, introducing contracting with private-sector providers, and increasing provider autonomy.

  At this stage, it is critical to strengthen procurement of commodities to ensure favorable prices and high quality and to ensure that frontline providers can access the commodities they need through domestic systems and absorb stockouts. It is also critical to improve efficiency by continuing to work on consolidating systems and processes across programs and strengthening information and reporting systems. High Impact Africa countries in this group include Burkina Faso and Uganda.

[16] Cashin C., Bloom D., Sparkes S., Barroy H., Kutzin J., O'Dougherty S. 2017. Aligning public financial management and health financing: sustaining progress toward universal health coverage. Geneva: World Health Organization; (Health Financing Working Paper No. 4).

- **Less constrained, significant opportunities for strategic health financing approaches.** In these countries, the level of government health financing is higher, although it is likely still significantly constrained, and transition from donor financing has either started or is imminent. These countries finance publicly funded health services through the government budget systems, but the higher level of resources and more sophisticated PFM system allow for strategic health financing tools and approaches that incorporate the components of HTM and other priority programs. In these countries, sustainability dialogue can focus on more advanced improvements to the PFM system to make more effective use of budget funds (e.g., improved program budgeting, automated functions), more advanced strengthening of the procurement system, and more advanced strengthening of strategic health financing tools and approaches to incorporate the components of HTM and other donor-funded programs. Opportunities to improve efficiency should also be explored, for example by harmonizing multiple funding streams within the budget and introducing a unified or interoperable data system on patient contacts. South Africa is an example of a High Impact Africa country in this group.

Mixed Health Financing for Publicly Funded Health Services

These countries have multiple financing schemes with multiple funding flows to public providers, and they often engage private health providers to deliver publicly funded health services. In addition to strengthening the PFM and procurement systems and continuing to improve the design of strategic health financing tools and approaches to incorporate the components of HTM and other donor-funded programs, the sustainability dialogue in these countries should support decisions about which financing arrangements will absorb which donor-funded programs and program components.

- **Highly constrained, fragmented mixed financing, and few opportunities for strategic health financing actions.** These countries have a low level of government funding for health combined with a fragmented, mixed health financing system. That is, they have multiple schemes in addition to government budget funding for publicly financed health services, but none of the schemes has significant population coverage. Even where opportunities for strategic health financing approaches (e.g., a performance-based financing program) exist, population coverage is low and the funding may flow outside of the PFM system. In these countries, sustainability dialogue should support decisions about which financing arrangements will absorb which donor-funded programs and program components in a way that reduces fragmentation. Besides basic strengthening of the PFM and procurement systems, there may be limited opportunities to strengthen or introduce strategic health financing tools and approaches to incorporate the components of HTM and other donor-funded programs. High Impact Africa countries in this group include Ethiopia, Mali, and Nigeria.

- **Less constrained, some mixed financing, and significant opportunities for strategic health financing actions.** In these countries, the level of government health financing is higher but likely still significantly constrained, and transition from donor financing has either started or is imminent. These countries finance publicly funded health services through both the government budget system and at least one other financing scheme, such as NHI, that has significant population coverage. In these countries, the sustainability dialogue needs to support decisions about which financing arrangements will absorb which donor-funded programs and program components. It can also focus on more advanced improvements to the PFM system to make more effective use of budget funds, more advanced strengthening of the procurement system, and more advanced strengthening of strategic health financing tools and approaches to incorporate the components of HTM and other donor-funded programs. Opportunities to improve efficiency should also be explored. High Impact Africa countries in this group include Côte d'Ivoire, Ghana, Tanzania, and Zambia.

The following sections explore how to support the three main streams of the dialogue on absorbing HTM and other donor-funded programs and program components into domestic financing arrangements for financial sustainability.

- Strengthening the fundamentals of PFM and procurement systems
- Assigning institutional responsibility for financing HTM programs and program components
- Informing the design or strengthening of strategic health financing tools and approaches to incorporate the components of HTM and other donor-funded programs

Strengthening the Fundamentals of PFM and Procurement Systems

Most countries can realize service delivery improvements and efficiency gains by strengthening the budget process and PFM system and/or consolidating functions across programs regardless of which health financing arrangements have primary responsibility for absorbing donor-funded programs. Key questions to address in a structured stakeholder dialogue are listed below.

General PFM improvements:

- How can health sector policies and priorities, including for HTM services and program components, be better reflected in the budget?
- How can health budget allocations align with needs to meet health sector objectives and commitments, including for HTM and other priority services?
- If program-based budgets are used in health, can key budget programs be improved to incorporate HTM services and program components without fragmentation?
- Is it possible to match (at least some) general budget revenues to service outputs in budgetary programs or subprograms? Or are budgets entirely input-based?
- What improvements are needed so funds (in general and for HTM services and program components) can be pooled, allocated, and disbursed across populations and geographic areas and in time to respond to health needs and ensure equity and financial protection for target populations?
- How can the MOH, MOF, and providers be held accountable for the proper use of public funds and effective delivery of health interventions, goods, and services?

Adapting PFM systems to expand the use of health financing policy tools:

- What PFM changes are needed to formulate and execute budgets based on a defined benefit package?
- How can health technology assessment be used to prioritize medicines and services to be included in the benefit package (especially for high-cost treatments at the margin)?
- What PFM changes are needed to allow health providers to receive funds through output-based provider payment and use funds effectively and efficiently to deliver high-quality services?
- Are any changes to the PFM system or any regulations needed to allow public funds to be used to pay community health workers and contract with CSOs/NGOs and other nonstate providers?
- How can budget accountability and information systems promote accountability for both financial management and service delivery outcomes?

Procurement systems:

- What institutions will handle forecasting, budgeting, financing, and supply chain, and at what administrative levels?
- What procurement mechanisms will be used to ensure quality-assured products at competitive prices?
  - Should pooled procurement mechanisms (e.g., UNICEF Supply Division, wambo.org, Global Drug Facility for TB diagnostics and treatment) be used? Are these mechanisms compatible with government procurement regulations (for example, regarding prepayment requirements), and if so, do regulations need to be amended to permit this?
  - How will decisions be made about domestic vs. international manufacturers?
- What needs to be done to integrate and strengthen elements of the supply chain?

Assigning Institutional Responsibility for Financing HTM Programs and Program Components

Consensus is needed on which domestic institutions will be responsible for financing and providing access to services and other program components when external funding declines. Key considerations include:

- **Institutional mandate, capacity, and politics**—which institutions have mandates related to the programs, have the relevant capacity, and want or do not want responsibility
- **Sustainable and efficient resources**—which financing arrangements are most able to sustainably absorb the cost of the programs and how resources can be made available and flow through the system efficiently
- **Universal entitlement and access**—which financing arrangements can ensure that access to priority services is universal
- **Potential for efficiency gains and quality improvement**—which financing arrangements have the most tools and potential to realize efficiency gains and service quality improvements

All institutional options should be weighed carefully against these considerations. NHI may not be the best option for sustainability for a given program or all of its components, despite the common assumption that it is a new source of funds that can most sustainably absorb donor-funded programs. In practice, NHI revenues in low- and middle-income countries are typically a small share of overall public funding for health. Those revenues are often not completely additive; rather, they may displace at least some of the other

funding sources, such as the general budget.[17,18] The transfer of donor-funded priority services into an integrated benefit package managed by an NHI fund must still be funded from the budget (either by transferring current funding for those services or using substitute funding). The upcoming case study from the Philippines, where TB services were integrated into the NHI scheme, PhilHealth, illustrates some of the potential limitations of absorbing HTM services through this financing arrangement. They include the small share of the total cost of TB services that is actually paid to providers through PhilHealth (because salaries and medicines are funded through other channels, which is typical of NHI systems in low- and middle-income countries) and the administrative burden of provider accreditation by NHI agencies and the claims filing process.

On the positive side, incorporating HTM and other priority services may offer efficiency gains or greater opportunities to contract with private providers. The efficiency gains can be realized only if the NHI agency (or another purchasing agency) has flexible purchasing tools, information and payment systems can be combined, or other tools are available for improving quality of care (Box 9).[19] In the Philippines example, even though PhilHealth has the flexibility to contract with private providers to deliver TB services, most of those providers are uninterested because of the administrative burden and low payment rates (especially to private providers who do not receive salary payments through government channels, as public providers do).

Box 9. Ghana's NHIS and Malaria Treatment

Ghana's National Health Insurance Scheme (NHIS) uses its purchasing power to increase the quality of malaria treatment. Historically, efforts by the MOH and Ghana Health Service to encourage adherence to malaria treatment guidelines have had limited leverage, whereas the NHIS purchasing agency can enforce treatment guidelines through contracts with providers, conduct clinical audits to identify quality gaps, and impose financial consequences for nonadherence.

Special consideration should be given to how procurement will be carried out and by which institution, to ensure that high-quality commodities are obtained at competitive prices. In most countries, the NHI agency is not responsible for procuring medicines, so if NHI is selected as the financing arrangement responsible for a program, responsibility for procurement and how that relates to the financing of services will need to be specified. Clear institutional responsibility and funding sources also will be needed for the public health elements of donor-funded programs, especially if an agency other than the MOH is given responsibility for financing the services and medicines.

[17] Kutzin J, Yip W, Cashin C. Alternative financing strategies for universal health coverage. In: Scheffler RM, ed. *World Scientific Handbook of Global Health Economics and Public Policy. Volume 1—The Economics of Health and Health Systems*. Singapore: World Scientific Publishing Company; 2016:269–309. https://doi.org/10.1142/9789813140493_0005.

[18] Cashin C, Sparkes S, Bloom D. *Earmarking for Health: From Theory to Practice*. Geneva: World Health Organization (WHO); 2017. Health Financing Working Paper, No. 5. https://www.who.int/publications/i/item/9789241512206.

[19] USAID. *Ghana's National Health Insurance Scheme: Ensuring Access to Malaria Services with Financial Protection*. Washington, DC: USAID; 2016. https://www.hfgproject.org/ghanas-national-health-insurance-scheme-ensuring-access-malaria-services-financial-protection/.

Key questions to address in a structured stakeholder dialogue are listed below.

Institutional mandates, capacity, and politics:

- Which institutions have what mandates, authority, and capacity related to the programs?
- Which institutions want or do not want responsibility and why?
- How does decentralization factor into institutional responsibility?
- Is it possible or desirable for certain program components to be absorbed and others to remain separate?

Sustainable and efficient resources:

- What are the estimated costs of including HTM services in domestic financing arrangements?
- Which financing arrangements are most able to absorb the costs of the programs? If current arrangements will be changed, what mechanism will be used to redirect part of the funding that currently flows to the HTM programs?
- Which financing arrangements can ensure that sustainable resources will be available and can flow through the system efficiently?

Universal benefit entitlement and access:

- Which financing arrangements can ensure universal access to priority services?
- What provisions will be made for ensuring access to program services if the financing scheme is not yet universal?
- Which financing arrangements allow for contracting with private providers and CSOs to ensure access to all services?

Potential for efficiency gains and quality improvement:

- Which financing arrangements have provider payment systems, contracting, information systems, and performance monitoring that can contribute to efficiency gains?
- Which financing arrangements have provider payment systems, contracting, information systems, and performance monitoring that can contribute to service quality improvements?
- Which financing arrangements can best integrate or be made interoperable with patient data systems for the programs?
- Which institutions are best positioned to ensure procurement of high-quality, affordable commodities, and how does procurement relate to various financing arrangements?

CASE STUDY: TB Coverage in the Philippines

The Philippines ranks in the top 30 countries globally in disease burden for TB, TB/HIV, and multidrug-resistant/rifampicin-resistant TB (MDR/RR-TB).[20] In addition, an estimated 42% of TB patients in the Philippines faced catastrophic medical costs in 2017.[21] The country has a longstanding NHI system called PhilHealth, and first-line TB treatment has been included in the benefit package since 2002. This case study explores how the benefit package works in practice, some of the challenges involved, and the contribution that PhilHealth makes to TB coverage in the Philippines.

TB Diagnosis and Treatment in PhilHealth's Benefit Package

PhilHealth was formed in 1995 as a government-controlled corporation attached to the Department of Health. It is funded through member premiums and general tax revenue. While PhilHealth's population coverage has been high for many years, it was not universal until 2019, when, under the Universal Health Care Act passed that year, all citizens became eligible for PhilHealth coverage.

First-line TB diagnosis and treatment was included in PhilHealth's benefit package starting in 2003. It was established that PhilHealth would pay 4,000 pesos to accredited providers of Directly Observed Therapy Short-course for TB (TB-DOTS)—2,500 pesos after the end of the intensive phase and 1,500 pesos after the end of the maintenance phase. This was equivalent to about US$78 at the 2003 exchange rate, and it was not expected to cover the full cost of treatment because provider salaries and other inputs, including the TB medications, were provided by other sources. Because the treatment was underutilized, the guidelines were revised in 2014 to cover new cases and retreatment (treatment for relapse, treatment after failure, treatment after loss to follow up, previous treatment outcome unknown, transfer in, and other). Payment remained the same, at 4,000 pesos. This was equivalent to about US$91 at the 2014 exchange rate.

PhilHealth is now exploring the development of an MDR-TB benefit package. This would likely be an outpatient package with separate payment for primary care because MDR-TB diagnosis and treatment is much more expensive than first-line TB diagnosis and treatment. Currently, PhilHealth pays for inpatient procedures to manage TB complications, and payment is by case rate. PhilHealth is also exploring how to integrate TB-DOTS into the primary care benefit package.

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[20] World Health Organization (WHO). *Global Tuberculosis Report 2022*. Geneva: WHO; 2020. https://www.who.int/teams/global-tuberculosis-programme/tb-reports/global-tuberculosis-report-2022.

[21] Defined as direct medical expenditures, direct nonmedical expenditures, and indirect costs (e.g., income losses) totaling >20% of household income, as reported in WHO's Global Tuberculosis Report 2022.

Challenges with TB-DOTS Coverage

Providers must be certified annually by PhilHealth as TB-DOTS providers. According to PhilHealth Stats and Charts, the number of accredited providers has steadily declined from a peak of 2,055 in 2019 to 1,509 in 2022, as shown in Table 5. Most accredited providers are public; less than 6% are private. The percentage of cities and municipalities with at least one PhilHealth-accredited TB-DOTS provider has also declined steadily since 2019, from 82% in 2019 to 57% in 2022. Some of this decline could be due to the COVID-19 pandemic, but problems with accreditation, claims filing, and payments were noted in interviews carried out in 2017.[22] Researchers found that of the 71 accredited TB-DOTS providers interviewed in given local government units (LGUs), only 33 reported filing claims for TB-DOTS services and only three reported receiving some payment. Providers reported cumbersome accreditation processes and difficulties with filing claims and receiving payments as reasons for not getting accredited or not filing claims. The administrative costs of accreditation and filing of claims can be much higher than the value of PhilHealth payments.

Table 5. PhilHealth-Accredited TB-DOTS Providers and Claims Paid, 2015–2022

	2022	2021	2020	2019	2018	2017	2016	2015
Total accredited TB-DOTS providers	1,509	1,612	1,809	2,055	2,004	1,996	1,973	1,739
Public TB-DOTS providers	1,426	1,528	1,722	1,948	N/A	N/A	N/A	N/A
Private TB-DOTS providers	83	84	87	107	N/A	N/A	N/A	N/A
Number of cities/municipalities with at least one accredited provider	935	1,003	1,169	1,340	1,217	1,410	1,403	1,286
% of cities/municipalities with at least one accredited provider	57%	61%	72%	82%	74%	86%	86%	81%
Number of TB-DOTS claims paid*	50,244	44,320	39,009	41,267	53,300	59,033	64,762	48,191

[22] Querri A, Ohkado A, Kawatsu L, Remonte MA, Medina A, Garfin AMC. The challenges of the Philippines' social health insurance programme in the era of universal health coverage. *Public Health Action*. 2018;8(4):175–180. https://doi.org/10.5588/pha.18.0046.

	2022	2021	2020	2019	2018	2017	2016	2015
Total value of TB-DOTS claims paid (millions of pesos)	251.7	236.5	167.3	148.3	140.5	121.9	133.5	101.6
Total value of TB-DOTS claims paid, (millions of US$, mid-year exchange rates)	$4.6	$4.8	$3.4	$2.9	$2.6	$2.4	$2.8	$2.2
TB-DOTS as % of total PhilHealth claims paid	0.4%	0.4%	0.4%	0.4%	0.1%	0.1%	0.1%	0.1%

*Full treatment would involve two claims per case.
Source: PhilHealth Stats and Charts. See https://www.philhealth.gov.ph/about_us/statsncharts/.

PhilHealth Contributions to TB Service Coverage

According to the Global Tuberculosis Report 2022, TB incidence in the Philippines in 2021 was an estimated 741,000 cases (range: 401,000 to 1,180,000). Recorded new and relapse cases totaled 321,564, making treatment coverage about 43%. That same year, PhilHealth paid only 50,244 claims. A fully treated case requires two claims payments, so that means PhilHealth paid for about 25,000 to 40,000 cases (depending on assumptions about how many cases had two claims). This is equivalent to only 8% to 12% of recorded cases in 2021. TB-DOTS claims paid in 2021 totaled 236.5 million pesos, equivalent to US$4.8 million using the 2021 exchange rate (as shown in Table 5). This is about 5% of the estimated US$99 million in TB expenditure (domestic and external) and 12% of estimated domestic expenditure in that year.[23]

Conclusions

The Philippines experience offers cautionary lessons about the extent to which NHI programs can contribute to financing for and ensure access to TB diagnosis and treatment, depending on their design. As noted above, coverage of accredited TB providers is uneven in the Philippines, with only 57% of cities and municipalities having at least one such provider in 2022. Some providers report finding the accreditation process and claims processing cumbersome and also report difficulties receiving payments, since payments go first to local government units for eventual distribution. Payments do not cover the full cost of diagnosis and treatment—they are more of a “top-up,” given that salaries and other inputs are provided by other sources. Despite universal coverage of the population, PhilHealth covers only a modest amount of the total cost of TB diagnosis and treatment under the current approach.

[23] World Health Organization (WHO) Global Tuberculosis Report 2022, Country Profiles website. Philippines page. https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&entity_type=%22country%22&iso2=%22PH%22&lan=%22EN%22.

This example shows that including TB within NHI programs does not automatically ensure sustainable financing and universal access to services, especially when only a small share of the cost of services is covered through NHI and access barriers are complex, as in the case of TB.

Creating, Modifying, and Strengthening Health Financing Tools to Incorporate Donor-Funded Programs and Program Components

Health financing tools may need to be created, modified, or strengthened to allow for donor-funded programs and program components to be absorbed into domestic health financing arrangements. For example, the benefit package (the specified package of services that will be covered by government funding through any health financing arrangement, not just NHI) may need to be updated to specify entitlement to HTM services. Contracting and provider payment systems may also need to be updated to accommodate the particular requirements of HTM services, such as contracting with community health workers and nonstate service providers (Box 10).[24]

The process of designing or adapting health financing tools to incorporate donor-funded program components provides an opportunity to avoid or mitigate fragmentation, including in benefit packages, provider payment systems, and data and monitoring systems. In systems with a mix of health financing arrangements, the built-in fragmentation (e.g., when separate budget-funded and NHI arrangements are not connected or when funds for priority health programs flow largely outside of other general revenue–funded health services) can be difficult to overcome if the country has not harmonized key functions from the start (such as benefit packages, contracting, provider payment [including information systems], data reporting, and performance monitoring).

Key questions to address in a structured stakeholder dialogue are listed below.

Benefit packages:

- What HTM services and medicines will be included?
  - Are all aspects of prevention, diagnosis, and treatment explicitly guaranteed, and are entitlements clear to providers and patients?
  - How can multiple packages be harmonized, or how can fragmentation between preventive and curative services be avoided?
- Will the basis for entitlement to HTM services be on a contributory or noncontributory basis (even if the entitlement for HTM services is embedded within a mainly contributory scheme)?
- What will be omitted from the benefit package (e.g., population-based interventions)?

[24] UNAIDS. Global AIDS strategy 2021–2026: End inequalities. End AIDS. Geneva: UNAIDS; 2021. https://www.unaids.org/sites/default/files/media_asset/global-AIDS-strategy-2021-2026_en.pdf

- Will any high-cost services (e.g., for MDR-TB) be carved out and financed separately?
- What other specific benefits and quality standards (e.g., specific services, tests) should be included, and how should they be delivered to ensure quality?
- What is the process for updating the benefit package to include HTM services?

Contracting:

- Will contracting arrangements reinforce or modify existing service delivery arrangements and utilization patterns?
- What contracting arrangements are needed to ensure access to public and private providers, as appropriate?
- How can accreditation requirements help ensure the quality of services from contracted providers without making compliance too burdensome?
- What other specifications should be included in contracts (e.g., quality standards, generic prescribing, data reporting requirements)?
- How will partnerships with CSOs and the private sector be governed, who will coordinate the discussions, and who will have a seat at the table?

Provider payment:

- What incentives are needed to expand access to high-quality HTM and other priority services, and which provider payment systems are most likely to create such incentives in the current context?
- Are any modifications needed to existing provider payment systems to account for particular issues related to HTM services, such as community-based services and prevention in priority populations?
- How will payment rates be set to ensure high-quality, efficient HTM and other priority services while ensuring financial sustainability?
- How will the cost structures of different providers serving different populations be understood and addressed?

Health information systems and performance monitoring:

- How can the information system (from data collection forms to database) be integrated for insured and uninsured populations and for HTM and other priority services?
- How can indicators related to access and quality of HTM and other priority services be integrated into routine performance monitoring systems?

Box 10. Financing CSO-Led Delivery of HIV/AIDS Services

The contributions of CSOs in service delivery are widely recognized as central to achieving impact across many priority programs. This is particularly so with HIV/AIDS. Recognizing the role of CSOs in achieving impact and improving equity, the Global AIDS Strategy and UN Member States have set targets for CSOs to deliver 30% of HIV testing and treatment services and 80% of HIV prevention services for high-risk populations by 2025.

CSO-led delivery is heavily financed by Global Fund and PEPFAR support in many countries. There are many complex issues to consider in supporting a shift to domestic funding of CSO-led services and integrating it into national financing arrangements. For example, what is the government's *interest or potential interest* in contracting with CSOs to deliver services? Governments may see contracting with CSOs as politically sensitive (given the populations they work with), too risky, or too difficult. They may perceive the unit costs of CSO delivery as high, especially relative to highly constrained budgets for purchasing goods and services. Unit costs may in fact be relatively high if CSOs are serving vulnerable and hard-to-reach populations and/or if donor support includes salaries and per diems at higher levels than the norm in the country. Costing studies and costing guidelines may be helpful here.

Another issue is the ability of the government to contract with CSOs. What issues would need to be addressed in the government's legal frameworks, health financing policies, and regulations in order to contract with CSOs? How are CSOs legally formed, licensed/certified/accredited, and taxed, or how will they be, and how does or will government oversight occur? Does the government have the capacity—or can it develop the capacity—to procure CSO services and manage such contracts? What payment modalities might make the most sense given the array of services to be provided, such as community-based HIV testing, preexposure prophylaxis, postexposure prophylaxis, outreach services, treatment referral, or treatment adherence?

On the CSO side, are they willing to work with governments, or can such willingness be developed? What are the risks for CSOs? Do they see public funding as a reliable financing source? Do they trust that they will be paid in a timely way? Do they have the capacity to form as a legal entity? Some CSOs are dependent on technical assistance from donors for elements of their operations. Are they ready to work independently, or can they develop that capacity? Can they handle contract negotiations and the financial management and reporting involved in contracting?

To explore government funding of CSO-led delivery, dialogue among the government, CSOs, and partners can start by finding common ground and starting to build an understanding of the roles that CSOs can play and identifying where they might offer a clear comparative advantage. A roadmap could be developed to guide the contracting process and identify issues that need to be addressed (by both the government and CSOs) to enable contracting. Finally, starting small, with pilot efforts that would involve relatively easy contracting, can be a good step for building confidence, achieving some early success, and learning from experience.

The following case study from Côte d'Ivoire describes how the approach presented in this guide can inform a country's sustainability planning process.

CASE STUDY: Applying the Methodology to Côte d'Ivoire's Sustainability Planning Process

Côte d'Ivoire continues to record rapid economic growth and is positioned to move gradually from external financing to domestic financing for key health programs. It is also in accelerated transition from Gavi support and is expected to fully self-finance vaccines starting in 2030. Thus, sustainability planning is increasingly a priority for Côte d'Ivoire, especially with new initiatives affecting the country's health financing arrangements.

A technical working group to help improve the efficiency of external financing and the sustainability of internal financing is leading a process to draft a sustainability plan for continued implementation of six key health programs (for HIV/AIDS, malaria, TB, vaccination, maternal and child health, and nutrition) after the transition from external to domestic funding. The plan includes a monitoring and evaluation mechanism for the six programs and a roadmap to support implementation from 2023 to 2030.

Context

Côte d'Ivoire has had a mixed health financing arrangement since the introduction of an NHI scheme called *Couverture Maladie Universelle* (CMU) in 2014. The main objective of the scheme, which began with a pilot in 2017 for students and the most vulnerable and then a scale-up program in 2019, was to offer quality health care under financially sustainable conditions to anyone residing in Côte d'Ivoire through a monthly and individual contribution and a noncontributory medical assistance system for the financially vulnerable. The national health insurance fund (*Caisse Nationale d'Assurance Maladie*, or CNAM), which is housed under the Ministry of Labor and Social Protection, was created to regulate the NHI scheme. More recently, the country created a performance-based financing (PBF) unit, which has since been transformed into the Technical Secretariat for Strategic Purchasing. Another scheme, *Gratuité Ciblée* (targeted free care for mothers and children), launched in 2012 and is slated to be integrated into the CMU. These active steps to integrate health financing schemes further highlight the need to develop a concrete sustainability plan to address reforms in light of the potential withdrawal of funding from external partners.

Methodology

The methodology used to develop the sustainability plan started with a situational analysis to present the epidemiological outlook of each of the six programs, along with interventions implemented, main results, and the roles of partners. The analysis included the financing flows for the six programs, total and current health expenditures of the programs, sources of funds, and projected funding gaps. One key risk highlighted for Côte d'Ivoire is households being the largest source of funds for the six programs from 2011 to 2020, which will present a problem as the country seeks to devise equitable strategies to make up for declining external funding.

Government actors, members of CSOs, and technical and financial partners came together in a workshop in October 2023 to collectively assess the risks involved in the transition from external funding to domestic funding for the six programs. The risks were divided into three categories—service delivery risks, programmatic risks, and financial risks—so participants could think about the impact of the transition for each program. The key risks identified by the participants for all six programs included:

- Reversal of key health indicators
- Decline in service delivery volume
- People dropping out of free/subsidized programs
- Low mobilization of domestic resources to close financial gaps
- Nonintegration of interventions into the CMU care package

The participants developed mitigation strategies with expenditure and revenue projections for the six programs in different transition scenarios. The plan includes a detailed roadmap for preparing for the transition, with roles and responsibilities assigned to key partners and programs.

The workshop provided an opportunity for stakeholders to reflect on key aspects of the sustainability process, such as who should lead the transition process, the role of each actor, and potential challenges in developing the plan. Participants also discussed the link between transition and the country's objectives in terms of UHC, as well as opportunities and risks given recent health financing initiatives.

Opportunities in Côte d'Ivoire

As the transition process moves forward, Côte d'Ivoire has an opportunity to define how to absorb financing of key programs into national financing arrangements. Preliminary conversations are taking place about HIV services, and development partners have expressed interest in exploring mechanisms for absorbing vertical programs into the CMU scheme. With support from development and implementing partners, and in line with the country's UHC strategy, the government is pursuing costing of key interventions and programs (including maternal and child health, family planning, and community health outreach services, among others) to determine how such services can best be integrated into the national financing arrangements and benefit package.

Analytical Tools and Approaches and Potential Data Sources for Creating, Modifying, and Strengthening Health Financing Tools

Fundamental PFM Improvements

- How to make budgets work for health?
- Montreux Collaborative on Fiscal Space, Public Financial Management and Health Financing
- Leveraging public financial management for better health - Video Podcasts

Procurement and Supply Chain

- UNICEF Supply Chain Analysis and Intelligence Tool
- Global Fund's Pooled Procurement Mechanism
- Reference prices for ARVs through pooled procurement
- Global Drug Facility (for TB diagnostics and treatment)

General Strategic Purchasing

- SPARC Strategic Purchasing Progress Tracking Framework

Benefits Packages and Health Technology Assessment

- What's In What's Out: Designing Benefits for Universal Health Coverage
- The JLN Health Benefits Revision Guide
- iDSI Health Technology Assessment Toolkit

Contracting and Provider Payment

- Costing of Health Services for Provider Payment
- Provider Purchasing and Contracting Mechanisms
- Designing and Implementing Health Care Provider Payment Systems: How-To Manuals
- Assessing Health Provider Payment Systems: A Practical Guide for Countries Working Toward Universal Health Coverage

Performance Monitoring

- Using Data Analytics to Monitor Health Provider Payment Systems
- Measuring the Performance of Primary Health Care: A Practical Guide for Translating Data into Improvement

Part 3. Recommendations to the Global Fund on Supporting System Strengthening for Sustainability

Key Messages

The Global Fund and other donors can take steps now to strengthen countries' health systems and improve the likelihood of sustainability beyond transition.

The Global Fund can support countries in determining how HTM program components will be absorbed into domestic health financing arrangements and can invest in preparing those systems through its future grants and health system strengthening investments.

Channeling funds through domestic systems is one option for strengthening these systems in some contexts, but other options should also be considered.

The Global Fund should also consider direct investments that benefit health systems more holistically, such as funding to improve the interoperability of health information systems or support integrated laboratories.

The Global Fund has supported many measures to improve the sustainability of its HTM investments in the context of domestic health financing and service delivery. Through its future grants and health system strengthening investments, it can support countries in determining how HTM program components will be absorbed into domestic health financing arrangements and invest in preparing those systems. Channeling funds through domestic systems is one option for strengthening these systems in some contexts, but other options should also be considered. The Global Fund should also consider direct investments that benefit health systems more holistically, such as funding to improve the interoperability of health information systems or support integrated laboratories.

All of the measures listed below would continue the shift in Global Fund grantmaking and health system strengthening investments toward a holistic, sector-wide approach that aligns with government plans and priorities, aligns with and complements the investments of other funding partners, and increasingly sends funds through domestic government systems.

These measures can serve as a kind of checklist of items for Global Fund staff and Country Coordinating Mechanisms (CCMs) to consider as they work with governments, partners, and other stakeholders. Some measures may not be immediately feasible but could become viable later.

1. **Engage and collaborate with other donors in the sustainability dialogue.** Fiscal sustainability is a governmentwide issue that goes beyond any one program or indeed a country's health system as a whole. The Global Fund has limited leverage on its own to affect fiscal sustainability, but it can engage with other donors and with technical

partners so its recommendations and decisions can be informed by and embedded within the broader context. Opportunities to strengthen sustainability planning with bilateral donors such as PEPFAR are increasing through vehicles such as "transformation plans" for HIV response and sustainability by 2030 and "sustainability roadmaps."

2. **Align donor and government efforts on financing around a shared health system performance framework.** A clear, timebound strategy that addresses the main obstacles to improving health system performance can lead to better policy decisions, resource allocation, and investments. And a shared performance framework that includes evaluation as an integral component—rather than disparate approaches that are linked to different funding sources—can facilitate health system strengthening for sustainability. This requires donors to work together and with the government to develop a mutually agreeable framework with joint monitoring indicators supplemented by targeted studies as needed.

   This approach can take different forms. For example, most World Bank lending links the achievement of certain performance indicators—known as *disbursement-linked indicators*—to additional payments of flexible funding. In the case of Pakistan and Lao PDR, the Global Fund has joined with the World Bank, Gavi, and others to work with those governments to design the lending operations and consider implementation milestones and performance targets in an integrated and realistic way. The upcoming case studies illustrate how this approach to align support can take significant time and effort but also help reduce fragmentation and protect the stability of health spending in challenging fiscal conditions.

3. **Where feasible, ensure that grant funding flows through government systems.** There have been calls for all major global health agencies and initiatives to make concerted progress toward aligning with and using, wherever feasible, government systems in order to facilitate transparency, efficiency, sustainability, and country ownership of supported programs.[25,26] This should include accelerating efforts to align behind one national plan, one budget, and one monitoring and evaluation system, as well as enabling pooled and joint financing approaches to support core health system objectives. Piatti-Fünfkirchen et al. (2021) detail the ways donor funds can align with government plans, be reflected in government budgets, and flow through domestic financing arrangements.[25] Figure 6 depicts five options along a continuum.

   - **Option A: Off-plan, off-budget support for direct service delivery.** In this scenario, donor funds are not harmonized with government plans or budgets, and funds flow directly to service providers or NGOs or through other channels

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[25] The Lusaka Agenda: Conclusions of the Future of Global Health Initiatives Process (2023). https://futureofghis.org/final-outputs/lusaka-agenda/ [Accessed March 20, 2024].

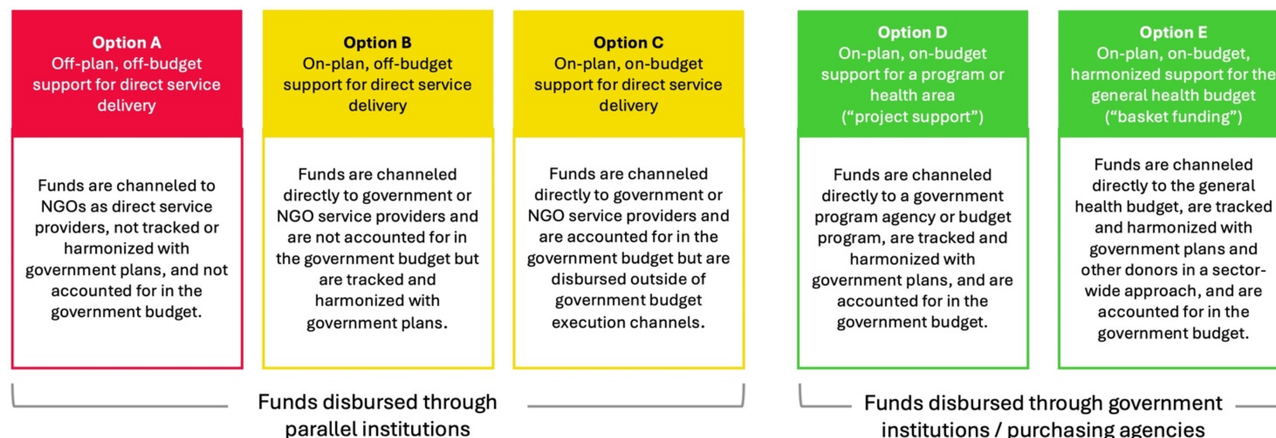
[26] Piatti-Fünfkirchen M, Hashim A, Alkenbrack S, and Gurazada S (2021). Following the government playbook? Channeling development assistance for health through country systems. Washington, D.C.: The World Bank.

to procure inputs (such as medicines or vaccines) or technical assistance. This is often the case when the principal recipient of a Global Fund grant is an NGO.

- **Option B: On-plan, off-budget support for direct service delivery.** This is similar to option A, but more efforts are made to harmonize donor investments with government plans. One example might be when a World Bank project includes a PBF program that is included in the government planning process but disburses PBF payments directly to health providers through a project implementation unit.
- **Option C: On-plan, on-budget support for direct service delivery.** This is similar to option B, but donor funds are reflected in the annual domestic budget even though they are disbursed outside of government budget execution channels.

  Options A, B, and C send funds outside of government institutions through parallel institutions and often use parallel procurement processes. Bypassing country systems can weaken existing structures and undermine development of the country's own systems.[25] However, options B and C align donor funding with government plans and Option C reflects donor investments in the domestic budget.
- **Option D: On-plan, on-budget support for a program or health area ("project support").** In this scenario, donor funds are channeled directly to a government program agency or budget program, are tracked and harmonized with government plans, and are accounted for in the government budget. For example, donor funds may be channeled to a national health insurance agency to provide coverage for priority populations for a package of services.
- **Option E: On-plan, on-budget, harmonized support for the general health budget ("basket funding").** In this scenario, also known as a sector-wide approach, funds are channeled directly to the general health budget, are tracked and harmonized with government plans and other donors, and are accounted for in the government budget.

Figure 6. Continuum of Options for Aligning Donor Funds with Government Plans and Budgets



Principal recipients of Global Fund grants include NGOs and governments. While many factors are important to consider in selecting principal recipients, sustainability is better served when the funding goes to governments and flows through domestic systems because of their awareness of, involvement in, and ownership of the funding and the visibility they can bring to priority programs. Global Fund support is also better aligned with national funding flows. The principal recipient for a Global Fund grant could be the MOF or national treasury, to incorporate funds into the general budget. For example, in Kenya the national treasury is a principal recipient of HTM grants from the Global Fund. NGOs also receive grants (e.g., Kenya Red Cross for HIV/AIDS and Amref Health Africa for TB and malaria). Similarly, in Cambodia, the Ministry of Economy and Finance was the principal recipient of HIV and TB grants in 2017.

Other government financing agencies can also serve as the principal recipient, such as a national health insurance agency to subsidize coverage of HTM and other services for target population groups. In a number of African countries, the Global Fund has identified opportunities for innovative funding pilots to cover insurance premiums for key populations (see the next case study). In Latin America, in collaboration with the World Bank, the Global Fund will support the government of Colombia and channel funds through Colombia's NHI system to cover premiums for Venezuelan migrants with HIV so they are ensured access to comprehensive care.

Disbursing grants to the MOH and MOF ("on budget") or other financing agencies is not without risks and tradeoffs, however—including potential delays and bottlenecks in funding flows, which can jeopardize the implementation of grant activities.[27] When on-budget financing is deemed too risky, it is essential to engage with relevant partners and government stakeholders to deal with the risks. If successive grants are managed

[27] Health Policy Plus. *Analysis of Fund Disbursement Bottlenecks Affecting the Cambodia Global Fund KHM-C-MEF Grant*. Washington, DC: Health Policy Plus; 2018. https://pdf.usaid.gov/pdf_docs/PA00TMB6.pdf.

outside of core government systems, that indicates a problem that is not being adequately recognized or addressed.

PFM weaknesses should be addressed through collaboration with key partners working on strengthening PFM, especially the World Bank and the International Monetary Fund, to identify the sources of PFM weaknesses and assess whether the bottlenecks are unique to the programs or part of a more general MOH or governmentwide problem. If these partners are supporting a plan for PFM improvement in the country, that plan can inform Global Fund decision-making.

4. **Align donor funding flows in a coordinated way behind government plans through Multi-Donor Trust Funds (MDTF).** For example, an MDTF was established with funding from Australia's Department of Foreign Affairs and Trade (DFAT) to support 12 countries in the World Bank's East Asia and Pacific region: Cambodia, Indonesia, Kiribati, Lao PDR, Myanmar, Papua New Guinea, the Philippines, Samoa, Solomon Islands, Tonga, Vanuatu, and Vietnam. The MDTF, managed by the World Bank, offers a way for donors to coordinate and align with governments on health sector financing and gives prominence to sustainability and transition issues for priority programs financed by global institutions such as the Global Fund, the Global Financing Facility, and Gavi. The MDTF has supported work to improve country-level PFM and strategic purchasing and identify legal avenues for governments to provide funding to CSOs for service delivery—all key sustainability issues for Global Fund–supported grants. The MDTF has also been used to ensure that government requirements for commodities for priority programs are included in budgets and in medium-term expenditure frameworks according to the government budget and planning cycle. With or without an MDTF and pooling of donor funds, governments benefit when donors work together to engage with ministries of health and finance on these important budgeting requirements. When they come together to engage in sustainability dialogue, they can be more effective and give more coherent messages to governments.

   Sometimes the Global Fund combines its grants with other sources of funding (primarily credits or loans from multilateral development banks) in what is known as *blended financing*. This can be more time consuming for the Global Fund to prepare and negotiate than its customary lending, but blended financing can be an important complement to the Global Fund's traditional grantmaking because the analysis, technical support, sector-wide dialogue, investments, and incentives that accompany such operations can be beneficial. Blended financing can also help support integration of certain elements of vertical programs into the broader health system, can incentivize countries to commit domestic resources to HTM, and can enable the Global Fund to leverage other partners' country presence and expertise.

5. **Link Global Fund investments to strengthen health financing arrangements that will absorb the programs.** Global Fund investments can be used to strengthen the health financing arrangements that will absorb HTM program components and to

improve the efficiency of spending in the health sector over the medium and longer term. This will enable greater levels of effective coverage to be attained from any given level of public spending on health. Taking the entire health system as the unit of intervention, a combination of "investment" (capital spending) and system reform are needed. This combined approach involves the following:

- Identifying specific health system areas, such as information systems, procurement, and disease surveillance/laboratories (e.g., through cross-programmatic efficiency analysis), that could be consolidated and strengthened through Global Fund investment.
- Considering investments (capital and training) in such systems on the condition that they are organized on a systemwide, population-wide basis rather than program by program.
- Considering pilots of more integrated approaches (such as pooling funds for conditional grants).
- Investing in integrated information systems.
- Where Global Fund resources are channeled to CSOs, working with the government so it can take on an increasing share of CSO contracts over time.
- Encouraging government-to-government sharing of experiences on contracting. Government officials may be nervous about trying innovations, and learning from peers could be helpful.

6. **Avoid approaches that are known to be unsustainable.** While HTM program staff are sometimes paid out of Global Fund grants, it is unsustainable to pay salary top-ups or differentials out of grant funds because it will make it difficult for skilled staff to transition back to government salaries.

CASE STUDY: Global Fund Coverage of Insurance Premiums in Two African Countries

In a number of African countries, the Global Fund has initiated innovative funding pilots in its seventh grant cycle (2024–2026) in which a portion of grants for resilient and sustainable systems for health (RSSH) will go toward covering insurance premiums for key populations. Such pilots are upcoming in Zambia and several states in Nigeria. In addition to covering premiums, a small additional amount is allocated to evaluation of the pilot, to help guide the design of similar investments—by the Global Fund and other donors—in the future.

Zambia

Established in 2018, the National Health Insurance Scheme (NHIS) in Zambia is compulsory for all Zambians. The National Health Insurance Management Authority (NHIMA) manages NHIS; premiums are a percentage of basic income (with exemptions

for vulnerable, elderly, and mentally/physically challenged populations) and are pooled into the National Health Insurance fund (NHIF). Ensuring adequate resources to provide coverage to poor and vulnerable populations has been a challenge.

The Global Fund received a request from NHIMA to finance the extension of NHIS coverage to certain noncontributing poor and vulnerable households currently enrolled in its Social Cash Transfer (SCT) Program. Through the RSSH grant beginning in 2024, the Global Fund will transfer money to NHIMA to cover premiums for SCT beneficiaries who are living with HIV or TB and disabled, in three provinces. The aim is to increase membership, improve access to health care for poor and vulnerable populations, and implement additional quality-related health system reforms. The grant will also cover implementation research and monitoring and evaluation.

Nigeria

Coverage under the National Health Insurance Authority (NHIA) in Nigeria remains very low. To support enrollment of vulnerable populations, the Global Fund will finance the enrollment of and premiums for women and children living with HIV and people diagnosed with drug-resistant TB in Lagos, Anambra, and Ebonyi states beginning in 2024. The funding will also support the states in increasing the number of facilities accredited under the state schemes, thereby expanding access to needed services in harder-to-reach areas.

After the initial three-year period, each state will assume responsibility for these key populations and ideally increase coverage beyond that. The accompanying evaluation will examine results in health expenditure, coverage, and treatment. It will also develop a state health insurance maturity model, to support donors and partners in funding similar investments in other states in the future.

Annex A. How This Guide Was Developed

Review of Existing Tools and Resources

The methodology used to develop this guide included reviewing existing tools and resources on sustainability planning for HTM, to avoid duplication and identify gaps in guidance on sustainability planning for countries with mixed health financing systems.

Tools and Resources Reviewed

- **Aceso Global/APMG Health:** Guidance for Analysis of Country Readiness for Global Fund Transition (2017)
- **Curatio International Foundation:** Transition from Global Fund Support and Programmatic Sustainability Research in Four CEE/CIS Countries–Synthesis Report (2015)
- **Eurasian Harm Reduction Network:** Transition Readiness Assessment Tool (2016)
- **The Global Fund/Pharos Global Health Advisors:** Guidance for Sustainability and Transition Assessments and Planning for National HIV and TB Responses (2021)
- **UCSF Malaria Elimination Initiative:** SUSTAIN: A Sustainability and Transition Readiness Assessment Tool for Malaria, Second Edition (2020)
- **USAID ASSIST Project/University Research Company:** Guide for Developing Sustainability and Transition Plans – Version 2.0 (2019)
- **USAID/PEPFAR/Health Policy Project:** Readiness Assessment: Moving Towards a Country-Led and -Financed HIV Response for Key Populations (2015)
- **WHO:** Preparations for Sustainability and Transition from Global Fund Support in the Eastern Mediterranean Region (2024)
- **WHO:** A System-Wide Approach to Analysing Efficiency Across Health Programmes (2017)
- **WHO:** Step-by-Step Guide to Conducting a Cross-Programmatic Efficiency Analysis (2022)
- **The World Bank:** Checklist for Transition Planning of National HIV/AIDS Responses (2016)

The review of the tools and resources also included a specific query for topics related to the absorption of priority programs into an established national health insurance mechanism. Some of the tools and resources make no mention of these topics and mention contracting only in the context of contracting with CSOs. Others mention national health insurance but only briefly, in one or two sentences that address expanding sources of domestic financing and including HTM in benefit packages, without further analysis.

Of the documents reviewed, a June 2022 draft of “Preparations for sustainability and transition from Global Fund support in the Eastern Mediterranean Region,” prepared for WHO, offered the most in-depth treatment of the topics and considered what aspects of services could be included or handled differently. Despite the increasing number of High Impact Africa countries that are developing laws or moving to implement purchaser-provider split arrangements (often under the heading of NHI), practical guidance is lacking in this area.

Stakeholder Interviews

Alongside the review of existing tools and resources, stakeholder interviews provided valuable insights into the strengths and weaknesses of current sustainability planning and opportunities for improvement. Over two rounds of interviews, 32 key informants (listed below) were consulted: representatives of global institutions, technical experts, and country stakeholders.

The Global Fund Health Finance Department provided an initial list of suggested interviewees and provided introductions; other connections were pursued through Results for Development leaders and partners. Those initial interviewees further provided suggestions for additional contacts.

Interviews included key questions (see below) about how sustainability conversations take place in the countries in which stakeholders are engaged, what types of analysis have been helpful, and how donors can play a more constructive role.

Interviewees were also asked for suggestions of relevant country examples where elements of sustainability or transition have been handled well and might illustrate themes or lessons. Those examples informed the case studies in this guide and also helped identify additional interviewees.

Interviewees

1. Abebe Alebachew Asfaw, health economist and health system consultant
2. Sarah Alkenbrack, World Bank Group
3. Chris Atim, Results for Development
4. Susanna Baker, USAID
5. Jhoney Barcarolo, Global Fund
6. Mark Blecher, National Treasury of South Africa
7. Emmanuel Bor, Gavi
8. Michael Borowitz, Global Fund
9. Peter Cowley, WHO
10. Annie Chu, WHO
11. John Fairhurst, Global Fund
12. Lisa K. Fleisher, USAID
13. Munir Kassa, Ministry of Health, Ethiopia

14. Anthony Kinghorn, Global Fund
15. Leizel P. Lagrada, University of the Philippines Manila
16. Elise Lang, USAID Tanzania
17. Maureen Lewis, Aceso Global
18. Benjamin Loevinsohn, Gavi
19. Lisa Luchsinger, USAID
20. Marty Makinen, health systems consultant and technical review panel member
21. Enos Masini, WHO
22. Noah Metheny, USAID
23. Somil Nagpal, World Bank
24. Justice Nonvignon, Africa CDC
25. Regina Ombam, health economics consultant for the East African community
26. Gene Peuse, USAID Tanzania
27. Elan Reuben, USAID
28. Michael Ruffner, PEPFAR
29. Susan Sparkes, WHO
30. Chris Wolff, Bill & Melinda Gates Foundation
31. Fikru Worku, United Nations Population Fund Ethiopia
32. Pierre Yaméogo, Ministry of Health, Burkina Faso

Interview Questions

Round 1:

1. What has been your involvement in sustainability and transition planning (from the Global Fund or other organizations) at the global and/or country level in the past several years?
2. What do you see as the major strengths and/or achievements of the exercises you have been involved in, in terms of process, political buy-in, technical substance, analytics, and tools? What were contextual enablers and/or mechanisms that led to this success?
3. What do you see as the major weaknesses and missed opportunities, and how might you suggest they be addressed? What do you see as the major failures—what went wrong, and what can we learn from those experiences in terms of what could have been done/planned better?
4. What kinds of questions do countries need answered through a sustainability planning process to inform system integration efforts and ground the analytics and processes in their health financing and service delivery systems? (Are there specific tools or analyses that have helped countries answer these questions?)
5. What kinds of issues arise when stakeholders discuss how programs will be sustained through different health financing arrangements (e.g., integration into national health insurance, engagement of private sector providers)? What analytics or tools could be most helpful to inform these discussions?

6. How do you see the challenges of getting partners better aligned on sustainability planning? Where do you see possible opportunities to make progress?
7. Are there particular programmatic areas, such as commodity sustainability, that need sharper focus?
8. Do you have suggestions of materials, tools, guidance, or case studies that could help low- and middle-income countries with sustainability planning that is integrated into overall domestic financing and resource mobilization efforts?
9. How should we be thinking about defining sustainability? What needs to be sustained? From whose perspective?

Round 2:

1. We have been using this table [show typology table] as an early framework for our process guide: One dimension is based on how services are delivered and financed, and the other is progress toward absorption of vertical Global Fund programs.
   - Does this resonate? Did we capture where you are as a country and the kinds of issues you are grappling with?
   - Given where the country is in terms of donor transition or health financing strategy, what questions are most relevant or pressing in thinking about sustainability?
2. Have there been any decisions or planning about where these programs would live once fully domestically financed, and have those conversations begun?
   - If yes, what's been discussed? Who has led those discussions? Who has participated? What kinds of analysis would be helpful to further those discussions or inform any decisions?
3. What are the mechanics, in terms of making the decision and actually seeing the programs absorbed? (Can probe on changes to the benefit package, provider payment mechanisms, governance/responsibility.)
   - If no, any thoughts on how to see the sustainability conversation brought up now? How to make sure that important conversation is started in plenty of time? How will that decision (about the future of the Global Fund programs) be made?
4. Are there ways that Global Fund processes could be changed to better support domestic systems and processes? Or better prepare the country for transition? (If you could wave a magic wand, what would you change?)

Annex B. Additional Case Studies

CASE STUDY: Pooled Donor Financing for the National Health Support Program in Pakistan

Pakistan's National Health Vision 2016-2025 found that the country's health system faced challenges of "vertical delivery structures and low performance accountability within the government, creating efficiency and quality issues" and that progress had been constrained by fragmented service delivery. The document laid out a strategic vision that included government support for the integration of vertical programs at the provincial level.

To support this vision, the Global Fund joined forces with the Bill & Melinda Gates Foundation, Gavi, the Global Financing Facility, and the International Development Association to improve equity and quality in the delivery of essential PHC services in Pakistan through the World Bank's National Health Support Program. The program is national in scope and provides considerable support to three provinces—Khyber Pakhtunkhwa, Punjab, and Sindh—given the decentralization of health care in Pakistan. It supports the government's path to UHC, with a focus on implementing the benefit package at the primary and secondary care levels. The program uses the World Bank's Program-for-Results (PforR) lending instrument, which disburses funds largely based on achievements rather than focusing primarily on input-based financing. One of the disbursement-linked indicators for the three provinces is the TB case notification rate in each year of the project, which is of particular interest to the Global Fund.

This approach has its challenges. The necessary coordination and alignment, especially when PforR is being used for the first time in a country, can require significant time. Funders may have different timelines and processes for preparing and clearing their involvement. As a results-based approach, PforR may be considered risky. But more integrated approaches to PHC may be seen as diluting the focus on a particular disease area.

At the same time, aligning and pooling financing across donors could yield important benefits to the government and to sustainability. Given the fiscal crisis in Pakistan, which has been worsened by climate-related emergencies, fiscal space is shrinking and the government faces many competing priorities. Donor alignment can help protect health spending, improve aid predictability, avoid conflicting policies, and align with country processes and systems, all of which is important for sustainability. Collaboration is particularly important given that health has been devolved to the provinces and the provinces have limited capacity to deal with many donors. The approach also moves away from earmarked funding for vertical programs to a greater focus on coordinated investments for integrated systems and on results.

Implementation is still at the early stage. The project was approved by the World Bank Board of Governors in June 2022 and became effective in October of that year. It is accompanied by a monitoring, evaluation, and learning agenda that should yield important insights to inform future donor collaboration.

CASE STUDY: A Promising Joint Financing Platform in Lao PDR

In Lao PDR, the Global Fund worked with the World Bank to develop and co-finance the Health and Nutrition Services Access Project (HANSA), providing US$10 million of the US$36 million in total funding. This was approved by the World Bank Board in March 2020. This approach pools external funding at the country level to jointly finance agreed-upon project expenditures. It aims to align donor efforts to improve health outcomes by increasing financing and improving performance at the front lines.

In regional partnership with Australia's DFAT, a costed essential health services package includes the cost of mainstreaming delivery of vertically delivered priority public health programs (including for HIV, TB, malaria, and immunization). Disbursement-linked indicators include the number of notified cases of all forms of TB and increased coverage of HIV testing of key populations and treatment for people living with HIV.

HANSA2 is now under development, with more donors joining the next phase of the project. It is expected to be financed by the Lao PDR government, the Global Fund, DFAT, Gavi, and the World Bank. Similar to HANSA, HANSA2 aims to reduce fragmentation in PHC financing and service delivery as an important step toward sustainability of financing and service delivery. This is particularly urgent for immunization, as Lao PDR is expected to transition from Gavi support (currently envisioned for 2025). But important lessons can be expected for HTM services as well.

CASE STUDY: Financing to Spur More Effective HIV/AIDS Coverage in Colombia's NHI for Venezuelan Migrants

The Global Fund has aligned with the World Bank on an operation that will provide financing for the Colombian government to address some of the challenges in the country's NHI program, Colombia General System of Social Security in Health.[28] Coverage is nearly universal, at about 98% of the population. The program provides good financial protection, with out-of-pocket expenditure on health in Colombia among the lowest in the Latin American region, at an estimated 14% of current health expenditure in 2020.[29] But challenges remain, particularly in terms of coverage in rural and remote areas and coverage of Venezuelan migrants living in Colombia. Venezuelan migrants tend to be highly vulnerable, with a higher burden of disease relative to the general Colombian

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[28] World Bank website. "The World Bank Group announces new country partnership framework with Colombia." https://www.worldbank.org/en/news/press-release/2024/02/13/el-grupo-banco-mundial-anuncia-nueva-alianza-estrategica-con-colombia. Accessed June 18, 2024.

[29] WHO Global Health Expenditure Database. https://apps.who.int/nha/database/. Accessed November 5, 2023.

population. Many are living in frontier areas that are relatively more underserved by the NHI system.

With the Global Fund’s modest contribution of US$5 million to the overall financing package, the operation, which uses the PforR lending instrument, will link disbursements to the achievement of defined results. Global Fund participation ensures a focus on HIV/AIDS. One of the planned disbursement-linked indicators is a defined increase in the number of Venezuelan migrants with HIV who have access to comprehensive care, including antiretrovirals. This innovative financing approach could produce a large impact with a relatively small investment.