Applying lessons learned from the USAID family planning graduation experience to the GAVI graduation process

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As low income countries experience economic transition, characterized by rapid economic growth and increased government spending potential in health, they have increased fiscal space to support and sustain more of their own health programmes, decreasing need for donor development assistance. Phase out of external funds should be systematic and efforts towards this end should concentrate on government commitments towards country ownership and self-sustainability. The 2006 US Agency for International Development (USAID) family planning (FP) graduation strategy is one such example of a systematic phase-out approach. Triggers for graduation were based on pre-determined criteria and programme indicators. In 2011 the GAVI Alliance (formerly the Global Alliance for Vaccines and Immunizations) which primarily supports financing of new vaccines, established a graduation policy process. Countries whose gross national income per capita exceeds $1570 incrementally increase their co-financing of new vaccines over a 5-year period until they are no longer eligible to apply for new GAVI funding, although previously awarded support will continue. This article compares and contrasts the USAID and GAVI processes to apply lessons learned from the USAID FP graduation experience to the GAVI process. The findings of the review are 3-fold: (1) FP graduation plans served an important purpose by focusing on strategic needs across six graduation plan foci, facilitating graduation with pre-determined financial and technical benchmarks, (2) USAID sought to assure contraceptive security prior to graduation, phasing out of contraceptive donations first before phasing out from technical assistance in other programme areas and (3) USAID sought to sustain political support to assure financing of products and programmes continue after graduation. Improving sustainability more broadly beyond vaccine financing provides a more comprehensive approach to graduation. The USAID FP experience provides a window into understanding one approach to graduation from donor assistance. The process itself—involving transparent country-level partners well in advance of graduation—appears a valuable lesson towards success.

Keywords GAVI, vaccine, immunization, family planning graduation, USAID
KEY MESSAGES
- The 2006 USAID FP graduation strategy is an example of a systematic phase-out approach from donor development assistance based on pre-determined criteria and programme indicators.
- Lessons learned from the USAID FP experience can be applied to the GAVI graduation process which is triggered by a macroeconomic indicator, gross national income.
- GAVI plays an important role in financing new vaccines; the role other partners play in providing technical support to health systems that strengthen the reliable and timely vaccinations is also critical.

Introduction
As countries develop economically, there is a decreasing need for donor development assistance. Phase out of external funds can be systematic and efforts towards this end concentrated on government commitments towards country ownership and self-sustainability. The 2006 US Agency for International Development (USAID) family planning (FP) graduation strategy is one systematic phase-out approach implemented by USAID. Criteria for graduation are based on pre-determined criteria and programme indicators. In 2009, the GAVI Alliance (GAVI), formerly known as the Global Alliance for Vaccines and Immunizations, which primarily supports financing of new vaccines, approved a graduation policy process (effective in 2011) from GAVI assistance. Countries whose gross national income (GNI) per capita that exceeds $1570 (based on $1500 GNI in 2010 adjusted to 2014 present dollars) enter into a 5-year tiered graduation process where GAVI support is incrementally decreased (GAVI Alliance 2009). Countries with this macroeconomic threshold have the fiscal space to support and sustain new vaccines and subsume costs currently paid through GAVI (Saxenian et al. 2011). These assumptions are based on the vaccine price and the number of doses countries will purchase. Fiscal space analysis of 16 graduating countries estimates that countries will need to spend on average 0.5% of domestic government health expenditures in vaccines (GAVI Alliance 2013a). This article compares and contrasts the USAID FP and GAVI graduation processes to apply lessons learned from USAID’s FP experience to the GAVI graduation process. The GAVI experience is nascent in that no country has yet graduated against the 2011 GAVI policy.

GAVI graduation
Since GAVI was created in 2000, only three countries (Bosnia and Herzegovina, China and Turkmenistan) have graduated from GAVI support. These countries graduated when no explicit policy was in place. Countries graduated by virtue of economically ‘growing out’ of the GAVI eligibility threshold at the time. These countries appear to have continued supporting GAVI-subsidized vaccine; however, new vaccine introduction has been limited (World Health Organization 2014a). GAVI seeks to support countries to phase in more sustainable domestic government financing for the procurement of vaccines, particularly for use at levels of governance (districts) where service delivery is often provided. GAVI’s business model is based on the assumption that countries will gradually absorb the costs of the vaccines that were introduced with GAVI support (GAVI Alliance 2010). The GAVI co-financing policy requires countries to have some level of domestic government spending on vaccines funded by GAVI to help foster country ownership and build sustainability over time. To prepare for phase out of GAVI funding, the GAVI graduation policy structures the 5 year graduation period by incrementally increasing a country’s annual co-financing requirement, the government’s contribution towards vaccine purchase. The first year of the 5-year period is a ‘grace period year’ wherein the co-financing requirement is the same as the previous year requirement. An incremental increase in the co-financing requirement occurs every year based on the difference between the grace year period co-financing and the full amount countries will have to absorb upon graduation. An incremental 20% of this difference is added each year during the GAVI 5-year graduation period from Year 1 to Year 5 when GAVI support ends beginning in Year 6.

GAVI transition plans
Recognizing the limitations and potential bottlenecks to graduation, GAVI created a framework to guide country assessments (to be done 2 years prior to entering into graduation) and develop transition plans (during the 5-year graduation period) in three areas necessary for successful graduation for financial sustainability: (1) ability of countries to finance their own immunization programmes with their own domestic government resources, (2) ability of countries to manage procurement and supply and (3) ability of countries to set up sound decision-making processes for selecting products and prioritizing future vaccine introductions (GAVI Alliance 2013b). When this framework was applied to a handful of countries, lessons emerged: (1) increased communication was needed from GAVI to countries about the graduation process, future financial requirements and ability to access GAVI-pricing on vaccines after graduation; (2) countries face varying financing challenges (e.g. cumbersome budgetary process and health reform), even in light of the fiscal space to pay for vaccines; (3) depending on the source of vaccine [i.e. procurement through a United Nations (UN) Agency, self-procurement and domestic vaccine producer], countries need to strengthen management of procurement including product and pricing strategies; (4) strengthening the national regulatory authority’s (NRA) functions, necessary for market authorization in a country, need to be separate from the vaccine procurement duties and (5) a country’s decision to adopt a new vaccine may impact the financial ability to sustain vaccines introduced through GAVI support.

To support graduating countries more broadly beyond financial sustainability alone, GAVI recently approved access to
funds to support a more comprehensive approach to graduation, seeking to improve coverage indicators, immunization programme performance and deeper systems issues. A large proportion, nearly 60% (as of October 2013), of graduating countries do not have access to funds that can be used for health systems strengthening (GAVI Alliance 2013c). Funds, including graduation grants to support activities in costed graduation plans (e.g. investments in NRA and laboratory capacity, investments in cold chain gaps, conducting disease burden studies and cost-effectiveness analysis for future vaccines to improve decision-making processes), and health systems funding to support graduating countries with diphtheria–tetanus–pertussis (DTP3) coverage levels below 90% have been made available to countries. Various GAVI funding streams come with eligibility requirements. The 2013 cohort of 17 GAVI countries will graduate between 2016 and 2019. Subsequent annual cohorts are estimated to be approximately two to three countries a year, depending on how well countries improve economically. As of 2014, three additional countries have entered into graduation (GAVI Alliance 2014).

What does successful GAVI graduation look like?
GAVI seeks to mitigate risk and optimize the graduation process by developing a country’s ability to finance and manage the procurement process of their entire (government purchased traditional and GAVI-supported new vaccines) portfolio and support future new vaccine introductions (Saxenian et al. 2011). Upon graduation, countries can continue to access GAVI prices for vaccines that have negotiated prices (for a limited period); however many countries are still not fully supporting their own purchase of traditional, less costly vaccines (GAVI Alliance and The World Bank 2012; GAVI Alliance 2013b; Kadar et al. 2013).

Because the current GAVI graduation policy is based on one economic indicator countries may have low performing immunization programmes (e.g. based on coverage levels, measures of equity and adoption of new vaccines nationally) upon graduation and/or a high number of vaccine costs to absorb (Table 1). Recognizing the implications of their current policy, GAVI is examining broader dimensions of sustainability and exploring additional criteria to support countries towards successful graduation. Such criteria include defining an ‘exit criteria’, to in part, address both financial and programmatic sustainability in ‘weaning’ countries off GAVI support (GAVI Alliance 2014). Added attention to programmatic needs of countries appears to better align with GAVI’s definition of successful graduation which includes programmatic along with financial performance. Moreover, GAVI seeks to increase support to countries prior to graduation by expanding country assessments and subsequently GAVI transition plans to include mitigation measures for systematic bottlenecks to financial and non-financial programmatic dimensions. Thus, successful graduation can be characterized as: (1) financial sustainability for the purchase of vaccine and support of immunizations with the use of domestic funds and (2) high performing immunization programmes with national coverage levels of 90% in each country and at least 80% in each district of a country.

USAID FP assistance: the graduation strategy and technical note
USAID is a global technical leader in FP and has been for over 50 years, advancing new technologies and supporting voluntary FP programmes that enable couples to determine whether, when and how often to have children. USAID is also the largest funder of FP programmes globally. The Agency invests in strengthening the essential elements of successful FP programmes—supportive policies, evidence-based programming, leadership and management, effective communication, contraceptive commodity security, high-performing staff, client-centred care, easy access, affordable services and integrated services—to improve knowledge, access and voluntary use of contraceptive methods (Knowledge for Health 2013). Two elements—supportive policies and contraceptive commodity security—have overlap with the GAVI model described in this article. Collectively, the essential elements support provision of FP as a routine part of primary health services in many countries. Over the past four decades, modern contraceptive prevalence levels (MCPR) for women in union, a direct measure of the desired outcome of family planning/reproductive health (FP/RH) programmes, have increased across the developing world (Singh and Darroch 2012).

USAID began a ‘strategic budgeting’ process in 2004 to refocus its FP investment in regions with greatest need for services, primarily sub-Saharan Africa and South Asia. This rebalancing of USAID’s FP portfolio through phase out of FP funding in countries with high potential for sustainable FP programmes lead to the recognition that an abrupt end to funding

Table 1 Key indicators for USAID priority countries projected to be in GAVI graduation process by 2018

<table>
<thead>
<tr>
<th>Country</th>
<th>Estimated GAVI graduation period</th>
<th>GNI per capita</th>
<th>Vaccination coverage DTP3 (%) 2009, 2010, 2011</th>
<th>Equity ratio (DTP3 highest wealth quintile:lowest)</th>
<th>Estimated GAVI supported vaccines at the time of graduation</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>2015–2020</td>
<td>1530</td>
<td>72, 72, 72</td>
<td>2.42 (DHS 2005–2006)</td>
<td>Penta</td>
</tr>
<tr>
<td>Indonesia*</td>
<td>2012–2017</td>
<td>3420</td>
<td>62, 63, 63</td>
<td>1.24 (DHS 2007)</td>
<td>Penta</td>
</tr>
<tr>
<td>Zambia</td>
<td>2017–2022</td>
<td>1350</td>
<td>94, 83, 84</td>
<td>1.21 (DHS 2007)</td>
<td>HPV, PCV, penta, RV</td>
</tr>
</tbody>
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*A current graduating country.

Abbreviations: GNI, gross national income; DTP3, diphtheria-tetanus–pertussis, third dose; HPV, human papilloma virus; menA, meningitis A; penta, pentavalent; PCV, pneumococcal conjugate; RV, rotavirus; YF, yellow fever; DHS, Demographic Health Survey.

Source: GAVI, World Bank, World Health Organization.
could damage or even reverse programme progress and investments made to date. With improving FP indicators and outcomes in Latin America and the Caribbean (LAC), this region was slated to see the biggest decrease in funding. USAID led a collaborative process internally to establish a graduation strategy, based on data-driven, defined technical criteria, developed and carried out deliberately over the course of several years. In developing the strategy, USAID drew on its experience phasing out FP assistance in countries during a period from 1990 to 2003 when no formal FP graduation strategy was in place: Tunisia, Morocco, Mexico, Brazil, Colombia, Chile, Costa Rica and Ecuador (Wichkm et al. 1995; Alkenbrack and Shepherd 2005).

USAID developed a graduation strategy in 2006, the Technical Note: Approach to Phase-out of USAID FP Assistance which defined two indicators as triggers for starting the strategic planning process: modern contraceptive prevalence rates (MCPR) of married women of reproductive age greater than 48%, including women in union, and a total fertility rate of less than 3.2 (USAID 2006). The Technical Note also considered additional programmatic criteria, which were difficult to measure but important to discuss in planning key activities: at least 80% of the population can access at least three methods of FP; no more than 20% of FP products, services and programmes offered in the public and private sectors are subsidized by USAID; and major service providers in all sectors [public, non-governmental organization (NGO), commercial] generally meet and maintain standards of informed choice and quality of care. Although not a requirement, the release of new Demographic Health Survey (DHS) or Reproductive Health Survey results often triggered the graduation discussion when threshold indicators were met.

USAID conducted country visits to perform a readiness assessment including site visits to service delivery sites and commodity warehouses at the central, regional and local levels; key informant interviews of relevant partners and government organizations including USAID projects; and a desk review of the country programme and existing data. A widely vetted country-tailored FP graduation plan that included strategic prioritization of critical areas, financially budgeted recommendations for action, associated benchmarks and indicators to assess progress and a timeline for final graduation was developed. The length of time planned for reaching FP graduation as well as key interventions was based on ‘readiness for graduation’ relative to national commitment to and adequate financing for programmes, technical proficiency and needs, considering the six foci:

- contraceptive product security (uniformity and predictability for demand forecasting);
- advocacy, policy dialogue and political commitment (in contraceptive financing and in support of the overall FP programme);
- data for decision making;
- focus on equity (e.g. special populations—rural, indigenous and youth);
- health reform
- and institutional capability and human resource development (including training in specific method provision such as clinical methods).

A total market approach that assessed the public, NGO and commercial private sector mix for FP products and service delivery was also considered. USAID sought to provide sufficient time to reinforce national commitment and strengthen public and private sector capacity to finance, lead and sustain FP programming by starting to plan for graduation years in advance. The graduation process was rolled into USAID’s on-going technical assistance and programme budget and did not represent significant marginal costs. Successful USAID graduation was defined as a country’s ability to meet the following criteria: (1) sustained or improved MCPR, (2) sustained on-the-ground technical, administrative and programmatic capacity to continue service delivery and (3) continued financing (or increases) of FP service delivery and commodities relative to levels prior to graduation (USAID 2006).

What are the differences between the two approaches?
The USAID and GAVI approaches seek to prepare countries to absorb costs previously subsumed by external funds. The differences between the two approaches are inherent to the missions of the respective organizations. USAID’s development mandate is to strengthen country health systems (e.g. human resources and governance) and country sub-systems (FP, immunization) to provide equitable and accessible health services for those who need them. GAVI’s model—to accelerate access to new vaccines— is predicated on sustainable vaccine financing with the recognition that a health system is critical to reaching every child in every birth cohort in a timely manner with immunizations. The majority of GAVI funds are for the financing of vaccines, though a portion of funds supports health system strengthening and new vaccine support for introduction. Partners, like USAID’s technical implementing partners and others, largely provide those inputs to countries to strengthening immunization systems. USAID is also a significant financial contributor to the GAVI Alliance and an Alliance partner.

Methods
The authors conducted content analysis of articles and documentation related to FP programming, graduation plans and funding decisions on FP. A review of documents was guided by a focus on the following questions:

1. What are the differences and similarities between the two health interventions, relative to the six focal areas in the FP graduation plan that may affect the applicability of FP graduation on the GAVI process?
2. What were lessons learned from the process of executing the 2006 USAID FP Technical Note?
3. Which of the six strategic foci used in the USAID FP graduation plans were most applicable to the GAVI graduation process and what were the characteristics of USAID support provided in these areas?

Results
Similarities and differences: FP and immunizations
The similarities and differences between the two programmes, through the lens of the six foci of the USAID graduation plans, are important to understand as these differences and
similarities may affect applicability of the USAID FP graduation experience to the GAVI process. Unlike FP, immunization programmes are largely a public sector responsibility and health policies dictate that immunization provided through public sector services are free. This is because vaccination is distinguished from other health interventions based on its public health benefit: immunization protects not only the individual vaccinated from vaccine-preventable diseases, but also those around them by reducing community exposure and potential transmission of bacteria and viruses to others. This concept of community immunity protects unvaccinated individuals, particularly the most vulnerable populations, when sufficient numbers of people are vaccinated and provides the basis for public support. Vaccination coverage levels must also be high in order to achieve herd immunity. Unlike FP, global targets have been established for immunization that prescribe the same targets for all countries—nationwide coverage of the third dose of DTP3 vaccine of 90% in each country and at least 80% in each district of a country (World Health Organization 2014b).

Contraceptive product security
Immunization programmes conform to a national schedule that is uniformly administered (with no choice on presentation or type of vaccine) to every birth cohort in each country. In contrast, FP programmes seek to improve method mix (choice) and services are delivered through a mixed public–private (commercial and NGO) sector system. This mixed system enables FP programmes to provide services and commodities to more of the population, with those who can afford to pay accessing services and commodities through the private sector while those who cannot afford to pay receiving services in the public sector for free.

This distinction has profound implications in product, vaccine or contraceptive, security and procurement. Although FP stresses method choice and requires routine re-supply of methods such as oral and injectable contraceptives, all children require the same vaccines and a fixed number of doses. An entire birth cohort every year receives the same vaccines in uniform dosage, all in accordance to the national schedule based on the premise that births are distributed evenly over the course of the year. Therefore, demand forecasting of vaccines for future needs is more straightforward. However, supply chain management can be more difficult because of the need for cold-chain capacity. Vaccines must be maintained at proper temperatures throughout the length of the cold chain and until they are used in vaccination sessions and occasional mass campaigns (e.g. polio and measles) lead to periodic surges in requirements for cold chain storage capacity and transport. Like FP products, vaccines are centrally procured [largely by the United Nations Population Fund (UNFPA) or USAID for FP commodities and the United Nations Children’s Fund for vaccines, (UNICEF) respectively] and often centrally distributed and managed by the government; vaccines used in the private sector are also often managed by the public sector (Levin and Kaddar 2011). Unlike vaccines, several long acting and permanent FP methods require clinical training and surgical and medical supplies.

Advocacy, policy dialogue and political commitment
Both FP and immunization programmes involve care-seeking behaviour. However, political leaders and communities tend to view routine immunization as an essential service, a ‘right’ that should be available to all. In contrast, FP programmes are more controversial with wide-ranging levels of support for FP programming. Assuring political commitment by governments to finance commodities and products and support health service delivery programmes is important to both programmes.

Data for decision making
Immunization programmes use real-time data generated by administrative health information systems at peripheral and district levels to monitor progress, problems and shape ongoing planning. Although population-based surveys such as the DHS and Multiple Indicator Cluster Survey supplement administrative data, these surveys occur too infrequently (often every five or more years) to support decision making to improve programme performance and efficiency. In contrast, FP utilizes survey data to monitor programmes over time and to trigger discussions on FP graduation. Routine data exist but have more limitations than population data. USAID has invested in building the capacity of Contraceptive Security Committees (CSCs) to analyse and use data and has worked to build sustainable capacities through data collection partners, with particular focus on in-country institutions (e.g. government, universities and NGOs) to be able to conduct population-based surveys, analyse and use data after graduation (Menotti and Sharma 2007). CSCs are often created to maintain a focus on contraceptive security and long-term product availability issues, strengthen co-ordination between a broad range of stakeholders and reduce duplication and inefficiencies in a country.

Focus on equity: special populations
Immunizations are indicated for all children in every birth cohort and detailed planning for routine immunization service delivery increasingly focuses on reaching hard to reach populations—defined in geographic, cultural or other terms. FP programmes also seek to close the equity gap among special populations (e.g. indigenous, rural and poor) with less equitable access to products and services. In Nicaragua, the graduation plan focused on reducing the disparity in access for rural women, reduction in out-of-pocket expenditures among poor women, addressing the needs of adolescents and gender-specific objectives such as seeking to increase participation of men in FP (Avila et al. 2012).

Health reform
Health reform is often designed to expand access, improve quality and decrease the costs of health care. In countries undergoing health reform, USAID has sought to ensure components of FP were explicitly included into the basket of essential health services. Vaccines are largely included in this basket. In Honduras, an innovative health reform model that was rolled out in several departments included public and private service provision of FP and had thoughtful budgeting and training components for FP which were being supported to reach scale at the national level.
Institutional capability and human resource development

Human resource and institutional capacity and capability are essential across health programmes and a fundamental building block of a functional health system. Immunization and FP programmes require relatively simple skills to perform properly (with the exception of procedures for implant, intrauterine device insertion and removal and surgical contraception for men and women). In many countries, only trained health workers (not volunteers) are permitted to provide injectable vaccines and perform invasive procedures (e.g. female sterilization).

Lessons learned: the process of implementing the technical note

USAID sought to foster a deliberate, systematic, data-driven approach through transparent country engagement and a strategy development process that emphasized communication and dialogue among host country counterparts and other assistance partners. FP graduation discussions were constructed around programme needs, gaps and realistic timelines towards graduation and public events were used to recognize host country counterparts for having taken steps to improve programme performance, sustainability and to celebrate success inherent in graduation itself. Although the time needed to develop and implement strategies in the FP graduation plan may have seemed lengthy; countries recognized the need for sufficient time to execute key activities (e.g. NGOs to reach financial self-sufficiency; governments to develop and institutionalize procurement, planning, financing and logistics management systems). The use of multi-sectoral, national-level CSCs, primarily in LAC, often served as an operational group established to raise awareness, foster dialogue and facilitate FP graduation by addressing critical gaps and challenges (Betancourt 2007; USAID 2013). Since graduation some of these CSCs have been officially recognized by their governments (via ministerial resolution or presidential decree (Dominican Republic, Nicaragua)) as multi-sectoral entities to support and strengthen development and consolidate universal access to sexual and reproductive health and, sometimes, prevention of HIV and the commodities required for treating it (Avila et al. 2012).

FP graduation plans served an important purpose by focusing on strategic needs across the six graduation plan foci and facilitated graduation with pre-determined financial and technical benchmarks. The goal of the FP graduation plan was to prioritize activities during the remaining recommended years of USAID funding. To date no countries have reported ‘backsliding’ whereby coverage rates declined. The FP graduation plans were specific to each country, accounting for different contextual factors such as government leadership, the level of dependency on USAID funding or the provision of FP methods across public and private sector service delivery providers. In select cases, USAID conducted evaluations of midterm progress of the graduation plans to determine whether the country was on track for planned graduation and meeting key benchmarks. These evaluations aided country offices in determining whether activities needed to be adjusted to improve progress. In some cases, recommendations were made to adjust the timeline for graduation (Avila et al. 2012).

Review of USAID graduates: characteristics of technical assistance relevant to GAVI

To date 11 graduation plans (Dominican Republic, Egypt, El Salvador, Honduras, Jamaica, Kazakhstan, Nicaragua, Paraguay, Peru, Ukraine and Uzbekistan) have been developed using the 2006 Technical Note: Approach to Phase-out of USAID FP Assistance. Eight of these countries have graduated and three countries are projected to graduate in USAID fiscal year 2014 (Ukraine and Honduras) and beyond (Egypt). From the time a country was identified as a candidate for graduation to full phase out of funding could take between 2 and 10 years, with most countries actually graduating in a 2- to 6-year time frame.

Contraceptive commodity security

A country could not graduate without contraceptive commodity security, meaning a government had to be able to sustainably finance and negotiate commodities at reasonable prices and manage the complex logistics process (forecasting, warehousing and distribution to end users). In 9 out of the 11 countries, USAID phased out of contraceptive donations before phase out of technical assistance. USAID generally viewed commodity donation as separate from technical assistance. As part of a FP Graduation Plan, commodity donations were often phased down over several years, concurrent with incremental percentage increases in the total commodity budget of the Ministry of Health (MOH), whereas still accepting donations from USAID or UNFPA until governments were purchasing all of the needed commodities for the public sector (USAID/Deliver Project 2012). This phase out was accomplished by technical assistance to build the MOH capacity to conduct public tenders (such as legislative changes to allow international procurement and/or prepayment of orders, a budget line item for FP commodities and training staff). In phasing out USAID-donated contraceptives, countries developed comprehensive contraceptive commodity security plans and phase-out schedules with USAID, the government, other donors and NGO recipients of USAID-donated contraceptives, co-ordinating closely with other commodity donations, including those from UNFPA, to ensure a continuous supply of products. USAID also co-ordinated with UNFPA to encourage graduating countries to buy contraceptives through UNFPA at typically lower prices than they would have paid through commercial drug distributors, and to pool contraceptive commodity procurement across host government agencies (e.g. Social Security providers and MOHs) and sometimes NGOs providing FP services to reduce costs.

USAID, with the aid of CSCs, supported efforts to ensure that national budgets had protected line items for FP that included funding for contraceptive commodities and clinical methods requiring surgical equipment and medical and consumable supplies (Betancourt 2007).

Commodity security also includes a strong supply chain and logistics systems. USAID worked through partners and local organizations to build sustainable capacity beyond commodity purchase (USAID/Deliver Project 2011). Under graduation strategies, support to MOH systems also included integrating the FP logistics process with that of other health commodities (Sanchez et al. 2006; Olson et al. 2008; Uribe et al. 2012). CSCs—supported by USAID technical assistance—were critical throughout this work in supporting contraceptive security.
primarily through strategic efforts in advocacy for action and legislative change for contraceptive procurement and equitable access to FP services.

Advocacy, policy dialogue and political commitment

Graduation plans concentrated advocacy efforts to national governments towards a political commitment of financing FP programmes at the provincial, regional and other governance levels where decision making and budgeting were occurring and for access to FP as an essential public health service. USAID supported country efforts to codify policy on FP including budget line items for FP commodities and to list these commodities as essential medications and supplies required to be provided within a country’s public sector services, as embodied by law in Paraguay (El Congreso De La Nacion Paraguaya 2006; Betancourt 2007).

Political commitment by governments to use their own funds to provide for the FP programme before, during and after graduation is central to sustainability—supporting and financing the budget line item for FP towards supporting FP programming—among other competing health priorities. USAID supported policy analyses of legislation related to contraceptive security, economic analysis of contraceptive prices by suppliers in the region and evaluation of various contraceptive logistics systems (Sarley et al. 2006). CSCs raised awareness about the issue and helped implement the FP Graduation Plan by designing national strategies and annual work plans aimed at achieving contraceptive security and making contraceptive security a priority (Betancourt 2007). Through these committees, USAID supported important activities with country CSCs: workshops on estimating contraceptive needs and financial planning; analysing the FP market (between the public and private sectors) that included RH surveys showing demand for different methods and unmet need that could help future planning and reaching youth, working with Social Security Institutes to provide FP services to their covered members and their dependents, and the design of strategies and work plans to reach a contraceptive supply and financing structure that appropriately met the needs of the population, including advocacy for local policy and legislative changes.

Discussion

The USAID experience has some lessons to offer the immunization community—primarily the importance of developing or relying on a system or champions (e.g. CSCs) to ensure sustainability of programming including financing and product (contraceptive or vaccine) security. An important role that cannot be undervalued is continued high-level advocacy from the GAVI Alliance with Ministries of Finance and Parliamentarians and key decision makers in countries. Long-term commitments to high impact and value for money programmes require investments in current systems that will continue well after graduation. Although current GAVI graduation (which may change) clearly ends after 5 years of preparation as a graduating country, government investments in health systems to strengthen vaccine delivery should continue. Dividends in health can pay off through long-term investments. These investments in future prosperity and forward income—investments that USAID and other partners can help shape through the support of technical capacity and capability of local and national governments—support high-quality programmes in service to reliable and robust immunization programmes. USAID FP graduation is an approach that has led to sustained FP programmes well after graduation as measured by tracer indicators.

If history serves to teach lessons, immunizations experienced significant improvements in reaching global targets after decades of global support pushing country programmes to perform; however, stagnation in global immunization programmes in the 1990s shows that achieving coverage targets without appropriate attention to sustainability and development of health capacity can lead to a reverse in progress (UNICEF 2006). GAVI and USAID recognize that countries continue to have systems deficiencies that need to be addressed. USAID funding like GAVI support is one of many factors—functioning health system, status of women and political turmoil—that contribute to a specific country’s programme performance. Unlike GAVI, in FP graduation USAID used multiple technical indicators as a litmus test for how well programmes were positioned towards graduation, relying on technical criteria and programmatic inputs in decisions as to when to graduate countries from donor development assistance. Budgeting multi-year FP plans served an important purpose, a tool used to focus on strategic needs and facilitate graduation with pre-determined financial and technical benchmarks. If a country was not deemed ready for graduation, they did not necessarily graduate from USAID support. To date no systematic analysis of the impact of USAID FP graduation has been performed with the exception of Nicaragua (Avila et al. 2012).

Like GAVI, USAID distinctly focused on securing contraceptive security as a general requirement to graduation with most countries phasing out of contraceptive donations before phase out of technical assistance to other elements of FP programmes. However, mechanisms towards this end were not restricted to self-financing product purchases as is the goal with the current GAVI business model. In some cases, FP funding shifted from USAID to other external sources as opposed to country governments. The GAVI model, based on co-financing, moves countries gradually towards fully adopting domestic financing of a country’s total vaccine portfolio, including GAVI-supported vaccines and eventually immunization programme costs. This model provides a deep commitment to development and country ownership; however, financing graduation does not correlate to coverage and health outcomes.

GAVI funds to countries, in addition to vaccine financing support and associated new vaccine introduction, are for health systems strengthening. These funds provide an opportunity for the country to tailor the use of cash-based support to their needs, whether this is to create or strengthen a country’s national immunization technical advisory group, interagency co-ordinating committee or fill other system needs. This separate window of funding provides flexibility to countries. It is the hope for these countries to work strategically, moving beyond plugging in holes in the health system. GAVI support to countries is vital to the immunization system. Graduation from this significant support should account for the long-term challenges of financial sustainability and emphasize the ability
of a country to mobilize efficient use of domestic resources while recognizing the magnitude of external resources currently consumed. Success in the long term is the ability to sustain a country’s vaccine portfolio as a whole and introduce future new vaccines as they become available. This can only be done when funds are ascribed to immunization for the procurement as well as the operational costs to reach every child.

GAVI is experiencing a strategic shift in attention from vaccine financing and procurement to immunization system performance (GAVI Alliance 2014). Issues of sustainability, criteria and support for graduation, and additional instruments to aid the graduation process itself become increasingly important for GAVI to contend with as they develop and refine their next strategic period with this new strategic emphasis in mind.

Conclusion

The FP experience provides a window into understanding one approach to graduation from donor development assistance. USAID’s FP strategy provides technical and financial support across all the broad elements necessary to FP programming. The process itself seems to provide valuable lessons towards successful graduation. The holistic view of graduating a programme from all its essential elements provides insights as to how countries can strengthen their programmes. GAVI plays an important role, largely financing new vaccines. The role other partners play in providing technical support to strengthen the systems that deliver reliable and timely vaccinations is also critical. GAVI is expanding its scope of funding, attempting to address immunization programme weaknesses beyond financing. As additional cohorts of countries enter into graduation, opportunities exist to secure the future of these countries to continue providing needed vaccines and support the introduction of future vaccines. Applications of these FP lessons and emerging lessons from GAVI’s graduation policy may benefit other global health initiatives in areas such as HIV/AIDS and malaria, which have also relied on external funding and are seeking ways to help countries move towards more domestic financial self-sufficiency and operational independence. USAID views graduation as a time to celebrate increased country ownership of programming, having achieved this over time and having prepared through a transparent process involving country-level partners well in advance of ending financial and technical assistance.

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Endnotes

1 Countries have been divided into three groups (low, intermediate and graduating) based on their ability to pay, determined by their GNI per capita (for 2013, the 2011 GNI per capita data released by the World Bank in July 2012). Low income countries pay $0.20 per dose with no annual increase. Intermediate countries pay $0.20/dose plus 15% annual increase. Co-financing groups are updated annually according to the latest GNI per capita data, released by the World Bank every July.

2 An NRA’s regulatory functions depend on how vaccines are procured. If procured through a UN Agency the following three functions are required: regulatory system, market authorization and licensing activities and pharmacovigilance activity. If countries self-procure two additional functions—lot release and laboratory access are required. If a country produces vaccine the last two functions—regulatory inspections and regulatory oversight of clinical trials—are also required.

3 DTP3 is a common indicator used for coverage.

References


