Synthesis of the results of the study "The Global Fund and Health Systems Strengthening in West and Central Africa".

Anne Bekelynck

This study was carried out with the support of Agence Française de Développement.

The "Global Health 2030" think tank has been in existence since October 2016. It brings together personalities involved in global health, including Françoise Barré-Sinoussi, Paul Benkimoun, Michel Cot, Sana de Courcelles, François Dabis, Annabel Desgrées du Lou, Jean-François Delfraissy, Eric Fleutelot, Frédéric Goyet, Mathieu Lamiaux, Michel Kazatchkine, Marie-Paule Kieny, Lélio Marmora, Benoît Miribel, Olivier Nay, Louis Pizarro, Anna-Laura Ross, Benoît Vallet. Stéphanie Tchiombiano is the coordinator.

The members of the group are acting in their individual capacities and not on behalf of their respective organizations. This document is the fruit of a collective effort within the group. It in no way commits or reflects the individual opinions of any of its members.

Acronyms used :

AECID: Spanish Agency for International Development Cooperation *(Agencia Española de Cooperación Internacional para el Desarrollo)*

AOC: West and Central Africa

CCM: *Country Coordinating Mechanism*

CSU: Universal health coverage

FCS: Fonds commun de santé

GF: Global Fund to Fight AIDS, Tuberculosis and Malaria

UNFPA: United Nations Population Fund

GAVI: *Global Alliance for Vaccines and Immunization*

LFA: Local *Fund Agent (Agent* local du Fonds mondial*)*

NFM: New funding model

OIG: Bureau de l'Inspecteur général *(*Office *of the Inspector General)*

WHO: World Health Organization **TFP:**

Technical and financial partner **HSS:**

Health systems strengthening

RSSH: *Resilient & Sustainable Systems for Health*

SRPS: Systèmes Résistants et Pérennes pour la Santé

TB: Tuberculosis

TERG: *Technical Evaluation Reference Group*

TRP: *Technical Review Panel*

UNICEF: Fonds des Nations unies pour l'enfance (*United Nations Children's Fund*)

HIV: Human Immunodeficiency Virus

Background to the study

The Global Fund was originally created in an emergency context, with the aim of achieving rapid, effective results to contain the HIV/AIDS, tuberculosis and malaria epidemics. During its first decade of existence, the "health systems strengthening" (HSS) or "cross-cutting" component was present, albeit poorly defined and fluctuating over the years in its modalities. This aspect was not seen as a central strategic element, but more as a secondary effect of its main mandate, with funding that remained marginal and little used[1]. From the time of the Global Fund's reform in 2014 and the adoption of its new funding model (NFM), HSS was to take on an increasingly strategic role. In 2015, the Global Fund defined seven main approaches to help countries establish "Resilient *& Sustainable Systems for* Health (RSSH*)*", following its own terminology (The Global Fund, 2015)[2]. In 2016, the Global Fund formalized its future 2017-2022 strategy, listing the implementation of SRPS as one of its four strategic objectives, with the aim of improving results in the fight against the three diseases and more generally in the field of health, strengthening protection and financial equity, contributing to the goal of universal health coverage (UHC) and better preventing potential health crises3. Although it shares similarities with the WHO's normative framework and its six pillars[4] , the Global Fund proposes its own conceptual framework, with a more operational scope, and the addition of a 7th pillar focusing on strengthening community responses and systems.

The Global Fund estimates that it is currently devoting 27% of its investments to building resilient and sustainable health systems (HSS)[5] , and around $1.1 billion in the West and Central Africa (WCA)[6] region between 2014 and 20197. The need for HSS is particularly great in this region, which faces major security, institutional, financial and human challenges.

As part of a partnership with Agence Française de Développement (AFD), the Global Health 2030 think tank wanted to contribute to the debate on the evolution of the Global Fund and its positioning on the issue of HSS. It was therefore decided to work with a sociologist, Anne Bekelynck, to conduct an in-depth study on this topic.

Study objectives

The study sought to analyze Global Fund support for health systems strengthening, in West and Central Africa, particularly since 2014, when the Global Fund's new financing model was introduced. It was initiated to complement studies/evaluations by the Technical Review Panel (TRP), the Technical Evaluation Reference Committee (TERG) and the Office of the Inspector General (OIG)[8] published on the subject.

It was structured around 3 lines of research:

Representations of HSS from the perspective of players in the Global Fund "ecosystem

- How do players in the Global Fund ecosystem define HSR (scope, prioritization of axes, theoretical foundations, etc.), and what are the differences and points in common with those of other international organizations?
- How has the Global Fund's HSS approach been appropriated by players in the Secretariat, beneficiary countries and other international organizations?

Global Fund HSS expenditures: investments, activities and indicators

- What exactly do the expenses labeled "RSS" relate to i n terms of concrete activities?
- How are RSS investments decided?

Institutional systems for implementing HSR

- What are the obstacles and opportunities of HSR in terms of operational and organizational constraints, particularly **at the level of beneficiary countries?**

The study was intended to serve as a basis for the *think tank*'s recommendations on the overall development of the Global Fund, on the positioning of the various French players, on the articulation between multilateral and bilateral programs, and on the links between the Global Fund and other programs (bilateral and multilateral) aimed at strengthening healthcare systems.

Methodology

This study was initiated in February 2020 until September 2020, lasting 4 months (full-time equivalent). It was conducted from Côte d'Ivoire (the researcher's field of residence) and for the most part, remotely, due to constraints linked to the Covid-19 epidemic. **This research focused on 3 interrelated levels of analysis**: 1) global health actors (international), 2) West and Central African countries (regional) and 3) insights through analysis of certain national issues (the concept note development process in Côte d'Ivoire, the common health fund in Niger, the "*stand-alone"* HSS grant in Benin) (national).

It was based on a mixed methodology, with :

- A review of the scientific and grey literature (Global Fund documentation, databases, country-level documentation)
- A qualitative field survey
- Semi-structured interviews (46 in total) (see table)

	International	Ivory Coast	Other countries	Total
Global Fund / CCM	10	1		11
Other multilateral IOs	5	2	1	8
French healthcare players worldwide	10	2	1	13
Civil society	2	2		4
Friends of FM	1			1
Consultants	4	1		5
National public players		3	1	4
Total	32	11	3	46

*Interviews conducted as part of the HSS and Global Fund study, 2020.

- Participant observation of a workshop in Cotonou on HSS and the Global Fund organized by Aidspan and the *African Constituency Bureau* (February 5-7, 2020) and meetings on the development of the NFM3 concept note in Côte d'Ivoire (n= 6).

Key findings

- Operationalizing the strategic objective of HSS remains a **major challenge** for the Global Fund, an organization with a culture and "DNA" of its own. deeply **vertical**

- In contrast to disease subsidies, there are many **areas of uncertainty**. the implementation of HSR. If countries with strong leadership to exploit these opportunities, countries with weaker governance - particularly in West and Central Africa - are more hampered in their strategies.

- Criticism of the Global Fund generally focuses on the **time lag** between the **rhetoric and** stated **ambitions** of HSR and its actual scope and impact. of its actions, which are more akin to support than reinforcement.

Main results

The Global Fund's approach to HSS is necessarily limited in scope, due to its "pandemic DNA" and external constraints.

The integration of HSS as a genuine strategic objective within the Global Fund has taken place in an institution which, for fifteen years, has been focused on the fight against disease, and whose history, operation, internal organization, skills and professional culture are characterized by a vertical approach and the quest for rapid, demonstrable effectiveness. In many respects, the HSS approach as advocated by WHO, i.e. meeting the requirements of sustainability, transversality and leadership left to countries, is at odds with the fundamental characteristics of the Global Fund in terms of temporality, accountability, required skills, internal organization, positioning vis-à-vis beneficiary countries, collaboration with other international organizations, and ultimately, culture. The Global Fund is also largely constrained by its financial resources, which, although substantial ($4.7 billion/year for the next three years), are not sufficient to meet the estimated needs of the fight against the three diseases (around $28 billion/year estimated9) and, a fortiori, to strengthen healthcare systems (around $100 billion/year10). These resources cannot be guaranteed for more than three years. The low uptake of HSS11 activities, coupled with the risk of funding dilution and the difficulty of demonstrating impact over a three-year cycle, is a major constraint on the Secretariat team, which has to justify its effectiveness on a regular basis in order to maintain donor contributions, continue its contribution to the fight against the three diseases and ensure the organization's survival.

The professional culture of Global Fund staff - characterized by a vertical approach and the technical specialization of individuals - has directly influenced the production of knowledge and the way in which the Secretariat has defined its approach to HSS. The global health players interviewed (both inside and outside the Global Fund) generally characterize its approach in two ways: 1) by its disease-centric scope and purpose, its aim being to remove the bottlenecks that stand in the way of scaling up the fight against the three pandemics in countries, and not to strengthen health systems for their own sake (HSS being more of a positive collateral effect); 2) by its functionalist character, i.e. it's

defined by the various pillars or technical areas. There is therefore no systemic, detailed definition of the Global Fund's HSS approach.

However, four levels of conflicting definitions have been identified, highlighting a lack of uniform understanding of its HSS approach by the players in its ecosystem. Firstly, in the internal documents produced by the Secretariat, the strategic documents adopt a broader scope of HSS, where the ultimate objective is to contribute to achieving universal health coverage (UHC), while the more operational documents are more focused on the three diseases. Secondly, within the Secretariat itself, the sensitivities of the players differ according to their professional skills, cultural background and individual characteristics, depending on whether they have a financial or public health profile, or are experts in monitoring and evaluation, for example. Thirdly, contradictory injunctions can be transmitted to countries between the country teams - which directly guide national players in the elaboration of concept notes - and which promote more a disease-centered HSS approach, and the TRP (*Technical Review Panel*) which is in charge of evaluating them, and which adopts a broader conception. Finally, at the level of national players in beneficiary countries, individuals integrated into the Global Fund mechanism (the "disease players") generally adopt a disease-centric approach, while players who have not been so integrated (Ministries of Health, Finance, Central Directorates, etc.) adopt a broader concept of HSS.

So, while the absence of a systematic definition of HSR gives the various players a degree of autonomy, this lack of common understanding can also generate operational tensions and give the Secretariat's country teams a strong power of normative orientation in beneficiary countries.

Obstacles to implementation o f Strategic Objective 2 ("SRPS")

Many players (both inside and outside the Global Fund) recognize the significant efforts made in recent years to move towards greater integration between the three diseases, whether in the context of health services delivered to patients, the reporting system, supply chains or supervision. However, these efforts remain limited from the point of view of an HSS approach as advocated by the WHO, which would be both sustainable and systemic. We have identified three main obstacles to its implementation
Organizational, technical and related to external players

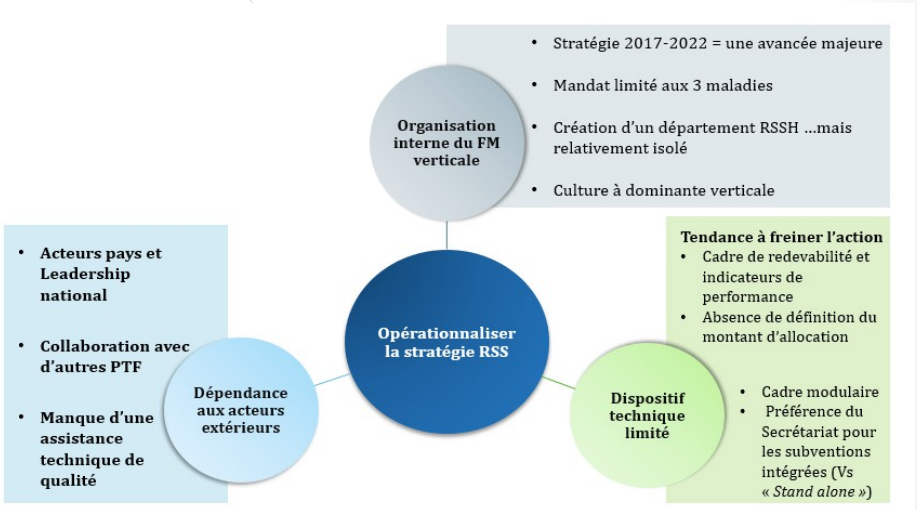

Figure 1: Obstacles to SRPS implementation at the Global Fund

→ The slow evolution of the organizational set-up: between institutional cumbersomeness and political will?

While the strategy represented a major step forward in formalizing HSS as a strategic objective, the Secretariat remains hamstrung by its institutional framework, i.e. by its mandate, which remains limited to the three diseases. For example, while the Global Fund in principle authorizes a community health worker to deliver services beyond the three diseases, if it does not finance inputs, nor compel him or her to report data on other diseases, action remains limited in practice. What's more, changes in the Global Fund's professional skills and internal organization are evolving, albeit slowly. Although an HSSR support team has been set up within the Strategy, Investment and Impact Division to support country teams, help operationalize the strategy and develop partnerships with partners, it remains isolated and outnumbered (13 permanent staff[12]) by the rest of the Secretariat (around 700 people). Although HSS skills are being developed within other departments of the Secretariat, the professional culture of its staff and the internal organization of the Global Fund remain largely a culture of specialists in the three pandemics, with a compartmentalized approach. In contrast to disease grants, HSS can be perceived by operational staff as a vague object, difficult to grasp, with no precise frame of reference or objectives, and which could jeopardize the results of grants (risk of dilution without impact, absorption difficulties) and therefore of the organization.

→ technical system that is still limited and poorly adapted to the specific features of RSS

The technical framework currently in place remains insufficient to effectively initiate, or even compel, the various players in the chain to initiate quality programs. Two types of consequences have been observed: on the one hand, it slows down or even paralyzes HSR initiatives; on the other, it generates a scattering and fragmentation of HSR activities.

The inadequacy of the accountability framework and performance indicators, or the lack of evaluation of portfolio managers on this theme, are generally pointed out as the decisive brake on action, being the main incentive for an organization that operates according to the principle of results-based financing. Also, HSS guidelines at country level are often out of step with those for diseases: the absence of a desired or expected amount for HSS in allocation letters is a major obstacle to the establishment of substantial, high-quality grants, and technical guidelines specific t o HSS are sometimes non-existent or unfamiliar to national players (e.g. HSS funding landscape, co-financing modalities).

In terms of fragmentation and dispersal, the complexity and standardization of the modular framework, and the Secretariat's preference for allocating HSS interventions in a way that is integrated with disease subsidies rather than "*stand-alone* "[13], tend to diminish the coherence of the proposed HSS strategies.

This "incomplete" technical set-up - compared to the technical set-up for diseases - can be justified by Global Fund players as a necessity, in order to create room for manoeuvre for countries and foster the principle of ownership - which appears even more fundamental in the context of HSS. As a result, countries with strong *leadership* and technical skills, such as Rwanda, Ethiopia and Benin, have been able to initiate separate HSS grants, exploiting the leeway left to them by the Global Fund. However, these areas of uncertainty need to be seen in a broader context, with the Global Fund becoming highly prescriptive in its strategic orientations and demanding in its compliance with complex procedures. In the context of most West and Central African countries, where national leadership in the health sector is not very strong, these uncertainties tend to paralyze - rather than encourage - action, for fear of not being able to benefit from funding.

The internal changes required to fully operationalize the SRPS strategic axis are taking place more or less rapidly, depending on the dimensions concerned (regulatory framework, internal organization, skills, technical and management systems, etc.), which is a major challenge for the company.

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characteristic of international organizations. While the integration of the HSS strategic objective into the 2017-2022 strategy represented a major step forward, providing the formal framework necessary for action, other dimensions are evolving more slowly, if at all, and today represent major obstacles: maintaining the mandate centered on the three diseases, the Global Fund's professional skills and culture, which remain essentially vertical, and the still limited adoption of managerial tools and adequate technical and financial procedures conducive to the implementation of HSS programs. While some of the people we spoke to stressed the real technical difficulties involved in developing an appropriate and effective HSS mechanism, and the fact that this is a relatively new issue for the Global Fund, others questioned the political will within the Secretariat to make this issue a priority.

→ Dependence on external players: national players, technical and financial partners (TFPs) and technical assistance

The HSS theme reveals and exacerbates the various challenges and difficulties that Fonda Mondiale encounters in countries in terms of collaboration and positioning with national players and technical and financial partners (TFPs).

Even more so than in the fight against pandemics, the issue of HSS needs to respond to needs defined by **countries**, and to be appropriated by public health authorities, so that responses are fair and sustainable, following the logic of respect for national sovereignty, in a balanced relationship of co-partnership. To promote HSS investment, a number of conditions must be met at country level, grouped into three main categories: the country's **political leadership**, with political commitment at the highest level, a strategic vision of HSS, and the ability to negotiate and coordinate with the various technical and financial partners; the appropriate **technical skills** to implement the strategic vision, and the ability to "fit into the matrix" of the Global Fund, in order to exploit its possibilities; and the choice of an appropriate **implementing institution**, i.e. one with a high hierarchical position and financial and programmatic capacities.

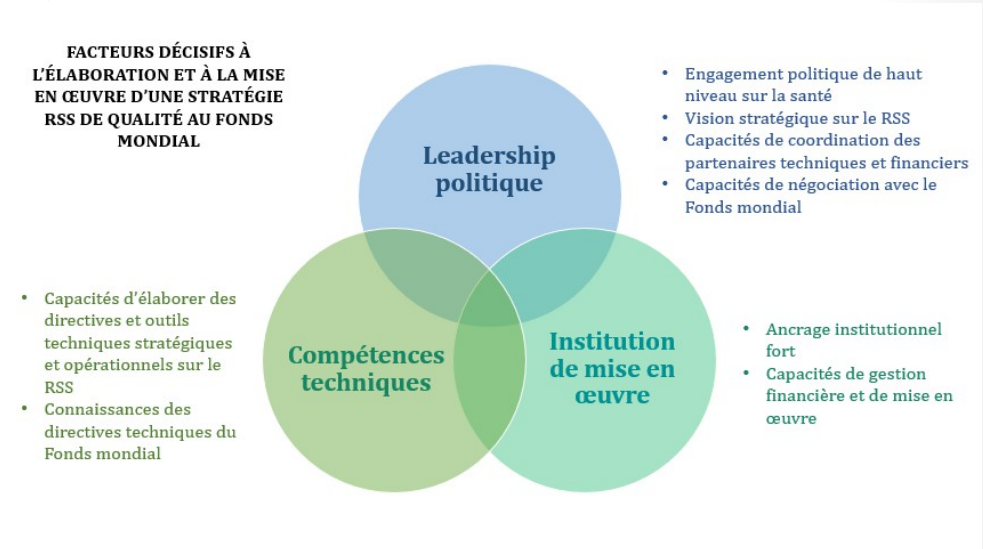

Figure 2: Decisive factors in the development and implementation of a quality HSS strategy at the Global Fund

In return, the Global Fund also has a responsibility to support and optimize national efforts. In many countries, however, national authorities - Ministries of Health, Finance, the Prime Minister's Office, central departments or non-disease programs - have had little or no involvement in the Global Fund ecosystem, either within participatory governance bodies (CCMs) or as grant recipients. Although the CCMs were originally set up to enable collaborative governance - with a strong emphasis on civil society - in practice, they have often..,

The Ministries of Health have been "bypassed", mainly because of fears of misappropriation of funds and lack of efficiency. The frequent use of management units is indicative of the 7

persistent difficulty in using Ministries of Health, for reasons of efficiency, adaptation and trust. HSS puts national health authorities back at the heart of the process. It highlights the unequal relationships that have developed in some countries between *insiders* (pandemic actors) and *outsiders* (non-pandemic health authorities) in the Global Fund system. For example, when a central department of the Ministry of Health is a sub-recipient of a National Disease Program within the framework of HSS activities, or when the Ministry of Health does not occupy a leadership position within CCMs, this can erode their legitimacy and coordination capacities, as well as blocking the implementation of certain activities. Non-pandemic health actors also find themselves at a disadvantage when it comes to mastering the Global Fund's complex technical framework, which contains its own procedures, language and specific requirements.

The Global Fund needs to interact more with the other **technical and financial partners (TFPs)** involved in HSS (who, again, are not always "familiar" with the Global Fund's operations), as the Global Fund can be considered a "small player" in the field of HSS, and its staff do not see their organization as a leader, particularly in pillars such as human resources, governance, financing or the supply chain. TFP coordination is a key factor in the success of HSS strategies. At present, however, coordination with other TFPs is focused more on sharing information and avoiding duplication, than on achieving genuine "synergy" between actions. WHO Africa tends to be criticized for its lack of leadership in this field, and there is a shared difficulty in coordinating TFPs, which today is largely person-dependent at country level, but also closely linked to country leadership and their ability to coordinate their partners. The Global Fund is not perceived as a driving force in TFP coordination, given that its primary focus is on compliance with its complex procedures, financial risk management and accountability requirements. Its lack of local roots also hinders the development of partnerships and collaboration with other TFPs. The example of the Fonds Commun de Santé (FCS) in Niger highlights the Global Fund's difficulty in adapting to common procedures to promote national coordination of PTFs. The Fonds Commun de Santé (FCS) is a multi-donor fund, bringing together the Agence Française de Développement (AFD), the World Bank, the Spanish Cooperation Agency (AECID), UNICEF, the GAVI Alliance and UNFPA, whose aim is to implement Niger's Health Development Plan by channelling partners' resources and stimulating the alignment, harmonization and predictability of actions, under the aegis of the Ministry of Health. Within the framework of the TB/HSSR grant (2019), important discussions took place between the Global Fund country team and the national authorities, the FSC team and the partners, in order to find an agreement for the Global Fund to integrate the pooled fund. In the end, an incompatibility emerged between the financial management safeguards requested by the Global Fund and the procedures and competencies of the FSC (the Global Fund required, for example, that its local agent (the LFA) monitor the FSC's financial management, or that programmatic monitoring be far more detailed than the FSC had planned).

The complexity of its procedures is thus a major obstacle to collaboration with national authorities and other partners. Although the Board of Directors has affirmed the need for simplification, some of our interlocutors have noted the relative contradiction between Board members who, on the one hand, wish for greater simplification (particularly for HSR) and, on the other hand, always want more indicators to report.

Finally, the difficulty of mobilizing quality **technical assistance** on HSS at the Global Fund, according to several of the people interviewed, makes it impossible to fill these gaps.

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A gap between rhetoric and practice

There is a gap between what the Global Fund says about its commitment to HSS and the concrete scope of its actions, in terms of cross-functionality and sustainability.

The Global Fund has adopted an extensive calculation method for its HSS interventions, which its critics may describe as "undemanding", enabling it to post a figure of 27% of its overall budget that would have been allocated to it for the 2014-2019 cycles. In its external communications[14], the distinction between direct and contributory (indirect) investments is not always emphasized or made clear, even though the latter account for two-thirds of funding. These contributory (indirect) investments are calculated retrospectively, following a methodology that selects interventions and financial inputs that may or may not correspond to HSS, "the main selection criterion being the relevance of these interventions for health systems "[15]. These criteria are therefore both relative (according to "relevance"), without taking into account the criterion of sustainability, and with an extensive definition of transversality, insofar as an expense is considered "transversal" from the moment it affects more than one disease. In the final analysis, it appears that most of the expenditure labelled as "SRPS" by the Global Fund is more support than reinforcement - as already shown by the TRP, which estimates that support expenditure accounts for 75% of SRPS funding[16].

For some (both inside and outside the Global Fund), the integration of HSS as a strategic objective of the Fund did not mark a real break with the past, but rather a formalization that was necessary for political reasons. They point out that the proportion of funding allocated to HSS has remained relatively stable since the Fund's creation at around 30% of the overall budget - although calculation methods have varied, making a strict comparison difficult - or that the activities actually financed have remained the same, such as supply chains or human resources, as a matter of "course" for program implementation. Others point out that the "leverage effect" often evoked by the Global Fund - i.e., the way in which disease-focused HSS actions lead to a more global strengthening of health systems - is little questioned or well defined.

For the more critical interlocutors, the Global Fund's commitment to HSS is above all initiated for symbolic, instrumental, even what they describe as "demagogic" purposes, with HSS holding a strong rhetorical value, making it possible to silence criticism of the negative impact of vertical health initiatives on health systems, while garnering support (notably financial) from donors sympathetic to the cause of HSS. The Global Fund (and its Secretariat) would thus be in a satisfying in-between position, without the necessary political will to move beyond it. Finally, some critics point to France's stance in favor of more HSS on the Global Fund Board, without any concrete proposals on the priorities to be defended.

Focus on two pillars

Community health systems: the Global Fund's untapped strength?

The "7th pillar", community systems strengthening, represents the specificity of the Global Fund's HSS approach. This specificity is rooted in the very history of the Global Fund, which was created as a public-private partnership and was one of the first donors to include civil society in its decision-making bodies, from Geneva to the CCMs of recipient countries (imposing a minimum 40% representation of civil society), reinforcing this attention to the community component by introducing the *dual* track rule (in 2011) and systematically involving a non-governmental actor (generally from civil society) as a co-lead recipient. Unlike the WHO, which focuses on strengthening state capacities, the Global Fund grants

This means paying particular attention to communities as key players in supporting HSS interventions. In the context of West and Central Africa, where health systems are profoundly mixed - public, community and private - and where community health is generally neither recognized nor institutionalized by national public authorities with their hospital-centric culture, the Global Fund can be perceived as an "ally", particularly by national community players. However, there is some confusion as to the meaning of the term "community-based", with the actors interviewed from the world of HIV naturally seeing it in terms of human rights and vulnerable populations, while those involved in formal community health or malaria see it more in terms of primary health care (community health workers, etc.), generating operational tensions, particularly when writing the concept note.

According to the Global Fund's calculation methods, community systems strengthening accounts for only 2% of funding labelled as HSS. However, this method of calculation undervalues actual expenditure, broken down into other pillars such as human resources, health information systems and the supply chain. This is indicative of the scattered nature of community activities financed by the Global Fund - between HSS sub-pillars, or between HSS and disease grants/modules - which tends to undermine its potential impact. The modular framework - which is highly fragmented - is an obstacle to developing comprehensive, coherent community strategies. Analysis of this pillar thus highlights the risks of fragmentation in Global Fund HSS strategies.

The thorny issue of health human resources

The issue of human resources for health is one of the greatest challenges facing health systems, particularly in the countries of West and Central Africa, where the number of human resources for health is three times lower than in the rest of Africa. The Global Fund's positioning on this pillar is indicative of its more general difficulties in getting involved in HSS. The Global Fund's relative unease (shared with other international organizations) with regard to the issue of human resources for health is exacerbated by all the difficulties associated with HSS: the scale of funding required to solve the problems, the difficulty of programming actions over a long period of time and relying on strong leadership from beneficiary states, the need to coordinate with other donors who are better positioned in terms of skills and country roots in this area, and the fear of replacing states by financing salaries. Thus, the Global Fund agents interviewed generally cite supply chains and health information systems as their organization's priority or legitimate areas of action, and rarely human resources, despite the fact that they account for 47% of expenditure allocated to HSS. And yet, while human resources represent the Fund's largest HSS budget item, they are in reality short-term operating expenses, such as bonuses, or what some describe as "disguised salaries"; and very little in the way of structuring and systemic expenditure (initial or qualifying training, curriculum development, etc.), which further illustrates the discrepancies between HSS rhetoric and concrete action.

Conclusions and recommendations

Given the Global Fund's deeply vertical "DNA", **its HSS approach necessarily remains limited in scope**, being essentially focused on the ultimate impact of HSS on the three pandemics. HSS focused on the fight against the three diseases is conceived as a gateway to improving health systems as a whole, although this is not always the case.
The concept of "leverage" has yet to be fully developed.

There is no common understanding of its approach, particularly among non-pandemic health actors in beneficiary countries, who tend to conceive of HSS in a broad way, which ultimately generates operational tensions.

The significant gap between the rhetoric surrounding HSS - the Global Fund claims that 27% of its funding is allocated to it - and its concrete practices, which are more a matter of supporting and implementing disease subsidies, is fuelling criticism and polarizing the debate in the world of global health between advocates and detractors of vertical health initiatives. This polarization of the debate prevents us from valuing and supporting the significant efforts made by the Global Fund in recent years, particularly in terms of integrating services across the three diseases.

Recommendations to clarify the Global Fund's HSS approach

- **Think concretely about** how to make the "**leverage effect**" effective so that the The current short-term "pandemic RSS" could become a broader RSS in the medium term. and long-term

- **Communicate more effectively** with health stakeholders in beneficiary countries outside the pandemic arena on the objective and real scope of the Global Fund's HSS approach, and on how to achieve it.
  that can be financed or not (e.g. for co-infections, community health worker service packages, etc.).

- Adjust HSS rhetoric and objectives to be more realistic and pragmatic, so that they are better aligned with **capabilities**.
  the Global Fund's current organizational structure.

Although significant efforts have been made since its formalization as strategic objective no. 2 in the 2017-2022 Strategy, **operationalizing HSS remains a colossal challenge**, requiring a major overhaul of the Global Fund (mandate, skills and culture, internal organization, temporality of funding cycles) that the organization and its donors are not yet ready to carry out. The technical tools required for its implementation leave many areas unclear. In theory, these areas should be left open, so as to give **countries a degree of autonomy**, and leave it up to national authorities to guide, coordinate and even implement these strategies according to their own guidelines.

However, HSS takes place in a context where 1) the Global Fund is usually prescriptive, with complex and specific procedures, which tends to destabilize national players; and 2) state governance - particularly in West and Central Africa - is often fragile. The conditions required for high-quality SSR programs - political leadership, technical skills and the choice of an appropriate implementation structure - are rarely in place. Only a few exceptions succeed in "entering the matrix" of the Global Fund, appropriating its rules and procedures to exploit the opportunities offered. The way the Global Fund operates, where financial risk management and the need to be accountable to donors tend to take precedence over respect for national sovereignty and collaboration with other international organizations, remains a major constraint to developing HSS strategies that are coordinated by national authorities, and in partnership with other technical and financial partners.

Recommendations to promote and encourage the operationalization of HSS via the Global Fund

- Identify the technical areas where the Global Fund needs to leave **some wiggle room** in order to foster country ownership, and the areas where it needs to be more proactive.
  more directive and improve its tools to encourage action

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(For example, regarding strategic orientations, performance indicators and accountability framework, RSS amount defined in allocation letters, modular framework, etc.).

- Better integrate and support **national public authorities** so that they (re)assume a leadership role, particularly in difficult intervention contexts.

  (For example, with the choice of a principal recipient reporting to the Ministry of Health (vs. international NGOs and UN agencies) with upstream support to build their capacities; the effective lifting of constraints linked to additional safeguards; the simplification of grant application forms for HSS; the easing and integration of national procedures for HSS; the clear and simplified communication of technical rules and guidelines, etc.).

- Encourage operational and concrete collaboration between **international organizations**, and rethink the SSR co-partnership framework.

Research avenues

This study - necessarily limited by its duration - raised other avenues for reflection that would be interesting to explore:

- Collaboration with other international HSS organizations (from international to national)
- The challenges of Global Fund HSS technical assistance
- Specific case studies on certain pillars (e.g. human resources for health, supply chains or community systems) in individual countries, in order to better describe and analyze the Global Fund's positioning and concrete avenues for collaboration with other partners.
- The Global Fund's relations with the research community

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APPENDIX 1: Presentation of Global Health 2030

Global Health 2030 is an independent think tank that since 2016 has brought together personalities who have long been involved in global health issues. Its reflections are part of the Sustainable Development Goals.

OUR COMMITMENT

France is one of the biggest providers of international healthcare funding, but its influence in international bodies and healthcare partnership platforms remains limited. We are convinced that France can only be heard and listened to in the international arena of global healthcare when its players succeed in conveying a strong, coherent message, structured around clear, stable objectives and underpinned by values that are attached to the history of healthcare in France. *Our aim is to **formulate recommendations** on France's global health policy, and to **mobilize all stakeholders** to ensure that health issues become a strategic focus of France's international aid.*

Our vision of Global Health

Global health is a **fundamental** human **right**. It is also a **global common good**. **Universal access to healthcare** and the construction of sustainable healthcare systems are central to **human development**, **the economy**, **the fight against poverty** and **security**. They therefore make a decisive contribution to **inclusive development** and **peace**. at **fro m**

Health issues are complex and call for **long-term strategic visions** to meet the challenges posed by globalization, the intensification of human exchanges, demographic transitions and climate change.

OUR PREVIOUS NOTES

- 1 - White paper on global health
- 2 - Manifesto: Our vision of global health
- 3 - Health is a priority for the Sahel
- 4 - Boosting the fight against tuberculosis
- 5 - The importance of the European Health Commission
- 6 - Contribution to the preparation of the next Global Fund Replenishment Conference
- 7- A European health commissioner is essential for the health of Europeans
- 8 - The French institutional framework for global health: reflections and proposals
- 9 - UNAIDS: what challenges, what future?
- 10 - Representations of French influence in global health in Geneva-based international organizations
- 11 - Structuring the academic field of global health in France
- 12 - Support WHO in its role of coordinating the global management of the Covid-19 epidemic.
- 13 - Inclusion and participation of society as a whole in the response to Covid-19. Food for thought
- 14 - Anticipating the evaluation of the international response to the first wave of Covid-19: issues, expectations and points of attention
- 15 - Should we save the OMS soldier?
- 16 - Rethinking Global Fund involvement in health systems strengthening

OUR MEMBERS

Global Health 2030 brings together personalities who have been involved th centu Françoise Barré-Sinoussi, Paul Benkimoun, Michel Cot, Sana de C Desgrées du Lou, Jean-François Delfraissy, Éric Fleutelot, Frédéric Kazatchkine, Marie-Paule Kieny, Lélio Marmora, Benoît Miribel, Olivier Nay, Louis Pizarro, Anna-Laura Ross, Benoît Vallet. Stéphanie Tchiombiano is the coordinator.

[1] Russo, Camille (2019) "The prism of 'health system strengthening' for a better cooperation and coordination between AFD, the Global Fund and Expertise France: analysis and perspectives", Master de Santé Publique, EHESP

[2] The seven areas of work are as follows: (1) Strengthening community actions and systems, (2) Providing support for reproductive, maternal, newborn, child and adolescent health programs, and integrated service delivery platforms, (3) Strengthening country and global procurement and supply management systems, (4) Foster essential investments in human resources for health, (5) Strengthen health data systems and countries' capacity to analyze and exploit these data, (6) Strengthen and harmonize national health strategies and national strategic plans to combat each disease, and (7) Strengthen financial management and oversight, The Global Fund. (2015). Supporting Countries to Build Resilient and Sustainable Systems for Health. https://www.theglobalfund.org/media/1306/publication_countriesbuildresilientsustainablesystemshealth_report_en._pdf?u=637244547820000000

[3] GF/B35/DP04: The Global Fund Strategy 2017-2022: Investing to End Epidemics. https://www.theglobalfund.org/media/2531/core_globalfundstrategy2017-2022_strategy_en.pdf. Other objectives are to maximize impact on the three pandemics, promote human rights and gender equality, and mobilize greater financial resources.

[4] World Health Organization (2007). Everybody's business - Strengthening health systems for better health outcomes. WHO Framework for Action. Geneva

[5] Global Fund, Annual Report 2020, page 50. https://www.theglobalfund.org/media/10162/corporate_2020resultsreport_report_fr.pdf?u=637375661976700000

[6] Like the Global Fund's IGO report, we are considering 23 countries in this zone: Benin, Burkina Faso, Cameroon, Cape Verde, Central African Republic 19, Chad, Congo, DRC, Côte d'Ivoire, Equatorial Guinea, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger. Sao Tome and Principe, Senegal, Sierra Leone, Chad, Togo.

[7] Grant Implementation in Western and Central Africa, the Global Fund: https://www.theglobalfund.org/en/oig/updates/2019-05-31-grant-implementation-in-western-and-central-africa/

[8] These are *"Report on RSSH investments in the 2017-2019 funding cycle"* (TRP, 2018); "*Thematic Review on Resilient and Sustainable Systems for Health (RSSH)*" (TERG, 2019); and "*Managing investments for resilient and sustainable systems for health (Audit Report)*" (OIG, 2019).

[9] This is an annual average calculated on the basis of estimated needs of $83 billion for the three-year cycle 2020-2022, published in the investment case for the Global Fund's 6th replenishment 2019 ("*Accelerating the movement*").

[10] These are estimates based on the study by Stenberg et al (2017) published in *Global Public Health* on the investments needed in 67 low- and middle-income countries to achieve the health-related targets of the Sustainable Development Goals (SDGs). These costs represent, initially (these scalable), $134 billion per year, of which 75% should be invested in healthcare systems with human resources and infrastructure as the main expenses (Stenberg 2017). Thus, the investments needed in healthcare systems would currently represent around $100 billion a year for these 67 countries. (Stenberg et al, 2017, "Financing transformative health systems towards achievement of the health Sustainable Development Goals: a model for projected resource needs in 67 low-income and middle-income countries", *Global Public Health*, Vol5, n°5, E875- E887, DOI:https://doi.org/10.1016/S2214-109X(17)30263-2)

[11] According to the OIG (2019) report, SRPS activities integrated into disease grants show absorption rates of 67%, compared with 75% for disease-only interventions. The average absorption rate for stand-alone SRPS grants is 56%.

[12] At the time of the survey

[13] *Stand-alone* grants represent only 2% of the Global Fund's total investments and 7% of its SRPS investments.

[14] See https://www.theglobalfund.org/en/resilient-sustainable-systems-for-health/

[15] See "*Tracking the Global Fund's Investments in Resilient and Sustainable Systems for Health*" (Global Fund, July 2019).

[16] Including program and grant management costs; without including them, the proportion is 66%, in "*Report on RSSH investments in the 2017-2019 funding cycle*" (TRP, 2019).

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