"Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria and Health Systems Strengthening (HSS)".

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Full report
A summary of this study is also available on the Global Health 2030 website.

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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 opinion of any member .

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List of acronyms

AECIDAgence espagnole pour la coopération internationale au développement AFDAgence française de développement
AOCWest and Central Africa
ARCHAssurance to strengthen human capital
ARV Antiretroviral
ASCCommunity health agent
ATAtechnical assistance
CACoard of Directors
CASubsidy Approval Committee
Country *Coordinating Mechanisms (* CCM*)*
CSUCouverture sanitaire universelle DHIS-2Système d'information sanitaire
DSCDirection de la santé communautaire EFExpertise France
EOCEomplex operating environments
FBRerformance-based financing
FCSFonds commun de santé
GFATM Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria UNFPA *United Nations Population Fund* PSM Purchasing and Supply Management
GACGrant Approval Committee GAPGlobal Action Plan
GAVIAlliance mondiale pour les vaccines et la vaccination (*Global Alliance for Vaccines and Immunization)*
GHIInitiatives de santé mondiale (*Global Health Initiatives*) GTTGroupe de travail technique (Technical Working Group)
ITP *Implementation Through Partnership*
KPIIKey Performance Indicators LFALocal *Fund* Agent
MOUMemorandum of Understanding
NFMNew Funding Model SDGsSustainable Development Goals
OIOrganisation internationale
OIGBureau de l'inspecteur général *(Office of the Inspector General)*
MDG Millennium Development Goals WHO World Health Organization
ONGOrganisation non gouvernementale ONUOrganisation des nations unies OSCOrganisation de la société civile
PAGProgramme d'actions du gouvernement WFPWorld Food Program
President 's *Emergency Plan for AIDS Relief* (PEPFAR)
PNDSPlan national de développement sanitaire
PSNIEPlan stratégique national intégré pour l'élimination (integrated national strategic plan for elimination)
PTFPartenaires techniques et financiers (technical and financial partners)
PLHIVPerson living with HIV
P4HThe Global Network *for Health Financing and* Social *Health* Protection
RCARentral African Republic
HRhuman resources
RHSHealth human resources

RPRécipiendaires principaux (*PR: Principal Recipients)*
RSSHealth systems strengthening
M&EMonitoring & evaluation
National health information systems
SRPSSystèmes résilients et pérennes pour la santé (*RSSH: Resilient and Sustainable Systems for Health*)
SSRMNEA Sexual, reproductive, maternal, newborn, child and adolescent health TB
Tuberculosis
TERGTechnical Evaluation Reference Group TRTechnical Review Panel
UNICEFonds des Nations Unies pour l'enfance (*United Nations Children's Fund*)
USAIDA *United States Agency for* International Development
USDUnited States Dollar HIVHuman
Immunodeficiency Virus

Executive summary

The Global Fund was created in an emergency context, with the aim of achieving rapid, effective results to contain the HIV/AIDS, tuberculosis and malaria epidemics. During the first decade of its existence, the "health systems strengthening" (HSS) component or
This "transversal" approach was present, albeit poorly defined and fluctuating over the years in its modalities. From the time of the Global Fund's reform in 2014 and the adoption of its new financing model (NFM), HSS took on an increasingly strategic role, until it was formalized in the 2017-2022 strategy. The establishment of Resilient and Sustainable Health Systems (RSS) is then listed as one of its four strategic objectives in the strategy, with the aim of improving results in the fight against the three diseases (and more generally in the health field), strengthening financial protection and equity, contributing to the goal of universal health coverage (UHC) and better preventing potential health crises.

By 2020, the Global Fund expects to devote 27% of its investments to building resilient and sustainable health systems (HSS), and more specifically around $1.1 billion in the West and Central Africa (WCA) region between 2014 and 2019. HSS needs are particularly great in this region, which is marked by major security, institutional, financial and human difficulties.

Several studies and evaluations by independent Global Fund bodies (TRP, TERG, OIG[1]) point to the progress made and the many challenges faced by the Global Fund in operationalizing its strategic objective on SRPS, notably: 1) the lack of a common understanding of the approach among players, 2) the tendency to focus more on *supporting* than on *strengthening* health systems, 3) the inadequacy of Global Fund structures and processes in relation to the implementation of SRPS financing (temporality, compartmentalized approach, competencies, etc.), 4) the weakness of monitoring indicators and performance frameworks, 5) the difficult involvement of national public authorities and 6) the problematic coordination of technical and financial partners.), 4) the weakness of monitoring indicators and the performance framework, 5) the difficult involvement of national public authorities and 6) the problematic coordination of technical and financial partners.

This study was initiated by the *think tank* Global Health 2030, as a complement to these reports, within the framework of a partnership with the French Development Agency (AFD), with the aim of bringing an external, global, qualitative and comprehensive vision to this issue, specifically in West and Central Africa (WCA). This four-month qualitative study was carried out mainly on the basis of interviews (n=46) with international (Geneva, Paris) and national (WCA) players.

Main results

- **The Global Fund's approach to HSR is shaped by its history, mandate, mode of operation, organization and skills.**
  of its agents, who remain deeply "vertical". It is thus directly oriented towards improving the results of subsidies for the three pandemics (HIV, tuberculosis, malaria), following a functionalist approach, i.e. by pillars. While this restricted approach is generally understood by Global Fund ecosystem players (international and national), "non-pandemic" national health players tend to take a broader view of HSS, generating "operational tensions".

[1] These are the Global Fund's independent evaluation and audit bodies: the *Technical Review Panel (TRP)*, the *Technical Evaluation Reference Group (TERG)*, and the *Office of the Inspector General (OIG)*.

- Criticism of the Global Fund generally focuses on the **discrepancy between the rhetoric or stated ambitions of HSS, and the actual scope of its actions**.
  are more akin to support than reinforcement. The "leverage effect" between an HSS limited to the three diseases and a broader HSS is poorly conceptualized.

- **Operationalizing the HSS strategic objective remains a major challenge for the Global Fund**. Although significant efforts have been made and some
  changes have taken place, this radical shift in focus - from vertical to horizontal - would require a major overhaul of the organization, with increased financial resources, which neither the organization nor its donors are yet ready to make. While some interlocutors emphasize the long time it takes for an international organization of the Global Fund's scale to change, others question the real political will of the Secretariat and its Board to make HSS a priority.

- **In contrast to disease subsidies, there are many areas of uncertainty surrounding the implementation of HSS** (accountability framework, amount allocated to HSS in letters, etc.).
  The Global Fund is generally very prescriptive, and HSS absorption rates are lower than for diseases.

- **The technical arrangements - such as the grant conditions, the modular framework or the grant-writing process - tend to fragment and disperse activities.**
  This is particularly true for community systems strengthening, a pillar that can be seen as the Global Fund's "strength" in SSR, due to its historic inclusion of civil society.

- **State governance** - particularly in West and Central Africa - is often fragile. The prerequisites for high-quality SSR programs, namely
  political leadership, technical skills and the choice of an appropriate implementation structure, are rarely found. Only a few exceptions manage to "enter the matrix" of the Global Fund, appropriating its rules and procedures to exploit the opportunities offered by HSS.

- The Global Fund (still) tends to prioritize **financial risk management and accountability** to donors over national sovereignty and the
  collaboration with other international organizations. The fear of possible misappropriation of funds is a major constraint on the establishment of HSS subsidies by national public authorities.

- Collaboration with other technical and financial partners (TFPs) is particularly necessary in the context of HSS - the Global Fund being a minority player in terms of funding.
  funding in this area - but it remains generally limited (essentially focused on information sharing and avoiding duplication), person-dependent and cyclical. Institutional agreements between headquarters are difficult to implement at country level, and many players are calling for a redefinition of the **partnership framework for TFPs** in this area.

Main recommendations

- **Think concretely about** how to make the "**leverage effect**" effective so that the current short-term "pandemic HSR" can become a broader medium- and long-term HSR;

- **Communicate more effectively** with health stakeholders in "non-pandemic" beneficiary countries on the real purpose and scope of the Global Fund's HSS approach, and on what can and cannot be financed (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 more in line with the **Global Fund's current organizational capacities;**

- Identify the technical areas where the Global Fund needs to leave some **breathing space** to encourage country ownership, and the areas where it needs to be more directive and improve its tools to encourage action,

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

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

Introduction

1. Study objectives

This study is part of a global reflection on the Global Fund's involvement in health systems strengthening and the challenges it faces in this transition from a "pandemic" approach to one that is more cross-cutting, structuring and sustainable.

Created in 2002 in a context of emergency, the Global Fund's primary objective was to fight HIV/AIDS, tuberculosis and malaria, thus following a vertical approach for the sake of efficiency. Recent developments in global health - notably with the adoption of the Sustainable Development Goals (SDGs) in 2015 - combined with the stagnation of its results, due to the fragility of recipient countries' healthcare systems, and the occurrence of epidemics such as Ebola (2014) have led it to place the strengthening of healthcare systems at the heart of its approach.

In its 2017-2022 strategy[2] , building resilient and sustainable health systems (SRPS)[3] "*to achieve universal health coverage and end epidemics faster*", as well as to prepare for possible future health shocks, is the second strategic objective of the four goals[4] . This decision is based on the recognition that "*strong health systems are essential not only to end the epidemics of HIV, tuberculosis and malaria, but also to achieve results beyond these three diseases, by delivering care sustainably, equitably and effectively*". The Global Fund's HSS strategy specifies seven areas of work, inspired by the six pillars of health systems strengthening, as defined by the WHO[5] . These are (1) Strengthen community actions and systems; (2) Support reproductive, women's, children's and adolescent health programs and integrated service delivery platforms; (3) Strengthen country and global procurement and supply management systems; (4) Promote 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 strategies and national strategic plans for each disease; and (7) Strengthen financial management and oversight. The Global Fund estimates that it currently devotes 28% of its investments to building "resilient and sustainable health systems"[6] .

At the October 2018 Board meeting, a roadmap was drawn up and validated to strengthen the quality and impact of Global Fund investments in HSS[7] . The issue of health systems strengthening is systematically addressed at Global Fund Board meetings, and several internal reports have been drawn up on the subject by the bodies

[2] Global Fund 2016b.
[3] *Resilient & Sustainable Systems for Health*; can also be translated as "systèmes résistants et pérennes de santé".
[4] Other objectives are to maximize impact on the three pandemics, promote human rights and gender equality, and mobilize greater financial resources.
[5] World Health Organization (WHO) 2007.
[6] Office of the Inspector General (OIG/OIG) 2019c.
[7] This roadmap focuses on 5 areas: (1) Strengthening countries' SSR capacities / in particular through country dialogue, (2) Taking an active approach to integration and a holistic approach, (3) Strengthening differentiation (by country), based on in-depth assessments and following national priorities, (4) Strengthening collaboration with Gavi and other partners involved in SSR, and (5) Setting up a more appropriate evaluation system.

Global Fund's independent evaluation and audit bodies, such as the reports of the Technical Review Panel (TRP)[8] , the Office of the Inspector General (OIG)[9] , and the Technical Evaluation Reference Committee (TERG)[10] . Although these reports highlight the efforts and progress made, they also point to the difficulties encountered, not only in terms of design, but above all implementation and monitoring and evaluation, and emphasize that the operationalization of this second pillar is proving to be particularly perilous.

The institution seems to be aware that it is eagerly awaited in this area, and the Secretariat's HSS team is currently being strengthened. Peter Sands, the current Director of the Global Fund, closed his general introductory speech to the Global Fund's May 2019 Board meeting with these words on the subject: "we're going to have to do things differently".

HSS needs are particularly acute in the countries of West and Central Africa (WCA)[11] , an area marked by major security, institutional, financial and human difficulties. Human resources in health, for example, are three times lower than in the rest of Africa. The Global Fund claims to be the region's leading multilateral donor to the health sector. It estimates that it invested $1.1 billion in WCA to strengthen health systems between 2014 and 2018, out of a total of $5.3 billion worldwide[12] . This amount combines the amounts of grants entirely dedicated to HSS and HSS activities included in HIV, TB or malaria grants. At the request of the Executive Director, the Office of the Inspector General (OIG) conducted a study to analyze the obstacles to the implementation of Global Fund programs in the region.

Complementing studies carried out by the Global Fund, this research sought to analyze Global Fund support for health systems strengthening, in West and Central Africa, since 2014, when the Global Fund's new financing model was introduced.

It will answer the following questions:

- How can we characterize the Global Fund's approach to health systems strengthening? We will discuss the foundations, assumptions and particularities of this approach, with a particular focus on assessing its consistency with the international recommendations of the WHO and UHC2030 in this area.
- How does this approach play out in the field? In particular, we will be presenting the content of Global Fund-financed interventions in the area, the system for monitoring these interventions, their operational modalities (types of main and sub-beneficiaries, implementation mechanisms, links with other international partners, procedures, etc.) and their limitations.

This study was initiated by the *think tank* Global Health 2030, which aims to contribute to the debate on the future of the Global Fund. It is being carried out in partnership with Agence Française de Développement (AFD), while remaining independent.

The study served as the basis for recommendations made by the *think tank* "Penser l'implication du Fonds mondial en matière de renforcement des systèmes de santé : Retour aux fondamentaux"[13] .

[8] Technical Review Panel (TRP) 2018.
[9] Office of the Inspector General (OIG/OIG) 2019c.
[10] Technical Evaluation Reference Committee (TERG) 2019.
[11] Following the example of the IGO (2019) report, we consider here 23 countries forming part of this zone (excluding Nigeria): Benin, Burkina Faso, Cameroon, Cape Verde, Central African Republic, 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, Togo. Cf. Office of the Inspector General (OIG/OIG) 2019a.
[12] Ibid.
[13] http://santemondiale2030.fr/wp-content/uploads/2020/11/Retour-aux-Fondamentaux.pdf

2. Context: health systems strengthening (HSS) within global health initiatives (literature review)

2.1. The rise of RSS in the world of global healthcare

From the mid-1990s to the mid-2000s, many organizations involved in global health focused on disease- and condition-specific projects rather than health system development, particularly in response to the implementation of the Millennium Development Goals (MDGs). Three of the largest vertical programs in the history of global health were created during this period (the *Global Health Initiatives*, GHI): the Global Alliance for Vaccines and Immunization (GAVI, created in 2000), the Global Fund (created in 2002) and the US President's Emergency Plan for AIDS Relief (PEPFAR, created in 2003), unprecedented in terms of scale, modes of operation and funding.
Vertical approaches have long been favored by large global health organizations and institutions, because they have centralized management and distinct resources (staff, vehicles, funds), have specific short- or medium-term objectives, usually quantitative and relating to a single condition or a small group of health problems; this allows for strong central technical and financial control, the ability to respond to changing circumstances and the identification of new strategies, and the appeal to external donors[14] .

However, it has been shown that these vertical approaches may have had negative effects o n national health systems, contributing to their fragmentation, distorting national health priorities, and placing an excessive reporting and coordination burden on the governments of low- and middle-income countries[15] . In response, global attention has been focused on health systems strengthening (HSS) since the late 2000s[16] .

In 2000, the *World Health Report* first proposed a framework in which strengthening is seen as being oriented towards the capacity of the system as a whole to raise, pool and spend the funds needed to become sustainable and equitable, provide effective, appropriate and equitable care, generate the resources (such as a trained workforce) needed to achieve this, and provide the stewardship needed to ensure its effective governance[17] . Subsequently, in 2007, the WHO introduced a framework aimed at creating a common understanding of HSS, in which it views the health system as a set of organizations and actors whose primary objective is to promote, restore and maintain health. This framework comprises six basic elements/dimensions: service delivery, an effective health workforce, a good health information system, access to medical products and technologies, financing, and leadership and governance to ensure and monitor performance[18] . Global health players, including PEPFAR, GAVI and the Global Fund, have adopted this definition[19] . These first two approaches were then deepened by the publication of the "*Systems Thinking for Health Systems Strengthening*" report by the WHO in 2009, which focused on understanding the links between the "blocks" (the 6 basic elements) within health systems, and on the fact that interventions must take into account *"the nature of the relationships between the blocks, the spaces between the blocks (and the understanding of what happens there), the synergies that emerge from the interactions between the blocks"* as each block is never independent of the others. The report advocates an integrated, systemic approach that would enable us to better understand and mitigate the impact of each intervention on the healthcare system as a whole.

[14] Cairncross, Periès, and Cutts 1997.
[15] Hafner and Shiffman 2013.
[16] Tsai, Lee, and Fan 2016.
[17] World Health Organization (WHO) 2000.
[18] World Health Organization (WHO) 2007.
[19] World Health Organization (WHO) 2008.

can have profound effects on the entire system, especially on the weakest[20] .

Gradually, the global health objectives around HSS have taken on greater prominence on global agendas with, notably, Sustainable Development Goal (SDG) #3 dedicated solely to health in 2015 and specifically mentioning the importance of health systems[21] , but also the adoption of HSS as one of GAVI's four strategic objectives in 2005 and again in 2011[22] , or as a fundamental guiding principle by the Global Fund in its 2017-2022 strategy[23] . The focus on strengthening health systems gained even greater momentum when HSS began to be seen as essential to achieving universal health coverage and accelerating the end of epidemics. Marie-Paule Kieny and colleagues emphasized in a 2019 article that achieving universal health coverage is a major goal for all countries (to achieve equitable and sustainable health outcomes and improve the well-being of individuals and communities), and that health systems strengthening is an essential means of achieving this[24] .

2.2. Moving from the theoretical concept to its operationalization

While the framework developed by the WHO has provided tools for reflection and elements of common understanding around the constituent elements of health systems, HSR today remains widely regarded as a fuzzy, multidimensional and continuous process, causing great **diversity in the approaches** adopted by the various players in global health. Numerous questions have been raised concerning the definitions and theoretical frameworks of HSR. From a conceptual point of view, in the late 2000s, some lamented the fact that health systems strengthening was becoming the new "*buzzword*" in the world of global health, i.e. a "container" concept, used to label very different interventions[25] . Many global health initiatives and agencies declare their activities to be HSS, whereas most actions labeled "HSS" are in reality selective, disease-specific interventions, and their effects can undermine progress towards the long-term goal of an effective, high-quality and inclusive health system[26] . There are calls to better define the exact purpose of HSS strategies, and to strike the right balance between a health system's role in disease prevention and treatment[27] . More specifically, despite the creation of a common language with the WHO's "*building blocks*", there is a lack of a common vision of HSS between the Global Fund and French cooperation actors, i.e. the Agence Française de Développement (AFD) and Expertise France (EF), which hinders the strengthening of their collaboration[28] .

From the same perspective, some point out that an important conceptual distinction needs to be made between **health systems support and health systems strengthening**. Health systems support can include any activity that improves services (e.g., from the distribution of bednets to the purchase of medicines), and helps to improve outcomes primarily by increasing inputs, whereas health systems strengthening is achieved through more comprehensive changes in performance factors, such as policies and regulations, organizational structures and relationships throughout the health system in order to motivate behavioral change and/or enable more efficient use of resources to improve multiple health services. This distinction is particularly

[20] World Health Organization (WHO) 2009.
[21] Objective 3: Enable everyone to live in good health and promote well-being at all ages. *Sustainable Development Goals*. https://www.un.org/sustainabledevelopment/fr/health/
[22] GAVI 2010.
[23] Global Fund 2016b.
[24] Kieny et al. n.d.
[25] Marchal, Cavalli, and Kegels 2009.
[26] Ibid; Tsai, Lee, and Fan 2016.
[27] Marchal, Cavalli, and Kegels 2009.
[28] Russo 2019.

important insofar as, if support activities are not distinguished from HSS activities or are wrongly characterized as HSS, and fail to improve the performance of a health system, this can lead to unmet expectations of health system strengthening and, consequently, to a discrediting of the value of HSS investments[29] .

Questions around **measuring the impact** of HSS projects are also being debated, and very little material has been produced and assimilated by global health development aid actors in terms of objectives, indicators, roles or priorities in the field of HSS. Despite calls for rigorous evaluations of health systems strengthening efforts, very few evaluations use a comprehensive, holistic approach to assess the impact of interventions with system-wide effects[30] . Possible obstacles to more comprehensive evaluations include a lack of funding and limited capacity, inadequate timeframes, and a lack of demand from researchers and research funders. There may be several untapped resources that could contribute to more comprehensive assessments, including systems thinking concepts, tools and approaches; and perspectives and approaches used in disciplines such as social sciences and health policy analysis[31] . However, in the logic of vertical programs, donors funding Global Health Initiatives (GHI) are committed to "quantifiable" results as part of their accountability requirements to their donors; for example, the Fund's main indicator used for communication remains the number of lives saved[32] . The danger of using such measures is that they could compromise investment in essential HSS interventions that do not easily translate into numbers of lives saved[33] . This observation highlights the need to develop, at least as a complement to these strictly quantitative measures, strategic roadmaps and a set of indicators to assess the real impact that global health actors can have on health systems.

Finally, improving the functioning of health systems requires **a change and simplification in the architecture of global aid in the context of HSS**. Firstly, the lack of collaboration and harmonization between the various technical and financial partners is a major obstacle, whether in terms of conceptual and operational understanding of what constitutes HSS, common criteria for expenditure classified as "HSS", a common classification system, or harmonization of programmatic and financial HSS data[34] . Next, various elements are identified as necessary for a better organization of stakeholders, including the coordination of international agencies under an identified leader; the necessary capacity of beneficiary countries to define a coherent national strategy and coordinate domestic and international funding; the need t o develop integrated activities between those specific to diseases and those of other health services; and the need to avoid resorting to overly narrow objectives that can distort behavior[35] .

2.3. A brief history of RSS at FM

The Global Fund was originally created in an emergency context, with the aim of achieving rapid, effective results to contain epidemics. However, the Global Fund

[29] Chee et al. 2013.
[30] Adam et al. 2012.
[31] Ibid.
[32] Global Fund 2019a.
[33] McCoy et al. 2013.
[34] Shakarishvili et al. 2011.
[35] Balabanova et al. 2010.

has always integrated, in one way or another, the issue of HSR into its strategic frameworks and operational guidelines.

✓ **2002-2014: HSS, a non-strategic issue for the Global Fund**

In the early years of its existence, the Global Fund focused exclusively on to the urgency posed by the three diseases. Although the framework document (2001) specified that programs focusing on the three diseases should at the same time "contribute to the strengthening of health systems", this mention was secondary. At a time when generic HIV drugs were not yet available, the debates revolved mainly around whether or not the Global Fund would be able to finance treatment, far from the challenges of health systems.

Between 2002 and 2007, while requests for funding were mainly focused on emergency and health supplies, it was still possible for applicants to apply for HSS funding, either through a "cross-cutting" or "integrated" component within the three diseases grants (*Round 1-4 then Round 6-7*); or via a separate "HSS" application (*Round 5*), which Rwanda, for example, benefited from[36] (Figure 1). For some, the HSS issue became increasingly visible from 2007 onwards, when the Global Fund began to place greater emphasis on financing comprehensive health programs, and to explore the possibilities offered by "diagonal" financing (targeting disease-specific outcomes through improved health systems)[37] . Back in 2006, Julio Frenk described the development of the concept of a so-called "diagonal" approach as an attempt to reconcile vertical and horizontal programs through HSS: *"a strategy in which we use explicit intervention priorities to bring about the required improvements in the health system, addressing generic issues such as human resource development, financing, facility planning, drug supply, rational prescribing and quality assurance"*[38] .

In 2009, the Global Fund, in cooperation with the GAVI Alliance, the World Bank and WHO, created the Health Systems Financing Platform, whose aim was to "*coordinate, mobilize, simplify and channel the flow of new and existing international resources to support national health strategies*" and to better harmonize HSS assistance between the three international organizations. However, this platform never really functioned, and following the suspension of the FM's participation in 2011, the platform was dissolved[39] .

In its 2012-2016 strategy, HSS became a "strategic action" (1.3. "*Maximize the impact of Global Fund investments in health systems strengthening*"[40]) within strategic objective no. 1 ("Invest more strategically"). It was also clearly stipulated that investments in health systems were seen first and foremost as a tool for achieving the Global Fund's main objective, namely accelerating the end of the three diseases: *"The Global Fund views health systems strengthening as a means to an end, not as an end in itself"*[41] .

Thus, during the first decade of the Global Fund's existence, the "HSS" or "cross-cutting" component was present, albeit poorly defined and fluctuating over the years in its modalities. This aspect was not considered a central strategic element, and its funding remained marginal and scattered, more akin to "shopping lists"[42] .

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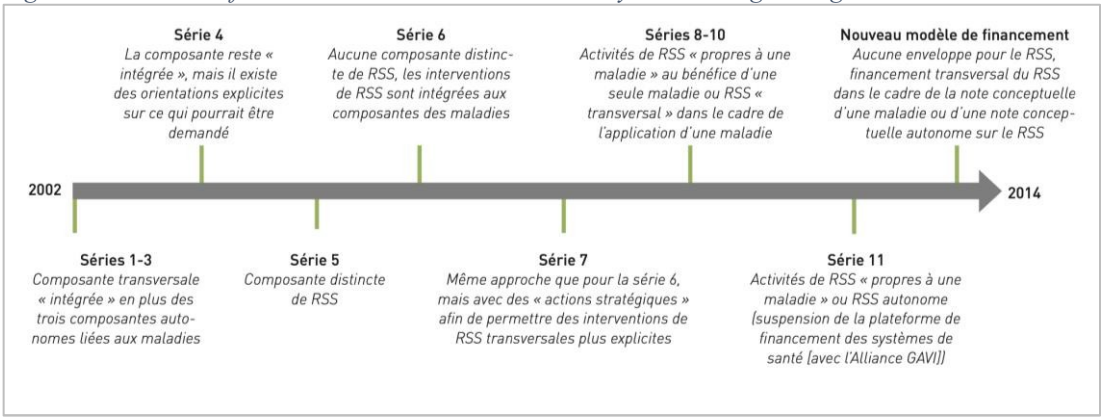
[36] World Health Organization (WHO) and Global Fund 2007.
[37] Ooms et al. 2008.
[38] Frenk 2006.
[39] World Health Organization (WHO) 2014.
[40] In the 2012-2016 strategy, it was noted that HSS "*is necessary to ensure the impact of core investments in the fight against HIV/AIDS, tuberculosis and malaria*", and that disease financing also contributed to health systems strengthening, with the need to invest more in core HSS needs for "*the proper functioning and long-term sustainability of the health system (such as governance, health financing, pharmaceutical and health commodity management)*" and improved alignment and harmonization of financing.
[41] Global Fund 2011.
[42] Global Fund 2005; Russo 2019.

Figure 1: Evolution of Global Fund investment in health systems strengthening[43]



✓ **From 2014: gradual formalization**

Following the reform of the Global Fund and the adoption of its new business model (NFM) in 2014, HSS is set to take on an increasingly strategic role within the Global Fund. There are several reasons for this. Firstly, it adapted to the international context of the time, characterized by growing criticism of vertical approaches and the adoption of the Sustainable Development Goals in 2015, which were intended to be more cross-cutting than the Millennium Development Goals (2000-2015). Secondly, the slowdown in progress in the fight against the three pandemics played an important role[44] , notably due to the weaknesses of health systems in certain countries, which represented real bottlenecks, with a negative impact on the performance of subsidies. This growing concern was taking place against a backdrop of scaling-up of access to treatments and inputs, resulting in ever-increasing demands on the various components of healthcare systems (human resources, supply chains, etc.). The outbreak of the Ebola virus epidemic in West Africa in 2014 also contributed to this development, revealing the fragility of healthcare systems and their low resilience in the face of health shocks, and jeopardizing all efforts to combat the three pandemics.

In the end, the Global Fund gradually introduced and formalized the HSS component within its strategic and operational framework. In 2015, it defined seven main approaches to help countries establish "Resilient and Sustainable Health Systems" (RSHS), following its own terminology[45] . In 2016, it asserted its specificity, departing in part from the framework laid down

[43] Source: World Health Organization (WHO) 2014, 16.
[44] Russo 2019; Global Fund 2019b.
45 "(1) support national health strategies and national strategic plans to fight HIV, tuberculosis and malaria; (2) focus on a person, not a disease: support integrated service delivery; (3) support specific aspects of a resilient health system that are at the heart of the Global Fund's mission and core competencies, such as procurement and chain management

by WHO focused on strengthening state capacities, with particular attention t o communities as key players in supporting HSS interventions[46] .

In 2016, it formalized its future 2017-2022 strategy and included "*building resilient and sustainable systems for health*" as one of its four strategic objectives[47] , to ultimately enable improved results in the fight against the three diseases and more generally in healthcare, while strengthening protection and financial equity, thus contributing to the goal of universal health coverage (UHC) and also to better detection and response against potential health crises (Global Fund 2016). To this end, the 2017-2022 Strategy defines seven operational objectives around projects that must contribute to the achievement of their strategic objective no. 2[48] . This approach has asserted that it is now patient-centric rather than disease-centric, and favors the integration of services. Also, the principles of national ownership and partnership were reaffirmed, insofar as these investments will be made *"as far as possible on the basis of sound national health strategies and robust disease control plans, in close collaboration with partners to ensure integration and harmonization of approaches*"[49] .

The Global Fund has also introduced an approach that defines the evolution of health system development in four stages, using the "4S model": *Start-Up, Support, Strengthening, Sustainability* (see appendices 1 and 2), to distinguish between support and strengthening.

✓ Current limits to the operationalization of the SRPS strategic objective at the Global Fund

SRPS subsidies, whether stand-alone or integrated with disease subsidies, have relatively low uptake rates, at 56% and 67% respectively, compared with 75% for disease-only interventions[50] . This finding reveals specific difficulties in implementing SRPS activities[51] . Thus, since the formalization of this HSS objective, several internal Global Fund reports and evaluations have pointed to the current challenges and limitations of implementing HSS investments in the

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procurement, program quality assurance through robust data and human resource management, and financial and risk management; (4) capture and catalyze innovation across all sectors to achieve greater impact and value for money; (5) promote and strengthen community-based responses and involve communities in national decision-making; (6) help countries increase domestic financing and leverage international financing for health; and (7) tailor investments to a country's unique stage of development, its specific health system and the unique constellation of partners in each nation. ", Global Fund 2015.

46 "The Global Fund's commitment to HSSR represents an important paradigm shift in thinking about health service delivery. Health systems, unlike healthcare systems, don't stop at a clinical facility, but reach deep into communities and can reach those who don't always make it to clinics, especially the most vulnerable and marginalized. Health systems focus on people, not problems and diseases. This new way of thinking reflects the shift from the Millennium Development Goals to the Sustainable Development Goals (SDGs) and the growing importance of universal health coverage (UHC) as a health policy objective", Global Fund 2016a.

47 Global Fund 2016b.

48 (1) Strengthen community-based responses and systems, (2) Support reproductive health, women's, children's and adolescents' health, and integrated service delivery platforms, (3) Strengthen global and national procurement and supply chain systems, (4) Leverage critical investments in human resources for health, (5) Strengthen data systems for health and country capacity for analysis and use, (6) Strengthen and align with national health strategies and disease-specific national strategic plans, and (7) Strengthen financial management and control, Ibid.

49 Ibid.

50 Office of the Inspector General (OIG/OIG) 2019c, 6.

51 Office of the Inspector General (OIG/OIG) 2019c.

countries. These include the Technical Review Panel (TRP) report analyzing lessons learned from HSS funding in the 2017-2019 grant cycle[52] , the Technical Evaluation Reference Group (TERG) thematic review[53] and the Office of the Inspector General (OIG) audit report[54] . Here is a brief summary of the problems observed in these three reports (Box 1).

Box 1: Summary of issues identified by the TRP, TERG and OIG relating to HSS (or SRPS) at the Global Fund

✓ **Designing/understanding RSS strategy**

- With a broad and unclear definition of HSR, there is a lack of consensus on its scope and reach between different stakeholders, i.e. whether HSS investments are intended to support the improvement of disease subsidies or to strengthen health systems for their own sake; or on the very definition of HSS activities. This lack of clarity generates "Operational tensions" (TERG, OIG).
- Some pillars - such as community responses and systems, or integrated service delivery - suffer from a lack of conceptualization and definition (TERG).

✓ **Implementing RSS activities**

- HSSR investments are largely focused on disease, both short-term and long-term. do not significantly improve the resilience of health systems and/or lead to sustainability. There is a need for greater **differentiation of** HSSR investments along the development continuum, with the need to shift more from support for health system strengthening and sustainability (TRP, TERG) to support for health system resilience.
- To avoid HSS grant applications becoming a "shopping list", it is necessary to better **prioritize HSS investments between the different pillars**, based on more solid country-level analyses identifying the main bottlenecks (TRPs).
- There is still a tendency to focus vertically on one disease, with many missed opportunities. There is a need for better **integration of** activities, both between the three diseases and beyond, with particular reference to sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH). This integration can be achieved at different levels and via different entry points: service delivery, human resources for health, the health information system, supply chain management, integration of community responses with conventional health systems, etc.
- The **Global Fund's structures and processes** are ill-suited to the implementation of HSSR funding: the length of the project cycle (too short for HSSR), a compartmentalized approach within the Secretariat, a lack of in-house skills, the structuring of HSSR in the countries (design, project management, links with disease stakeholders, etc.) (IGO). Funding application and grant-awarding processes can hamper the optimization of HSS investments (TERG).
- FM HSSR guidelines are little used by **national players** (TERG)
- There is little integration of key partners such as ministries of finance and/or planning, community groups (beyond disease advocates) and the private sector. There is a need for greater

[52] Technical Review Panel (TRP) 2018.
[53] Technical Evaluation Reference Committee (TERG) 2019.
[54] Office of the Inspector General (OIG/OIG) 2019c.

national health authorities and players (beyond the Ministry of Health) to promote planning, national ownership, implementation and sustainability of actions.

- **CCMs** generally find it difficult to engage effectively in broader discussions with other coordinating structures in the country that are responsible for health systems and HSSR investment planning (TERG).
- **International technical and financial partners** involved in HSS are poorly coordinated at all levels (planning, financing, implementation, supervision, monitoring & evaluation). Also, **technical assistance** (TA) for HSS is neither well understood nor well coordinated between partners (TERG).

✓ **Monitoring and assessment**

- The weakness of **HSSR indicators** (relevance, absence, difficulty in assessing impact), as well as their poor use in the **performance frameworks** of funding applications, have a negative impact on performance monitoring and the accountability of the players involved. There is a need to improve the performance framework (modular framework, indicators) (TERG, TRP, OIG).

✓ **Specific pillars :**

- The low level of interest in the essential issues of leadership, strengthening **governance, financing** and financial management, which are essential for the implementation of subsidies, as well as for transition and sustainability.
- Efforts are being made in the areas of national health information systems (SNIS) and purchasing and supply management (GAA), but remain insufficient, with a continuing tendency to create compartmentalized, parallel systems.
- Spending on human resources for health (HRH) is extremely high. These "short-term" measures (essentially salaries and remuneration) do not address the fundamental issues (shortages, poor distribution across the country, quality of training), and are rarely part of national plans with a view to sustainability (particularly for community health workers).
- There is a lack of clarity and understanding about the objectives and scope of **community systems and responses**. The focus is mainly on the deployment of community health workers (CHWs). Community activities are poorly integrated into public systems at all levels (service delivery, monitoring and evaluation, input/medication distribution, health human resources plans, etc.).

3. Methodology

3.1. Research questions

The study sought to analyze the Global Fund's support for health systems strengthening (HSS), in West and Central Africa (WCA), since 2014, when the Global Fund's new financing model was introduced, in complementarity with the various reports produced internally,

At the outset, we identified three main areas of research:

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

- How the Global Fund's new HSS strategy has been perceived and appropriated by players in the Global Fund ecosystem (Secretariat, recipient countries, international organizations)

2. The Global Fund's HSS expenditures
   - How are RSS expenses calculated?
   - From an operational point of view, how are RSS investments decided?
   - How far is the Global Fund "prepared" to go with HSR? What are the limits and why?

3. Institutional systems for implementing HSR
   - Complementing the IGO report (2019) which documents the operational and organizational constraints of FM HSS investments in West and Central Africa, we will focus on analyzing the obstacles and opportunities of HSS at the recipient country level.

3.2. Three levels of analysis: from global to local

This research focused on three interrelated levels of analysis:

1) At the international level, global health players, including the Global Fund and other multilateral international organizations, as well as French global health players (bilateral cooperation, civil society, others) and international consultants.

2) On a regional level, the countries of West and Central Africa. The choice to focus on this region in particular was made for a number of reasons. It is an area marked by particularly significant difficulties in terms of security, institutions, finance and human resources, and where healthcare systems are particularly fragile. It also made it possible to target priority countries for France's official development assistance; and to focus the analysis on a precise geographical area in order to build a coherent grid for understanding local issues.

3) At the national level,[55] sheds light on certain issues in four countries:

- In Côte d'Ivoire (main focus), on the development of the concept note (NFM3), analyzing the process, the way in which the HSS component is integrated (or not) in relation to other subsidies, the players who participate and those who take the *lead*, the way in which the axes/activities to be financed are decided, the way in which other technical and financial partners are involved in the process, etc.
- In Benin, on the conditions for drawing up and implementing a separate grant dedicated to HSS, (known as "*stand alone*") i.e. where HSS modules and activities are not integrated into disease grants, as is generally the case.
- In Niger, on the Global Fund's positioning vis-à-vis the multi-donor Fonds Commun de Santé (FCS).
- In the Central African Republic (CAR), on the NFM3 concept note allocation letter.

3.3. Research methods

[55] We use the terminology "illumination", since the duration of the study did not allow us to carry out real case studies, which would have required more time.

The present study was initiated in February 2020 and lasted until September 2020 (four months full-time equivalent). It was conducted from Côte d'Ivoire (the researcher's place of residence) and, for the most part, remotely, due to constraints linked to the Covid-19 epidemic.

In order to gather detailed, precise data, this research employed a qualitative methodology, combining three survey tools: a literature review, semi-structured interviews and participant observation.

→ Review of scientific and grey literature

A review of the scientific literature was carried out beforehand, to situate the subject within the academic field.

A review of the grey literature was conducted throughout the study, collecting several types of documentation:

- **Global Fund documentation**, with a strong focus on public reports from the Office of the Inspector General (OIG), the Technical Evaluation Reference Committee (TERG) and the Technical Review Panel (TRP) etc.), and from the Secretariat (Strategy, roadmaps, guidance notes, etc.)[56] ; complemented by internal documentation relating to the methodology for calculating SRPS expenditure[57] .
- **The Global Fund database** (https://data.theglobalfund.org/investments/home)
- **Country documentation,** including concept notes, performance frameworks, allocation letters, etc.

→ Qualitative field survey

Semi-structured interviews (46 in total) (see table) were conducted with a wide range of stakeholders (international multi- and bilateral organizations, civil society, consultants, public stakeholders in beneficiary countries), with around 2/3 of the interviews conducted with international stakeholders and 1/3 with stakeholders from West and Central Africa (mainly Côte d'Ivoire).
Interviews were either recorded (with the prior authorization of the interviewee) or collected with systematic note-taking.

	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.

[56] Notably: Technical Proposal Review Committee (TRP) 2018; Technical Evaluation Reference Committee (TERG) 2019; Office of the Inspector General (OIG/OIG) 2019c.
[57] Global Fund 2019c.

Participant observations were conducted during the workshop "*Investing in the health system: a major lever for increasing the impact of grants in West Africa*" co-organized in Cotonou (Benin) by Aidspan and the *African Constituency Bureau* (February 5-7, 2020); as well as during six meetings on the development of the NFM3 concept note in Côte d'Ivoire (Country Dialogue, HSS sub-committee meetings, coordination meetings).

Data analysis was carried out using qualitative analysis software (©Nvivo). Interviews were anonymized before being processed according to thematic coding.

This study complies with international laws in terms of health and social science research ethics, following the principles of (1) non-conditioning of participation, (2) information, (3) obtaining informed consent from participants and (4) confidentiality of data.

3.4. Limits and precautions

With a limited duration of four months, this study does not claim to cover exhaustively a subject as technical and complex as the integration of HSS into the Global Fund, the primary objective being to provide an external, global, qualitative and comprehensive vision.

There is an over-representation of French players (French bilateral cooperation players, but also agents of the Global Fund and other international organizations, civil society and consultants of French nationality) in the list of interviews conducted, which represents a significant bias in the representations described in this study.
There is an under-representation of players from Global Fund implementing countries, due to the time constraints of this survey.
The context of the Covid-19 epidemic prevented us from carrying out missions to Geneva and Paris, and reduced our ability to observe meetings in Côte d'Ivoire during the drafting of the concept note, which was also a limitation.
Certain aspects could not be explored in depth, and deserve further study (see "Research avenues").

3.5. Thanks

I would like to thank all those who accepted and took the time to participate in this study, despite the specific context of the Covid-19 epidemic.

In particular
- Veronica Montes and Nelly Common for organizing the study at the Global Fund
- Perrine Bonvalet for her support at AFD
- Stéphanie Tchiombiano, Héloïse Mahé and the members of the Think tank Santé mondiale 2030 for their support throughout the study.

Part 1. Integrating and defining HSR in a disease-focused organization

1. Integrating HSS into the Global Fund, or "putting squares in circles"?

HSS has taken its place in a disease-centric institution, in tension with the principles and modalities of HSS implementation. For the Global Fund, HSS is a non-natural object, subject to various constraints, both internal, due to its history, objectives, organization, culture and skills; and external, in relation to its relatively limited funding and the international environment of global health.

1.1. Vertical "DNA" and results-based financing (RBF) of the Global Fund Vs HSS

One of the distinctive features of the Global Fund is that, since its inception, it has been a public-private partnership. Ongoing evaluation of the results obtained for each dollar invested is one of the driving forces and distinctive features of the Global Fund, which was one of the first to adopt a results-based model. Its ability to mobilize substantial funding at the replenishment conferences, which take place every three years, is based on its capacity to prove its effectiveness over a short period of time, through eloquent and meaningful impact indicators for donor countries, such as the number of lives saved. Several interlocutors pointed out the difficulty of mobilizing funding for HSS, which is not perceived as a "selling" subject by donors because of the difficulty of proving its impact over a short period of time.

> "RSS results are not as tangible as disease results, and you can't always deliver results in a three-year cycle. They require many more years**.** That's why the three-year funding cycle is a problem. You invest in an infrastructure for three years and then you have no money because you don't know how the replenishment conference is going to go, the money is lost, how you carry on". (Global Fund stakeholder)

The choice of donors is also conditioned by the ability of a discourse to mobilize emotions and values, following a compassionate logic[58] , which the discourse on HSR is still struggling to produce.

> "We've never appealed to the generosity of donors by making them cry about health systems. Vaccines, HIV and malaria work. But the Global Fund is totally dependent on donors (and 85% on Northern countries). It's "*Raise it, fund it and prove it*". *Raise it*, fund it and prove it". To raise money, you have to pitch it! and it worked... I have the impression that we'll always be stuck with that. (French global health actor)

> "The *sine qua non* for getting money, especially for Americans, is to see a difference quickly. You talk to them about RSS, i.e. something where even if there were 500 or 1000 billion

[58] Fassin 2009.

> for HSS, the fact that it takes an easy ten years to start making a difference to mortality and morbidity...we've lost them" (civil society stakeholder).

This dependence on the generosity of donors, which occurs at very short intervals (every three years), tends to condition the functioning of the Global Fund and its Secretariat, which is more focused on the rapid disbursement of its financing, the justification of its impact and the control of possible misappropriation scandals, generating a very strong focus on compliance with procedures and risk management[59] . These Global Fund constraints tend to clash with the basic principles of HSS, i.e. those based on country *leadership* and the adaptation of objectives and procedures to national contexts.

Several people mentioned the term "culture", whether Anglo-Saxon or professional.
- Global Fund agents to underline the difficulty of integrating the HSS theme, requiring more cross-functional approaches and skills in public health or reproductive and sexual health, for example. According to some interlocutors, the "Anglo-Saxon culture" is defined by its "*value for money*" approach and its disease-centric vision of health, as opposed to a more European vision based on universal access to basic health services, which is ultimately opposed to the conditions for implementing HSS.

> "So you have to understand that the Global Fund is a very Anglo-Saxon structure. You carry out an action, you measure a result and you have an impact. That's why the Global Fund's figures, with the number of lives saved, allow us to say that the Global Fund is carrying out necessary actions. But the way we measure them is very much oriented towards quantifying results and selling them in the form of numbers. This doesn't apply to human rights, it doesn't apply to HSS" (Civil society actor).

In terms of professional culture, mention was made of the fact that Global Fund agents generally have a technical approach, being specialists in precise functions (financial risks, monitoring & evaluation, etc.) or specific diseases, tending to think in silos. This professional culture of the global health ecosystem, where professionals make a career around a specific disease, is not unique to the Global Fund[60] . This "disease culture" is also part of the Global Fund's history. It stems directly from the emergency context in which the Fund was created, and the fear aroused by the three pandemics at the time.

> "Originally, the Global Fund was set up as an emergency response in the early 2000s, when forecasts for the three pandemics were in the millions of deaths per year. You have to remember there were years when there were 3-4 million people dying of AIDS...it was a very, very strong thing. The FM has had a culture of fighting disease for a very long time" (French global health player).

[59] Tchiombiano, Nay, and Eboko 2018.
[60] Storeng 2014.

Box 2 Cross-cutting features of the Global Fund and HSS approaches

Objectives	Emergencies, illnesses	Sustainable and systemic actions
Key principles	Efficiency, accountability Absorption of financing	Country-specific, simple procedures Integration and ownership
Internal organization	Mandate 3 illnesses	
	Partitioned organization, process functions ++.	Systemic and cross-functional approaches
	Vertical professional culture (diseases, techniques)	Expertise in public health, maternal and child health, etc.
Country positioning	No country office	Need for ongoing collaboration with countries and other IOs
Financing	~ $5 billion (USD) / year (available next three-year cycle)	~ $100 billion (USD) / year (estimated needs in 67 low- and middle-income countries) intermediate)
Temporality	Short (3 years)	Long (at least 6-10 years)

1.2. The major constraint of limited resources

While the Global Fund has a strong capacity to mobilize funds - as demonstrated by the success of the Replenishment Conference in Lyon (2019) and its mobilization of 14 billion dollars (USD) - most of the people we spoke to pointed out that its financial capacities are not sufficient:
1) to meet the growing needs of the fight against the three pandemics, which is still far from complete, particularly in terms of universal access to antiretroviral treatment (around 1/3 of people living with HIV still do not have access to ARVs worldwide), controlling the resurgence of new cases of malaria or responding to multi-drug-resistant tuberculosis. 2) *a fortieri*, to meet the colossal needs of healthcare systems in low- and middle-income countries. Although estimates are not made on a strictly comparable basis[61] , the Global Fund's contribution will amount to around 4.7 billion dollars (USD) per year for the next cycle, with around 1.3 billion dollars per year allocated to HSS on average, while current needs to strengthen health systems in 67 low- and middle-income countries are estimated at around 100 billion dollars (USD) per year (Box 3).

[61] 67 middle- and low-income countries for the Stenberg et al. 2017 Health MDG Achievement Study, and the 70 countries covered by the Global Fund for its Global Fund 2019a assessment.

Box 3 Estimates of needs linked to achieving the MDGs (health) and those linked to the three pandemics

✓ **Needs related to the health targets of the MDGs by 2030 in 67 countries**

To achieve the health-related targets of the Sustainable Development Goals (SDGs) in 67 low- and middle-income countries by 2030, one study estimated the costs required for an investment increasing over time from $134 billion a year at the beginning, to $371 billion a year at the end - 75% of which would have to be invested in healthcare systems, with human resources and infrastructure as the main expenses[62] . Thus, the investment needed in healthcare systems would represent **around $100 billion a year.**

Most resources will be needed to support primary care services (57%).

✓ **Needs related to the three pandemics (HIV, tuberculosis and malaria)**

The FM has estimated that $101 billion (USD) in financing will be required over the period 2021- 2010.

2023, in order to be on track for 2030 and achieve the goal of defeating the three pandemics by that date (i.e. $33.6 billion per year). The Global Fund's contribution amounts to $14 billion (**or $4.7 billion per year**), which it considers to be the largest contribution to the fight against the three pandemics.

"minimum requirements" to achieve the 2017-2022 strategic objectives[63] .

Following an extensive definition of its contribution to HSS (*cf. 2.3*), the Global Fund estimates that 28% of its 2019 budget is allocated to resilient and sustainable health systems (in a direct and contributory manner). The GF's annual contribution to HSS would be around **$1.3 billion per year**.

Concerns about the evolution of the Global Fund to fight the three diseases towards a Global Fund covering broader health issues are not new[64] . Many players (both inside and outside the Global Fund) continue to stress that HSS investments can only be made to the detriment of the fight against the three pandemics, for which funding is already fair, given the targets set and the growing needs. This situation leads to several risks identified by the respondents: 1) reducing the share allocated to the fight against pandemics, despite the fact that this remains the Global Fund's primary mission, and that many countries remain heavily dependent on the Global Fund for the purchase of medicines and inputs in particular; 2) investing in health systems on a "sprinkling" basis, i.e. without any real impact, and 3) at country level, the risk of reducing the funding allocated to a country from one year to the next, insofar as HSS funding absorption capacities are generally lower than for pandemics[65] , and insofar as the funding allocated to a country is calculated on the basis of its past results. So, for some players - notably in HIV civil society - this extension of Global Fund targets to HSS is more akin to a lose-lose strategy.

> "The Global Fund's mission is to fight the three pandemics, which it is unable to do and does not have sufficient resources. If it were to expand to do something else, it would be to the detriment of the fight against pandemics, and the needs that are not sufficiently covered would be even less so" (civil society player).

[62] Stenberg et al. 2017.

[63] According to these estimates, $46 billion should be provided by domestic resources (2021-2023), representing an increase of almost 50%; cf. Global Fund 2019a.

[64] Already in 2008, Ooms et al noted that "*a transformation of the Global Fund to Fight AIDS, Tuberculosis and Malaria into a Global Health Fund is possible, but only if it is accompanied by a substantial increase in donor commitments to the Global Fund. The transformation of the Global Fund into a 'diagonal' and perhaps even 'horizontal' funding approach should be gradual and cautious, and accompanied by measures to preserve its unique characteristics*" (translated from the original version), Ooms et al. 2008.

[65] 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% Office of the Inspector General (OIG/OIG) 2019c.

These tensions and constraints between the Global Fund and HSS are felt on two levels: on the production of knowledge and the definition of the Global Fund's HSS approach (below); and on the implementation of HSS actions, which currently remains limited (Part 2).

2. Defining the Global Fund's HSS approach

The TRP, TERG and OIG reports highlight the major progress made in conceptualizing the Global Fund's HSS approach, while also pointing out certain limitations, particularly in terms of clarity and common understanding (Box 4).

Here, we analyze how the players we interviewed, both inside and outside the Global Fund, perceive and characterize its approach, and where any conflicts of definition may lie.

Box 4: Definitions of the Global Fund's HSS approach: synthesis of TERG, TRP and OIG reports

- The TRP, IGO and TERG emphasize that a major effort has been made in the conceptualization of HSSR at the Global Fund in recent years, particularly with the new 2017-2022 Strategy
- **According to TERG[66] , the Global Fund's definition of HSSR is broad and unclear, particularly as regards its scope**. There is a lack of common understanding and interpretation of HSSR at the Global Fund, within the Secretariat itself and among stakeholders at large, including major donors. It calls for greater clarification of the scope of the Global Fund's HSSR, in order to reduce ambiguities, uncertainties and "operational tensions". The main ambiguities highlighted are as follows:
    1. Between **disease-focused** support and **more cross-functional support** across healthcare systems; although in theory the two are not mutually exclusive, in practice, priority is given to disease-focused approaches.
    2. Between **short-term and long-term** gains and financing, with ambivalence in the definition of the term "resilience".
    3. Between prioritization of investment areas based on comparative advantages for the Global Fund (e.g. supply chain and health information system) - an approach generally supported by global stakeholders - or broader prioritization, to enable greater country ownership - an approach more strongly supported by national stakeholders.
- The TERG reiterates that it is at least essential to ensure that **the Global Fund's global investments do not "undermine" countries' health systems**.
- The TERG and TRP emphasize that the differentiated approach of HSSR according to the degree of development of countries is a good approach, but one that is lacking in its operationalization.
- The TRP recognizes the definition of the Global Fund's Strategy, where the HPRS aims to maximize impact against the three diseases, with the ultimate goal of progressing towards Universal Health Coverage (UHC); its assessments point towards a broader conception, where the HPRS would also benefit health systems as a whole, taking greater account of national health plans and the integration of actions beyond the three diseases[67] .

[66] The TERG report is the one that most addresses this issue

[67] For example, in its evaluation of the 2017-2019 grants, the TRP recommends that greater efforts be made to achieve better integration between the three diseases and with other health programs, such as the sexual, reproductive, maternal, newborn, de

2.1. Between proximity and specificity vis-à-vis WHO

As early as 2015, the Global Fund developed its own conceptual framework, at once close to the WHO's, while differing from it in certain respects, which other organizations such as the World Bank or Unicef have also done. It has defined seven components (instead of WHO's six "blocks"), to help countries establish "Resilient and Sustainable Health Systems" (RSHS), following its own terminology (The Global Fund, 2015).

Box 5: WHO and Global Fund approach to HSS/SRPS

Pillars	WHO (2007)[68]	Global Fund (2016)[69]
Community systems	NA	Strengthening community responses and systems
Service provision	Good health services are those that deliver effective, safe and qualitative personal and non-personal health interventions to the people who need them, at the right time and in the right place, with minimum waste of resources.	Supporting reproductive health, women's, children's and youth health, and integrated service delivery platforms
Access to medicines	A well-functioning healthcare system ensures equitable access to essential medical products and technologies of guaranteed quality, safety, efficacy and cost-effectiveness.	Strengthen global and national purchasing and supply chain systems
Health human resources	High-performing health workers are those who work responsively, fairly and efficiently to achieve the best possible health outcomes.	Leveraging essential investments in human resources for health
Health information	A well-functioning health information system must ensure the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status.	Strengthen countries' health data systems, analysis and utilization capacities
Leadership and governance	Leadership and governance involve ensure the existence of working environments strategic policies and that these	Strengthen national health strategies and the strategicplans and disease-specific national

Child and Adolescent Health (SSRMNEA) and non-communicable diseases, where integration can strengthen service delivery, improve efficiency, equity and/or impact and value for money, Technical Review Panel (TRP) 2018.

Also, in feedback from the TRP's evaluation of grant applications for the 1ère NFM3 window, it pointed out that the focus on the three disease programs was too strong: "*The HSSR component of the funding application often addressed only the specific needs of the three disease programs rather than the underlying HSSR needs reflected in national health plans that respect national sovereignty, are based on epidemiological evidence and are shaped by extensive consultative processes.*" (Author's translation), Technical Review Panel (TRP) 2020b.

[68] World Health Organization (WHO) 2007.

[69] Global Fund 2016b.

	These must be combined with supervision, coalition dynamics, regulation, attention to system design and effective accountability.	align with it
Health care financing	A good health financing system raises adequate health funds to ensure that people can access the services they need, and stimulates service delivery to ensure efficiency for providers and beneficiaries.	Strengthening financial management and control

The Global Fund's approach is characterized both by its proximity to that defined by the WHO, and by the nuances and specificities that reflect its positioning.

Firstly, the vision is more restricted and circumscribed, with a more operational focus. It is thus more focused on the three diseases[70] , less oriented towards broader issues such as the social determinants of health and equitable access to care for populations[71] , and pursues more operational objectives[72] .

This dual proximity-differentiation of the Global Fund's normative framework from that of the WHO can give rise to ambivalence in its understanding, by displaying a similar, cross-cutting approach, i.e. one based on its six pillars, while at the same time being concretely focused on achieving its own objectives and therefore investing in the various pillars in a piecemeal fashion.

> "Mark Dybul came up with RSSH ("*Resilient and Sustainable Systems for Health*"), in other words, with the idea that we should invest externally in those parts of the system that enable us to achieve results on AIDS, malaria and tuberculosis. **It's an approach which is very similar in its acronyms, but different in its objectives**. When we say strengthening the system, we mean enabling a greater number of people to have access to integrated services that include the three diseases, but also immunization, a large proportion of non-communicable diseases, minor surgery and so on. It's not at all the same philosophy to say 'I'm going to invest in the eras that will enable me to obtain my results for my three diseases, or for GAVI on my immunization indicators' (actor, multilateral international organization).

Similarly, some point to the difference between the term "resilience" used by the Global Fund and that of "strengthening" generally accepted in the world of global health, as indicative of the allegedly less ambitious and more restrictive nature of the definition:

> "Resilience means returning to the initial state, whereas the ambition in most countries is to be resilient, but also to strengthen. The definition is not good enough. The title isn't very ambitious (...) The aim is to do no harm, but as the leading donor in global health, we should go beyond that, and strengthening health systems should be the primary aim" (French global health player).

[70] As an example, in the "leadership and governance" section, one of the objectives is to strengthen disease-specific national strategic plans.

[71] We can cite as an example here, in the essential medicines pillar, the WHO's focus on equitable access to essential medical products and technologies, or in the health financing pillar, the fact that the objective is to "ensure that populations can use the necessary services and stimulate service delivery that ensures efficiency for providers and beneficiaries".

[72] Examples include the Global Fund's medicines component, which focuses on the operationalization of procurement and supply chain systems, and the health financing component, which aims to "strengthen financial management and control".

The second specificity of the Global Fund's definition concerns the addition of a seventh pillar, focused on strengthening community responses and systems. This specificity is directly in line with its history. Indeed, the Global Fund was one of the first donors to include civil society organizations in its decision-making bodies, from Geneva to the Country Coordinating Mechanisms (CCMs) of beneficiary countries (imposing a minimum of 40% CSO representation), reinforcing this focus on the community component through the introduction of the *dual track* rule (in 2011) and the systematic involvement of a non-governmental actor (generally from civil society) as principal recipient. Unlike the WHO, which focuses on strengthening state capacities, the Global Fund p a y s particular attention to communities as key players in supporting HSS interventions[73] , a priority that has been taken up by France on the Board.

In contexts, notably in West and Central Africa, where health systems are profoundly mixed (public, community and private), the Global Fund can be perceived as an "ally", particularly by national community players.

> *"Question: Do you feel that the Global Fund is an "ally" of community health?* Answer: Yes, definitely. Frankly, the Global Fund has understood that in Côte d'Ivoire (and in several other countries), the trend in the various indicators of maternal and infant mortality is levelling off, or even regressing. We're facing a glass ceiling on maternal and child health, yet there are a lot of players (the Global Fund, GAVI, the World Bank), a lot of investments, and the health indicators aren't improving. Where we can change the trend is in community health. It's all very well to pour resources into health systems and so on, but if the population doesn't have confidence in the health systems, the investments are in vain... All investments at community level are designed to put the community back at the heart of the process (...) that's really the key. The Global Fund has understood this and is trying to make a lot of investments" (Executive of a principal community recipient NGO, Côte d'Ivoire).

However, there is some confusion about the meaning of the term "community", with those interviewed from the world of HIV naturally seeing it in terms of human rights, vulnerable populations and community advisors or peer educators, while those involved in formal community health or malaria spontaneously see it in terms of primary health and the involvement of community health workers (CHWs). One consultant interviewed spoke of "two parallel systems", leading to confusion when concept notes were drawn up.

In the end, some consider that by developing its own conceptual framework, the Global Fund is overstepping its role as a financial instrument, seeking to acquire "symbolic power", while others point to a desire to compensate for a WHO reference framework that is too broad and too conceptual, even if it does not go all the way.

> "The Global Fund is a funding agency that tends to be prescriptive and normative, which is not its role. But the problem is that the WHO is too conceptual in its prescriptive nature, very general and not operational; it relies on the PNDS (*editor's note: national health development plan*), that's all (...). The added value of the Global Fund may lie in its capacity for more detailed analysis, but it doesn't have the means to do so" (International consultant).

2.2. Features of the Global Fund's HSS approach

[73] "The Global Fund's commitment to HSSR represents an important paradigm shift in thinking about health service delivery. Health systems, unlike healthcare systems, don't stop at a clinical facility but reach deep into communities and can reach those who don't always make it to clinics, especially the most vulnerable and marginalized. Health systems focus on people, not problems and diseases. This new way of thinking reflects the shift from the Millennium Development Goals to the Sustainable Development Goals (SDGs) and the growing importance of universal health coverage (UHC) as a health policy goal," in Global Fund 2016a.

Based on interviews conducted with both Global Fund staff and global health stakeholders (French operators, international organizations, associations), it is clear that the Global Fund's HSS approach is characterized, in practice, by two aspects: 1) its disease-focused scope and purpose, and 2) its functionalist nature, i.e. the approach is defined by its various pillars or technical areas.

2.2.1. A three-disease approach

For most of the international players interviewed, the Global Fund's HSS approach is defined above all by its focus on the three diseases, its primary objective being to remove the bottlenecks that stand in the way of scaling up the fight against the three diseases in countries, and not to strengthen health systems for their own sake, HSS being more of a positive collateral effect.

> "In my experience, in the different countries I've worked in, HSS is always based on the three diseases approach, i.e. what are the challenges in the health system that are preventing the country and its programs from achieving results" (Global Fund agent).

The disease-centric approach has been chosen and justified by various interlocutors and advocates of the Global Fund, for a number of reasons. Firstly, given the scale of the task, it is necessary for the organization - which has limited funds at its disposal - to circumscribe its actions in order to avoid diluting its financing, and naturally to choose components that are directly useful to it.

> "And the problem is that, in the end, it's (*editor's note: HSS funding from the MF*) a drop in the bucket compared to the total needs of West African countries, but our HSS investments are a drop in the bucket! For HIV, TB, malaria, it's not a drop in the bucket (...) That's why we're somewhat obliged to limit ourselves to certain niches, but there's so much to do in HSS" (Global Fund agent).

This approach can be shared by national operational players, noting its pragmatic and effective nature, such as the director of an NGO, principal recipient of the Global Fund.

> "The advantage of the Global Fund is that it has to help boost investment in these three pandemics, so it's circumscribed and more effective. Even if it's not always the case, I really appreciate this approach. (Principal Community Recipient NGO, Côte d'Ivoire)

The second argument is that the Global Fund *de facto* strengthens healthcare systems by reinforcing those parts of the system that are useful to it.

> "We can't say that the Global Fund hasn't done HSS. It has done so in relation to its entry points, which are the three pandemics. So, of course, it doesn't address all the pandemics, but we can't say that having machines or staff trained in the use of machines doesn't strengthen health systems" (civil society player).

Thirdly (and following on from this), the argument of pandemics as gateways and opportunities for strengthening health systems more broadly is put forward, underpinning the idea of a positive leverage effect between the Fund's primary objective - the fight against the three diseases - and its impact on health systems, notably thanks to actions that integrate other health issues, and in particular via consultations dedicated to maternal and child health, as has often been emphasized.

> (*continued from interview*) "...And we start from the principle that HSS is already partly achieved through actions financed by the Global Fund, when it finances a certain number of human resources or equipment activities that are used for other pathologies.

Fourthly, the limitation of the Global Fund's mandate - still limited to the three diseases - can also be invoked to justify this limitation of scope.

"Talking about integration beyond the three diseases and purely health is difficult: we haven't yet changed our mandate" (Global Fund officer)

→ Definition conflicts

More specifically, conflicts of definition have arisen in the understanding of the Global Fund's HSS approach, essentially concerning its scope.

In the **internal documents produced by the Secretariat**, strategic and policy documents adopt a broader scope of HSS, where the ultimate goal is to contribute to the achievement of universal health coverage (UHC), while the more operational documents are more focused on the three diseases (Box 6).

Box 6: Scope of the SRPS according to Global Fund Secretariat documents

→ Documents from the most strategic to the most operational :

- **Strategy 2017-2022 (very broad)**: "*the implementation of SRPS will have the following impact*
  improved results in the fight against the three diseases and in the field of health in general, greater protection and financial equity contributing to the goal of universal health coverage (UHC), better preparedness for global health crises and, ultimately, improved health and safety for all"/.
- **HSS Roadmap (2019)** (intermediate): the overall objective is "*to improve the quality and impact of Global Fund HSS investments in a way that advances the fight against the three diseases and helps build resilient and sustainable health systems*".
- **Guidance note for the development of a SRPS (2020) funding application** (restricted to the 3 diseases): "*better take into account the challenges related to resilient and sustainable systems for health (SRPS) that have an impact on the achievement and sustainability of disease outcomes*".

Within the Secretariat itself, sensitivities differ according to the professional skills, culture and individual characteristics of staff members, depending on whether they have a financial, public health or M&E profile, for example. A Global Fund Secretariat staff member reported that internal staff tended to perceive HSS in terms of their specific skills and departments:

"There's a big difference in the way HSS is conceived, depending on the person involved...for those in the supply chain, it's the supply chain, for those in health information, it's health information" (Global Fund agent).

At country level, contradictory injunctions can be transmitted to countries between the country teams, which directly guide national players in drawing up concept notes, and the TRP (*Technical Review Panel*), which is responsible for evaluating them. For example, during the HSS Country Dialogue organized in Côte d'Ivoire (January 24, 2020), the country team specified that the amount allocated could not "*meet all the health challenges facing Côte d'Ivoire today*", but that it was necessary "*first and foremost, to think about the systems challenges that most affect the realization of the three programs*", while thinking of HSS as "*funding catalysts*", if they are used in a "sustainable" way.
"This is "*one of the first questions the TRP asks itself: 'How is this going to help National Programs?*

24/01/2020). However, in its various documents[74] , the TRP recommends that the Global Fund support SRPS investments with a broader scope than the three diseases, to achieve better integration between the three diseases but also with other health programs, such as the Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health (SRMNEA) program and non-communicable diseases[75] . For example, in its lessons learned from Window 1 of the NFM3 funding applications:

> "The HSSR component of the funding request often only addresses the specific needs of the three disease control programs rather than the underlying HSSR needs reflected in national health plans that respect national sovereignty, are based on epidemiological evidence and are shaped by extensive consultation processes."[76]

Finally, we observed[77] an opposition between national "disease" players who are well integrated into the Global Fund ecosystem and have appropriated its operational approach centered on the three diseases, and "non-pandemic health players" who are less integrated - whether as recipients, within national coordination bodies (ICN/CCM) or in the context of direct consultations and negotiations with country teams - and who spontaneously understand the HSS approach as being able to benefit the entire health sector. For example, an agent from a Central Directorate in Côte d'Ivoire recounted his experience at the time of writing:

> "We've come to understand that HSS is a support for the three diseases, whereas initially we thought it was broader. It's not RSS pure and simple, but it's designed to have an impact on the three diseases" (Côte d'Ivoire public sector).

> "There's a tendency towards verticality. When a player is HIV-positive, he only sees HIV. Even the coordination mechanisms see HIV coordination. While the country, the Minister of Health, wants to strengthen coordination of the fight against the three diseases, he would even like to go beyond that with transmissible and non-transmissible diseases. But in people's minds, it's the approach against the disease that takes precedence" (international consultant).

These definitional conflicts can send conflicting messages and generate operational tensions, as reported by the TERG (2019) evaluation, and as we observed during the development of the concept notes. HSS funding from the Global Fund may appear as a natural opportunity for a country's non-pandemic health actors to respond to systemic health issues; while one portfolio manager interviewed stressed that the Global Fund is not intended to "*compensate for what should be financed by the state*".

With regard to the evolution of the Global Fund, it emerged that, overall, given its financial resources, the interlocutors emphasized that the evolution of its mandate to embrace

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[74] Technical Review Panel (TRP) 2020b; Technical Review Panel (TRP) 2020a.

[75] For example, in its 2017-2019 grant evaluation, the TRP recommends that greater efforts be made to achieve better integration between the three diseases and with other health programs, such as the Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health (SRMNAH) program and NCDs, where integration can strengthen service delivery, improve efficiency, equity and/or impact and value for money.
Also, in the TRP's initial feedback made on the grant applications for the 1ère window of the NFM3 pointed out that the focus on the three disease programs was too great: "The HSSR component of the funding application often only addressed the specific needs of the three disease programs rather than the underlying HSSR needs reflected in national health plans that respect national sovereignty, are based on epidemiological evidence and are shaped by extensive consultation processes."

[76] Technical Review Panel (TRP) 2020b.

[77] This observation was made directly through interviews with national players in Côte d'Ivoire, and confirmed indirectly by other interlocutors.

other health issues, or even to become a Global Health Fund, is not on the agenda. A Global Fund officer summed up these tensions:

> "That's the big debate! One of the strengths of the Global Fund is that it manages to produce tangible, concrete results for the three diseases, and it's a fairly agile institution. That's a strength, and that's why we receive a fair amount of money. Now, if we go too far, can we remain agile? Do we have the skills? Can we deliver an expanded mandate with the resources we have? The budget we have? The people and skills we have? (...) We're aware that we have to invest and work with HSS, but there are these legitimate fears of not going too far, too fast, with a three-year cycle and partners in the country who aren't specific HSS partners. You know that a national program is working on malaria, so you have a direct contact. For HSS, you have to work with four institutions at once, there's no coordination" (Global Fund agent).

At the same time, the TRP stressed the need for the Global Fund to clarify guidance on what can be funded for key co-morbidities such as hepatitis, cervical cancer screening and other support programs (e.g. antenatal care and maternal and child health services); and should consider including indicators for these activities in its list of core indicators[78] .

2.2.2. A functionalist, technical approach

The Global Fund's HSS approach is also defined by its functionalist and technocratic character, i.e. by its various pillars. According to some interlocutors, this orientation has been produced in direct relation to the professional culture and dominant knowledge of its agents.

> "The Secretariat quickly proposed (and validated by the Strategy Committee and the Board of Directors) to work on things they had activities on anyway, be it the health information system, the supply chain and human resources (a bit). *They couldn't do anything else*. But it was complicated to get them into things where they didn't have all the keys in hand to move them forward" (Civil society actor).

In interviews with Global Fund staff, when asked "How would you define the Global Fund's approach to SSR?", some responded by describing the different pillars, revealing the functional nature of this approach.

When asked which pillars are the most promising or best suited to the Global Fund's objectives, those mentioned first by the players in the FM[79] grants management department are clearly the supply chain and health information. They thus appear to be natural and legitimate fields of action for the Global Fund - whose primary mission is to finance inputs/drugs, basing their programs on evidence, in line with the principle of accountability. The community health system is the third most cited pillar, highlighting the specificity of the Global Fund's HSS approach.

This emphasis on these two pillars contrasts with the areas of action they actually finance as a matter of priority - counting direct and contributory investments[80] - led by

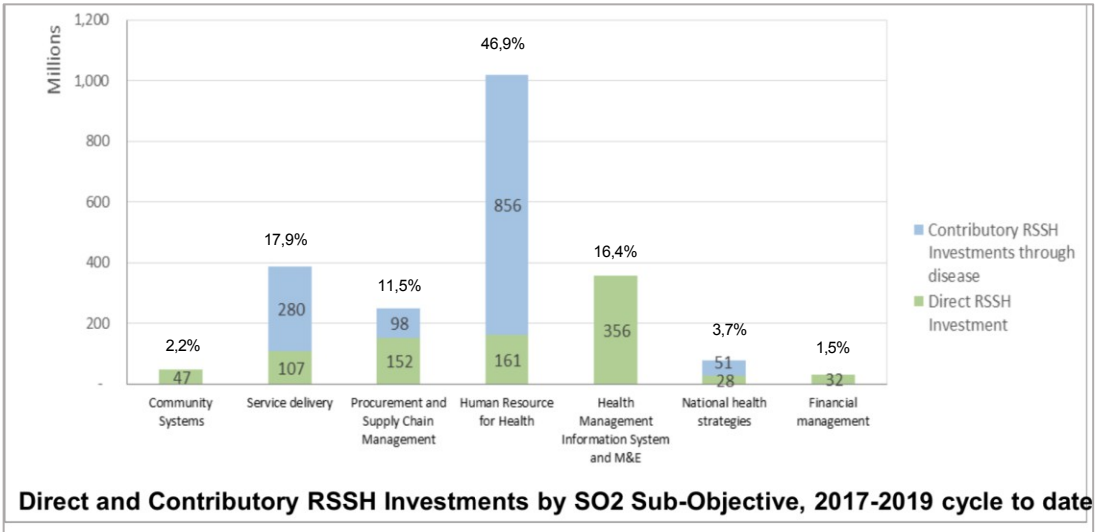
[78] Technical Review Panel (TRP) 2020a.

[79] Of the 4 interviewees from this department, we have ranked them according to the order in which the pillars are mentioned during the interview, either spontaneously, when the individual responds to the definition of HSS by listing the different pillars, or in response to the question of which pillars are the highest priority for the Global Fund. It is clear that the supply chain and the health information system are at the top of the list, followed by the community health system, then human resources and integrated service delivery/laboratories, and finally governance and financing. Although this ranking is based on subjective data, it does give a general trend, confirmed by other interviews.

[80] The fields of action most financed by the fund change when direct RSS investments alone are taken into account. The choice to account for direct and contributory investments was made in the

human resources far ahead (46.9% of overall expenditure) and service provision (including laboratories) (17.9%), followed by health information systems and M&E (16.4%), the supply chain (11.5%), and far behind national health strategies (3.7%), community systems (2.2%) and financial management (1.5%) (Box 7).

Box 7: Direct and contributory SRPS investments by sub-target (2017-2019)



NB: Based on Board approved grants to date from 80 countries plus 5 multi-country grants
NB: HRH module includes investments in informal (community) and formal health workers

*Source : Strategy Committee "Deep Dive: RSSH For Committee Information", GF/SC08/04 Geneva, Switzerland 4-5 October 2018

On the one hand, this shows how important it is for Global Fund agents to produce a discourse that underlines their organization's legitimacy to intervene in this HSS issue, which was not, *a priori*, assured. They thus position themselves in technical areas (supply chain, health information), as opposed to more political areas (governance, financing, even human resources), in line with the organization's foundations and their professional culture. This observation also shows the relative unease of the Global Fund (shared with other international organizations) with regard to the issue of human resources for health, which exacerbates all the difficulties associated with HSS (Box 8).

Box 8: The thorny issue of health human resources

The issue of **Human Resources for Health** (HRH) is one of the greatest challenges facing healthcare systems, particularly in West and Central Africa, where the number of HRH per patient is three times lower than in the rest of Africa[81] . The Global Fund's positioning on this pillar is indicative of its more general difficulties in getting involved in HSS.

The Global Fund (along with other international organizations) is relatively uneasy about the issue of human resources for health, which 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.

For example, the Global Fund agents interviewed generally cite the following as examples

Insofar as the Global Fund generally highlights these two types of investment (28%) to underline its significant contribution to HSS.

[81] Office of the Inspector General (OIG/OIG) 2019a.

supply chain or health information systems, and rarely human resources, despite the fact that they account for 47% of HSS expenditure. And yet, while HR represents the largest budget item in HSR expenditure, it is in reality short-term current operating expenditure, 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 illustrates in an exacerbated way the discrepancies between the rhetoric produced on HSR and concrete actions.

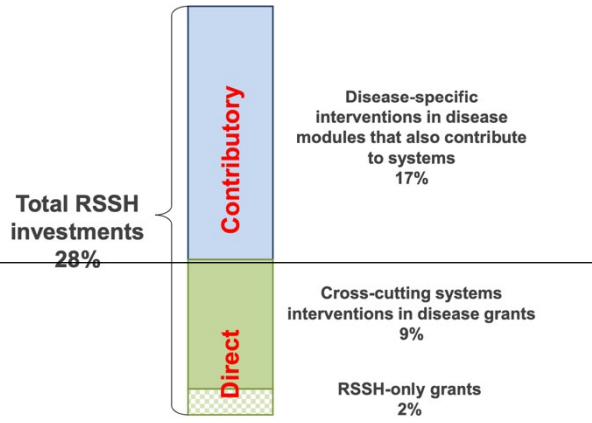
2.3. What do expenditures labeled "SRPS" represent?

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[82] , 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 and are directly targeted at a disease, with a less systemic scope (Box 9).

Box 9 The Global Fund's three types of "SRPS" investments

The 3 types of RSS investments :

1. **Direct investments within a separate HSS grant**, with the aim of providing cross-cutting systems support, strengthening interventions that benefit multi-disease programs and strengthen countries' national systems (e.g. scaling up DHIS-2 or developing a national Human Resources for Health strategy).
2. **HSS direct investments integrated into a health subsidy**. With the same programmatic content as for HSS investments in a separate grant (i.e. cross-cutting systems interventions), but with a difference in institutional architecture.
3. **Contributory HSS investments**, i.e. investments in subsidies for diseases that contribute to systems. They are primarily focused o n a single disease program, and contribute to strengthening the system's capacity to deliver quality services to varying degrees (for example, ensuring the quality of medicines and other health products for malaria).



Distribution of RSSH investments for 2014-16 funding cycle: total $12.2B*

According to the internal methodology document sent out at the time of the study[83] , there are two ways of calculating SRPS expenditure.

- For **direct investments** (1. and 2.), the Global Fund uses the "modular framework" on which countries base their concept notes. Seven "modules"[84] are dedicated to SRPS, with an additional module linked to program management. The

[82] For example, see https://www.theglobalfund.org/en/resilient-sustainable-systems-for-health/
[83] Global Fund 2019c.
[84] These seven modules are based on the seven pillars

Activities/interventions included in these "SRPS modules" must be cross-cutting, i.e. benefit more than one disease program. The Global Fund then aggregates the costs of cross-cutting SRPS interventions to calculate the cost of
These "SRPS modules" are used *to* define the total cost of SRPS "direct investments".

- **Contributory investments** are calculated retrospectively, i.e. they are not identified as such when the conceptual notes are drawn up (unlike direct investments). This calculation process is carried out in two stages.
    1. The Secretariat **selects interventions** from the disease-specific modular frameworks that contribute to health systems, "*the main selection criterion being the relevance of these interventions to health systems*". Around half of the interventions are selected (85 out of a total of 180). These interventions are broad and include, for example, HIV testing for key populations or the ongoing distribution of long-lasting insecticide-treated mosquito nets (LLINs).
    2. For each intervention selected, the Secretariat **identifies the costs** that "*make the intervention relevant to the system*". From the standard list of 63 types of cost, the Secretariat has selected 32 considered relevant to healthcare systems.

An analysis of the various lists of costs considered (or not) to be relevant to healthcare systems (see Appendix 3) reveals that the criteria of sustainability, transversality and area of action (e.g. input procurement, human resources, supply chain, etc.) can be taken into account, but rarely in combination.
For example, when it comes to healthcare products, the distinction between financial inputs that are considered relevant or irrelevant to healthcare systems is based on the criterion of sustainability, not transversality. Healthcare equipment, such as CD4 counters or molecular testing equipment for tuberculosis, are considered relevant to healthcare systems (and therefore covered by the SRPS), according to the sustainability criterion, whether or not they are dedicated to a single disease; whereas pharmaceutical or non-pharmaceutical healthcare products (e.g. antiretrovirals or rapid diagnostic tests - RDTs) are excluded, as they are not sustainable by definition.

Costs selected as relevant to healthcare systems (SRPS) (extract)

Health Products - Equipment (HPE)	6.0 Health Products - Equipment (HPE)
	6.1 CD4 analyser/accessories
	6.2 HIV Viral Load analyser/accessories
	6.3 Microscopes
	6.4 TB Molecular Test equipment
	6.5 Maintenance and service costs for health equipment
	6.6 Other health equipment

Source: List of cost inputs selected for system-relevant disease modules and interventions (in *Tracking the Global Fund's Investments in Resilient and Sustainable Systems for Health,* Global Fund, 2019)

Costs selected as NOT relevant to healthcare systems (non-SRPS) (extract)

Health Products - Pharmaceutical Products (HPPP)	4.0 Health Products - Pharmaceutical Products (HPPP)
	4.1 Antiretroviral medicines
	4.2 Anti-tuberculosis medicines
	4.3 Antimalarial medicines
	4.4 Opioid substitution medicines
	4.5 Opportunistic infections and STI medicines
	4.6 Private Sector subsidies for ACTs (co-payment to 4.3)
	4.7 Other medicines
Health Products - Non-Pharmaceuticals (HPNP)	5.0 Health Products - Non-Pharmaceuticals (HPNP)
	5.1 Insecticide-treated Nets (LLINs/ITNs)
	5.2 Condoms - Male
	5.3 Condoms - Female
	5.4 Rapid Diagnostic Test
	5.5 Insecticides
	5.6 Laboratory reagents
	5.7 Syringes and needles
	5.8 Other consumables

Source: List of cost inputs NOT selected for system-relevant disease modules and interventions (in *Tracking the Global Fund's Investments in Resilient and Sustainable Systems for Health,* Global Fund, 2019)

Certain expenses will also be considered as relevant to the SRPS, insofar as they affect one of its seven pillars (human resources, supply chain, etc.), but without taking into account sustainability or transversality criteria. For example, expenditure on salaries, financial incentives, perdiems, transport costs or technical assistance costs are considered relevant to health systems, even though they may be linked to a single disease in the short term.

Costs selected as relevant to healthcare systems (SRPS) (extract)

Human Resources (HR)	1.0 Human Resources (HR)
	1.1 Salaries - program management
	1.2 Salaries - outreach workers, medical staff and other service providers
	1.3 Performance-based supplements, incentives
	1.4 Other HR Costs

Travel related costs (TRC)	2.0 Travel related costs (TRC)
	2.1 Training related per diems/transport/other costs
	2.2 Technical assistance-related per diems/transport/other costs
	2.3 Supervision/surveys/data collection related per diems/transport/other costs
	2.4 Meeting/Advocacy related per diems/transport/other costs

External Professional services (EPS)	3.0 External Professional services (EPS)
	3.1 Technical Assistance Fees/Consultants

Source: List of cost inputs selected for system-relevant disease modules and interventions (in *Tracking the Global Fund's Investments in Resilient and Sustainable Systems for Health,* Global Fund, 2019)

The same is true for other pillars, such as the supply chain or the management of national disease control programs[85] , where costs are considered to fall *de facto* under the SRPS, although these actions may maintain the creation and/or strengthening of parallel systems specific to a disease and/or a donor.

As a result, the criteria used to identify SRPS expenditures are both relative (based on the "*relevance*" of interventions to health systems) and extensive, since an expenditure is considered "cross-cutting" when it affects more than one disease, and the criterion of sustainability is rarely taken into account. The failure to combine the criteria of transversality, sustainability and field of action also weakens the Global Fund's definition of HPRS. In the final analysis, it appears that most of the expenditure labelled "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[86] ; and that more structuring and sustainable expenditure (still) tends to concern diseases financed by the Global Fund.

[85] Costs relating to grant management, policy, planning, coordination and management of national disease control programs are considered as contributing to the systems, with the exception of costs relating to program administration, communication and publications.

[86] Including program and grant management costs; without including them, the proportion is 66%, in Technical Review Panel (TRP) 2018.

the Global Fund and maintain vertical systems, although significant efforts are being made to move towards greater integration between the three diseases.

As a result, so-called "contributory" investments are not perceived as financing that has a direct impact on healthcare systems for some operational players, but rather as an abstract operation far removed from field considerations.

> "It's a problem to have a legibility of what the Global Fund does in the framework of HSS. They don't say that these are HSS interventions. Maybe it's someone who does an evaluation and can start to look at the financial flows, the expenditure, to be able to identify in this expenditure which were the HSS components and the others. But there's no direct readability: for example, in their reports, you don't see HSR in relation to the others. It doesn't look like that" (international consultant)

2.4. From discourse to practice: a critical look

The Global Fund's commitment to developing programs to strengthen healthcare systems has given rise to a long-standing and highly polarized debate, between advocates of vertical initiatives (Global Fund, GAVI, Bill & Melinda Gates Foundation, etc.) and those of cross-cutting institutions (WHO, World Bank, certain bilateral agencies). Criticism focuses on the discrepancy between the Global Fund's ambitious rhetoric about the impact of its actions and actual practices. Various types of argument are raised by those critical of the Global Fund.

→ limited, if not (yet) harmful impact on healthcare systems

Some point out that, despite its apparent efforts, the Global Fund is still having an impact.
negative impact on healthcare systems: cumbersome procedures for accessing funding and specific reporting methods that are not harmonized with other donors, multiplication of coordination structures and services/interventions focused on a single disease, incentive systems that unbalance the healthcare sector by creating competition, and so on. Already fragile health systems thus continue to be swamped by these external burdens and by this detour of national actors' attention from real national priorities, ultimately generating a weakening of the overall provision of health services[87] .

Also, the Global Fund's approach to SSR appears superficial to some, with colossal gaps between the challenges and actions posed.

> "The Global Fund just wants to put a patch on a wheel that's leaking everywhere" (actor, International Multilateral Organization)

Critical interlocutors refer to a form of "sprinkling", of "shopping list", of "shopping list", of "shopping list", of "shopping list".
The Global Fund's HSS approach is best described as a "Christmas tree", or "pick & choose" approach.

The rhetoric used by the FM, notably on "integration" and "pandemic gateways", can be perceived as obscuring local realities and structural needs that are far more extensive than a one-off pooling of human resources or equipment:

> "We mustn't think that, thanks to the three pandemics, we'll be able to avoid reinforcing primary healthcare. The principle of primary healthcare is that it's a global approach to all the diseases in the health pyramid". (French global health actor)

[87] The criticisms made in WHO's internal document "Importance of convergence between external funding for health systems strengthening and national health systems priorities", published in 2014, and repeated here, were scatteredly mentioned by various interlocutors incriminating the FM, particularly from bi- or multilateral international organizations. World Health Organization (WHO) 2014.

→ Lack of conceptualization of the leverage effect

Some note that the "**leverage effect**" of "HSS disease" actions towards a stronger
The question of how to achieve this is not clearly defined.

> "Afterwards, yes, a lot is done by the Global Fund on HSS, but sometimes it's too focused on the three pandemics, without thinking about how it can also benefit other branches and sectors of health that are not necessarily pandemics but also HSS" (French global health actor).

This leverage effect would require colossal financial efforts to be effective. One stakeholder took the example of Ethiopia and Rwanda, which he said had "siphoned off" Global Fund financing for highly ambitious programs to strengthen their health systems, not because their systems were fragile, but to ensure that initiatives initially focused on diseases could be used as a basis for expanding primary health care (Ethiopia) or universal health coverage (Rwanda) to the entire population.

→ political instrumentalization of RSS rhetoric

For the more critical interviewees, the Global Fund's commitment to HSS is above all a question of initiated for symbolic and instrumental purposes, 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 "comfortable in-between position"[88] that satisfies it, without the necessary political will to go beyond it.

So, if some donors are asking the Global Fund to step up its efforts in HSS, it's not so much out of conviction as out of convenience or lack of solid alternatives.

> "My feeling is that we're asking an existing instrument that allows us to reallocate funds fairly quickly to respond to the full range of healthcare issues, with limited resources" (civil society stakeholder).

> "I've always thought that the Global Fund, by virtue of its mandate, the way it was run, the way it operated, the way it financed its PRs *[principal recipients],* was not a player in HSS. It was not in its mandate (...) *(But)* as development aid resources are not extensible, the Global Fund is asked to do HSS" (French global health player).

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 necessary formalization for political, even "demagogic" reasons[89] . They point out that the proportion of funding allocated to HSS has remained relatively stable since the creation of the Fund, at around 30% of the overall budget[90] - although calculation methods have varied, making a strict comparison difficult - or that the activities financed in concrete terms have remained the same, such as supply chains or human resources, as a matter of "course" for program implementation.

Lastly, some critics point to the discrepancy between France's strong position on this issue within the Global Fund's Board of Directors, and its reference framework, which is described as "too restrictive".
"not built", "not solid" or "vague".

> "Our HSS doctrine is not solid (whereas our HIV doctrine was solid). We sell our system in general, but then what does aid that strengthens health systems mean? AFD does this, but theorizes it extremely poorly". (French global health player).

[88] Entretien acteur français santé mondiale
[89] Entretien acteur français santé mondiale
[90] Entretien acteur français santé mondiale

France's approach can be criticized for being idealistic and consensual, underestimating the concrete implications of a strong position in favor of HSS on the Global Fund Board, in terms of financial resources and commitment over time. Commenting on France's position, an association representative said:

> "Nobody looks at how much it would cost to do RSS in money and time...It's very vague, we talk about a system...what's a system? but where does it start and where does it stop? They say it's strong, so it's hard to be against it...In general, we put across the idea that if we'd had HSR, we wouldn't have had Ebola" (actor in an association).

Others criticize France's lack of concrete proposals and clear positions in specific areas of action, such as pharmaceuticals and purchasing groups.

> "France's global health strategy should include a medicines component. It's the health pillar that accounts for 60% of investments. France could open its eyes: are we supporting the *Wambo* Platform, the PPM [editor's note: *Pooled Procurement Mechanism*] or are we moving towards another strategy, which would be more of an SSR approach at the regional level in West Africa?

Part 2. Implementing HSS within the Global Fund

According to the TRP, TERG and OIG reports, the most significant challenges facing the Global Fund with regard to HSS concern its operationalization. While these autonomous bodies of the Global Fund agree that the Secretariat has made significant efforts to implement Strategic Objective 2, they point to major problems: the structures and processes of the Global Fund and recipient countries are currently inadequate.

for HSS; shortcomings in the monitoring and evaluation system (particularly in terms of performance indicators and accountability frameworks); difficulties in integrating key national public authorities; and a lack of coordinated collaboration with other technical and financial partners. All these challenges tend to slow down implementation, to produce actions that are more a matter of support than reinforcement, and to maintain a certain verticality in the HSS actions financed (see Box 1, p.17).

In this second section, we will analyze the obstacles to the Global Fund's implementation of HSS, as identified and currently perceived by players both inside and outside the Global Fund, at both international and national level. In order to provide a synthetic view of these various obstacles beforehand, we have categorized them into three types: organizational, technical and relating to external players.

As a preliminary remark, it is important to remember that the implementation of the strategic objective relating to HSR (or SRPS) is specific insofar as it cannot be initiated in a straightforward manner.
The Global Fund's "top-down" approach is fundamentally one of co-construction between players, from the development of HSS strategies (decision-making level) to their implementation (operational level). While the Global Fund has, from the outset, adopted an approach based on country "ownership", whereby national players draw up grant applications within the framework of Country Coordinating Mechanisms (CCMs), this country ownership appears all the more crucial in the context of HSS, since it concerns the health sector in a more systemic and structural way, beyond emergency action targeted at pandemics. What's more, the HSS field includes a greater diversity of players than for the three diseases, among whom the Global Fund is a relatively marginal player. This group of players has diverse representations, interests and practices, which tends to complicate the process. This "*multiplicity of participants and stakeholder logics combine to turn the program into an obstacle course. When a program depends on so many players, the possibilities for disagreements and delays are numerous*"[91] . Each level poses specific challenges, for which the Global Fund has more or less power to act.

1. Slow organizational change: institutional unwieldiness or lack of political will?

The Global Fund, like any international organization, is more predisposed to permanence than to change, due to the universe of rules, procedures, customs, routines, representations and configurations of interests that constitute it[92] . In order to fully integrate Strategic Objective 2 (SRPS), changes will have to be made, but they will generally be gradual, in stages, and more or less rapidly, depending on the dimensions concerned.

1.1. Regulatory framework

Many players recognize the major step forward represented by the adoption of the 2017-2022 strategy, with the formalization of HSS (or SRPS) as a strategic objective, which has made it possible to "*open the door to conversations, giving more visibility and more challenges*" (Global Fund agent) and compel Fund agents to commit to it.

> "In 2014, I remember some pretty heated discussions, with a hint of annoyance 'we're already doing it'...but I think between 2014 and 2017 it was fully integrated into the strategy and it

[91] Hassenteufel 2011, 100.
[92] Nay and Petiteville 2011.

> That's the only way it works, and that's why it's a success. Because it's simple: as long as it's not written into lines of accountability, people don't do it, because they've got lots of other things to deal with" (French global health player).

However, the Secretariat remains hamstrung by its institutional framework, i.e. by its mandate, which remains limited to the three diseases. For example, while in practice the Global Fund 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, de facto, limited.

1.2. Internal organization, skills and culture

The IGO's audit of SRPS investments (2019) focused on analyzing the adequacy and effectiveness of the Global Fund's SRPS management processes, with particular challenges identified at the level of the Global Fund's internal organization (Box 10).

Box 10: Internal organization of SRPS at the Global Fund and challenges identified by the Office of the Inspector General as part of its audit of SRPS investments (OIG, 2019)

→ Organization of teams and skills within the Secretariat

- Within the Strategy, Investment and Impact Division, **a dedicated team**
  SRPS support facilitates the implementation of SRPS components and creates the conditions to ensure increased and sustained investment in SRPS, notably by providing support to country teams (from the Grants Management Division) and working to develop external partnerships.
- SRPS activities associated with the **seven sub-objectives** are implemented through three different divisions and four departments. For example, the Country Monitoring, Evaluation and Analysis team (Strategy, Investment and Impact Division) is responsible for **strengthening country health data systems.**

→ Challenges identified by the IGO

- SRPS activities are undertaken in a **compartmentalized approach**, with no single effective mechanism for generating synergies and a global vision.
- The various departments in charge of SRPS activities adopt different approaches and are at different stages of progress.
- A lack of skills has been identified in certain areas, whether in terms of technical knowledge or project management skills, for example in infrastructure or non-medical equipment.

Changes in the Global Fund's internal organization and professional skills are evolving, but slowly. Within the Secretariat, SRPS is strategically supported and implemented on two levels: via a specific SRPS team housed within the Strategy, Investment and Impact Division, which is responsible for supporting country teams, helping to operationalize the strategy and develop partnerships, and via specific skills relating to the seven sub-pillars, within four departments from three divisions.

The Strategy Division's SRPS support team remains isolated and outnumbered (13 permanent staff[93]) by the rest of the 700-strong Secretariat. It is also predominantly English-speaking[94] , which is an additional difficulty for French-speaking African countries. Although HSS skills are being developed within the Secretariat's other departments, the professional culture of its staff and the internal organization of the Fund remain predominantly a culture of specialists in the three pandemics, with a compartmentalized operation, and a primary objective focused on the disbursement of funding. Several interlocutors pointed out that

[93] At the time of the survey
[94] Only the team leader is bilingual French/English

the risk of isolation of the SRPS department, like the teams in charge of human rights or CCMs, with varying degrees of ownership of these issues by the grants management division (the largest in the Secretariat, in direct contact with countries), depending on the portfolio managers.

> "In organizational terms, it's exactly the same problem as for Human Rights. There's a subsidies department, which is there to disburse funds. Then there are units in other departments that are supposed to deal with HSR or human rights issues. There's bound to be a certain disconnect! You have to cross-reference things" (French global health player).

Some of the people we spoke to questioned the real interest of *top management* in this issue, as it does not encourage a collective impetus. Ultimately, the vertical culture is still largely dominant, with limited competencies in terms of maternal and child health, for example, and a difficult transition to a more cross-functional approach.

> "This vertical, siloed approach is what has made the Global Fund so effective, because it has concentrated money, strategy, energy and political will, and it has produced results. But the downside is that they're finding it hard to move away from this vertical approach and think a little more horizontally about all the countries' health systems, including community health systems" (French global health player).

Unlike disease subsidies, HSS can be perceived by operational staff as a vague object, difficult to grasp, with no precise reference framework or objectives, and which could jeopardize the results of subsidies (risk of dilution without impact, absorption difficulties) and therefore of the organization.

> "In fact, what I find very complicated about HSS is that as far as HIV, tuberculosis and malaria are concerned, we have very specific needs, we can say almost to the penny how much we need over the next three years, it's very specific in terms of drugs, transport of samples, whatever we want... As far as HSS is concerned, it's really vague, it's very vague" (FM agent).

In the end, there is a certain gap between the evolution of the strategy and its cognitive and normative appropriation by its players, as one consultant summed up:

> "The reference documents, with the 2017-2022 strategy with HSS, already show great openness on the part of the Global Fund in relation to this, and in its guidance documents for drafting concept notes. But there is a problem of culture, as the Global Fund has for a very long time favored verticality. Since Geneva, it's still in people's minds. And national coordination mechanisms also have this approach, they are used to verticality. Transversality doesn't go down very well. The Global Fund has documents to help with this, but the problem is people's mentality, first of all with the mechanisms and also with the partners who are into vertical support, they take advantage of it. So one of the constraints is the mentality" (International consultant).

Today, the integration of HSS has not profoundly changed the Global Fund's organization or culture. There is no shared knowledge of HSS (i.e., a common understanding of its approach) (cf. 2.2.1), no shared standards (with high variability in portfolio managers' adherence to HSS, for example), and no HSS culture (the dominant culture is still largely vertical). The formal integration of HSR, as a strategic objective in its own right, is relatively recent in FM's history, and necessarily takes time, although some question the political will of *top management* to accelerate the movement.

2. A technical system that is currently inadequate and poorly adapted to the specific features of RSS

Compared to the technical framework created to implement health subsidies, the technical framework for HSS, while constantly being improved, remains insufficient to meet the needs of our customers.

effectively initiate, or even compel, the various players in the chain to initiate quality RSS programs. It has become apparent that the system currently in place has two types of consequences: it tends to slow down or even paralyze RSS initiatives; and it tends to generate a scattering, fragmentation or verticalization of RSS activities.

2.1. A tendency to hold back

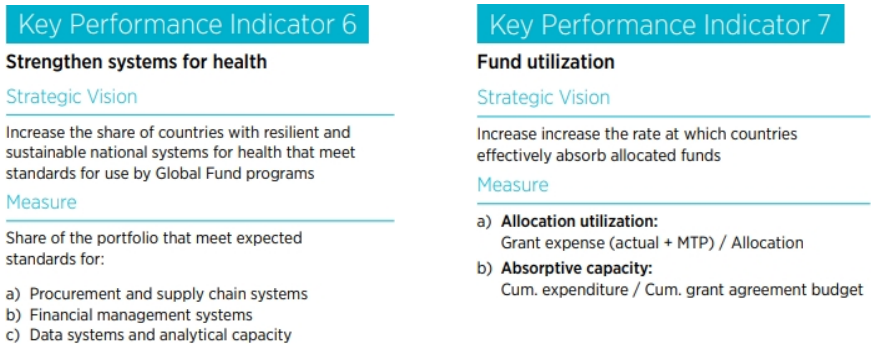
2.1.1. Accountability framework and performance indicators: drivers for action

Since the 2017-2022 Strategy, efforts have been made to better define how to evaluate HSR. (Box 11).

Box 11: M&E for the Global Fund's SRPS program

The Global Fund's M&E for HSSR has three main aspects:

1. Key performance indicators (KPIs) at strategy level - two of which are specific to HSSR (indicators 6 and 7[95]).



2. Key performance indicators (KPIs) at the implementation level, which include impact and coverage (or outcome) indicators as well as the monitoring of specific inputs and outputs ("work plan monitoring measures"), based on the indicators in the "(see Appendix 4).

3. Monitoring specific inputs and results.

Source: TERG 2019

The interviews corroborated the observations made in various internal Global Fund reports, which point to the weakness of HSSR indicators (relevance, absence, difficulty in assessing impact), as well as their poor use in the performance frameworks of funding applications, generating a negative impact on performance monitoring and the accountability of the players involved (Box 12).

> "If there's one thing that has emerged clearly from the various HSS reviews, it's that there was a need to work on indicators, and that these actions could not really be assessed" (French global health player).

[95] KPI 6, proposed as an aggregate of several implementation indicators measuring progress in strengthening priority areas of national health systems; and KPI 7, which tracks the extent to which health systems are sufficiently robust to make effective use of the level of funding required to address the burden of disease.

We were told of the difficulty of agreeing on indicators that satisfy everyone, with compromises that ultimately satisfy few.

Box 12: Summary of observations related to Global Fund performance indicators (TRP 2018, TERG 2019, OIG 2019)

→ **Calculation methods: identifying SRPS funding**
- As most SRPS funding is integrated into control subsidies against diseases, it is difficult to identify specific HSSR funding and differentiate between what is "direct" HSSR funding and what is "contributory" (TERG 2019)

→ **No indicators for some sub-objectives**
- Key strategic performance indicators have been defined to monitor progress. only 4 of the 7 sub-objectives, namely financial management, alignment of funding with national strategic plans, supply chain and data; not integrating human resources for health, community responses and systems and reproductive, women's, children's and adolescents' health, which account for 65% of total SRPS investments (OIG 2019)

→ **Difficulties in measuring impact**
- SRPS investments are often tracked by product and sales indicators. process rather than results and impact indicators (TRP 2018 and OIG 2019)
- As the completion of SRPS activities requires several years by their very nature, the duration of the monitoring framework is not appropriate (OIG 2019).

→ **Indicators not used systematically in subsidies**
- Subsidies involving SRPS investments do not always include SRPS-based indicators. There may therefore be a significant gap between results and reality (TRP 2018 and OIG 2019).

→ **Recommendations**
- Health system indicators in the modular framework need to be revised, expanded and used, to better assess t h e results and impact of SRPS activities. (TRP 2018, OIG 2019)
- Greater emphasis on small/medium-scale qualitative studies and relevant thematic reviews (TERG 2019).

The interviews helped to identify the perceived explanatory factors for this observation, including 1) the slowness inherent in institutional change, in particular the evolution of the skills and culture of its agents

> "It's a question of maturity once again. Our specialists are familiar with all three diseases. They're better at defining indicators for people on treatment, etc., and less good at *project management*, because at the end of the day, all RSS investments are *project management* investments (...) Things are going to change. It's more difficult, and we're less skilled in this area than we should be. We've been doing disease subsidies for years, but RSS subsidies are fairly recent. It's normal to make mistakes at the beginning, but what's important is to learn and make fewer and fewer mistakes" (Global Fund agent).

2) The technical and specific complexity of HSR. Unlike the three pandemics, the impact on HSS is inherently more difficult to measure, due to the more systemic results sought, its qualitative nature and the longer time required to observe effects.

> "We can see what the best indicators are for working on *output*, i.e. investing to get something in return. What is this something in return that we'd like to have? The community system is a very good example!

> money to a community health worker, what do I expect in return and what do I measure? How many cases are on my doorstep? How many visits have I made? What do I measure to justify the investment? You have to think about it and adapt it to fit into a performance framework" (Global Fund agent)

> "But can't we have multi-year funding for HSS, or are you obliged to follow a project cycle for structural projects? When you talk about bringing in mosquito nets every year, you know you're going to deliver them! As soon as you fall behind schedule, you're six months behind schedule! I can understand why they don't want to do it! Board meetings are held twice a year, and deadlines are very tight!

The difficulty of reporting on actions that are not the sole responsibility of the Global Fund was also mentioned, as was the difficulty of measuring impact in a context of co-accountability with other technical and financial partners and recipient countries.

> "It *[the Global Fund]* was essentially able to *draw* up indicators for actions over which it had some control, in the knowledge that, once again, it didn't have all the keys in hand to measure results and ensure that these objectives were fully functional, since not everything belongs to it (...) So it's normal that the RSS indicators aren't good - it's no surprise! We're asking him to do the impossible" (civil society player).

Also, given the diversity of national contexts, it has been noted that it is impossible to standardize monitoring and evaluation tools, which tends to make them more complex for the sake of completeness, as each country has its own specific issues.

3) Some question the political will to overcome these shortcomings, particularly on the part of the Secretariat, and put the technical complexity of HSS indicators into perspective. For example, one interviewee noted at the time of the survey that technical areas such as laboratories were not yet tracked by indicators such as sample transport systems or inventory management. Others called for greater adaptation of the Global Fund to this issue, including a more qualitative methodology (as advocated by the TERG), the adoption and adaptation of the Global Fund to UHC 2030 indicators, the use of differentiated absorption between disease and HSS grants, and the creation of new models.

> "There's always a way to find an indicator that shows that because there are more healthcare staff, there are more people who have access to care. We could be smarter about finding indicators, which are proxies, it's not direct. Donor countries make very sophisticated calculations to say how many dollars have reached the farthest reaches of Chad, they could find indicators to say how this has contributed to having an impact, knowing that it hasn't contributed only to that." (French global health player)

Ultimately, in the context of an organization where funding is based on results, these shortcomings are perceived as the decisive brake on action, throughout the chain of actors involved. In the first place, the ambivalence of the Board of Directors is widely indexed, between on the one hand the declared will to invest more in HSR, and on the other hand the difficulty of reporting on a rapid impact for this issue, as a consubstantial brake on real commitment.

> "It's also the Board of the World Health Fund (i.e. the donors) who push the Secretariat in a particular direction, so it's a bit of a tail wagging the dog, because everyone says that it's increasingly important to support certain parts of HSS in relation to pandemics, and which enable all health policies to be better harmonized; and on the other hand, donors who don't want to invest too much in this area" (French global health player).

Some players have also pointed out that the Global Fund's overall performance - and that of its country teams in particular - does not take sufficient account of HSS to encourage the various players in the chain to commit themselves fully to it. For example, there is a de facto inequality between the level of development of indicators for strategic pillar no. 1 on the three pandemics, and those for the other three pillars (HSSR, human rights and resource mobilization).

> "The majority of the Global Fund's performance is linked to key indicators related to the three diseases; there are a few on other themes such as HSS, human rights, etc., but the majority are the three diseases. And the performance of country teams is linked to the progress made in reducing the incidence of malaria, the number of people with access to ARVs, the number of people diagnosed, confirmed and on treatment for tuberculosis... When part of the grant is dedicated to HSS, we don't have any key indicator that will contribute to assessing the performance of the men and women who make up the Global Fund country teams" (French global health player).

In a context where country teams are essentially evaluated on absorption rates, and where absorption rates for HSS are lower[96] , they tend to be less involved in this issue. One interviewee recounted an exchange with a Global Fund portfolio manager:

> "A *portfolio manager* in Geneva told me, 'You understand, we're all evaluated on country absorption, and an HSS subsidy doesn't absorb as well as a malaria subsidy, where you buy mosquito nets. For us, it's more difficult to track. On the *board*, they're not happy with the countries' results, so it's true that we don't push'" (French global health actor).

2.1.2. The absence of an amount dedicated to HSR in allocation letters: encouraging country ownership or weakening this component?

The "allocation letter" is a letter sent by the Global Fund shortly before the start of the drafting of the concept note. It provides the amount of money allocated per country, a suggested breakdown between the three pandemics, and a recommended approach. For several interlocutors - consultants, operators or bilateral players - the absence of a desired or expected amount for HSS in this letter was a major obstacle to the establishment of consistent, high-quality HSS grants when applying for funding.
"NFM3" (2021-2023). In several countries, such as the Central African Republic and the Democratic Republic of the Congo, consultants and Ministries of Health first had to conduct conflicting preliminary negotiations in order to secure funding from disease envelopes to develop an HSS component. These negotiations could drag on for several months, paralyzing the drafting process, with a "*high risk that the HSS component would be treated as secondary*" (French actor, Santé Mondiale). As a result, some have pointed out that this approach
"These negotiations take place against a backdrop of unequal power relations between non-pandemic health players (who are poorly integrated into the Global Fund system) and pandemic players, who know the ins and outs of the system. These negotiations take place against a backdrop of unequal power relations between non-pandemic health players (who are poorly integrated into the Global Fund system) and pandemic players, who know the ins and outs of the system and are generally supported by Global Fund country teams.

> "What we've seen is that when you have to give money to an HSS component, it's seen as a sacrifice, not a benefit. We don't see that strengthening the supply and drug chain in a country will be beneficial for the three diseases and the whole system...ditto for the laboratory network or the decentralization of primary health care (...) The Programs (and this is a huge concern) don't really want there to be a big HSS subsidy, since it's out of their own budget that they have to contribute to HSS. We need clarification from the Global Fund, because it's not possible for programs to make sacrifices, and it's not possible for HSS to impose itself" (French global health player).

In terms of application quality, the TRP also underlined the causal link between the lack of a suggested amount and the risk of RSS funding being split between several applications.

[96] As a reminder, SRPS activities integrated into disease-focused grants show absorption rates of 67%, compared with 75% for disease-only interventions. The average absorption rate for stand-alone SRPS grants is 56% (OIG, 2019).

> "In addition, since there is no specific allocation for HPRS, these investments are often divided into several funding requests that may even be spread over different windows, making it even more difficult to examine HPRS investments in the context of the health system." (TRP Lessons 1ère NFM3 window)

It has been observed that, in general, countries with strong leadership (such as Benin) succeed in benefiting from these opportunities offered by the Global Fund, while countries with more fragile governance (such as the Central African Republic and the Democratic Republic of Congo) are unable to negotiate with the Global Fund to obtain substantial envelopes dedicated to HSS (Box 13).

According to various Global Fund agents, the absence of a prescription for the amount allocated to HSS is justified by the desire to leave this decision up to countries, according to the "*country driven*" principle, based on their specific needs. Another French global health player also pointed to the risk of reopening a debate perceived as time-consuming and sterile on the "*disease split*" - where 50% of Global Fund financing must be allocated to HIV, 32% to malaria and 18% to tuberculosis. One Global Fund official suggested modulating the prescriptive character according to the maturity of countries, being more prescriptive for countries with weaker governance, and more flexible for countries with stronger governance. Another proposal was to impose a minimum 10% allocation to HSS, as was the case in Côte d'Ivoire, where the negotiation process took place by consensus.

Box 13: Case study: development of the HSS concept note (NFM3) in the Central African Republic (CAR)

A particularly *challenging* environment

The Central African Republic has been experiencing periods of violent conflict for over 30 years. As a result, the country's healthcare system is particularly weak, with a lack of human resources in both quantitative and qualitative terms, and a problem of distribution and retention across the country, with half of the workforce concentrated in Bangui, to the detriment of the other six health regions. The country is regularly confronted with drug stock-outs, such as in March 2019 for antiretroviral treatments, suggesting major gaps in the supply chain, albeit managed by the UN agency, the World Food Programme (WFP). A theft of significant quantities of medicines reported to the Secretariat in 2017 had prompted an investigation by the Office of the Inspector General, which confirmed significant detour of medicines to the illicit market. In terms of governance, the country ranks 159ème out of 176 countries according to the Corruption Perception Index published in 2016 by *Transparency International*. In terms of funding mobilization, the country depends on the Global Fund for around 75% of its funding to fight the three diseases, although this contribution ultimately represents only 20-30% of the country's real needs, with many gaps.
The country faces a generalized HIV/AIDS epidemic, with a prevalence of 3.5% of the adult population, and around half of all PLWHA having initiated treatment. Particularly challenging is the number of patients who are lost to follow-up, since it is estimated that for every ten patients who initiate ARV treatment, six drop out of the system. Malaria and tuberculosis are major public health concerns, with 1.4 million cases of malaria each year (half of which affect children) and 39,000 new cases of tuberculosis (with internally displaced populations particularly hard hit). The Central African Republic is an "essential" country for the Global Fund, i.e. an important portfolio with a high disease burden and high risk; it is one of the

countries classified as "Complex Operating Environments" (COEs) and is subject to the additional safeguard policy[97] . Its main recipients are international NGOs, with the French Red Cross for the HIV/TB grant and World Vision for malaria.

The 30% controversy

In the allocation letter received in December 2019, the Global Fund announced a 120% increase in funding compared with its last grant. This increase appears to be an opportunity for the Ministry of Health to strengthen health systems. In the absence of a suggested amount from the Global Fund, the Cabinet of the Ministry of Health is proposing that 30% of funding be allocated to the HSS component. For those defending the Ministry's position, this proposal is justified in view of the colossal shortcomings of the health systems, which risk undermining the results of the disease subsidies, especially as funding has increased by 120%, which means that bottlenecks need to be removed in order to carry out activities and avoid absorption problems, first and foremost the lack of health personnel.

This proposal is seen as unacceptable and "excessive" by the Global Fund, as the budget requested exceeds what is usually allocated. This proposal was seen as unacceptable and "excessive" (FM agent) on the part of the Global Fund, given that the budget requested exceeded what was usually allocated; those involved in disease programs as well as vertical technical and financial partners shared this same view, as the HSS budget should, in their opinion, be made up of the remainder of disease control budgets or by releasing 5% of disease grants, and Global Fund financing was already below estimated needs. Indirectly, some interviewees suggested that the Global Fund's great mistrust of countries was linked to the perceived financial risk, due to their limited management capacities, but also to the risk of misappropriation of funds.

These negotiations took place in a context where the balance of power between "pandemic health actors" and "non-pandemic health actors" was unequal. Although the Minister of Health was well versed in the mechanisms of international aid against pandemics - having worked for 17 years for UNAIDS both at headquarters in Geneva and in the countries - the non-pandemic health players found themselves in a minority vis-à-vis the CCM, the international NGOs and the technical and financial partners; and of the twenty or so technical experts, only one was a specialist in HSS, financed by the Presidential Initiative for Health in Africa (managed by the 5% Initiative), the WHO experts having had no part in drawing up the HSS grant.

These negotiations also weighed on the efficiency of the drafting process and the quality of applications. A certain "cacophony" was thus observed, with an HSS team working on one side on HSS activities (notably the supply chain) and the HIV/TB and malaria teams also working, each on their own, on these same HSS aspects, without a defined budget.

Ultimately, this example crystallizes a series of difficulties and dilemmas facing the Global Fund:

- In fragile state contexts, while defining an HSS allocation amount may seem prescriptive, not defining it tends to penalize HSS, with the "pandemic players" (Global Fund, Principal Recipients, technical and financial partners) de facto supporting their own objectives.
- In contexts where countries are heavily dependent on the Global Fund to meet the needs of the three diseases, HSS tends to be perceived as a sacrifice made to the detriment of the fight against the three pandemics, rather than as a potential benefit, which would facilitate the implementation of activities.
- In contexts where health systems lack the basic elements (health personnel, medicines), the Global Fund's priorities are focused on the implementation of health systems.

[97] The Additional Safeguards Policy provides for a set of additional measures that may be put in place by the Global Fund to strengthen budgetary and supervisory controls in a particularly risky environment

implementing disease subsidies, bypassing national public institutions. The shortcomings of health systems appear to be too abysmal for the Global Fund to engage in this way, raising the question of whether it is possible to truly strengthen health systems in these contexts.

Finally, this example highlights the discrepancy between the discourse produced by the Global Fund, showing a 27% investment in HSSRS, and the Ministry of Health's request to allocate 30% of the grant to HSS, which appears to be "excessive".

2.1.3. Technical guidelines that are either non-existent or poorly understood by players

For some players involved in the process of drawing up concept notes in Côte d'Ivoire, the lack of clear strategic priorities and technical guidelines on SSR aspects is an obstacle to optimal use of these investments. One director of a recipient NGO expressed this frustration:

> "That's why, in the long term, it would be good for the Global Fund to flesh out its guidelines to say "(...) The Global Fund is a good model, with a propensity to bring many players to the table, but in terms of choices, priorities and investments, we need to provide a bit of a framework" (actor, principal recipient NGO, Côte d'Ivoire).

These areas of hesitation are perceived as harmful, insofar as they favor the voice of the strongest and not necessarily that of the most relevant needs; because they tend to make it more difficult to demonstrate the profitability behind the investment; or because they paralyze the actors responsible for writing grant applications. The example of the development of the HSS funding landscape in Côte d'Ivoire illustrates this point (Box 14). In a context where the Global Fund is usually clear and prescriptive for its disease grants, with complex procedures that require insider knowledge, these areas of uncertainty are perceived, a priori, more as the mark of a lack of knowledge on the part of the players concerned, rather than as an opportunity left by the Global Fund that countries could exploit. According to one of the Secretariat staff interviewed, these flexibilities do exist, but few countries are able to "enter the matrix" of the Fund to exploit them. For example, the co-financing conditions for accessing Fund allocations are flexible for certain categories of country,

but relatively unknown, as low-income countries[98] have no restrictions and cannot demonstrate that their investments are 100% for HSS and not necessarily for the three diseases as is usually the case.

> "The Fund offers flexibility. The problem is often linked to a lack of knowledge of the Global Fund's HSS guidelines on the part of countries and portfolio managers. There's a tendency to remain basic, with the health information system (HIS), the supply chain... With a block approach, without a systemic approach. Special advisors are needed to help countries define their HSS priorities and fit into the Global Fund matrix" (international consultant).

Box 14 The HSS funding landscape in Côte d'Ivoire

In Côte d'Ivoire, a meeting was convened at the end of May 2020 at the Budget Sub-Directorate of the General Directorate of Health, in order to identify - in the absence of clear guidelines and/or known by the players - the eligibility of state health expenditure that could form part of the HSS financing landscape.
Various questions were raised, such as '*Can the entire government health budget be considered as HSS? If not, what should be subtracted?*', '*Should spending on the three diseases be subtracted, especially as they have already been accounted for in the financing landscapes dedicated to them?*', '*Is buying drugs for HIV RSS*?During the meeting, several phone calls and internet searches were made in an attempt to obtain an answer to this last crucial question, to no avail. After 3h30 without any clear decision, a DGS agent attending the meeting declared "*we didn't get any guidance...we just had to be carriers of materials and we have to build our approach*!"

2.2. A tendency to fragment action

2.2.1. Implementation methods: "*stand-alone*" versus "disease-integrated" subsidies

Countries can submit HSS investments in two main ways: either as a *stand-alone* grant, which is rarely the case (only 2% of FM funding goes through this channel), including in West and Central Africa, where only Benin and Nigeria have such a grant underway (see Appendix 5); or as an integrated grant within disease grants, which come in a variety of configurations (Box 15).

[98] For low-income countries, regardless of disease burden, co-financing contributions are not limited to the disease program or related costs of SRPS; they have the option of demonstrating that their investment is 100% for SRPS interventions, and for lower-middle-income countries, they have the option of their investment in disease programs being a minimum of 50% (presentation "Co-financing in the Global Fund Grants", workshop "Investing in the health system: un levier majeur pour accroître l'impact des subventions en Afrique de l'Ouest", Cotonou February 7, 2020)

Box 15 Different ways of allocating HSR investments

→ **Stand-alone grant**: grant dedicated to HSR, with a separate submission and principal recipient.

→ **Subsidy integrated with disease subsidies** with a variety of possible configurations, depending on two main factors:

- The degree of absorption/autonomy with respect to the "host" grant, with several possible scenarios:
  - HSS activities are included in the subsidy (significant absorption)
  - RSS modules are housed in the subsidy (intermediate position)
  - The HSS subsidy, with its main recipient separate, is housed within the health subsidy for administrative reasons (significant autonomy).

- The degree o f fragmentation/gathering within one or more disease grants, with several possible scenarios:
  - The entire RSS is housed in a single grant
  - HSS sub-pillars (e.g. governance, health information systems) are divided into different grants
  - The same sub-pillar is split between different disease subsidies

Several interlocutors stressed the crucial importance of this question of allocation modality, with important consequences in terms of internal coherence, coordination (between the different RSS components, as well as with disease components) and implementation.

> "When it comes to HSR, you must never separate substance from form. You always have to ask the question of how it's going to be implemented, who's going to manage it, how it can be implemented with its constraints." (international consultant)

Although this is a long-standing debate within the Global Fund, the first possibility of submitting a dedicated grant separately appeared in *Round 5*[99] *(2007)*, before the Global Fund retracted its position in *Round* 6[100] . In practice, it has been reported that the Secretariat's preference is clearly for integrated grants, with the main reason advanced being the simplification and saving of administrative management costs generated by separate submission and the designation of an additional Principal Recipient, to facilitate implementation but also (and this has been reported more informally), because of the fear that countries will see access to the (easy) resource, with the liability of embezzlement that may have existed.

For those who favor separate HSS subsidies, the perceived advantages are its greater capacity to provide a more consolidated vision of the system, and to avoid fragmentation between different disease concept notes. The example of Guinea-Bissau illustrates the significant risk of scattering and fragmentation of HSS activities, as well as the resulting challenges of coordinating actors. At the time of the study[101] , it was planned that HSS investments would be dispersed between the malaria and TB/HIV concept notes, with the two notes being submitted at different submission windows (1ère and 2ème of 2020 respectively), with limited visibility for the consultants of the second note on the content of the first note. For most sub-pillars

[99] Before 2014 and the adoption of the New Funding Model (NFM), Global Fund grants were called "*rounds*".
[100] Cf Figure 1: Evolution of Global Fund investment in *health* systems strengthening, p.19
[101] At the time of the study, the concept notes had not been validated by the TRP and GAC. These are therefore data collected from concept notes that were not finalized.

(community health, supply chain, laboratories, health information systems, integrated service delivery), the two concept notes proposed parallel activities, with similar angles of approach, or even similar activities. Both notes include, for example, activities linked to medical waste management, laboratory quality control or the strengthening of civil society players. And in general :

> "The TRP also identified poor coordination between HSSR elements in disease-related funding applications: in several cases, HSSR data was inconsistent between different funding applications (e.g. warehousing and distribution costs), leading to unreliable budgets and the impression that the applicants themselves also lacked a clear picture of the healthcare system or the proposed investment."[102]

Another argument put forward by the advocates of autonomous concept notes is that they are more likely to prevent the risk of HSS being abandoned by the principal recipients of the diseases at the time of implementation. In Côte d'Ivoire, for example, a Director of a central department described the difficulties he had encountered in implementing NFM2, as he was not a sub-recipient, had no managerial or financial autonomy, and was totally dependent on the National Malaria Control Program (principal recipient of the malaria/HSR subsidy) to initiate its activities, for which HSS was not the top priority. Regarding the prioritization of activities to be implemented, he stated that "*in the final arbitration, it's always us who lose out*" (Central Management Director, Côte d'Ivoire). A Global Fund agent described a similar situation in Benin:

> "It's true that when we had HSS in our disease grants, the HSS component was the fifth wheel. First I do all my HIV activities, then I do my HIV studies, and after that the HSS activities. It's one of the drawbacks of disseminating TB, malaria etc. grants, there's less focus on activities that concern them less directly" (Global Fund agent).

In Benin, the personal involvement of the President of the Republic in the health sector and the Global Fund in particular - notably as Chairman of the CCM - combined with a high level of technical expertise, led to the development of a separate HSS concept note (2019 - 2022). However, despite the strength of the country's leadership and the quality of the grant, its implementation has proved (so far) problematic, underlining the fact that the success of an HSS grant is an equation with multiple variables (see 3.1.3 Case study: Benin, below). Most of the players interviewed thus qualify the terms of the debate and agree that the choice of modality is not the only factor for success, and that - even if it is particularly important - other factors come into play for a national HSS strategy to be both relevant and effectively implemented, notably country leadership, technical skills and the institution in charge of implementation, which must have financial and programmatic management skills, while having a strong hierarchical link to the central directorates in particular.

In the background, the interviewees recognize that no solution is perfect in absolute terms, but some mitigate more risks than others: the choice of an integrated subsidy enables better control of financial risks, while the choice of an autonomous subsidy reduces the risks of fragmentation.

2.2.2. The concept note process: the challenges of complex coordination

The inclusive development of concept notes by all stakeholders is one of the Global Fund's most distinctive features. The open and participatory nature of this process is hailed as a major quality of the Global Fund by the various stakeholders interviewed who took part. Nonetheless, considerable challenges were encountered in terms of coordinating the various

[102] Technical Review Panel (TRP) 2020b.

These factors were closely linked to the fragmentation and vertical nature of HSS activities.

Four main challenges in coordinating the players involved in drawing up HSS concept notes have been identified:

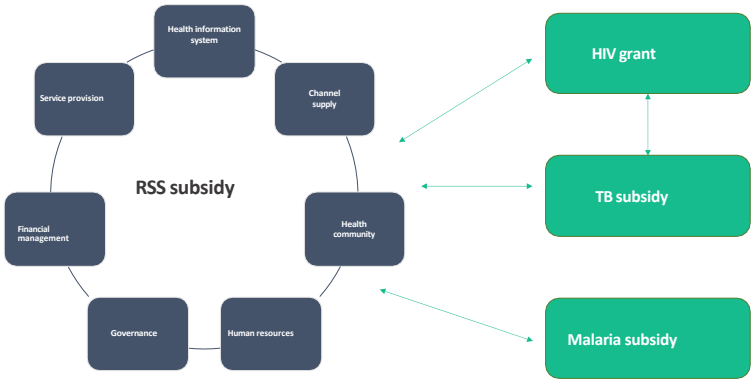
- Between the different elements of the same HSS pillar: for example, how can we harmonize the activities, training, service packages and remuneration of the different community health advisors or agents?
- Between the different pillars of HSS, raising the question of the transversality of actions: For example, for the supply chain pillar, how can we build bridges with the health information system pillar (to strengthen interoperability and stock management), the governance pillar (to increase regulation), the community health pillar (to enable the last mile to be reached) and the human resources pillar (to revise curricula and train logisticians and dispensers?)?
- Between HSS and disease subsidies: For example, for the same action - such as the creation of a community health observatory - is it more appropriate to include it in the HSS grant or the HIV grant? Or how can we divide up actions relating to malaria community health agents between the HSS and disease components, without hampering the efficiency of the process during implementation?
- Between HSS and other external national or international players involved in HSS: For example, on the question of computerizing inventory management in the supply chain in Côte d'Ivoire, how can we ensure good collaboration between USAID and the Global Fund, and ensure that choices are aligned with the national vision?

The players involved in the concept note process are constrained in terms of human, time and financial resources, preventing them from participating in all the sub-committees that would be relevant to ensuring a global strategy. For NFM3, this situation was exacerbated by the Covid-19 epidemic, as well as by the simultaneous drafting of concept notes (HIV, TB, malaria). The case of community health is particularly illustrative of this difficulty. Indeed, according to the methodology adopted to track Global Fund HSS-related expenditure, community systems strengthening accounts for just 2% of funding labelled as HSS, undervaluing actual expenditure, which is broken down into other pillars such as human resources, the health information system, or the supply chain.

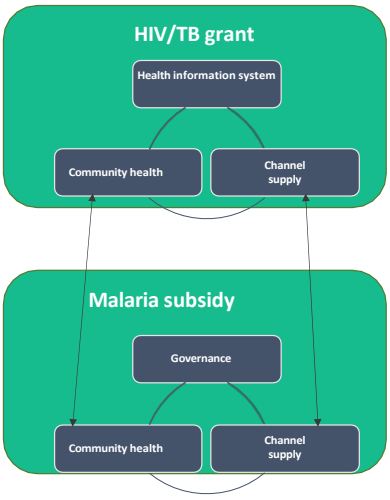
For example, in Côte d'Ivoire, five sub-groups were created to work on the HSS concept note (a stand-alone note, but housed within the malaria grant) - governance, health information system, supply chain, community health and quality of care - working in parallel to the various sub-committees dedicated to the three disease grants. For example, the Community Health Department (DSC) was involved in all the sub-committees of the HSS and HIV, TB and malaria grants (reaching the last mile via the community, integration of community sector data into the national health information system, community health governance, involvement of community health workers in improving the quality of care and service delivery, etc.). However, out of a total SDC staff of 35, six people were involved in the writing process on a full-time basis, essentially following the progress of the HIV/TB community grant, malaria and the sub-committee dedicated to community health - to the exclusion of the other HSS sub-committees. In return, the Community Principal Recipients expressed a problem with the availability of their staff (the drafting process took around six months) and felt less concerned by the sub-pillars apart from community health. Thus, while collaborative efforts were made to align community health workers' service packages with the national strategy, priority issues for the Global Fund such as the integration of community health data into SNISs or reaching the last mile via CHWs could not be addressed with the stakeholders concerned.

Box 16 The challenges of coordinating HSS activities in autonomous and integrated grants

1. in the case of a stand-alone grant (scheme)



2 In the case of a subsidy integrated into a concept note (scheme)



2.2.3. The modular frame

Several consultants mentioned the problem of the modular framework, ill-suited to systemic HSS strategies - and in particular for community health. In their view, countries (such as Senegal) that have tried to fit their HSS subsidies into boxes or modules have impoverished their strategy, as this formatting has led to "*the essence of things being lost*" (international consultant), "*the modular framework pushing(ing) consultants to make shopping lists*" (another international consultant).

In conclusion, although significant efforts have been made to ensure that the HSS strategic objective can be implemented, the technical framework remains insufficient today to effectively encourage players to implement coherent, systemic and well-coordinated strategies with disease subsidies. The tools deployed are more akin to recycling instruments initially created for pandemics, or even "half-measures", than to genuine innovations adapted to the specificities of HSS[103] .

[103] According to Lascoumes and Sinard, "the instrument materializes intentions, and often makes it possible to distinguish more precisely what is a genuine innovation, a recycling or a half-measure." Lascoumes and Simard 2011.

Some of the people we spoke to pointed to the real technical difficulties involved in developing a suitable and effective system for HSS, and to the fact that this is a relatively new issue for the Global Fund, while others questioned the political will within the Secretariat to make this issue a priority.

Also, some of those interviewed justify maintaining these "floating zones" in order to promote the "*country-driven*" principle - which makes all the more sense in the context of HSR - and avoid being overly prescriptive, and out of step with real national needs. Indeed, counter-intuitively and contrary to the theory of *New Public Management*, zones of vagueness can have a strong functional dimension, encouraging actors to take action while leaving them room for manoeuvre. However, they appear in a context where the Global Fund is usually very prescriptive in its directives to countries. This vagueness tends to paralyze rather than encourage action. Only countries with the strongest leadership and technical skills, such as Rwanda, Ethiopia and Benin, can seize the opportunities offered by the Global Fund.

3. Dependence on external players

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

3.1. Develop partnerships with national players

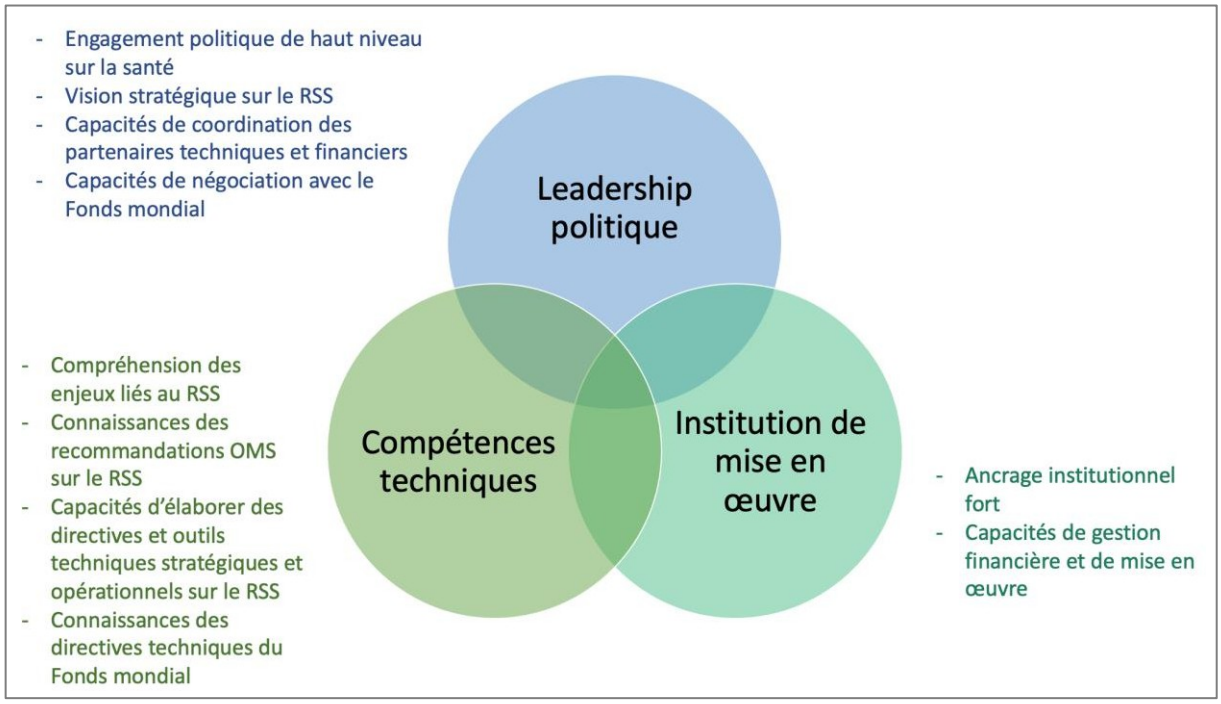
Even more so than in the fight against pandemics, the question of HSS needs to respond to needs defined by countries, and to be appropriated by public health authorities, so that responses are fair and sustainable, following the logic of respect for national sovereignty, in a balanced relationship of co-partnership.

3.1.1. At national level: facilitating factors

According to the people we spoke to (mainly from the Global Fund), a number of ingredients need to be present at country level to facilitate HSS investment, grouped into three main categories: the country's political leadership, technical skills and the choice of an appropriate implementing institution (Figure 2).

> "It's always more or less the same point of entry: when Ministers have very clear strategies with operationalization plans, with departments that are strong and carry out their strategies well and coordinate their partners well, it becomes much easier to invest. Because we can talk about prioritization, about what we can and can't do through our grants. But without this leadership, things become more complicated" (Global Fund agent).

Figure 2: Decisive factors in the development and implementation of a Global Fund-supported HSS strategy at country level



Political leadership can be seen in a number of ways: high-level government commitment to healthcare in general, with a strategic vision of HSS in particular; solid co-financing, combined with a diversification of donors (to avoid a monopolistic situation focused on the interests of a single donor); the ability to coordinate technical and financial partners; and negotiating skills with the Global Fund.
Technical skills are then needed to draw up relevant technical and operational guidelines on HSS, to master the Global Fund's own technical guidelines and to be able to "fit into its matrix" and exploit the flexibilities offered.
Finally, the choice of the institution in charge of implementing HSS activities is of prime importance, as it must have good administrative, financial and programmatic management capabilities, with a strong institutional anchoring that enables it to have a hierarchical link of authority over the actors in charge of implementation - in particular the central directorates or other national programs; and lastly, good coordination capabilities with other partners.

3.1.2. The Global Fund's responsibility: supporting and optimizing national strengths

In return, it was pointed out that when it comes to the issue of national leadership, the Global Fund also has a responsibility to support and optimize national strengths.

> "In fact, I find that when it comes to HSR, they're quick to say 'we can't do that, it's up to the States to do it'. So if we want to help with ongoing or medium-term training, they say 'that's the prerogative of the States'. In fact, as soon as it's complicated, it's the prerogative of the States. Now, buying medicines is also a national prerogative, but we do it, so can't we help in other ways?

In terms of political leadership, the importance of the Global Fund working with the right interlocutor, i.e. the real decision-making bodies, was mentioned. For example, a Global Fund agent mentioned one of the difficulties encountered in West and Central Africa, linked to the habit of negotiating with the Ministry of Health rather than the Ministry of Finance - as is generally the case in East A f r i c a - which can cause problems for the holding of meetings.

cofinancing pledges in particular. In addition, the absence of an in-country presence makes it more difficult for the Global Fund to identify the real locus of decision-making in terms of health policies, the configuration of which depends on each context (Prime Minister's Office, Presidency, Ministry of Finance, Ministry of Health, etc.).
In a significant number of countries, national authorities have had little or no involvement in the Global Fund ecosystem, either within participatory governance bodies (CCMs) or as grant recipients. While the CCMs were originally set up to enable collaborative governance - with a strong emphasis on civil society - the Global Fund is now a key player in this area.
In practice, however, they have often led to health ministries being bypassed. 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 capacity, as well as blocking the implementation of certain activities. As we have already seen, debates over the size of HSS allocations or the choice of Principal Recipients (PRs) reveal the dividing lines between the priority given to efficiency and financial risk management (generally adopted by the GF) and national sovereignty (defended by countries). The frequent use of management units to manage HSS grants is indicative of the persistent difficulty of using Ministries of Health, for reasons of efficiency, adaptation and trust.

Some of those interviewed stressed that, while mastery of the Global Fund's procedures is one of the prerequisites for countries to negotiate with the Fund as equal partners, it is up to the Fund to simplify these procedures, making them more accessible to all. In the same vein, if donors' ability to coordinate is a necessary condition, it is up to them to better coordinate among themselves, in order to alleviate the constraints weighing on countries[104] .

3.1.3. Case study: Benin

Benin is one of the few French-speaking West African countries to have initiated a separate HSS grant for 2019-2022, worth around 12 million euros (see Appendix 5)[105] . The development and approval of this grant is the result of a long and complex negotiation process between the Global Fund and the Beninese public authorities, oscillating between technical arguments and political considerations.

When Patrice Talon became President of the Republic in 2016, he included healthcare as one of the major components of his "Programme d'Actions du Gouvernement" (PAG), notably with his "Assurance pour le Renforcement du Capital Humain" (ARCH) project[106] . He maintained close relations with Mark Dybul, then Director of the Global Fund, whom he appointed Commandeur à l'ordre national du Bénin (February 2017), then chargé de mission pour le développement des partenariats dans le secteur de la santé (March 2017), the latter showing particular interest in his "ARCH" universal health coverage project. Wishing to (re)take control of Global Fund financing, he created by decree (April 19, 2017) an Instance nationale de coordination (INC/FM/Benin) to replace the Conseil national de coordination et d'orientation des subventions du Fonds Mondial (CNCO), with the main change being that the president of the CCM is no longer elected by the general assembly, but that the function is statutorily assumed by the President of Benin.

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[104] See *3.2 Working with technical* and financial *partners,* below.
[105] Benin already had an HSS grant in 2014-2017, a program promoting results-based financing (RBF), but which had been essentially donor-driven. The 2019- 2022 grant, entitled "Améliorer l'accès et la qualité des soins de santé au Bénin, grâce à un système de santé plus intégré, plus efficace et plus résilient", was developed at the initiative of the national authorities.
[106] Pillar 3, strategic axis 6, action 1 of the PAG

In 2017, the joint multi-donor program (Global Fund, World Bank, GAVI Alliance and Belgian cooperation) to promote results-based financing (RBF) at health facility level, begun in 2014, is coming to an end. Global Fund financing was substantial - around 25 million euros, in a grant labeled RSS[107] , but absorption rates were low and results in terms of impact and sustainability disputed by the head of state. At the beginning of 2017, an informal agreement was formulated between the President of the Republic and Mark Dybul to reprogram part of the grant (11 million euros) on an exceptional basis and avoid following the classic procedure for a new grant application, which is more restrictive and time-consuming. For Benin, this is an opportunity to finance part of the social protection reform (ARCH), whose budget is estimated at 535 million euros. However, following Mark Dybul's departure from the Global Fund, and deprived of his political support, exchanges between the Presidency of the Republic and the Secretariat - which are now played out at a strictly technical level - are highly conflictual. The main points of disagreement concern the possibility of reprogramming versus the need for a new application, as well as the quality of the application, with expenses that are difficult to qualify (e.g. a large vehicle fleet, studies, etc.).

Negotiations reached an impasse: with the Secretariat's technical responses failing to meet Benin's political injunctions, Patrice Talon threatened to refuse Global Fund financing (11 million euros of the RBF grant), denouncing an infringement of his national sovereignty, and a breach of the principle of national ownership. After several months of tension, the situation was finally resolved at a technical level during 2018, with an SRPS grant able to begin in April 2019.

To this discord surrounding the reprogramming of the "FBR grant" were added tensions linked to Benin's request to revise the breakdown of disease programs at the end of 2017, reducing the share allocated to HIV, tuberculosis and malaria respectively by 3 million, 1 million and 6 million euros respectively, so as to generate an additional budget of 10 million euros for a SRPS component, to which would be added 2 million euros via counterpart funds, for a total of 12 million euros[108] (i.e. 23 million euros in total). From the point of view of the Beninese players, they seized the opportunities offered by Global Fund guidelines, which specify in allocation letters the possibility of reviewing the distribution of allocations, and the fact that each program must be able to support health systems up to around 11.4% of their budgets: "*but until recently, most countries didn't exploit this*"[109] . They also invoke the need to pool resources in order to achieve economies of scale in the management of pandemic subsidies, as well as respect for national sovereignty. This proposal provoked concerns from the Grant Approval Committee (GAC) and the Technical Review Panel (TRP), fearing that this reallocation would be to the detriment of the three pandemics, and would create significant programmatic gaps[110] .

In line with this dynamic, Benin embarks on a far-reaching institutional reform of its health system. An Integrated National Strategic Plan for the Elimination of Epidemics (PSNIE) has been drawn up for the period 2020-2024, with the aim of creating a coordination framework for the three pandemics (HIV, tuberculosis and malaria), viral hepatitis and other diseases with epidemic potential. The aim is to gradually move away from vertical programs towards a horizontal approach, with systematic pooling of HSS-related activities at all levels (studies, training, supervision, communities, human resources, equipment, etc.). The Plan is accompanied by a provisional budget, a monitoring & evaluation framework and a resource mobilization plan. In November 2019, the Ministry of Health and the Office of the Presidency in charge of epidemics will convene technical and financial partners for an information and harmonization meeting around their three RSS axes that they consider to be priorities (community health, health system, etc.).

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[107] The Global Fund amount for the FBR grant ("Health System Results Strengthening Program") was 25 million euros, i.e. almost equivalent to the HIV grant (28 million euros), out of a total of 90 million euros (Office of the Inspector General (OIG/OIG) 2019b.); HSS aspects such as supply chain were housed in disease grants

[108] Aidspan 2017.

[109] Beninese public actor, during the workshop in Cotonou February 2020

[110] Aidspan 2017.

logistics information system, national data information system) to curb the creation of parallel systems for each donor and/or each disease, and to assert their national vision.

However, although the development of the concept note (NFM2) was exemplary on paper, driven by strong country leadership and based on strategic documents, it was lacking in implementation, as observed in other countries[111] . At the time of the study (March 2020), the Office of the Presidency in charge of epidemics, chosen as the principal RSS recipient, had not yet set up its management unit, and no disbursements had been made. The stumbling block reported by various interlocutors was the hypercentralization of power at the level of the Presidency of the Republic and its Epidemics Office, which relies on a few individuals and maintains conflicting relations with the Ministry of Health and the national programs to combat the three pandemics. Donors find it difficult to position themselves in the face of this two-headed health governance. Moreover, the institutional anchoring is problematic, since the principal RSS recipient is located within the Office of the Presidency, with a hierarchical position superior to that of the CCM, which is also anchored within this Office, going against the principle of total autonomy of the CCM vis-à-vis the principal recipients. While from a technical point of view, this institutional set-up does not comply with Global Fund rules, from a political point of view, it was difficult for the Global Fund to refuse it, given the first choice that the Global Fund had already rejected, which was the Belgian cooperation[112] . Similarly, Benin managed to pull off a coup de force, negotiating an 80% increase in the future HSS grant (NFM3), due to start in July 2022, even though the results of the current HSS grant were poor (at the time the concept note was drawn up).

The example of Benin illustrates several points. Firstly, in order to implement an HSS strategy, driven by the beneficiary country and in partnership with other technical and financial partners, a set of conditions must be met, each of which is necessary. Here, Benin has demonstrated political leadership at the highest level, with the direct involvement of the President of the Republic, reappropriating the openings left by the Global Fund, drawing on relevant technical documents and setting out its demands, even if this meant generating open conflict. When asked about the lessons learned from this experience, a Beninese public player replied:

> "You have to negotiate with the Global Fund (and not without) and have a frank dialogue, which at first may be considered a dialogue of the deaf, but they always end up sitting down next to you to better understand and perhaps better teach you how to express yourself in your request" (public stakeholder, Benin)

However, the missing ingredient was in the choice of the principal recipient, whose managerial and programmatic capacities could not be developed as initially planned, with a lack of pragmatic vision on the part of the political leadership.

On the other hand, this example underlines the fact that negotiations between the Global Fund and recipient countries - far from the technocratic ideal that *New Public Management* would impose - constantly tangle and oscillate between technical and political levels. Discussions stalled at first, due to the opposition between Benin, which was formulating a political demand, and the Global Fund, which was responding on a technical level. Gradually, the Global Fund was forced to abandon certain technical requirements, in view of the major political risk involved in going against the wishes of the national authorities.

In return, the case of Benin underlines the importance for countries to rely on high-level national technical skills in order to be able to negotiate as equals with the Global Fund.

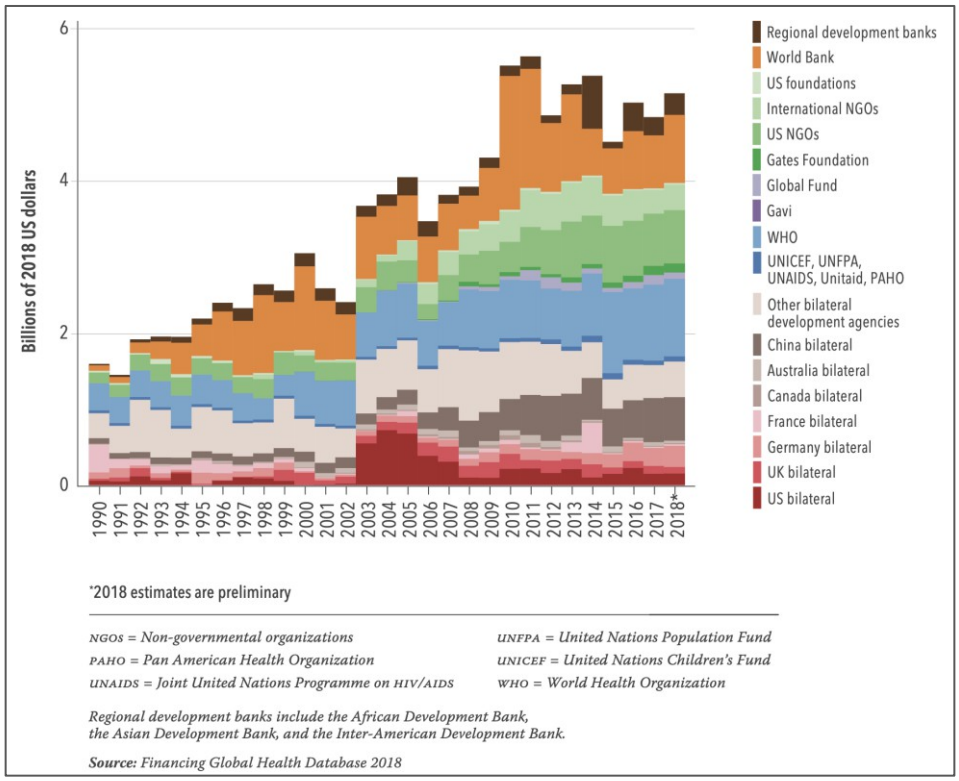
3.2. Working with technical and financial partners (TFPs)

3.2.1. The Global Fund: a "small player" in the field of HSS

[111] Office of the Inspector General (OIG/OIG) 2019c.
[112] A bilateral organization that cannot be a principal recipient for HSS

While in the fight against the three pandemics, the Global Fund is a major donor, contributing 69% of international funding for tuberculosis, 65% for malaria and 20% for HIV, it is largely a minority donor in the field of HSS, where it ranks far behind the WHO, the World Bank, international NGOs (including American ones), and bilateral cooperation agencies (Figure 3). It is therefore called upon to intensify its collaboration with other technical and financial partners who are more in the forefront of HSS issues.

Figure 3 Development aid for health systems strengthening and health SWAps by channel of assistance, 1990-2018 (IHME 2018)[113]



Most of the players interviewed recognize and emphasize that this new configuration of minority player is a major challenge for the Global Fund in the planning and implementation of HSS activities, complicating the process and forcing it to move away from a bilateral relationship with national authorities, all the more so in countries such as Chad and Togo, where Global Fund financing is by far the majority in the health sector (47% and 50% respectively).

> "We're not all alone on HSS. In *[Editor's note: name of country],* on TB and HIV we're a bit alone with the government, on malaria there's PMI (the Americans) and the National Malaria Program. Otherwise, for TB and HIV, we talk to the government, so it's pretty easy to get along. On the other hand, there are so many players involved in HSS, that we'd gain a lot by better coordinating all aspects of HSS. I don't have a magic wand, but it's really a cacophony of players" (Global Fund agent).

[113] IHME 2018, 92.

Global Fund staff do not see their organization as a leader in HSS, particularly in pillars such as human resources, governance, financing or the supply chain, which outstrip them in terms of amounts allocated, diversity of players and country roots.

3.2.2. The challenges of multi-tenant collaboration

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.

→ From theory to practice

Collaboration between technical and financial partners takes place at several levels (headquarters and country teams) and at different points in the funding cycle: strategic planning (areas of collaboration, definition of each party's responsibilities, information exchange, parallel/joint grant application process, etc.), implementation (selection of individual/joint prime contractors, financial and programmatic procedures) and monitoring/evaluation (individual/collective supervision, indicators, audits, etc.).

In theory, there is a real complementarity between donors, in terms of approaches (systemic/functionalist), skills (technical/generalist), country positioning (on site or not) or financing. A good example is the co-financing by AFD and the Global Fund of the construction in Bouaké of the regional branch of the public drug purchasing center (Côte d'Ivoire). The presence of the French bilateral cooperation agency in the country has enabled us to forge strong links with the Ministry of Health and the Prime Minister's Office, and to initiate a context favourable to strategic planning in the supply chain and distribution sector, by creating and co-chairing the technical working group (TWG) on medicines (with Expertise France), bringing together national departments and institutions as well as other international donors. In this way, the Global Fund - whose lack of a country office can be an obstacle to HSS - has been able to take part in the discussions and consultations initiated by AFD. In return, the Global Fund's technical skills - notably those of its procurement and supply chain department - have helped to offset the generalist skills of AFD's local staff.

However, our interlocutors emphasize the lack of systematic collaboration between TFPs, with today's tendency towards ad hoc, relatively fragmented and person-dependent collaborations. About collaboration between the Global Fund and GAVI:

> "Even if there are clear messages about the need to strengthen coordination between the Global Fund and GAVI, it's still very person-dependent and linked to portfolio managers on both sides. We need joint strategies, and coordination to ensure that these strategies are implemented in a coordinated and harmonized way at country level" (International Organization Officer).

For example, several players have pointed to current efforts to organize joint supervision missions between backers, enabling them to communicate, pool human resources and avoid repeatedly mobilizing players in the field; in practice, however, these too remain subject to the individual relationships of the players.

Certain pillars are identified as being more conducive to multi-donor collaboration - such as health information systems and the scaling-up of DHIS-2, often cited as an example,

a sector with a relatively limited number of players. Examples of support for strategic dialogues around healthcare financing or HSS - i.e., one-off events - are also identified as success stories of multi-donor joint working. On the other hand, engaging in collaboration in particularly complex sectors - such as the supply chain, with its large number of players and sensitive governance issues - while offering potential, is generally a deterrent.

Finally, in terms of the degree of collaboration, some note that significant efforts are being made to share information and avoid duplication, but that these rarely go beyond this, i.e. into joint planning, coordination and monitoring, in order to achieve the real pooling of resources, optimization of funding and "synergy" that the players are calling for.

→ The challenges of inter-landlord collaboration

As many of those we spoke to pointed out, "*the technical and financial partners are calling for greater coordination, but nobody wants to be coordinated*".

Historically, the Global Fund (like other international organizations) has tended to operate in silos to gain efficiency, and there have been reports of a tendency to make the Global Fund a "one-size-fits-all" organization.
"Some players pointed to the lack of communication between donors, and little visibility of what each is doing, as the first obstacle to pooling efforts. Some players pointed to the lack of communication between donors, and the lack of visibility of what each is doing, as the first obstacle to pooling efforts. A player from another multilateral organization raised the issue of the lack of communication on financial management, a critical area for institutions that are primarily financial in nature:

> "For example, financial management! We're financial institutions...this should be the first area where we coordinate. But we have problems communicating budgets, audits are done separately, financial allocations are separate. Six months apart, we get the same memo for doing exactly the same job of auditing financial management capacities...For me, it's really a leadership problem" (officer with a multilateral international organization).

The players interviewed emphasize the importance of country leadership, and the strategic direction they must give (which can take the form of a roadmap, a well-budgeted NSDP, an operational plan, etc.), within which technical and financial partners can fit. Without this, it's a case of "*building blocks being laid side by side, with no vision provided by national players*" (international consultant), and no pooling or synergy possible.
In return, a number of players emphasize the shared responsibility of donors to coordinate upstream and stop drowning countries in non-aligned financial cycles and specific procedures.

> "I think we also have a structural problem: we can't ask countries to resolve our own contradictions! and that's what we tend to do. When it comes to strategic management and operational simplification, there's a lot to be done between us, the Global Fund and GAVI. Because with 50 parameters for us, 50 parameters for them, plus 50 from the government...mix it up and you don't even know what's going on anymore, and that's a problem of competition" (agent, international multilateral organization).

In terms of timing, the lack of synchronization of each donor's financial cycles and anticipation of the national planning process is an obstacle to pooling HSS investments.

> "It's a shame, because in many countries, opportunities are lost. For example, in

> In Chad, the same year, the Global Fund and GAVI prepared grants, but not in a coordinated way, and therefore with different teams. Despite all our efforts to set up an HSS steering committee that could monitor both partners and adopt a joint approach, this was not done" (multilateral organization agent).

Maintaining the specific procedures of each donor is a recurring and structural problem, with the difficulty of harmonization, whether in terms of submission forms, choice of prime contractor (with separate management units), financial and programmatic procedures or monitoring indicators and accountability frameworks.

> "All donors talk about coordination and convergence on HSS, but in practice, each has its own procedures and objectives" (International consultant).

For example, while significant efforts are being made to develop collaborative management units, or to integrate common health funds, these processes are not always successful, as was the case with the integration of the Global Fund into Niger's common health fund (Box 17). This example highlights the Global Fund's difficulty in adapting to common procedures to promote national coordination with other technical and financial partners (TFPs). This means mobilizing competent national human resources, with additional financial costs and a diversification of administrative and financial management procedures to which field players have to adapt.

The issue of harmonizing monitoring indicators, far from being new, remains a major challenge, with the tension that donors encounter between adapting to national conditions and capacities and meeting the requirements defined by donors.

> "We can be very bad together, but sometimes we forget the right principles. We're well aware that sometimes we impose indicators that are more additional than they need to be... It's a question of finding the balance between facilitating *reporting* and justifying funding from our backers (...) It's a bit like the dog biting its own tail, in terms of governance, our backers remind us that it would be good to have joint procedures, but at country level, we need such and such an indicator, etc. We're all somewhat aware that we need to make efforts. We're all somewhat aware that we need to make an effort. (Global Fund agent)

> "I don't understand why we can't understand each other when it comes to these financial issues, why GAVI, the Global Fund, the World Bank, the Americans...each one is making assessments in its own corner, but based on a common diagnosis! it's incredible, it's 2020 and I think we've got a workload problem" (employee of a multilateral international organization).

> "We have to adapt to the countries with the most vulnerable conditions...not start asking them for a whole series of supporting documents that they can't produce, otherwise we'll go to the wall!" (agent from a multilateral international organization)

Power relations and competition between donors can also obscure the terms of their collaboration. In Côte d'Ivoire, for example, collaboration between the US government and the Global Fund can turn into a power struggle[114] , as in the case of the computerization of stock management in the supply chain, where USAID initiated the project by choosing costly m-supply software (IBM), which it began to deploy in health establishments, only to ask the Global Fund to take it over due to budget restrictions, putting the latter in an uncomfortable position.

Finally, some lamented the lack of coordination among international organizations, with WHO Africa tending to be criticized for its lack of leadership in the field, and its greater involvement in malaria than in HSS.

[114] Bekelynck 2019.

Box 17 The example of Niger's Common Health Fund [115]

During 2018, important negotiations took place between Niger's Ministry of Health and the Global Fund, to explore the possibility and possible arrangements for the Global Fund's TB/HSSR grant to integrate Niger's Common Health Fund (CHF). However, despite extensive discussions, no agreement was reached, as the grant was rejected by the Grant Approval Committee (GAC). Finally, a specific management unit was created within the Ministry of Health to implement the TB/HSSR grant.

→ **Presentation of the Fonds commun de santé**

The Fonds commun de santé is a multi-donor fund created on the initiative of AFD and the Banque de France. Mondiale in 2006, and now includes - in addition to its original co-founders - the Spanish Agency for International Development Cooperation (AECID), the GAVI alliance, Unicef (2011), and UNFPA (2014). In terms of funding volumes, the pooled fund has seen significant growth (albeit relative to external funding from donors/NGOs), rising from around 20 million euros to support the 2011-2015 SDP to around 77 million euros for the 2017-2021 SDP, with funding clearly in the majority from the World Bank and GAVI. In the spirit of the Paris Declaration, this fund aims to channel and harmonize the resources of technical and financial partners (TFPs) on the priorities, lines and procedures of the Ministry of Public Health (MSP) via its Health Development Plan (PDS). It is presented as a financial instrument at the service of the Ministry and as a sectoral aid tool of an extra-budgetary nature, which could be situated halfway between budgetary aid and the management unit. It is perceived as a "model" by GAVI and AFD, specifically in terms of its financial management, although it is limited in its capacity to support programming, monitoring/reporting and coordination.

While the FCS originally operated on the principle of total fungibility, giving the Ministry of Health considerable autonomy in planning activities, the arrival of new players and the growth of the FCS have led it to target and prioritize interventions to a greater extent. In particular, this is reflected in the earmarked funding initiated by GAVI in 2011 (followed by AFD and the World Bank) and the creation of specific technical units and parallel accounts for several projects. One of the current challenges facing the FSC is to clarify

This is a "red line" that must not be crossed, so as not to distort its original mandate and remain an instrument focused on supporting the Ministry of Health and not on *reporting* to donors.

PDS 2017-2021

Volumes de financement	30/06/17	31/12/17	30/06/18	31/12/18	30/06/19	31/12/19	total	%
AFD	2.623.828.000	655.957.000		0	0	0	3.279.785.000	7%
AECID	787.148.400	655.957.000		655.957.000	0	0	2.099.062.400	4%
UNICEF	423.047.200	0	374.404.800	396.875.900	0	1.182.064.000	2.376.391.900	5%
UNFPA	132.500.000	21.206.250	131.962.000	0	0	0	285.668.250	1%
BM (PAPS)	3.523.027.845	0	21.794.469.412	0	4.100.413.258	32.830.974	29.450.741.489	58%
Gavi Alliance	0	4.415.734.694	126.263.680	0	5.979.381.376	2.267.512.051	12.788.891.801	25%
Autres Projets					155.357.104	0	155.357.104	0%
Autres ressources	19.988.550	63.924.306	15.346.835	-72.134.586	-40.124.793	3.245.656	-9.754.032	0%
Total	**7.509.539.995**	**5.812.779.250**	**22.442.446.727**	**980.698.314**	**10.195.026.945**	**3.485.652.681**	**50.426.143.912**	

Affectations budgétées	30/06/17	31/12/17	30/06/18	31/12/18	30/06/19	31/12/19	total	%
P1: gouv & lead	1.064.801.528	2.058.279.527	1.450.469.714	2.225.756.510	2.326.617.198	4.528.602.557	13.654.527.034	36%
P2: accès aux soins	2.800.094.864	3.932.218.[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
P3: qualité	531.701.207	1.101.814.588	679.423.310	721.121.224	2.548.070.103	2.330.480.000	7.912.610.432	21%
Total	**4.396.597.599**	**7.092.312.927**	**5.318.389.653**	**5.170.957.515**	**7.256.778.128**	**8.905.393.345**	**38.140.429.167**	

FCS financial monitoring report for the 2017-2021 SDP (source: AFD evaluation, 2020, p.22)

→ **The failure of Global Fund negotiations to integrate the FCS**

Negotiations are underway to integrate the Global Fund into the FSC for

The implementation of the TB/HSSR grant is the third attempt since the creation of the FSC, the first two having been unsuccessful. They took place in a specific context, Niger being under additional safeguard measures, with international NGOs or the UNDP.

115 This case study is based on the AFD evaluation (Agence française de développement (AFD) 2020) and interviews with French global health players and technical and financial partners (TFPs) (notably the Global Fund) involved in this issue.

as principal recipients for many years - with the exception of the HIV grant, which is managed by a national recipient[116] . The aim was to give the management of TB and HSS back to a public player. The players interviewed agree on the investment made by the Global Fund to reach an agreement, and on the intensity of the exchanges with the Ministry of Health and the other technical and financial partners involved in the FSC, but which has been blocked for a number of reasons, essentially linked to currently incompatible financial logics. As a preamble, the possibility of the Global Fund aligning itself with the fungible funds model was not envisaged, given the basic incompatibility with all the Global Fund's specific management modalities, and negotiations took place on the hypothesis of integration via earmarked funding. Two types of reasons led to the refusal: on the one hand, the team's weak capacities in programmatic management and performance monitoring, with the inability of the pooled fund to report results with the level of detail expected from the Global Fund, for example; and on the other (and above all) financial management, with rather strict safeguards vis-à-vis Niger and incompatible with the operation of the FSC, notably the imposition of the fiscal agency (LFA) to monitor Global Fund financing, which was not acceptable to the other PTFs. In the end, a management unit was created within the Ministry of Health, under the same coordination of the Secretary General, but with separate teams.

→ Players' perceptions

For some, this is a "missed opportunity", or even a "failure" on the part of the Fund.

They note that it has been structured over time and operates on the basis of a strong support system from the Ministry of Health and good collaboration between donors, with multi-year funding (AFD, WB). They note that it has developed over time, and operates on the basis of a strong support system for the Ministry of Health and good collaboration between donors, with multi-year funding (AFD, WB) that gives the Ministry visibility and a cash advance, a guarantee of autonomy. It enjoys good evaluations for its financial management, and although limited in certain respects (notably program management and monitoring capacities), it is showing a willingness to improve by adapting to its new conditions (increased number of donors and funding). In addition to financial collaboration, this instrument offers opportunities for dialogue and greater complementarity between donors. The principle of pooling human resources - enabling economies of scale - is also highlighted as a success.

Some interviewees have the impression of an "inflexible" Global Fund (particularly its financial teams), which prefers to prioritize financial and programmatic risk management over respect for national sovereignty.

> "Finally, for the Global Fund, it's always the mentality of saying 'we work like this, we want this'. But in a spirit of common ground, it's not 'I want this', there's a series of documents, deliverables that the Ministry gives and that the technical and financial partners validate, always by common agreement to simplify financing, whether it's accounting, *reporting*, financing, in the spirit of the Paris alignment" (actor, international organization).

For the Global Fund players interviewed, integration into the common fund is not an end in itself, as it is primarily a financial tool. Other areas of collaboration are possible, with priority given to joint planning exercises, identification of common objectives and indicators, joint coordination of implementation and monitoring, or harmonization of the procedures manual.

> "For me, the real missed opportunity is when we fail to coordinate planning and implementation efforts, rather than funding efforts, especially when funding is predefined (...). Not being in the common fund should not prevent us from working with the common fund" (Global Fund agent).

[116] The National Cell for Technical Coordination of the National Response to AIDS and Hepatitis

→ From global to national

The Global Fund is involved in global initiatives aimed at strengthening collaboration between technical and financial partners, such as the *Global Action Plan* (GAP), the *Implementation through Partnership* (ITP) - an initiative designed to help countries experiencing difficulties in implementing grants, or P4H (the global network for health financing systems and social protection in health). It has also bilaterally signed MOUs (*Memoranda of Understanding*) with other bilateral or multilateral international organizations including HSS (but not necessarily focused on it), relatively recently (e.g. with WHO in 2014 and reviewed in 2019, the World Bank and AFD at the end of 2019, Unicef, UNFPA, etc.).

So far, several of our interviewees have pointed to the difficulty of implementing these agreements, which are designed and signed at head office level, demonstrating a certain disconnect between the players acting internationally and those in the countries, both at the strategic level ("*We have people who work on strategy, but these people don't know the conditions on the ground, they have a whole bunch of filters... So we're a bit handicapped", agent of a multilateral organization) and* at the operational level ("At Global Fund level, there's a lack of people in charge of operationalizing all these agreements", agent of a multilateral organization).*So we're a bit* handicapped", agent for a multilateral organization) and at the operational level ("*At Global Fund level, there's a lack of people in charge of operationalizing all these agreements*", international consultant*)*.

> "One challenge is how to ensure that the messages, the '*agreements*' at global level are reflected at country level...there are a lot of efforts made at regional global level, but at country level, it's more an exchange of information, but not real collaboration for planning, design and actual execution...Often it's linked to individuals but that shouldn't be the case." (Global Fund agent)

For example, with regard to the agreement signed between the Global Fund and AFD in December 2019, it was reported that the choice of countries (Niger, Côte d'Ivoire and DRC) had been made for essentially political rather than operational reasons, i.e. in relation to possible areas of collaboration or locally available funding.

Many players are calling for a collective reflection at global level, in order to re-examine the partnership of the structures that revolve around the Global Fund, to better define the roles and responsibilities of each, and to refine the definition of accountability.

> "And that's where it gets complicated, and that's where I re-question the Global Fund partnership: what are we asking the Global Fund to do? What is the role o f WHO? What is the role of other technical and financial partners?

For some, this would mean redefining the responsibilities of each donor at operational level, with a pre-existing strategic vision to enable a leverage effect, including the identification of strategic areas in which a common approach is needed and the modalities of implementation, while remaining flexible to adapt to country priorities. For example, in the case of community health workers, define the care package and funding arrangements for workers; in the case of car logistics management, reach agreements on common inventory models, maintenance, motivating the people who use them, etc.

3.3. Technical assistance

As a final obstacle, several interlocutors stressed the difficulty of mobilizing high-quality technical expertise on HSS and the Global Fund, with a twofold difficulty: 1) finding technical experts with sufficiently generalist skills to be able to coordinate the various pillars (without being too specialized on one pillar in particular), but without being too

They also need to be generalists, to have an operational vision of HSS, and 2) to be familiar with the technical guidelines and functioning of the Global Fund, which is currently lacking, as HSS experts in the world of global health generally do not have the necessary "culture" or knowledge of the Global Fund.
In addition, these technical experts specialized in HSS found it difficult to carry out their missions, due to the lack of history and evaluation of past HSS requests, the lack of a national strategy, the lack of precise directives from national authorities, the difficulty of finding a consensus between the various entities (Ministries, CCM, Programs, etc.) and finally, the absence of a clear budget for HSS in allocation letters (cf. 2.1.2, p.47).

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 "leverage effect" is still poorly conceptualized.

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 current short-term "pandemic RSS" can become a broader RSS in the medium and long term.
- **Communicate more effectively** with health stakeholders in beneficiary countries outside pandemics, on the objective and real scope of the Global Fund's HSS approach, and on what can and cannot be financed (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 more in line with the **Global Fund's current organizational capacities.**

Although significant efforts have been made since its formalization as strategic objective no. 2 in Strategy 2017-2022, **operationalizing HSS remains a colossal challenge**, which would require a major overhaul of the Global Fund (mandate, skills and culture, organization

The technical tools required to implement it leave a lot to be desired. The technical tools required for implementation leave many areas unclear. In theory, these areas need to be left open, in order to give **countries a degree of autonomy**, so that it is up to national authorities to guide, coordinate and even implement these strategies according to their own guidelines.

However, SSR takes place in a context where 1) the FM 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 HSR via the Global Fund

- Identify the technical areas where the FM needs to leave **room** for **manoeuvre** to encourage country ownership, and the areas where it needs to be more directive and improve its tools to encourage action.
  (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.).

- Promote 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 (notably human resources for health, supply chains or community systems) in certain countries, 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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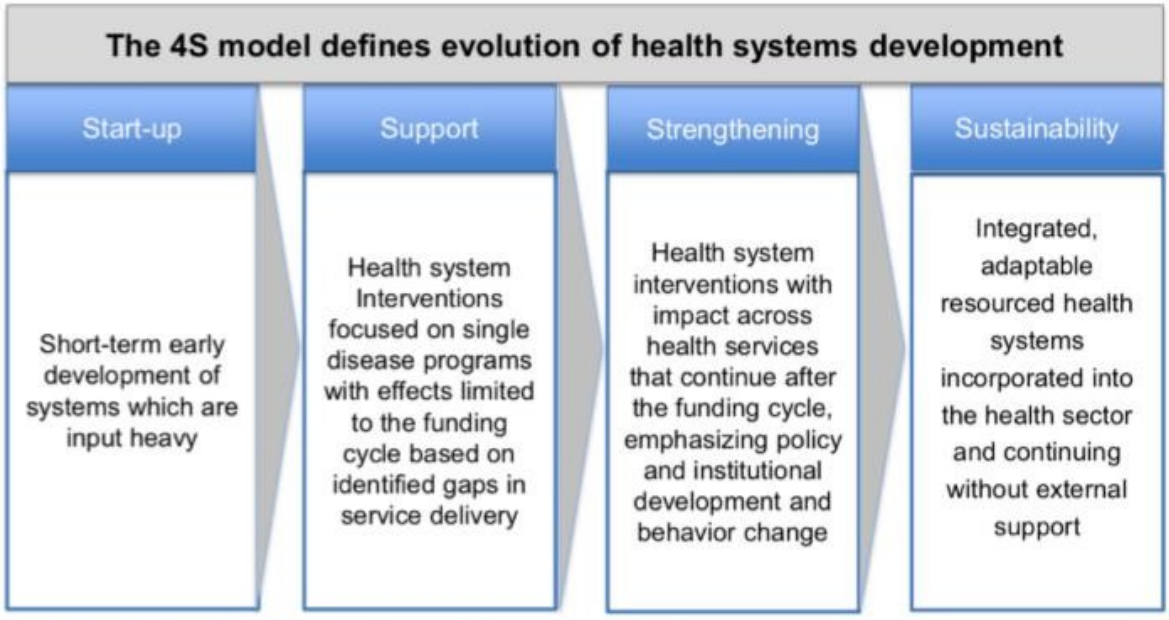
Appendices

Appendix 1: The Global Fund's "4S model" (The Global Fund, 2018)



Modified from: G. Chee, N. Pielemeier, A. Lion, and C. Connor. 2013. "Why differentiating between health system support and health system strengthening is needed." International Journal of Health Planning and Management 28(1):85-94.

Appendix 2: General evolution of healthcare system development: the "4S" model. (TRG, 2018)

Table 1: General evolution of health systems development: the 4Ss model

Parameter	System start-up (establishment)	System Support	System Strengthening	System Sustainability
Scope	Emergency; early development of systems	May be focused on a single disease or intervention	Activities have impact across health services and outcomes	Systems are integrated, resourced and fully incorporated into the overall health sector
Longevity	Short term; depending on country situation	Effects limited to period of funding	Effects will continue after activities end	Effects are continuing without external/ extra support
Approach	Input heavy for all systems	Provide inputs to address identified system gaps impacting service delivery	Revise policies and institutional relationships to change behaviors and resource use to address identified constraints in a more sustainable manner	Systems are adjusted to adapt to changes and resources are continuous, relevant and available domestically

Appendix 3. List of costs included in and excluded from costs considered to fall under the SRPS (Global Fund)

→ **3a. List of costs arising from disease modules and interventions, considered relevant to healthcare systems** (source: *Tracking the Global Fund's Investments in Resilient and Sustainable Systems for Health, Global Fund, 2019*)

Cost Category	Cost Input
Human Resources (HR)	1.0 Human Resources (HR)
	1.1 Salaries - program management
	1.2 Salaries - outreach workers, medical staff and other service providers
	1.3 Performance-based supplements, incentives
	1.4 Other HR Costs
Travel related costs (TRC)	2.0 Travel related costs (TRC)
	2.1 Training related per diems/transport/other costs
	2.2 Technical assistance-related per diems/transport/other costs
	2.3 Supervision/surveys/data collection related per diems/transport/other costs
	2.4 Meeting/Advocacy related per diems/transport/other costs
External Professional services (EPS)	3.0 External Professional services (EPS)
	3.1 Technical Assistance Fees/Consultants
Health Products - Equipment (HPE)	6.0 Health Products - Equipment (HPE)
	6.1 CD4 analyser/accessories
	6.2 HIV Viral Load analyser/accessories

	6.3 Microscopes
	6.4 TB Molecular Test equipment
	6.5 Maintenance and service costs for health equipment
	6.6 Other health equipment
Procurement and Supply-Chain Management costs (PSM)	7.0 Procurement and Supply-Chain Management Costs (PSM)
	7.5 Quality assurance and quality control costs (QA/QC)
Infrastructure (INF)	8.0 Infrastructure (INF)
	8.1 Furniture
	8.2 Renovation/construction
	8.3 Infrastructure maintenance and other INF costs
Non-health equipment (NHP)	9.0 Non-health equipment (NHP)
	9. 1IT - Computers, computer equipment, Software and applications
	9.2 Vehicles
	9.3 Other non-health equipment
	9.4 Maintenance and service costs non-health equipment

→ **3b. List of costs arising from disease modules and interventions, considered NOT relevant to healthcare systems** (source: *Tracking the Global Fund's Investments in Resilient and Sustainable Systems for Health, Global Fund, 2019*)

Cost Category	Cost Input
Travel related costs (TRC)	2.5 Other Transportation costs
External Professional services (EP	3.2 Fiscal/Fiduciary Agent fees
	3.3 External audit fees
	3.4 Other external professional services
	3.5 Insurance related costs (EPS)
Health Products - Pharmaceutical Products (HPPP)	4.0 Health Products - Pharmaceutical Products (HPPP)
	4.1 Antiretroviral medicines
	4.2 Anti-tuberculosis medicines
	4.3 Antimalarial medicines
	4.4 Opioid substitution medicines
	4.5 Opportunistic infections and STI medicines
	4.6 Private Sector subsidies for ACTs (co-payment to 4.3)
	4.7 Other medicines
Health Products - Non-Pharmaceuticals (HPNP)	5.0 Health Products - Non-Pharmaceuticals (HPNP)
	5.1 Insecticide-treated Nets (LLINs/ITNs)
	5.2 Condoms - Male
	5.3 Condoms - Female
	5.4 Rapid Diagnostic Test
	5.5 Insecticides
	5.6 Laboratory reagents

	5.7 Syringes and needles
	5.8 Other consumables
Procurement and Supply-Chain Management Costs (PSM)	7.1 Procurement agent and handling fees
	7.2 Freight and insurance costs (Health products)
	7.3 Warehouse and Storage Costs
	7.4 In-country distribution costs
	7.6 PSM Customs Clearance
	7.7 Other PSM costs
Communication Material and Publications (CMP)	10.0 Communication Material and Publications (CMP)
	10.1 Printed materials (forms, books, guidelines, brochure, leaflets...)
	10.2 Television/Radio spots and programmes
	10.3 Promotional Material (t-shirts, mugs, pins...) and other CMP costs
Program Administration costs (PA)	11.0 Program Administration costs (PA)
	11.1 Office related costs
	11.2 Unrecoverable taxes and duties
	11.3 Indirect cost recovery (ICR) - % based
	11.4 Other PA costs
Living support to client/ target population (LSCTP)	12.0 Living support to client/ target population (LSCTP)
	12.1 OVC Support (school fees, uniforms, books...)
	12.2 Food and care packages
	12.3 Cash incentives/transfer patients/beneficiaries/counsellors/mediators
	12.4 Micro-loans and micro-grants
	12.5 Other LSCTP costs
Payments for Results	13.0 Payment for Results

Appendix 4. Main list of indicators and follow-up measures of the work plan for Resilient and Sustainable Health Systems (RSHS)

→ **4a. Key indicators for Resilient and Sustainable Health Systems (RSHS)**
(see Global Fund modular framework, October 2019)

Module	Type d'indicateur	Code de l'indicateur	Description de l'indicateur	Catégorie(s) de ventilation
Indicateurs de résultats (tous les modules)	Résultats	HSS O-5	Pourcentage des établissements de santé disposant de médicaments traceurs pour les trois maladies le jour de la visite ou le jour du rapportage	
	Résultats	HSS O-6	Pourcentage d'établissements délivrant des services de diagnostic le jour de l'évaluation	
	Résultats	HSS O-7	Système de gestion de l'information sanitaire entièrement déployé et fonctionnel: Pourcentage de composants du SGIS en place (système d'information sanitaire déployé, complétude, promptitude et rapportage intégré des indicateurs aggrégés du VIH, de la tuberculose et du paludisme)	
	Résultats	HSS O-8	Agents de santé actifs pour 10,000 habitants	Groupe professionnel (médecins, infirmiers et sages-femmes, techniciens de laboratoire, pharmaciens et agents de santé communautaires)
	Résultats	HSS O-9	Pourcentage de femmes ayant eu une première consultation prénatale avant 12 semaines	Âge (10-14, 15-19 ans)
	Résultats	HSS O-10	Part de la population consacrant d'importantes dépenses du ménage dans la santé par rapport aux dépenses totales ou au revenu total du ménage (dépenses catastrophiques dans la santé)	
Systèmes de gestion des produits de santé	Couverture	PSM-3	Pourcentage des établissements de santé fournissant des services de diagnostic avec des éléments traceurs le jour de la visite ou du rapportage.	
	Couverture	PSM-4	Pourcentage des établissements de santé disposant de médicaments traceurs pour les trois maladies le jour de la visite ou du rapportage	
	Couverture	PSM-5	Pourcentage de lots expédiés livrés en intégralité et dans les délais par rapport au nombre total de lots expédiés devant être fournis pour les trois maladies pendant la période de rapportage	
	Couverture	PSM-6	Pourcentage de produits de santé pour les bons de commande confirmés avec les fournisseurs par rapport aux quantités prévues, pour les trois maladies pendant la période de rapportage.	

Module	Type d'indicateur	Code de l'indicateur	Description de l'indicateur	Catégorie(s) de ventilation
	Couverture	PSM-7	Pourcentage de lots de produits de santé pour les trois maladies ayant fait l'objet d'un test de la qualité, conformément à la politique d'assurance qualité du Fonds mondial	
Systèmes de gestion de l'information sanitaire	Couverture	M&E-2a	Complétude des rapports des établissements de santé: Pourcentage de rapports mensuels attendus des établissements (pour la période de rapportage) qui ont été réellement reçus	Type de rapport (rapports sur le VIH, sur la tuberculose, sur le paludisme, rapports intégrés)
	Couverture	M&E-2b	Promptitude des rapports des établissements de santé: Pourcentage de rapports mensuels remis par les établissements (pour la période d'établissement de rapport) reçus dans les délais, conformément aux directives nationales	Type de rapport (rapports sur le VIH, sur la tuberculose, sur le paludisme, rapports intégrés)
	Couverture	M&E-4	Pourcentage de rapports de prestation de services d'agents de santé communautaires intégrés dans le SGIS	
	Couverture	M&E-5	Pourcentage d'établissements de santé ayant enregistré et transmis des données à l'aide du système d'information électronique	
	Couverture	M&E-6	Pourcentage de districts ayant rédigé un ou des rapports analytiques périodiques selon le plan national et le format convenus, au cours de la période de rapportage	
Ressources humaines pour la santé, y compris agents de santé communautaires	Couverture	HRH-1	Taux de vacance: Nombre de postes à temps complet restés vacants pendant au moins 6 mois, en pourcentage du nombre total de postes financés	Groupe professionnel (médecins, infirmiers et sages-femmes, techniciens de laboratoire, pharmaciens et agents de santé communautaires)
	Couverture	HRH-2	Proportion d'étudiants diplômés d'un programme d'éducation et de formation des agents de santé par rapport au nombre d'étudiants inscrits en première année	Groupe professionnel (médecins, infirmiers et sages-femmes, techniciens de laboratoire, pharmaciens et agents de santé communautaires)
	Couverture	HRH-3	Proportion d'agents de santé communautaires qui ont bénéficié d'au moins une supervision formative au cours de la période de rapportage	
Prestation de services intégrés et amélioration de la qualité	Couverture	SD-3	Nombre de consultations ambulatoires par personne par an	
	Couverture	SD-4	Pourcentage d'établissements de santé dotés d'un comité de la santé en fonction (ou similaire) qui comprend des membres communautaires et se réunit au moins tous les trimestres	
	Couverture	SD-5	Pourcentage d'établissements de santé ayant bénéficié d'une supervision formative (au moins une fois par trimestre)	
	Couverture	SD-6	Nombre de conditions PEC-C traitées parmi les enfants de moins de cinq ans dans zones cibles au cours de la période de rapportage	Condition PEC-C (paludisme, pneumonie, diarrhée, malnutrition)

Module	Type d'indicateur	Code de l'indicateur	Description de l'indicateur	Catégorie(s) de ventilation
Systèmes de gestion financière	Couverture	FMS-1	Pourcentage de composants du système de gestion financière publique utilisés pour la gestion financière de la subvention	
Gouvernance et planification du secteur de la santé	Couverture	HSG-1	Pourcentage d'équipes de gestion de la santé dans les districts ou d'autres unités administratives qui ont élaboré un plan de suivi comprenant des objectifs de travail annuels et des mesures de résultats	
Renforcement des systèmes communautaires	Couverture	CSS-1	Pourcentage de rapports de suivi d'organisations basées dans la communauté présentés aux mécanismes de suivi pertinents	
	Couverture	CSS-2	Nombre d'organisations basées dans la communauté ayant reçu un paquet prédéfini de formation	
Systèmes de laboratoire	Couverture	LAB-1	Pourcentage de laboratoires nationaux de référence accrédités selon la norme ISO15189 ou ayant obtenu au moins quatre étoiles en vue de l'homologation	
Gestion du programme	Couverture	PM-1	Pourcentage d'exécution du budget des subventions (c.-à-d. taux d'absorption financière dans le pays)	
	Couverture	PM-2	Pourcentage d'utilisation des fonds décaissés (c.-à-d. taux d'utilisation des fonds décaissés dans le pays)	

→ **4b. Follow-up actions to the work plan for Resilient and Sustainable Systems for Health (RSSH)** (see Global Fund modular framework, October 2019).

Module	Mesures de suivi du plan de travail
Systèmes de gestion des produits de santé	1.Système d'information de la gestion logistique établi
	2.Évaluations des systèmes nationaux de régulation des produits médicaux réalisées
	3.Tests d'assurance qualité des produits pharmaceutiques réalisés
	4.Laboratoires de contrôle de la qualité des produits pharmaceutiques mis en place
	5. Infrastructure de niveau central et/ou périphérique mise à niveau (entrepôts, etc.)
	6. Délai d'approvisionnement administratif des achats effectués par l'intermédiaire des systèmes nationaux - pourcentage d'achats répondant aux demandes de l'appel d'offres/de la fourniture selon la référence de remise du bon de commande par rapport à l'ensemble des bons de commande.
	7. Achats à prix abordables effectués à travers les systèmes d'achats nationaux – Pourcentage de produits faisant partie d'un ensemble de produits défini achetés à un prix moyen pondéré (par subvention) égal ou inférieur au prix de référence du Mécanisme d'Achats Groupés (PPM) par rapport au nombre total de produits achetés durant la période de rapportage.
Ressources humaines pour la santé, y compris agents de santé communautaires	1. Plan et stratégie nationaux de ressources humaines pour la santé élaborés
	2. Programme et plan de formation nationaux de ressources humaines pour la santé élaborés
	3. Nombre de personnes formées (formation continue)
	4.Système national d'information sur les ressources humaines pour la santé développé et déployé
	5. Évaluation du marché du travail de la santé réalisée
Gouvernance et planification du secteur de la santé	1. Plan/stratégie/politique du secteur de la santé élaborés
	2. Plans annuels sectoriels liés aux plans stratégiques nationaux élaborés
	3. Nombre de plans conjoints et de réunions de revues du Ministère de la santé avec les programmes nationaux de lutte contre les maladies en vue d'améliorer la coordination entre les programmes
	4. Nombre de mesures prises par le Ministère de la santé avec des partenaires internes et externes, au cours de la période d'établissement de rapport, sur l'harmonisation des objectifs, le budget et/ou les plans opérationnels pour les programmes nationaux de lutte contre les maladies (les initiatives doivent être convenues au moment de l'octroi de la subvention et doivent mesurer les progrès attendus dans la garantie de la coordination entre les programmes et l'efficacité de la mise en œuvre des programmes)
	5. Cadre régissant le secteur privé à but lucratif développé/mis à jour
	6. Stratégie de santé numérique ou e-santé nationale et plan de mise en œuvre chiffré élaborés
	7. Nombre d'organisations de la société civile ayant bénéficié de ressources publiques nationales pour soutenir les programmes communautaires en faveur des populations clés dans le cadre de la riposte nationale

Module	Mesures de suivi du plan de travail
Systèmes de laboratoire	1. Plans stratégiques et politiques des laboratoires nationaux élaborés/mis à jour
	2. Réseau intégré de transport d'échantillons pour toutes les maladies développés
	3. Normes et systèmes nationaux de laboratoire de qualité pour l'octroi de licence aux laboratoires publics/privés établis
	4. Normes/directives nationales pour la gestion des déchets, la biosûreté, la biosécurité et les procédures opérationnelles normalisées élaborées
	5. Services de laboratoire intégrés dans les établissements mis à niveau/déployés
Prestation de services intégrés et amélioration de la qualité	1. Nombre d'établissements rénovés/mis à niveau/équipés
	2. Système de référence entre les établissements de santé et la communauté mis en place
	3. Pourcentage d'établissements de santé ayant réalisés des sessions de sensibilisation intégrées
Renforcement des systèmes communautaires	1. Plateformes et mécanismes nationaux de soutien à la coordination, à la planification et à l'engagement communautaires dans les processus nationaux mis en place/renforcés
	2. Stratégies de plaidoyer/notes d'informations communautaires développées par les populations clés et vulnérables en vue de fournir des informations aux stratégies, plans et aux directives nationales
	3. Engagement et représentation des communautés au sein des instances, processus et organes de décision nationaux
	4. Stratégies nationales (plans stratégiques nationaux, stratégies de santé communautaires, feuilles de route de la prévention, programmes en lien avec les adolescentes et jeunes femmes) disponibles, exposant les rôles des communautés (y compris la prestation de services différenciés, la gouvernance de la santé, le suivi et le plaidoyer)
	5. Capacité des organisations communautaires renforcée/améliorée
	6. Analyse de rentabilité élaborée sur la pérennité des services communautaires en faveur des populations clés et vulnérables
Systèmes d'information de gestion de santé et suivi et évaluation	1. Revues/évaluations/enquêtes/études de programmes réalisés
	2. Stratégie de systèmes d'information de santé nationale et plan de mise en œuvre budgetisé élaborés
	3. Proportion de réunions revues trimestrielles ou semestrielles organisées dans les districts au cours de la période de rapportage
	4. Développement et diffusion de procédures opérationnelles standards pour l'utilisation des données au niveau national et sous-national
	5. Formation du personnel des établissements de santé, du district et régional/provincial aux procédures opérationnelles standards pour l'utilisation des données
	6. Liste de référence géocodée des infrastructures élaborée/mise à jour
	7. Liste de référence géocodée des agents de santé communautaires élaborée/mise à jour

Appendix 5. List of Global Fund stand-alone grants in Africa (before NFM3)

Region	Country	Grant Name	Status	Principal Recipient
West and Central Africa	Benin	HSS GRANT FOR BENIN	In Closure	Health System Performance Program
	Benin	To improve access and quality of health care in Benin, through a more integrated, effective, and resilient health system	Active	Conseil National de Lutte contre le VIH/SIDA, la Tuberculose, le Malaria, Hepatitis, Sexually Transmitted Infections and Epidemics
	Burkina Faso	Strengthening health systems and scaling-up of integrated community case management interventions	Administratively Closed	Programme d'Appui au Développement Sanitaire du Burkina Faso
	Congo (Democratic Republic)	Contribute to improving the health information system and availability and quality of care in selected health zones	In Closure	Ministry of Health and Population of the Democratic Republic of Congo
	Guinea-Bissau	Guinea-Bissau - RSSH - Ministry of Health of the Republic of Guinea-Bissau	Administratively Closed	Ministry of Health of the Republic of Guinea-Bissau
	Niger	Niger - RSSH - Save the Children Federation, Inc.	Terminated	Save the Children Federation, Inc.
	Nigeria	Nigeria - RSSH - National Agency for the Control of AIDS	Administratively Closed	National Agency for the Control of AIDS
	Nigeria	Strengthening Health Management Information Systems, Laboratory Network and Procurement and Supply Chain Management Systems in Nigeria	Active	Management Sciences for Health
	Senegal	Sustainably improve the health of the Senegalese populations through health systems strengthening	In Closure	Ministry of Health and Social Action of the Republic of Senegal
Africa (other)	Eswatini	Eswatini - RSSH - National Emergency Response Council on HIV and AIDS	Administratively Closed	National Emergency Response Council on HIV and AIDS
	Ethiopia	Ethiopia - RSSH - Federal Ministry of Health of the Federal Democratic Republic of Ethiopia	Administratively Closed	Federal Ministry of Health of the Federal Democratic Republic of Ethiopia
	Ethiopia	Strengthening Health Systems capacity to provide equitable, effective and efficient package of comprehensive and quality health services to Ethiopian people	Active	Federal Ministry of Health of the Federal Democratic Republic of Ethiopia
	Malawi	Malawi - RSSH - Ministry of Health of the Republic of Malawi	Administratively Closed	Ministry of Health of the Republic of Malawi
	Morocco	Morocco - RSSH - Ministry of Health of the Kingdom of Morocco	In Closure	Ministry of Health of the Kingdom of Morocco
	Mozambique	Strengthening Health Systems and Communities through Government-Civil society Partnerships	In Closure	Ministry of Health of Mozambique
	Rwanda	Rwanda - RSSH - Ministry of Health of the Republic of Rwanda	Administratively Closed	Ministry of Health of the Republic of Rwanda
	South Sudan	Strengthening Health System in Southern Sudan	Administratively Closed	United Nations Development Programme
	Sudan	Ministry of Finance, Government of the Republic of	In Closure	Federal Ministry of Health of the Republic of Sudan
	Tanzania (United Republic) Uganda	Sudan Enhance HIV prevention services in Tanzania	Administratively Closed	Ministry of Finance and Planning of the United Republic of Tanzania
		Uganda - RSSH - The AIDS Support Organisation (Uganda) Limited	Administratively Closed	The AIDS Support Organisation (Uganda) Limited
	Uganda	Uganda - RSSH - Ministry of Finance, Planning and Economic Development of the Republic of Uganda	Administratively Closed	Ministry of Finance, Planning and Economic Development of the Republic of Uganda
	Uganda	Strengthening the health and community systems for quality, equitable and timely service delivery	Administratively Closed	Ministry of Finance, Planning and Economic Development of the Republic of Uganda
	Uganda	Strengthening the health and community systems for quality, equitable and timely service delivery	Administratively Closed	The AIDS Support Organisation (Uganda) Limited
	Pakistan	Pakistan - RSSH - Ministry of National Health Services, Regulations and Coordination of Pakistan	In Closure	Ministry of National Health Services, Regulations and Coordination of Pakistan
	Zimbabwe	Health Systems Strengthening Cross-Cutting Interventions	Administratively Closed	United Nations Development Programme

*Source: https://data.theglobalfund.org/investments/home (consulted in February 2020)