

Technical Evaluation Reference Group: Position Paper - Thematic Review on Resilient and Sustainable Systems for Health (RSSH)

July 2019

Context

1. With the introduction of the New Funding Model (NFM)¹ in 2014, the Global Fund decided to strategically prioritize its approach to strengthening health and community systems by developing new guidance with optimized scope of investments, primarily based on an analysis of system-related programmatic risks and bottlenecks for HIV, TB and malaria. Thereafter, the importance of resilient and sustainable systems for health (RSSH) was elevated to a Strategic Objective level (SO2) in the 2017-22 Global Fund Strategy, which stated: *“Building resilient and sustainable systems for health is crucial to ensuring that people have access to effective, efficient, and accessible services through well-functioning and responsive health and community systems. The existence of strong systems for health is essential to making progress against HIV, TB and malaria, and to ensuring that countries can address the varied health challenges they face from reproductive, men’s, women’s, children’s, and adolescent health, to global health security threats, to non-communicable diseases”*².
2. At the request of the Strategy Committee (SC) of the Global Fund’s Board, the Technical Evaluation Reference Group (TERG) conducted in 2018 the Thematic Review to Assess the Current Approach to Investments in Resilient and Sustainable Systems For Health (the review) in close coordination with the Technical Review Panel (TRP), Office of the Inspector General (OIG) and the Secretariat to generate evidence on the implementation, successes and challenges related to RSSH investments.

Questions this paper addresses

3. The paper provides the TERG’s position and opinions regarding the findings and recommendations from the review that have the most strategic and operational relevance for the Global Fund. The purpose is to inform future SC decisions and the work of the Secretariat, partners and countries, while drawing attention to the trade-offs that need to be considered when investing in RSSH. The paper is intended to help further advance the design, implementation and impact of RSSH investments generally and particularly in preparation for the 2020-2022 allocation cycle.

Conclusions and recommendations

4. The TERG generally agrees with the findings of the review and recommends several interlinked actions. These build on the seven strengthening actions that were jointly identified by the TRP, TERG and Secretariat, and agreed with the Strategy Committee in October 2018. The TERG recognizes the complementarity between the Global Fund strategic objectives and the inherent trade-offs between these when deciding on RSSH investments. The TERG is of the opinion that the following actions will help increase effectiveness and impact of RSSH investments.
5. First, there is a need for the Global Fund to initiate a process to clarify the scope and expectations of its investments in RSSH and how it: (a) supports disease control objectives of the Global Fund across the development continuum, in the short and long-term; (b) boosts health system resiliency and sustainability; and (c) contributes to supporting Universal Health Coverage (UHC) objectives. This process will: (i) help clarify the importance of both short term “health system support” and longer term “health system strengthening”; (ii) inform the measurement parameters for RSSH investment inputs and outcomes; (iii) assist in advancing the development of a prioritization and differentiation framework that can guide decision-making on RSSH, in line with national health sector strategic plans; and (iv) help clarify upfront guidance for countries and inform Global Fund application, review and

¹ For list of abbreviations, please refer to Annex 6

² GF/B35/DP04: *The Global Fund Strategy 2017-2022: Investing to End Epidemics*.

https://www.theglobalfund.org/media/2531/core_globalfundstrategy2017-2022_strategy_en.pdf

implementation processes to better reflect RSSH priorities and requirements in the grants. This in turn will help streamline the end-to-end application, review, implementation, and M&E of RSSH investments during the grant cycle. Secondly, the above-mentioned activities and recommendations should be reinforced at country level with improved RSSH–relevant representation and CCM engagement in building RSSH, alongside engagement/linkage of the CCM, National Programs and PRs with other health sector planning and coordination structures relevant to RSSH, including standard government planning processes as well as other donor platforms (such as those employed by Gavi and GFF). The Secretariat should continue exploring opportunities for greater engagement with development partners for coordination around community and health systems strengthening, including potential "quick-wins" with Gavi, consideration of a joint HSS technical assistance hub among key funders, and support to countries in coordinating donor investments (e.g. through capacity building).

Input Received

6. In preparation for this review, the TERG solicited the SC's and the Secretariat's input to shape the Terms of Reference (ToR) for the assignment; coordinated the review focus and processes with the TRP and OIG work on RSSH and with the TERG's Prospective Country Evaluations (PCEs). In October 2018, the TERG presented preliminary findings; and presented findings and solicited inputs from the Secretariat staff and partners during consultative workshops organized in January and February 2019.

Report

Objectives

7. To assess the Global Fund's progress on its **Strategic Objective 2 (SO2) – Build Resilient and Sustainable Systems for Health (RSSH)**, the Strategy Committee requested the TERG to undertake an in-depth review of the Global Fund's investments in RSSH since 2014. The aims of the review were to: (i) assess implementation of the RSSH investment framework at the country level; (ii) review how RSSH investments ensure/facilitate complementarity of domestic and other donor efforts, and identify gaps, overlaps and missed opportunities in order to achieve sustainable impact; (iii) review country and partner perceptions on the effectiveness of RSSH investments; and (iv) provide recommendations to enhance the effectiveness of RSSH investments in countries.

8. The TERG's position reflected in this paper is primarily based on the thematic review of RSSH³ commissioned by TERG and conducted in 2018 by Cambridge Economic Policy Associates (CEPA) (the 'Reviewers'), and is supplemented by the findings of the PCEs from eight countries⁴, the TRP's review of RSSH investments⁵ and the OIG's audit⁶.

Review Methodology

9. To meet the review objectives, the review framework was structured as four interrelated areas of: (i) strategy and design; (ii) policies, processes and tools; (iii) investment areas; and (iv) partnerships. The review focused on five out of seven of the RSSH investment areas of SO2 namely: Community Systems and Responses (CSR), Human Resources for Health (HRH),

³ Please refer to Annex 5 for full text of the review.

⁴ Using PCEs the TERG is taking a close look at the implementation, effectiveness and impact of Global Fund-supported programs in selected countries namely: Cambodia, the Democratic Republic of the Congo (DRC), Guatemala, Mozambique, Myanmar, Senegal, Sudan and Uganda

⁵ TRP Report on RSSH Investments in the 2017-2019 Funding Cycle.

https://www.theglobalfund.org/media/8093/trp_rssh2017-2019fundingcycle_report_en.pdf?u=636794383790000000

⁶ Global Fund management of investments in Resilient and Sustainable Systems for Health. Audit Report. (Office of Inspector General, Global Fund, Forthcoming) <https://www.theglobalfund.org/en/oig/reports/>

Integrated Service Delivery (ISD), data systems and national health strategies. The other two, Procurement and Supply Chain Management (PSCM) and Financial Management were covered by the OIG's audit.

10. The review considered RSSH funding over the 2014–16 and 2017–19 allocation cycles,⁷ i.e. New Funding Model (NFM) 1 and 2 and included a review of relevant documents⁸ and databases, including the Global Fund RSSH portfolio database, stakeholder interviews⁹ and country case studies. Eleven countries were studied, of which there were six country visits: Ethiopia, Georgia, Ghana, India, Tanzania and Zambia; and five desk reviews: Cote d'Ivoire, Sierra Leone, South Africa, Sudan and Vietnam¹⁰. The countries covered a wide range of Global Fund country portfolios, grant amounts invested in RSSH, varying RSSH grant structures and investment foci, and wide-ranging country contexts.

Limitations of the review

11. The review report identified several limitations, including those summarized here. First, the review was made complex by diverging interpretations and understanding of RSSH and HSS within Global Fund and amongst external global and country-level partners.

12. Secondly, RSSH investments are difficult to track within country grants, especially when these are embedded in disease grants. Comparisons of RSSH investment categories across multiple country documents pose challenges due to lack of clear conventions for classifying expenditure categories and limited knowledge of the specifics of RSSH funding amongst stakeholders, especially for the 2014–16 allocation period. This has particularly affected the desk-based country studies and to a degree limited the robustness of RSSH investment quantification, which exposes findings to open interpretation.

Thematic Review findings

13. RSSH has gained in strategic importance in the Global Fund and is reflected in countries' investment choices. Investments in RSSH under both NFM periods were significant and amounted to US\$ 5.8 billion to date, or 27% of the total Global Fund investment of US\$ 21.4 billion. This figure includes both US\$2.4 billion for “direct RSSH” (stand-alone grants or crosscutting RSSH/ HSS modules within disease grants) and a further US\$3.4 billion as “contributory RSSH” (disease-specific investments that are also considered to provide benefits to health systems) over the two allocation periods. Figure 1 shows the investments across functional areas, revealing four priority investment foci: HRH, HMIS-

⁷ The periods between NFM1 and NFM2 are different.

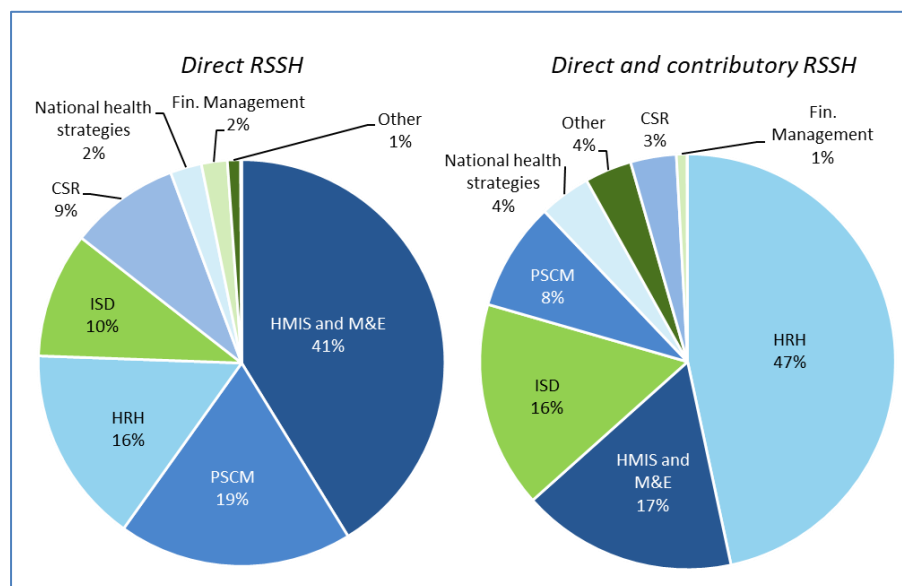
⁸ Documentation on Global Fund and RSSH (e.g. 2017-22 Strategy, RSSH Investment Framework, RSSH guidelines, previous evaluations, etc.), country documentation (concept notes/ funding requests, budgets and work plans, TRP and the Grant Approval Committee (GAC) review forms, national health and disease plans, etc.), partner documentation (e.g. from the World Health Organization (WHO), Universal Health Coverage 2030 (UHC2030), other donors), and the broader literature (e.g. Lancet articles).

⁹ In-depth interviews with the Secretariat, TERG and TRP members, and partners (July – October 2018, in-person and by phone), and a second round of interviews with the Secretariat to discuss emerging findings and conclusions (November 2018, in-person). Secretariat meetings were conducted with the Secretariat staff including RSSH and CSS team members, Country Teams (CTs) and monitoring and evaluation (M&E) officers. Partner consultees included WHO, the United States (US) government, the World Bank Group (World Bank), Gavi the Vaccine Alliance (Gavi) and the Bill and Melinda Gates Foundation (BMGF). (Many of whom are members of the Global Fund Board and Strategy Committee).

¹⁰ The selected countries are “covering the range of Global Fund country classifications, mostly large funding amounts but with a few countries with smaller RSSH grants, varying RSSH grant structures and investment foci and wide-ranging country contexts, and thereby providing a robust evidence base for this review” (TERG, “Technical Evaluation Reference Group (TERG) Thematic Review To Assess The Current Approach To Investments In Resilient And Sustainable Systems For Health (RSSH). Final Report”. 13 February 2019, p.4 (Annex 5).

M&E, ISD and PSCM absorbing about 88% of both “direct” and “contributory” RSSH investments, with HRH absorbing almost half of the investments.

Figure 1: Share of investment areas showing “Direct RSSH” and “Direct and Contributory RSSH” across the two allocation periods 2014–2016 and 2017–2019



14. How RSSH investments are intended to support achievement of disease outcomes and strengthen health systems is not clear to many stakeholders among the countries studied. The review attributed this, in part, to the absence of an articulated theory of change. The broad and unclear definition and lack of commonly agreed scope of RSSH leads to considerable diversity in understanding and interpretation of RSSH across the Secretariat and wider stakeholders. Importantly, this creates several “operational tensions” such as whether to focus investments on: (i) disease control priorities versus crosscutting health system issues; (ii) short-term rather than long-term RSSH gains; (iii) narrow versus broad-based funding across RSSH investment areas; and (iv) disease-specific versus integrated service delivery (ISD) models. Each of these decisions involve trade-offs with legitimate arguments on both sides. At the least, it is essential to ensure that overall Global Fund investments “do no harm” to the health systems in the countries. Ambiguity around the expectations of RSSH investments creates uncertainty and inefficiencies in the operational model and processes, and presents particular challenges for RSSH implementation and performance tracking. A process that clarifies the scope and expectations of Global Fund investments in RSSH could help align stakeholders around RSSH and reduce ambiguity around the purpose of Global Fund RSSH investments.

15. The Global Fund’s commitment to differentiation of RSSH investments across the development continuum is appropriate and should be further pursued. One of the strategic enablers for the 2017–22 Strategy is to “innovate and differentiate along the development continuum”.¹¹ The review noted that there is a need for more differentiation of RSSH investments according to the country context and maturity of the health system. The

¹¹ The Strategy outlines differentiation by a number of factors including disease burden and income level, but also “epidemiological and other socio-political contextual factors, financing gaps, fiscal space, absorptive capacity, risk and where and how the Global Fund, with partners, can have the most catalytic impact.” The Strategy also notes that differentiation in terms of team structures and processes for engagement with countries will be applied, based on factors such as size of portfolio and estimated risk associated with investments. <https://www.theglobalfund.org/en/strategy/>

recent TRP review of RSSH investments¹² reached a similar conclusion. The review found some good country-driven differentiation examples (such as Zambia and Ethiopia) and evidence at the global RSSH portfolio level of the effective differentiation in practice, with Focused and Core countries generally demanding a greater proportion of RSSH funding compared to High Impact countries. High Impact and Core countries also allocated more funding for HRH and PSCM, while Focused countries have generally requested more support for Community Systems and Responses (CSR). The noted examples of bottom-up differentiation are a positive development; however, without more guidance, achieving similar results across the Global Fund portfolio may not be possible. The review drew attention to the difference between “health systems support” and “health systems strengthening” associating the latter with UHC and successful transition.¹³ The recent TRP analysis classed two thirds of RSSH investments as systems support, rather than sustainable system strengthening. With the notion of differentiation across the development continuum in mind, the TERG views both system support and system strengthening as critical investments, depending on the context. In many countries without supporting health systems, usually in human resources, delivery of services for the three diseases would be severely hampered, particularly, but not only, in complex operating environments.

16. Global Fund guidance to countries on RSSH investments is not effectively used. The review found that the guidance provided to countries on RSSH was often not used in the preparation of grants. One reason identified by the review was that some stakeholders found the guidance complex and ambiguous. This may, in part, explain why the majority of Global Fund RSSH investments remain focused on short-term systems support for the three diseases, while longer-term investments to ensure resilience and sustainability of the health systems are given less priority. These findings are corroborated by reports from several PCE countries where RSSH resources are used as a stopgap measure to address short-term issues. RSSH investments are largely disease focused, short-term and do not significantly enhance health systems resilience and/or lead to sustainability.

17. There is a need to ensure strengthening the capacity of RSSH representation on the CCMs in order to avoid adverse effect on the content of RSSH investments and their coordination with broader HSS planning. The review concluded the lack of specific RSSH allocation does not particularly inhibit country RSSH funding. Similarly, it found that lack of expertise in RSSH on the CCM was not a critical factor in the prioritization of RSSH. Countries are strongly guided by the suggested level of funding in the allocation letters. The basis for decision making on RSSH funding varies substantially by country and the review found it to be mostly ad hoc. However, the review identified the broader issue of whether the CCM is able to effectively engage in wider discussions with other in-country coordination structures with responsibility for health systems and for RSSH investment planning. CCMs may not always have the capacity to engage in a crosscutting RSSH discussion and prioritization, which probably negatively affects the effectiveness of the Global Fund's RSSH investments.

18. The embedding of RSSH investments within disease grants has contributed to them being more disease-focused than crosscutting. Countries have a choice to request funding for stand-alone RSSH grants; however, the review showed that not many countries use this option. The review reported that Secretariat country teams might dissuade countries from this grant structure because of historically low absorption rates of RSSH grants (and hence low grant performance ratings) as well as greater management demands. In addition, the disease programmes may not be best placed to implement/manage broader health systems strengthening interventions. Under NFM 2, there have been some positive cases of embedded RSSH grants with separate implementation by a centralized or crosscutting

¹² TRP Report on RSSH Investments in 2017-2019 Funding Cycle.

https://www.theglobalfund.org/media/8093/trp_rssh2017-2019fundingcycle_report_en.pdf?u=636794383790000000

¹³ Also argued in the WHO paper on UHC as “getting more health for the money”. WHO. (2013). Arguing for Universal Health Coverage. <https://apps.who.int/iris/handle/10665/204355>

health systems department (e.g. Ghana, Tanzania). The potential of RSSH grants (whether stand-alone or crosscutting but embedded in disease grants) could be enhanced by such an approach, based on country-specific circumstances.

19. The funding request and grant making processes may hinder optimal RSSH investments. In an effort to enhance country ownership and flexibility, integrate/align disease and RSSH applications and reduce transaction costs, the Global Fund has tried to reduce specific requirements for RSSH during the funding request stage. While there are benefits to such a somewhat open-ended approach, without adequate guidance, countries are employing ad hoc approaches to determining RSSH funding. In contrast to the disease areas, there are no standardized packages or guidance from normative agencies. The Secretariat country teams can play a strong role in steering RSSH funding priorities. RSSH funding is often substantially revised during grant making, which may be both inefficient and detrimental to its effectiveness. In funding requests, there is often limited RSSH-specific information provided to guide effective TRP and GAC review and grant making. This raises questions linked to better overall guidance concerning the appropriate balance between country ownership and stronger guidance of the RSSH investments and revision/reduction of RSSH investments during grant making.

20. Tracking of the contribution of RSSH investment to disease control efforts should be improved. The Global Fund's M&E for RSSH comprise three main aspects: (i) Strategy level key performance indicators (KPIs) – of which there are two specific to RSSH; (ii) implementation KPIs that include grant level service delivery performance (based on indicators in the grant performance framework); and (iii) the tracking of specific inputs and outputs. In general, there is a challenge in tracking RSSH investments (also noted by the TRP review and PCEs). Most are embedded in disease grants, and identification of specific RSSH funding can be difficult, as well as differentiation between what is “direct” RSSH funding and what is “contributory”. Various other factors make analysis of RSSH investments complex, for example, variability across countries in how RSSH investments are recorded. Measurement of results requires uniform definitions of what constitutes RSSH funding in the disease grants and expected RSSH related outcomes. Grant-level input and activity tracking, along with disease-specific indicators on intervention coverage and outcomes, do not adequately reflect the results achieved for the three diseases by RSSH investments. There is a need for more qualitative measurement as there are insufficient outcome metrics defined by technical partners on long-term effectiveness, sustainability or resilience of health systems.

21. Two RSSH investment areas require better definition and design: Community Systems and Responses (CSR) and Integrated Service Delivery (ISD). The Global Fund Strategy 2017–22 prioritizes CSR and ISD as components of SO2.

The review found that there is a lack of clarity and understanding among global and country level stakeholders on the aims and scope of CSR. Funding requests tend to be limited in scope and scale, and the dominant focus on community health workers (CHWs) obscures the invaluable contribution of broader community-led responses. Although CSR is core to the resilience concept within RSSH, grants have not been implemented with this approach in mind. CSR is under-invested, often with no investment in many grants, furthermore CSR programmes are often not effectively designed, or implemented, with a sustainability focus.

The ISD sub-objective of the Strategy refers to integrated service delivery for the continuum of care across Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH). The review found that while the Secretariat considers that the Strategy clearly sets out the need for integration, most stakeholders interviewed questioned the approach, and stated that there were challenges with its operationalization. Some stakeholders considered it limited in comparison to a broader in – country integration agenda. WHO defines integrated health services differently than the Global Fund.¹⁴ While efforts have been made to align the support of the Global Fund with the more recent WHO Framework on Integrated People-centered

¹⁴ WHO. (2016) Framework on Integrated people-centered health services. Report by the Secretariat.

Health Services, the review considered that the four areas that are highlighted in the RSSH Investment Framework are not aligned adequately with the WHO framework. The review concluded that a more holistic and broad-based approach to integration across Global Fund investments is needed, including strengthened planning, coordination, and collaboration between communities and formal health systems for the co-production of health.

22. Technical Assistance (TA) for RSSH is not well understood nor well coordinated among partners. The review found that RSSH TA per se has little meaning to stakeholders. Only a few Secretariat members and stakeholders were able to specifically identify RSSH TA examples. Health systems strengthening, or HSS, TA is slightly better understood. The Global Fund estimates that close to 70% of TA needs during grant implementation are systems-related and not disease-specific (e.g. covering issues of supply chain management or M&E). The review found it challenging to engage in a discussion with stakeholders on the systems aspects of this TA and how countries access and utilize it. The review noted that while general improvements in coordination of financing and TA among partners have been made over time this varies by country and area of investment. Government stewardship of donor funding was identified as a key enabling factor for supporting effective coordination. Key bottlenecks include donors using multiple in-country platforms/stakeholders for planning or designing HSS interventions, a lack of an overarching country strategy for coordination, and poor efficacy of some partners in country.

Recommendations

23. The TERG's recommendations arising from the review build on the seven strengthening actions that were jointly identified by the TRP, TERG and Secretariat, and agreed with the Strategy Committee in October 2018. These are as follows: (1) Strengthen differentiation and prioritization of RSSH investments along the development continuum; (2) Prioritization should be based on careful assessment of what is most critical to achieve particular service delivery outcomes for the three diseases, rather than on input categories alone; (3) Strengthen operationalization and implementation of existing investment guidance; (4) More proactively advance integration in a cross-cutting and holistic manner; (5) Strengthen RSSH capacity and voice in the country dialogue process; (6) Improve measurement of the outcomes of RSSH investments; and (7) Continue to deepen collaboration with Gavi and other partners.

24. The TERG's recommendations are organized in three broad categories: (A) strategic recommendations to be considered by the SC and the Board; (B) operational recommendations to be acted upon primarily by the Secretariat but also by partners and countries and (C) recommendations for selected RSSH investment area to be acted on by the Secretariat in close cooperation and coordination with technical partners and countries.

25. TERG recommends the Strategy Committee to request that the Secretariat considers and acts upon TERG's recommendations outlined in this document as it prepares for the deployment of 2019–2021 allocations.

(A). Strategic Recommendations

26. The Global Fund should consider initiating a process that clarifies the scope and expectations of its investments in RSSH for the next strategy period. Meeting the multiple demands of the Global Fund's Strategy, with finite resources, implies many complex trade-offs. Given that the needs for investment will always outstrip the availability of funding, it is important for the Board to be clear about its expectations with respect to RSSH and that these are aligned with the available allocations to countries. Investment in RSSH should be driven by what is most critical to achieve disease outcomes rather than spread across multiple boxes under which funding can be categorized as RSSH.

27. In the context of the SDGs and the growing commitment to UHC aspirations, it is important for the Global Fund to clearly articulate how its RSSH investments can be used

for: (a) supporting disease control objectives across the development continuum, in the short and long-term; (b) boosting health system resiliency and sustainability; and (c) contributing to UHC objectives through both short term “health system support” and longer term “health system strengthening” interventions. This process will: (i) help clarify the importance of both short term “health system support” and longer term “health system strengthening”; (ii) inform the measurement parameters for RSSH investment inputs and outcomes; (iii) assist in advancing the development of a prioritization and differentiation framework that can guide decision-making on RSSH, in line with national health sector strategic plans; and (iv) help clarify upfront guidance for countries and inform Global Fund application, review and implementation processes to better reflect RSSH priorities and requirements in the grants. Once agreed, a documentation of these strategic issues should be widely shared and communicated with both internal and external audiences to promote a uniform understanding, ownership and application of the Global Fund’s RSSH approach.

(B). Operational Recommendations

The TERG recommends that the Secretariat:

28. Develop a prioritization and differentiation framework to guide decision-making on RSSH and translate the framework into clear upfront guidance for countries at different points on the development continuum. The framework could marry assessment of the health system maturity (e.g. as per the TRP 4S framework) with the Global Fund’s current differentiation approach based on High-impact, Core and Focused countries. It will be important to link these documents to the end-to-end application, review, and implementation cycle described below.

29. Revisit and improve the overall guidance on RSSH, with greater definition/prescription, and a focus on encouraging its active use. The guidance should distinguish between: (i) investment planning guidance for countries; (ii) operational guidance for the Secretariat (Country Teams); (iii) an information note explaining the Global Fund’s RSSH approach to external stakeholders and partners. Different ways to facilitate the compliance and use of guidance by countries and Global Fund Country Teams should be considered.

30. Consider revising standard Global Fund application, review and implementation processes to better reflect RSSH priorities and requirements. Revise the application form to better reflect the suggested prioritization and differentiation framework and to include complementary information to further guide an effective TRP review—such as from previous applications, applications to Gavi, GFF, and information from the RSSH Dashboard. Provide incentives for countries to effectively manage the sequencing of their RSSH funding requests and ensure that funding for RSSH is not de-prioritized during the grant making process. Revise the program continuation approach to factor in RSSH continuity aspects alongside the existing disease-focused criteria.

31. Consider using the RSSH Strategic Initiative to advance RSSH M&E and address its shortcoming by enabling country systems to collect and improve documentation on RSSH investments allowing for better tracking of RSSH funded interventions and their progress over time. Consider an appropriate balance of enhanced work plan tracking measures and health systems and disease related coverage/outcome measures included in the Modular template that would allow for a more relevant assessment of the funded interventions. This requires clearer guidance on what constitutes RSSH, expected outcomes of RSSH investments and related budget line items especially in the area of “contributory RSSH” and how this is differentiated from direct disease funding. Give further emphasis to small/medium scale qualitative studies and relevant thematic reviews. Revisit the scope and operational guidance of the work planning tracking measures to focus on key outputs linked to grant support.

32. Reinforce support through funding and review processes for integrated program design, funding requests and implementation across HIV, TB and malaria

programs and also other platforms in close collaboration and coordination with the global and country partners. Integrated service delivery should be better defined to overcome the current confusion and lack of consensus. Integration should not be framed as a specific RSSH investment area, but an overarching approach integrating systems and not only services. The Global Fund should more proactively use its investments in data, supply chain, service delivery, communities and other areas to advance integration. This should be complemented by increased accountability for integration through more granular, sensitive and relevant indicators of integration.

33. Strive to strengthen the RSSH capacity and voice in country dialogue processes. Improve RSSH-related representation and CCM engagement, along with encouragement of linkages of the CCM, National disease programs and PRs with other health sector planning and coordination structures including standard government planning processes as well as other donor platforms (such as those employed by Gavi or GFF).

34. Continue to explore opportunities for greater development partner coordination for HSS and CSS. Consideration should be given to a joint hub for HSS investments and TA between key funders and support for countries in coordinating donor investments (e.g. through capacity building). The Global Fund's increasing collaboration with Gavi should seek opportunities for joint support for HSS initiatives globally or in specific countries.

(C). Recommendations for selected RSSH Investment Area

The TERG recommends that the Secretariat, in close collaboration and coordination with the technical partners and countries, consider a number of specific recommendations to enhance the effectiveness of specific RSSH investment areas.

35. Community Systems and Responses (CSR): The range of community system and response interventions should be more clearly articulated, with community systems strengthening being prioritized to support community-led and community-based organizations. Community-based monitoring should be scaled up and community data systems strengthened and linked to the national data systems, in order to improve access and quality of services. More flexible funding channels to support a range of CSR efforts should be explored beyond the PR-SR model, for example multi-year service agreements for smaller CBOs (including key population CBOs), with less burdensome reporting requirements. CSR should be seen as part of the main disease control or RSSH effort and conceptualized, planned and programmed as such.

36. Human Resources for Health (HRH) investments should, where possible, have a larger focus on sustainability and be linked to country plans incorporating a longer-term view. The current HRH investment planning, which is largely through salary support, should include a plan to graduate to a more strategic focus and follow general principles for funding: (i) invest according to the country's HRH labor market and national salary scales; and (ii) invest more sustainably with a clear plan for transition into country absorption; (iii) consider integrated service delivery specially at PHC level. There is also a need for more coordinated work on HRH-related policy and guidance to support countries and the related programs.

37. Data Systems: Investments should be strengthened through enhanced partner engagement, improved partner coordination, an emphasis on capacity building around data analysis and use, the promotion of data integration into national health data systems (e.g. from private sector and community) and through the adoption of a longer-term view in particular to data digitization.

Annexes

The following annexes are included herewith:

- Annex 1: Relevant Past Decisions
- Annex 2: Links to Relevant Past Documents & Reference Materials
- Annex 3: TERG Thematic Review on RSSH
- Annex 4: List of Abbreviations

Annex 1 – Relevant Past Decisions

Relevant Past Decision Point	Summary and Impact
GF/B35/DP04: The Global Fund Strategy 2017-2022: Investing to End Epidemics (April 2016) ¹⁵	Through this decision point, the Board approved the Global Fund Strategy 2017-2022. Strategic Objective 2 focuses on building resilient and sustainable systems for health.
GF/B22/DP4: Implementing the New Grant Architecture for Health Systems Strengthening Activities (December 2010) ¹⁶	The decisions allowed submission of stand-alone crosscutting HSS proposals in addition to proposals for the three diseases.
GF/B16/DP10: Strategic Approach to Health Systems Strengthening (November 2007) ¹⁷	<p>The decision allowed 'broad flexibility regarding HSS actions eligible for funding' and requested the Secretariat to develop 'guidance with few prescriptions' for HSS funding.</p> <p>The decision allowed applicants to request funding for 'cross-cutting HSS' that could be attached to a disease application.</p>

Annex 2 – Links to Relevant Past Documents & Reference Materials

- [Building Resilient and Sustainable Systems for Health through Global Fund Investments. Information Note \(Global Fund, 30 May 2017\)](#)
- [The Global Fund Strategy 2017-2020: Investing to End Epidemics.](#)
- [Global Fund management of investments in Resilient and Sustainable Systems for Health. Audit Report.](#) (Office of Inspector General, Global Fund)

Annex 3 – TECHNICAL EVALUATION REFERENCE GROUP (TERG) THEMATIC REVIEW TO ASSESS THE CURRENT APPROACH TO

¹⁵ <https://www.theglobalfund.org/board-decisions/b35-dp04/>

¹⁶ <https://www.theglobalfund.org/board-decisions/b22-dp04/>

¹⁷ <https://www.theglobalfund.org/board-decisions/b16-dp10/>

INVESTMENTS IN RESILIENT AND SUSTAINABLE SYSTEMS FOR HEALTH (RSSH)

Report is attached separately.

Annex 4 – List of Abbreviations

Cambridge Economic Policy Associates	CEPA
Civil Society Organizations	CSOs
Community Health Workers	CHWs
Community Systems and Responses	CSR
Country Coordinating Mechanism	CCM
Global Financing Facility	GFF
Health Management and Information System	HMIS
Health Systems Strengthening	HSS
Human Resources for Health	HRH
Integrated Service Delivery	ISD
Key Performance Indicators	KPIs
New Funding Model	NFM
Procurement and Supply Chain Management	PSCM
Prospective Country Evaluations	PCEs
Resilient and Sustainable Systems for Health	RSSH
Strategic Objectives	SO
Strategy Committee	SC
Sustainable Development Goals	SDG
Technical Assistance	TA
Technical Evaluation Reference Group	TERG
Universal Health Coverage	UHC



Secretariat management response to TERG evaluation

Resilient and Sustainable Systems for Health

September, 2019

Introduction

The Technical Evaluation Reference Group (TERG) is a critical component of the Global Fund Partnership, providing independent evaluations of the Global Fund's business model, investments and impact to the Global Fund Board through its Strategy Committee. The Global Fund operates with a high degree of transparency and now publishes most non-advisory TERG reports on our website after they are reviewed by the Board.

The Global Fund Secretariat appreciates the Thematic Review of Resilient and Sustainable Systems for Health (RSSH) by the TERG. We agree with the findings of the TERG report and started to implement most of its recommendations as part of our broader initiative - the *RSSH Roadmap*. The Roadmap has been informed by the TERG review, as well as TRP's analysis of RSSH funding requests and OIG's RSSH Audit.

Areas of agreement

We agree with the TERG's findings that RSSH has gained in strategic importance in the Global Fund, which is reflected in countries' investment choices, and that the absence of a specific country allocation for RSSH does not particularly affect the volume of investments in RSSH. We also agree that the Global Fund's differentiated approach to RSSH investments in countries across the development continuum is appropriate and should be further pursued, while tracking the contributions of RSSH investments to disease control efforts should be improved.

TERG's emphasis on the complementarity between the Global Fund's strategic objectives, particularly between the SO1 (Maximize Impact Against HIV, TB and Malaria) and SO2 (Build Resilient and Sustainable Systems for Health), and the inherent trade-offs between these when deciding on RSSH investments, are well noted.

We are currently implementing the TERG's recommendations to address short-term objectives (i.e. before launching the 2020-2022 funding cycle), such as - improving the overall guidance on RSSH, revising standard Global Fund application, review and implementation processes, as well as strengthening the RSSH capacity and voice in country dialogue processes. We are also implementing the recommendations with a longer time-frame, without focusing on a specific funding cycle, such as – using the RSSH Strategic Initiative to advance RSSH M&E and address its shortcomings, reinforcing support for integrated program design, funding requests and implementation across HIV, TB and malaria programs, and exploring opportunities for greater development partner coordination for RSSH.

We particularly appreciate the TERG noting that the needs for investments in RSSH will always outstrip availability of funding, and therefore it is important to be clear about expectations with respect to RSSH and that these are aligned with the financial and Secretariat resources available. Meeting the multiple demands of the Global Fund's Strategy, with finite resources, implies many complex trade-offs. Investment

in RSSH should be driven by what is most critical to achieve disease outcomes rather than spread across multiple boxes under which funding can be categorized as RSSH.

Areas requiring further discussions

We appreciate the TERG's conclusion that the Global Fund, being a critical player in the SDG era, has to more clearly define its role and place with regards to health systems strengthening and its contribution to achieving UHC aspirations. However, we believe that the TERG's Strategic Recommendation that calls upon the Global Fund to develop the *theory of change* dealing with these strategic issues and promoting a uniform understanding, ownership and application of the Global Fund's RSSH approach, requires a broader partnership engagement. Since the Global Fund's investments in RSSH are intrinsically and reciprocally linked with other stakeholders' (domestic and donors) investments/interventions in countries' health systems, the Secretariat believes that the scope of this recommendation goes beyond the Global Fund and requires participation of a range of HSS/RSSH stakeholders. The Secretariat believes that the leading role in initiating and facilitating such consultations belongs to WHO. The Secretariat will discuss this recommendation with WHO and will inform the Strategy Committee on its outcomes (and on specific actions as relevant) in due course. For the Global Fund the relevant period for such consultations will be the preparatory period for developing the next Global Fund strategy. These consultations can inform the new corporate strategy, while the strategy itself will reflect the Fund's revised approach to the RSSH programmatic scope and investment framework.

Next steps

The Global Fund has developed the RSSH Roadmap that was presented to the Strategy Committee in March 2019. Recommendations derived from the TERG's RSSH review have been embedded in the Roadmap objectives. The RSSH Roadmap is a Secretariat-wide process. While the RSSH team is tasked for its overall coordination, multiple Departments and Teams across the Secretariat contribute to implementing its specific activities according to the agreed operational workplan. The Strategy Committee will be updated on the Roadmap implementation in due course.

We thank the TERG for our continued partnership to strengthen the impact of the Global Fund partnership.

Exhibit 1: RSSH Roadmap

RSSH Roadmap includes 5 priority areas

The RSSH Roadmap builds directly on the strengthening areas jointly identified by TRP, TERG and Secretariat, and agreed with Strategy Committee in October 2018

- 1 Strengthen RSSH capacity and voice in country dialogue process
- 2 More proactively advance integration in a cross-cutting and holistic manner
- 3 Strengthen differentiation and prioritization of RSSH investments along the development continuum
 - 3a Prioritization should be based on careful assessment of what is most critical to achieve particular outcomes rather than input categories
 - 3b Strengthen operationalization and implementation of existing investment guidance, while secondarily filling targeted gaps in guidance
- 4 Continue to deepen collaboration with Gavi and other partners for maximum leverage, efficiency and complementarity
- 5 Improve measurement of the outcomes of RSSH investments

The Roadmap aims to operationalize these actions in a manner that advances the fight against the three diseases and helps build resilient and sustainable systems for health.

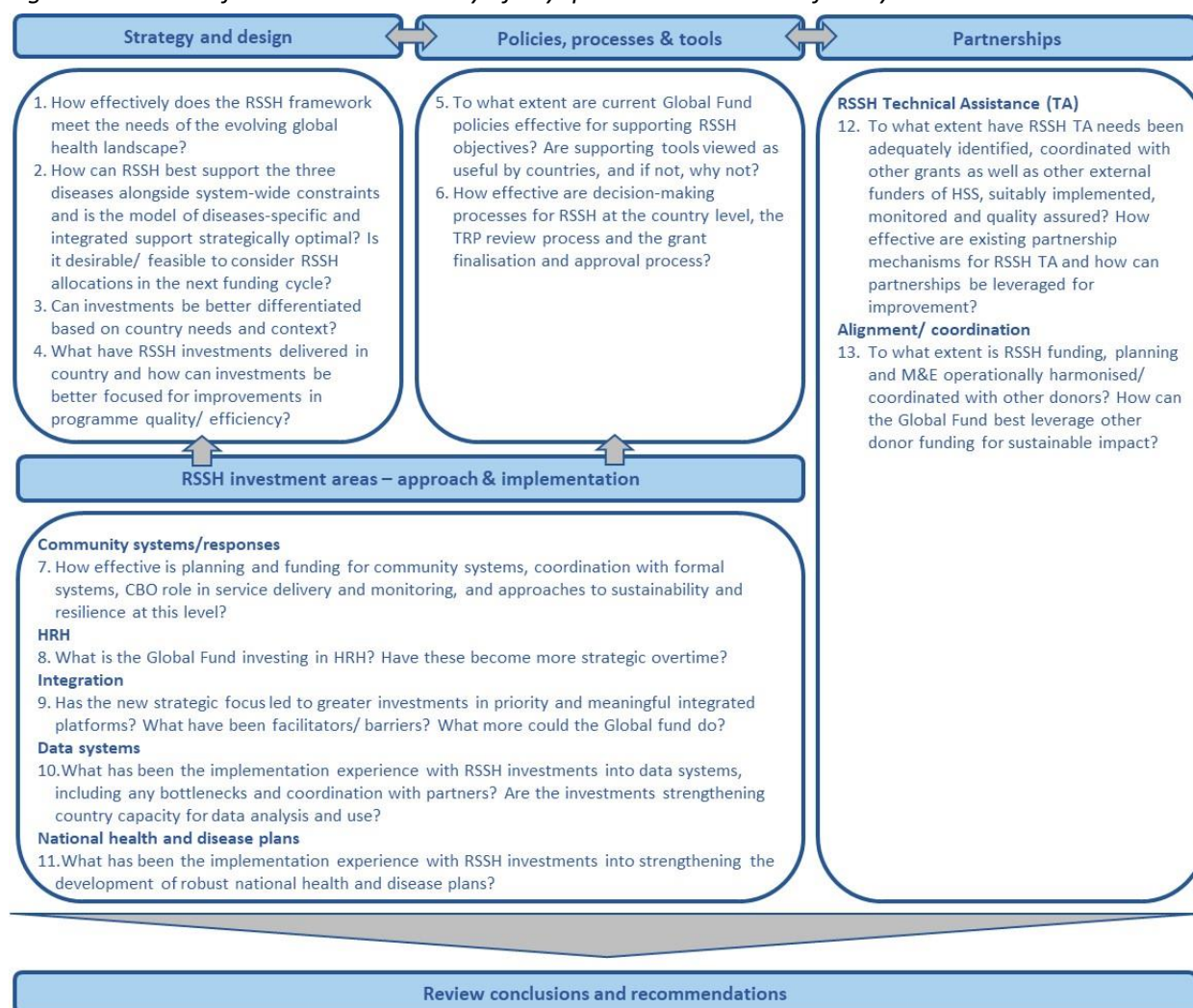
EXECUTIVE SUMMARY

This document provides a summary of Cambridge Economic Policy Associates' (CEPA's) review of the approach to Resilient and Sustainable Systems for Health (RSSH), commissioned by the Global Fund Technical Evaluation Reference Group (TERG).

Review scope and methodology

The aims of the review are to: (i) assess implementation of the RSSH investment framework at the country level; (ii) review complementarity with domestic and other donor efforts in order to achieve sustainable impact; (iii) review country and partner perceptions on the effectiveness of RSSH investments; and (iv) provide recommendations to enhance the effectiveness of RSSH investments in countries. The review framework (Figure E.1) is structured as four inter-related areas of: (i) strategy and design; (ii) policies, processes and tools; (iii) RSSH investment areas (covering five of seven areas); and (iv) partnerships.

Figure E.1: Review framework – summary of key questions and areas of analysis



The review employed a mixed methods approach including: desk review of documents and data; stakeholder consultations with Global Fund and global level partners; and case studies from eleven countries, including Ethiopia, Georgia, Ghana, India, Tanzania and Zambia (visit-based) and Cote d'Ivoire, Sierra Leone, South Africa, Sudan and Vietnam (desk-based).

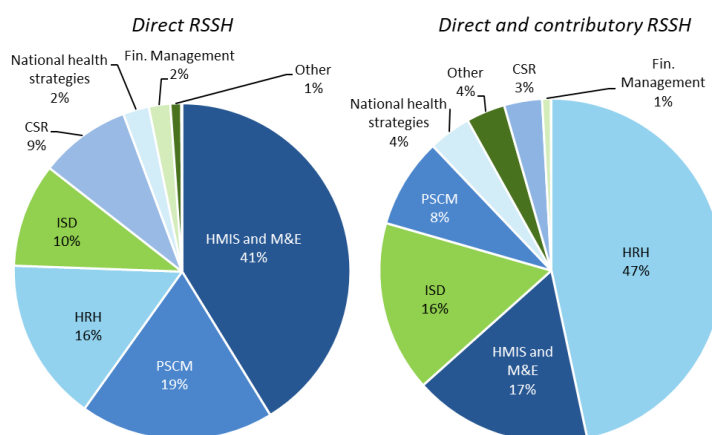
The following section provide a background to Global Fund RSSH support by way of context, followed by a summary of key findings across the four review areas, as well as the overall conclusions and recommendations.

Background to Global Fund RSSH support

With the introduction of the New Funding Model (NFM) in 2014, the Global Fund aimed to strategically prioritise its approach to health systems strengthening (HSS) by developing new guidance with “optimised scope of HSS investments”, primarily based on an analysis of health system-related programmatic risks for HIV, TB and malaria.¹ A total of US\$1.5b and US\$0.9b has since been funded for “direct RSSH” (stand-alone or cross-cutting RSSH/ HSS modules within disease grants) for the 2014-16 and 2017-19 allocations respectively. A further US\$2.0b and US\$1.4b is considered as “contributory RSSH” (disease-specific investments that are also considered to provide benefits to health systems) over the two allocation periods. This brings the total RSSH funding under the NFM to US\$5.8b to date, equating to 27% of the total Global Fund investment of US\$21.4b.

Figure E.2 shows the share of RSSH investment areas across the two allocation periods. Across both periods, health management and Information Systems (HMIS) and monitoring and evaluation (M&E), procurement and supply chain management (PSCM) and human resources for health (HRH) are the largest investment areas for direct RSSH funding. When considering both direct and contributory RSSH funding, HRH funding is the largest investment area.

Figure E.2: Share of investment areas across the two allocation periods



Review area 1: Strategy and design

RSSH relevance with evolving global health landscape

Evolving global health landscape

¹ The Global Fund. (2015). SIIC, TERG Position Paper on HSS and PPT titled “HSS in the NFM (Feb 2015)”.

The world has witnessed unprecedented improvements in global health in recent years and significant for the Global Fund is that progress against HIV, TB and malaria control has been extraordinary. While progress has been uneven between and within countries and substantial funding needs remain to sustain and further the progress, these considerable strides present a new situation away from the “emergency approach” of the early 2000s, and the justification for the three diseases “exceptionalism” is increasingly questioned. Simultaneously, the move from the Millennium Development Goals (MDGs) of 2015 to the Sustainable Development Goals (SDGs) of 2030 represents a shift from a vertical health-focused approach to a cross-sectoral and integrated approach. Central to the integrated and “health for all” approach of the SDGs is also the importance accorded to Universal Health Coverage (UHC). Further, commencing with the experience of the Ebola crisis of 2013, there has been increasing recognition of the need to develop country health systems that are “resilient”, referring to their ability to withstand crises or shocks and highlighting the important role of communities.

Global Fund RSSH positioning and extent of alignment

The 2017-22 Global Fund Strategy notes that strong health systems are essential for progress against AIDS, TB and malaria, as well as many other aspects of health, including reproductive health, non-communicable diseases (NCDs) and global health security threats. We note that the Global Fund has led the agenda to some extent in setting forth the concept of resilient health systems, which is gaining ground in wider fora. The Strategy also recognises the need for full alignment with partner plans and with the SDGs. As such, the Global Fund has entered into a number of partnerships to promote RSSH and UHC, including UHC2030.

However, there continues to a diversity of opinion as to whether the Global Fund RSSH approach is well-aligned with the evolving global health agenda, which may in large part be a consequence of the varying interpretations and understanding of how to operationalise UHC. From one perspective it is seen that the Global Fund is clearly supporting all three UHC objectives of equity, quality and financial protection, through both RSSH and disease support. From another, UHC is considered interchangeably with integration of health services and supporting Primary Health Care (PHC); and here it was argued that the Global Fund’s focus on the three diseases can conflict with, or lag behind, the broader approach to the integration of services being pursued in many countries.

Our analysis supports the view that the Global Fund needs to be doing more to embrace UHC; RSSH funding in a number of countries continues to be disease-focused and/ or with a strong disease-orientation in its structuring and implementation, often with inadequate consideration of wider UHC-promoting objectives.

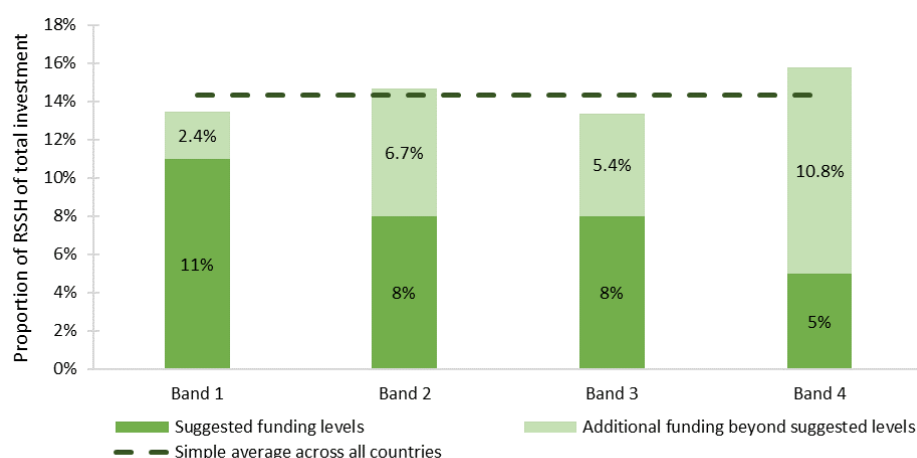
Efficacy of Global Fund RSSH model

RSSH importance in practice

While the disease mandate remains central to the Global Fund, and impacts the priority accorded to RSSH, RSSH has gained conceptual priority, especially from NFM1 to NFM2. It is now firmly part of the Global Fund mandate and RSSH funding has gained importance in countries. It was apparent from this review that the lack of specific RSSH allocation does not particularly inhibit country RSSH

funding – in the 2014-16 allocation cycle, countries across bands² allocated more funding to HSS/ RSSH than the suggested level by the Global Fund³, (Figure E.3).

Figure E.3: Proportion of RSSH funding by country band vis a vis suggested funding levels in 2014-16 (direct RSSH funding)



However, there has been 24% decline in the total allocation in NFM2 (from US\$12.1bn to US\$9.3bn)⁴ which has contributed to a 40% decline in direct RSSH funding (roughly speaking, based on the data included in the RSSH portfolio database, and noting that NFM allocation amounts differ for a number of reasons). This reflects the likelihood that when overall funding declines, diseases get prioritised (accepting other factors are also likely, such as a lower capacity to absorb RSSH funding may have resulted in reallocations of RSSH funding, as was the case in Sierra Leone). As a result, 65% of countries in NFM2 did not manage to maintain their proportion of direct RSSH to total funding compared with NFM1 (as set out in the indicative guidance for RSSH funding levels in the allocation letters to countries). However despite this funding decline, our consultations in country strongly suggested that RSSH is being better noted and widely supported within country discussions.

Diversity in interpretation of RSSH concept and operational tensions

Despite the first-time strategic prominence accorded to RSSH within the current Global Fund Strategy, there remains considerable diversity in understanding and interpretation of RSSH across the Secretariat and wider stakeholders including key donors to the Fund. This diversity applies to the definition and objectives of RSSH (including how to operationalise “sustainability” what is meant by the concept of “resilience”), the contribution of RSSH investment to disease control efforts and vice versa, the potential scope of feasible RSSH investment, how to effectively invest in RSSH, as well as how to measure results.

There are several factors that have driven the diversity of views on RSSH, key being divergent views on RSSH in the Secretariat and wider stakeholders including key donors to the Fund, the lack of

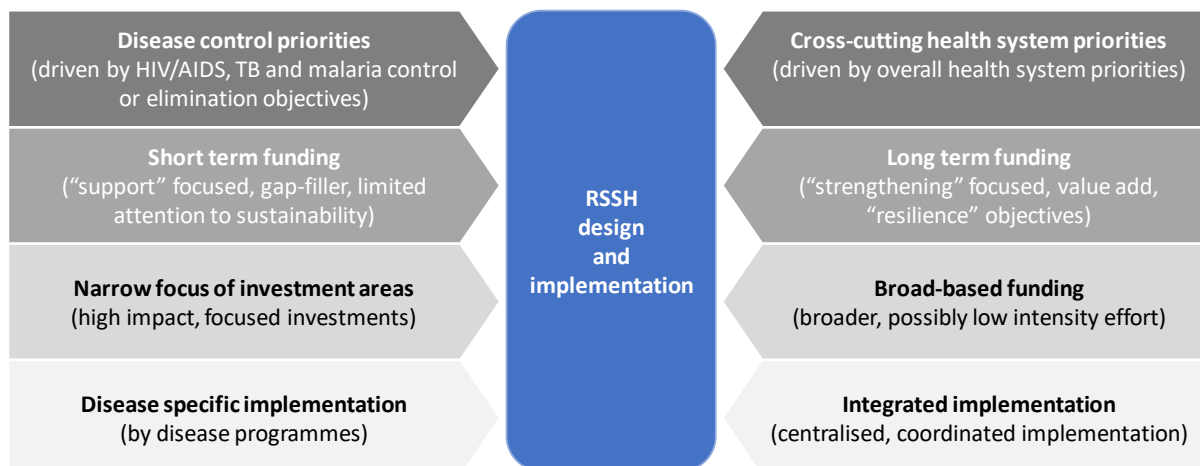
² The four country bands are based on country income and disease burden as set out in the 2014-16 Allocation Methodology. Band 1 includes countries with low income and high disease burden.

³ Based on average funding by country bands included in the allocation letters.

⁴ These numbers are based on the RSSH portfolio database and do not include matching funding, catalytic funding or above allocation. Additionally, only around 90% of the 2017-19 allocation period grants were included in the database. This is likely to explain part of the decline. Further details are provided in Supporting Annex E.

exposition of an overall theory of change linking disease and RSSH support, silo-ed implementation of the RSSH investment areas across Secretariat teams, and mixed/ confusing messaging in Global Fund Strategy and guidance documents (discussed further below). This has created several “operational tensions” that have resulted in a wide range of operational approaches to RSSH. Figure E.4, and the discussion below, summarises the key tensions observed.⁵ As such, there is a need for better definition and “prescription” for RSSH funding.

Figure E.4: “Operational tensions” facing RSSH



Disease focused versus cross-cutting support: i.e. whether the funding is driven by disease control bottlenecks and priorities, or more cross-cutting system wide development. Although it is recognised that the two may not be mutually exclusive in that disease-focused RSSH can also be system-wide supportive, our broad assessment is that Global Fund RSSH funding, for the most part, is disease-focused rather than cross-cutting.

Short term versus long term funding: i.e. funding for short term needs as compared to adopting a longer-term approach (notwithstanding country need for both types of funding). Central to this is the lack of definition and understanding of the concept of “resilience”. This tension is also heightened by a lack of comprehensive health systems strategy in countries which prevents a “bigger picture” view of the investments. Our finding has been that majority of Global Fund RSSH investments are focused on short term systems support for the three diseases, rather than longer term investments supporting resilience and sustainability of the system.

Narrow versus broad funding of investment areas: There are diverging views as to whether RSSH investment should be prioritised for select investment areas in line with the Global Fund’s comparative advantages or kept broad to enable more optimal country ownership in prioritisation of RSSH funding. This is in part driven by the limited understanding of the scope of potential support under all investment areas. In general, global stakeholders prefer an approach to support a narrower number of investment areas (with PSCM and data systems unanimously supported as priorities), while country-based stakeholders are in favour of a more diverse range of funding across investment areas.

⁵ The tensions have been presented to show the spectrum of options, recognising they may not necessarily represent polarised or negative positions, and that there are a number of trade-offs involved.

Stand-alone, disease programme or integrated implementation: Current guidance provides flexibility for countries to propose structuring of their RSSH funding as a stand-alone grant or integrated with a disease grant. In practice, there are very few stand-alone grants for RSSH, and only one at the time the analysis was conducted in 2017-19 (Ethiopia). We note that there are pros and cons to the available options (stand-alone and various integrated options). However, stand-alone grants and grants integrated with disease programmes and implemented by a cross-cutting HSS unit/ department have more beneficial attributes than recognised.

Efficacy of investment differentiation approach

There are some good examples of country differentiation (such as Zambia and Ethiopia). There is also some evidence at the global RSSH portfolio level of the effective differentiation in practice, with Focused and Core countries generally demanding a greater proportion of RSSH funding compared to High Impact countries. However, for the most part, the country studies suggest there was insufficient differentiation of RSSH investments according to country context and maturity of health system. Examples from our country case studies include: (i) Georgia - many investments were noted to be for health systems support with very limited focus on “system sustainability” investments despite Georgia being a transition preparedness country; (ii) India, where investments are much needed but there is mixed experience as to the alignment with the country’s development status and the nature of the investments, with substantial HRH salary support for the malaria programme; (iii) Sudan - the introduction and roll-out of District Health Information System (DHIS)2 is a key RSSH investment, although some questioned its value for money where basic infrastructure, including electricity and internet, are often unavailable. Our findings correlate with that of the recent TRP RSSH review, which found that further differentiation of RSSH investments is needed along the health system development continuum.⁶

Measurement of contribution of RSSH investment

Global Fund’s approach to M&E of RSSH and key issues on results monitoring

There is a challenge in tracking RSSH investment across country documentation given RSSH investments are generally integrated in disease grants, and as such specific identification of RSSH funding is difficult. Although activities may be included under certain budget line items as per the Modular Framework, these also vary by country given different country contexts, and as such, a line item description is less clear than it is in disease grants. Finally, there is a lack of documentation reporting synthesised activity progress.

In terms of the Global Fund’s current M&E approach for RSSH, there was general consensus that both strategy and implementation level monitoring has gone too far in terms of simplification and standardisation, and there is a need for more effective and engaged M&E to better track results. In particular, the strategy-level KPIs cover only four of the seven RSSH areas, with the other three areas (CSR, HRH and integrated service delivery) currently not represented. Significant issues were flagged on the M&E approach for RSSH funding in grants, including:

⁶ The Global Fund (2018). Strategy Committee: TRP Report on RSSH Investments in 2017-2019 Funding Cycle.

- A lack of qualitative approaches to assessing contribution of RSSH investments; there were requests in country for a more localised and tailored approach.
- Poor linkage between RSSH funded interventions and standardised outcome/ coverage indicators included in the Modular Framework. The inclusion of workplan tracking measures are also not particularly encouraged or supported and they do not currently span the full spectrum of RSSH activity;
- Insufficient outcome metrics on long-term effectiveness, sustainability or resilience of country health systems. A by-product and negative consequence of this is that countries are prioritising activities with short-term rather than sustainable long-term results. That an indicator is not required for each investment area can also lead to a patchy reflection and measurement of the overall RSSH investment;
- The collection of community data was not prioritised. The Global Fund's emphasis appears to be on national level, quantitative coverage indicators. The more traditional top-down model of monitoring (focused on reporting, pre-defined formats, indicators, milestones and criteria) provides inadequate accounts of the local realities (experiences and impacts) of the programmes and limits the capacity of the Global Fund to respond effectively to changing local conditions.

Absorption of RSSH funds

There are two specific issues of relevance here. First, the Global Fund Strategy KPI framework considers an increase in absorption as an indication of the effectiveness of RSSH spend. However, we view this a poor measure of RSSH impact as there are many other factors driving improving absorption (such as Global Fund processes, reprogramming and the year within the allocation cycle, amongst others). Second, we have understood there to be a bias amongst the Secretariat and countries to not request stand-alone RSSH grants due partly to their lower absorption rate (which is then viewed negatively for performance). It was also suggested that this focus can encourage perverse incentives in that it may promote spend for immediate gain at the cost of investment aimed at more longer-term quality and impact.

Review area 2: Policies, processes and tools

Global Fund policies and supporting tools for RSSH

Relevance and efficacy of overarching Global Fund policies for RSSH

In addition to the differentiation policy (discussed above), the main Global Fund policies that determine country funding are the Eligibility Policy (and related allocation methodology) as well as the Sustainability, Transition and Co-financing (STC) Policy.⁷ From the RSSH perspective, we observe that these policies are largely oriented around the requirements of the three diseases. For example, the Eligibility Policy defines eligibility for Global Fund funding on the basis of income level and

⁷ The Global Fund. (2016). 35th Board Meeting: The Global Fund Sustainability, Transition and Co-Financing Policy. GF/B35/04 – Revision 1.

disease burden, with no health systems-specific criteria that forms the basis of a country allocation.⁸ A desk-based rapid review of the STC Policy suggests a well-rounded approach that considers health planning and funding as a whole (rather than disease-specific approaches), with for example, the co-financing incentive being pegged on increases in domestic financing for health and not disease-specific funding alone. However, noting the “sustainability” and “resilience” objectives for RSSH, we question whether the policy goes far enough. While our critique of these policies is not based on a full-scale review but rather from an RSSH lens, it does suggest that to fully reflect and operationalise RSSH within the Global Fund approach, there is a need for further thinking on how best to incorporate RSSH-relevant objectives and priorities within these policies.

Our assessment of the key RSSH tools and guidelines is as follows:

RSSH Investment Framework: This serves not only as the main strategy document on RSSH, but also as a guideline document for countries and this dual purpose of the document is a key problem in itself. Feedback also indicated that the guidance in this document is not adequately clear or precise and conflicts with other guidance to countries. A review of successive versions of this document from 2013 onwards also indicates that the approach and framework has moved around several times, which may reflect evolving thinking and alignment with successive Global Fund strategies, but it can create confusion at the country level over definition of RSSH investment areas and funding requirements.^{9,10} In all eleven of our country case studies, stakeholders were mostly unfamiliar with this document and reported that they had not consulted it for RSSH-related application development.

RSSH investment area-specific guidelines/ technical briefs: A common view among partners was that, while these are technically strong (especially with regards to HRH), the additionality of these documents alongside WHO and other partner guidance was questioned. Countries were largely unaware of these additional technical guidelines and professed to not having consulted them during application development.

Application and grant-making tools: Our assessment is that the overall approach to applications undermines RSSH in that the emphasis is on the disease applications and RSSH is positioned as “another disease”, which is ineffective. The programme continuation approach is largely based on disease-specific criteria, with limited consideration of RSSH continuity.

Country decision-making and application cycle

Our key findings in relation to **country decision-making** on RSSH are as follows:

⁸ The revised Eligibility Policy notes that one of the key revisions is the introduction of language to encourage countries to use their allocations for RSSH, in line with the new strategic framework for 2017-19.

⁹ For example, (i) CSR has more of a strengthening and cross-disease focus in the 2017 Note, while the 2015 Note provides looser language around whether these should be considered as RSSH or disease-specific investments; (ii) the 2016 Note refers to integrated service delivery as an investment area focusing on RMNCAH and integration, whereas the 2015 Note refers to service delivery in terms of district health systems; HRH definitions vary regarding community work force; etc.

¹⁰ The Global Fund. (2013, 2014, 2015). Health systems strengthening for Global Fund applicants – information note.

- Countries are strongly guided by the suggested level of funding in the allocation letters, although the basis for RSSH funding varies substantially by country and is mostly ad hoc.
- Some CCMs have good representation for RSSH, and while others may be more disease-oriented, they do not necessarily de-emphasise RSSH. Across the board, we did not observe any de-prioritisation of RSSH (contrary to oft claimed Secretariat views), suggesting RSSH representation on the CCM is not a critical factor for RSSH prioritisation, and countries as a whole are cognisant of RSSH need. There is a broader issue of whether the CCM is able to effectively engage in wider health system discussions, and whether it could be viewed as parallel to other in-country coordination structures.
- Country decision-making on RSSH is strongly influenced by guidance or steering by the Global Fund Country Team.

TRP review of RSSH applications: There is inadequate focus on a review of RSSH by the TRP, seemingly a function of the limited information available to the TRP and as arising from disease-dominated discussions within the TRP.

Grant-making and approval processes: There have been varied country experiences with regards to grant-making for RSSH. Where it is not working well, key issues relate to high transaction costs and Country Team-led processes undermining country ownership.

A review of the end-to-end application cycle for RSSH reveals several gaps in the processes, which may contribute towards sub-optimal RSSH investment planning. All of these factors suggest a need for a closer examination of the RSSH application process, specifically in terms of whether there are opportunities to better define certain aspects upfront for smoother and country-owned decision-making, as well as aspects where RSSH needs distinct consideration, rather than as an extension of the disease programme.

Review area 3: Investment areas – approach and implementation

This section highlights the key findings from a deep dive into the five investment areas which were the focus of this review.

Community systems and responses

- Over the last ten years, community systems strengthening (CSS) has increasingly been seen through a broader health and community lens, reflective of the paradigm shift from “health systems” to “systems for health” that is central to the RSSH concept. The Global Fund is one of few organisations prioritising CSR at a corporate objective level.
- There is however a general lack of clarity and understanding on the aims and scope of the CSR investment area. This is noted in part within the inconsistencies in the categorisation of CSR activity which raise misconceptions in terms of the level and scope of CSR activity actually funded.
- CSR funding requests tend to be limited in scope and scale, though this should not be seen as a reflection of a lack of demand at country level. There also appears to be a common

assumption that CSR is predominantly about CHWs rather than a broader link between the community system and the health system.

- There is considerable variability in community representation in the planning and management of grants in country.
- CSR programmes are not often effectively designed with a sustainability focus. In addition, although CSR is core to the resilience concept within RSSH, activities are often not implemented with this approach in mind.
- The role of community society organisations (CSOs) in supporting service delivery has been limited and small in scale in a number of countries, though there are some positive, early examples of CSO activity in community monitoring.

Human resources for health

- The majority of HRH support has been for salaries, which have often not been embedded in a wider strategic and sustainable approach and transition of salary support has continued to be a major challenge. For the HRH investment area, the proportion of salaries and associated costs has increased from 52% in the 2014-16 allocation period to 83% in the 2017-19 allocation period.¹¹
- The equitable distribution of HRH continues to be a concern with a lot of HRH investment continuing to be targeted at capital cities. This has been a specific consideration for NFM2 however and there are some positive examples across countries, such as in Ethiopia, Tanzania and Zambia.
- The majority of HRH support reflects short-term gap filling such as in-service training, as opposed to long-term investments in aspects such as robust HRH policies, career development and pre-service training.¹²

Integrative service delivery

- The Global Fund Strategy 2017-22 has prioritised integrated service delivery for the continuum of care across RMNCAH as a key sub-objective of its strategic objective on RSSH. However the ISD investment area is not well defined, nor fully understood across stakeholder groups, and it has been suggested that the Strategy is too narrow in its technical focus. While country requests exhibit some increases in integration aspects such as on HIV-TB and Integrated Community Case Management (iCCM), there fewer on other components of RMNCAH, or NCDs, and even fewer on UHC (relating in part to challenges in operationalising UHC as already discussed).
- However, while it is suggested that the disease focus for ISD remains (in large part perpetuated by the historic verticalisation of disease programmes), there are some good

¹¹ This was partially due to a considerable increase from 3% to 31% in performance-based supplements. This was mostly driven by HRH investments in DRC and Zimbabwe.

¹² The Global Fund RSSH team has issued guidance around HRH with the aim of promoting the sustainability of investments, and whilst the Secretariat and partners view this guidance to be fairly comprehensive, it is reportedly little used, thus reducing its efficacy.

examples of strategic and value-adding investments in support of ISD, which are reflective of country specific integration agendas. Examples include cross-cutting laboratory investments in Ethiopia, support for a pilot for integrative service delivery for HIV, TB and hepatitis C virus (HCV) in Georgia and health facility quality improvements in Tanzania.

Data systems

- This area has received substantial funding, with a number of critical data systems development investments, although a considerable proportion are disease-specific.
- In select countries, investments in data systems have been broad and patchy, impeded by the lack of comprehensive country plans and operational strategies on health data systems.
- The analysis and use of data, especially at lower administrative levels, remains a key gap.
- There has been varied progress in the coordination and alignment of investments with partners and further improvements are needed to reduce duplications.

National health and disease plans

- This is a poorly understood investment area across countries, with few requests for support and a wide range of activities funded. Our view is that more definition is required.
- The relevance of this investment area was questioned for two key reasons: (i) in contexts where there are established processes and available resources for development of the national health plan and disease plans, it is considered that the government should retain ownership of funding these (such as India) and (ii) other partners already provide support for this investment area.

Review area 4: Partnerships

Technical assistance related to RSSH

Systems-related technical assistance (TA) is not well classified or understood within the Global Fund architecture. Lack of dedicated TA partner for HSS and CSS, fragmentation of the health systems TA landscape and limited guidance from the Global Fund on TA for HSS are key issues.

Noting the challenges with the TA landscape and delivery, we consider the range of TA delivery mechanisms available to the Global Fund and their suitability for providing cross- systems-related TA as related to Global Fund RSSH support (including: (i) multilateral UN partners such as WHO, United Nations International Children's Emergency Fund (UNICEF), United Nations Development Programme (UNDP), etc.; (ii) bilateral donor partners such as the USG, French 5% Initiative and German (GIZ) Backup Initiative; and (iii) the Global Fund Secretariat contracting TA directly). Overall, consultees noted that there is no one perfect solution and that combinations of the three different approaches are all needed. However, the drawback of having multiple TA channels is that coordination becomes more complex.

Harmonisation and coordination with other donor funding

A review of donor funding approaches highlights some key findings:

- Each donor has its own “entry point” or lens for HSS, with some overlap. For example, the Global Fund RSSH and USAID consider the three diseases, with USAID also being broader to consider prevention of child and maternal deaths, family planning and reproductive health, global health security and nutrition.
- There is a degree of alignment in terms of funding recipients, though there are different platforms/ stakeholders for engagement for planning/ designing of the HSS funding.
- HSS funding by donors are not aligned in terms of their timing/ duration, and eligibility for funding is markedly different.
- Monitoring systems are for the most part focused on different indicators and approaches.

As regards to donor coordination, the review concludes that there have been general improvements in donor coordination over time, although this varies by country and by area of investment and there is still extensive need for more effective coordination. Key bottlenecks include donors using multiple in-country platforms/ stakeholders for planning or designing HSS interventions, a lack of Global Fund in-country presence, a lack of an overarching country strategy for coordination, and poor efficacy of partners in country. Government stewardship of donor funding has been identified as a key enabling factor for supporting effective coordination.

Conclusions and recommendations

Drawing on the summary findings by review area, the following overall **conclusions** apply:

1. There is a notable stronger prioritisation of RSSH within the Global Fund.
2. There remains a disconnect between the Global Fund Strategy on RSSH – which is broad-based and cross-cutting and broadly reflective of UHC – and its operationalisation. As a result, RSSH funding is largely disease-focused, short-term and gap-filling in nature, and as such, not adequately reflective of the evolving importance being accorded to UHC.
3. There has been limited effective differentiation of RSSH investments, impeded by a lack of a framework and guidance, as well as absence of country health systems plans and comprehensive funding information.
4. RSSH guidance for countries is complex, ambiguous and not used by countries to support investment planning.
5. An RSSH allocation and RSSH representation on the CCMs are not key for effective RSSH prioritisation and planning. Countries are demanding RSSH funding and suggested levels of funding provided in the allocation letters have served as guidance for countries. CCMs may not have the capacity to engage in a cross-cutting RSSH discussion and prioritisation exercise which is reflective of wider HSS discussions and coordination bodies in country.
6. While there are benefits to an open-ended and composite (i.e. diseases and RSSH) approach to country applications, current operational processes are not adequately cognisant of RSSH requirements. Without adequate “prescription”, countries are employing ad hoc approaches to determine RSSH funding, often based on Country Team steering. RSSH funding is also

substantially revised and fine-tuned in the later parts of the application cycle, namely grant-making, implying inefficiencies in process. Integrated application forms mean that there is often limited RSSH-specific information to guide an effective review, with the review processes themselves being disease-focused.

7. RSSH grants have for the most part been integrated with disease grants, with the potential of separate RSSH implementation (whether through stand-alone or integrated RSSH grants with separate implementation through a centralised or cross-cutting health systems department) not fully realised.
8. Tracking of RSSH investments is difficult, largely due to the grant structuring and reporting arrangements. RSSH M&E is ineffective with limited emphasis on qualitative assessment, poor linkage between RSSH investments and standardised outcome (coverage) indicators, limited inclusion of work plan tracking measures in the RSSH module M&E frameworks, insufficient outcome metrics on long-term effectiveness, sustainability or resilience, and limited use of community-based data. Grant performance measurement through absorption creates perverse incentives for RSSH.
9. Across the RSSH investment areas, there are some good examples of strategic and value-adding investments, though there is general lack of clarity and understanding on the full technical scope of potential funding available and a dominance of disease specific investment.
10. Although there have been some improvements over time, donor and development partner coordination for HSS funding continues to be weak.

Below are a series of **strategic and operational recommendations**, as well as specific **recommendations by RSSH investment area**. The detailed report provides links with RSSH-related actions proposed at the last Strategy Committee meeting in October 2018, as well as operational details in terms of suggested period for implementation and stakeholder responsibility.

Strategic recommendations
<ol style="list-style-type: none"> 1. Clarify the scope and role of RSSH, in relation to the primary disease focused mandate of the Global Fund, health system resiliency and sustainability, and UHC. Develop a clear and coherent “consensus statement” on the scope and role of the Global Fund’s RSSH investment, to include how RSSH funding: (a) supports disease control objectives across the development continuum, including both in the short- and long-term and as relating to a ‘support’ and ‘strengthening’ focus; (b) boosts overall health system resiliency and sustainability; and (c) supports UHC. Once agreed, this statement should be widely shared and communicated with both internal and external audiences to promote a uniform understanding, ownership and application of the Global RSSH approach.
Operational recommendations
<ol style="list-style-type: none"> 2. Develop a prioritisation and differentiation framework to guide decision-making on RSSH in line with national health strategic plans, and translate this into clear upfront guidance for countries and link with the end-to-end application and implementation cycle. To include the trade-offs which can exist between ‘supporting’ and ‘strengthening’ health systems, and how to balance RSSH in support of disease control objectives with broader health systems strengthening. It should also include a framework for effectively differentiating “what” is funded under RSSH by country context, i.e. marrying the assessment of the health system maturity (e.g. as per the TRP 4S framework) with Global Fund’s current differentiation approach of distinguishing between High-impact, Core and Focused countries, to identify “application focus requirements” by country type. The prioritisation framework should be

translated into clearly defined/ prescribed upfront application guidance to countries, TRP review criteria and GAC decision-making as well as RSSH grant M&E.

3. **Revisit and improve the overall guidance on RSSH, with greater definition/ prescription, and focusing on encouraging its active use.** Distinguish between: (i) investment planning guidance for countries; (ii) operational guidance for the Secretariat (Country Teams); (iii) an information note explaining the Global Fund's RSSH approach to external stakeholders and partners. Consider ways to make the RSSH guidance accessible to countries – e.g. provide a FAQs document.
4. **Consider revising a number of standard Global Fund application, review and implementation processes to better reflect RSSH priorities and requirements.** To involve a revision of the application form to better reflect the suggested prioritisation and differentiation framework and to include complementary information to further guide an effective TRP review such as from previous applications, applications to Gavi, GFF, etc., and information from the RSSH Dashboard; an increase in RSSH technical expertise and incentives to support Country Teams with the effective design and implementation of RSSH investments that are adequately differentiated by country context; support for greater implementation of RSSH investment through cross-cutting departments in health ministries, rather than disease programmes; ring-fencing of RSSH funding to avoid reprogramming of RSSH funds into other interventions to boost absorption; revision of the programme continuation approach to factor in RSSH continuity aspects alongside the existing disease-focused criteria.
5. **Improve RSSH grant documentation and M&E.** Improve documentation on RSSH funding allowing for better tracking of RSSH funded interventions and their progress over time. Give further emphasis to small/medium scale, qualitative studies and relevant thematic reviews. Consider an appropriate balance of enhanced work plan tracking measures and coverage/ outcome measures included in the Modular Framework that would allow for a more relevant assessment of the funded interventions. A “long list” of output measures could be developed, which better reflect the focus and range of RSSH funded interventions.
6. **Improve RSSH-relevant engagement in the CCM, alongside engagement/ linkage of the CCM with other health sector planning and coordination bodies** including standard government planning processes as well as other donor platforms (such as that employed by Gavi or GFF).
7. **Continue to explore opportunities for greater development partner coordination for HSS**, including some “quick-wins” with Gavi as well as other large donors such as the GFF and World Bank, consideration of a joint TA hub between key funders, and support for countries in coordinating donor investments (e.g. through capacity building).

Recommendations by RSSH investment area

8. **Consider a number of specific recommendations to enhance the effectiveness of specific RSSH investment areas.**

CSR: The range of permissible community systems and responses interventions should be more clearly articulated, alongside clarification on how a broad range of community data is linked with the formal health system. More flexible funding channels to support a range of CSR efforts should be explored.

HRH should have a larger focus on sustainability, linked to country plans incorporating a longer-term view. HRH investment planning should have more steps in place to ensure guidance is practically enacted, particularly as relating to salary support.

Integration should be a cross-cutting approach, reflective of WHO's people centred approach, rather than a narrowly defined RSSH investment area.

Data systems: Investments should be strengthened through improved partner coordination, an emphasis data analysis and use, the promotion of community data into national health data systems, and through the adoption of a longer-term view in particular to data digitisation.

NHPs: The national health plans investment area should be further defined or revisited in line with governance and leadership considerations.

Disclaimer

Views expressed in this executive summary are those of the author. The author has been commissioned by the Technical Evaluation Reference Group (TERG) of the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) to conduct an assessment to provide input into TERG's recommendations or observations, where relevant and applicable, to the Global Fund. This assessment does not necessarily reflect the views of the Global Fund or the TERG.

THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

TECHNICAL EVALUATION REFERENCE GROUP (TERG) THEMATIC REVIEW TO ASSESS THE CURRENT APPROACH TO INVESTMENTS IN RESILIENT AND SUSTAINABLE SYSTEMS FOR HEALTH (RSSH)

13 February 2019

Final Report

Prepared by:

Cambridge Economic Policy Associates Ltd

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Acronyms and abbreviations

Acronym	Full description
ART	Antiretroviral therapy
BMGF	The Bill and Melinda Gates Foundation
CBM	Community-based monitoring
CBO	Community Based Organisation
CCM	Country Coordinating Mechanism
CHW(s)	Community Health Worker(s)
COE(s)	Challenging Operating Environment(s)
CSO	Civil Society Organisation
CSS	Community Systems Strengthening
CT	Country Team
CSR	Community Systems and Responses
DHIS2	District Health Information System (referred to as DHIMS2 in Ghana)
FPM	Fund Portfolio Manager
GAC	Grant Approval Committee
Gavi	Gavi, the Vaccine Alliance
GFF	Global Financing Facility
UMIC	Upper-middle income country
HMIS	Health Management and Information System
HRH	Human Resources for Health
HSS	Health Systems Strengthening
iCCM	Integrated Community Case Management
ISD	Integrated Service Delivery
KPI(s)	Key Performance Indicator(s)
LIC	Lower income country
LMIC / UMIC	Lower-middle income country / Upper-middle income country
M&E	Monitoring and Evaluation
MDG(s)	Millennium Development Goal(s)
MoH	Ministry of Health
NCD(s)	Non-communicable disease(s)
NFM	New Funding Model
NHP(s)	National Health Plan(s)
NSP(s)	National Strategic Plan(s)
OIG	Office of the Inspector General
PEPFAR	The US President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PR	Principal recipient
PSCM	Procurement and Supply Chain Management
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RSSH	Resilient and Sustainable Systems for Health
SDG(s)	Sustainable Development Goal(s)
SIIC	Strategy, Investment and Impact Committee
SR(s)	Sub-recipient(s)
STC	Sustainability, Transition and Co-financing
TA	Technical Assistance
TERG	Technical Evaluation Reference Group
TRP	Technical Review Panel
UHC	Universal Health Coverage
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization

PART A: INTRODUCTION, SUMMARY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

1. INTRODUCTION

Cambridge Economic Policy Associates (CEPA) was appointed by the Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund) Technical Evaluation Reference Group (TERG) to conduct a review to assess the current approach to investments in Resilient and Sustainable Systems for Health (RSSH). This is CEPA's Final Report, presenting the analysis, conclusions and recommendations from the review.

The introduction section outlines the review scope and objectives (Section 1.1), review framework and methodology (Section 1.2) and structure of the report (Section 1.3).

1.1. Review scope and objectives

This is the first in-depth review of RSSH since it has been given strategic prominence in the Global Fund's 2017-22 Strategy as one of the four Strategic Objectives.

The aims of the review are to: (i) assess implementation of the RSSH investment framework at the country level; (ii) review complementarity with domestic and other donor efforts in order to achieve sustainable impact; (iii) review country and partner perceptions on the effectiveness of RSSH investments; and (iv) provide recommendations to enhance the effectiveness of RSSH investments in countries.

The scope and objectives of the review encompass a number of strategic issues on the positioning of Global Fund RSSH within the evolving global health landscape, the overall approach to health systems strengthening (HSS) alongside disease support by the Global Fund, the effectiveness of Global Fund policies, processes and tools for RSSH, and the functioning of the RSSH partnership environment. Five of seven RSSH investment areas have been selected for detailed analysis, namely community systems and responses (CSR), human resources for health (HRH), integrated service delivery (ISD), data systems and national health strategies, complementing an ongoing RSSH review by the Global Fund Office of the Inspector General (OIG) that is examining the remaining two investment areas of procurement and supply chain systems (PSCM) and financial management.¹ The review considers RSSH funding over the 2014-16 and 2017-19 allocation cycles (i.e. New Funding Model (NFM) 1 and 2).

The review builds on previous reviews (the HSS thematic review of 2015 and the Global Fund Strategic Reviews of 2015 and 2017), as well as several concurrent reviews including a review of RSSH by the Technical Review Panel (TRP), the previously noted OIG review as well as TERG-commissioned prospective country evaluations and review of partnerships.

¹ The TERG will provide consolidated findings from this review with that from the OIG to the Strategy Committee.

1.2. Review framework and methodology

1.2.1. Review framework

In line with the review scope and objectives, the review framework has been structured as four inter-related areas of:

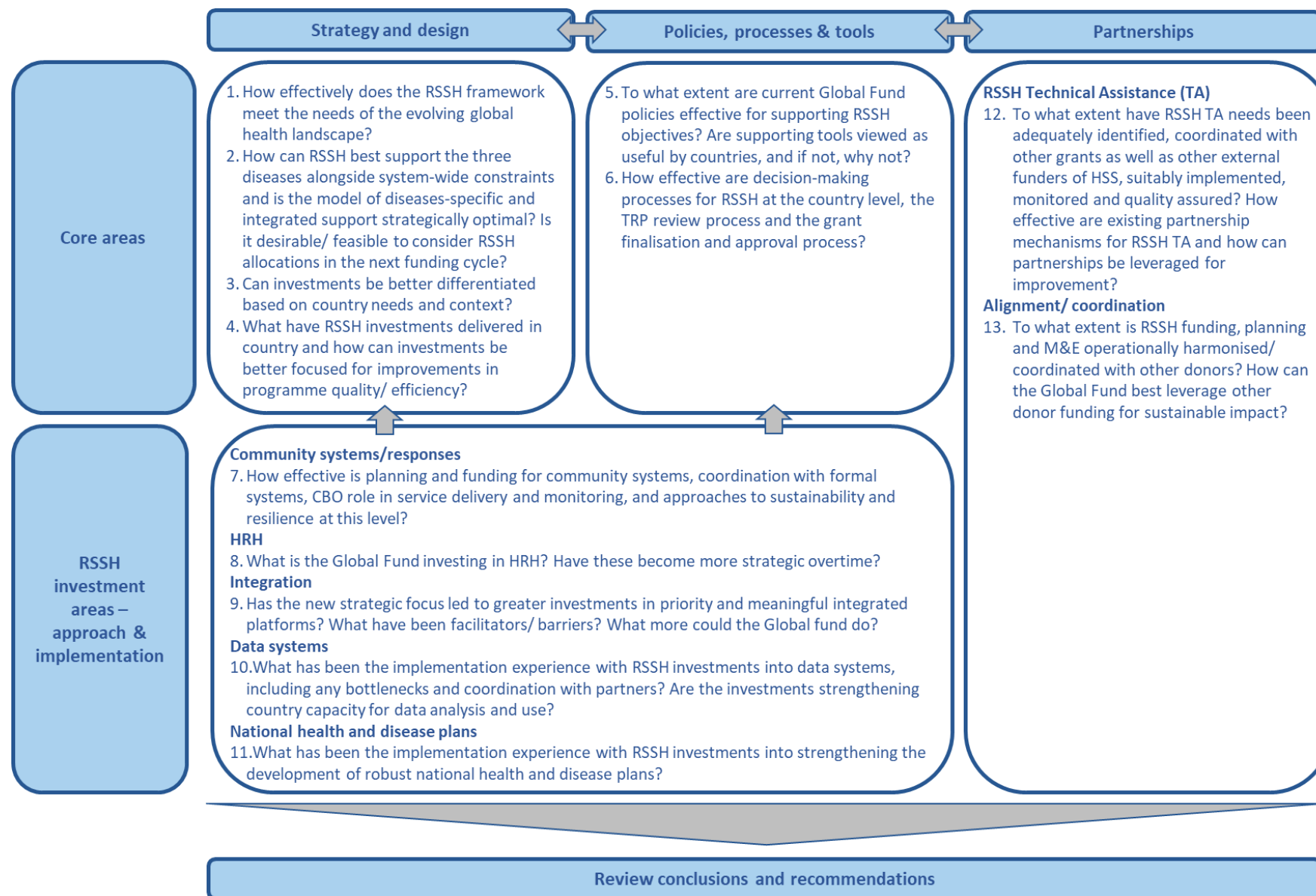
- **Strategy and design:** encompassing a review of the relevance and alignment of Global Fund RSSH with the evolving global health landscape, efficacy of the model of support for RSSH, efficacy of differentiation in practice, and measurement of the contribution of RSSH investments.
- **Policies, processes and tools:** considering the efficacy of Global Fund's policies and guidance for RSSH, alongside the processes for country-level planning and decision making, review by the TRP and grant-making to approval.
- **RSSH investment areas:** covering the approach and implementation experience of five of the seven RSSH investment areas namely, CSR, HRH, ISD, data systems and national health strategies. Several specific review questions of interest have been considered for each of the specific investment areas analyses.
- **Partnerships:** covering efficacy of partnerships for RSSH, both in terms of TA as well as other donor funding for health systems development.

Figure 1.1 over page provides the review framework, with focus questions under each pillar being reflective of the Organisation for Economic Co-operation and Development's (OECD's) Development Assistance Committee evaluation criteria of relevance, effectiveness, efficiency and sustainability.²

The analysis and findings are organised by the four review areas and questions included within each review area. As each of the review areas is closely related to the others, cross-cutting findings are brought together to inform overall conclusions and recommendations on Global Fund RSSH funding.

² As outlined in Section 1.1, impact assessment is not in scope for this review.

Figure 1.1: Review framework – summary of key questions and areas of analysis



1.2.2. Methodology

This is a mixed-methods review, comprising the following information sources:

Document review – including documentation on Global Fund and RSSH (e.g. 2017-22 Strategy, RSSH Investment Framework, RSSH guidelines, previous evaluations, etc.), country documentation (concept notes/ funding requests, budgets and work plans, TRP and the Grant Approval Committee (GAC) review forms, national health and disease plans, etc.), partner documentation (e.g. from the World Health Organization (WHO), Universal Health Coverage 2030 (UHC2030), other donors), and the broader literature (e.g. Lancet articles). Supporting Annex A provides a list of references.

Data review – including the RSSH portfolio database developed by the Global Fund Secretariat, grant absorption rate database, country-level data on funding and results, etc. Supporting Annex A also includes the data sources.

Stakeholder consultations – including an initial scoping mission with the Global Fund Secretariat and key stakeholders (June 2018, in-person), in-depth interviews with the Secretariat, TERG and TRP members, and partners (July – October 2018, in-person and by phone), and a second-round of interviews with the Secretariat to discuss emerging findings and conclusions (November 2018, in-person). Secretariat meetings have been conducted with the senior management, RSSH and CSS team members, Country Teams (CTs), monitoring and evaluation (M&E) officers, etc. Partner consultees have included WHO, the United States (US) government, the World Bank Group (World Bank), Gavi, the Vaccine Alliance (Gavi), the Bill and Melinda Gates Foundation (BMGF), etc. (many of whom are members of the Global Fund Board and Strategy Committee). Supporting Annex B provides a list of interviews and Supporting Annex C provides the interview guides.

Country case studies – eleven countries were studied to support this review including Ethiopia, Georgia, Ghana, India, Tanzania and Zambia (visit-based) and Côte d'Ivoire, Sierra Leone, South Africa, Sudan and Vietnam (desk-based). Table 1.1 provides a summary of the spectrum of countries (reflecting 27% of the direct RSSH funding for 2017-19), covering the range of Global Fund country classifications, mostly large funding amounts but with a few countries with smaller RSSH grants, varying RSSH grant structures and investment foci, and wide-ranging country contexts, and thereby providing a robust evidence base for this review. Country visits were generally conducted by a two-member team over five days with meetings with the Country Coordinating Mechanism (CCM), government, civil society, key population groups and development partners, as well as field visits to review services/ projects being funded through the RSSH grants. Desk-based country studies were carried out through document reviews and two-three telephone consultations (usually the Fund Portfolio Manager (FPM) and other members of the CT at the Secretariat, CCM Chair and Ministry of Health (MoH) representative). Supporting Annex D provides details on the criteria for country selection and country reports are provided for all eleven countries in a separate Country Annexes document.

Table 1.1: Summary of country case studies – highlighted represents visit-based case studies

Country	Sierra Leone	Ethiopia	Tanzania	Zambia	Ghana	Côte d'Ivoire	India	Vietnam	Sudan	Georgia	South Africa
GDP pc 2017, country classificn.	<ul style="list-style-type: none"> • \$499 (LIC) • Core-COE 	<ul style="list-style-type: none"> • \$767 (LIC) • High impact 	<ul style="list-style-type: none"> • \$936 (LIC) • High impact 	<ul style="list-style-type: none"> • \$1,509.8 (LMIC) • High impact 	<ul style="list-style-type: none"> • \$1,641 (LMIC) • High impact 	<ul style="list-style-type: none"> • \$1,662 (LMIC) • High impact 	<ul style="list-style-type: none"> • \$1,939 (LMIC) • High impact 	<ul style="list-style-type: none"> • \$2,343 (LMIC) • High impact 	<ul style="list-style-type: none"> • \$2,899 (LMIC) • High impact - COE 	<ul style="list-style-type: none"> • \$4,078 (UMIC) • Focused 	<ul style="list-style-type: none"> • \$6,160 (UMIC) • High impact
RSSH funding, NFM1 and 2 (% of country funding)	\$36.8m (34%), \$3.9 (12.3%)	\$61.4m (11%), \$32.7m (8.6%)	\$43.7m (9.8%), \$57m (9.6%)	\$24m (9.9%), \$38.8m (14.3%)	\$27.6m (10.7%), \$27m (13.9%)	\$23m (15.1%), \$25.6m (12%)	\$46.4m (7%), \$32m (6.5%)	\$4.3m (3.5%), \$7.4m (6.9%)	\$23.2m (13%), \$11.3m (8.7%)	\$3.7m (12%), RSSH not yet allocated	\$64.2m (18%), RSSH not yet allocated.
Structure of RSSH grant (2017-19) – explained further in Section 4.2.4	Integrated with disease grant, but separate RSSH implementation	Stand-alone	Integrated with disease grant, but separate RSSH implementation	Integrated with disease grants	Integrated with disease grant, but separate RSSH implementation	Integrated with disease grants	Integrated with disease grant	Integrated with disease grants	Consolidated concept note, with separate implementation	Integrated with disease grants	Integrated with disease grant (2014-16; 2017-19 under consideration)
Main RSSH investment areas (2017 – 19)	PSCM, HMIS	ISD, HMIS, HRH	HMIS, PSCM, ISD	HRH, HMIS, CRS	HMIS, PSCM, CRS	ISD, NHP, HMIS	HRH, HMIS, PSCM	HMIS, PSCM, CSR,	PSCM, HMIS	For 2014-16: HMIS, CSR, NHP	2014-16: HMIS, CRS, PSCM
Key country and health system context	LIC, heavily impacted by: Ebola outbreak (2014-16); cholera epidemic (2012); civil war ending in 2002	Long term national health sector transformation plan, health financing through SDG Pooled Fund	Partnership coordination through the sector wide approach, significant gaps in HRH, in particular at the community level	LMIC context, FBOs and private sector providing 20% of health services, restructuring of PHC system	LMIC context but with governance issue, debtor to Global Fund	Fast growing economy, large number of donors supporting health system.	Large country, federal structure, high % of govt. health expenditure, small no. of donors	Government aims to cover 100% of the population with social health insurance by 2020	Conflict and challenging context, huge HRH issue	Health system predominantly privatised, universal health care programme launched in 2014	UMIC with significant government contribution, heavy double burden of TB and HIV

The above-noted information sources have been used to employ several approaches, including **investment mapping analysis** (employed for the review of RSSH funding in each of the eleven country case studies), **process analysis** (employed to assess the processes from receipt of country allocation letters to grant signing and approval), **comparator analysis** (i.e. learnings from other organisations such as Gavi and the World Bank) and **counterfactual or value-add analysis** (to consider the value of the activity/ process/ intervention on the basis of the hypothetical situation of when it did not occur – usually employed as an interview technique to “pressure-test” review questions). In general, our approach to accessing and analysing information has been a mix of both **deductive** (i.e. testing hypotheses) and **inductive** (i.e. considering unexpected themes arising out of the investigation).

1.2.3. Synthesis of evidence

In reviewing and analysing information gathered under the review, our role as evaluators has been to adopt a “neutral position” and consider both the “quality” and “quantity” of evidence to assess robustness of findings and conclusions. In terms of quality, we consider aspects such as reliability of the data and information (where possible/ relevant), significance of the consultee providing feedback for a specific issue (e.g. implementers are conflicted to provide positive rather than critical feedback, etc.). In terms of quantity, we consider the extent to which findings can be triangulated across the sources of information. In terms of consultations, we consider how many consultee responses supported the same view, or instances in which views might have been contradictory.

Bringing these together, we adopt a four-point scale for robustness rating of findings, as described in Table 1.2 below (with rating D findings not being presented per se - rather this rating level is used to demonstrate the scale). All robustness rankings are relative robustness rankings and are ultimately judgement-based.

Table 1.2: Robustness rating for findings

Rating	Description
A/ Strong	The finding is supported by majority of the documentation and/ or data, which are categorised as being of good quality; and/ or majority of consultations, with relevant consultee base for specific issues at hand; and/ or represents a common theme across majority of the country case studies.
B/ Good	The finding is supported by some of the data and/ or documentation which is categorised as being of good quality; and/ or majority of the consultation responses; and/ or several country case studies.
C/ Limited	The finding is supported by some data and/or documentation which is categorised as being of poor quality/ limited relevance; or some consultations; or reflects the experience of a few countries only.
D/ Poor	The finding is supported by various data and/ or documents of poor quality; or by a few consultations or contradictory consultations; or has limited support from country case studies.

Summary findings tables are presented at the end of each review question, with a robustness rating and explanation.

1.2.4. Limitations

A limitation is the diverging definitions and understanding of RSSH/ HSS, within the Secretariat and external global and country-level partners. This is discussed as a key issue under the review of RSSH strategy and design in Section 4.2.

Second, it is difficult to track RSSH investments within country grants, especially where RSSH investments are integrated within disease grants (discussed in Section 4.4). This is also because RSSH investments vary across multiple documents without an audit trail of changes, and there was limited knowledge of the specifics of RSSH funding amongst several CTs and at the country-level (another key issue discussed in Section 4.4), especially for the 2014-16 allocation period. This has particularly impacted the desk-based country studies.

Third, despite requests for meetings with systems-representatives, interviews with partners/ donors at both the global and country-levels were at times with personnel with greater expertise in a specific disease, rather than a detailed knowledge, or understanding of RSSH.

Finally, given the wide scope and coverage of the review, certain aspects have not been analysed in detail, given available time and budget. The OIG RSSH review is examining two key RSSH investment areas on PSCM and financial management, with the former in particular being a key area of RSSH funding in countries where this review has not focused in detail.

1.3. Structure of the document

CEPA's RSSH review is presented in a set of **four documents**:

This **Main Report**, with Part A on the introduction (Section 1), summary findings, conclusions and recommendations (Section 2) and Part B with the detailed analysis – context and background to Global Fund RSSH (Section 3), analysis and findings for the four review areas of strategy and design (Section 4), policies, processes and tools (Section 5), five RSSH investment areas (Section 6) and partnerships (Section 7). An **Executive Summary** document is also provided.

Supporting Annexes, on the methodology (bibliography (Annex A), list of consultees (Annex B), interview guides (Annex C) and selection of country case studies (Annex D)) and background analysis (RSSH portfolio (Annex E), UHC measurement (Annex F), progress against Strategy KPIs for RSSH (Annex G), grant absorption rates (Annex H), evolution of RSSH information notes (Annex I), CCM composition across countries (Annex J), RSSH funding in case study countries by investment area (Annex K) and comparison of RSSH with other donor HSS funders operational processes (Annex L)).

Country Annexes, which provide country case study reports for the eleven countries studied under this review.

2. SUMMARY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

Section 2.1 provides a summary of findings across the four review areas (with detailed analysis in Part B), followed by overall review conclusions in Section 2.2 and recommendations in Section 2.3.

2.1. Summary findings

Key issue/ theme	Findings
Review area 1: Strategy and design (<i>reference review question included in brackets</i>)	
Alignment of RSSH with evolving global health agenda (Qs 1)	<ul style="list-style-type: none"> • The global epidemiological and policy landscape has evolved considerably in recent years. While the Global Fund Strategy has positioned RSSH for UHC, this has not been adequately realised in practice, reflecting the overall disease mandate of the Fund. The largely disease-focused investments are not adequately integrative, or cognisant of broader health needs. • While the Global Fund is one of the leaders on resilience and the vital role of communities, a clearer definition and operationalisation of the concept is needed. Likewise, sustainability of RSSH investments has received inadequate attention, particularly in the context of health system sustainability as a building block of UHC.
RSSH strategic prioritisation and operationalisation (Qs 2)	<ul style="list-style-type: none"> • Despite strategic prominence, the lack of a theory of change for RSSH and ambiguous/ confusing messaging across Global Fund documentation has resulted in multiple interpretations of RSSH, creating several “operational tensions” in terms of (i) a focusing on disease control priorities and cross-cutting health system issues; (ii) short-term versus long-term funding; (iii) narrow versus broad-based funding across investment areas; and (iv) disease-specific versus integrated implementation. • RSSH funding is regarded as important by countries, so the lack of specific RSSH allocations does not appear to impede country RSSH funding.
RSSH funding – balance of the “operational tensions” (Qs 2)	<ul style="list-style-type: none"> • Global Fund RSSH funding, for the most part, is disease-focused rather than cross-cutting. • The majority of Global Fund RSSH investments remain focused on short-term, gap-filling, systems support for the three diseases, rather than longer-term health systems strengthening investments, also reflective of the Global Fund’s three year funding cycle. • Global Fund RSSH investments are currently focused on a few priority areas, namely data systems, PSCM and HRH. Other investment areas have received limited investments (i.e. CSR, national disease plans, financial management and integration). • The majority of RSSH grants are integrated with disease programmes and also implemented by them. Both the stand-alone and integrated approaches to RSSH grants have pros and cons, but stand-alone grants, or grants integrated with disease programmes, but implemented by a cross-cutting HSS unit/ department, have some advantages.
Differentiation for RSSH (Qs 3)	<ul style="list-style-type: none"> • There is a need for more effective RSSH differentiation and improved guidelines that can be operationalised across a range of contexts.
Tracking of RSSH investment (Qs 4)	<ul style="list-style-type: none"> • It is difficult to track RSSH investments largely due to grant structuring and reporting arrangements.
RSSH M&E approach (Qs 4)	<ul style="list-style-type: none"> • The approach to measuring RSSH investment results is ineffective, with a focus on macro-quantitative monitoring, rather than potentially more insightful

Key issue/ theme		Findings
		qualitative evaluations, as well as a limited emphasis on community level monitoring.
Absorption as a performance metric (Qs 4)		<ul style="list-style-type: none"> Performance monitoring based on absorption of funds has created perverse incentives for RSSH.
Review area 2: Policies, processes and tools		
Relevance of overarching Global Fund policies for RSSH (Qs 5)		<ul style="list-style-type: none"> Overarching Global Fund policies have been largely structured around disease requirements, with allocations not including any health systems criteria, and the sustainability, transition and co-financing policy does not go far enough to address sustainability issues from an RSSH perspective.
Efficacy of RSSH related tools and guidelines (Qs 5)		<ul style="list-style-type: none"> The RSSH Investment Framework lacks clarity and stability, with frequent updates. There is close to no knowledge and use of the Framework in country. RSSH investment-specific guidelines are technically strong, but also receive limited use. The application approach undermines RSSH, with RSSH being treated as “another disease” (e.g. application templates do not allow for RSSH relevant information, programme continuation approach does not consider RSSH context). There is inadequate definition/ prescription in the application process (e.g. timing of RSSH applications vis a vis diseases).
RSSH application process	Country decision-making (Qs 6)	<ul style="list-style-type: none"> In the absence, in many cases, of a strong evidence-based rationale for funding, guidance in the allocation letters, alongside strong steering by the Secretariat is driving country RSSH funding levels. RSSH-related representation on the CCM is not the key issue – rather, there are questions whether the CCM is able to effectively engage in wider health systems discussions, and whether it is well integrated with other in-country coordination structures.
	TRP review (Qs 6)	<ul style="list-style-type: none"> There is inadequate focus on RSSH; a function of limited information in the application forms and disease-dominated discussions within the TRP.
	Grant-making and approval process (Qs 6)	<ul style="list-style-type: none"> Grant-making processes are complex, time-consuming and with high transaction costs. The Country Teams play a strong role in determining RSSH funding, often undermining country ownership.
Review area 3: RSSH investment areas – approach and implementation		
CSR design and implementation (Qs 7)		<ul style="list-style-type: none"> The Global Fund is one of the few organisations prioritising CSR at a corporate objective level, but there is a general lack of clarity and understanding on the aims and scope of this investment area. CSR funding requests tend to be limited in scope and scale, and there is a dominant focus on the extension of service delivery through community health workers (CHWs) at the community level. The role of civil society organisations (CSOs) in supporting service delivery has been limited and small scale in a number of countries. Although CSR is core to the resilience concept within RSSH, grants have not been implemented with this approach in mind. CSR programmes are often not effectively designed, or implemented, with a sustainability focus.
HRH design and implementation (Qs 8)		<ul style="list-style-type: none"> The majority of HRH support has been for salaries, often reflecting short-term gap filling, rather than longer-term HRH objectives and sustainability. Transition of salary support has consequently been challenging.

Key issue/ theme	Findings
ISD design and implementation (Qs 9)	<ul style="list-style-type: none"> The investment area is not well defined, nor fully understood by stakeholders, with suggestions that it is overly narrow in focus.
Data systems design and implementation (Qs 10)	<ul style="list-style-type: none"> This investment area has received substantial funding, with a number of critical data systems development investments, although a considerable portion are disease-specific. In select countries, investments have been broad and patchy, impeded by the lack of comprehensive country plans and operational strategies on health data systems. Analysis and use of data remains a key gap. There has been varied progress in the coordination and alignment of investments with partners.
National health plans design and implementation (Qs 11)	<ul style="list-style-type: none"> This is a poorly understood investment area amongst stakeholders, with a broad range of activities funded, but many countries not applying for support. There is a need for more definition and strategic prioritisation.
Review area 4: RSSH investment areas – approach and implementation	
RSSH Technical Assistance (TA) delivery (Qs 12)	<ul style="list-style-type: none"> Identification of RSSH TA in Global Fund grants is complex and not well understood or effectively leveraged. Lack of dedicated TA partner for HSS and CSS, fragmentation of the health systems TA landscape and limited guidance from the Global Fund on TA for HSS are key issues.
Partnership mechanisms for RSSH-related TA (Qs 12)	<ul style="list-style-type: none"> A combination of approaches to TA, including from the UN and bilateral organisations, as well as Global Fund direct TA funding is needed to ensure that countries can choose the approach best suited to their needs. Improved coordination on TA amongst donors and development partners is important.
Coordination of donor funding for HSS/ RSSH (Qs 13)	<ul style="list-style-type: none"> Although coordination has improved, HSS/ RSSH alignment across donors is still weak. Key bottlenecks include donors using multiple in-country platforms/ stakeholders for planning/ designing HSS, lack of Global Fund in-country presence, lack of an overarching country strategy for coordination and the poor efficacy of partners in country. Government stewardship of donor funding is a key enabling factor for coordination.

2.2. Review conclusions

Drawing on the summary findings by review area, the following overall conclusions apply:

1. Stronger RSSH prioritisation.

The current 2017-22 Global Fund Strategy presents a first-time strategic prioritisation of RSSH by the Global Fund, with consequent increased Secretariat focus on RSSH. Countries are increasingly viewing the Global Fund as an important funder of health systems. There has been a notable shift in the dialogue from “the three diseases or RSSH” to “the three diseases and RSSH”.

2. There remains a disconnect between the RSSH strategy and its operationalisation, with the estimated RSSH funding of US\$5.8b (27%) under the NFM to date being largely disease-

focused, short-term and gap-filling in nature, and as such, not adequately reflective of the evolving importance being accorded to UHC.

The 2017-22 Global Fund Strategy for RSSH is broad-based and cross-cutting, framing RSSH in the context of the three diseases, as well as Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH), non-communicable diseases (NCDs) and global health security threats, alongside reference to people-focused integrated funding. The Strategy is broadly reflective of the evolving imperatives in the global health landscape, including the importance accorded to UHC.

However, the Strategy has not yet been effectively operationalised, reflecting the overall disease mandate of the Fund and the consequent trade-offs thereof. Among the reasons: divergent views on RSSH in the Secretariat and wider stakeholders including key donors to the Fund, absence of an overall theory of change for RSSH, conflicting/ ambiguous documentation, and several issues with the Global Fund operational model and processes (such as siloed RSSH implementation across Secretariat teams and issues with the application cycle, discussed below). There is also poor definition and clarity on the concept of resilience and sustainability of RSSH investments – both of which are central to the RSSH concept and key building blocks to UHC.

As a result, there is a divergence between the RSSH vision in the 2017-22 Global Fund Strategy and implementation in practice, with current RSSH not being adequately reflective of the evolving importance accorded to UHC. Rather, RSSH funding is largely focused on:

- *Key disease bottlenecks* (e.g. antiretroviral (ARV) supply chains, data investments for specific diseases), *rather than those impacting the health system as a whole.*
- *Short term systems support for the three diseases (while arguably important), rather than longer term investments supporting system resilience and sustainability.* For example, the majority of HRH support has been for salaries, which while necessary, are often not embedded within a long-term plan to achieve sustainability. Support to CSOs is also often activity orientated, rather than encompassing a more long-term view of capacity building or strengthening of the sector. The analysis and use of data, especially at lower administrative levels, continues to remain a key gap, with insufficient attention in grant design.
- *Investments that are not adequately integrative in nature,* with RSSH funding focusing on the three diseases and specific platforms, rather than an overarching approach reflective of the evolving integration agenda (e.g. with NCDs).
- *A few RSSH investment areas, such as HMIS, PSCM and HRH, with less less prioritisation and funding of others.* RSSH investment areas such as integrated service delivery, CSR and national health strategies are poorly defined and understood by stakeholders, resulting in inconsistencies in the categorisation of investments results and inaccuracies in the level and scope of RSSH activity funded.

3. There has been limited effective differentiation of RSSH investments, impeded by a lack of a framework and guidance, as well as absence of country health systems plans.

There has been limited effective differentiation of RSSH investments by country context, maturity of the health system and growth/ sustainability/ resilience objectives. Insufficient attention to differentiation in the RSSH Investment Framework has impacted effective operationalisation. Effective differentiation may also be impeded in countries which lack national strategies or plans on health systems development (different from national health plans that are more high-level and disease national strategic plans (NSPs) that are disease-focused). These, alongside comprehensive information on who is funding what in countries, would provide a country “roadmap” for RSSH, the lack of which serves as a major constraint to effective Global Fund RSSH programming.

4. RSSH guidance for countries is complex, ambiguous and not used by countries to support investment planning.

The Global Fund’s RSSH guidance is complex (e.g. uses international jargon), confusing (with multiple versions over the years) and inadequately tailored for transition countries and Upper-middle income countries (UMIC). Successive updates to the documents over the years have resulted in “guidelines fatigue” and a tendency to continue with the thinking provided in previous versions. Across our case study countries, stakeholders were mostly unfamiliar with the Global Fund RSSH guidance (overall and investment area specific) and did not consult it for RSSH investment planning.

5. An RSSH allocation and RSSH representation on the CCMs are not key to effective RSSH prioritisation and planning.

We did not find evidence that an RSSH allocation and RSSH-related representation on the CCM would resolve issues with effective RSSH prioritisation and planning. In fact:

- As noted, countries are increasingly demanding RSSH funding, despite the lack of a specific RSSH allocation. Countries were broadly not in support of an RSSH allocation and appreciated the flexibility to determine RSSH funding levels themselves. Further, the lack of an RSSH allocation is in name only, as suggested levels of funding provided in the allocation letters have served as guidance/ benchmarks for countries. However, this guidance has evolved over time, which has caused confusion on RSSH funding levels. The suggested guidance also receives different interpretation from the Country Teams, who play a major role in determining RSSH funding. Clearer and stable guidance would reduce transaction costs for countries.
- CCMs vary in terms of the extent of RSSH-related representation, but generally appear to support RSSH investments. However, CCMs may not have the capacity to engage in cross-cutting RSSH discussions on prioritisation reflective of wider HSS discussions and coordination bodies in country. This reflects a discord between the mandate of the CCM and the “agency” (both in terms of knowledge and incentive) required to assess health systems issues, as well as inadequate coordination and possible overlap with other health systems planning bodies in country.

6. While there are benefits to an open-ended and composite (i.e. diseases and RSSH) approach to country applications, current operational processes are not adequately cognisant of RSSH requirements.

The Global Fund has tried to reduce specific requirements for RSSH in order to enhance country ownership and flexibility as well as integrate disease and RSSH applications to reduce transaction costs.

However, notwithstanding the trade-offs countries face between disease coverage and systems investments, without adequate “prescription”, countries are employing ad hoc approaches to determine RSSH funding, often based on Country Team steering and what they understand will be approved by the TRP. RSSH funding is also substantially revised and fine-tuned in the later parts of the application cycle, namely grant-making, implying inefficiencies in process.

Integrated application forms mean that there is often limited RSSH-specific information to guide an effective TRP review, and the review processes themselves (TRP and grant-making) are disease focused, with limited emphasis on RSSH.

Throughout the application process, the Country Team plays a strong steering role in determining RSSH funding for countries, perhaps more so than for the diseases, where there are standardised packages of care and hence less room for ambiguity. There are cases where country proposals have been dropped during the grant-making stages, without adequate communication and discussion. This raises questions within the Global Fund operational model concerning the capacity of the Country Teams to determine RSSH priorities, and the relative balance between country ownership and funder-driven steering of the RSSH investments.

RSSH-specific requirements such as complex investment planning in the absence of country RSSH roadmaps, the need for long-term investments (rather than three-year funding cycles) and lack of standardised packages of investment implies that RSSH investments need separate consideration, rather than a standardised approach within the Global Fund as “just another disease programme”.

7. RSSH grants have for the most part been integrated with disease grants, with the potential of separate RSSH implementation not fully realised.

The model of disease-RSSH integrated grants has dominated within the Global Fund, which has contributed to disease-focused RSSH investments. However, the disease programmes may not be best placed to implement health systems investments, notwithstanding trade-offs within the overall Global Fund grant context. Stand-alone grants have hardly been employed, with Country Teams often dissuading countries on this grant structure on account of historically low absorption (and hence performance) indicators, as well as greater management requirements. Under NFM2, there have been some cases of disease integrated RSSH grants with separate implementation through a centralised or cross-cutting health systems department (e.g. Ghana, Tanzania). These approaches may yield some strong benefits if a further cross-cutting HSS approach is warranted and the approach is feasible (such as in High impact or Core countries, more so than in Focused countries which tend to have one grant and one PR).

8. Tracking of RSSH investments and RSSH M&E is ineffective, with grant performance measurement through absorption creating perverse incentives for RSSH.

As RSSH funding is for the most part integrated with disease funding, it is difficult to fully understand and appreciate its scope. The documentation on RSSH is also weak, with limited description of RSSH and a limited “audit trail” of changes over time. Use of standardised categories through the Modular Framework masks the detailed and specific nature of the RSSH investments.

The M&E of RSSH investments has been ineffective. There is limited use of qualitative approaches to evaluation of RSSH investments, poor linkage between RSSH investments and standardised outcome (coverage) indicators included in the Modular Framework, and the use of work plan tracking measures (activity-orientated process indicators) is not particularly encouraged or supported, leading to their limited inclusion in RSSH module M&E frameworks. It is broadly accepted that there are insufficient outcome metrics on long-term effectiveness, sustainability or resilience of country health systems and that the emphasis on standardised M&E through the Modular Framework applies more usefully to disease control rather to RSSH implementation efforts. These limitations, combined with the overall intention to reduce the monitoring burden at the country level, have led to the over-simplification of RSSH M&E, and a reliance on a macro-quantitative, rather than a more targeted, qualitative, approach. Particularly within RSSH specific modules, there has also been limited emphasis on the collection of community data or community-based monitoring.

Finally, the emphasis of grant performance monitoring on absorption creates perverse incentives for prioritising and structuring of RSSH funding (e.g. limited interest in stand-alone grants to address more system wide and longer-term issues which may have lower absorption rates).

9. Across the RSSH investment areas, there are some good examples of strategic and value-adding investments, though there is general lack of clarity and understanding on the full technical scope of potential funding available and a dominance of disease specific investment.

HMIS and M&E, PSCM and HRH are the largest investment areas for direct RSSH funding, although when considering total RSSH funding (i.e. direct and contributory), HRH funding is the largest investment area. There are numerous examples across the RSSH investment areas of strategic investments, prioritised effectively in line with country needs. In particular, the Global Fund has played an important leadership role in the progression of CSR thinking and the application of approaches to multi-disease contexts.

However, amongst both country and global level stakeholders, including the Secretariat, there remains considerable variability in understanding and appreciation of the full technical scope of potential funding available across the RSSH investment areas. Amongst other factors, this is influenced by particular experience gathered in certain activity areas and preconceived ideas as to how funds can best be spent for maximum impact at scale. This appears to contribute to the domination of funding in some activity areas within RSSH specific modules, for example, the extension of service delivery through CHWs at the community level in CSR funding requests,

commonly narrow foci in efforts to boost integration under the integrated service delivery investment area, etc.

A notable proportion of RSSH funding also remains singular disease specific, for instance, support to HIV parallel data systems or support to TB laboratory development under integrated service delivery investment area, with some more than others offering broader benefits to the overall health system. Despite the guidance available, further support and capacity building may be required to enable countries to benefit from the full breadth of RSSH support available.

10. Donor and development partner coordination for HSS funding continues to be weak.

Although there have been some improvements over time, the analysis of donor HSS funding presented in this report is telling in terms of the continuing unique focus of different donors regarding HSS, risking sub-optimal approaches and results. The Sustainable Development Goals (SDGs) and UHC frameworks provide imperatives for better coordination – both in terms of what is funded as well as funding processes.

2.3. Recommendations

The above conclusions present key opportunities for the Global Fund to better align and attune its RSSH funding to the evolving context and country needs. This section sets out a series of strategic and operational recommendations for Global Fund RSSH, as well as specific recommendations by RSSH investment area.

Recognising that there are different views on RSSH, the proposed recommendations are based on the strategic framework for RSSH set out in the 2017-22 Global Fund Strategy. Most of the recommendations are closely linked and represent a coordinated set of actions to improve the overall efficacy of Global Fund RSSH funding.

The proposed recommendations build on the RSSH-related “actions” identified through the Strategy Committee meeting in October 2018.³ These are referenced below as they relate to specific recommendations. In addition, in setting out the recommendations, we provide suggestions on:

- their operationalisation and related actions, although detailed operationalisation of recommendations is not within the scope of this work;
- whether the recommendations may be implemented over the short term (i.e. for the next allocation cycle) or longer term (i.e. for the next Global Fund Strategy period), where relevant; and
- stakeholder responsibility (e.g. Global Fund, partners, countries), recognising the multi-stakeholder environment for the implementation of Global Fund RSSH. This is provided in *italics* against specific actions, where relevant.

³ Presentation to the Strategy Committee (October 2018). Strategy Implementation Deep Dive: RSSH.

2.3.1. Strategic recommendation

1. Clarify the scope and role of RSSH, in relation to the primary disease focused mandate of the Global Fund, health system resiliency and sustainability, and UHC.

In line with the current 2017-22 Strategy, it is assumed that the first order of business will continue to be the control and eradication of AIDS, TB and malaria. However, to address the continued ambiguity around the scope and role of RSSH investment, the following would be critical in the short-term:

- Develop a clear and coherent “consensus statement” on the Global Fund’s role with regards to RSSH investment, including how RSSH funding: (a) supports disease control objectives across the development continuum, both in the short- and long-term and as relating to a ‘support’ and ‘strengthening’ focus; (b) boosts overall health system resiliency and sustainability; and (c) supports UHC (a corporate objective of the Global Fund), including the full spectrum of quality health services according to need and coverage for the entire population. *(Responsibility: Global Fund Board and Strategy Committee).*
- Once agreed, this statement should be widely shared and communicated with both internal and external audiences to promote a uniform understanding, ownership and application of the Global RSSH approach going forward. *(Responsibility: Global Fund Secretariat).*

Building on this, in the longer term, the Global Fund should renew efforts to encourage and actively support a strategic dialogue with its partners to ensure that financial, technical assistance and implementation support to health systems strengthening is optimised and to better define the Global Fund’s comparative advantage.

With the evolving global health agenda, there is an increasing case for the Global Fund to consider a broad-based, cross-cutting and UHC-based approach to RSSH in the next Strategy period, which would be contingent upon the direction of travel of the overall mandate of the Global Fund going forward.

Linkage with Strategy Committee October 2018 actions: This recommendation was not made directly, however we view the development and communication of an RSSH consensus statement as an important “first-step” for improved efficacy of Global Fund RSSH going forward.

2.3.2. Operational recommendations

2. Develop a prioritisation and differentiation framework to guide decision-making on RSSH in line with national health strategic plans, and translate this into clear upfront guidance for countries and link with the end-to-end application and implementation cycle.

Closely following on from Recommendation 1 (which would help define the scope and role of RSSH), it would be useful to develop operational guidance in the form of a prioritisation framework for use by the Global Fund Secretariat/ Country Teams. This would aid a better understanding and appreciation of how to support countries in their prioritisation and programming of Global Fund RSSH support, based on their country national health strategic plans. *(Responsibility: Global Fund Secretariat)*

This should include the trade-offs which can exist between ‘supporting’ and ‘strengthening’ health systems, and how to balance RSSH in support of disease control with broader health systems strengthening. It should also include a framework for effectively differentiating “what” is funded under RSSH by country context. This could involve, for example, marrying the assessment of the health system maturity (e.g. as per the TRP 4S framework) with the Global Fund’s current differentiation approach of distinguishing between High-impact, Core and Focused countries, to identify “application focus requirements” by country type. The framework would also require a consideration of community systems and recognition that community system differentiation may be different to that of the formal health system.

The prioritisation framework should be linked with the end-to-end application cycle, as well as implementation, by translating the framework into clearly defined/ prescribed upfront application guidance to countries, TRP review criteria and GAC decision-making as well as RSSH grant M&E.

Linkage with Strategy Committee October 2018 actions: This recommendation is aligned with Action 1 “strengthen differentiation and prioritisation of RSSH investments along the development continuum” and Action 2 “prioritisation should be based on careful assessment of what is most critical to achieve particular outcomes rather than input categories”.

3. Revisit and improve the overall guidance on RSSH, with greater definition/ prescription, focusing on encouraging its active use.

We suggest that the current RSSH guidance, in terms of the Information Note in particular, be revisited for simplification and accessibility for countries. While the Secretariat is rightly keen to focus on operationalisation of the guidance, we see merit in improving the guidance first, with a clear distinction between: (i) investment planning guidance for countries, which should be a very short and focused document reflective of the above noted prioritisation and differentiation framework, simple, easy to follow and including the priority information that countries need to be aware of (including what is not funded by the Global Fund); (ii) operational guidance for the Secretariat (Country Teams) that include a detailed exposition of RSSH scope, objectives and priorities, including rationale for certain approaches, examples where relevant, etc.; and (iii) information notes explaining the Global Fund’s RSSH approach to external stakeholders and partners (i.e. the consensus statement on RSSH). The detail, length, drafting (including use of jargon, infographics, etc.) would differ for each of these types of guidelines. Country guidance for RSSH should provide upfront definition/ prescription on aspects to aid country decision-making such as an evidence-based approach to determine RSSH funding within the country’s total allocation, timing and sequencing of RSSH funding requests in relation to disease funding requests, etc. *(Responsibility: Global Fund Secretariat)*

Importantly then, it would be instrumental to consider ways to make the RSSH guidance accessible to countries – for example, provide a FAQs document, tailor the guidance by country type, consider providing spotlight updates that communicate any changes in RSSH approach over time. Beyond written guidance, there should be greater efforts at training and dissemination, ensuring targeting of key country stakeholders and uniform messaging by the Country Teams. *(Responsibility: Global Fund Secretariat)*

Linkage with Strategy Committee October 2018 actions: This recommendation is aligned with Action 3 “strengthen operationalisation and implementation of existing investment guidance, while secondarily filling targeted gaps in guidance”.

4. Consider revising a number of standard Global Fund application, review and implementation processes to better reflect RSSH priorities and requirements.

The following options could be considered, all of which are feasible for the next allocation cycle:

- Revise the application form to better reflect the prioritisation and differentiation framework discussed above. This could include requests for more specific context information on the proposed focus of RSSH funding, a justification for the suggested priorities considering support and strengthening aims, disease specific and health systems benefits, etc. There should also be provision to include complementary information to further guide an effective TRP review such as from previous applications, applications to Gavi, GFF, etc., and information from the RSSH Dashboard. *(Responsibility: Global Fund Secretariat)*
- Increase RSSH technical expertise and incentives to support Country Teams with the effective design and implementation of RSSH investments that are adequately differentiated by country context. *(Responsibility: Global Fund Secretariat)*
- Support opportunities for greater implementation of RSSH investment through cross-cutting departments in health ministries, rather than disease programmes. Appropriate steps would need to be taken to ensure engagement of these cross-cutting departments with Global Fund processes, including familiarity with the overall model and reporting requirements. *(Responsibility: Global Fund Secretariat, CCMs, countries)*
- Revise the programme continuation approach to factor in RSSH continuity aspects alongside the existing disease-focused criteria. *(Responsibility: Global Fund Secretariat)*
- Explore the possibility of ring-fencing RSSH funding to avoid reprogramming of RSSH funds into other interventions (to boost absorption) when these activities are delayed. *(Responsibility: Global Fund Secretariat)*

Linkage with Strategy Committee October 2018 actions: Revision of standard Global Fund processes was not discussed amongst the actions, however we view this as a key gap for the effective functioning of RSSH support.

5. Improve RSSH grant documentation and M&E.

Improve documentation on RSSH funding as a short-term action, allowing for better tracking of RSSH funded interventions and their progress over time. These may require more enhanced templates. It may also require the introduction of an improved audit trail for documents from application to review to implementation, that clearly identify changes along the way, including the rationale/justification. *(Responsibility: Global Fund Secretariat)*

Critically, develop a more relevant and comprehensive approach to M&E and performance measurement of RSSH investments, also as an action for the next allocation cycle, focusing on the

qualitative evaluation of the investments (*Responsibility: Global Fund Secretariat*). Specific suggestions include:

- Further emphasis on small/medium scale, qualitative studies focused on specific investment areas from which enhanced insight could be most valuable for strengthening further investment or to boost health systems strengthening efforts in country. These could highlight direct as well as indirect outcomes from RSSH investment.
- Thematic reviews targeting certain investment areas across a range of country contexts could also be particularly insightful for generating insight for optimal investment. Joint reviews with donors with similar investments could be particularly efficient and valuable to improve coordination and implementation.
- Consider an appropriate balance of enhanced work plan tracking measures and coverage/ outcome measures included in the Modular Framework that would allow for a more relevant assessment of the funded interventions. A “long list” of output measures could be developed, which better reflect the focus and range of RSSH funded interventions.

Linkage with Strategy Committee October 2018 actions: This recommendation is aligned with Action 6 “improve measurement of the outcomes of RSSH investments”.

6. Improve RSSH-relevant engagement in the CCM, alongside engagement/ linkage of the CCM with other health sector planning and coordination bodies.

In particular (with these actions being both short and longer term, depending on country context):

- Continue to enhance RSSH representation and capacity on CCM, including greater engagement from Ministry of Finance, communities and NGOs, as well as private sector in the application process. (*Responsibility: Global Fund Secretariat, CCMs, countries*)
- Encourage CCMs to engage in wider health systems discussions, including standard government planning processes as well as other donor platforms (such as that employed by Gavi or GFF). These additional platforms should be effectively leveraged by the CCMs, and with the changing environment and drive for UHC, there should be increasing effort to embed CCM functions in the broader health sector arrangements. This could be approached country by country, based on CCM context of that country. (*Responsibility: Global Fund Secretariat, CCMs, countries*)

To our knowledge, the current CCM evolution process has not adopted this approach.

Linkage with Strategy Committee October 2018 actions: This recommendation is aligned with Action 5 “strengthen RSSH capacity and voice in country dialogue process”, although goes further to encourage CCM linkage with wider health sector and donor coordination bodies.

7. Continue to explore opportunities for greater development partner coordination for HSS.

The Global Fund should continue to consider opportunities for better coordination of HSS and CSS amongst development partners, building on the existing efforts in place. In particular:

- There may be some “quick wins” in terms of better coordination with Gavi, through joint country missions, sharing of data and information (such as from the RSSH Dashboard) and harmonised investment tracking (as is currently being conducted by WHO). As mentioned above, there may also be opportunities for coordinated country application reviews (i.e. between the Global Fund TRP and Gavi Independent Review Committee (IRC)), including sharing of expertise and leveraging each other’s reviews (e.g. Gavi has introduced in-country reviews in some cases). In addition, the Fund should explore modalities to improve sharing of information and coordination with other large donors such as the GFF and World Bank. *(Responsibility: Global Fund Secretariat, partners)*
- With multiple funders and providers for TA, the Global Fund may explore the option of setting up a “joint TA hub” with other large funders such as Gavi, World Bank/ GFF, etc (i.e. coordinated TA funding that covers systems as a whole rather than individual focus areas, joint pool of experts that can be shared across, etc.). This would encourage coordination of TA efforts as well as improve efficiencies by cross-sharing of expertise. *(Responsibility: Global Fund, partners)*
- Opportunities to support countries in leading the coordination of donor investments should be maximised (e.g. by funding capacity building). *(Responsibility: Global Fund Secretariat)*
- Supporting CCM collaboration with other country health sector donor coordination bodies. *(Responsibility: Global Fund, countries, partners)*

Linkage with Strategy Committee October 2018 actions: This recommendation is aligned with Action 7 “continue to deepen collaboration with Gavi and other partners for maximum leverage, efficiency and complementarity, where it makes sense to do so”.

2.3.3. RSSH investment area recommendations

8. Consider a number of measures to enhance the effectiveness of specific RSSH investment areas.

a) The range of permissible community systems and responses interventions should be more clearly articulated, alongside clarification on how a broad range of community data is linked with the formal health system. More flexible funding channels to support a range of CSR efforts should be explored.

- CSR should be seen as part of the main disease control or RSSH effort and conceptualised, planned and programmed as such. However, specific care and attention needs to be given in relation to key populations and the prioritisation given to activities which may offer high impact at a low scale. *(Responsibility: Global Fund, countries)*
- The range of permissible CSR investments needs to be articulated in the Modular Framework, including a clearer distinction between systems strengthening for responses conducted at community level and those that are community-led; and with particular attention to those reaching marginalised, under-served and key and vulnerable populations across the three diseases (it is understood this is already underway). As part of this guidance,

support to CHW and formalised cadres should be included under the HRH module, or integrated service delivery, with the CSR module focusing on systems strengthening to support community-led cadres. Also consider revising the module name to clarify the focus on community systems strengthening (that support community-led responses) given the confusion the name currently creates. *(Responsibility: Global Fund Secretariat)*

- Promote support for community engagement in the development of national strategies, including community health strategies, especially marginalised and most vulnerable communities. This will require timely access to community level data in useful summative or aggregate forms, as well as the promotion of national mapping of key community actors and responses need relating to different diseases. *(Responsibility: Global Fund, countries)*
- Clarity is needed on how communities can better link, refer and share data with the formal health system to support integrated programming and data based decision making. How community aggregated data is fed back and used at the community level to plan, support and evaluation further implementation efforts also requires elaboration. *(Responsibility: Global Fund, countries)*
- Operational policies and procedures should be revisited to support more flexible funding channels beyond the traditional PR/SR model, that allow for investments that not only leverage and bring community responses to scale but also ensure better alignment, coordination and collaboration with formal health systems. A creative, country specific approach should be taken to their development i.e. social contracting of CSOs, flexible financing and reporting approaches, the use of technology or performance-based mechanisms (based on process as well as outcome). This requires looking at overall systems for health and how to utilise all resources in country, including the private sector, to respond to the three diseases and wider health and rights. Appropriate associated management as well as financial, monitoring and reporting tools will also be required to be developed, tailored to country specific systems. *(Responsibility: Global Fund)*

Linkage with Strategy Committee October 2018 actions: This recommendation supports Action 2 “prioritisation should be based on careful assessment of what is most critical to achieve particular outcomes rather than input categories” and Action 3 “strengthen operationalisation and implementation of existing investment guidance, while secondarily filling targeted gaps in guidance”.

b) HRH should have a larger focus on sustainability, linked to country plans incorporating a longer-term view. HRH investment planning should have more steps in place to ensure guidance is practically enacted, particularly as relating to salary support.

- Support long-term comprehensive in-country planning on HRH which also articulates the linkages between different interventions i.e. HRH production, deployment, retention, as well as legal and regulatory frameworks, coordination of efforts and monitoring. *(Responsibility: Global Fund, countries)*
- The Global Fund should ensure HRH requests are framed within plans to absorb recurrent costs. The Global Fund should only invest in short-term HRH needs when robust needs

assessment and risk analysis show that such investments are required to mitigate imminent risk of disruption of service delivery - in such cases, it is critical to address the underlying drivers of the risk and strengthen the HRH function in a sustainable manner based on well formulated strategic plans, to avoid the need to address short-term gaps repeatedly over several cycles. Where short-term salary support is provided, there should be a specific requirement of a salary transition agreement, with agreed handover requirements at milestone points. *(Responsibility: Global Fund, countries)*

- Articulate, based on evidence and examples, the Global Fund's preference to support pre-service training over in-service training, linked to country specific human resource plans. However, the TRP should also give due consideration to requests for support to in-service training in their review. *(Responsibility: Global Fund)*
- Further guidance should be provided around what is included in this investment area, for example, guidance on support to the sustainably developing the CHW cadre, in line with WHO guidelines. Our suggestion is that support to CHWs should be incorporated under the HRH rather than CSR investment area. *(Responsibility: Global Fund Secretariat)*

Linkage with Strategy Committee October 2018 actions: This recommendation supports Action 2 "prioritisation should be based on careful assessment of what is most critical to achieve particular outcomes rather than input categories" and Action 3 "strengthen operationalisation and implementation of existing investment guidance, while secondarily filling targeted gaps in guidance".

c) Integration should be a cross-cutting approach, reflective of WHO's people centred approach, rather than a narrowly defined RSSH investment area.

- The Global Fund should move away from structuring integration as a specific RSSH investment area, and rather, consider integration as an overarching approach, orientated for example around the PHC delivery platform. *(Responsibility: Global Fund, countries)*
- More proactively use Global Fund investments in data, supply chain, service delivery, communities and other areas to advance integration. Global Fund funding and review processes should be used more proactively to reinforce integrated programme design, planning, funding requests and implementation. *(Responsibility: Global Fund, countries)*
- Increase accountability for integration through more granular, sensitive and relevant indicators of integration. *(Responsibility: Global Fund Secretariat)*

Linkage with Strategy Committee October 2018 actions: This recommendation aligns with Action 4 "more proactively advance integration in a cross-cutting and holistic manner".

d) Investments in data systems should be strengthened through improved partner coordination, an emphasis on capacity building around data analysis and use, the promotion of community data into national health data systems, and through the adoption of a longer term view in particular to data digitisation.

The Global Fund should consider the following:

- Support in-country/ country-led mapping of existing data system activities, to support coordination and alignment of government and donor funding. *(Responsibility: Global Fund, countries)*
- Prioritise improving the dissemination, analysis and use of data at the point of collection, in terms of identifying trends, measuring progress, and in developing and reviewing yearly plans and budgets. This may require considerable capacity building across different levels of the health system, including the community. *(Responsibility: Global Fund, countries)*
- Emphasise country strategic planning for data system investments, including a long-term vision/ pathway to the digitisation of data. *(Responsibility: Global Fund, countries)*
- Actively support the roll-out of community-based monitoring (CBM) efforts to support for service users or local communities in the gathering and use of information on service provision or on local conditions impacting on effective service provision, in order to improve access to and the quality of services. Case studies could help convey the range of CBM approaches and the value. *(Responsibility: Global Fund, countries)*
- Boost the linkage of community data to formal health systems data to support integrated programming and data based decision making (as per Recommendation 8 above). *(Responsibility: Global Fund, countries)*

Linkage with Strategy Committee October 2018 actions: This recommendation supports Action 2 “prioritisation should be based on careful assessment of what is most critical to achieve particular outcomes rather than input categories”, Action 6 “improve measurement of the outcomes of RSSH investments” and Action 7 “continue to deepen collaboration with Gavi and other partners for maximum leverage, efficiency and complementarity, where it makes sense to do so”.

e) The national health plans investment area should be further defined or revisited in line with governance and leadership considerations.

Revisit the need for this investment area, with a re-definition or re-think that considers governance and leadership challenges to the development of a sustainable and resilient health system. *(Responsibility: Global Fund)*

Linkage with Strategy Committee October 2018 actions: This recommendation supports Action 2 “prioritisation should be based on careful assessment of what is most critical to achieve particular outcomes rather than input categories”.

PART B: DETAILED ANALYSIS

3. GLOBAL FUND RSSH – CONTEXT AND BACKGROUND

To provide context to the review, this section provides a summary of the evolution of HSS funding at the Global Fund (Section 3.1), the current approach to RSSH (Section 3.2) and RSSH funding levels since the start of the NFM (Section 3.3).

3.1. Evolution of HSS funding at the Global Fund

The Global Fund was established in January 2002, as an international financing organisation to combat the communicable diseases of AIDS, TB and malaria. At the time of its establishment, the burden of these diseases and their crisis nature, implied that the Fund was set up as an emergency organisation for the three diseases. However, from its conception, the Global Fund recognised the importance of HSS, with its framework document from 2001 highlighting its purpose and scope as focusing on the three diseases, with support for programmes that “address the three diseases in ways that will contribute to strengthening health systems” (p. 93).⁴

Under the Rounds-based system, in the early years, “HSS support was narrowly focused to address disease-specific issues”, however from Round 5, “the concept of cross-cutting HSS was introduced to address broader system-related issues across the three disease programmes”.⁵ The last three Rounds prior to the launch of the NFM allowed for “broad flexibility with few prescriptions for health systems actions”, which “contributed to sub-optimal programmatic quality of country applications”, labelled by the TRP as “a shopping list of interventions with activities that would contribute to neither systems strengthening, nor to HIV, TB and malaria”.⁶

During this period, in 2010, the main multilateral funders of country programmes, namely the World Bank, Gavi and the Global Fund, alongside WHO, came together through the Health Systems Funding Platform (HSFP) to provide joint and coordinated funding for health systems, alongside their respective focus areas of support. However, for a number of reasons, including different funding cycles and incompatible funding and accountability systems, the HSFP never obtained traction, and all three organisations continue to largely provide separate funding.

The Global Fund Strategy for 2012-16 had five “Strategic Objectives” and associated “Strategic Actions”, with HSS being reflected in Strategic Action 1.3 (“Maximise the impact of Global Fund investments in strengthening health systems) within Strategic Objective 1 (“Invest more strategically”). The Strategy noted that HSS “is necessary to ensure the impact of core investments in HIV/AIDS, tuberculosis and malaria” and that disease funding also contributed to strengthening of health systems, with a need to invest more in critical HSS needs for the “long-term good functioning and sustainability of the health system (such as governance, health financing,

⁴ The Global Fund. (2001). The Framework Document.

⁵ The Global Fund. (2015). Strategy, Investment and Impact Committee, TERG Position Paper on HSS.

⁶ Ibid.

pharmaceutical and health product management)” and improved alignment and harmonisation of funding.⁷

3.2. Current RSSH support – objectives and approach

With the introduction of the NFM in 2014, the Secretariat, as guided by the Global Fund Strategy, Investment and Impact Committee (SIIC), aimed to strategically prioritise its approach to HSS by developing new guidance with “optimised scope of HSS investments”, based on an analysis of health system-related programmatic risks for HIV, TB and malaria, and included support for PSCM, data systems, HRH, service delivery and financial management.⁸ Several “Information Notes” were developed by the Secretariat over the years, which outline the (changing) scope of HSS investments (discussed in Section 5.1.2).⁹

More recently, and currently, the 2017 Information Note, sets out the Global Fund’s strategy (and newly coined term) on Resilient and Sustainable Systems for Health (RSSH) (referred to as the “RSSH Investment Framework” in this document).¹⁰ This RSSH strategy/ Investment Framework makes reference to “strong health systems that integrate robust community responses”, with a focus on “systems for health” (as opposed to “health systems”) in order to enable a country to cope with any potential future shocks.¹¹

The current 2017-22 Strategy, “Investing to End Epidemics”, accorded strategic prominence to RSSH, as one of four Strategic Objectives.¹² The Strategy notes that “the existence of strong systems for health is essential to making progress against HIV/AIDS, TB and malaria, and to ensuring that countries can address the varied health challenges they face from reproductive, men’s, women’s, children’s, and adolescent health, to global health security threats, to non-communicable diseases” (p. 4). It also notes that “investments will be made to benefit patients, not combat specific diseases” with integration, community and quality and equitable access defining the frame of support (p. 23).

Correspondingly, the RSSH Investment Framework defines seven operational objectives: (i) strengthen community systems and responses; (ii) support reproductive, women’s, children’s and adolescent health, and platforms for integrated service delivery; (iii) strengthen global and in-country PSCM; (iv) leverage critical investments in HRH; (v) strengthen data systems for health and countries’ capacities for analysis and use (HMIS and M&E); (vi) strengthen and align to robust national health strategies and national disease-specific strategic plans; and (vii) strengthen financial management and oversight.¹³

⁷ The Global Fund. (c2012). The Global Fund Strategy 2012-2016: Investing for Impact.

⁸ The Global Fund. (2015). SIIC, TERG Position Paper on HSS and PPT titled “HSS in the NFM (Feb 2015)”.

⁹ Global Fund HSS Information Notes for 2013, 2014 and 2015.

¹⁰ The Global Fund. (2017). Building RSSH through Global Fund Investment – Information Note.

¹¹ Ibid, page 3.

¹² The Global Fund. (2016). SIIC, The Global Fund Strategy 2017-2022: Investing to End Epidemics.

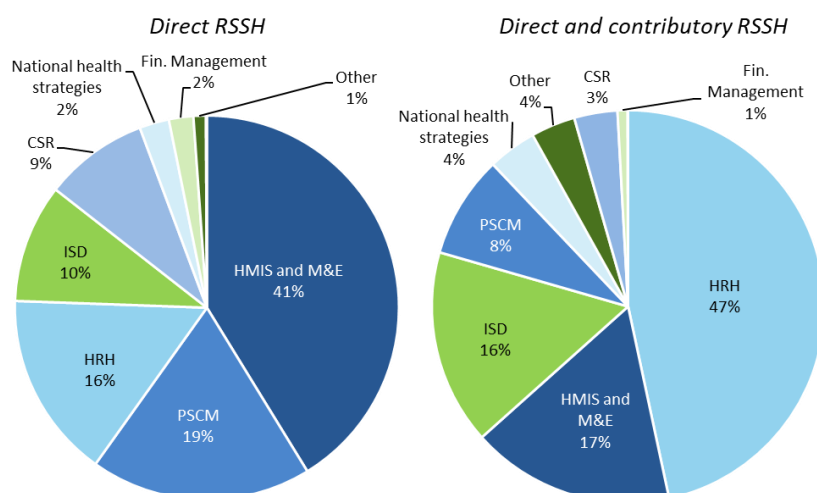
¹³ The Global Fund. (2017). Building RSSH through Global Fund Investment – Information Note.

3.3. RSSH funding to date

Based on data collected by the Secretariat on RSSH/ HSS funding since the NFM, a total of US\$1.5b and US\$0.9b has been funded for “direct RSSH” (i.e. stand-alone or cross-cutting RSSH/HSS modules within disease grants) for the 2014-16 and 2017-19 allocations respectively.¹⁴ A further US\$2.0b and US\$1.4b is considered as “contributory RSSH” (i.e. disease-specific investments that have been viewed by the Global Fund Secretariat to also provide benefits to health systems, as a per a defined methodology) over the two allocations. This brings the total RSSH funding to US\$5.8b to date under the NFM, or 27% of the total investments of US\$21.4b.

In the 2014-16 allocation period, only 2% of the grants were stand-alone RSSH grants and this decreased to 0.3% in the 2017-19 period. The average amount of direct RSSH funding by country per allocation cycle was around US\$12m (with a median of US\$4.4m). HMIS and M&E, PSCM and HRH are the largest investment areas for direct RSSH funding, although when considering total RSSH funding (i.e. direct and contributory), HRH funding is the largest investment area (Figure 3.1).

Figure 3.1: Share of investment areas across the two allocation periods



Supporting Annex E provides more details on the RSSH portfolio analysis, including limitations to the database.

¹⁴ This reflects around 90% of the NFM2 allocation, so can be viewed as largely representative of this NFM period.

4. REVIEW AREA 1: STRATEGY AND DESIGN

The first review area considers the strategy and design of Global Fund RSSH support, in terms of its relevance and alignment with the evolving global health landscape (Review Q1, Section 4.1), the strategic linkage between RSSH support and the three disease control components alongside the efficacy of the overall model of support (Q2, Section 4.2), the efficacy of implementation of differentiation in practice (Q3, Section 4.3), and the measurement of the contribution of RSSH investments (Q4, Section 4.4).

4.1. RSSH relevance with evolving landscape

Q1: How effectively does the RSSH framework meet the needs of the evolving global health landscape?

Section 4.1.1 discusses the evolving global health landscape and Section 4.1.2 presents Global Fund's current positioning for RSSH within this, drawing on current Global Fund Strategy documentation, feedback from consultations and evidence from the country studies.

4.1.1. Evolving global health landscape

Since the creation of the Global Fund in 2002, the world has witnessed unprecedented improvements in global health. Child and maternal mortality have been halved since 1990 and life expectancy in most countries has increased dramatically.¹⁵ Progress on AIDS, TB and malaria has also been extraordinary:

- in 2002, around 100,000 people living with HIV/AIDS had access to antiretrovirals, while in 2017 around 21.7m people are on treatment¹⁶;
- the malaria related mortality rate declined by 47% between 2000 and 2013 globally, and by 54% in Africa, with the malaria target under MDG 6 being met, and 55 countries being on track to reduce their malaria burden by 75%;
- the MDG target to halt and reverse the TB epidemic by 2015 has already been achieved, with TB incidence declining at a rate of 1.5% per year between 2000 and 2013.¹⁷

These considerable strides present a new situation away from the “emergency approach” of the early 2000s, and while key challenges remain, the disease control agenda is becoming more priority focused e.g. funding and sustaining antiretroviral treatments, boosting surveillance efforts in support of malaria elimination aims, and finding the missing cases for TB.¹⁸

However, while these achievements are laudable, the progress has been uneven between and within countries and substantial funding needs remain to sustain and further progress on AIDS, TB

¹⁵ The Global Fund, Development Continuum Working Group. (2017). Evolving the Global Fund for Greater Impact in a Changing Global Landscape.

¹⁶ UNAIDS 2018 Factsheet.

¹⁷ Ibid.

¹⁸ www.globalfundadvocatesnetwork.org/wp-content/uploads/2018/07/Get-back-on-Track-Full-Report-FINAL.pdf

and malaria control. Although, whether “exceptionalism” for the three diseases continues to be justified is increasingly questioned. The additional context of the epidemiological transition in which the global burden of disease is shifting from infectious to non-communicable diseases (NCDs) in many countries adds to this debate.

The move from the Millennium Development Goals (MDGs) to the Sustainable Development Goals (SDGs) of 2030 represents a shift from a vertical health-focused approach to a cross-sectoral and integrated approach. Central to the integrated and “health for all” approach of the SDGs, is the importance accorded to Universal Health Coverage (UHC) – SDG 3.8 aims to “achieve UHC, including (i) the full spectrum of quality health services according to need, (ii) financial protection from direct payment for health services when consumed; and (c) coverage for the entire population”.

Further, commencing with the Ebola crisis of 2013, there has been increasing recognition of the need to develop country health systems that are “resilient”, referring to their ability to withstand crises or shocks and highlighting the important role of communities. This has contributed to a linkage of global health epidemics and security issues, with an endeavour to elevate global health security through multi-sectoral approaches, as set out in the Global Health Security Agenda.¹⁹

4.1.2. RSSH positioning and alignment with evolving landscape

Global Fund Strategy for RSSH and some recent developments

As outlined in Section 3, the Global Fund Strategy for 2017-22 notes that resilient and sustainable systems for health are crucial to ensure access to effective, efficient, and accessible health services. The Strategy notes that strong health systems are essential for progress against AIDS, TB and malaria, as well as for progress in many other aspects of health, including reproductive health, NCDs and global health security threats. The Strategy also recognises the need for full alignment with partner plans and with the SDGs. The RSSH Investment Framework also emphasises that the Global Fund’s focus on RSSH will continue to strengthen and expand the capacity of systems to address health issues in a sustainable, equitable and effective manner, including for the three diseases.

Further, the Global Fund has entered into a number of partnerships on RSSH and UHC, including UHC2030.²⁰ In 2018, in recognition of uneven progress on meeting the health SDGs, the Global Fund also joined with ten other global partners to begin preparing a Global Action Plan to accelerate progress towards the health-related SDGs. The Global Fund has also recently embarked on a collaboration with the Primary Health Care Performance Initiative, which aims to catalyse improvements in PHC systems and accelerate progress towards achieving UHC through better, more comprehensive, and actionable measurement of quality PHC and better insights into interventions that effectively address performance gaps.²¹

¹⁹ The Global Health Security Agenda was launched in February 2014 “to advance a world safe and secure from infectious disease threats, to bring together nations from all over the world to make new, concrete commitments, and to elevate global health security as a national leaders-level priority.” [Online]. Available from <<https://www.ghsagenda.org>> [accessed 17 December 2018].

²⁰ UHC 2030. (2018). UHC 2030 Partners.

²¹ The Global Fund. (2018). The Global Fund PHC Framework & Performance Measurement (draft).

However, a substantiated direction or approach which balances – in both theoretical and operational terms – the Global Fund’s disease control objectives with UHC, is not yet clear.

Consultation feedback and country case study analysis

Our global level consultations presented a diverse range of views as to whether the Global Fund RSSH approach is well-aligned with the evolving global health agenda. At one end, the majority of those consulted in the Global Fund Secretariat thought that there was good alignment with the UHC agenda (“everything we do is about UHC”). However, partner organisations were more of the view that there is still a considerable way for the Global Fund to progress towards supporting UHC objectives and principles.

This divergence in opinion may be in large part a consequence of the varying interpretations and understanding of how to operationalise UHC. (suggested approaches and challenges in the measurement of UHC are discussed in Annex F).

- Some noted that the Global Fund is clearly supporting all three UHC objectives of equity, quality and financial protection, through both RSSH and disease support, by focusing on key marginalised populations and improving access and affordability of the latest quality preventive, diagnostic and treatment commodities. Within this framework, it was noted that the Global Fund needs to do more to support financial protection, by for example, extending its RSSH Investment Framework to consider broader health financing issues, including insurance and social protection.
- Others considered UHC interchangeably with integration of health services, as well as supporting Primary Health Care (PHC); and here it was argued that the Global Fund’s focus on the three diseases, as per its core mandate, can conflict with, or lag behind, the broader approach to the integration of services being pursued in many countries.
- Other consultees noted the difference between health systems support and health systems strengthening (see also Sections 4.2 and 4.3) and associated the latter more with UHC.²² With recent Global Fund analysis showing a significantly large focus of RSSH investments on systems support (66%), rather than system strengthening or system sustainability,²³ some noted that the Global Fund is not effectively embracing UHC objectives.

Evidence from the country case studies supports the wider partner view that the Global Fund needs to be doing more to embrace UHC. RSSH funding in a number of countries continues to be disease-focused and/ or with a strong disease-orientation in its structuring and implementation (as per the Global Fund’s “first order of business”), often with inadequate consideration of wider UHC-promoting objectives. Section 4.2 discusses this issue in more detail, reflecting upon this in relation to the RSSH strategy and its operationalisation. Many country stakeholders highlighted that Global Fund funding (and RSSH orientation in particular) did not sufficiently recognise the demographic and epidemiological transition to NCDs. Stakeholders also emphasised that RSSH support is not well

²² Also argued in the WHO paper on UHC as “getting more health for the money”. WHO (2013). Arguing for UHC.

²³ The Global Fund (2018). Strategy Committee: TRP Report on RSSH Investments in 2017-2019 Funding Cycle.

integrated with the broader health systems (given that the RSSH investment area of ISD remains largely disease control focused), presenting missed opportunities for leverage and efficiencies.

Some of the recent publications on UHC issued by the Global Fund also suggest a degree of “retro-fitting” of its RSSH approach within the UHC context²⁴ - indeed, as one of the partner consultations indicated, “the Global Fund is trying to keep up with, rather than lead, the UHC agenda”. Published commentary suggests that if the Global Fund remains a three diseases-only fund, with potentially dwindling resources for countries nearing elimination or control stages, general health service delivery might in any case be severely affected resulting in delayed establishment of UHC.²⁵

As such, we conclude that while the Global Fund Strategy has positioned RSSH for UHC, this has not been adequately realised in practice, reflecting the overall disease mandate of the Fund, with largely disease-focused investments that are not adequately integrative, or cognisant of broader health needs.

Resilience concept

The Global Fund has been one of the leading agencies setting forth the concept of resilient health systems and within it, the key role of community organisations and networks.²⁶ The concept is gaining ground in wider fora (for example, this is set out in the UHC2030 Global Compact and is also reflected in the Global Action Plan framework, where community systems are highlighted alongside public health systems).²⁷ However, the resilience concept has not been adequately defined and operationalised (discussed in Section 4.2). Similarly, what the Global Fund means by sustainability of its RSSH investment is subject to wide interpretation, with a range of operational implications and inadequate consideration as a building block for UHC (also discussed in Section 4.2).

4.1.3. Summary findings

Key issue/ theme	Findings	Robustness rating and explanation	
Alignment of RSSH with evolving global health agenda	<ul style="list-style-type: none"> • The global epidemiological and policy landscape has evolved considerably in recent years. While the Global Fund Strategy has positioned RSSH for UHC, this has not been adequately realised in practice, reflecting the overall disease mandate of the Fund. The largely disease-focused investments are not adequately integrative, or cognisant of broader health needs. • While the Global Fund is one of the leaders on resilience and the vital role of communities, a clearer definition and operationalisation of the concept is needed. Likewise, sustainability of RSSH investments has received inadequate attention, particularly in the context of health system sustainability as a building block of UHC. 	A/B	Unanimous partner and country stakeholder feedback, supported by CEPA’s assessment of relevant documentation, although some different views from the Secretariat.

²⁴ For example: The Global Fund. (2018). Focus on Universal Health Coverage.

²⁵ Postma, S. (2018). The Global Fund as an ATM plus. *Lancet*. London, England, 392, 10154, 1192-1193.

²⁶ The Global Fund. (2014). Community systems strengthening framework, Revised edition, February 2014.

²⁷ WHO. (2018). Global Action Plan for health lives and well-being for all.

4.2. Efficacy of RSSH model – programmatic and structural

Q2: How can RSSH best support the three disease alongside system-wide constraints and is the model of disease-specific and integrated support strategically optimal? Is it desirable/ feasible to consider RSSH allocations in the next funding cycle?

This section considers one of the core questions for this review on the efficacy of the RSSH model adopted by the Global Fund, through an assessment of: (i) programmatic efficacy – the Global Fund strategy and approach to RSSH alongside disease support, and its operationalisation; and (ii) structural efficacy – the approaches to grant structuring. Section 4.2.1 considers the Global Fund strategic prioritisation of RSSH, followed by Sections 4.2.2-2.2.4 that analyse its operationalisation in practice, with Section 4.2.5 bringing these together and considering overall implications.

4.2.1. Strategic prioritisation of RSSH

As noted in Section 3, the 2017-22 Global Fund Strategy presents a first-time strategic prioritisation of HSS/ RSSH, with “building resilient and sustainable systems” being one of the four Strategic Objectives, within its overall disease-focused mandate. The ambition within this Strategy is broad-based and cross-cutting health systems funding – the Strategy positions RSSH within the context of the three diseases as well as Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH), NCDs and global health security threats, and refers to people-focused integrated funding.

4.2.2. Diversity in interpretation of RSSH concept

However, despite this strategic prominence, there remains considerable diversity in understanding and interpretation of RSSH amongst stakeholders. This diversity applies to the definition and objectives of RSSH (including specifically what is meant by the concept of “resilience”), the contribution of RSSH investment to disease control efforts and vice versa, the scope of feasible and effective RSSH investment (i.e. how to best invest in RSSH) and the measurement of results. Importantly though, the dialogue is by no means polarised i.e. it is less now about the ‘three diseases or RSSH’ but very much about the ‘three diseases and RSSH’.

There are several factors that have driven the diversity of views on RSSH, key being divergent views on RSSH in the Secretariat and wider stakeholders including key donors to the Fund, the lack of exposition of an overall theory of change linking disease and RSSH support, silo-ed implementation of the RSSH investment areas across Secretariat teams, and mixed/ confusing messaging in Global Fund Strategy and guidance documents. For example, the current RSSH Investment Framework notes both that “systems for health, differently from health systems... focus on people, not issues and diseases” and that “the Global Fund has always recognised that strong health systems that integrate robust community responses are needed to end HIV, TB and malaria as threats to public health”.²⁸ While these statements by no means conflict, and the importance of a broad scope to promote in-country contextual funding is recognised, the statements reflect the spectrum of

²⁸ The Global Fund. (2017). Building RSSH through Global Fund Investments Information Note.

opinion and the somewhat apparent dichotomy of adopting a more UHC orientation with the need for stronger health systems to optimise disease control efforts. It also reflects the long-term tensions that have faced “vertical” financing institutions such as the Global Fund and Gavi on whether to focus health systems funding on their respective mandates, or on the broader systems for health, resulting in a wide range of operational approaches for RSSH.

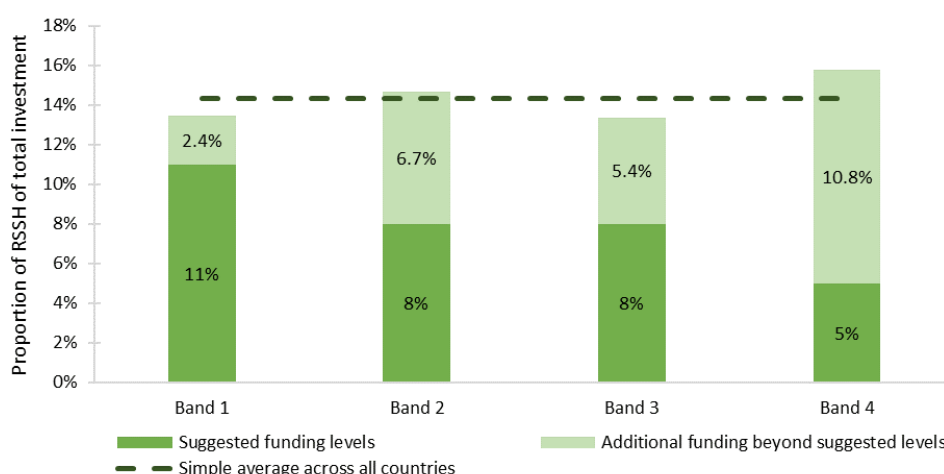
This is described below (in Section 4.2.4), followed by our assessment on the overall implications. First, however, we reflect on the importance given to RSSH in practice and discuss opinion on the need for a specific RSSH allocation.

4.2.3. RSSH importance in practice, including need for RSSH allocation

While the disease mandate remains central to the Global Fund, and impacts the priority accorded to RSSH, RSSH has gained conceptual priority (especially from NFM1 to NFM2). Discussions with the Secretariat indicate varying views on the approach to RSSH (as noted above and discussed in more detail in the next section), but there was all-round support for RSSH funding alongside disease support. Discussions with country stakeholders as well indicated that they are demanding and emphasising RSSH funding (including by representatives from the disease programmes, who noted the value and efficiencies to be secured through cross-cutting health systems funding, despite competition for funding).²⁹ As one country stakeholder noted, echoing the view across several countries: “The Global Fund is now recognised as a serious funder for health systems”. This finding was also supported by the TRP report on RSSH investments in the 2017-19 Funding Cycle, where the TRP observed that “attention to RSSH increased significantly in the 2017-19 allocation period”.³⁰

RSSH funding data indicates notable country prioritisation of RSSH – in the 2014-16 allocation cycle, countries across bands allocated more funding to HSS/ RSSH than the suggested level by the Global Fund, based on average funding by country bands included in the allocation letters (Figure 4.1).

Figure 4.1: Proportion of (direct) RSSH funding by country band vis a vis suggested funding levels in 2014-16



²⁹ India was an exception however, where there was little recognition of RSSH funding.

³⁰ The Global Fund (2018). Strategy Committee: TRP Report on RSSH Investments in 2017-2019 Funding Cycle.

However, there has been 24% decline in the total allocation in NFM2 which has contributed to a 40% decline in direct RSSH funding (roughly speaking, based on the data included in the RSSH portfolio database, and noting that NFM allocation amounts differ for a number of reasons³¹). This reflects the likelihood that when overall funding declines, diseases get prioritised (although other factors could also have been at play, such as a lower capacity to absorb RSSH funding may have resulted in reallocations of RSSH funding, as was the case in Sierra Leone). As a result, 65% of countries did not manage to maintain their proportion of direct RSSH to total funding, compared with 2014-16 (as was set out in the indicative guidance for RSSH funding levels in the allocation letters to countries). However despite this funding decline, our consultations in country strongly suggested that RSSH is being better noted and widely supported within country discussions.

Recognising this context, Box 4.1 considers the need for an RSSH allocation.

Box 4.1: Need for an RSSH allocation

There has been a long-standing debate within the Global Fund on the need for a specific allocation for RSSH to increase its prioritisation. At present, the programme split communicated to countries at the start of each allocation period provides a suggested split for the relevant diseases only. However, as noted previously, there have been varying guidance issued by the Global Fund on RSSH funding levels over time.

We understand that there is little Board level support for an RSSH allocation, so as not to divert money away from the three diseases and to also promote country ownership on RSSH application scope. We specifically also understand that the discussion on an RSSH allocation for the next funding cycle has been closed. Thinking within this framework, our findings suggest the following with regards to the need for an RSSH allocation:

- First, as described above, countries are demanding RSSH funding, and the lack of an allocation has not impeded this. Contrary to expectations, countries were broadly not in support of an allocation for RSSH and appreciated the flexibility to determine RSSH funding levels themselves.
- Second however, diseases (and specifically commodity) funding receive the top priority in majority of countries, and with declines in overall allocations, RSSH is most likely to be “squeezed”. The lack of an allocation also adds complexity to the negotiation process for RSSH, with considerable transaction costs.
- Finally, we view the lack of an RSSH allocation as in name only, as in practice, countries have been closely guided by the suggested levels for RSSH included in the allocation letters.

As such, we do not view the lack of RSSH allocation as a particularly strong issue in preventing country RSSH funding. A larger discussion around country-decision making for RSSH is also provided in Section 5.2.

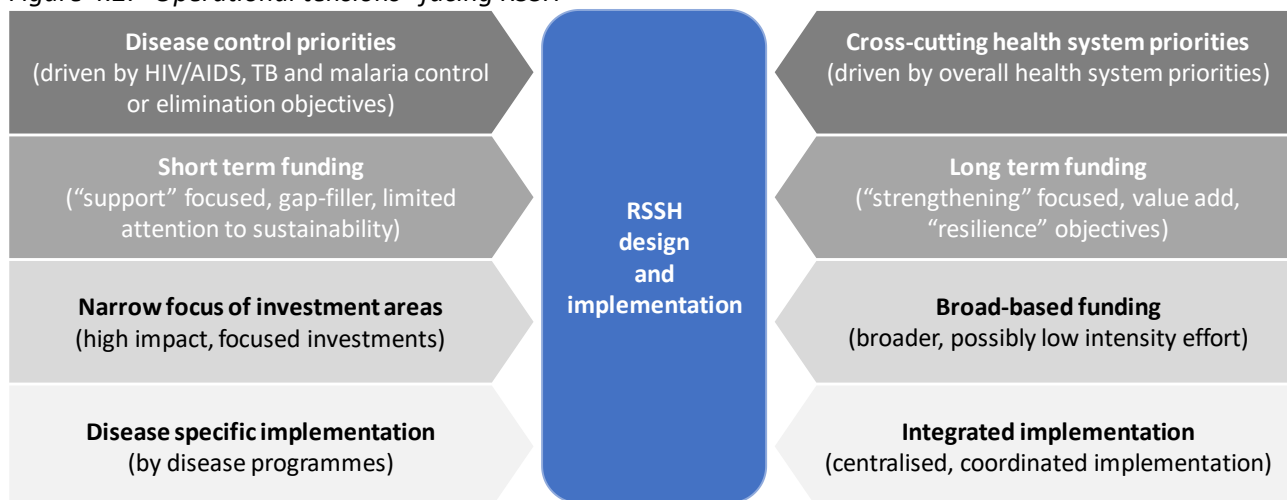
4.2.4. Operational tensions

As noted, the lack of a theory of change for RSSH, alongside confusing/ ambiguous messaging across Global Fund documentation has resulted in diversity of views on the RSSH concept, creating several “operational tensions” that have resulted in a wide range of operational approaches to RSSH. Figure 4.2 attempts to summarise the key tensions observed, followed by a more detailed discussion. The tensions have been presented to show the spectrum of options, recognising they may not

³¹ These numbers are based on the RSSH portfolio database and do not include matching funding, catalytic funding or above allocation. Additionally, the 2014-16 allocation included some remaining funding from the Rounds-based model and only around 90% of the 2017-19 allocation period grants were included in the database. This is likely to explain part of the decline. Further details are provided in Supporting Annex E.

necessarily represent polarised or negative positions, and that there are a number of trade-offs involved.

Figure 4.2: “Operational tensions” facing RSSH



For each “operational tension”, we first set out a description of the tension in terms of key issues, followed by a consideration of where the balance lies for Global Fund RSSH at present.

Disease focused versus cross-cutting support

Description of the tension

A key operational tension for Global Fund RSSH is whether the funding is driven by disease control bottlenecks and priorities, or more cross-cutting system wide development. The former applies the lens of the disease programmes, focusing on key health systems bottlenecks specifically impeding progress on the diseases (and not necessarily the biggest bottlenecks across the health system), and may result in investments in systems for the diseases (e.g. supply chains for antiretrovirals, developing data modules for specific diseases, etc.), with inadequate consideration of wider linkages. The latter considers health systems bottlenecks as a whole – for example, starting with an equity or population coverage lens to ascertain the key priorities for improved service access for all. The two may not be mutually exclusive in that disease-focused RSSH can also be system-wide supportive, but the dichotomy is presented for the sake of exposition of the operational tension.

Where does the balance lie for Global Fund RSSH at present?

Our assessment is that Global Fund RSSH funding, for the most part, is disease-focused rather than cross-cutting. While there are some exceptions to this e.g. the RSSH portfolio in Ethiopia through the stand-alone grant, examples of cross-cutting funding in Ghana and Zambia, etc., the portfolios usually comprise more disease-focused funding. Box 4.2 provides a summary of the case study country experiences.

Box 4.2: Disease focused RSSH support in majority of the case study countries

In **Tanzania**, RSSH investment is cross cutting in design, but implementation remains oriented to the three diseases. As a result, government and development partners in Tanzania raised concern that the Global Fund’s focus on the three diseases was “distorting the equity picture” and prioritisation was not effectively given to activities which would contribute the highest impact from a UHC perspective.

In **India**, one of the largest recipients of RSSH funding, there is no recognition of RSSH funding in country, in that country stakeholders were unaware of the concept and purpose of RSSH funding, and made no distinction between disease and RSSH funding (i.e. budget lines marked as RSSH were not considered as such, and rather considered as disease funding only). It is clear that the investments will directly impact disease programmes only.

In **Ghana**, there is a clear view in country that the RSSH investments are targeted at key health systems bottlenecks to disease control, but are not fully reflective of the wider health systems strengthening priorities beyond the three diseases (*"RSSH funding is not going to support a credible health system, but is more of Global Fund grant systems funding"*). There are some examples of cross-cutting support on PSCM, including last mile delivery.

In **Sudan**, an integrated concept note was submitted for all diseases and RSSH in one, however many view the concept note as a loose joining-up of individual disease focused elements, and implementation has been more vertical.

In **Georgia**, a transition preparedness country, RSSH support has primarily targeted activities for TB and HIV, although there is an increasing emphasis on integrated approaches and a clear view that investments need to be more cross-cutting going forward, especially given Georgia's transitioning status.

In **South Africa**, an upper-middle income country (UMIC), the support has a mix of cross-cutting investments for CSR, alongside some more disease-specific investments in other RSSH investment areas.

Zambia presents a more positive picture, with RSSH funding supporting a broader health and community systems strengthening (CSS) orientation, with e.g. salary support for rural nurses, midwives and community health assistants. Investments in data systems including the district health information system (DHIS2) are seen to have positive benefits across the system. However, the absence of operational plans spanning the investment areas may impede effective coordination, or prioritisation of RSSH investments with other donors, or the development of a long-term strategic vision.

Vietnam and **Ethiopia** appear to have been more successful in using RSSH investments to strengthen national health systems as well as targeting control of the three diseases. Both countries have strong national systems in place which can effectively plan and coordinate RSSH investments amongst donors and country stakeholders. A number of investments in **Côte d'Ivoire** and **Sierra Leone** have also been cross-cutting in nature.

Another important finding in this regard, is that while the Global Fund distinguishes between direct and contributory RSSH funding, there are several examples of contributory RSSH funding as being viewed to have a larger impact on the health system as a whole as compared to direct funding. There are good examples of this within the funded portfolios in India and Georgia for example, such as the disease-specific work of some of the civil society organisation principal recipients (CSO PRs) in India supporting the development of community systems by creating a structured approach for introduction of additional community health workers or expansion of the scope of work of existing community health workers. As such, the distinction between direct and contributory funding is not always particularly helpful in terms of assessing the 'degree of contribution from the support'.

Short term versus long term funding

Description of the tension

A second key operational tension is in terms of funding for short term needs as compared to adopting a longer-term approach (notwithstanding country need for both types of funding).

Central to this is the lack of definition and understanding of the concept of "resilience"; while key to the renewed Global Fund approach to HSS, there is no clear definition. The move from "health

systems” to “systems from health” to reflect public and community systems as a continuum was the premise, but this has not been operationalised, and there seems to be confusion amongst those consulted. Some consultees thought resilience implied supporting development of legal and regulatory systems (including systems for registration of drugs, which is directly linked to the Global Fund commodity support), as well as governance strengthening, however this is not a priority area of funding within RSSH. Others, and especially country stakeholders, viewed the interventions that would support resilience being specific to each country.

This view also extends to the difference between health systems “support” and “strengthening”, where for example, some contend the latter to relate to resilience and others indicate that this dichotomy is not helpful as resilience-making can also be through health system support activities (e.g. HRH salary funding in Sudan’s low HRH/ brain drain context, as is the case for other countries as well). The positioning of Global Fund RSSH within the support versus strengthening continuum has not been clarified. While the desire at the Secretariat level appears to be to fund strengthening activities, as a value add and catalytic funder, in practise there is mostly support-related and gap-filler funding (as noted by the TRP, and as noted in Section 4.1.2 above).

This operational tension is also on account of lack of a comprehensive health systems strategy in countries which prevents a “bigger picture” view of the investments – an issue flagged during some of our country-level consultations, as well as in our discussions with the TRP. It is also compounded by the fact that RSSH funding requests are often developed without a comprehensive gap analysis of other domestic and donor funding, thereby also contributing to limiting emphasis on sustainability and resilience in overall investments.

A further issue is in terms of the three-year duration of the RSSH funding within an allocation cycle, which is relatively short to achieve systemic institutional change. While there are good examples of continuity in funding from NFM1 to NFM2, the three-year planning cycle is not suitable for overall health systems strengthening efforts. There is a larger question as to how the Global Fund’s internal incentives to disburse money and achieve results (see Section 4.4) marries long term goals and long-term funding for HSS.

Where does the balance lie for Global Fund RSSH at present?

Our finding has been that majority of Global Fund RSSH investments are focused on short term systems support for the three diseases, rather than longer term investments supporting resilience and sustainability of the system. RSSH investments continue to be predominantly for PSCM, HMIS and HRH in support of the three diseases, with insufficient focus on the sustainability of these investments, let alone the sustainability or resilience of the wider health system. For example:

- In Tanzania, sustainability is considered on an activity-specific basis, rather than reflective of a broader, more strategic thinking. There were efforts under the current grant to boost sustainability with regards to the payment of health worker salaries with government takeover, yet long term thinking and official agreement around the Global Fund’s support to HRH was lacking.

- In Ghana, there was little reflection of both sustainability and resilience in the grant design in that CSR is viewed as separate from RSSH. Stakeholders also noted issues on the sustainability of some activities currently funded under RSSH.
- There are questions on the sustainability of HRH investments in a number of countries. For example, in Zambia, the Global Fund is funding considerable salary support of Community Health Assistants, which the government has agreed to take over after a two-year period, as documented in a Memorandum of Understanding. However fiscal feasibility is unclear, and there are mixed views on the likelihood of a successful handover. Some previous salary handovers give confidence, but this will require a significant expansion of the wage bill within a short timeframe.

Narrow versus broad funding of investment areas

Description of the tension

There are diverging views as to whether RSSH investment should be prioritised for select investment areas in line with the Global Fund's comparative advantages or kept broad to enable more optimal country ownership in prioritisation of RSSH funding. A more focused, prioritised RSSH investment was suggested by a number of Secretariat informants so as to reduce risks on disease investments (i.e. by focusing on PSCM and HMIS) and to enable a more quality, effective and efficient investment. Similarly, it was seen by many that the seven RSSH investment areas are too many to enable effective implementation focus and impact. Countries on the other hand for the most part appear to be keen on broad-based funding.

Part of this tension is also driven by the limited understanding of the scope of potential support under all investment areas despite the guidance in the Investment Framework. As such, it is challenging to unpick the extent to which specific funding requests are based on demand according to country needs and context, or an understanding of what the Global Fund may be willing to fund. In particular, there appeared to be limited knowledge of the investment area on national health and disease plans, insufficient understanding of the integration investment area (as a distinct area within RSSH rather than an approach as a whole), lack of appropriate programming for CHWs as HRH or CSR investment area funding, limited linkages between RSSH-CSR funding and community interventions funded in the disease programmes, amongst others.

Where does the balance lie for Global Fund RSSH at present?

At the global level, PSCM and data systems were unanimously supported as priority investment areas, while there were differences in views on the Global Fund's focus on HRH and financial management. PSCM, data and HRH also receive the most RSSH funding currently, particularly in comparison to national health plans and CSR which receive very little (as shown in Section 4.3 above). With few exceptions, there has been minimal funding for financial management or governance, and our understanding is that these funds are largely allocated to ensure financial and operational accountability for Global Fund resources such as for programme management costs, rather than for larger health system improvements in performance.

Stand-alone, disease programme or integrated implementation

Description of the tension

Current guidance provides flexibility for countries to propose structuring of their RSSH funding as a stand-alone grant or integrated with a disease grant. In practice, this structuring is driven by a number of factors, including:

- A disincentive to propose stand-alone RSSH grants, largely due to historic views on poor absorption (as compared to disease grants), and apparent additional effort/ management costs both in country and at the Secretariat level.
- A penchant to propose integrated grants in countries to continue with the disease-focused approach to RSSH design and implementation (e.g. in India, Georgia). This is also led by the historically vertical structure of the disease programmes in most countries and commonly a lack of cross-cutting HSS groups to advocate or coordinate a stand-alone grant. Even where there have been efforts to decentralise the planning and management of health services in-country, the Global Fund's risk management strategy also lends itself to a tight, "vertical" coordination of funding.

Where does the balance lie for Global Fund RSSH at present?

As noted in Section 3.3, there are very few stand-alone grants for RSSH, and only one to date at the time of the analysis in 2017-19 (Ethiopia).³² Box 4.3 provides some of the pros and cons of the experience of the stand-alone grant in Ethiopia.

Box 4.3: Stand-alone grant in Ethiopia – pros (+) and cons (-)

- + Facilitates a coordinated and centralised approach to RSSH leading to potential cost-savings and efficiency gains.
- + Allows for better tracking of activities, aiding coordination with other programmes and partners.
- + Strong view in-country that this structure allows disease programmes to focus more on the disease grant activities and not to be 'burdened' through focusing on RSSH activities which they are less well placed to coordinate.
- + Facilitates tailoring RSSH support to country health system needs.
- Lower grant absorption rate is likely (or at least more visible) as only RSSH activities are funded that tend to have lower absorption.
- Challenges with coordination may arise as many actors are likely to be involved in the implementation of the grant (though assigning specific coordination responsibilities to individuals can alleviate this).
- High transaction costs of setting up the grant.

We find however, that integrated grants are not well-elucidated and understood within the Global Fund grant structuring system, as there appear to be three options for RSSH:

- Integrated with disease programmes and implemented by the disease programmes (e.g. the case in India, Georgia, Zambia).

³² Nigeria also received a RSSH stand-alone grant in early 2019.

- Integrated with disease programmes and implemented in a centralised and coordinated manner (e.g. the case in Ghana, Tanzania).
- Disease programmes and RSSH integrated as one grant (e.g. the concept note for Sudan, although not implemented as such).

We find that there is a rising trend in integrated grants being implemented through centralised units/ departments in NFM2, which is viewed as an effective and efficient approach to support cross-cutting RSSH.³³ There are however teething challenges with this implementation arrangement, as these units/ departments do not have experience with the Global Fund model (Ghana) and may have some additional human resource (HR)/ programme management costs (Ghana, Tanzania) which would need to be carefully reviewed to not represent parallel implementation arrangements.

Fully integrated grants, as in the case of Sudan, have the theoretical potential to encourage a comprehensive and integrated approach to RSSH activities that is well reflective of disease programme needs, although this has not been realised in practice due to the particularly challenging context of the country (e.g. US sanctions and risk profile) as well as the fact that Global Fund systems (coupled with their risk management approach) are not supportive of this level of integrated implementation.

Therefore, we note that there are pros and cons to all of the available options. However, in order to encourage support for cross-cutting and more integrative support, stand-alone grants and grants integrated with disease programmes and implemented by a centralised unit/ department are more effective.

4.2.5. Implications

Clearly there has been increasing importance accorded to RSSH overtime. However, as highlighted above, there are a range of operational tensions resulting in varied approaches to RSSH funding across countries, and specifically not adequately reflecting the strategic prioritisation and ambition of the 2017-22 Global Fund Strategy – notwithstanding the overall disease mandate of the Fund and the trade-offs thereof. As such, our conclusion to this evaluation question is that the current Global Fund model and approach to RSSH is not strategically optimal and requires revisions to better respond to the overall Global Fund Strategy. Our findings also suggest that an RSSH allocation may not be a “sufficient condition” for increased prioritisation of RSSH.

Consultations have indicated the need for better definition and “prescription” for RSSH funding. This was an issue flagged towards the end of the Rounds-based funding as well (as noted in Section 3), and despite attempts to develop an optimised scope of investments over time, the appropriate balance between definition and flexibility for countries has not yet been struck. Rather, the Global Fund has leaned towards more open-ended funding, with few definitions and prescriptions, resulting in a strategically sub-optimal portfolio of RSSH investments. While the importance of the

³³ We understand that this would be more feasible in High impact and Core countries only as for Focused countries there is usually one grant and one PR only.

flexibility afforded through open-ended funding cannot be undermined, currently there is inadequate direction and prioritisation through the guidance. This is also contributed to by a number of process-related challenges discussed in Section 5.

4.2.6. Summary findings

Key issue/ theme	Findings	Robustness rating and explanation	
RSSH strategic prioritisation and operationalisation	<ul style="list-style-type: none"> Despite strategic prominence, the lack of a theory of change for RSSH and ambiguous/confusing messaging across Global Fund documentation has resulted in multiple interpretations of RSSH, creating several “operational tensions” in terms of (i) a focusing on disease control priorities and cross-cutting health system issues; (ii) short-term versus long-term funding; (iii) narrow versus broad-based funding across investment areas; and (iv) disease-specific versus integrated implementation. 	A	Based on CEPA’s assessment of document review and consultations with Global Fund Secretariat, country stakeholders, partners, and TRP.
	<ul style="list-style-type: none"> RSSH funding is regarded as important by countries, so the lack of specific RSSH allocations does not appear to impede country RSSH funding. 	B/C	A strong finding from this review, although has been contradictory to previous findings.
RSSH funding – balance of the “operational tensions”	<ul style="list-style-type: none"> Global Fund RSSH funding, for the most part, is disease-focused rather than cross-cutting. 	B	Based on TRP feedback and supported by CEPA’s assessment of relevant documentation as well as findings from the majority of country case studies.
	<ul style="list-style-type: none"> The majority of Global Fund RSSH investments remain focused on short-term, gap-filling, systems support for the three diseases, rather than longer-term health systems strengthening investments, also reflective of the Global Fund’s three year funding cycle. 	B	Based on CEPA’s assessment of relevant documentation as well as findings from the majority of country case studies.
	<ul style="list-style-type: none"> Global Fund RSSH investments are currently focused on a few priority areas, namely data systems, PSCM and HRH. Other investment areas have received limited investments (i.e. CSR, national disease plans, financial management and integration). 	B	Based on stakeholder feedback at the global level as well as the majority of country case studies.
	<ul style="list-style-type: none"> The majority of RSSH grants are integrated with disease programmes and also implemented by them. Both the stand-alone and integrated approaches to RSSH grants have pros and cons, but stand-alone grants, or grants integrated with disease programmes, but implemented by a cross-cutting HSS unit/department, have some advantages. 	C	The finding is supported by some country case studies and select Secretariat and country stakeholders.

4.3. Efficacy of investment differentiation approach

Q3: Can investments be better differentiated based on country needs and context?

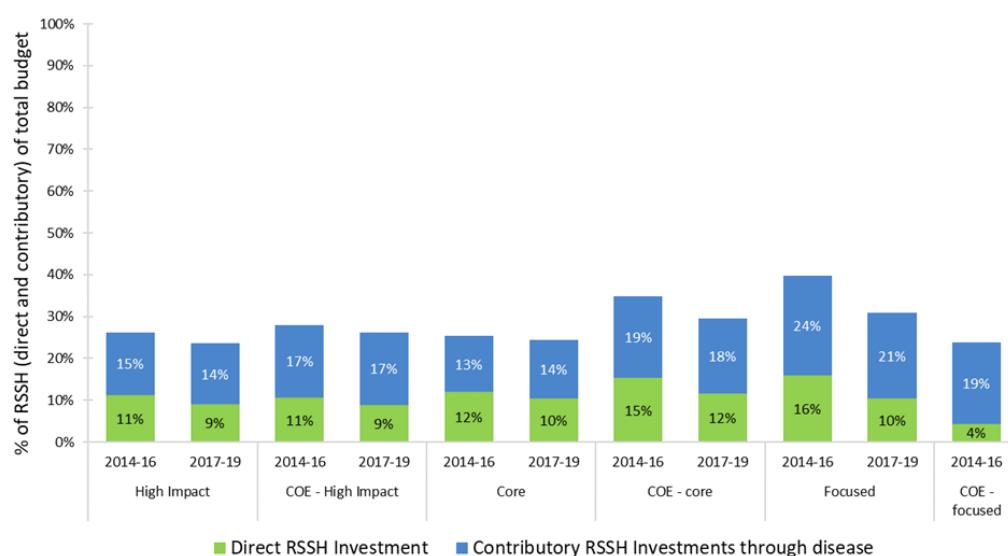
4.3.1. Operationalisation of differentiation as relevant to RSSH

Overall, our assessment, based on the range of evidence gathered for this review, is that there has been mixed experience in terms of the efficacy of differentiation for RSSH in practice, although with the balance leaning towards the need for more effective differentiation.

Some good examples of country differentiation are in the case of Zambia, where the Global Fund has been seen as a service delivery partner (through supporting the deployment of health workforce at sub-national levels and the procurement of key commodities) as well as a technical assistance partner (through supporting facility and community data systems, DHIS2 implementation and capacity building). This was considered appropriate for a low-middle income country (LMIC) with a maturing health system, where the government faces significant resource constraints. Further, in Ethiopia, there is strong alignment of RSSH funding with the national health strategy, where strong government stewardship and planning has ensured close linkages with current gaps and other government and partner funding.

There is also some evidence at the global RSSH portfolio level of the effective differentiation in practice, with Focused and Core countries generally demanding a greater proportion of RSSH funding compared to High Impact countries (Figure 4.3 presents this data evidence).

Figure 4.3: Proportion of direct and contributory RSSH investment by country classification



However, for the most part, the country studies suggest there was insufficient differentiation of RSSH investments to country context and maturity of health system – for example:

- In Ghana, our assessment is that while the activities are aligned with country demand and needs, there is no distinction between “support” and “strengthening” related funding across

the RSSH investment areas to reflect the relative maturity of different sectors, as well as its LMIC status.

- Similarly, investments are much needed and useful for the India context, but there is mixed experience as to the alignment with the country's development status and the nature of the investments, with substantial HRH salary support for the malaria programme.
- In the case of Georgia, many investments were noted to be for health systems support with limited focus on "system sustainability" in investments, such as the provision of technical assistance, despite Georgia being a transition preparedness country. In general, it was highlighted that transitioning countries should be investing more in RSSH, and in Georgia in particular, the most significant transition needs relate to RSSH.
- In Sierra Leone (a COE country), direction as to how to approach sustainability based on country context was considered to be missing. There was a focus on RSSH investment as a filler of immediate gaps rather than based on long term strengthening needs which encompass considerations of the maturity level of the health system and sustainability.
- In Sudan, the introduction and roll-out of DHIS2 is a key RSSH investment, although some questioned the value for money from Global Fund funding of this roll-out in a situation where basic infrastructure such as electricity and internet is often unavailable.

These findings correlate with that of the recent TRP RSSH review, which found that further differentiation of RSSH investments is needed along the health system development continuum.³⁴ The TRP has proposed the '4S framework' which categorises support by (i) system start-up (establishment); (ii) system support; (iii) system strengthening and (iv) system sustainability. The TRP noted that there is a need for a greater shift from systems support to systems strengthening and sustainability (e.g. with an estimated 66% of funds currently being on systems support interventions, as noted previously), and that additional guidance is needed from the Global Fund to clarify the steps of the continuum (start-up, support, strengthening, and sustainability) for each health system pillar, and to encourage movement toward sustainable systems. Indeed we view that while the RSSH Investment Framework emphasises the need for differentiation, it is insufficiently specific and inadequately operationalised.

Although generally supportive of the TRP 4S framework, we consider two key challenges in its effective operationalisation. First, countries do not usually have a national strategy or plan that focuses on "health systems" development needs (different from the national health plans that are more high-level and disease NSPs that are disease focused) as well as plans across the seven RSSH investment areas. Situational analysis data is also lacking/ weak, as is information on funding gaps (i.e. comprehensive tracking of who is funding what). These gaps were also flagged in our consultations with the TRP, which highlighted these as key issues to effective reviews of country applications (discussed further in Section 5.2 below). In the absence of this information, it would be very complex to effectively programme RSSH investments in the manner suggested, also recognising that a health systems "support" investment may very well be a "strengthening" investment in a

³⁴ The Global Fund (2018). Strategy Committee: TRP Report on RSSH Investments in 2017-2019 Funding Cycle.

different country context. Secretariat work towards developing the RSSH Dashboard as well as WHO work to develop disease National Strategic Plans (NSPs) that are reflective of system-wide bottlenecks may be useful initiatives to address this key issue. Second, as discussed in Section 4.2, there is a wide variation in Secretariat (and specifically CT) understanding of RSSH, and in our view, limited expertise to appreciate these nuances in RSSH funding. As such, without additional RSSH expertise within CTs, we do not view this framework as feasible to be successfully implemented.

4.3.2. Summary findings

Key issue/ theme	Findings	Robustness rating and explanation	
Differentiation for RSSH	There is a need for more effective RSSH differentiation and improved guidelines that can be operationalised across a range of contexts.	B	Based on CEPA's assessment of country case studies, supported by TRP feedback.

4.4. Measurement of contribution of RSSH investment

Q4: What have RSSH investments delivered in country and how can investments be better focused for improvements in programme quality/ efficiency?

The focus of this question is an assessment of the M&E approach to RSSH investments. Section 4.4.1 provides an overview of the Global Fund's approach to M&E for RSSH, followed by Section 4.4.2 that looks at specific issues regarding results monitoring and Section 4.4.3 at absorption of RSSH funds.

4.4.1. Overview of the Global Fund's approach to M&E of RSSH

The Global Fund's approach to M&E for RSSH comprises:³⁵

- **Strategy-level monitoring:** These are the Strategy Key Performance Indicators (KPIs), of which there are two KPIs relevant to RSSH under Strategic Objective 2: KPI 6 – Strengthen systems for health: share of the portfolio that meets expected standards for PSCM, financial management and data systems and alignment with national strategic plans; KPI 7 – Allocation utilisation: portion of allocation that has been committed or is forecast to be committed as a grant expense.
- **Implementation-level monitoring:** This includes implementation KPIs, which include impact and coverage (or outcome) indicators as well as tracking of specific inputs and outputs (“work plan tracking measures”), as included in the RSSH Modular Framework.

4.4.2. Key issues on results monitoring

RSSH investment tracking

It is important to note upfront the challenge in tracking RSSH investment across country documentation (which has also been a key limitation for this review). In particular: (i) as RSSH

³⁵ In addition there is also thematic reporting and evaluations, which is Geneva-led and not implemented by countries and hence not reviewed here.

investments are generally integrated in disease grants, specific identification of RSSH funding is difficult; (ii) although activities may be included under certain budget line items as per the Modular Framework, these vary by country given different country contexts, and as such, a line item description is less clear than it is in disease grants;³⁶ and (iii) there is a lack of synthesised activity progress reporting documentation. Another limitation is the varying knowledge of the specifics of RSSH funding amongst Country Teams and at the country-level, with countries employing the Modular Framework categorisation in different ways.

The Secretariat RSSH team has developed a new database on RSSH investments across countries, which is a useful first step in identifying RSSH investment, although does not provide information on the detailed nature of the investments across countries as it is based on the Modular Framework categorisation. Supporting Annex E provides more details on the data and its limitations.

Strategy-level monitoring³⁷

As presented, the strategy-level KPIs cover only four of the seven RSSH areas, with the other three areas (CSR, HRH and integrated service delivery) being agreed to be omitted. We understand that this is primarily because of the challenge in agreeing meaningful KPIs which would span the activity scope of the investment areas, as well as an endeavour to focus on investment areas most closely linked to Global Fund disease investments, and where there are substantial investments and thus an ability to impact results. While this reasoning may be justified to some extent, it contributes to ambiguity about priority RSSH investment areas (as discussed in Section 4.2), with many arguing that the omitted areas are equally important (e.g. CSR is a core component of the RSSH definition, HRH is a significant share of funding).

Implementation-level reporting

Significant issues were flagged on the M&E approach for RSSH funding in grants, including:

- **Lack of use of qualitative approaches to assessing RSSH investments:** The focus of RSSH M&E has been on process and quantitative monitoring of RSSH investments, with very little emphasis on qualitative evaluation. There were requests in country for a more localised and tailored approach to assessing the contribution of RSSH investments, through more qualitative operational or implementation learning of both process and impact.
- **Poor linkage between RSSH funded interventions and standardised outcome/ coverage indicators included in the Modular Framework, and a limited focus on process measurement:**³⁸ The Modular Framework includes high-level outcome indicators (e.g. percentage of women attending antenatal care, ratio of household out of pocket payments for health to total expenditure on health) as well as standardised coverage indicators (e.g. health worker density or the availability of medicines), which is recognised to be challenging given that country RSSH funded interventions may not be directly linked to any of these

³⁶ This finding was also supported in the OIG RSSH Draft Audit Report (2018).

³⁷ The KPI on fund absorption is discussed as part of a larger analysis in Section 4.4.3.

³⁸ This finding was also supported in the OIG RSSH Draft Audit Report (2018).

indicators, there are a myriad of influencing factors and in most cases, difficulty in establishing baselines. The inclusion of work plan tracking measures are also not particularly encouraged or supported and they do not currently span the full spectrum of RSSH activity, with CSR presenting a particular gap (though progress is currently underway in this regard). Input/ process related tracking is anyhow an inadequate approach to RSSH results measurement. That an indicator is not required for each investment area can also lead to a patchy reflection and measurement of the overall RSSH investment.

- **Insufficient outcome metrics on long-term effectiveness, sustainability or resilience of country health systems:**³⁹ This is linked to the point above, and undeniably a challenge. But given the long-term nature of many RSSH investments and the short three-year grant cycle, without better metrics and evaluation approaches, it is difficult to determine whether Global Fund RSSH investments are contributing to longer term strengthening and sustainability (including relating to integration of services). A by-product and negative consequence of this is that countries are prioritising activities with short-term rather than sustainable long-term results e.g. the prioritisation of three diseases in health service quality improvement efforts, or to malaria specific CHWs rather than to CHWs in the implementation of Integrated Community Case Management (iCCM).
- **Collection of community data not prioritised:** The performance framework promotes the collection of both facility and community level data and both are reported in the Progress Updates and Disbursement Requests (PUDRs). However, the Global Fund's emphasis appears to be on national level, quantitative coverage indicators, with limited emphasis on community data, particularly within RSSH specific modules and/or standalone grants. Further, the collection of community data tends to prioritise community activities which are formalised under health systems (such as on CHWs) over community responses which are partially captured under health systems (e.g. community education and adherence support or home care) or those which are outside the formal health sector (i.e. community led social accountability efforts).⁴⁰ The more traditional top-down model of monitoring (focused on reporting, pre-defined formats, indicators, milestones and criteria) also provides inadequate accounts of the local realities (experiences and impacts) of the programmes.⁴¹

A number of these findings also resonate with that provided in the TRP RSSH review, which recommends that health systems indicators in the Modular Framework be “revised, expanded and utilised” and to include “relevant and sensitive” indicators for RSSH, ideally drawing on the WHO SDG framework. The previous TERG-commissioned review of HSS also highlighted that the Global

³⁹ Ibid.

⁴⁰ The Global Fund. (2018). The Crucial Role of Communities: Strengthening Responses to HIV, TB and Malaria.

⁴¹ Over the last two years, however, the Global Fund has stated working with partners to promote the uptake of community-based monitoring (CBM) – a process by which service users or local communities gather and use information on service provision or on local conditions impacting on effective service provision, in order to improve access to and the quality of services and to hold service providers to account.

Fund does not have a systematic mechanism for evaluating HSS investments and encouraged its development.⁴²

4.4.3. Absorption of RSSH funds

Analysis of data on fund absorption

Results to date for Strategy KPI 7 indicate that total fund utilisation in countries (i.e. committed versus spent funds) has improved from 66% (based on 2014-16 data) to 75% (based on 2015-17 data).⁴³ The data is disaggregated by disease components and reports that the gains for RSSH investments in stand-alone grants have been particularly strong (improving by 13% points), however, it remains the area with the lowest absorption rate at 65% compared to disease grants that have rates ranging between 69% and 78%. An analysis of additional data supplied by the Global Fund Secretariat for this review indicates broadly similar results (see Supporting Annex H). Between 2010-17, RSSH investments had an absorption rate of 64% as compared to disease-specific investment absorption at 75%.⁴⁴ Our data analysis also suggests that RSSH stand-alone grants have a lower absorption rate than disease grants, at 57% for RSSH as compared with 74% for diseases.

Our review also suggested further bottlenecks for RSSH grant spend which were apparent across a number of countries and which may be heightened when compared with disease grants (e.g. lack of capacity for HSS planning and delivery; lack of ownership over HSS spend etc). Annex H provides further details.

Strategic issues with measurement approach

There are two specific issues of relevance here.

First, the Global Fund Strategy KPI framework considers an increase in absorption as an indication of the effectiveness of RSSH spend. However, we view this a poor measure of RSSH impact as there are many other factors driving improving absorption. For example, the higher absorption for the 2015-17 period noted above may also be due to 2017 being the last year of the 2014-16 allocation period, where most of the spend took place. Further, the Global Fund highlights that the increased absorption has been due to improved Global Fund processes, reprogramming and other efforts.⁴⁵

Second, we have understood there to be a bias amongst the Secretariat and countries to not request stand-alone RSSH grants due to their lower absorption rate (which is then viewed negatively for performance), as communicated in numerous consultations with Country Teams and country-based stakeholders. Integrated grants are preferred for RSSH as they allow for averaging out of the lower absorption rates of RSSH interventions. However, we view this approach (and the overall emphasis

⁴² Euro Health Group. (2015). Thematic Review on the Global Fund's Health System Strengthening Support related the "Middle" of the Results Chain. Final Synthesis Report.

⁴³ The Global Fund. (2018). 40th Board meeting: Strategic Performance Reporting.

⁴⁴ Slight discrepancies between the KPI 7 results, figures presented in the OIG report (2018) and the CEPA data analysis is likely due to methodological differences such as the selection of years and grants included in the analysis. Supporting Annex H outlines the dataset and approach used by CEPA.

⁴⁵ The Global Fund. (2018). 40th Board meeting: Strategic Performance Reporting.

on absorption as a performance metric) as counterintuitive as one of the objectives of RSSH funding is to improve absorption. Further, the nature of RSSH investment (e.g. infrastructure, procurement of specialised equipment) implies lower implementation, with higher risks of delays as compared to disease spend, which is primarily focused on the purchase of drugs and commodities. It was also suggested that this focus can encourage perverse incentives in that it may promote spend for immediate gain at the cost of investment aimed at more longer-term quality and impact.

4.4.4. Summary findings

Key issue/ theme	Findings	Robustness rating and explanation	
Tracking of RSSH investment	<ul style="list-style-type: none"> It is difficult to track RSSH investments largely due to grant structuring and reporting arrangements. 	A	This was apparent across country case studies and from discussions with Secretariat staff.
RSSH M&E approach	<ul style="list-style-type: none"> The approach to measuring RSSH investment results is ineffective, with a focus on macro-quantitative monitoring, rather than potentially more insightful qualitative evaluations, as well as a limited emphasis on community level monitoring. 	A/B	Broad consensus at both global and country levels.
	<ul style="list-style-type: none"> Performance monitoring based on absorption of funds has created perverse incentives for RSSH. 	B/C	CEPA view based on country feedback, although not emphasised by Secretariat.

5. REVIEW AREA 2: POLICIES, PROCESSES AND TOOLS

The second review area covers an assessment of the relevance and efficacy of Global Fund's policies and guidance for RSSH (Q5, Section 5.1), alongside the end-to-end application cycle for RSSH, from country decision-making on RSSH, to the TRP review and grant making (Q6, Section 5.2).

5.1. Global Fund policies and supporting tools for RSSH

Q5: To what extent are current Global Fund policies effective for supporting RSSH objectives? Are supporting tools viewed as useful by countries, and if not, why not?

Section 5.1.1 considers the relevance and efficacy of overarching Global Fund policies for RSSH and Section 5.1.2 considers the utility of RSSH-relevant application tools and guidelines.

5.1.1. Relevance and efficacy of overarching Global Fund policies for RSSH

In addition to the differentiation policy (discussed in Section 4.3), the main Global Fund policies that determine country funding are the Eligibility Policy (and related allocation methodology) as well as the STC Policy.^{46,47} From the RSSH perspective, we observe that these policies are largely oriented around the requirements of the three diseases. For example, the Eligibility Policy defines eligibility for Global Fund funding on the basis of income level and disease burden, and while the importance of simple criteria cannot be overemphasised, there is no health systems-specific criteria that forms the basis of a country allocation (such as domestic spending on health, state of the health system, etc.).⁴⁸ Further, the allocation methodology introduces a downward adjustment for low absorption capacity⁴⁹ – whilst undeniably a useful approach to encourage high utilisation of Global Fund funds and we understand that the adjustment is not extensive, it is counter-intuitive to the objective of RSSH which aims to remove bottlenecks and improve absorption. This issue was also flagged in one of our donor consultations for this review, where a re-look was suggested in light of the RSSH funding objectives.

A desk-based rapid review of the STC Policy suggests a well-rounded approach that considers health planning and funding as a whole (rather than disease-specific approaches), with for example, the co-financing incentive being pegged on increases in domestic financing for health and not disease-specific funding alone. However, noting the “sustainability” and “resilience” objectives for RSSH, discussed in Section 4.2, we question whether the policy goes far enough. For example, sustainability of health systems activities/ interventions requires a broader perspective than financial sustainability alone – there is a need to consider programmatic sustainability in terms of the demand for systems development (and hence the potential for the funding to be sustained) or

⁴⁶ The Global Fund. (2016). 35th Board Meeting: The Global Fund Eligibility Policy. GF/B35/06 – Revision 1.

⁴⁷ The Global Fund. (2016). 35th Board Meeting: The Global Fund Sustainability, Transition and Co-Financing Policy. GF/B35/04 – Revision 1.

⁴⁸ The revised Eligibility Policy notes that one of the key revisions is the introduction of language to encourage countries to use their allocations for RSSH, in line with the new strategic framework for 2017-19.

⁴⁹ The Global Fund. (2017). Detailed explanation of the allocation methodology 2017 – 2019.

efficiency improvements brought about within the health system (more health for the money). While the policy requires countries to progressively absorb the costs of key RSSH interventions such as human resources and procurement of essential drugs and commodities,⁵⁰ we view the need to think beyond intervention by intervention funding (as noted in several of our country case studies) to consider sustainability in a more holistic manner.

To conclude, while our critique of these policies is not based on a full-scale review but rather is from an RSSH lens, it does suggest that in order to fully reflect and operationalise RSSH within the Global Fund approach, there is a need for further thinking on how best to incorporate RSSH-relevant objectives and priorities within these policies.

5.1.2. Efficacy and utility of RSSH tools and guidelines

The key RSSH tools and guidelines include the RSSH Investment Framework as well as a range of investment area-specific guidelines or Technical Briefs. In addition, we also consider the efficacy of wider application tools and guidelines such as the application handbook and templates, Modular Framework and grant-making documents. Our assessment, based on a review of these documents, discussions with different Global Fund Secretariat teams and partners, and importantly, with a range of country-level stakeholders through our visit-based country case studies, is as follows:

RSSH Investment Framework

The RSSH Investment Framework document is the Global Fund's flagship document on RSSH and serves not only as the main strategy document on RSSH (for partners, and as a resource for Country Teams) but also as a guideline document for countries. This dual purpose of the document is the key problem in itself – our assessment, as also intimated through our global and country consultations, is that the document has not been written as a guideline document for countries, employs excessive use of Global Fund and international policy frameworks/ jargon and is not user-friendly (e.g. it contains multiple web-links for important information to be accessed elsewhere, it is a lengthy document). The guidance in this document is not adequately clear or precise and conflicts with other guidance to countries (as discussed in Section 4.2). Specific feedback from our country case studies included that the guidance was considered to be (i) ambiguous (Ethiopia); (ii) complex (Ghana); (iii) not adequately tailored for transition and UMIC countries (Georgia/ South Africa) and (iv) in particular, countries reported not being aware of the detailed guidance regarding investment areas (Côte d'Ivoire, Ghana, Zambia), as evidenced by a number of different categorisations within the Modular Framework.

Secondly, a review of successive versions of this document from 2013 onwards indicates that the approach and framework has moved around several times, which may reflect evolving thinking and alignment with successive Global Fund strategies, but it can create confusion at the country level over definition of RSSH investment areas and funding requirements. Practically speaking, there is document inertia with repeated versions, and a tendency to not keep abreast of iterative changes

⁵⁰ As outlined in para 25 of the policy document included in the Board paper: The Global Fund. (2016). 35th Board Meeting: The Global Fund Sustainability, Transition and Co-Financing Policy. GF/B35/04 – Revision 1.

over time (as was evident from our consultations with the Secretariat Country Teams and country-level stakeholders). In fact, from a review of these versions, we note that several of the definitional/ conceptual issues currently plaguing RSSH investment areas are reflected in evolving descriptions included in the guidelines – e.g. CSR has more of a strengthening and cross-disease focus in the 2017 Note, while the 2015 Note provides looser language around whether these should be considered as RSSH/ HSS or disease-specific investments; the 2016 Note refers to integrated service delivery as an investment area focusing on RMNCAH and integration, whereas the 2015 Note refers to service delivery in terms of district health systems; HRH definitions jump around in terms of whether it includes community work force; etc. Further, some key pieces of guidance are included in some years and not in others, which runs the risk of countries being misinformed when the most recent guidance is not consulted. For example, the 2014 HSS Information Note provides indicative funding amounts across country bands, which are not included in the documents for other years. Supporting Annex I provides more details.

Thirdly, in all eleven of our country case studies, stakeholders were mostly unfamiliar with this document and reported that they had not consulted it for RSSH-related application development. In some countries, select working-level government officials and/ or consultants appointed to draft the funding request were familiar with this document, although there was no major support for the document and a strong preference to reduce written guidelines and replace with hands-on training. More generally, country stakeholders indicated that the Secretariat Country Team is the main source of information and guidance on all aspects relating to the Global Fund, and they depend on them for RSSH-specific guidance as well.

Finally, some stakeholders commented that the Information Note does not adequately distinguish between different country contexts and suggested the need to tailor guidance by development continuum (and at an extreme, even having country-specific guidance). Country stakeholders consulted for the South Africa country study for example, indicated the lack of applicability of this guidance for their country given its more developed/ advanced status.

RSSH investment area-specific guidelines/ Technical Briefs

Several partners commented on the technical excellence of the RSSH Technical Briefs, especially with regards to HRH. However, at the same time, the additionality of these documents alongside WHO and other technical partner guidance was also questioned. Secretariat colleagues indicated that the additionality is in operationalising more high-level and strategic guidance from WHO and other United Nations (UN) partners, but country stakeholders largely noted that additional documents issued by the Global Fund can cause confusion and mis-alignment with global guidance. A case in point is the Global Fund's approach and guidance in relation to ISD, which is seen as different from that proposed by WHO in its "people-centred services" approach (discussed in more detail in Section 6.3). Countries were largely unaware of these additional technical guidelines and professed to not having consulted them during application development. Additional details on investment area-specific guidelines/ Technical Briefs are provided in the respective investment area sections within Section 6 of this report.

Application and grant-making tools

Our assessment is that the overall approach to applications undermines RSSH in that the emphasis is on the disease applications and RSSH is positioned as “another disease”, which is ineffective. There is also inadequate definition and guidance/ prescription of the application requirements. This is in terms of some overall approaches to country applications as well as the application templates and tools. In particular:

- The funding request template requests for generic information relevant for RSSH, but: (i) it does not require, or steer countries to provide the “bigger picture” for health systems investments or links with the other government/ donor funding (also flagged by the TRP as a key gap in reviewing RSSH components in applications); and (ii) as a result, countries provide information with varying degrees of RSSH-relevant information in the forms, based on their interpretation of Global Fund objectives (as observed from the review of funding requests for our case study countries).
- The programme continuation approach is largely based on disease-specific criteria, with limited consideration of RSSH continuity. Two of our case study countries have adopted the programme continuation approach in 2017-19 (Georgia and Sudan), however RSSH needs have evolved significantly from NFM1 to NFM2. For example, in Georgia there is a significant recognition of the need to prioritise RSSH in future funding to support the transition process, which may entail a heightened focus and specific intervention funding; in Sudan, RSSH funding was considerably delayed and re-programmed under the 2014-16 allocation, with a need to re-think feasible and priority interventions for the next phase of funding.
- While countries have been advised to submit RSSH and disease applications together, or at least submit RSSH with the first disease application, in practice countries are not steered adequately towards an effective investment planning approach. The TRP has suggested that the first country application include the RSSH request, however some discussions in country indicated preference to submit RSSH towards the end of the process, once disease priorities have been confirmed and there is a chance to holistically look at the gaps for programme implementation. This may be a country-specific issue, but in effect, one or the other approach to timing of Global Fund RSSH needs to be considered.

5.1.3. Summary findings

Key issue/ theme	Findings	Robustness rating and explanation	
Relevance of overarching Global Fund policies for RSSH	<ul style="list-style-type: none">• Overarching Global Fund policies have been largely structured around disease requirements, with allocations not including any health systems criteria, and the sustainability, transition and co-financing policy does not go far enough to address sustainability issues from an RSSH perspective.	C	Largely based on CEPA’s critique of the policy documents, and supported by some donor partner consultations although limited traction with Secretariat colleagues.

Key issue/ theme	Findings	Robustness rating and explanation	
Efficacy of RSSH related tools and guidelines	<ul style="list-style-type: none"> The RSSH Investment Framework lacks clarity and stability, with frequent updates. There is close to no knowledge and use of the Framework in country. RSSH investment-specific guidelines are technically strong, but also receive limited use. 	A	Unanimous feedback provided in country, and supported by evidence generated through review of these guidelines documents.
	<ul style="list-style-type: none"> The application approach undermines RSSH, with RSSH being treated as “another disease” (e.g. application templates do not allow for RSSH relevant information, programme continuation approach does not consider RSSH context). There is inadequate definition/ prescription in the application process (e.g. timing of RSSH applications vis a vis diseases). 	B/ C	Largely based on CEPA’s assessment, with some consultation feedback.

5.2. Country decision-making and application cycle

Q6: How effective are decision-making processes for RSSH at the country level, the TRP review process and the grant finalisation and approval process?

Section 5.2.1 describes the functioning of country decision-making processes with regards to RSSH, Section 5.2.2 provides a review of the efficacy of the TRP review process, Section 5.2.3 describes varying country experiences with regards to grant-making and Section 5.2.4 brings all of these together to consider overall implications.

5.2.1. Country decision-making on RSSH

Consultations with the Secretariat highlighted several concerns with country decision-making for RSSH including whether disease-dominated CCMs might be able to adequately prioritise RSSH. Our findings in country present new and additional learnings in relation to these issues highlighted by the Secretariat, and indicate the following:

Countries are strongly guided by the suggested level of funding in the allocation letters, although the basis for RSSH funding varies substantially by country, and is mostly ad hoc.

As noted in Section 4.2, in the absence of an RSSH allocation, countries largely work with the guidance/ benchmarks included in the allocation letter. This can be viewed as problematic in one sense, as this guidance is based on historic levels of funding only (rather than RSSH need, for example). How countries get to a defined level of RSSH funding in an allocation period is largely ad hoc, rather than being evidence-based on need or gaps in funding. Box 4.1 provides some examples of the varied approaches to country determination of RSSH funding.

Box 4.1: Varying country approaches to determining RSSH funding

In **Ghana**, RSSH funding was based on which disease could most likely “spare” resources for RSSH. As the HIV and TB allocations were significantly reduced from NFM1, while that for malaria was relatively stable, the decision was made to assign resources from the malaria allocation for RSSH.

In **Zambia**, once the overall RSSH amount was determined, the MoH reportedly allocated an amount to each RSSH investment area with suggested priority activities, though this process was suggested to lack transparency. While not specific to RSSH alone, the consultation and engagement process was widely criticised for lacking focus and effective coordination, given the large number of stakeholders and cost involved.

Some CCMs have good representation for RSSH, and while others may be more disease-oriented, they do not necessarily de-emphasise RSSH.

For our case study countries, there were varying experiences of adequate RSSH representation on the CCM (e.g. in Ghana, while the cross-cutting health systems government department is represented on the CCM, most of the members are disease focused, including the disease programmes, disease-focused CSOs and key affected populations groups, and disease focused personnel from the development partners; in Ethiopia however, the Ethiopia CCM is well represented for RSSH through the specialised public sector agencies and the range of Federal MoH members).⁵¹ A global database on CCM membership in 2016 suggests that only a minority of CCM members (8%) were exclusively representing RSSH (see Annex J for more details); however, the picture becomes more balanced if the 24% of CCM members representing multiple disease components are regarded as also representing RSSH (although this may not necessarily be the case and so must be considered as an upper bound of RSSH representation). Interestingly, CCM members representing RSSH are more likely to have a public sector background (42%) compared to CCM members representing disease-specific issues (23%).⁵² However, across the board, even where CCMs were disease-dominated, we did not observe any de-prioritisation of RSSH (contrary to oft claimed Secretariat views), suggesting RSSH representation on the CCM is not a critical factor for RSSH prioritisation, and countries as a whole are cognisant of RSSH need (as also indicated in Section 4.2.3).

There is a broader issue of whether the CCM is able to effectively engage in wider health system discussions, and additionally that it could be viewed as parallel to other in-country coordination structures.

While CCMs are able to prioritise and emphasise RSSH, as noted above, we question whether they are able to effectively design RSSH interventions, in terms of being able to identify the highest priority gaps for the health system and coordinating with other funding. The challenge lies in the discord between the structure and mandate of the CCM and the “agency” (both in terms of knowledge and incentive) required to assess health systems issues.⁵³ Further, there are several health systems planning and coordination fora in country – e.g. in addition to the standard government planning processes for national health and disease-specific NSP development, there

⁵¹ The CCM Guidelines/ CCM Policy includes a requirement on membership (requirement 4), which noticeably does not make any specific mention of RSSH-relevant membership. (‘The Global Fund. (2018). CCM Policy Including Principles and Requirements’). This does not appear to be a focus for the ongoing CCM Evolution, based on a review of the main tenets outlined in: ‘The Global Fund. (2018). CCM Evolution.’

⁵² This analysis excluded all CCM members that do not have a defined sector as background.

⁵³ It is useful to think about this problem in terms of behavioural economics theories such as on “bounded rationality”, where individuals make satisfactory rather than optimal decisions as their decisions are limited by the tractability of the decision problem.

are also platforms for HSS funding through e.g. Gavi, the World Bank and the Global Financing Facility (GFF), with each prioritising HSS through their respective foci. The role and participation of the CCM in these other fora are not clear, nor aligned.

The extent to which this is an issue can however vary by country e.g. in Ethiopia, with the strong stewardship of the health sector by the Federal MoH, and their leadership of the CCM, it can be assumed that the CCM-related RSSH discussions are well coordinated with wider health systems discussions in country. This is also the case for India, where the Global Fund investments are guided by strong national plans and all key cross-cutting decision-makers (e.g. from the National Health Mission) are on the CCM.

Fundamentally, country decision-making on RSSH is strongly influenced by guidance/ steering by the Global Fund Country Team.

Through our country case studies, we found that the most important factor driving country-decision making on levels and areas of RSSH funding came from guidance from the Global Fund CT. There are several examples of countries wanting to fund more RSSH (e.g. Ethiopia, Tanzania) or wanting to fund different/ additional RSSH investment areas (e.g. Ghana), and being steered differently by the CTs. This is also discussed further below on the grant-making and approval processes.

5.2.2. TRP review of RSSH applications

The TRP structure reflects the operationalisation of RSSH prioritisation within the Global Fund strategy, with 28 RSSH experts amongst the total of 122 TRP serving members (i.e. 23%), being the highest proportion amongst all categories of expertise on the TRP.⁵⁴ However, a number of key issues on the process of TRP review with regards to RSSH were highlighted:

- Discussions with the TRP and Secretariat members highlighted a number of issues with the TRP reviews for RSSH including: (i) TRP reviews being dominated by the diseases, with “little voice” for the RSSH reviewers; (ii) the challenge of reviewing RSSH in the face of limited information in the application forms (as discussed above in Section 5.1.2) or specific outcome data on previous RSSH investment, alongside a view that Secretariat members may not always have good knowledge and insight into country RSSH needs; and (iii) pressures to approve RSSH quickly, especially when integrated with diseases, in order to not delay access to treatment commodities (an issue of the allocation model more generally).
- While consultations did not indicate any issues per se with the TRP review criteria, our assessment of the criteria is that: (i) there is a degree of misalignment with the current RSSH framework (e.g. the review guiding questions are not fully encompassing of the priorities identified in the RSSH Investment Framework); and (ii) there are a number of generic criteria that often reflect ideal states (e.g. “satisfactory investments”, “clear investments”) and are not country-context specific.⁵⁵

⁵⁴ Information shared by the TRP Secretariat via email in December 2018.

⁵⁵ Based on a review of the TRP Terms of Reference (‘The Global Fund. (2016). TRP: Terms of Reference.’) and the “TRP Review Criteria Guiding Questions” and “Funding Request Scoring Tool and Assessment”.

These issues may result in inconsistent and/ or subjective review approaches by the TRP on RSSH, which was an issue flagged by some Secretariat members. However, it is also recognised that the nature of RSSH investments (different from standardised disease programmes) will inevitably bring in a degree of subjectivity in assessment.

Country feedback on the TRP reviews have generally been positive – although our judgment is that this feedback is reflective of the overall TRP review, rather than being specific to RSSH. We observe that the TRP review forms for the case study countries include comments on the disease applications for the most part, with limited review comments on RSSH. For Ghana, for example, we found that the TRP review on RSSH did not include anything additional to issues flagged in the Secretariat Briefing Note, with RSSH planning and prioritisation pushed out to the grant-making stages. For Zambia as well, there were no major comments on RSSH components of the application. The TRP also indicated that majority of their comments were to be resolved by the Country Teams, an approach that may have some conflicts of interest as the Country Team incentives are to accelerate disbursements.

Countries are strongly of the view that review comments are usually “non-negotiable”, without adequate room for discussion and clarification and that their grant application has to be geared to what might or might not be acceptable to the TRP. These views point towards a degree of imbalance between country ownership and technical review objectives, with potentially a need to revisit this issue within the Global Fund model.

5.2.3. Grant-making and approval processes

Country experiences with the grant-making and approval process have varied substantially across our case study countries, with generally positive feedback in some countries (e.g. Ethiopia, Georgia, India, Tanzania) and more challenging experiences in others (Ghana, Sudan and Zambia). Key issues have been as follows:

The grant-making process has been viewed as highly complex and time-consuming, with considerable transaction costs

For example, several countries viewed the grant-making process as highly complex (Ghana, Sudan and Zambia), with multiple requests and iterations from the Global Fund Secretariat

The Country Teams are driving the grant-making process, with considerable changes through to approval

Several country stakeholders commented that the grant-making process is Country Team led rather than country-led, and similar to the case of the TRP review, there is a view that the comments/ feedback from the Country Team during this process are non-negotiable. As such, country RSSH investments are very much driven by the level of knowledge/ understanding and support for RSSH within the Country Team – which as discussed in Section 4.2 has varied substantially across the Secretariat and resulted in a range of different operational approaches. For example:

- In Zambia, country stakeholders noted that there was little information/ feedback on how the final budget was determined and decisions were made to reallocate resources (e.g.

reduction of RSSH grant by one third in NFM2), with the result that some country prioritised activities were not funded.

- In Ghana, the grant-making process was viewed as strongly Country Team led, with several country stakeholders noting that country proposed priorities were dropped without adequate communication and discussion. Country Team representatives noted the challenge with ensuring implementation-ready and effective grants, especially with the large debtor status of Ghana on account of the recent national warehouse fire.
- For Sudan, the Prospective Country Evaluations report notes that there was strong involvement of the Country Team during both NFM1 and NFM2, with the strong guidance being viewed as “helpful and challenging at the same time, risking reduced country ownership”⁵⁶ (page vii). It was also noted that the comments from the Country Team “were often not relevant to the country context but reflected Global Fund concerns” (page 20). Our discussion with the country also indicated a request for the country to be able to shape their funding according to their needs.

There is reduced attention to RSSH details during grant-making

Several Country Teams noted that with the heavy requirements of the grant-making process and the tight timelines, attention is usually placed on the more significant areas of funding – i.e. diseases get more emphasis than RSSH, the key RSSH investment areas such as PSCM and HMIS get more emphasis than lower cost interventions such as CSR.

There is reduced stakeholder engagement during grant-making, with limited coordination across PRs and with other donor funding

It was highlighted in multiple country case studies that following a multi-stakeholder country dialogue process at the start to determine the funding request, the grant-making stage involved more isolated engagement of individual PRs, with the result that multiple PRs/ SRs involved in RSSH components were not aware of each other’s work and how they were all adding up to contribute to resilient and sustainable systems. For example, in Ghana, there was no collaboration between the RSSH government department PR and the CSO responsible for implementing the CSR component within RSSH. This has varied across countries though – in Ethiopia for example, there was much more collaborative working during the grant-making stage across multiple implementers.

5.2.4. Implications

A review of the end-to-end application cycle for RSSH reveals several gaps in the processes, which may contribute towards sub-optimal RSSH investment planning, including: (i) limited definition and clarity in country guidance (as per the findings from Sections 4 and 5.1), alongside relatively open-ended processes to country decision-making for RSSH, which while useful to account for different country contexts, may not be resulting in the most effective approach to RSSH planning and prioritisation; (ii) some tensions or imbalances within the TRP review structure, which may put to

⁵⁶ Euro Health Group. (2018). Prospective Country Evaluation (PCE). Annual Report 2018. Sudan.

question as to whether RSSH is receiving its needed technical review; and (iii) a largely Country Team driven approach to RSSH determination for grant sign-off, which as described in Section 4.2, is subject to a range of operational tensions. All of these factors suggest a need for a closer examination of the RSSH application process, specifically in terms of whether there are opportunities to better define certain aspects upfront for smoother and country-owned decision-making as well as aspects where RSSH needs specific consideration rather than a standardised approach within Global Fund as another disease programme.

5.2.5. Summary findings

Key issue/ theme	Findings	Robustness rating and explanation	
Country decision-making on RSSH	<ul style="list-style-type: none"> • In the absence, in many cases, of a strong evidence-based rationale for funding, guidance in the allocation letters, alongside strong steering by the Secretariat is driving country RSSH funding levels. • RSSH-related representation on the CCM is not the key issue – rather, there are questions whether the CCM is able to effectively engage in wider health systems discussions, and whether it is well integrated with other in-country coordination structures. 	B	Good evidence across the range of our country case studies, although some differences in Secretariat and partner views on key issues.
TRP review of RSSH applications	<ul style="list-style-type: none"> • There is inadequate focus on RSSH; a function of limited information in the application forms and disease-dominated discussions within the TRP. 	B/ C	There have been some diverging views on the conclusions, and to some extent, this is based on CEPA's assessment of different country situations.
Grant-making and approval process for RSSH	<ul style="list-style-type: none"> • Grant-making processes are complex, time-consuming and with high transaction costs. The Country Teams play a strong role in determining RSSH funding, often undermining country ownership. 	B/ C	Evidence across the range of our country case studies, with these also being corroborated through other ongoing evaluations and some stakeholder feedback.

6. REVIEW AREA 3: RSSH INVESTMENT AREAS – APPROACH AND IMPLEMENTATION

The third review area is a deep-dive into five of the seven RSSH investment areas of (i) CSR; (ii) HRH; (iii) ISD; (iv) data systems; and (v) national health strategies (Q7-11, Sections 6.1-6.5), encompassing an assessment of the approach to these investment areas as well as implementation experience in practice.

The specific evaluation questions and scope are presented in turn below for each of the investment areas. Supporting Annex K includes an overview of funded activities by investment area across case study countries, with details for case study countries in the Country Annexes.

6.1. Community systems and responses

Q7: How effective is planning and funding for community systems, coordination with formal systems, community-based organisation (CBO) role in service delivery and monitoring, and approaches to sustainability and resilience at this level?

This section discusses the RSSH CSR investment area, specifically: (i) context and rationale for CSR and a summary of the CSR investment area and funding to date (Section 6.1.1); and (ii) key findings regarding the investment area (Section 6.1.2).

6.1.1. Summary of investment area and funding to date

Context and rationale for CSR

A review of Global Fund documentation indicates that over the last ten years,⁵⁷ CSS has increasingly been seen through a broader health and community lens, reflective of the paradigm shift from “health systems” to “systems for health” that is central to the RSSH concept. The current Global Fund Strategy for 2017-22 provides a stronger strategic focus on strengthening CSR within disease-specific funding and as part of RSSH. The link between CSS and the three diseases continues to be emphasised however, given disease control efforts can be enhanced through the mobilisation of key affected populations and community networks, and the importance of strengthening community-based and community-led systems for prevention, treatment, care and support, as well as the development of an enabling and responsive environment.⁵⁸ The strengthening of *community systems* is also seen as essential for strong *community responses*, which requires capacity building for planning, programme and financial management, and engagement, as well as access to resources through appropriate channels of funding, and support for coordination with other entities.⁵⁹

As with other components of the RSSH framework, CSR is intentionally broad to enable specific interventions or approaches to be suggested and designed according to country needs and contexts. In terms of programmatic structure, community-led service delivery is usually included in disease

⁵⁷ Countries have been able to seek funds for community systems strengthening since 2007.

⁵⁸ The Global Fund. (2014). Community systems strengthening framework, Revised edition, February 2014.

⁵⁹ Ibid.

requests, but CSR activity requests that go beyond the three diseases, or are integrated, can be applied for under RSSH.

Summary of CSR funding to date

There has been a decrease in CSR investment across the two periods from US\$137.9m to US\$44.9m. While this is likely in a large part driven by the overall reduction in Global Fund funding, the proportion of CSR investment of total direct RSSH specifically declined from 11% to 5% from NFM1 to NFM2.⁶⁰

CSR as a percentage of total direct RSSH is much lower in High impact and Core countries, while it reached above 25% in Focused countries (Supporting Annex E provides further details). Indeed, the decline in funding was more driven by High Impact, COE and Core countries that have the largest overall allocations, despite their proportion of overall CSR investment being lower.⁶¹ It is noted that support to CHWs, which in many countries represents a significant proportion of community level support, is often included as HRH and not CSR funding (although notable funding for CHWs is also included under CSR and disease grants), and support to the retention and scale-up of health workers (discussed under the HRH investment area, Section 6.2) saw an increase across allocation periods.

Finally, an analysis of the spread of direct RSSH-CSR funding across disease (or RSSH stand-alone) grants globally suggests that the majority of CSR funding is within HIV and HIV/TB grants, as indicated in Table 6.1 below.^{62,63}

Table 6.1: The proportion of CSR funding in NFM1 and NFM2 split by disease

Disease component	2014-16	2017-19
HIV	42.2%	28.9%
HIV/TB	20.3%	30.3%
Integrated	2.3%	0.0%
Malaria	23.4%	25.4%
RSSH	0.2%	0.0%
Tuberculosis	11.5%	15.4%

Analysing the coverage of grants that have a CSR component highlights similar results. Across allocation periods, HIV and HIV/TB grants have the highest coverage of CSR investments with 52.4% and 46.9% respectively. In contrast, only 28.1% of TB grants and 28.5% of malaria grants have a CSR component. Many of these include small investments in CSR though, for instance only 12.5% of HIV grants have CSR components above US\$1m.

⁶⁰ The difference may be partly explained by the use of different methodological approaches between periods.

⁶¹ One further factor which could be considered as an explanation for this extent in drop in funding is the lack of NFM2 allocation for South Africa as yet, which could be sizable given it had an allocation of US\$24m in NFM1.

⁶² Interpretations of the data in this table should consider inconsistencies in the categorisation of CSR activities. These are further outlined in section 6.1.2. below.

⁶³ In comparison, it is noted that the majority of non-RSSH community investment takes place through malaria grants: The Global Fund. (2018). Overview of Investments in Community Systems and Responses.

6.1.2. Key findings

The Global Fund is one of the few organisations prioritising community systems and response at a corporate objective level but there is a general lack of clarity and understanding on the aims and scope of the CSR investment area.

The difference between CSS and CSR, in that CSS is needed to enable a more effective functionality of the community 'system' to boost the means by which communities act on the challenges and needs they face (their 'responses')⁶⁴ is little understood at both global and country levels, and the terms are often used inter-changeably. CSR, by definition, needs to be people-centred, reflecting an integration of services, though disease interventions can contribute positively to CSS efforts if well planned and coordinated.

It was raised by a number of global partner organisations that the Global Fund is one of few organisations prioritising community systems and responses at a corporate objective level. However, some challenges remain in effectively operationalising CSR efforts. That CSS is not incorporated into the WHO health systems framework (though the CSS building blocks do correspond to the WHO HSS building blocks) can both complicate understanding of the concept within and beyond the Global Fund, and also dampen the Global Fund's efforts to champion communities. How CSR (or CSS) fits within the RSSH concept also remains confusing – often RSSH is seen as HSS + CSS, implicating CSS/CSR as a separate or not a core component, as compared with other investment areas. Understanding or ownership of CSS within RSSH may also vary, for example tensions exist between formal and informal cadres supported within RSSH.

Some Secretariat staff suggested that there is an ineffective linkage between the Global Fund Strategy, the CSS framework, the Modular Framework and the guidance often provided by the Country Team on the scope of, and operational implications for, CSR. This lack of clarity has contributed to differences in opinion and understanding of the overall purpose and scope of CSR investment opportunity.

Furthermore, the concepts of resilience and sustainability that are central to the Global Fund's new RSSH approach are not adequately reflected within the grants. This is particularly relevant to the CSR component given the importance assigned to disease preventative and treatment seeking behaviours and the strength of community systems during the West African Ebola outbreak, and the subsequent promotion in the global discourse of community interventions as central to building health system resilience. Across countries, there is limited understanding around how resilience should be operationalised under Global Fund funding, though many informants indicated the importance of bottom-up planning and harnessing local solutions.

Inconsistencies in the categorisation of CSR activity can raise misconceptions in terms of the level and scope of CSR activity actually funded.

There is diversity in how CSR activity has been categorised across countries and over allocation periods, with, in particular, inconsistency in activity categorisation across CSR and HRH. In Zambia,

⁶⁴ The Global Fund (2018). The Crucial Role of Communities: Strengthening Responses to HIV, TB and Malaria.

for example, salary support for Community Health Assistants was funded as CSR under NFM1 but under HRH in NFM2. In Ethiopia, there was no particular funding allocated to CSR within the RSSH stand-alone grant, however the health extension programme (HEP), which aims to strengthen the link between the formal health system and community has received extensive Global Fund support under the HRH investment area. Some recent analysis on CSR data conducted by the Global Fund also suggests considerable community funding was actually programmed in other RSSH investment areas during NFM2, specifically, HRH (US\$7.7m), HMIS (US\$1.73m) and ISD (US\$1m).⁶⁵ The discrepancy in classification of RSSH-related CSR and community interventions across RSSH investment areas within disease or RSSH stand-alone grants can lead to misconceptions of the extent of community systems activity supported.

CSR funding requests are limited in scope and scale, and there is a dominant focus on the extension of service delivery through CHWs at the community level.

A review of the grants' scope, coupled with feedback from Secretariat and country informants, suggests that CSR funding requests tend to be limited in scope and scale. There appears to be a common assumption that CSR is predominantly about CHWs rather than a broader link between the community system and the health system, which has likely contributed to the prioritisation of CHW support in activity selection across countries. In comparison, there is less focus on the community systems themselves, institutional aspects, promoting community access to services or social accountability, or community-based M&E. Communities can also be seen as difficult to conceptualise given the range of actors from CHWs to peer educators to human rights activists, which can hamper in particular the inclusion of marginalised and vulnerable populations as well as community-led initiatives during grant planning.

The TRP reported similarly, that few applications requested support to increase the engagement of communities to address the gaps in coverage across the three diseases, or to strengthen community health systems in ways which encourage integration with the overall health system.⁶⁶ However, the country case studies suggested that this was not due to a lack of demand, but rather a myriad of factors which include:

- A sense that there is a need to preserve 'what has been going on' and to focus on the front-end, 'big-ticket' items, given grant management teams are stretched. There is also concern that boosting CSR creates a disconnect with the main disease control focus of the grant(s). Frequent questions arise as to whether focus should go to direct implementation or supportive strengthening efforts.
- Smaller, and complex grant components also become easier to not pay too much attention to, especially when they are difficult to measure in standard indicator frameworks, as is the case with CSR (see Section 4.4.2).
- There is also an ownership issue for CSR – in many countries it is considered outside government and as representing the interests of civil society and communities rather than a

⁶⁵ The Global Fund. (2018). Overview of Investments in Community Systems and Responses.

⁶⁶ The Global Fund (2018). Strategy Committee: TRP Report on RSSH Investments in 2017-2019 Funding Cycle.

concern of overall health responses. There can be a reluctance of governments to support civil society and communities with the expectation that they may challenge or hold them to account for what they are doing/ not doing. There are also limitations in civil society representation in many countries (see further discussion on this below).

- The lack of in-country evidence from the community level to justify priority focus areas, or to determine impact of CSR programmatic activity, was an issue highlighted by many. This may reflect the lack of support given to communities to collect and analyse their own data and that their contribution often remains poorly collated.

There is considerable variability in community representation in the planning and management of grants in country.

In particular, findings from the country case studies suggested the following:

- **There is limited input from CSOs or key and vulnerable populations into the design of RSSH investments, including CSR in a number of countries.** CSR priorities are more commonly determined at the national level and based on health system gaps, or population wide targeting based on achieving a geographic spread of activity. In addition to being a resource limitation issue, this is reportedly influenced by PRs often being state actors with a reluctance to fully engage with CSOs depending on the political and institutional context (i.e. this appeared to be the case in Tanzania), the disjointed coordination of civil society (i.e. Sierra Leone), the low coverage of CHWs which may prevent consideration of CSOs/ community-based organisations (CBOs) in supportive roles (i.e. Zambia), strong leadership/ control of the CCM by the government (e.g. India) or the prioritisation of other investment areas. Where communities are represented in the design of the proposed grant, the diversity of community actors is reportedly rarely well represented, including in particular key and vulnerable populations.
- Even where CSO activities are incorporated into funding requests, follow-up in terms of **budget allocations at the grant making stage may result in little actual budget for CSO support.** This has been particularly the case in Zambia where CSOs reported a significant mismatch between CSO activities proposed and CSOs activities budgeted for.
- **Participation in the CCM tends to be dominated by HIV and TB focused CSOs,** which reflects maturity of understanding on contribution of communities and levels of activism, and correlates with the spread of direct RSSH-CSR funding across disease grants, as indicated by Table 6.1 above. This also emphasises that, despite considerable need and in-country support, cross-cutting CSR has received little focus until recently and is still a marginal component of RSSH investment. Ghana and South Africa however are examples of countries where support has been provided to community cadres to address more than one disease e.g. in South Africa, ward-based outreach for TB covers screening and education for TB, HIV and Sexually Transmitted Infection (STIs) in order to count a person as ‘reached’. It was also suggested in a small number of countries (i.e. Tanzania) that CSO representation on the CCM is in some cases ‘managed’ by the government to reduce the likelihood of, and funding for, CSOs in exploring government accountability issues, an issue highlighted previously.

CSR programmes are not often effectively designed with a sustainability focus.

CHWs, for example, can be supported to conduct disease specific activities but they may not be subsumed into human resources for health plans or financial support arranged for CHWs in the longer term. A similar conclusion was reached from the TRP's broad review of recent applications with a CSR inclusion.⁶⁷ Zambia, provides an example of challenges in incorporating a long term orientated, sustainable approach to supporting the CHW programme (Box 6.1). In Sierra Leone too, donors (including the Global Fund) are funding 100% of the CHW programme. While the government have committed to taking on a greater share of wages with a gradual phase-out of Global Fund support, it is unclear when and how this will be possible given limited in-country financial resources. It was suggested by informants at both the global and country levels that sustainability and transition needs to be considered as early as possible in the grant design process, including taking a long-term view across consecutive funding cycles, and aligned to national plans. In Côte d'Ivoire however Global Fund support aided progress of inclusion of community health in the national health plan for 2016-2020, thus aiding sustainability of CHW support.

Box 6.1: Sustainability of support to CHWs in Zambia

In NFM2, the Global Fund is supporting the training of CHWs and the provision of enablers (i.e. supplies) to support the implementation of iCCM. Despite the recent approval of the National CHW Strategy, which aims to provide guidance to link relatively piecemeal implementation to an overall strategy, it has reportedly had limited impact so far at the implementation level. The strategy is also being utilised outside the framework of an overall HRH plan in-country. While support to CHWs is seen as important, there continues to be significant challenges in CHW programme delivery in Zambia. In particular, different disease control or community health interventions utilise or support different CHW cadres in accordance with various vertical strategies (i.e. iCCM, community antiretroviral therapy (ART)). This results in a lack of standardisation of CHW support and incentive packages which can impact considerably on CHW motivation. The lack of integration of service delivery also impacts on the comprehensiveness of the care from the patient perspective. A lack of transportation affects the ability of CHWs to collect supplies and submit reports and inhibits effective support supervision from the health facilities (which is further exacerbated by a lack of staff, particularly rural health posts). There are also specific challenges with regards to the quality and level of integration of community reporting efforts. These issues, as well as the general dependency on external donors to support the CHWs, have brought into question the overall sustainability of investing in CHWs.

Support to CSOs can often also be activity orientated rather than encompassing a more long-term view of capacity building or strengthening of the sector. Among countries approaching transition from Global Fund support, few have developed robust mechanisms to ensure sustainable funding for CSR activity (i.e. from local and government sources), despite recognition that these organisations can in some cases provide the most effective opportunities for reaching and engaging key populations in many disease control programmes.⁶⁸ In Georgia, Global Fund grants have supported the formation of a strong CSO platform, but the sustainability of CSOs is uncertain, especially in terms of social contracting for CSOs, legal and regulatory frameworks for their work, CSO financial support and the need for further capacity building for CSO institutional management. There were attempts to address some of these challenges under NFM1, though these activities were

⁶⁷ The Global Fund (2018). Strategy Committee: TRP Report on RSSH Investments in 2017-2019 Funding Cycle.

⁶⁸ The Global Fund (2018). Strategy Committee: TRP Report on RSSH Investments in 2017-2019 Funding Cycle.

included in the disease modules, not under the CSR investment area, despite the strong link with resilience and sustainability. India is also an example where there is a financial sustainability risk for most of the CSO PRs and work conducted by the CSO, Caritas, in the 2014-16 allocation period was not taken forward under the 2017-19 allocation, which has been viewed unfavourably in-country given abrupt discontinuation of programmes funded.

Under Global Fund grants, there are a few examples of the development of social contracting mechanisms or other innovative financing approaches to support the continuation of critical work by CSOs/ non-governmental organisations (NGOs), especially with respect to the provision of services to key populations.⁶⁹ It is suggested that the Global Fund's low appetite for risk, coupled with country governments' varying willingness to support civil society (the PRs are responsible for contracting civil society groups), are key contributing factors. Countries which support numerous CSOs, such as Zambia, noted that grant management of, and by, CBOs takes a lot of effort, and in many cases, the requirements of the grant are pushing them away from implementation efforts which are their strength - there was concern, often at the state PR level, that the activation of more independent funding approaches may reduce grant management requirements, but could further raise overall risk. One global level informant also commented that the focus on long-term funding for CSOs, while important, also unfortunately positions CSOs as "recipients rather not actors".

Some Secretariat staff suggested that as CSR sustainability has been cited as a key post-transition risk, this needs to be considered as a priority area for technical assistance (TA).

The role of community organisations in supporting service delivery has been limited and small in scale, though there are some positive, early examples of CSO activity in community monitoring.

Given the focus on CHWs in CSR grants, there are some examples where CSOs have played an active role in supporting CHW programme delivery (such as in Zambia where CSOs have supported Volunteer Adherence Support Officers, and India where CSOs are supporting the Accredited Social Health Activists (ASHA)⁷⁰ in capacity building, supervision and data collection in relation to mother to child transmission), though these are generally limited both within and across countries. There have been some positive examples of community monitoring efforts in particular recently initiated under NFM2, but again, these have been small scale and are more included as a CSR implementation activity, with the broader opportunity for collecting data for grant evaluation perhaps overlooked or not considered relevant to the performance monitoring framework. In Tanzania, for example, community score cards, which enable the community to set priorities on their health needs and to provide feedback on the gaps in the existing service delivery, are starting to be supported on a small scale under NFM2. The approach is welcomed in-country, given it acknowledges community leadership and the role of communities in planning and the tool is flexible and adaptable to different contexts. In a review focused on CBM commissioned by the Global Fund, CBM was emphasised as important for capitalising on users' experience of services, enabling community ownership and buy-

⁶⁹ Ibid.

⁷⁰ The Accredited Social Health Activists (ASHA) are CHWs instituted by the Government of India – there is an aim for one ASHA in every village.

in, creating feedback loops and a learning environment, as well as improving quality of health services and health outcomes. The Global Fund is some way off incorporating, and optimising, CBM as a more routine activity.⁷¹

6.1.3. Summary findings

Key issue/ theme	Findings	Robustness rating and explanation	
CSR design and implementation	<ul style="list-style-type: none"> The Global Fund is one of the few organisations prioritising CSR at a corporate objective level, but there is a general lack of clarity and understanding on the aims and scope of this investment area. 	A/B	Evidenced by scope of CSR activity across countries and country consultations, as well as Secretariat, TRP and global partner consultations, and documentation and data review.
	<ul style="list-style-type: none"> CSR funding requests tend to be limited in scope and scale, and there is a dominant focus on the extension of service delivery through CHWs at the community level. The role of CSOs in supporting service delivery has been limited and small scale in a number of countries. 	B	Most countries emphasised limited participation of a range of civil society in grant design. Varied implementation experience across countries though broad consensus in some of the common challenges. Based on country case studies for this review only.
	<ul style="list-style-type: none"> Although CSR is core to the resilience concept within RSSH, grants have not been implemented with this approach in mind. CSR programmes are often not effectively designed, or implemented, with a sustainability focus. 	A/B	Represents a common view across countries and reflected across global level consultations. Also backed up by documentation review. Based on country case studies for this review only.

6.2. Human resources for health

Q8: What is the Global Fund investing in HRH? Have these become more strategic overtime?

This section discusses the RSSH HRH investment area, specifically: (i) a summary of the HRH investment area and funding to date (Section 6.2.1); and (ii) key findings regarding the investment area (Section 6.2.2).

6.2.1. Summary of the HRH investment area and funding to date

The RSSH Investment Framework notes that HRH is fundamental to health systems and RSSH, with the following general principles for funding: (i) invest according to the country's HRH labour market;

⁷¹ The Global Fund, LSE Department of Methodology, University of Copenhagen, International HIV/AIDS Alliance. (n.d.). Four models of community-based monitoring: a review.

(ii) invest more sustainably; (iii) invest in more integrated HRH approaches; and (iv) engage in strategic partnerships.⁷² As elaborated in Annex E, over the two allocation periods, interventions related to the retention and scale-up of health workers received the most funding, especially in the current allocation period. The overall share increased from 40% in 2014-16 to around 65% in 2017-19. This trend is especially driven by High Impact countries but can also be observed in other Global Fund eligible countries.

There is also a substantial investment in HRH through contributory RSSH of US\$1.3bn in 2014-16 and US\$1bn in 2017-19. Up to 60 different interventions were supported through contributory RSSH across a wide range of different modules.⁷³

6.2.2. Key findings

The majority of HRH support has been for salaries, which have often not been embedded in a wider strategic and sustainable approach.

Annex E provides an analysis on salary support within the HRH investment area and within all direct RSSH investment more broadly. The analysis illustrates that the proportion of salary spending has increased both for the HRH investment area specifically and for the all direct RSSH investments generally. For the HRH investment area, the proportion of salaries and associated costs has increased from 52% in the 2014-16 allocation period to 83% in the 2017-19 allocation period.⁷⁴ This includes a considerable increase from 3% to 31% in performance-based supplements.⁷⁵ For all direct RSSH, the proportion of salaries and associated costs increased from 16% to 25% across allocation periods.

However, this salary support is considered not to be embedded in a wider strategic approach, a concern raised by members of the Global Fund Secretariat, the TRP and the TERG. The Global Fund RSSH team has issued guidance around HRH with the aim of promoting the sustainability of investments, particularly emphasising salary support, and whilst the Secretariat and partners view this guidance to be fairly comprehensive, it is reportedly little used, thus reducing its efficacy.

A particular concern raised related to country plans and strategies and CHW support. It was highlighted in consultations that while salary support for CHWs is highly needed, it is a riskier investment given often inadequate plans for governments to take over this funding. This was supported by the TRP which noted that few countries indicated plans to incorporate CHWs into their national payrolls. In addition, it was noted that CHWs receive insufficient support more broadly (e.g. inadequate supervision, continuing education etc) which impacts effectiveness and retention, thus posing further risk to the (programmatic) sustainability of these investments.⁷⁶ Examples of salary support for CHWs in our country case studies include: (i) Tanzania, where the Global Fund will support the salaries of 600 CHWs in NFM2 and (ii) Sierra Leone, where Global Fund support is

⁷² The Global Fund. (2017). Building RSSH through Global Fund Investments Information Note.

⁷³ The modules receiving the most support included programme management, TB care and prevention, HIV/ AIDs treatment, care and support, case management and vector control.

⁷⁴ RSSH portfolio database analysis, HRH investment area cost input data representing direct RSSH only.

⁷⁵ This was mostly driven by HRH investments in DRC and Zimbabwe.

⁷⁶ Ibid

supporting incentives for part-time CHWs in a fully donor-supported CHW programme. Furthermore, reportedly the requests for CHWs are not well integrated across diseases and not integrated with formal health care systems. An example from our country case studies was from Zambia where support for CHWs was not well aligned amongst partners, and in a setting in which there is no clear current strategy for CHWs. Partners also criticised that some funded CHW positions are vertical, with a clear focus on the three diseases and it was considered that this leads to inefficiencies, especially without a coordinated approach to this support.

Transition of HRH salary support continues to be a major challenge.

It has been raised by partners that the Global Fund has not been bold enough in putting conditionalities into grants and then enforcing them to ensure that governments take up funding of salaries after donor support concludes. In addition, it was noted that many countries are not taking over salary costs as per the conditionalities and handover agreements made (largely due to apparent insufficient availability of funding), and in some countries, this has resulted in the continuation of Global Fund salary support.

In particular, some countries nearing transition are still receiving support for salaries from the Global Fund. For example, the majority of HRH support in India, which is an LMIC with an impending transition agenda, is for salaries or the malaria programme, including district level consultants and malaria technical supervisors at the sub-district level and lab technicians.

There have been a few examples of efforts to promote sustainability of salary support investments, such as in Tanzania, whereby the salary handover agreement (focused at the end of the grant period) was incentivised by the government having the flexibility to request support for more health professionals if it can absorb a proportion of the salary costs earlier. However, it is too early to discuss the effectiveness of this approach.

While pre-service training investment is considered a more strategic and effective investment than in-service training, in-service training still dominates in funding requests.

Where pre-service training has been supported, it has generally been viewed as a more strategic and efficient investment with better long-term outcomes (and involving less disruption to ongoing service delivery) than in-service training, according to a range of global and country level informants. For example, in Vietnam an evaluation of Global Fund support for doctor training showed that it contributed to a 24% increase in the numbers of doctors per 10,000 habitants in the 15 provinces the support for training.⁷⁷ However, despite the intended shift to the support of pre-service training, and the range of examples of pre-service training across the country case studies,⁷⁸ the TRP review found that in funding requests, 90% of support for trainings is still for in-service training.⁷⁹

⁷⁷ Vietnam Health Economics Association, End-of-project Evaluation Report, HSS Project, funded by Global Fund.

⁷⁸ Examples of pre-service training support across the country case studies include (i) Ethiopia, where support was provided for the upskilling of health extension workers (and 18 month course from level 3 to level 4 qualification), considered key both in their training as well as in contributing to their retention; (ii) Tanzania, where support was provided for the construction of training facilities for health professional cadres such as nurses, pharmacists and laboratory technicians, (iii) Sierra Leone, where the Global Fund is supporting the pre-service training of nurses.

⁷⁹ The Global Fund. (2017-2018). Debrief slides: Technical Review Panel Window (1, 2, 3, 4 and 5).

Support for the equitable distribution of HRH continues to be a concern, though there are some positive examples across countries.

One of the aims of HRH support in this allocation period was to further support more equitable distributions of HRH in countries. Overall, this is raised as an area of ongoing concern with some in the Secretariat noting that most of the HRH investments continue to be targeted at capital cities. The TRP RSSH report also noted that many funding requests do not address the important human resource issue of maldistribution of health personnel.⁸⁰ However, while this may be the prevailing opinion, there were a number of good examples of Global Fund support promoting more equitable distribution of HRH:

- In Ethiopia, separate training is provided for health extension workers in “emerging regions” allowing to tailor the training to specific needs of pastoral communities. This is seen as a step towards reducing inequities between the regions.
- In Tanzania: Salary support for the current grant is for regions with high disease burdens. For the current grant, 280 positions are funded. Additionally, under NFM1, staff housing in remote areas was supported in order to address the shortage of quality housing and increase retention rates.⁸¹
- In Zambia: the investment in supporting salaries for nurses and community health assistants is boosting staff availability at rural health posts.

Task shifting has not been a notable focus of countries but some HRH investments have had some positive effects in this regard.

An aspect that has been considered within this review is the extent to which Global Fund support has been used to aid task shifting, though the country case studies highlight that this was not considered by countries to be an important aim of the Global Fund HRH support. However there were some examples of HRH support which is considered to have had a positive effect in terms of task shifting: (i) In Ethiopia the upskilling of health extension workers is expected to reduce some of the burden on facility-based nurses; (ii) in Zambia, support for salaries and training of community health assistants is expected to reduce the burden on nurses; and (iii) in Georgia there was support to provide TB training of around seven internal medicine/ cardiologist specialists in regions that did not have TB specialists so that the internal medicine/ cardiologist specialists could manage people affected by TB instead.

The majority of HRH support reflects short-term gap filling rather than longer-term HRH objectives.

The TRP report has commented that the HRH funding requested is often for short term support (e.g. in-service training etc.), as opposed to long-term investments in aspects such as robust HRH policies, career development and pre-service training. One of the partners also commented that HRH support needs to be broader, going beyond salary support and training to include a comprehensive

⁸⁰ Ibid.

⁸¹ This support for staff housing is viewed as contentious by some but our review found that it was much needed investment in the Tanzania context.

package of HRH interventions on management, supportive supervision, integration, etc. and which logically links activities over time.

Gavi, for example, also adopts a differentiation approach to HRH: (i) with two types of HRH support, one for management support and another for service delivery support and (ii) it also differentiates countries based on their status of transition. A similar differentiation approach for the Global Fund may support a longer-term planning perspective.

Finally, there were mixed opinions among partners as to whether the Global Fund should be supporting HRH strategy development in countries, with some emphasising its importance alongside the Global Fund's HRH investment and others considering this to potentially overlap with the ongoing support provided by others such as WHO and the World Bank. This points to the urgent need to improve coordination in key countries.

6.2.3. Summary findings

Key theme	issue/ Findings	Robustness rating and explanation	
HRH design and implementation	<ul style="list-style-type: none"> The majority of HRH support has been for salaries, often reflecting short-term gap filling, rather than longer-term HRH objectives and sustainability. Transition of salary support has consequently been challenging. 	B	Unanimous partner and country stakeholder feedback, supported by CEPA's assessment of relevant documentation and data relating to salary support. Based on country case studies for this review only.

6.3. Integrated service delivery

Q9: Has the new strategic focus led to greater investments in priority and meaningful integrated platforms? What have been facilitators/ barriers? What more could the Global fund do?

In this section we outline the following: (i) a summary of the integrated service delivery investment area and funding to date (Section 6.3.1); and (ii) key findings regarding the investment area (Section 6.3.2).

6.3.1. Summary of investment area and funding to date

The RSSH investment area on “reproductive, women’s, children’s and adolescent health, and platforms for integrated service delivery” recognises RMNCAH as a vulnerable and marginalised group for the three diseases, and aims to avoid duplication, fragmentation and inefficiency by supporting integrated delivery.⁸² The Investment Framework prioritises four platforms for ISD – antenatal care, iCCM, integrated sexual and reproductive health, and HIV services and adolescent health.

⁸² The Global Fund. (2017). Building RSSH through Global Fund Investments Information Note

Funding for ISD has slightly declined from US\$128.1m in 2014-16 to US\$107.4m in 2017-19. However, the overall proportion of ISD of total direct RSSH has stayed stable at around 16% across allocation periods suggesting that the decline is driven by lower overall RSSH funding rather than by any specific factors related to ISD.⁸³

6.3.2. Key findings

The integrated service delivery area is not well defined, nor fully understood by Secretariat, TRP, or country stakeholders.

The Global Fund Strategy 2017-22 has prioritised integrated service delivery for the continuum of care across RMNCAH as a key sub-objective of its strategic objective on RSSH. Some Secretariat members consider that the Strategy clearly sets out the need for integration, focusing on areas of Global Fund comparative advantage. However, this approach has been questioned by most stakeholders, and challenges with the operationalisation of this approach are evident:

- The TRP, and other **stakeholders have questioned why the Global Fund Strategy on integration has been narrow in its technical focus.** The TRP and Global Fund Secretariat noted that country requests exhibit some increases in integration aspects such as on HIV-TB and Integrated Community Case Management (iCCM) but fewer on other components of RMNCAH, or NCDs, and even fewer on UHC (which in part relate to challenges in operationalising UHC as discussed in Section 4.1.2). Stakeholders in some countries noted that the Global Fund's approach to integration is limited in comparison to a broader in-country integration agenda e.g. an increased emphasis on integration between public and private sectors. More generally, it was noted that integration needs to be considered at both the policy/ planning level as well as at the service delivery level.
- This investment area **has evolved over the years (previously termed 'service delivery') and this has created confusion for country stakeholders** regarding which investments to apply for within it.⁸⁴ Many countries have applied for support under this area which "does not fit well under the other investment areas", e.g. infrastructure investments in Ethiopia, and in Tanzania the funding was primarily used for improving the quality of broad service delivery rather than integrating services.
- **The WHO Framework on Integrated People-centred Health Services (which was issued after the current Global Fund strategy) defines integrated health services for people centred care differently from the Global Fund.**⁸⁵ Efforts have reportedly been made to align the support of the Global Fund with this definition, but it is considered that the activities that have been funded, and the four areas that are highlighted in the RSSH Investment Framework, are not aligned adequately with the WHO framework. Therefore, it was noted

⁸³ As elaborated in Supporting Annex E, laboratory systems and infrastructure have received the most funding under this investment area across both NFM allocation periods, which may be expected given the high unit cost for these investments in comparison to other areas covered under this RSSH investment area.

⁸⁴ 'The Global Fund health system strengthening information notes 2013, 2014 and 2015.

⁸⁵ WHO. (2016) Framework on Integrated people-centred health services. Report by the Secretariat.

that whilst the integrated service delivery module is considered worthwhile, it does not sufficiently address the broad range of issues around integration - and that instead, a more holistic and broad-based approach to integration across Global Fund investments, which includes communities and strengthens coordination, linkages and collaboration, is needed.

- **There is limited understanding of this RSSH investment area as a distinct area of funding.** Several of our case study countries had no or limited funding allocated under this RSSH investment area and there was limited understanding of the specific objectives of this investment area, distinct from integration efforts more broadly. There are also examples of activities in support of integrated service delivery being funded under other investment areas. In India, for example, CSO PRs working on elimination of mother to child transmission of HIV, are building the capacity of the formalised community health workers (“Accredited Social Health Activists - ASHAs”) and developing systems to expand ante-natal care ANC/ postnatal care (PNC) services to include HIV-related services. This is a good example of the type of integrative service delivery envisaged to be funded under this RSSH investment area, but is not categorised as such, with limited attention to the integration objectives within the project.⁸⁶ In Zambia, iCCM is funded under the malaria grant and there is no specific linkage with the objectives relating to RSSH.

There are some good examples of strategic and value-adding investments in support of integrative service delivery, which are reflective of country specific integration agendas.

There are a few key examples of highly strategic, value-add investments under this investment area, as outlined in Box 6.2 below. Discussions in country also indicated that the integrative interventions very much reflect the ongoing thinking and approaches within countries, and do not specifically reflect a steering/ prioritisation by the Global Fund. For example, the quality improvement work in Tanzania has been funded for many years by the government and different donors. The laboratory improvement work in Ethiopia has been considered under the SDG pooled fund in the country, and following delays in construction under the Global Fund grant, have been taken up as part of the pooled fund investments.

Box 6.2: Examples of strategic and value-adding investments in support of integrative supportive delivery

In Tanzania, the majority of the funding under this investment area is being used to support quality improvements at health facilities (specifically 240 health facilities and nine regional referral hospitals in nine of 27 regions in Tanzania). These investments have high potential impact, with poor quality services and insufficient integration being identified as key health systems challenges affecting coverage and quality of services.

In Ethiopia, the majority of funding was designated for the construction and purchase of equipment of integrated laboratories. While the implementation faced delays and challenges, country stakeholders emphasised the importance of this funding to meet a key health system-wide bottleneck, with funding through RSSH supporting benefits for the wider system rather than prioritising progress in specific diseases. Other critical integrative investments include strengthening of laboratory capacity to undertake post-shipment batch testing and post market surveillance of drugs, including training and equipment to

⁸⁶ It may also reflect the view that work towards integration needs to be spear-headed by the government rather than CSOs (and hence can go “unnoticed”).

identify counterfeit medicine. All of these investments have been seen as very valuable by stakeholders as they are areas of high need for Ethiopia's broader health system, alongside benefits for the three disease.

In Georgia, a relatively small amount of funding has supported a pilot for ISD for HIV, TB and hepatitis C virus (HCV) in the context of historically vertical disease programmes. Whilst not integrative beyond these three diseases at this stage, these pilots are considered to be catalytic. Their importance has been especially commended given that Georgia is a transition preparedness country and integration of these vertical disease programmes is considered to be a key aspect influencing the sustainability of the Global Fund's investments to date.

The disease focus for integrated service delivery remains, in large part perpetuated by the historic verticalisation of disease programmes.

In the Tanzania example above, the quality improvements assessment tool employed a specific emphasis on the three diseases (e.g. it is targeting specific regions with the highest prevalence across the three diseases, the standardised tool has been adjusted to incorporate more indicators on the three diseases, particular emphasis is given to the three diseases when deciding on priority interventions), although is also considered to target systems strengthening as a whole. Other activities in Tanzania funded under this investment area have a singular disease focus – e.g. procuring microscopes, X-ray machines and upgrading of multi-drug-resistant tuberculosis wards that will benefit the TB programme, with tenuous linkage to efforts to integrate service delivery. This was also the case for some activities funded in other countries – e.g. funding for a specimen referral system in Ethiopia, covering both TB and HIV, and in Zambia funding was provided for viral load specimens transfer under a laboratory improvement component. That there remains a strong verticalisation of disease programmes within the MoH structure across many countries is also relevant context when considering efforts to integrate or spread investment for broader health system or services strengthening.

6.3.3. Summary findings

Key issue/ theme	Findings	Robustness rating and explanation	
ISD design and implementation	<ul style="list-style-type: none"> The investment area is not well defined, nor fully understood by stakeholders, with suggestions that it is overly narrow in focus. 	A/B	Based on stakeholder feedback from TRP, partners and country stakeholders as well as CEPA's critical assessment based on the documentation. There were some divergent views within the Secretariat.

6.4. Data systems

Q10: What has been the implementation experience with RSSH investments into data systems, including any bottlenecks and coordination with partners? Are the investments strengthening country capacity for data analysis and use?

In this section we outline the following: (i) a summary of the HMIS and M&E investment area and funding to date (Section 6.4.1); and (ii) key findings regarding the investment area (Section 6.4.2). Note that our analysis is focused on the RSSH investments in countries, and does not encompass

wider data systems work being undertaken by the Global Fund such as through the Strategic Initiatives.

6.4.1. Summary of investment area and funding to date

The RSSH Investment Framework sees the strengthening of health data systems as critical in establishing a resilient and sustainable health system. The current RSSH Investment Framework emphasises the need to focus on quality and timely data, as well as active use of data and integrating multiple data collection systems. For this, the Global Fund recommends that grants allocate around 5-10% to M&E.

Data systems constitute the largest area of direct RSSH investments by the Global Fund representing 42% of total direct RSSH investments in 2014-16 and 40% in 2017-19,⁸⁷ with routine reporting the activity to receive the largest proportion of funding (42% in 2011-16, 33% in 2017-19).⁸⁸ There was an overall reduction in HMIS and M&E funding from US\$618m in 2014-16 to US\$354m in 2017-19, which is likely reflective of the total reduction in RSSH investment.⁸⁹

6.4.2. Key findings

The data systems RSSH investment area has received substantial funding, with a number of critical investments in improving HMIS in countries.

Investments in data systems by the Global Fund have been seen as crucial investments. In particular, Global Fund funding in this area has helped lay the groundwork for, and support the rollout and maintenance of, the integrated national HMIS (i.e. DHIS2-based). Many countries in southern and eastern Africa have fully rolled-out national HMIS systems that are used for national reporting and decision making and the Secretariat reports increased data availability and quality reported in the PUDRs. For example, in Ethiopia, DHIS2 is now used in approximately 80% of districts and in Tanzania, DHIS2 has a 95% completion rate. In addition, a number of smaller investments have been seen as having important contributions such as the investment in Human Resource Information Systems in Ethiopia.⁹⁰

A considerable emphasis of the investments is on disease specific investments.

The approach followed in the Modular Framework is that all data systems investments, whether disease-specific or cross-cutting, are classified as RSSH data systems investments. This is also one of the reasons this is the largest RSSH investment area.

⁸⁷ With regards to contributory RSSH, HMIS and M&E is the second largest investment area receiving 18% in 2014-16 and 15% in 2017-19. There are no contributory RSSH investment in HMIS and M&E.

⁸⁸ In 2014-16, this is followed by activities relating to analysis, review and transparency and surveys. In 2017-19, programme and data quality became the second largest activity. See Annex E for further details.

⁸⁹ Reasons for this are varied including the incomplete data for the 2017-19 period, the reduction in RSSH allocation and the fact that other donors/ government might take over certain investments especially if they are gap-filling nature.

⁹⁰ In Ethiopia, this support will be used to develop an electronic Human Resource Information Systems with the objective to keep track of existing staff across all positions in the health system. It is seen as a key to gain a better understanding, and to ultimately manage, the issue of attrition in the health sector with a key stakeholder noting, "this data system is as important as the DHIS2".

A significant portion of the overall data systems investments have been for disease-specific surveys and studies, quality assurance and assessments, in line with the overall mandate of the Global Fund. Disease-specific surveys and studies in Ghana, for example, made up nearly one third of total Global Fund investment in HMIS and M&E. Country stakeholders noted that while the importance of disease-specific data investments cannot be under-emphasised, the focus on wider data platforms or a wider lens for the data systems development was generally not there. A number of these investments also have cross-cutting impacts in terms of strengthening wider health data systems. Some Secretariat informants also raised that disease-specific surveys are also important in collecting information about specific target areas or groups e.g. key population data which may not be collected through routine information systems such as DHIS2.

In addition to the broad support to HMIS/DHIS2, further examples of support to data integration efforts were seen across the country case studies. For example, in India, current efforts are focused on consolidating the fragmented data systems within the HIV programme as a first step; in South Africa one of the interventions in the current grant is to support the integration of TB and HIV information systems, and to roll-out a patient registration system; and in Sierra Leone, the Global Fund is a main investor in DHIS integration.

In select countries the investments in HMIS and M&E was broad and patchy and some of the investments have been hampered by bottlenecks and barriers, especially relating to a lack of operational strategies.

Stakeholders in some countries commented that a wide range of activities are supported under the investment area. This broad investment has made it difficult to track the investments and has potentially reduced the impact of the investments. For example, stakeholders in Tanzania and Zambia stipulated that a more concentrated investment in HMIS could have a greater impact.

In addition, some of the investments have been hampered by bottlenecks and barriers, especially the absence of comprehensive country plans and operational strategies relating to health data systems. Global and in-country stakeholders commented on the need to embed and align the Global Fund's HMIS and M&E investment more comprehensively with national plans and strategic guidance, as available, that map out the development and approaches of health data systems. This would serve as an important prerequisite to reducing the use of parallel systems across diseases and geographies and also help to avoid duplications with other development partners. An example of a setting where this has worked well, Ethiopia launched strategic plans as part of achieving an "information revolution" set out in its Health Sector Transformation Plan.⁹¹ This was seen as extremely helpful to understand the country's vision and improve coordination and alignment of HMIS and M&E activities in-country. It is noted that the Global Fund, through the Health Data Collaborative,⁹² is contributing to efforts to improve collaboration for effective country health data.

Another barrier that was noted is that some countries lack the infrastructure required for a successful rollout of electronic data systems, such as DHIS2. This included data connectivity,

⁹¹ Federal Ministry of Health. (2015). Health Sector Transformation Plan, 2015/16 – 2019/20.

⁹² <https://www.healthdatacollaborative.org/>

availability of laptops/tablets, skills at different levels (including supervisory), as well as the necessary understanding and motivation for CHWs or health care workers to collect the data. In some countries, such as Sudan, this has been particularly challenging given the limited infrastructure available to support an electronic HMIS. This highlights the need to adopt a differentiated approach based on the country context.

The analysis and use of data, especially at lower administrative levels, remains a key gap.

The need for better quality data for better use and analysis of data has been noted in a number of reports⁹³, however the country case studies suggest that a clear gap remains here. Country case studies indicate that this may be due to capacity weaknesses in lower administrative level of health care management, a lack of prioritisation linked to undefined specific needs or uses, and potentially weaknesses in the analytical modules of DHIS2. Country case studies also highlighted that triangulation with community data, ensuring community data can fit into national data systems and ensuing access to timely data for participatory decision making, also remains a gap. despite the awareness of the need for it in-country. Examples from country case studies include:

- In Tanzania, many stakeholders commented that the analysis and use of DHIS2 and HMIS data is restricted to the central level. Even though data is collected at lower-tier health facilities, the data is not analysed at the lower-tier facilities.
- In Zambia, stakeholders largely agreed that efforts to boost data quality are needed, especially regular data quality assurance efforts, more effective and resourced support supervision, enhanced availability of data clerks at health facility levels, as well as streamlined and focused TA to support analysis and use for decision making.

There has been varied progress in the coordination and alignment of investments with partners and further improvements are needed to reduce duplications.

While there has reportedly been more progress regarding the coordination and alignment of activities with other donors in this investment area than in some others, country case studies highlighted the need for further improvement. Data systems have historically been a very fragmented area of support. Though it is increasingly rare that partners support the introduction of parallel systems (partly due to the endorsement of integrated national HMIS (e.g. DHIS2-based), the data system space remains crowded, including for various vertical programmes, which has led to limited leveraging of efficiencies. For example, in Ghana, stakeholders indicated that multiple partners fund tablets for data collection, which are then used exclusively for specific diseases.

6.4.3. Summary findings

Key theme	issue/ Findings	Robustness rating and explanation	
	<ul style="list-style-type: none"> • This investment area has received substantial funding, with a number of critical 	B	Based on stakeholder feedback from the Secretariat TRP,

⁹³ Euro Health Group. (2015). Thematic Review on the Global Fund's HSS Support related to the "Middle" of the results chain; The Global Fund. (2018). Debrief: Technical Review Panel Window (1, 2, 3, 4 and 5).

Key issue/ theme	Findings	Robustness rating and explanation	
Data systems design and implementation	data systems development investments, although a considerable portion are disease-specific.		partners and country stakeholders as well as CEPA's critical assessment based on the documentation. Based on country case studies for this review only.
	<ul style="list-style-type: none"> • In select countries, investments have been broad and patchy, impeded by the lack of comprehensive country plans and operational strategies on health data systems. • Analysis and use of data remains a key gap. • There has been varied progress in the coordination and alignment of investments with partners. 	B	Primarily based on our review of country case studies, as well as some stakeholder feedback at the global level (Secretariat, TRP and partners).

6.5. National health and disease plans

Q11: What has been the implementation experience with RSSH investments into strengthening the development of robust national health and disease plans?

This section discusses the RSSH national health and disease plans investment area, specifically: (i) a summary of the investment area and funding to date (Section 6.5.1); and (ii) key findings regarding the investment area (Section 6.5.2).

6.5.1. Summary of investment area and funding to date

As per the RSSH Investment Framework, investments in this area focus on interventions that support the development of NSPs and alignment of disease-specific plans. This includes activities aimed at planning and reviewing national health strategies, as well as the financing of plans and integration at various levels, including the community.

The national health and disease plans received the least funding of all investment areas, with only 3% of total direct RSSH investments in the 2017-19 allocation (see Annex E). Across allocation periods, the amount stayed largely stable, dropping only slightly from US\$31m to US\$27m.

6.5.2. Key findings

This is a poorly understood investment area across countries, with few requests for support and a wide range of activities funded.

There is a high need for strong national and disease health plans in countries which facilitates the efficacy of disease and RSSH investments, thus underpinning the justification for support for this investment area. In addition, the integration between disease NSPs and available National Health Plans (NHPs) has been highlighted by the TRP as an area in which country applications are very

weak.⁹⁴ However, this investment area has been poorly understood by partners and country stakeholders with very little support being provided. This may be due to the fact that previously there was a 'policy and governance' module which this module replaced,⁹⁵ and a number of Secretariat stakeholders still refer to this module interchangeably as "governance". Therefore, a broad range of intervention requests have been included with one informant describing it as "a mix of things that did not fit elsewhere... the kitchen sink module". Box 6.3 demonstrates the range of ways in which funding was understood or utilised in this area.

Box 6.3: Examples of the range of activities funded under the national health and disease plans investment area.

Côte d'Ivoire: funding has been provided for a Leadership and Governance project which includes efforts to strengthen district structures and to support planning, management, coordination and supervision in selected regions, resulting in a strengthening of the National Malaria Control Program.⁹⁶

Ethiopia: support was provided for leadership training for district managers and primary health care unit managers in order to address a lack of capacity at these manager levels that were seen as a key bottleneck in the health system.

Georgia:⁹⁷ the funding was predominately used for training of PHC level staff as well as for external TA and national consultants. The training for PHC level staff in particular has reportedly supported a more integrative approach, and the external TA and national consultants supported worked to address a number of the significant transition challenges. Funding was also provided to support for the development of the TB NSP which was considered especially useful. In addition, support was also provided for discussions and workshops around integration of HIV and TB activities, and updates to the TB Strategy to be were made following the introduction of government supported social protection for TB patients.

Sierra Leone: The Government led the development of a series of policies, strategies and plans during and after the recovery phase with funding from various sources, including some partial funding from the Global Fund in NFM1. Reportedly, the national plans are consistent and well-aligned with each other in their efforts to provide cohesive policies and strategies for improving health system performance.

There is a need for more definition and strategic prioritisation in this investment area

Partners raised the question regarding the relevance of this investment area, for two key reasons: (i) in contexts where there are established processes and available resources for development of the national health plan and disease plans, it is considered that the government should retain ownership of funding these (such as India) and (ii) other partners, such as the US government which provides TA support for planning and development of country national health and disease plans, already provide support for this investment area.

Furthermore, as the TRP RSSH report and Global Fund KPI 6f demonstrate, while most proposals are demonstrably consistent with national strategies,^{98,99} there is limited funding requested for strengthening governance, accountability or improved stewardship. In particular, the integration of

⁹⁴ The Global Fund. (2017-2018). Debrief slides: Technical Review Panel Window (1, 2, 3, 4 and 5).

⁹⁵ The Global Fund. (2015). Health systems strengthening for Global Fund applicants – information note.

⁹⁶ The Global Fund. (n.d.). Standard concept note for malaria. 2015-2017.

⁹⁷ National health and disease plans received the second largest amount of direct RSSH funding in Georgia in NFM1. Although this was under the 'HSS policy and guidance' investment area as it was categorised in NFM1.

⁹⁸ The Global Fund (2018). Strategy Committee: TRP Report on RSSH Investments in 2017-2019 Funding Cycle.

⁹⁹ The Global Fund. (2018). 39th Board meeting: End-2017 Key Performance Indicator Results.

implementation of national health and disease plans can be seen as a broader governance activity, which may also require leadership support. Our view therefore is that more definition is required for this area. Gavi may provide an example on strategic investments.¹⁰⁰ Their support for leadership, management and coordination, includes (i) strengthening government EPI teams at the national level; (ii) boosting national coordination forums to improve their functionality and (iii) enhancing the ability of national immunisation technical advisory groups to advise countries on their immunisation programmes.¹⁰¹ These are supported through a 'menu' of interventions offered by Gavi.

6.5.3. Summary findings

Key issue/ theme	Findings	Robustness rating and explanation	
National health plans design and implementation	<ul style="list-style-type: none"> This is a poorly understood investment area amongst stakeholders, with a broad range of activities funded, but many countries not applying for support. There is a need for more definition and strategic prioritisation. 	A/B	Based on an analysis of the available data as well as broad stakeholder feedback from Secretariat, partners and in-country stakeholders.

¹⁰⁰ Based on a review of Gavi's website, not through assessment of operational implementation of this support.

¹⁰¹ Gavi. (2018). LMC. [Online]. <<https://www.gavi.org/support/hss/leadership-management-coordination>>

7. REVIEW AREA 4: PARTNERSHIPS

The final review area is on the efficacy of partnerships for RSSH, in terms of TA (Q12, Section 7.1) as well as other donor funding for health systems development (Q13, Section 7.2).

7.1. Technical assistance related to RSSH

Q12: To what extent have RSSH TA needs been adequately identified, coordinated with other grants as well as other external funders of HSS, suitably implemented, monitored and quality assured? How effective are existing partnership mechanisms for RSSH TA and how can partnerships be leveraged for improvement?

This review question has two parts: (i) a review of the delivery of TA as relating to RSSH (Section 7.1.1); and (ii) a consideration of appropriate mechanisms for the Global Fund to adopt/ leverage with regards to meeting country TA needs as relating to RSSH (Section 7.1.2).

7.1.1. Review of TA delivery

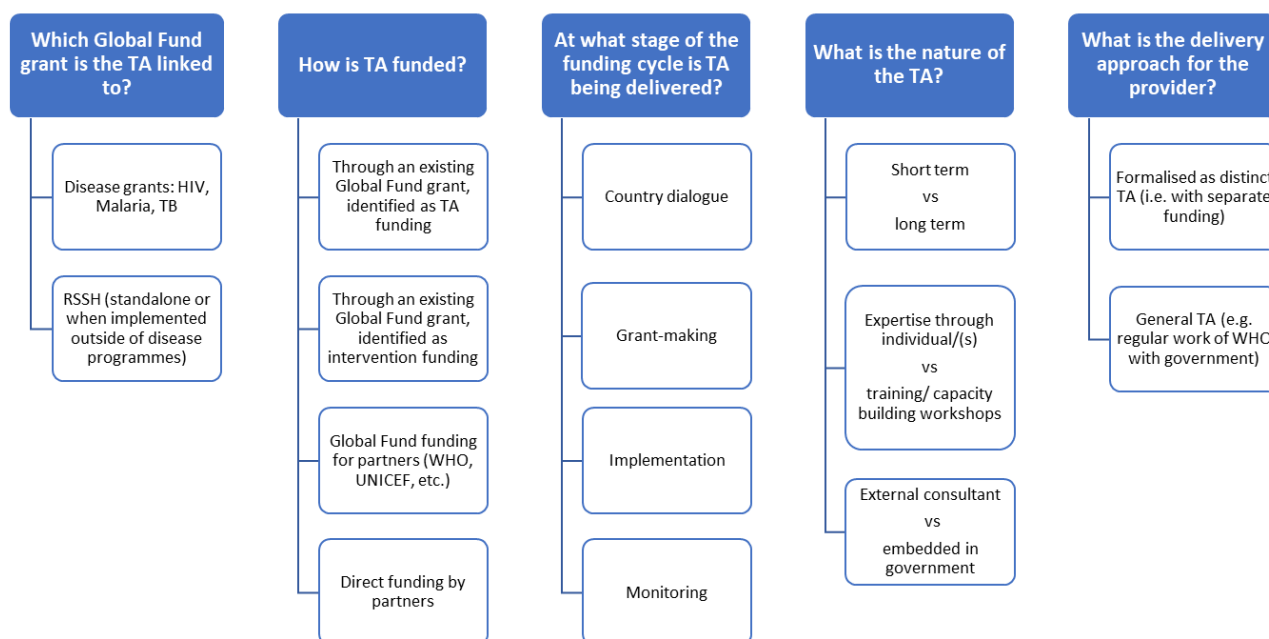
The starting point for this review was to consider what RSSH TA is – such as key areas of TA, types and/ or examples of this TA for countries for further examination under this review. However, RSSH TA per se (as coined in the terms of reference for this review) has little meaning to stakeholders, beyond select Secretariat members and stakeholders were unable to specifically identify RSSH TA examples for this review. Health systems or HSS TA is slightly better understood however, and an estimation by the Global Fund states that close to 70% of TA needs during grant implementation are systems-related (covering issues of supply chain management, M&E, project management, etc.) and not disease-specific.¹⁰² As these are still classified (and understood) as disease TA, it was challenging to engage in a discussion with stakeholders on the systems aspects of these TA.

Further, it was very difficult to identify examples of RSSH/ HSS TA for the case study countries in this review because there was no country documentation provided on RSSH TA received and FPM/ CT consultations did not reveal relevant information. Discussions in country as well were unable to identify health systems TA – because (i) TA in relation to the Global Fund is in many cases understood as disease-specific TA,¹⁰³ (ii) the more generic issue that there is a lack of comprehensive mapping of TA at the country level and (iii) a lack of a consistent understanding or interpretation of what comprises TA. Indeed, the complexity of TA in relation to Global Fund grants is presented in Figure 7.1, where we provide some examples on the different nature and forms of TA.

¹⁰² The Global Fund. (2018). Slides for PS Briefing, Presentation May 2018.

¹⁰³ The exception to this was TA for the development of the RSSH components of Global Fund applications, which was the case in Zambia and Georgia.

Figure 7.1: Complexity of TA within the Global Fund model



As such, we have been unable to conduct a detailed review of the planning/ design, implementation, monitoring and quality assurance of TA relevant to RSSH, as was planned for this review. However these aspects, and any issues thereof, for TA more generally (i.e. not RSSH/ HSS specific), were assessed as part of the TERG-commissioned review of the Cooperation Agreements between the Global Fund, WHO and the Stop TB Partnership, conducted by CEPA.¹⁰⁴

More generally however, building on findings from the Cooperation Agreements review, as well as additional evidence-base collected under this review, we note the following key issues with regards to TA for cross-cutting health systems needs within the Global Fund context:

- **Supply side issues:** There is no dedicated TA partner for HSS and CSS for the Global Fund, as is the case for the three diseases (i.e. the Joint United Nations Programme on HIV/AIDS (UNAIDS), Stop TB Partnership, Roll Back Malaria). The health systems TA landscape is highly fragmented – with multiple funders and providers, including from the range of UN organisations. In addition, there is lack of dedicated HSS/ CSS personnel in WHO Regional/ Country Office to help take forward the HSS agenda in relation to funding requests for the Global Fund, and where these HSS personnel do exist, they have limited familiarity with Global Fund processes. Further, there is an insufficient consultant database for HSS TA, with expertise being available for specific building blocks/ investment areas rather than cross-cutting, some more so than others. For example, there was a comment that there are good TA sources to support development of national plans but less so for supply strategy or HRH issues, with a need for different partners/ funders to better pool their resources.
- **Demand side issues:** With RSSH funding mostly integrated with disease funding, there is a challenge in effectively originating TA requests with a systems perspective. The disease programmes are usually implementing the Global Fund monies (with limited involvement of

¹⁰⁴ CEPA. (2016). Review of the Cooperation Agreements Between the Global fund, WHO and Stop TB Partnership

HSS/ RMNCAH focused MoH staff in Global Fund processes) and may not always adopt a systems perspective in their approach to TA. Even at the global level, disease-specific “Situation Rooms” have been set up by disease to discuss country bottlenecks and TA needs, which may not always employ a cross-cutting systems approach and expertise. There has been limited guidance from the Global Fund on TA for HSS, an issue that was also highlighted during the Cooperation Agreements review.

- **Collaboration and coordination:** With Global Fund RSSH encompassing seven different investment areas, there is a need to collaborate with a diverse group of partners. Coordination across TA requests does not work very well, with lack of awareness on who is funding which aspects. Feedback received in this review indicates that there has been an endeavour for greater transparency of TA that is funded outside of grants, although fundamentally coordination is weak.

7.1.2. Partnership mechanisms for TA

Noting the above challenges with the TA landscape and delivery in relation to systems-related TA, in this section we consider the range of partnership mechanisms available to the Global Fund for TA more generally, and consider their suitability for providing cross- systems-related TA as related to Global Fund RSSH support.

In essence, there are three main options, in terms of TA provision through: (i) multilateral UN partners such as WHO, United Nations International Children's Emergency Fund (UNICEF), United Nations Development Programme (UNDP), etc.; (ii) bilateral donor partners such as the USG, French 5% Initiative and German (GIZ) Backup Initiative; and (iii) the Global Fund Secretariat contracting TA directly. Table 7.1 provides the main points of feedback regarding TA mechanisms and the associated pros and cons, alongside our critical assessment.

Table 7.1: TA mechanisms and pros and cons from an HSS perspective

Partnership mechanism	Multilateral UN partners	Bilateral donor partners	Direct contracting by Global Fund
Pros	<ul style="list-style-type: none"> • Mainstay of TA support for many years • Country presence 	<ul style="list-style-type: none"> • Can be flexibly delivered 	<ul style="list-style-type: none"> • Easily accessible by FPMs to provide quick turnaround TA when needed
Cons	<ul style="list-style-type: none"> • WHO TA can take a long time to procure • Does not cover all aspects of health systems (e.g. WHO and private sector) and has specific foci (e.g. UNICEF and children) • Funding challenges over the years 	<ul style="list-style-type: none"> • Provide support to Focused countries only • Can be limited in scope (e.g. USG focus on PSCM and HMIS) • There is limited transparency regarding what is supported by donors 	<ul style="list-style-type: none"> • “Scope creep” in terms of steering Global Fund role from funder to implementer • Viewed as being duplicative and creating coordination challenges (e.g. feedback on some of the RSSH-related Strategic Initiatives from other donor partners)

Overall, consultees noted that there is no one perfect solution and that combinations of the three different approaches (UN organisations, bilateral organisations and the Global Fund direct TA support) are all needed. However, the drawback of having multiple TA channels is that coordination becomes more complex. In this regard, the Gavi Partner Engagement Framework (PEF) offers a useful model (see a summary of the approach in Box 7.1), as also highlighted in the Cooperation Agreements review.¹⁰⁵

Box 7.1: Gavi’s Partnership Engagement Framework for TA¹⁰⁶

The Gavi PEF model is a useful model that can offer important lessons. In particular, we note the following positives with this model: (i) PEF clearly defines the type of support that each Vaccine Alliance partner provides and therefore reduces overlaps and leverages the comparative strengths of each Partner; (ii) countries identify their challenges and express their targeted country assistance (TCA) needs through the joint appraisal, an annual review of Gavi’s support to each country and countries also state who they think is best suited to provide the support they need; and (iii) countries assess the effectiveness and quality of support that each Partner provides. Findings from the TCA Evaluation Baseline Assessment Report indicates that across all programmatic areas, Partners noted the highest contribution from the TA to be within HSS.¹⁰⁷ As highlighted in the Cooperation Agreements review, the PEF model utilises a strongly country-led approach where countries identify TA needs and the most appropriate/ cost-effective TA provider. In addition, through the Foundational support offered through the PEF, long-term funding is made available, usually to pay for staff working at the global and regional levels and this has been provided for HSS aspects such as supply chain management.¹⁰⁸

Consultations indicated that coordination amongst the Global Fund, Gavi and the World Bank/ GFF would represent “low hanging fruit” and would be important to pursue.¹⁰⁹ There was also a suggestion of developing a joint technical hub amongst the three donor groups, as a mechanism to encourage coordination and better leveraging.

7.1.3. Summary findings

Key issue/ theme	Findings	Robustness rating and explanation	
RSSH TA delivery	<ul style="list-style-type: none"> Identification of RSSH TA in Global Fund grants is complex and not well understood or effectively leveraged. Lack of dedicated TA partner for HSS and CSS, fragmentation of the health systems TA landscape and limited guidance from the Global Fund on TA for HSS are key issues. 	B	Based on feedback from stakeholders (Secretariat, partners) as well as from across our country case studies.
Partnership mechanisms for RSSH-related TA	<ul style="list-style-type: none"> A combination of approaches to TA, including from the UN and bilateral organisations, as well as Global Fund direct TA funding is needed to ensure that 	B	Based on feedback from a number of stakeholders (Secretariat, partners and country stakeholders), alongside CEPA’s assessment.

¹⁰⁵ CEPA. (2016). Review of the Cooperation Agreements Between the Global fund, WHO and Stop TB Partnership

¹⁰⁶ Gavi. (2018). Partners’ Engagement Framework. [Online]. <<https://www.gavi.org/support/pef/>>

¹⁰⁷ Gavi. (2018). Evaluation of TA through PEF. [Online]. <<https://www.gavi.org/results/evaluations/evaluation-of-technical-assistance-through-the-partners-engagement-framework/>>

¹⁰⁸ Gavi. (2018). Foundational support. [Online]. <<https://www.gavi.org/support/pef/foundational-support/>>

¹⁰⁹ This finding was also supported in the Itad Partnerships Review. (Itad. 2019. Final Report (draft) Thematic review of the Global Fund country level technical support partnership model.)

Key issue/ theme	Findings	Robustness rating and explanation	
	<p>countries can choose the approach best suited to their needs.</p> <ul style="list-style-type: none"> Improved coordination on TA amongst donors and development partners is important. partners is important to pursue. 		

7.2. Harmonisation and coordination with other donor funding

Q13: To what extent is RSSH funding, planning and M&E operationally harmonised/ coordinated with other donors? How can the Global Fund best leverage other donor funding for sustainable impact?

In support of this assessment, Section 7.2.1 reviews key donor funding approaches to HSS and Section 7.2.2 considers consultation and country case study learnings on this issue.

7.2.1. Review of donor funding approaches

Supporting Annex L provides details on planning, application, funding and M&E processes for Global Fund RSSH in relation to other donors for HSS namely, Gavi, the World Bank, GFF and USAID/ PEPFAR.¹¹⁰ The review highlights some key findings:

- **Each donor has its own “entry point” or lens for HSS, with some overlap.** For example, the Global Fund RSSH and USAID consider the three diseases, with USAID also being broader to consider prevention of child and maternal deaths, family planning and reproductive health, global health security and nutrition. However, Gavi uses immunisation as an entry point to HSS funding, the GFF is focused on HSS through reproductive, maternal, new-born, child and adolescent health, and nutrition services (RMNCAH-N) and the World Bank has a wider sustainable development agenda.
- **Each donor has focuses on specific investment areas, with some areas of overlap** such as the Global Fund’s seven RSSH investment areas, Gavi’s four strategic focus areas and the World Bank’s work on health sector policy, financing, financial management and procurement processes. There are some areas of overlap/ harmonisation, for example, the Global Fund, Gavi, the World Bank and USAID/ PEPFAR are all involved in work towards data systems strengthening and PSCM.
- **There is a degree of alignment in terms of funding recipients** (i.e. governments, although there may be different departmental foci within governments such as is the case for the Global Fund and Gavi) and some donors also fund NGOs/ CSOs (USAID/PEPFAR).
- **Eligibility for funding is markedly different.** For instance, the Global Fund considers a country’s income level and disease burden and has different application restrictions for different country groupings. Distinct from this, World Bank lending is based on countries’

¹¹⁰ USAID/ PEPFAR captures all HSS-related funding from the US government, including USAID, PEPFAR, PMI and CDC.

income levels as well as performance record in managing their economies and ongoing projects. GFF has prioritised 27 countries at present and USAID/ PEPFAR has also prioritised their own set of countries.

- **There are different platforms/ stakeholders for engagement for planning/ designing of the HSS funding.** For example, the Global Fund uses the CCM, Gavi uses the HSCC/ ICC, World Bank/GFF works directly with the MoH and the Ministry of Finance on public finance, “the Investment case” and to leverage IDA financing, while USAID/PEPFAR engages with governments but usually implements through large US NGOs.
- **HSS funding by donors are not aligned in terms of their timing/ duration**, with the World Bank and GFF being more flexible, the Global Fund and Gavi being structured around specific funding cycles that may or may not be aligned and the USAID/PEPFAR providing annual commitments only) as well as their **structuring of funding** (Global Fund grants are mostly integrated with disease support, while the World Bank, the GFF and USAID HSS funding is part of the overall loan, investment or grant).
- **Monitoring systems are for the most part focused on different indicators and approaches.** For example, the Global Fund has activity progress indicators for RSSH and outcome and impact indicators for the three diseases. Gavi also has output indicators for HSS, and like the Global Fund, monitors PSCM, HMIS and integration in service delivery, although using different indicators. In addition, Gavi conducts HSS evaluations and meta-reviews. The data sources and collection for the organisations is also somewhat different. The GFF focuses on survey data such as demographic health surveys and multiple indicator cluster surveys, whereas the Global Fund and Gavi largely use national level data that can be disaggregated by geographical location.

As such, there are several differences between different donor HSS funding, which was also one of the key reasons why the Health Systems Funding Platform never obtained traction (as noted in Section 3).

7.2.2. Consultation and case study feedback on donor coordination

Key findings with regards to donor coordination have been as follows:

There have been general improvements in donor coordination over time, although this varies by country and by area of investment. There is still extensive need for coordination.

Stakeholders from the consultations and country visits revealed specific examples of improvements in coordination between organisations, particularly in the areas of data systems strengthening and PSCM. For example, there is good coordination between the Global Fund and the US President's Emergency Plan for AIDS Relief (PEPFAR) in South Africa in support of the government's eHealth vision to link all data across services to a new health patients registration system. The organisations are working together to integrate TB and HIV data into this registration system. Tanzania provided a good example of collaboration through the organisation of the inter-sectoral sector wide approach (SWAp) and its designated sub-committee for health – the Development Partner Group for Health.

However, despite this functioning mechanism, in-country stakeholders were outspoken on the lack of the Global Fund's engagement into the SWAp, which currently involves only information exchange. Further, in Zambia implementation continues to be relatively fragmented by specific donor programmes - although there is the Health Coordinating Partner Group at national level, only some partners are engaged.

Government stewardship of donor funding is a key enabling factor for coordination.

The consultations and country visits suggested enabling factors for harmonisation as in-country donor coordination groups, transparency of grant-making processes, and most importantly, government stewardship, which was regarded as the key enabling factor. For example, in Ethiopia, strong government stewardship of the health sector and existence of a pooled fund were found to support alignment and coordination of Global Fund investments. This was seen as an achievement of the Federal MoH approach to have "one plan and one budget".

Key bottlenecks to coordination include donors using multiple in-country platforms/ stakeholders for planning/ designing HSS funding (as described above), disharmony between Global Fund RSSH concept and other donor HSS funding and approaches to support for communities, lack of Global Fund in-country presence, lack of an overarching country strategy for coordination, inadequate funding information sharing between partners, etc.

The challenge of donor coordination was well recognised amongst partner and country stakeholders. There was a view that there are some obvious or "low hanging fruit" that are not being adequately explored. Key amongst this was the need for coordination between the Global Fund and Gavi HSS funding, which was viewed as unacceptably poor in most countries. Some immediate opportunities for coordination include sharing country health systems background information, coordinating country application review processes, and where possible, joint funding. More generally, it was indicated that there is an imperative for donors to cross-share reviews and evaluations to avoid duplication and inefficiencies. An example cited was the RSSH Dashboard, which is currently being used as an internal tool, but could benefit with wider partner sharing.

7.2.3. Summary findings

Key issue/ theme	Findings	Robustness	rating	and explanation
Coordination of donor funding for HSS/ RSSH	<ul style="list-style-type: none"> Although coordination has improved, HSS/ RSSH alignment across donors is still weak. Key bottlenecks include donors using multiple in-country platforms/ stakeholders for planning/ designing HSS, lack of Global Fund in-country presence, lack of an overarching country strategy for coordination and the poor efficacy of partners in country. Government stewardship of donor funding is a key enabling factor for coordination. 	B		Based on stakeholder feedback (Secretariat, partners, TRP) as well as findings across most of our country case studies and some documentation.