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The prism of 'health system strengthening' for a better cooperation and coordination between AFD, the Global Fund and Expertise France: analysis and perspectives

Camille RUSSO

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Agence Française de Développement (AFD), France

Professional advisor: Philippe WALFARD, Agence Française de Développement
Academic advisor: Bruno MARCHAL, Institute of Tropical Medicine Antwerp

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Table of Contents

Abstract

Context: Recent changes in the global health landscape, such as critique on the vertical approach and the shift towards Sustainable Development Goals have put Health System Strengthening (HSS) at the forefront of the global health agenda. If this consensus is likely to facilitate cooperation and coordination, there is a crucial need to understand what HSS entails for actors, especially since 2019 represents a key moment for the French Development Aid in Health (DAH).

Objective: This study analyses how the harmonization of the HSS concept for AFD, the Global Fund and Expertise France is likely to foster cooperation and collaboration.

Methods: This study is based on literature review and interviews. Literature review was performed to compare strategies on HSS between organizations and congruencies with the conceptions and definitions provided through interviews. Then, 23 semi-structured interviews were conducted with professionals of DAH, aiming at exploring the views and perceptions of the respondents regarding HSS and coordination.

Results: Actors present a limited common understanding of HSS; which is coherent with the plurality of strategies developed on HSS. They share a diagnosis of unsatisfactory cooperation and coordination both at headquarter and field level. Several common bottlenecks were identified: the challenge of HSS's operationalization and the lack of stewardship at various levels. Nevertheless, the actors share the same situation analysis and express willingness to strengthen collaboration, which opens the door to positive changes.

Conclusion: Harmonization of the HSS concept for AFD, the Global Fund and Expertise France is likely to be a long-term process, due to their different mandate and *modus operandi*. To facilitate progress, engagement in stronger dialogue platforms and in concrete examples of cooperation is recommended. Attention should also be brought to coherence among the actors of the French DAH to build a stronger strategic positioning. Eventually, commitment towards the strengthening of the beneficiary states' capacities and leadership is critical.

Word count: 301.

Key words: *health system strengthening*, *French development aid in health, global health agenda*

Résumé

Le prisme du renforcement des systèmes de santé pour une meilleure coopération et collaboration entre l'AFD, le Fonds Mondial et Expertise France : analyse et perspectives

Contexte : Les récents changements observés dans le paysage de la santé mondiale, tels que la remise en question des approches verticales et la transition vers les Objectifs de Développement Durable, ont placé le Renforcement des Systèmes de Santé (RSS) au premier plan de l'agenda international en santé. Si le consensus autour du RSS doit pouvoir faciliter la coopération et la coordination, il n'en demeure pas moins essentiel de comprendre ce que cette notion signifie pour les acteurs de ce domaine. Cette nécessité est accentuée par le fait que l'année 2019 soit un moment clé pour l'aide au développement française en santé.

Objectif : Ce travail de recherche vise à étudier comment une harmonisation du concept de RSS entre l'AFD, le Fonds Mondial et Expertise France permettrait de favoriser la collaboration et la coopération entre ces acteurs.

Méthode : Cette étude est basée sur une revue de la littérature et des entretiens. La revue de la littérature a été réalisée afin de comparer les stratégies autour du RSS entre les organisations, ainsi que le niveau de concordance avec les conceptions et les définitions partagées lors des entretiens. Par la suite, 23 entretiens semi-directifs ont été réalisés avec des professionnels de l'aide au développement en santé, avec pour but d'explorer les visions et perceptions des répondants sur le RSS et la coordination entre les partenaires.

Résultats : Les acteurs présentent une perception commune limitée du RSS, ce qui paraît cohérent avec la diversité des approches stratégiques sur le sujet. Ils partagent le même diagnostic d'une coopération et d'une coordination insatisfaisantes, tant au niveau du siège des organisations que sur le terrain. Plusieurs goulots d'étranglements communs ont été identifiés : le défi de rendre opérationnel le concept de RSS ainsi que le manque de pilotage institutionnel à différents niveaux. Cependant, les acteurs interrogés partagent la même analyse de la situation et expriment une volonté de renforcer la collaboration autour du RSS, ce qui ouvre la porte à des évolutions positives.

Conclusion : L'harmonisation du concept de RSS pour l'AFD, le Fonds Mondial et Expertise France est un processus qui doit s'envisager sur le long terme, du fait de leurs différences de

mandats et de modes opératoires. Afin de faciliter les progrès, une plus grande implication dans des espaces de dialogues et la mise en place d'exemples concrets de collaboration sont recommandées. Une attention particulière devrait également être portée à la cohérence entre les acteurs français de l'aide au développement en santé afin de construire un positionnement stratégique plus fort. Enfin, l'engagement dans le renforcement de capacités et le leadership des états récipiendaires de l'aide est essentiel.

Mots-clés : *renforcement des systèmes de santé, aide française au développement en santé, agenda en santé mondiale*

List of acronyms used

AFD	*Agence Française de Développement* – French Agency for Development
AIDS	Acquired Immune Deficiency Syndrome
BMGF	Bill and Melinda Gates Foundation
CCM	Country Coordination Mechanism (for the Global Fund's grants management)
CIS	*Cadre d'Intervention Sectoriel* - AFD Strategic Document
CICID	*Comité Interministériel de la Coopération Internationale et du Développement* - Interdepartmental Committee for International Cooperation and Development
CSO	Civil Society Organizations
DAH	Development Aid for Health
EF	*Expertise France* – French Agency for International Technical Assistance
GAVI	Gavi, the Vaccine Alliance
GHI	Global Health Initiative
HIV	Human Immunodeficiency Virus
HR	Human Resources
HSS	Health Systems Strengthening
I5PC	The Initiative 5%
MDG	Millennium Development Goals
MoH	Ministry of Health
OECD	Organization for Economic Co-operation and Development
PEPFAR	President's Emergency Plan for AIDS Relief
RSSH	Resilient and Sustainable Systems for Health
SDG	Sustainable Development Goals
SWAp	Sector Wide Approach
TB	Tuberculosis
ToR	Terms of Reference
UHC	Universal Health Coverage
UN	United Nations
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization

Background

Despite its crucial importance and omnipresence in the discussions related to health and development nowadays, the topic of health systems strengthening (HSS) has not always been on the agenda of the multilateral and bilateral institutions. Rather, it is the result of numerous efforts of reshaping and reframing the global health and development landscapes.

At the beginning of the 2000s, when global health emerged as a priority within the development community, the most common approach was disease-specific and relied on vertical programs. This segmented vision was notably due to major milestones, along with the emergency context of the HIV/AIDS epidemics: the enactment of the Millennium Development Goals (MDGs), the creation of the three major Global Health Initiatives (GHI), the growing influence of the civil society and the formation of the Bill & Melinda Gates Foundation (BMGF) as a crucial actor in the agenda's setting. First, the MDGs were a turning point as they set precise targets for the developing countries that the international community agreed on reaching by 2015, among which three out of eight goals were directly related to health. Therefore, "*the MDGs have become the dominant global framework for development and have shaped national policy priorities*" (Fukuda-Parr and Hulme, 2011).

Concomitantly, the establishment, between 2000 and 2003, of Gavi, the Vaccine Alliance (GAVI), the Global Fund to Fight AIDS, Tuberculosis and Malaria (known as the Global Fund) and the US President's Emergency Plan for AIDS Relief (PEPFAR) radically changed the face of aid in global health, due to both their operating mode and the unprecedented amount of funding they received. At the time, each organization set its own objectives, with an important emphasis on quantitative results in a restricted number of areas such as access to anti-retroviral drugs for HIV/AIDS or expansion of child immunization, which is known as a vertical approach – that is to say the "*interventions (..) provided through delivery systems that typically have separate administration and budgets, with varied structural, funding and operational integration with the wider health system"* (Atun et al., 2008). Furthermore, "*this vertical approach was supported by a huge upsurge of civil society activity in developed countries, most strikingly through the efforts of NGOs such as AIDES and ACT UP but also through the Red Cross and faith-based groups.*" (Atlani-Duault et al., 2016): the strong activism that had emerged in developed countries, notably in the fight against HIV/AIDS, contributed to the agenda setting and the shaping of an emergency response needed at a global scale.

Last and not least, the creation of the BMGF in the early 2000 also marked an important shift, as "*[it] has emerged as the current era's most influential global health […] agenda-setter.*" (Birn, 2014). This influence relies on a colossal private budget, surpassing the WHO's annual one, that reached a total of US$28.3 billion over the past 15 years (Birn, 2009), enabling to finance initiatives that align with a technologically and vertically oriented vision. As Storeng points out, "*These new global health actors' agenda-setting power is clearly more than just financial, however, and reflects the personal power that Bill Gates has acquired as a global health leader.*" (Storeng, 2013). To sum up, vertical programs were therefore seen as the solution to face what had been framed as the most urging issues in terms of health in developing countries. Nevertheless, if this vertical approach resulted in enormous progresses in terms of drugs or vaccine coverage for vulnerable populations and participated in a better control of major infectious pandemics, it also rapidly revealed important limitations. It is worth noting that it also echoes historical precedents in the fight against pandemics, both in terms of implementation and results, such as the goal of malaria eradication through the use of insecticides in the 1940-50s (Packard, 1997) or smallpox eradication in the 60s. The debate on vertical approach is therefore rooted in the history of global health, that goes beyond the past two decades.

By 2015, at the time of the MDGs' assessment, numerous critics and concerns had been raised against the vertical approach arguing that GHIs "*were contributing to the fragmentation of health systems, distorting national health priorities and placing undue reporting and coordination burdens on the governments of low-income countries*" (Msuya 2004; High Level Forum on the Health Millennium Development Goals, 2005). Furthermore, some limited results in the most challenging and yet demanding environments of sub-Saharan Africa pushed for an in-depth analysis of the bottlenecks and obstacles impeding the achievement of the GHI's goals (UN, 2015). As stated by Marchal et al., the overall conclusion was that "*effective global initiatives require well-functioning health systems"* (Marchal et al., 2009). Conditions were set for a change of paradigm towards more attention to sustainability, cross-sectional approaches and emerging notion of HSS (Hafner & Shiffman, 2012).

This shift can be noted at various levels. One of the most striking examples might be the renewed approach to international development objectives with the adoption in 2015 of the Sustainable Development Goals (SDGs). Indeed, among the 17 goals, a unique broad one is dedicated to health, stating the ambition to "*Ensure healthy lives and promote well-being for all at all ages*". And if quantitative targets are still used to measure progress, some are very wide, such as "*3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and*

affordable essential medicines and vaccines for all." (UN, 2015). Above all, HSS has progressively been integrated into GHIs' strategic documents. For instance, GAVI endorsed HSS as one of its four strategic goals in 2005, later on refining its position to HSS and immunization strengthening which became a strategic focus area including data, supply chain and improved management of immunization's programs (GAVI, 2016). In 2017, after an extensive review of its strategy, the Global Fund explicitly stated that to "*Build resilient and sustainable systems for health*" was one of its core guiding principles for the 2017-2022 period (The Global Fund, 2016). The development of the concept of a so-called diagonal approach can be considered as an attempt to reconcile vertical vs. horizontal programs through HSS: that is to say "*a strategy in which we use explicit intervention priorities to drive the required improvements into the health system, dealing with such generic issues as human resource development, financing, facility planning, drug supply, rational prescription, and quality assurance*" (Frenk, 2006). Therefore, the international aid community in global health seems to have agreed on a consensus that would lead to coordination and cooperation around a similar priority, enabling sustainable health systems to function well.

Within this international framework, France's positioning in terms of public aid for global health is complex, as it mostly relies on multilateral channels and vertical funds; it also includes advocacy for sustainable action through HSS – reflecting the dilemma in French Development Aid for Health (DAH)'s policies of "*state humanitarian verticalism versus universal health coverage*". This dilemma finds its origins in the history of the French contribution to global public health, rooted in the colonial period: the example of the programs focused on the eradication of sleeping sickness through mass screening and radical methods (called 'Pasteur Model') contributed in establishing legitimacy of the vertical approach from a very long time (Atlani-Duault et al., 2016). Nowadays, also in line with the international trend previously described, the country channels its DAH at around 80% through GHIs prioritizing the fight against pandemics, which reflects a strong commitment towards this goal (Ministère de l'Europe et des Affaires Etrangères, 2017). For instance, France is the second largest contributor to the Global Fund, with a total pledge of more than US$1,2B for the 2017-2019 financing round (the Global Fund, 2019)[1]. It has also been the founding member of UNITAID, an organization created in 2006 which aims at developing innovations to prevent, diagnose and treat HIV/AIDS, tuberculosis, malaria and co-infectious diseases and remains its main funding donor, allocating on average US$110M per year to the initiative (Ministère des Affaires Etrangères, 2016). Finally, it is the 5th State-contributor to GAVI with a pledge of US$533.5M for the 2016-2020 round (GAVI, 2019). Besides the fact that the French DAH is mostly spent

[1] The difference between the pledge amount and the total contribution reported by the Global Fund is due to the amount withheld for technical assistance through Initiative 5% (see details below)

through contributions to GHIs, and therefore priorities and strategies in fund allocation are not directly set by the country, France also presents an agenda in global health with an important focus on HSS.

Its main political tool is the current French Strategy in Global Health 2017-2021 that officially sets the key priorities for the next five years. The top priority is to "1. *Strengthen health systems while fighting against diseases*", advocating for an integrated approach within the fight against pandemics (Ministère des Affaires Étrangères et du Développement International, 2017). One of the most important means to achieve this political agenda relies on the French bilateral cooperation structures: the French Development Agency (AFD) and the French Agency for International Technical Assistance known as Expertise France (EF). Among its various fields of action, the public financing institution AFD provides financial support in the health domain to developing states. In 2016, this support was around €280M, divided into grants and loans (AFD, 2017). According to the *Cadre d'Intervention Sectoriel* (Strategic document of the AFD group) 2015-2019, and in line with the French political stance, HSS is defined as the core principle and one of the main priorities of AFD in health – as "*the vast majority of the AFD's interventions in the health sector contributed directly or indirectly to the health systems strengthening in the recipient countries*" (CIS, 2015). EF is the French agency for international technical expertise for developing countries. Created in 2014 after the merger of six existing French public operators working in the field of international technical cooperation, and operating under the Ministers' of Foreign Affairs and Economy oversight, the agency operates in the health sector, among other fields – and is responsible for the implementation of the 5% Initiative. The 5% Initiative (I5PC) stands at the crossroads of the French priorities in global health aid: created in 2011, it aims at bringing technical expertise to recipient countries facing structural difficulties in order to facilitate their access to financing or management of grants from the Global Fund. In terms of HSS, I5PC intervenes at two levels: either through short-term technical assistance missions to support the country (Channel 1) or through 2 to 3 year funding allocated to projects aiming at tackling structural bottlenecks to the fight against the pandemics (Channel 2). For the last years, the calls for proposal have focused on HSS and access to care for vulnerable and key populations.

Therefore, in this complex landscape, HSS progressively became a key notion of DAH to such an extent that even disease-specific vertically prone GHIs eventually prioritized HSS in their strategies. At the French level, despite an important amount of public aid dedicated to the fight against pandemics, France is committed to support HSS – and this political will is mainly illustrated by AFD's mandate in the health sector. Nevertheless, if HSS seems to embody a consensual goal that enables coordination among actors, important challenges remain when

digging deeper into HSS' multiple definitions and visions within the global health field. The latter is defined by Shiffman as "*a social arena in which actors claim and draw on expertise and moral authority to gain influence and pursue career, organizational and national interests*" (Shiffman, 2015).

2019 represents a momentum for France's DAH. First, the country is hosting the Global Fund replenishment conference in Lyon on the 10th of October. During this conference, the donors of the Global Fund pledge financial support for the next three year cycle. Even though the Global Fund's strategy will not be discussed at this occasion, the advocacy work it implies to mobilize greater resources and the allocation of the final amount that will be collected involve some important strategic thinking, especially in the HSS domain. Furthermore, the fact that the replenishment conference will take place in France can be seen as an opportunity to strengthen the links between this GHI and the French bilateral aid structures in health, AFD and EF.

2019 is also an important year for the health and social protection unit of AFD. As announced in February 2018, the government has decided to integrate EF into a larger AFD group by mid-2019 with the aim of "*renewing the French public aid and solidarity policy to be closer to the needs expressed by the beneficiaries, more inclusive to all actors and better coordinated with its partners"* (CICID, 2018). The creation of this enlarged AFD group therefore raises the challenge of building a single and coherent strategy bringing together the two previously independent entities, especially in the field of HSS which remains both the core priority of AFD and the core orientation for the French DAH policy. In addition to this crucial structural change, an internal reflection will be conducted by the Health unit on its priorities for the upcoming years, as its current strategic framework expires in 2019.

Objectives

Due to these numerous factors, the timing seems appropriate to focus on the coherence and coordination among the actors of this triangle in terms of HSS, as health systems strengthening has been set as a priority for all, and especially to reflect on AFD positioning in relation with the Global Fund and EF-I5PC.

Therefore, the overall objective of this study is to bring elements of answer to the following research question: to what extent would a harmonization of the 'health system strengthening'

definitions and conceptions from the actors of the triangle AFD / The Global Fund / EF-I5PC help AFD in reinforcing coherence and collaboration with these partners?

The specific objectives are as follows:

- Identify the definition of HSS, along with vision and priorities, for each of the three actors, focusing on a two-pronged analysis of literature and key informant discourse;
- Conduct a situation analysis on how cooperation between actors is currently perceived through the frame of HSS;
- Examine the underlying mechanisms that explain the situational analysis for a more in-depth understanding;
- Explore potential avenues and opportunities in terms of collaboration and synergies for AFD to improve coherence with partners in terms of HSS.

The results of the study aim at feeding reflections around HSS and collaboration conducted by AFD regarding its strategic positioning in global health. Beyond this internal purpose, this work could also be shared with partners to strengthen discussion on these topics.

Methods and materials

1. Scope of the study

This research work mainly focuses on AFD, the Global Fund and EF-I5PC's understanding of HSS and their interactions around this notion. Perspectives and elements of context brought by other sources (academic, international organizations, civil society organizations) have been collected in relation to this scope. The study also focuses on the review of the current situation, that is to say the first semester of 2019. Historical elements mentioned and studied have been integrated to better explain and contextualize this situational analysis. Results and discussion mainly focus on sub-Saharan Africa, as this region is an official geographical priority for French Oversea Development Aid (ODA) and channels the largest part of funding and projects of AFD, the Global Fund and EF-I5PC.

As the scope of this qualitative study is voluntarily restrained due to the rules of this thesis, not all concepts encountered during the literature review and mentioned during the interviews were taken up (for instance: community health systems, the historical records of the financial flows in development aid, Universal Health Coverage). They could be addressed if the research were to be extended.

2. Methodology

The methodology of the study relied on two main pillars: (1) literature review and (2) semi-structured interviews with key informants.

2.1 Aim of the method

The first goal of the chosen method was to see if the elements that were found in the literature review (both in terms of concepts and strategies) were similar across organizations and would be congruent with the conceptions and definitions provided through interviews. The corollary was to determine to what extent the concepts described in documents, especially in the grey literature, have been appropriated by people in their professional practice and also see to what extent the perception of the situation can diverge from what is described on paper – in order to address the research question and objectives.

2.2 The literature review

A first review has been performed at the very beginning of the study, in order to get a proper understanding of the background notions that would be used. It translated into a literature research and review of both academic papers and grey literature provided by WHO, as the normative global health institution, on the concepts of health systems, HSS, vertical and horizontal interventions in health and their impact on health systems, and the landscape of public and private actors in the development aid in health sector. The goal was not to perform an exhaustive review of the topic, but to get an overview of the concepts in order to analyze properly the visions and points of view that would be shared during the interview phase.

In a second step, a specific literature review has been conducted with a narrower scope, aiming at defining concepts and visions of HSS used by the three organizations of interest. This review was mainly based on the grey literature sources that were made available (internal and external strategic publications, evaluation reports), supplemented by some analytic research papers and comparative elements from similar foreign organizations such as the Back Up Initiative (German equivalent of I5PC). The process has been iterative as some relevant documents or references were provided by the key informants during the interview phase and contributed to enrich the review.

The literature review has been conducted as follows: research through key words using databases such as PubMed or ResearchGate, or publications like The Lancet; review of internal documents made available or provided by the organizations themselves; and follow-up of references provided by the academic and professional advisors or key-informants.

2.3 The semi-structured interviews

These interviews aimed at exploring the views and ideas of the respondents regarding HSS and coordination, for further analysis on how they match findings from the literature. They were conducted among a wide range of actors, and a total of 23 people were interviewed. As required for semi-structured interviews, a list of questions and themes was prepared in order to guide the interview. The resulting interview guide was discussed with the professional advisor, who facilitated the contact with the majority of the interviewees. A smaller proportion of respondents was identified through a snowballing technic: they were either invited for an interview by the principal interlocutor or through the facilitation of the first contact. The guidelines are available in Annex 1, along with the list of key-informants.

Interviews have been conducted from March to May 2019, face-to-face whenever it was possible and by phone in other cases – all in French, except one. They lasted on average around 35min. Due to methodological and time constraints, interviews were not recorded but notes and verbatim were taken all along. Saturation was reached at the end of the phase (i.e. the point where no more new and relevant information in order to enrich the research is mentioned in the interviews). No software was used for data management and analysis of the material.

Results

1. The notion of HSS: one concept, a plurality of meanings

1.1 The World Health Organization framework and its scope

(a) Results from literature review

Attention related to HSS started to grow exponentially from the beginning of the 2000s. Among the reasons that shed light on HSS, "*The 2000 World Health Report focused on health systems performance and was a catalyst for global debate on that issue*" (Hafner & Shiffman, 2012). For the first time, this report proposed a set of normative definitions regarding health systems, their structure and purposes in order to build an international common language around these notions. A health system is defined as "*all the activities whose primary purpose is to promote, restore and/or maintain health*" (WHO, 2000). The concept of 'health system strengthening' is not used *per se* but is the implicit *raison d'être* of the report as it focuses on improving the performance of the health system's vital functions, which were defined as "*service provision, resource generation, financing and stewardship*" (WHO, 2000). The report also insisted on the

notion of interactions between functions, a breeding ground for the systemic approach that would later be developed. Furthermore, important conclusions were drawn even at this early stage, such as: *"Health systems are not just concerned with improving people's health but with protecting them against the financial costs of illness*" or "*Stewardship is ultimately concerned with oversight of the entire system, avoiding myopia, tunnel vision and the turning of a blind eye to a system's failings*" (WHO, 2000) – which echoes nowadays Universal Health Coverage's global health priority or the challenge of getting out of silos' approaches.

Another major milestone was set by the release of the WHO's framework for action in 2007. This document was crucial, as it detailed for the first time the building blocks' approach to health system and health system strengthening. This single framework encompasses 6 dimensions, which are service delivery, a well-performing health workforce, a good health information system, access to medical products and technologies, financing, and leadership and governance to ensure and monitor performance (WHO, 2007). It has a triple purpose: "*[the building blocks] allow a definition of desirable attributes – what a health system should have the capacity to do in terms of, for example, health financing (…),, they provide one way of defining WHO's priorities (…), by setting out the entirety of the health systems agenda, they provide a means for identifying gaps in WHO support*" (WHO, 2007). By creating this common framework to facilitate dialogue and interventions, the international organization aimed at making HSS "*everybody's business*" (WHO, 2007).

This approach was deepened by the publishing of the report 'Systems Thinking for Health Systems Strengthening' in 2009, which focused on understanding the linkages within the system in order to strengthen it (WHO, 2009). It means that interventions should take into account "*the nature of relationships among building blocks, the spaces between the blocks (and understanding what happens there), the synergies emerging from interactions among the blocks*" (WHO, 2009) as each block is never independent from the others. Therefore, it advocated for an integrated and systemic approach that would enable to better understand and mitigate the impact of each intervention on the entire health system. It also conveyed the idea that all complex interventions "*can be expected to have profound effects across the system, especially in weaker ones*" (WHO, 2009).

Other international organizations developed policy guidance related to HSS: for instance, the World Bank through the ongoing training of individuals in health systems performance (Hafner & Shiffman, 2012). UNICEF developed an approach and framework to HSS defined as "*actions that establish sustained improvements in the provision, utilization, quality and efficiency of services delivered through the health system, and encourage the adoption of healthy behaviors*

and practice" (UNICEF, 2016) and areas of focus that slightly differ from the WHO framework. Nevertheless, these guidelines have not reached the same level of general acceptance as the building blocks approach developed by the WHO.

(b) Results from the interviews

Results from the interview phase show a certain level of harmonization on language regarding the definition of health systems and HSS, even though the two were often used indistinctly. Indeed, the majority of the interviewees (15/23) would spontaneously refer to the WHO building blocks' framework when they were asked to define what HSS meant for them, regardless of their institutions or professional affiliation. Some mentioned about this framework that "*It's comfortable"* (*P15),* that these blocks constituted the *"technical pieces of the puzzle"* (*P14)* and that "*it remains the dominant framework, it enables a common language and points of agreements*" (*P2)*. Therefore, it appears at first sight that a certain level of common understanding has been reached regarding the terms of the debate, through the impulse of WHO, which could facilitate coordination as all actors share the same language.

Nevertheless, after acknowledging its utility, limits were also raised by the interviewees regarding the same framework:

> "*Nevertheless, it surely lessens the systemic, complex dimension. (…) If we focus only on one block, it is a vertical intervention. Admittedly, we're not focusing on a disease, yet it remains a single prism of intervention." (P15)*
>
> *"It is a fragmentation, and what needs to be strengthened is usually the interconnexion between blocks." (P2)*

One of the main questions raised by the respondents was about the extent of the definition of HSS, that is to say whether it means reinforcing the blocks themselves or the links between them. Some questions were also raised about the scope of the definition: on how the various actors of the health systems are integrated within this framework, especially the community health workers or the private sector who are not necessarily mentioned in the normative documents.

Some interviewees insisted on a different aspect of the definition, stepping aside the building blocks framework:

> "*[HSS is] any action that aims at acting at a structural level, acting on the weaknesses of the health system […], to be in a dynamic, with an action that goes beyond projects, acting on the structural weaknesses, with a systemic impact." (P17)*
>
> "*[HSS is] everything that contributes to the improvement of the quality, the efficiency and the resilience of the health system." (P22)*

These definitions align with the systemic approach developed by WHO, nevertheless it is worth to mention that no references were made to a normative document on this specific aspect. Some respondents also referred to notions such as "*integration to the health system*", "*horizontal or transversal interventions*" as opposed to vertical programs to specify what an intervention in HSS entails.

Therefore, asking the interviewees for a definition of HSS already revealed that, if the building blocks approach contributed to create a common language around health systems, it did not build a full consensus around the concept. Unclear elements remain on the actors and the process itself of strengthening health systems. These differences of definition can be found, too, in the strategic approaches of AFD, the Global Fund and EF-I5PC around HSS.

1.2 The differences in interpretations of HSS strategies

(a) Strategy for HSS according to AFD

Defining the strategic vision of HSS for AFD is challenging, as little written elements are available on the topic. This section presents the results of both the review of strategic documents and the interviews.

As mentioned in the introduction, the *Cadre d'Intervention Sectoriel 2015-2019* (CIS) is the roadmap that establishes the 5-year health strategy of AFD. Three main axes of intervention were defined in the CIS, among which the second one is to "*Promote Universal Health Coverage (UHC)*". It is stated that "*health systems strengthening remains AFD's main priority, UHC providing the conceptual framework"* (CIS, 2015). For AFD, helping developing countries to achieve UHC can only be conceived through the strengthening of the six building blocks through a transversal approach – in order to reinforce the offer of health services. In terms of activities, examples are given such as "*Support the adaptation of the political and legal framework*", *"Strengthen health services through governance support; [make available] health infrastructure and equipment; health products"* etc. (CIS, 2015). Therefore, the definition of

HSS for AFD is mostly conceived on an operational basis: what has already been done and to what extent interventions can fit into the WHO health system's building blocks framework.

The interviews conducted within the Health Unit enabled to specify the definition, linking HSS and the specific position of a bilateral development agency.

> "*It means working directly with the health system in its institutional dimension – the Ministry of Health and its branches (…). The action should be led towards the institution or even better, through it*. *[…] We cannot only be satisfied by reaching health targets [indicators], we need to go beyond that." (P1*4)

> "*It refers to something deeply rooted at AFD: the modus operandi is through the States, the gateway to HSS is the State, the Ministry of Health. (…) In each aspect, the Ministry of Health is indispensable." (P16)*

Viewed from within the organization, the strategy of AFD's Health Unit in terms of HSS is therefore mostly related to its *modus operandi* and the fact that, as a development agency, it is part of its mandate to dialogue with the States and reinforce developing countries' capacities.

(b) Strategy for HSS according to the Global Fund

Getting a clear picture of the Global Fund's current strategic vision around HSS can also be challenging, as it is at the crossroads of many dimensions: historical, political and financial. Unlike AFD, many written documents aim at defining what HSS entails for the organization and a large amount of grey literature has been produced since the Global Fund declared "*Build resilient and sustainable systems for health*" (The Global Fund, 2016) as one of its four strategic priorities for the 2017-2022 period. Nevertheless, the shift from a vertical to a more transversal strategic approach is still a major challenge, as it implies to reconcile different objectives through an overall mandate that has not changed.

As stated in a report commissioned by the Development Cooperation branch of the European Commission regarding the impact of the Global Fund, "[*It] was established in 2002 with a mission to deliver an emergency response in the face of the rising burden created by the three diseases (AIDS, TB and Malaria). As an emergency response, the challenge for the newly created (and, at the time, small) organization was to rapidly disburse funds in response to immediate need, and plug financing gaps with a view to stopping and then reversing incidence of the three diseases especially in the poorest countries, saving millions of lives and livelihoods"* (HAS, 2019). Not entering into the allocation method's details, in addition to a

funding exclusively dedicated to the fight against the three pandemics, the recipient States could also apply for funding of cross-cutting or integrated issues relevant to the fight against the three diseases (The Global Fund, 2007). Nevertheless, it was not seen as a strategic element for the Fund, and the issue of HSS can rather be seen as a "side-effect" to its core mandate, also as these types of funding remained both very marginal and poorly used (The Global Fund, 2007).

This perception of HSS started to change in 2007, as the Global Fund Board agreed to give more importance to funding comprehensive health programs (Ooms et al., 2008), also related to the growing number of criticisms against vertical programs mentioned in the background section. Furthermore, progresses towards achieving the core mandate of the Global Fund – a decrease in the three diseases' incidence – have recently stalled (The Global Fund, 2019). These observations, which strongly question the ability to contribute to the achievement of the SDGs, highlight the limits of the approach, and the need to adapt the model. Since then, the Global Fund worked on the elaboration of a tailored strategic framework integrating HSS. In 2015, prior to the adoption of the 2017-2022 strategy and in the context of the post Ebola crisis in West Africa, the Fund defined the seven main components on which it would focus to support countries in building Resilient and Sustainable Systems for Health (RSSH). This strategic work served as a basis to define the seven sub-objectives established in 2017, aligned with the Fund priorities in terms of Human Resources (HR), supply chain or data management (The Global Fund, 2017). In its information note aiming at offer guidance to recipient countries in order to identify how to strengthen systems for health, the Fund provides elements to understand what HSS means in the context of a vertical program: *"Investments in RSSH are a necessary complement to the core investments in HIV, TB and malaria control programs. (…) RSSH investments contribute to addressing system-wide constrains that not only affect the three diseases but other health programs as well. To this end, the Global Fund's RSSH investments help strengthen the level of integration of national HIV, TB and malaria programs into national systems for health."* (The Global Fund, 2017).

In this context, investments in health systems are first and foremost considered as a tool to achieve the principal goal of the Fund, which is accelerating the end of the three diseases. Furthermore, "*The Global Fund's commitment to RSSH represents an important paradigm shift in thinking about the delivery of health services. Systems for health, differently from health systems, do not stop at a clinical facility but run deep into communities […]. Systems for health focus on people, not issues and diseases. This new thinking reflects the transition from the Millennium Development Goals to Sustainable Development Goals (SDGs) and the increasing importance of universal health coverage (UHC) as a health policy goal*" (The Global Fund,

2017). Therefore, the Global Fund is partly stepping aside from the WHO building blocks framework and giving a specific focus on communities as the key actors to support HSS interventions – which makes its strategic approach a bit dissonant compared to other actors who focus on strengthening State's capacities.

The first report on RSSH investments made during the 2017-2019 funding cycle identified six key high-level issues (see Annex 2) impeding progress in this domain, such as weak country situational analyses of RSSH bottlenecks or challenges (The Global Fund, 2019). Key recommendations need to be taken into account to refine the Fund HSS strategy. This theme is also discussed at a high strategic level, as shown by the Strategy Implementation Deep Dive on RSSH session from October 2018: this session took place during the 8th Strategy Committee and aimed at informing the Committee on the key issues related to the investments in RSSH for further refinement of the strategy. These current strategic discussions reflect serious concerns on the impact of the Fund on health systems. They also demonstrate a willingness to improve the articulation between the vertical approach and the need to better take into account the context of health systems for significant improvements in the fight against the three diseases. Yet, it also largely complexifies the interpretation, scope and extent – as shown by the extended amount of literature and documents produced on the topic.

(c) Strategy around HSS according to Expertise France – Initiative 5%

Unlike the first two institutions, which are primarily funders, EF offers technical expertise and assistance. Its mandate focuses on the operational aspects of development by bringing technical expertise where needed at country level. Its strategy regarding HSS needs to be considered at two different levels. Indeed, the Health Department is organized into various divisions: a first one is mainly focused on HSS priorities, whereas a second one is the "Pandemics – Initiative 5%" division[2]. As described in the background section, the latter is specifically dedicated to technical assistance and projects related to the action of the Global Fund – mostly in francophone Africa. Even though they share the same head office, the approach is quite different.

No proper strategic document was made available that defines a global positioning of EF regarding HSS. As a public agency and an operator of the French development policy, it aims at implementing the current French Strategy in Global Health 2017-2021 and its organization mirrors the first axis described as "1. *Strengthen health systems while fighting against*

[2] A third division is dedicated to hospital cooperation but is not referred to in this study.

diseases". The first division will therefore mobilize experts on missions and projects, that could usually be labelled as HSS.

Regarding I5PC, no specific strategic document was available either. Its implementation is guided by the Terms of Reference (ToR) defined by the Ministry of Europe and Foreign Affairs. This document provides broad functioning guidelines of the initiative. The "5%" refers to "*Application of the Initiative takes the form of an indirect contribution from France to the Global Fund equivalent in an amount equal to 5% of the total French contribution to the Fund each year*" (Initiative 5%). This amount withheld for technical assistance has increased from 5 to 7% of the French contribution to the Global Fund for 2017-2019 (Aidspan, 2018). Therefore, since its purpose and mandate are directly linked to the Global Fund, the strategy of the Initiative is aligned with the Fund's priorities and visions to end the three epidemics. This positioning is explicitly expressed in context documents of the ToR of I5PC (Initiative 5%, 2019). Also aligning with the changes in the Global Fund's 2017-2022 strategy, HSS is indicated as a priority, which is expressed at different levels[3]. The technical expertise brought by the Channel 1 responds to a need identified at country level. Therefore, it can be related to HSS if support is needed to write up a national policy, to support supply chain management etc. Regarding Channel 2, a call for proposals is launched yearly by Expertise France. It includes two themes approved by the steering committee of the Initiative on the basis of its assessment of key priorities and bottlenecks in the fight against the three diseases, in line with the Global Fund strategy. Given the current gaps, particularly in francophone countries, HSS and access to care for vulnerable and key populations have constituted the recurring themes of these calls since 2016.

Aligned with the Global Fund priorities in HSS and at the same time operated within EF, the positioning of I5PC is therefore at the crossroads between vertical and horizontal approaches. The very broad mandate adopted by France through its Strategy in Global Health 2017-2021 enables this attempt to reconcile the fight against pandemics and HSS. Nevertheless, from the literature review no clear positioning emerged, which was confirmed during the interview phase with answers expressing ambivalent understanding. This confusion may also be reinforced by the fact that most organizations applying for a funding through Channel 2 are actors such as NGOs and Civil Society Organizations (CSOs) historically committed to the fight against the three diseases – and more specifically HIV/AIDS. Therefore, the selection mechanism contributes to sustain an approach based on the fight against pandemics:

[3] Even though the structure of the Initiative is about to change, as the number of funding Channels and the funding capacities are about to increase, we will focus on the present state as described by the available documents.

"*It is possible to end up with projects labelled 'HSS' that reinforce a vertical approach." (P17)*

"I5PC does HSS, as it is a condition to keep its funding, but it seems to mix up all the approaches at the same time." (P15)

These findings are also aligned with the conclusions of the Initiative's evaluation conducted in 2017 that recommended the revision of its strategic framework (Technopolis, 2018). The comparable German facility – Back Up Initiative – could be an example as their definition, priorities and scope of HSS are clearly expressed in their framework document.

2. The impact on cooperation and coordination: a shared diagnosis of room for improvements

2.1 The diagnosis at the headquarter/macro level

(a) Axis 1: an identified need for a better mutual knowledge

The second part of the results section is based on the interviews: in addition to their definition of HSS, respondents were asked to provide their own situational analysis of the coordination and cooperation between partners in terms of HSS. Results show first an incomplete mutual knowledge. This was directly acknowledged by the interviewees and confirmed by the analysis of the difference between the strategy on HSS defined for each actor and the perception of the interviewees

Regarding AFD, various interviewees spontaneously expressed an approach in health based on HSS and systemic approach, although references were made most often to infrastructure projects (such as building of hospitals). Also, projects were labelled "HSS" because not focused on pandemics. Due to the differences in their mandates, the bilateral agency was also perceived to be competing rather than cooperating with the Global Fund.

"*[The Global Fund] could be perceived as a competitor of the AFD." (P9)*

"It seemed that there was little appetite for working with the Global Fund." (P1)

Regarding the Global Fund, the interviewees usually mentioned the recent strategic shift of the organization – or at least acknowledged a movement initiated towards HSS that is growing bigger within the institution. Nevertheless, the strategic orientations remained unclear to most respondents. Many referred to a Global Fund that would act upon health systems in order to reinforce its impact in the fight against the diseases and, as a vertical fund, the articulation

between this new priority and its operationalization remains uncertain. It has also been mentioned that HSS was seen as a mandatory topic to get funding, yet competencies in this domain and/or real strategy were not available.

> "*HSS seems to be an important element [for the Global Fund], yet when we look at the program per country, priority remains the supply of ART and the aspects of HSS taken into account remain targeted." (P23)*
>
> *"There is also an issue of funding: what they get barely covers their initial mandate, their priority remains the fight against pandemics." (P17)*
>
> *"What is considered HSS among the allocation process remains unclear." (P6)*

I5PC was usually perceived as a potential tool to strengthen the collaboration between bilateral and multilateral aid, yet with a need to stimulate and support requests for technical assistance from the beneficiary States in terms of HSS. A need for a greater coherence among the French actors of development in health was also highlighted. This means creating more synergies between AFD and EF, starting by a stronger mutual knowledge in terms of expertise, job sectors, and projects funded. It means also more dialogue and synergies among the health divisions of EF, currently perceived as weak. Another aspect mentioned by several respondents is the lack of capitalization on the projects and technical assistance brought by I5PC, which would be useful to all partners.

The lack of knowledge was also expressed regarding other actors: several interviewees mentioned the potential benefits of a European dialogue regarding HSS – both with other bilateral structures such as the German development agency and the European Commission. Question marks also remained regarding the implication of the private sector on this dialogue, but also CSOs and academic research. The perceived scope of HSS was broader than only public or international institutions and the fragmentation, especially in the French context of DAH, was identified as a major weakness - as there is little room for a broad dialogue around HSS with all actors of the sector.

(b) Axis 2: a momentum for change

Another result to be introduced in this section is the overall consensus on the current momentum for change. Many interviewees draw attention to the greater willingness they perceived for better coordination around HSS between the three organizations of interest, and more specifically AFD and the Global Fund. It is worth to mention that these recent favourable

dispositions were expressed by actors from both organizations – yet with some questions regarding the form of the cooperation:

> "*The dialogue is opening with the AFD, […] which is great, to benefit from their expertise and added value in order to strengthen the impact." (P12)*
>
> *"It is really worth the effort to get closer […]; yet I am still wondering how it will work practically." (P18)*
>
> *"I consider [the integration of EF within a larger AFD group] as a tremendous opportunity to reach a critical mass." (P11)*
>
> *"Things are changing and improving [in terms of dialogue], even though we are not there yet. […] I am quite optimistic when I see the Global Fund going towards something more integrated." (P16)*

Aligned with this perception, various concrete steps have been taken during the past few months. Among them, the first high-level meeting between AFD chief executive and the Global Fund executive director that took place in July 2018 aiming at identifying potential synergies between the two organizations sent an important message. A workshop in November 2018 resulted in the identification of axis for coordination, and HSS was one of the main opportunities seen for an improved collaboration. As one of the interviewee said, *"It is not about implementing programs together but having a real strategic coordination" (P9).* A synthetic roadmap had been shared with milestones regarding the improvement of mutual knowledge. Yet, it appears that designing these new forms of coordination remains also strongly conditional on the persons themselves and how much they prioritize the issue. A loose follow-up, explained by all the operational constraints and tight schedules experienced by people working in both organizations, could be observed regarding this roadmap.
The replenishment conference of the Global Fund to be held in Lyon in October 2019 will represent another window for dialogue on HSS, as a side-event conference will be organized by AFD and German Cooperation on "*The fight against pandemics and health systems strengthening in Western and Central Africa: a new paradigm for integration*". A common meeting between the Global Fund, AFD and EF-I5PC planned in July 2019 will enable a first tripartite dialogue and an opportunity to go beyond the first roadmap.

Results of the investigation on the diagnosis of cooperation and coordination on HSS at the headquarter level are contrasted, yet promising. Even though major barriers remain in terms

of mutual understanding and knowledge among actors, new fora for discussion have emerged. As mentioned in interview, "*since philosophies [transversal vs. vertical] are radically different, it will take time" (P21)*, which explain the pace of the progress.

2.2 The diagnosis at the field level

(a) Axis 1: weak coordination and cooperation mechanisms

The situational analysis was then conducted at the field level: respondents also gave their feedback on cooperation and coordination on HSS in relation to their experiences in developing countries. This additional scale of analysis was particularly informative as positions and perceptions could differ from the diagnosis made at the macro level.

Overall, interviewees were quite critical in their assessment, pointing out various reasons limiting cooperation. Actions in HSS were collectively perceived as too fragmented, due to many reasons. Despite common areas and themes of intervention, several gaps were identified: the fact that each organization has its own *modus operandi* and accountability constraints for instance. Therefore, the lack of coordination refers to something more complex than a mere absence of willingness.

> "*It's dramatic. We [the technical and financial partners] are collectively bad on this topic." (P16)*
>
> *"It is not necessarily that people don't want to collaborate, it's more related to the fact that each one has its own constraints and it's easier to work alone." (P14)*
>
> *"[To be able to coordinate] you need to let go of something from your part and align with others." (P17)*

Another observation frequently made is that, despite efforts and progress over the past few years, respondents felt like it was an endless process showing little results in the end – which can be discouraging in the long-term:

> "*We spend a lot of time on coordination, yet it feels like it's never enough. […] The tools for a better coordination, we all fantasize about them." (P22)*
>
> *"No one is satisfied but no one has found the solution." (P19)*

Many referred to the image of having “everyone seated at the same table” – that is to say create more dialogue mechanisms in the field, specifically dedicated to the improvements of coordination, setting objectives and targets. It has been highlighted that, when it exists, current platforms such as regular meetings do not gather all the partners. This can be due to the fact that these mechanisms are seen as heavy and time-consuming. Differences in schedules (in terms of programmatic sequences, length of projects and funding etc.) are also an important constraint. The *modus operandi* can also be a barrier: for instance, the Global Fund does not have local offices in countries, relying on contracted independent organizations called “Local Fund Agents”. This has been identified as a potential constraint:

> *“We are not based [in the country], that’s also an issue […]. I think that this model, with teams ‘off the ground’ may have limits” (P18).*

Furthermore, these platforms usually aim at exchanging information on projects implemented by each technical or financial partner. Therefore, coordination in countries is a downstream process seen through the lens of not duplicating interventions rather than creating synergies on HSS.

(b) Axis 2: a common analysis of the context

Aligned with this acknowledgment, respondents also mentioned common features in their situational analysis on the key factors impeding cooperation, and the priorities needed to be addressed through HSS. They would usually refer to the WHO’s building blocks to entrench their diagnosis into this shared conceptual framework.

The key factor that was highlighted by almost all the respondents was the lack of national political leadership in the beneficiary country. This issue has been seen as crucial: the only entity able to assess the specific needs in terms of HSS, and harmonize the interventions is the state. Yet, this role of leadership is almost never embodied by the national institutions. Most common reasons to be mentioned were the structural weaknesses in terms of management and strategic capacities both in the health sector of the developing countries and more broadly the impact of larger determinants of health and health system’s capacities. These weaknesses encompass infrastructures (access to water and sanitation, electricity), fiscal space and national funding allocated to health, etc. The difficult position as recipient countries of DAH was also emphasized: control over the spending is rarely devoted to the state. The lack of governance was also mentioned at the WHO level: offices of the international organization in each country do not fulfil the leadership role on HSS as it could be expected.

Also related to financing, respondents draw attention upon the fact that overall funding is extremely scarce compared to the needs for HSS in developing countries. This lack of financial resources does not pledge for improved coordination as "*international agencies are themselves actors of great variation; multilateral, bilateral and non-government organizations are fueled by different goals and values*" (Walt and Gilson, 1994). Furthermore, as 'health system strengthening' is still perceived as a multidimensional and rather theoretical concept, it remains difficult to establish common norms of efficacy. One example given by the interviewees was that it is easier to coordinate around the fight against HIV/AIDS thanks to the guidelines in terms of treatment, costs etc. whereas the lack of operationalization of HSS impedes agreement on priorities and progress on the ground.

As these reasons were, again, almost systematically mentioned by the interviewees and are explained by deeply-rooted and multidimensional issues, they are further commented in the Discussion section.

Discussion

1. Analysis of the most recurring underlying mechanisms that limit harmonization on HSS

1.1 The challenge to get from the theoretical concept to its operationalization

(a) Going further than a catch-all notion: the definition beyond the building blocks

As previously described, the framework developed by WHO provided tools to think about the concept of HSS, which contributed to creating a common understanding around the building blocks of health systems. Yet, it has not been sufficient to create a common culture on HSS, as shown by the diversity of approaches undertaken by the financial and technical partners – here AFD, the Global Fund and EF-I5PC. One of the most salient obstacles to a better coordination is the identified need for a harmonization that goes beyond the conceptual framework.

As it has been pointed out during the interview phase, HSS is not a goal *per se*. Nevertheless, HSS is still largely considered a blurred, multidimensional and continuous process – without clear boundaries of when it starts and stops – which fuels this little common understanding and fragmentation of actions. In her academic work from 2010, Grace Chee insists on the distinction that should be made between health system strengthening and health systems support (see Annex 3): "*Supporting the health system can include any activity that improves*

services, from distributing mosquito nets to procuring medicines. These activities improve outcomes primarily by increasing inputs. Strengthening the health system is accomplished by more comprehensive changes to performance drivers such as policies and regulations, organizational structures, and relationships across the health system to motivate changes in behavior and/or allow more effective use of resources to improve multiple health services. […] A basic outcome difference between health system strengthening and support is that whereas providing support addresses the constraints currently found, strengthening the system actually changes the system so that it can address these constraints in the future." (Grace *et al.*, 2010). Her work has been took up by Back Up Initiative (the German equivalent of I5PC) to define its strategy regarding HSS, which entails precise criteria on what is considered HSS and therefore can be eligible for funding (see Annex 4). This effort put into defining the content of HSS is crucial, in order to create more than a common understanding around the framework and create solid grounds for cooperation. The Global Fund has also initiated the development of an approach based on the paper by Chee and colleagues, through the '*4S Model*'. This model aims at defining the evolution of health systems development through 4 stages: '*Start up*', '*Support*', '*Strengthening*' and finally '*Sustainability*' (See Annex 5). Yet, this tool has not been used to its full potential: a review on RSSG investments in the 2017-2019 funding cycle recommended that "*Further differentiation of RSSH investments is needed along the health systems development continuum, with a greater shift from systems support to systems strengthening and sustainability. Additional guidance is needed from the Global Fund to clarify the steps of the continuum*." (TRP, 2018).

Lately, WHO developed a categorization of health systems based on a holistic and dynamic approach. The FIT typology aims at identifying and bringing the support in HSS needed depending on the stage of the system. F stands for Foundations, that is to say building these foundations in least-developed and fragile countries, I is about strengthening the institutions where foundations are already in place and T focuses on supporting transformative and sophisticated reforms in countries with mature health systems (WHO, 2017). Yet, this approach needs to be further developed and communicated about.

There is little chance to achieve collaboration and cooperation on HSS if the concept itself remains blurry. The very broad definition of HSS enabled the emergence of a consensual concept, yet it remained too heterogeneous. More research and advocacy is needed to properly define the boundaries and the content of HSS. If the great echo created by Chee's work demonstrates an interest and demand for a definition going further than the building blocks, it is also likely that this process would erode the current consensus and the different paradigms it covers.

(b) The question of implementing and measuring HSS: the confrontation of paradigms?

Aligned with the question of developing a common understanding of HSS, another feature mentioned in interviews is the little material that has been produced, and above all, assimilated by the actors of development aid for global health in terms of objectives, indicators, roles or priorities in HSS. This absence of a shared roadmap can be interpreted as the symptom of the different operational approaches of HSS that remain to be reconciled.

Donors financing GHIs such as the Global Fund or the GAVI are characterized by a strong emphasis on quantified results and achievements as part of their accountability process: the Fund's main indicator used for communication remains the number of lives saved (the Global Fund, 2019). Yet, as analyzed by McCoy et al., "*The emotive metric of 'lives saved' could undermine investment in interventions that are important but which are not easily translated into a measure of saved lives*" such as HSS (McCoy et al., 2013). It is worth to mention that the challenge of measuring HSS progress is well-known by the Global Fund as "*Not all operational objectives under the Strategic Objective 2 to [RSSH] have performance indicators attached to them. This makes it difficult to measure progress for these areas.*" (the Global Fund, 2019). Beyond communication purpose, the Fund has developed a very wide matrix of key-performance indicators and efforts are made to better define how to assess HSS, even though monitoring of results remains very quantitative-oriented.

The results-based approach needs to be put in perspective with the massive amount of funding GHIs still mobilize (The Lancet, 2019). For France, around two-thirds of DHA is channeled through GHIs (Ministère de l'Europe et des Affaires Etrangères, 2017). As analyzed by Storeng, "*[Why] donors prefer GHIs is that they are incredibly high profile, which makes bilateral aid to these organizations garner attention. The GHIs are also arguably successful, even if only in terms of their narrowly defined goals, making it easy for donors, who are themselves under increasing pressure to demonstrate aid effectiveness, to claim results for their investments. The GHI model fits well with the political cycle because, unlike intersectoral action, it produces results quickly. More generally, […] technical-medical approaches is appealing not only because they can be demonstrated to be cost-effective, but also because they offer a seductive solution to problems that appear to be insurmountable"* (Storeng, 2014). This idea was also expressed by interviewees: "*I don't think the country team [of the Global Fund] is, per se, against HSS but they are judged on their capacity of spending money and the disease approach is 'easier'" (P13).* The notion is still perceived as very technical, it does not fit political cycles or quantitative accountability standards and strong capacities on the topic are still missing within GHIs. Moving away from an approach that is perceived as 'efficient' is

therefore risky for vertical programs, as it would potentially jeopardize their funding and reputation.

Even though restricting the evaluation of progress in HSS to quantitative measures may neither be desirable nor achievable, the development of strategic roadmaps, sets of indicators, and comparative advantages of each actor could help to reconcile multilateral with bilateral functioning. At the opposite end of the spectrum, actors of HSS need to capitalize on what they achieved. For instance, the interview phase revealed a lack of knowledge on AFD and I5PC projects and a thirst for better understanding from various actors (the Global Fund, OSCs, EF). This operationalization is also crucial in terms of cooperation: having harmonized approaches of HSS would ideally fill the gap created by the current fragmented interventions. It also aligns with recommendations to reinforce the tracking of donors' HSS expenditures (Shakarishvili et al., 2010) and therefore building more trust in investing in HSS.

1.2 The specific position of the leadership and governance's building block

(a) The issue of leadership at the macro level

Another major underlying issue that has been referred to at several occasions is the problem of overarching leadership that should be embodied by the WHO to guide the harmonization in HSS. The international organization is perceived by most as the reference institution that could build and diffuse standards of HSS and that should lead the coordination mechanisms.

This role was indeed endorsed by WHO itself, establishing three main directions for its leading role in terms of HSS: producing norms and guidance at the international level including "*health systems concepts, methods and metrics; synthesizing and disseminating information on 'what works and why', and building scenarios for the future"*, shaping the international systems impacting health and "*working more directly with other international partners on their support for health systems strengthening*" (WHO, 2007).

Yet, it appears that this overarching stewardship is not achieved, neither at the international, nor at regional and national levels. This can be attributed to various causes, interrelated with the crucial question of the international organization's financing. The role of WHO in the global health governance, in a global health context crowded with multilateral and public/private initiatives with strong financial resources (the Global Fund, Bill and Melinda Gates Foundation etc.), has been one of the three core challenges leading the process of WHO 2010's consultation. This consultation, first focused on financing and then expanded over time, aimed at proposing in-depths reforms of the institution (Reddy, Mazhar, Lencucha, 2018). The financial stability of WHO is likely to have an impact on the leadership in the HSS agenda at

two levels. First, investments in HSS research and/or stewardship may remain secondary to the numerous trade-offs between priorities, because its budget has been qualified "*incommensurate with its worldwide mandate*" (Gostin, 2015). Second, "*Many global health scholars have argued that WHO's reliance on voluntary and earmarked contributions creates a situation where external donors dictate the organization's priorities and action agenda*" (Reddy, Mazhar, Lencucha, 2018) which might not include HSS or directly favour certain conceptions of HSS through funding. Nevertheless, it is worth mentioning that paradigms are shifting: for instance, the BMGF, who strongly defended a technologic approach to health issues with little concern for HSS (Storeng, 2014), has recently incorporated goals such as "*Improve ownership and capabilities of government delivery system immunization"* in its polio vaccination strategy (BMGF, 2019). This change may represent a major turning point in the setting of the global health agenda.

The situation is also likely to evolve soon with the Global Action Plan that will be launched during the UN General Assembly in September 2019 and which already triggers many expectations. This "*historic commitment by global health and development agencies to advance collective action and accelerate progress towards the health-related targets of the [SDGs]*" (WHO, 2019) is a framework organized under the principles of alignment, acceleration and accountability. It is expected to help strengthening the performance of health systems by focusing on seven cross-cutting accelerator areas. Yet, if this initiative may transform the cooperation between the WHO and the major GHIs, among which the Global Fund, the question of coordination with bilateral partners and above all the developing countries remains to be defined.

(b) The issue of leadership in the field

The quasi-systematic reason given by the interviewees (16/23) to explain their critical perception of coordination and cooperation of HSS, especially at the field level, was the limited leadership and governance capacities of the beneficiary States. The overall agreement on this key bottleneck was very high, as it has been mentioned by respondents from all categories of organizations represented (the Global Fund, AFD, EF-I5PC, CSOs).

The question of the national leadership and capacities has always been at the core of the HSS's problem. In the 2000's World Health Report, the WHO already concluded that "*Ultimate responsibility for the performance of a country's health system lies with government.*" (WHO, 2000). This vision is reinforced in the building blocks framework, as this block is described as "*arguably the most complex but critical building block of any health system*", encompassing topics such as policy guidance, intelligence and oversight or collaboration and coalition

building (WHO, 2007). More broadly, this topic also echoes the Paris Declaration on Aid Effectiveness endorsed by both countries and financial and technical partners in 2005 under the impulse of the OECD and which set as a first guiding principle 'Ownership' (i.e. that developing countries set their own strategies for poverty reduction, improve institutions etc.) (OECD, 2005).

Yet, these declarations face different realities on the ground, as it has been reported by respondents and confirmed by the literature. Indeed, developing countries and more specifically sub-Saharan African countries, which represent the larger share of spending by far both for the Global Fund and the French public aid institutions are characterized by weak leadership and governance, "*including weak institutional and organizational arrangements and capacities*", "*poor overall stewardship*" and also "*low and inequitable domestic financial investments"* (Muthuri Kirigia et al., 2016). These characteristics affect coordination on HSS through various dimensions. First, because personnel with strong management and coordination skills are scarce at the Ministry of Health (MoH)'s level – in addition to the competition from the technical and financial partners who usually recruit the most qualified local professionals to manage their own programs. The second phase of this vicious circle is that, since the state has not the capacity of producing national-tailored frameworks, and these tools are not available at a macro level for HSS, each partner remains free to set its own priorities and label its actions as 'HSS', especially in donor-dependent countries. Therefore, meetings that could improve cooperation would only serve for exchanging information, without contributing to an overarching vision supported by the State. Also, by creating various management entities and national vertical programs, financing partners foster competition. Therefore, pooling of resources can be seen as the loss of funding and/or power rather than an opportunity at national level.

The level of public financing of the health systems is also intrinsically linked to the stewardship function. Indeed, as the DAH represents extra-budgetary contributions, it means that the Ministries of Health and Finance have little overview and control over the amount of money available. In 2016, 16 countries had the amount of DHA received exceeding by more than 100% the government health expenditures, reaching possibly unsustainable levels of DAH as these countries become extremely vulnerable to any changes in DAH policies from donor countries and cannot plan long-term programs (HAS, 2018). Therefore, there are major incentives for national programs or Ministries to align with various donors' identified priorities in order to maintain the funding, even it is still synonymous with fragmentation.

The performance-based funding also influences relationships with partners in recipient countries: "*Ideally, external funding should have an indirect impact on health by catalyzing national health systems development and supporting ministries of health and other local agencies to perform more effectively. But if [they] are judged against the delivery and impact of specific interventions, they may encourage vertical programs and stand-alone systems (over which they can have greater control), and neglect local institution building and national systems strengthening"* (McCoy, 2013). Yet, "*the longer we isolate public health's technical aspects from its political and social aspects, the longer technical interventions will squeeze out one side of the mortality balloon only to find it inflated elsewhere*" (Burn, 2005).

Nevertheless, over the time, approaches aiming at reconciling strengthening of health systems, stewardship of the State and coordination have emerged such as Sector Wide Approach (SWAp) or pooled funds, evoked in the interview phase and detailed below.

2. Proposals and suggestions for improvement

2.1 At the headquarters' level

(a) Among the French actors of Development Aid in Health

The first area of work is the harmonization of HSS interventions among French actors of DAH. It appears that this group of actors is still fragmented and does not present an overarching coherence especially on HSS with a *"terrible dispersal [...] that makes [them] inaudible" (P11)*. This detrimental situation is also challenging for the positioning of external actors – despite great assets in terms of expertise and potential for synergies. Yet, it will be easier to defend strong positions on HSS priorities with a national political alignment.

The propositions to improve this first axis are listed as follows:

- Create spaces for discussion to brainstorm on HSS within EF-I5PC and AFD: what does HSS means, what does it entail, the scope and limits. This first brainstorming would enable to sort out all the concepts.
- Work on an overarching new group's strategy between EF's health divisions and AFD and communicate it to external actors: the design of the next CIS is an important opportunity to conduct these consultations.
- Identify potential pilot projects that could bring together EF's health divisions and AFD
- Have upstream work to prepare the next French Strategy in Global Health: create coordination platforms on HSS that could be led by the Ministry of Europe and Foreign Affairs bringing together also CSOs, the private sector and academic research groups. These meetings could be regularly scheduled with specific themes (HR in health, countries

case studies). It would strengthen the mutual knowledge of each entity and help better understand the added value of France as a single actor with multiple resources.

- Create an interactive map that shows who intervenes on HSS, to do what and where. This can be done at AFD group level or at a larger scale.
- Brainstorm on the relationships with the French diplomacy network in the field: how to share information, how to facilitate coordination.

(b) Between French bilateral cooperation and other actors (the Global Fund, WHO)

The cooperation and coordination on HSS between AFD and the Global Fund has been on track for a year. Willingness has been expressed by both sides, as a significant and encouraging signal. Yet, the limited harmonization on HSS due to different *modus operandi* and paradigms of action needs to be taken into account. Aligned with what has already been achieved (new spaces of discussion, meetings), the following propositions aim at reinforcing this impulse.

Regarding the Global Fund

- Achieve and/or adapt the milestones from the roadmap established in November 2018: as discussions goes by, the roadmap needs to adapt to changes and refinements
- Improve follow-up and more regular dialogue on both sides: even though both organizations expressed their willingness and welcomed this new relationship, it appears that it is still conditioned by the willingness of individuals. Having a clear map of the persons to contact and of who is responsible for what in each institution would facilitate discussions.
- Establish a Memorandum of Understanding between the two organizations that would formalize the framework of cooperation.
- Follow-up of recommendations and guidelines on HSS by the Global Fund: the official integration of HSS within the strategy of the Fund is still new and efforts are put in order to improve concepts and operations. It is therefore crucial to keep a watchful eye on all the strategic decisions related to HSS to better understand the positioning of the Fund and identify axis of cooperation. The creation of a focal point with a strong knowledge about the Fund within the AFD Health division is an important step forward. Yet, aligned with the previous recommendation, there is still a need to formalize the way this information can be disseminated and incorporated. The example from German cooperation, who deployed one of their staff to the HSS unit of the Fund, showing results in both better understanding and channelling their ideas to this Unit could be studied for capitalization.

Regarding other partners

- Make use of the coordination tools that will be available within the WHO Global Action Plan and Reforms: this major plan will be disclosed during the United-Nation General Assembly in September 2019 and is likely to change the way UN agencies and GHIs will operate towards SDGs and impact partnership. It can be an opportunity to benefit from tools to facilitation coordination on HSS both at the headquarter and regional (WHO AFRO) levels.
- Strengthen a European position and leverage: a proposal mentioned by several respondents was to strengthen links on DAH and HSS at a European level and more specifically with the German cooperation, with whom France share positions on the importance of HSS in the global health agenda. Dialogue and synergies need to be further expanded after the replenishment conference.

2.2 At the field level

(a) Among technical and financial partners

At the field level, one of the potential tools to be developed is the participation of AFD to a new version of the Global Fund's Country Coordination Mechanism (CCM). CCMs "*consist of representatives of government, multilateral or bilateral development agencies, CSOs, academic institutions, private businesses and people living with or affected by the HIV/AIDS, tuberculosis or malaria*" and are in charge of the development and submission of funding applications and grant strategic oversight (Aidspan, 2018). They represent major platforms of dialogue in the beneficiary countries. Yet, CCMs "*are set up with little emphasis on cross-cutting health system issues*" (The Global Fund, 2019) which also explains why grants on HSS are scarce. Traditionally, the French embassies are represented in the CCMs through the participation of the Regional Advisor on Global Health (CRSM – *Conseiller Régional en Santé Mondiale*) or the embassy itself. AFD is not represented since this follow-up is encompassed by the diplomatic mandate. Yet, participating in these mechanisms would be a mean to foster dialogue directly at the country-level, to benefit from AFD expertise and knowledge on HSS and to have a greater overview on the planned programs of HSS to be implemented by the Fund. It would be also the opportunity to hear the voice of the civil society and beneficiaries on cross-cutting issues. This suggestion has already been discussed in the AFD/Global Fund meeting of November 2018 and many respondents encouraged this option, highlighting the numerous potential benefits on harmonization and collaboration. Yet, it is important not to under-estimate the investment and the initial costs of this representation in terms of dedicated HR, preparation and follow-up. The perfect match to experiment this new feature would be a country where AFD already has a health concentration, where a HSS component in the allocation process of the Fund has already been presented in the past, and where a high level of coordination exists between AFD local office and the French embassy. It could be facilitated by a technical assistance of the I5PC on HSS grant-making, which would also strengthen an

AFD group position. This topic should be submitted to further discussion between AFD, the Fund and I5PC, and capitalized upon if achieved.

(b) Between partners and beneficiary countries

In order to address the major challenges related to national stewardship, approaches have been developed since the 1990s such as Sector-Wide Approaches (SWAp). Defined as "*sustained partnership led by national authorities whose purpose is to improve people's health*" (Peters et al., 2015) the main principle is to pool all significant funding to support national policies, strategies and expenditure frameworks (Cassels, 1997). It can be considered in some ways the precursor of HSS approach. With the evolutions of the DAH in the 2000s, SWAps have progressively been neglected and most financial partners did not align with these overall frameworks that presented mixed results. Yet, with the growing criticisms against vertical programs, these approaches may gain renewed interest if addressing some of its previous limitations further described.

As stated by a capitalization report based on AFD's case studies in education and health sectors, this type of approach enabled major progress that cannot be reached through project-mode and aligned with the international commitments on development aid. More specifically, it helps strengthen national political stewardship and coordination among partners. It also better takes into account the institutional local context, enabling tailored programs. Yet, the report also highlights that these approaches tend to be idealized in terms of achievements, and actors minimize the complex operational implications in terms of planification, harmonization of the procedures, monitoring and evaluation – with a heavy dialogue more often focused on bureaucratic excesses than strategy and technical aspects. The report concludes that the SWAps are relevant tools to strengthen national capacities and public policy making, provided non-negligible adjustments (Cafferini & Pierrel, 2009).

Nowadays, one of the biggest challenges is also to integrate GHIs into these mechanisms as the pooled approaches remain very far from their DNA and crucial operational challenges remain. Nevertheless, some changes have recently taken place. One example is the pooled funding of the health sector put in place in Niger in 2006, bringing together first AFD and the World Bank, and later on the Spanish cooperation, GAVI, UNICEF and UNFPA. The main goal was to support the implementation of the sector-wide policy in health (*Plan de Développement Sanitaire*) established by the MoH (see further details in Annex 6). The Global Fund has demonstrated interests in the initiative but its participation to the mechanism is not planned in a near future notably due to the difficulties in adapting its own accountability and transparency rules. Therefore, the option to distinguish the HSS financing of the Fund from the grants

dedicated to the three diseases and use these specific investments into pooled mechanisms is still very unlikely. This feature would require strong adaptability and flexibility of the Fund in terms of reporting and management of financial risks. Yet, the report from the Global Fund on the grant implementation in Western and Central Africa very recently slightly opened the door for applying more flexibility in terms of internal procedures management in challenging operating environment (The Global Fund, 2019). To apply a balanced approach of risk management in specific contexts would be a first test that should be documented for replication. Some modalities could then be considered to support broader and progressive shifts: in less advanced countries, strengthen first the capacities of the managing unit within the MoH (with each donor financing one component such as HR, accountability etc.), harmonization of procedures and guidelines.

Another major consideration that should be taken into account is the need for documenting and capitalizing on these new features. Only the lessons learned from the first attempts will help create examples and facilitate replication. An important work remains to be done on the collecting, use and dissemination of information.

Conclusion

Harmonization of the HSS concept for AFD, the Global Fund and EF-I5PC is very likely to take time, as they respond to different logics, mandate and *modus operandi*. This long-term process reflected in the limited common understanding of HSS presented by the actors and the variety of strategies developed on the topic. It can also explain the shared diagnosis of unsatisfactory cooperation and coordination both at headquarter and field levels, with several common bottlenecks identified: the challenge to operationalize the HSS concept beyond the theory and the crucial role of stewardship both at macro and national scale. Nevertheless, the fact that the actors share the same situation analysis and the willingness expressed to strengthen collaboration is a positive signal towards changes.

To facilitate progress, engage in stronger dialogue platforms and concrete pilot examples of cooperation both at the headquarters and on the ground is recommended. Special attention should also be brought to coherence among the actors of the French DAH in order to build a stronger strategic position. Eventually, commitment towards strengthening national management capacities and leadership in the health sector is crucial.

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List of annexes

- Annex 1 – Guidelines for interviews
- Annex 2 – List of the key high-level issues identified by the first report on RSSH investments from the Global Fund (the Global Fund, 2019)
- Annex 3 – The health system cube differentiating between health system support and strengthening (Chee et al., 2012)
- Annex 4 – BACKUP intervention area: health systems strengthening – building resilient and sustainable systems for health (BACK UP SANTÉ, 2016)
- Annex 5 – The Global Fund '4S Model' (The Global Fund, 2018)
- Annex 6 – Focus: Basket Fund for Health in Niger

Annex 1 – Guidelines for interviews

Aim
Describe the perception of the actors from DAH on HSS and get a situation analysis of cooperation and collaboration on this topic
Method
Qualitative and descriptive study for semi-structured interviews with key-informants
Population targeted
Professionals of the DAH
Sample
Total of 23 persons interviewed: - 1 from Santé Mondiale 2030 (French think-tank) - 1 from Mott McDonald Health division (Private sector) - 1 Regional Advisor on Global Health (French diplomacy) - 1 from Health Advisory Service (Advisor to EU Directorate General for Development Cooperation on Health and Development matters) - 3 from Solthis (French NGO) - 4 from The Global Fund - HSS Department / Portfolio Managers - 1 from Santé en Entreprise / Health Commission of the Counsel of Investors in Africa (Private sector) - 1 from Expertise France – HSS Division - 1 from the GIZ (German cooperation) - 4 from the AFD - Health Division - 2 from Coalition Plus (French NGO) - 1 from Expertise France – Pandemics/I5 Division - 1 from Sidaction (French NGO) - 1 from WHO (Director General Secretariat) The list of interviewees was established with the professional advisor, who facilitated the contact with the majority of the interviewees. A smaller proportion of respondents was identified through snowballing: they were either invited for an interview by the principal interlocutor or through the facilitation of the first contact.
Selection criteria
- Person related to the three organizations of interest, either working in the organization or having professional links with them - Person who developed knowledge/with professional experience related to RSS
Tool
Semi-structured interviews guidelines of 6 key-questions, backed up with specific question depending on the respondent List of the key-questions (translated from French): 1. Can you explain me what HSS is according to you? 2. Can you explain me how HSS is part of your professional activity? 3. Can you tell me about the link you make between HSS and AFD/the Global Fund/EF-I5? 4. What is the position of HSS in the global health agenda nowadays according to you? 5. Can you explain me your current perception of the coordination between technical and financing partners in HSS? 6. Can you explain me how you would improve this coordination, if you think it that there is room for improvement?
Presentation of results and discussion

Discussion from the previous literature review
Analysis
Analysis of qualitative content without the use of software
Calendar
April-May 2019
Personal participation
Redaction of guidelines, initial contact through the facilitation of the professional advisor and schedule of the interviews, conduction of the interviews, notes during the interviews, data analysis, redaction of the thesis' body.

Annex 2 – List of the key high-level issues identified by the first report on RSSH investments from the Global Fund (the Global Fund, 2019)

"Based on the review, the TRP commends the Global Fund on RSSH investments made to date; supports further RSSH investments; and encourages refinement of RSSH strategic efforts, country dialogue and funding processes to improve health and disease impacts from health systems strengthening components. The TRP identified six key high-level issues for the attention of the Strategy Committee:

- Focused attention to RSSH has been observed in funding requests, however significant challenges remain. Further prioritization of RSSH investments should be encouraged across the health systems pillars, based on stronger country situational analyses of RSSH bottlenecks or challenges.

- Further differentiation of RSSH investments is needed along the health systems development continuum, with a greater shift from systems support to systems strengthening and sustainability. 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.

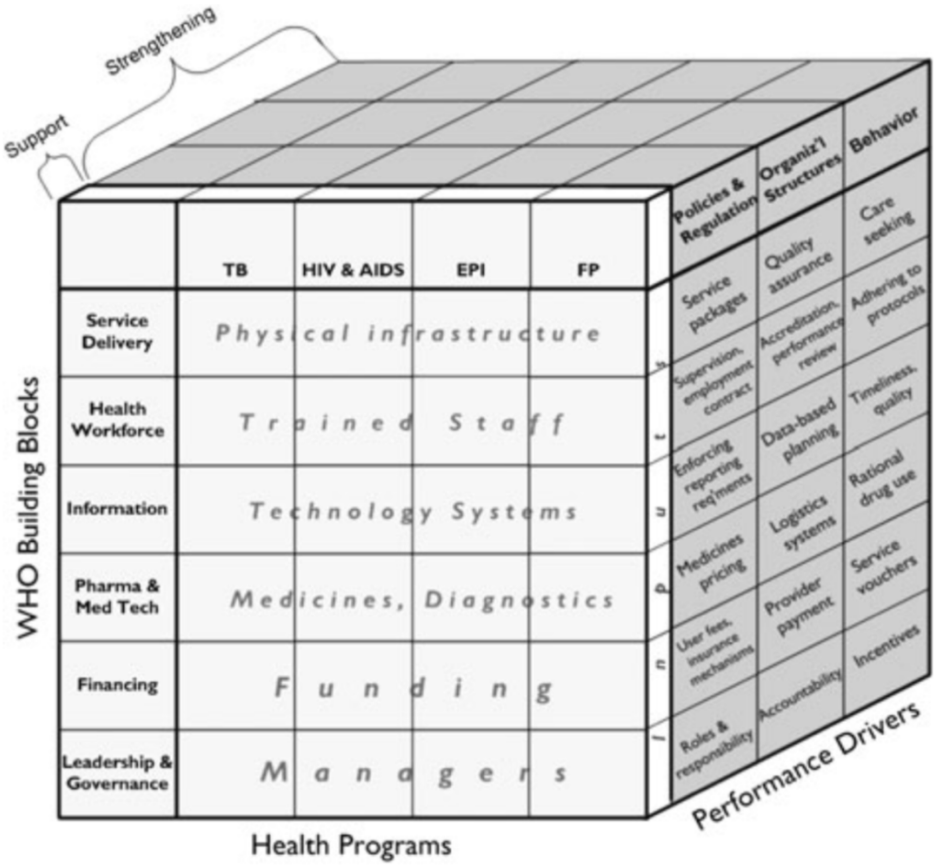
- Weak indicators in the modular framework and few and/or poor indicators in funding requests impact performance monitoring of RSSH investments. Health systems indicators in the modular framework need to be revised, expanded and utilized.

- Significant efforts are needed to achieve stronger integration across the three diseases and with other health programs, such as reproductive, maternal, newborn, child and adolescent health (RMNCAH) and non-communicable diseases, where integration can strengthen service delivery, improve efficiency, equity and/or impact and value-for-money.

- Comprehensive broad engagement beyond the health ministry is needed to strengthen vital elements of the health system. This includes supporting community engagement processes and capacities, addressing human rights and gender, health workforce planning and finance, and engaging private health service providers in addressing the three diseases.

- There is limited attention in funding requests to strengthening health system components that may be vital to sustaining disease impacts such as governance and accountability and financial management. These components are relevant for all countries but particularly those nearing transition. Global Fund program implementation arrangements should be designed to reinforce health system capacity.

Annex 3 – The health system cube differentiating between health system support and strengthening (Chee et al., 2012)



Annex 4 – BACKUP intervention area: health systems strengthening – building resilient and sustainable systems for health (BACK UP SANTÉ, 2016)

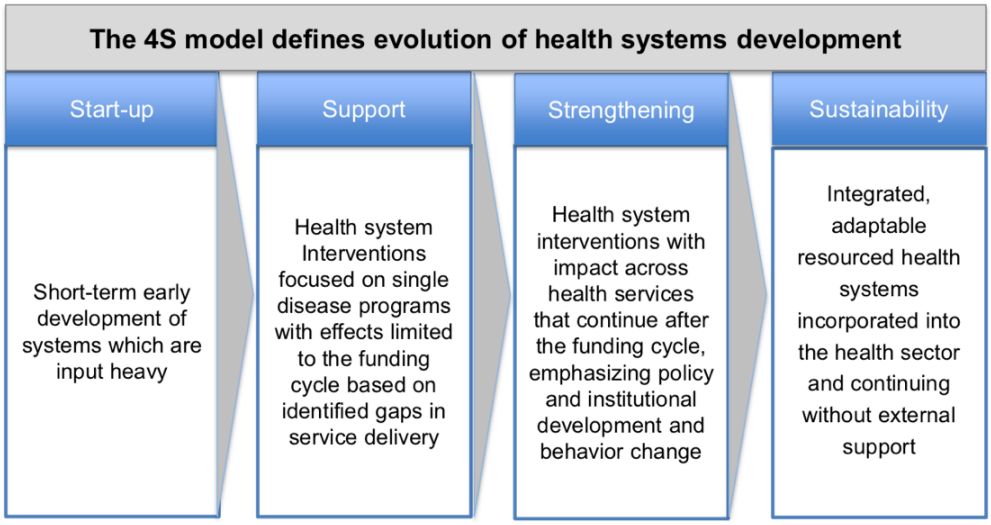
BACKUP definition of the intervention area

The overall objective of health system strengthening (HSS) is to improve health outcomes. As this can only be achieved in the long term, one crucial aspect of HSS is sustainability. BACKUP defines its contribution to HSS as (a) enabling health systems to provide sustainable, accessible, equal, equitably financed and high-quality services to HIV, tuberculosis or malaria infected and affected persons and (b) contributing to the integration of these services with other health services. Disease control for the three diseases should form an integral part of the overall health service portfolio. BACKUP is particularly interested in supporting projects that focus on health system policy and governance issues.

WHO also defines sustainable interventions to be those that focus on interactions between the single components of a health system. Approaches for achieving this goal can focus on one or several building blocks at the same time. If interventions target one building block of the health system, it is important to consider how this interacts with other building blocks and its impact — be it positive or negative — on these. Additionally, it is important to differentiate between health system support and health system strengthening. This is especially relevant in the context of Global Fund activities. While health system support comprises short-term problem-solving interventions, measures can be deemed to strengthen a health system if they:[9]

- benefit the health care system in its entirety, having an impact beyond a single disease;
- target identified weaknesses in the system and/or strengthen collaboration between the building blocks;
- trigger long-term changes beyond the time frame of the intervention;
- are country specific, taking into account the cultural context and the division of labour of national institutions.

Annex 5 – The Global Fund '4S Model' (The Global Fund, 2018)



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

Annex 6 – Focus: Basket Fund for Health in Niger

In Niger, a basket fund to support the implementation of the sector-wide national policy in health (*Plan de Développement Sanitaire*) has been put in place in the in 2006, bringing together various donors: in a first phase, AFD and the World Bank, then the Spanish cooperation. Second phase added contributions from GAVI, UNICEF and UNFPA.

Basket Funds can be defined as "*fiduciary instrument(s) enabling the defragmentation of several DAH flows and increasing the synergy between the government's action and its partners. It's about transferring to a single implementer the prerogatives of several ones through financial instruments and rules accepted by all*" (HAS, 2018). It means that donor

mutualize their funding, targeted to the financing of one sector but due to an important fiduciary risk and weak management capacities from the beneficiary State, this funding is usually not executed through the national budgetary procedures or national accountability (unlike budgetary support).

A first evaluation conducted in 2015 identified the main following results:

Main improvements	Remaining gaps
- Better predictability of the financial resources - Better availability of the financial resources for the operational activities - Better harmonization of aid in the health sector - Reduction of the functioning costs - Strengthening of the local capacities in terms of planification, implementation, monitoring and evaluation (M&E) - Better aid efficacity in terms of MoH leadership, alignment with national priorities etc. - Strengthening of the health system at all the levels of the healthcare pyramid	- Remaining fragmented aid flows - Not a sufficient pooled amount of money to represent a critical mass of DAH - Financing partners are not using shared programmatic, implementation and M&E frameworks - Remaining identified needs for technical support - No further investments in health from the State - Large inequalities in terms of access to healthcare and quality of care among regions

(Compilation of results based on the evaluation report from Hera)

Even though partners earmarked some of their contribution to the pool towards some specific areas of the health sector (GAVI to immunization or AFD towards reproductive health), the Nigeran case study represent an important example of HSS through the harmonization aid. Participation of the Global Fund is not planed in a near future. Yet, it is worth to mention that the MoH became for the first-time recipient of a Global Fund's grant this year, opening the door to further cooperation and coordination with the national institutions and partners.