Technical Evaluation Reference Group: Global Fund Mapping Health Systems Strengthening (HSS) Component of the Resilient and Sustainable Systems for Health (RSSH) Investments

TERG Position Paper, Management Response, and Final Report

June 2023

TERG Position Paper on Global Fund Mapping Health Systems Strengthening (HSS) Component of the Resilient and Sustainable Systems for Health (RSSH) Investments

Executive Summary

Context

The Strategy Committee (SC) requested the Technical Evaluation Reference Group (TERG) to undertake a mapping of Global Fund investments in Resilient and Sustainable Systems for Health (RSSH) to produce for the Global Fund Board (the Board) a comprehensive overview of the investments having a cross-cutting impact on health systems beyond a single disease i.e., health systems strengthening (HSS) investments in countries and recommending how to improve the operationalization of these investments and their tracking. The purpose is to inform the next round of grants (Grant Cycle 7) and implementation of the 2023-2028 Strategy. The assignment looked at two broad areas:

i. These mapping and investment estimates were to serve as a baseline and help the Global Fund (GF) better align its investment to cross-system areas, strengthening those needed to deliver on the three disease targets and beyond.
ii. This global mapping was complemented with 15 country case studies to determine whether the identified investments in HSS were (a) part of (or focus on) government priorities reflected in the health sector strategy (reform) plans and budgets; (b) whether government public financial management and procurement systems were used during the implementation, and (c) if HSS investments were additional, complementary, or leveraged national or donor funding for strengthening health systems.

Based on the findings of the mapping exercise, the consultant team came up with thirteen high-level conclusions across four main areas of interest. Eight recommendations arising from the conclusions were then grouped into four strategic and four operational ones. These were further categorized as 'high' and 'medium' priority.

This evaluation was commissioned and conducted as part of the 2022 workplan for the TERG. As of 2023, the TERG has been replaced by a new independent evaluation model approved by the Board (GF/B46/DP06).

TERG Position

The TERG highlights the mapping exercise's narrow scope compared to the broader definition of RSSH used by the Global Fund. In light of this, the TERG broadly endorses the findings about investment in HSS, and conclusions and fully supports six of the eight recommendations made by the team. The TERG supports the general direction of the other two recommendations but with caution, given the operational challenges they could pose.

Input Received

The scope of the mapping, including zeroing down on the investments with a cross-cutting impact on health systems beyond a single disease, and the evaluation questions were developed after extensive consultations with the Secretariat, WHO and the SC. This mapping exercise was conducted with substantial contributions from the Global Fund Secretariat staff, from SC members as well as relevant

external partners. The TERG worked particularly closely with the WHO to guide the mapping exercise, from clarifying the terms, definitions, and methodology for the mapping to providing feedback on various draft reports. Inputs were also received from a wide range of stakeholders at global and country levels to help develop the view of how the Global Fund investments sit within the constellation of health systems resources.

Report

Part 1: Background:

1. The Global Fund's 2023 – 2028 Strategy[1] aims to maximize people-centered, integrated systems for health to support the Strategy's primary goal of ending the three diseases. The new strategy intends to strengthen health systems and make them more people-centered by focusing on seven sub-objectives. Despite previous efforts of the Secretariat to measure the level of Global Fund investments in RSSH relative to national and other donor investments, this funding category and its actual size continue to raise questions within the Board. Additional mapping for a baseline was needed to inform how the Global Fund can better align and harmonize its HSS investments in RSSH with national health sector priorities, planning, and budgeting and how the Global Fund should improve its investment tracking system for RSSH generally, and HSS specifically. Also needed is categorization/classification that, on one hand, serves the Global Fund's corporate strategic and programmatic objectives, and on the other produces the expenditure categorization that is **comparable to internationally available health expenditure data** produced by nations using System of Health Accounts (SHA) (or other commonly used National Health Accounting approaches - NHA). The Strategy Committee requested to have a better understanding of the Global Fund's overall contribution (level of funding and areas of funding) to the health systems strengthening of recipient countries, relative to domestic and other donors' investments with a particular focus on the grant implementation phase (see Annex 2 in the main report for more details).

2. While the Secretariat has been tracking investments in RSSH and estimating the Global Fund's contribution to health system strengthening, the quantitative information has been with clearly defined categories/boundaries (following a modular template that also links to health systems building blocks) for internal use, but with a lack of comparability to the investments made by other development partners or countries themselves. This mapping potentially will serve as a baseline for the Global Fund to reorient its grant operations to better align and harmonize support to health system strengthening efforts with national priorities and inform the Global Fund on how these investments could be better monitored for internal use as well as for international comparability.

[1] Fighting Pandemics and Building a Healthier and More Equitable World Global Fund Strategy (2023-2028) https://www.theglobalfund.org/media/11612/strategy_globalfund2023-2028_narrative_en.pdf

3. **Objectives** - The original Terms of Reference (ToR) had six main objectives, the review team, in discussion with the TERG and WHO re-organized these into three objectives that were supported by seven main questions as follows:

   Objective 1: Critically evaluate the RSSH tracking methods/tools and expenditure data categorization used by the Global Fund Secretariat and what differentiates investments in RSSH from other Global Fund investments.

   MQ1.1 What are the Global Fund's existing approaches to tracking RSSH single disease area investments, and cross-cutting area investments?
   MQ1.2 How do existing Global Fund tracking approaches align to and/or differ from other development partners (DP) HSS tracking approaches?
   MQ1.3 How do Global Fund RSSH tracking approaches align to and/or differ from National Health Accounts systems?

   Objective 2: Estimate the magnitude of Global Fund investments in health systems globally and at country level.

   MQ2.1 What proportion of the Global Fund's investments go into the cross-cutting areas and the single disease area?

   MQ 2.2 What types of interventions does the Global Fund support in the cross-cutting health system funding, and how has the budget allocation changed over time?

   Objective 3: Understand how Global Fund RSSH investments align to domestic and government investments and national health priorities.

   MQ 3.1 How do Global Fund investments in RSSH compare with domestic and government expenditure on HSS?

   MQ 3.2 How do Global Fund investments in RSSH compare with other external development assistance to health, where relevant?

4. **Methods and approaches** – The mapping used qualitative and quantitative data from primary and secondary data sources collected through 242 key informant interviews, both at the central (98) and country level (144) and from reviewing the literature and numerous documents. The literature included previous TERG, Office of the Inspector General (OIG), and Technical Review Panel (TRP) reviews and reports produced by the RSSH Team. Fifteen (15) countries were selected for deeper analysis. The TERG appreciates the facilitation of country-level interviews by WHO country offices. The mapping report provides substantial information on methodologies used across the three workstreams addressing the three mapping objectives.

5. **Limitations –**
   - **Varied definitions and interpretations of key terms** used in the mapping. RSSH is a term the Global Fund uses but is not commonly used by other DPs and countries, which leads to confusion when referring to Global Fund **investments in RSSH in an external context**. In addition, the lack of commonly agreed definitions around HSS globally means that the terminology used is open to broad interpretation, which imposes comparability challenges with other DPs and countries.

- **Data Limitation for assessment of benefits**; The definition of the investment focus that was used for the mapping exercise was limited to those having a cross-cutting impact on health systems beyond a single disease. Therefore, consultants approached the analysis and – in full agreement with the TERG – promoted a major focus on mapping those investments that have been specifically identified as designed to deliver 'cross-cutting' benefits. However, the data used to inform this analysis does not allow for assessing the benefits derived from these investments.
- **The time-consuming nature of the categorization** exercise under global analysis (which involved a line-by-line review of all Global Fund investments under RSSH modules and disease-specific modules of all grant types – see Annex 3 in the main report) means the analysis was only conducted in a sub-sample of countries. However, the desk-top mapping exercise was scaled up to 38 countries, representing 80% of the Global Fund's portfolio for NFM 2 and NFM 3. These 38 countries included the 15 case study countries.
- **Series of logistical challenges** faced by consultants around timing and access to key stakeholders at a country level required permissions from both WHO and Global Fund. And these delays compressed the period in which data collection and analyses were conducted.

Part 3: Key Conclusions from the RSSH Mapping Exercise Report

6. Although the RSSH mapping exercise initially had several mapping questions, for the clarity of presentation of the findings, conclusions, and recommendations, the evaluators grouped them around three objectives (1) Critically evaluate the RSSH tracking methods/tools and expenditure data categorization used by the Global Fund Secretariat and what differentiates investments in RSSH from other Global Fund investments. (2) Estimate the magnitude of Global Fund investments in health system strengthening globally and at the country level, and (3) Understand how Global Fund investments align with domestic and government investments and national health priorities. This approach facilitated teasing out the cross-cutting investments (the focus of the mapping) from those benefiting only one disease (that could be termed as contributory). This also allowed the evaluators to differentiate between system-supporting and strengthening investments, how different stakeholders define HSS, and the consequent challenges with tracking these types of investments in countries. Based on their findings, the evaluators came up with the eight key conclusions listed in Table 1 below:

Table 1: RSSH Mapping Exercise Conclusions

Conclusions
Conclusions related to the definition and categorization of HSS
1. **The lack of a standard definition of HSS, together with the limited comparability of 'HSS' interventions, leads to inconsistency between agencies in defining and targeting investments for systems strengthening, including between those that focus on disease specific areas and those that focus on cross-cutting outcomes.** The Global Health field generally lacks a standard definition for health system strengthening (HSS), which undermines the comparability of 'HSS' interventions and relevant investments. Therefore, there is an inconsistency between Global Health agencies in defining and targeting investments for systems strengthening, including between those focusing on disease-specific areas and those focusing on cross-cutting outcomes. While the definitions used by Development Partners (DPs) are largely based on the

WHO health system building blocks, **it is common for DPs to adopt a definition of HSS-type investments related to specific organizational strategies or program objectives.** This is the case with the Global Fund as well, where RSSH is much broader than HSS and includes WHO building blocks and additionally community systems.

2. **For the Global Fund, issues relating to misclassification, subjectivity, and rigidity of budget codes hinder the effective categorization and definition of RSSH investments, reducing the ability to use financial data to answer strategic questions on how RSSH investments are used – even as the new Global Fund Strategy proposes to make RSSH a mutually reinforcing contributory objective to the overall goal of ending AIDS, TB, and malaria.** These limitations are not unique to Global Fund. Other DPs confirmed there are issues with internal and external reporting, including misclassification, subjectivity, and rigidity of budget codes.

   TERG Comment – these issues also hinder cross-comparison with other development partners as well.

3. **The Global Fund methodology for measuring RSSH investments uses a definition that does not correlate with what most stakeholders consider to be HSS (and this mapping analysis of cross-cutting investments); definitions vary on the extent to which HSS includes disease-specific vs a focus on cross-cutting.** The main point of departure is the inclusion of RSSH Contributory in the measure of RSSH, which assumes that some investments in disease-specific interventions contribute to cross-cutting outcomes. Although these assumptions may be theoretically valid, the extent to which they hold true across all Global Fund countries is unclear and will require further country-level evaluation to be able to reach a better conclusion on the cross-cutting benefits of the interventions/activities.

   TERG Comment – not only is the Global Fund's definitions related to HSS different to other partners it is also different to the definitions of cross-cutting HSS interventions ultimately used by the consulting team for this mapping exercise, to facilitate better comparability across organizations.

Conclusions related to tracking of RSSH investments

4. **Analysis of the available Global Fund data sets provides limited visibility of what happens to RSSH grants post-budget approval stage, which means it is hard to answer questions about how strategic priorities on RSSH are operationalized. Specifically, this means that RSSH spending cannot be tracked at sufficiently granular level to address questions about type of RSSH spend (contributory, cross-cutting, support vs strengthening, etc.).** GAC budgets allow for RSSH planned investments to be tracked in detail by module, intervention, cost category, and cost input alongside a description of each budget line, in using information from Progress Update Disbursement Request (PUDR) forms to assess Global Fund RSSH spending, this mapping exercise observed that the level of granularity in the analysis of RSSH investments is lost, as PUDR reports do not allow for cross-tabulation of costs.

   *TERG Comment: As a result of the above, Global Fund has limited visibility of what happens to RSSH investments **post-budget approval stage**, which means it is hard to answer questions about how strategic priorities on RSSH, including HSS, are operationalized.*

5. **In order to better track relevant RSSH spending from the Global Fund in alignment with other partners, it is theoretically possible to improve the approaches to track RSSH and cross-cutting investments at country level. However, this requires both an investment in developing standardized monitoring frameworks and a focus on accessing detailed information through national study databases.** Most health expenditure tracking exercises are guided by the System of Health Accounts (SHA). While the conceptualization of health systems has evolved over time, health expenditure tracking frameworks have not kept pace. While it is technically possible to track Global Fund investments at the country level this requires both an investment in updating Global standardized expenditure tracking frameworks and securing access to detailed information being collected through national accounting systems/databases. Furthermore, **the time lag in national health expenditure production to inform financing gap analysis will also limit the ability of countries to clearly identify current RSSH or HSS gaps.**

6. **The current Global Fund approach for tracking RSSH investments has limitations, and routinely evaluating health system strengthening outcomes comes with significant challenges and costs. However, a more accurate, low-cost, and timely measure of Global Fund investments in RSSH is to track investments (budget and expenditure); this may be possible through a greater emphasis on tracking RSSH modules.**

Conclusions related to the magnitude and nature of Global Fund RSSH investments

7. **The estimated magnitude of RSSH investment (direct and contributory) using the current Global Fund Secretariat approach to tracking these investments is significantly higher than the cross-cutting investment estimated in this mapping exercise. This is because the Global Fund Secretariat approach uses a broader definition and set of assumptions than the methodology for this mapping exercise.**
   a. The definition used for the global analysis in this mapping exercise aims to estimate the proportion of Global Fund HSS investments that are primarily for cross-cutting rather than disease-specific objectives. It is designed to provide a baseline for mapping of Global Fund investments which aim to strengthen the health system. It does not seek to evaluate whether these investments have resulted in cross-cutting benefits. It is a much higher standard against which to measure Global Fund investments in health system strengthening, **so we would expect the proportion of investments falling into this category to be much smaller than for other measures.**
   b. The Global Fund Secretariat approach tags all investments labelled 'RSSH' as cross-cutting systems strengthening, whereas our analysis found that some investments under RSSH modules did not meet this criterion. The Secretariat methodology also assumes that some disease-specific modules and interventions in the programme management module have HSS benefits. Although these assumptions may be theoretically valid, the extent to which they hold true across all Global Fund countries is unclear and will require further country-level evaluation to be able to reach a better conclusion as to the cross-cutting benefits of the disease specific and programme management interventions/activities.

8. **At budget level, about 7% of the** Global Fund **'s total investments in NFM 2 & NFM 3 are cross-cutting (HSS) investments. These are found within RSSH modules and not in disease modules.** This estimate was reached by applying the narrower definition of investments in cross-cutting health systems, as agreed with the TERG and WHO for this mapping study. The cross-cutting investments make up about 77% of the investments in the RSSH modules. The Global Fund's investment was categorized into cross-cutting investments, single disease investment (based on a line-by-line mapping of activity descriptions under the

disease specific modules and RSSH modules across all grant types), programme management and COVID-19-related investment. Applying the definition and methodology for this mapping exercise and reviewing all the investments in the disease-specific modules, no cross-cutting investments were identified in these modules.

TERG Comment: Nonetheless some investments in disease specific modules e.g., Malaria Indicator, Integrated Biological-behavioral Surveillance surveys, Laboratories, etc. bear system strengthening characteristics but they do not meet the cross-cutting criteria set out for this mapping).

9. **Mapping interventions into system support and strengthening can be highly subjective, and accurately tracking the balance between *support and strengthening* is extremely difficult. Our analysis was able to generate some limited insights into the way RSSH investments have been divided across these two areas in the Global Fund, but they necessarily need to be interpreted with these limitations in mind. Currently, Global Fund systems are not set up to track this routinely; as such, decisions about the optimal balance between these types of investment are not well informed.** The debate on what constitutes system support and strengthening is ongoing, and it is not appropriate to label one as desirable and the other undesirable**.** Country health systems differ in maturity/progression and weaknesses; systems support and strengthening interventions should be tailored according to country-specific constraints and opportunities.

   The mapping was able to generate some limited insights into the way Global Fund investments have been divided across these two areas in the Global Fund, but they necessarily need to be interpreted with these limitations in mind.

   a. The analysis identified some important trends. For example, distributions of health systems support and HSS investments varied by specific RSSH module, with a high proportion of support investments in Human Resources for Health (HRH) and a high proportion of strengthening investments in health sector governance and planning.
   b. Although supporting the system alone can improve performance in the short term, only activities that go beyond strengthening the system beyond one disease can improve the system's (resilience) ability to respond to future challenges. Support investments are necessary, but there is a need to strike the right balance between these investments, and this decision is a policy/strategic decision that is highly country specific. The process of mapping and categorizing these investments to support and strengthening can be helpful in helping to frame the decision around what the optimal balance should be. Currently, Global Fund systems are not set up to track this routinely; as such, decisions about the optimal balance between these types of investment are not well informed.

Conclusions related to operations of the current Global Fund business model

10. **The analysis at the country level highlighted that stakeholders in countries widely perceive Global Fund investments in RSSH to be well aligned with national priorities, health sector strategies, and disease-specific plans. However, we also found that the alignment of disease grants with disease national strategic plans (NSPs) is stronger than the alignment of RSSH investments with national health priorities and sector plans, indicating that there may be ways to improve alignment**. The strong stakeholder agreement on alignment is a testament to the robust and consultative Global Fund funding request process which provides a critical foundation and starting point for ensuring alignment of investments with government HSS priorities. RSSH continues to feature more prominently in recent NSPs, albeit still largely in the context of health system needs required for the delivery of HIV, TB, and malaria programmes.
11. **Our analysis highlighted some key insights around the ways in which RSSH investments are being used at country level. In other cases, it was noted across a number of case study countries that insufficient attention has been given to subnational resource allocation and decision-making processes, and that community-level health systems should be given more priority. The case studies**

also generated a number of recommendations (from in-country stakeholders) that could be leveraged to help improve future alignment. Key insights included the fact that countries reported.

- Reprogramming of Global Fund grants had enabled them to shift funds from disease-specific investments to wider systems investments.
- Others highlighted an opportunity for the Global Fund to increase the impact of its RSSH investments by expanding its engagement with subnational governments and processes, especially in countries where decentralization is advanced. This is already practiced in disease grants through differentiated delivery, subnational tailoring, etc.
- Further opportunities include for the Global Fund to work with the Ministry of Health (MOH) and other partners to strengthen its focus on community needs and community health systems as well as leveraging its RSSH and disease specific grants to highlight broader sector and health system issues of relevance to Global Fund grant implementation.

12. **Countries continue to face significant challenges in reporting spending toward health from their domestic financial commitments. In addition, there is a lack of data on co-financing commitments, and expenditures in RSSH spend.** The COVID-19 pandemic has had devastating effects on public spending – which has implications for health and health spending – countries are facing a wide range of challenges in reporting spending towards health from their domestic financial commitments.

13. **Country stakeholders confirmed that Global Fund RSSH investments generally use national systems at the central level which are associated with greater alignment.** Some countries generate data and information from national public financial management (PFM) and health information systems for financial and programmatic reporting to the Global Fund, while in other countries separate systems have been set up. The implementation of most HSS funding (RSSH modules) is managed by government institutions, and in these cases management of this was generally associated with increased integration and use of national systems.

Part 4: Recommendations and TERG Position

7. One of the intentions in conducting the mapping exercise was to provide clarity on the Global Fund investments with a cross-cutting impact on health systems beyond a single disease as requested by the SC, including the extent of investments in systems strengthening and system support. Further clarity was also needed on the measures in place to track these investments and the overall contribution to national health systems strengthening initiatives beyond disease-specific programs. TERG recognizes the challenges surrounding these investments including low and poor absorption of funds requiring long-term planning and implementation.

8. Several issues, challenges, and bottlenecks covered in the recommendations have been raised repeatedly in other TERG, TRP and OIG evaluations, observations, and advisories, respectively. TERG wishes to particularly draw the SC's attention to four Strategic recommendations and the associated issues, including the caveats provided by the TERG.

9. The mapping exercise has been particularly difficult because of variations in definitions and categorization of health systems strengthening (HSS) and Resilient Sustainable Systems of Health (RSSH) investments and what their components are, including activities categorized as cross–cutting and disease/program-specific RSSH investments, which adds an additional layer of complexity in the analysis. Therefore, the definition of cross-cutting investment has been narrowed for this mapping exercise. Hence the lower numbers of the investment with a cross-

cutting impact on health systems beyond a single disease estimate is a logical result of this exercise.

10. **The TERG largely endorses key findings and high-level conclusions and fully supports two recommendations, with noted caveats for others, out of eight proposed in this mapping exercise.** The TERG assesses that the six objectives of the mapping exercise in the RFP have been addressed, despite the constraints under which the team had to work, which included unclear and unstandardized definitions and categorization of HSS and RSSH. The recommendations and TERG position are detailed in Table 2 below.

Table 2: Consultant Team Strategic and Operational Recommendations

Recommendations	TERG Position
Recommendations related to the definition and categorization of HSS	
Recommendation 1 (High Priority/Strategic): The Global Fund Secretariat and DPs should work towards making explicit the contents of the RSSH/HSS composition in their resource tracking. This implies that health expenditure tracking reflects relevant (and comparable) RSSH spending from the Global Fund and other partners. The mapping should develop links between the Global Fund and SHA categories to have a one-to-one relation. In practice, this is challenging, as category content in both systems is based on different taxonomies. In fact, RSSH interventions may overlap several SHA categories and classifications. The Global Fund can work in a number of ways toward updating frameworks for health expenditure tracking. These are outlined in the full report.	**Agree with the following caveat:** the TERG suggests Global Fund to focus on mapping its own RSSH expenditure onto SHA accounting framework for country and international comparability purposes. The TERG understands that such mapping could lead to loss of granularity. However, it could be used for external reporting/comparability purposes, while granularity of RSSH data could be retained for internal use by the Secretariat and Board.
Recommendation 2 (High Priority/Strategic): The Global Fund should work with DPs to ensure greater standardization of definition and categorization of HSS investments building on ongoing work with the Health Systems Strengthening Evaluation Collaborative (HSSEC), Total Official Support for Sustainable Development (TOSSD) and working groups on resource tracking and development finance statistics.	The report recommends and the TERG supports, if resources permit, that the Global Fund works with partners to achieve greater standardization of definition and categorization of HSS investments. Global Fund could join ongoing work with the Health Systems Strengthening Evaluation Collaborative (HSSEC), Total Official Support for Sustainable Development (TOSSD), and working groups on resource tracking and development finance statistics. However, the TERG thinks that it might be prudent to consider collaboration with WHO/OECD/EU that have worked on health accounting standard setting for the countries – SHA, which most likely needs updating to better reflect developments in the HSS field and RSSH/HSS relevant expenditure from national budgets, private and external sources.
Recommendation 3 (High Priority/Strategic): Given that existing reporting to the Board is based only on budgeted investments in RSSH	The TERG suggests SC and Board consider routine tracking of the RSSH expenditures reflected in the RSSH Modules that can be easily produced and at a

and that RSSH Contributory is not aligned with the way other DPs define HSS, a potentially more accurate, low-cost, and timely measure would be for the Secretariat to track investments using existing RSSH modules (both budget and expenditure). This can be complemented by a review of disease-specific modules by the Secretariat for purposes of detailed mapping to identify and propose approaches to increase cross-cutting effects and efficiencies.	low cost with more reliable and "objective" estimates. For the contributory part of RSSH investments, where some investments do bear HSS characteristics (with cross-cutting impact or without) a review of disease-specific modules by the Secretariat could be considered to identify and propose areas and approaches that help increase the cross-cutting effects of RSSH investments embedded within disease-specific modules.
Recommendations related to tracking of RSSH investments	
Recommendation 4 (High Priority/Operational): The Global Fund Secretariat should explore the feasibility of extending PUDR expenditure reporting to enable cross-tabulation of module, intervention, cost category and cost input by budget line item. Cross-tabulation would allow for the level of granularity in analysis based on strategic priorities such as disease specific vs cross-cutting.	**Recommendation 4** implies restructuring the Global Fund's financial management information system to produce better estimates for analyzing RSSH investments, which might be costly internally for Global Fund and could impose a significant additional burden on countries with poor quality data outputs arising from a lack of consistent Global HSS expenditure definition and classification standards. According to the report, countries cannot adequately track RSSH expenditure using global health accounting frameworks such as the System of Health Accounts (SHA). In TERG's opinion, before considering this recommendation, the SC and Board should consider several aspects (a) the costs vs. benefits afforded by the recommended changes to the Global Fund and countries; (b) how much such a decision would be aligned with the Paris Declaration and how it will help countries and DPs improve health expenditure tracking for HSS/RSSH; (c) how the quality of collected and reported expenditure data will improve in the environment that lacks clear definitions and classification conventions HSS investments and (d) how this information could help increase the value of Global Fund investments in RSSH under the new strategy implementation.
Recommendation 5 (High Priority/Operational): The resource tracking system of the Global Fund should be shared with country NHA teams to facilitate proper visibility of RSSH investments. Cooperation between the Global Fund, resource tracking teams at national level and other resource tracking associated organisations should be encouraged	As an interim solution, before achieving global alignment on RSSH/HSS definition, categorization, and accounting standards (suggested in recommendation 2), TERG recommends the secretariat develops an RSSH investment tracking guidance to be shared with country NHA teams to facilitate proper visibility of RSSH expenditures in the national health accounting process (this also links with recommendation 1 and

to ensure a better mix of modules/interventions/cost categories and cost inputs for RSSH tracking.	TERG's caveat). Cooperation between the Global Fund, resource-tracking teams at the national level, and other resource-tracking organizations could be encouraged to ensure a better mix of modules/interventions/cost categories and cost inputs for RSSH tracking.
Recommendations related to the magnitude and nature of Global Fund RSSH investments	
Recommendation 6 (High Priority/Operational): The Global Fund should continue to support further alignment through the existing country-led process for preparing funding requests (FRs) and should support and engage in national alignment frameworks led by the government. The FR preparation process should include assessment and dialogue on opportunities to manage Global Fund investments in RSSH that include budgets, use of program-based budgeting and/or integration with pooled donor funding mechanisms as relevant and appropriate to the country context.	**Recommendation 6** is formulated in general terms and seems theoretically logical and appropriate. However, it falls short of providing specificity and actionability of what exactly the Global Fund could do differently beyond using program-based budgeting (if a country uses such an approach in its Public Finance Management system for health and beyond health) and/or integration with pooled donor funding mechanisms, which is not practiced broadly within the development community and evidence for the recommendation arises only from one country out of 15 case study countries. TERG thinks both suggestions are valid, though limiting it to RSSH investments without holistically treating Global Fund grants could be misleading.
Recommendation 7 (Medium Priority/Strategic): Over time, the Global Fund should move towards use of national systems for reporting as countries' capacities in reporting increase and should (where appropriate) continue to strengthen such systems. RSSH grants should be implemented by the national structures that have a formal mandate to implement the health system interventions, but adequate consideration of community health systems needs to be built into the FR preparation process and grant implementation.	**Agree**
Recommendations related to operations of the current Global Fund business model	
Recommendation 8 (Medium Priority/Operational): The principal recipients (PRs) of the Global Fund should ensure that the data they provide to the NHA team in MOH is comprehensive, disaggregated and	**Agree**

submitted in a timely manner. The Global Fund should work with MOH and WHO to enable regular access to relevant disaggregated data from the NHA database to track investments in HSS. Given that accounting efforts are not produced every year and given the time lag, the Global Fund can direct investments to facilitate routine reporting to financial management systems (interoperable with Health Management Information Systems (HMIS)) which are accessible to the Health Accounts team.	

11. The TERG also notes the following:

- **A definition for cross-cutting investment in this mapping exercise** was provided to the consultants in the ToR to facilitate the conduct of this exercise. This **definition is significantly narrower compared to RSSH used by the Global Fund.** We emphasize again that the lower estimates of investments having a cross-cutting impact on health systems beyond a single disease should not be surprising nor seen as a negative finding.
- **Quantitative evidence indicates that the RSSH investments reported by the Global Fund are higher** than the figure presented in this mapping exercise, which potentially points to the fact that the real amount of investments with cross-cutting impact lies somewhere between the amount revealed by this mapping and RSSH investments reported to the Board, which on top of direct RSSH includes contributory RSSH component.
- **Externally, the Global Fund reports to OECD/DAC a smaller percentage of investments in RSSH than to the Board, which is comparable to the mapping estimates produced by consultants.** Global Fund Reporting to OECD/DAC is based on only disbursements of RSSH stand-alone grants, so RSSH modules within disease-specific grants are not included in the figures. Assuming reported categories allow Global Fund to better compare HSS investments with others (DPs and government).
- **Prioritization of effective and efficient cross-cutting RSSH Investments** are key to holistic health systems strengthening and the Global Fund business model and its attainment of the ambitious 2023 – 2028 strategic goal and the supporting objectives **"***Resilient and sustainable systems for health are the essential foundation to fighting infectious diseases, whether ending HIV, TB and malaria as epidemics, fighting new pandemics like COVID-19, or preparing and responding to future health threats. These systems are underpinning all our work, and it is only by continuing to invest in systems for health that COVID-19 can be defeated and its knock-on effects on HIV, TB and malaria halted and reversed".* The Impact of COVID-19 on HIV, TB, AND MALARIA Services and systems for health 2019 - 2020, page 10.

Annexes

The following items can be found in Annex:

- **Annex 1:** Relevant Past Board Decisions
- **Annex 2:** Relevant Past Documents & Reference Materials
- **Annex 3:** List of Abbreviations
- **Annex 4:** Terminology, Methods, and mapping Framework

Annex 1– Relevant Past Board Decisions

Relevant past Decision Point	Summary and Impact
GF/EB01-2021/DP03: Approval of Strategy Framework, (22 July 2021)	Board Approval of the Global Fund 2023-2028 Strategy Framework.
GF/B34/DP04: Strategic Framework 2017 - 2022 (November 2015)	Board Approval of the Global Fund Strategy 2017-2022: Investing to End Epidemics
GF/B35/DP04: The Global Fund Strategy 2017 - 2022: Investing to End Epidemics (27 April 2016)	Based on the recommendation of the Strategy, Investment and Impact Committee, the Board approves the Global Fund Strategy 2017 - 2022: Investing to End Epidemics, as presented in Annex 1 to GF/B35/02- Revision 1.
GF/B36/04 – Revision 2: **Catalytic Investments for the 2017-2019 Allocation Period, (16-17 November 2016)**	1. The Board notes that up to USD 800 million is available for catalytic investments, subject to the amount of sources of funds for allocation, in accordance with the allocation methodology approved in April 2016 under decision point GF/B35/DP10 and set forth in Annex 1 to GF/B35/05 - Revision 1. 2. Based on the recommendation of the Strategy Committee (the "SC") and the amount of sources of funds for allocation recommended by the Audit and Finance Committee (the "AFC") in GF/B36/03, the Board decides USD 800 million will be available for catalytic investments over the 2017 - 2019 allocation period for the priorities and associated costs presented in Table 1 of GF/B36/04 - Revision 2, of which no portion will be moved to further balance scale up, impact and paced reductions through country allocations.
2021 TRP RSSH Advisory Paper: Technical Review Panel Advisory Paper on Resilient and Sustainable Systems for Health, (October 2021)	This paper is intended as a TRP advisory on how Global Fund RSSH investments can be optimized to strengthen health systems in support of the implementation of HIV, TB, and malaria programs, while also strengthening pandemic preparedness and response. It is based on TRP observations from its review of Funding Requests for the 2020-2022 allocation cycle as documented in the TRP "Lessons Learned"; previous analysis of RSSH investments in the 2017-2019 allocation period; and the professional experience of TRP members with the impacts of the Coronavirus disease (COVID-19) pandemic on HIV, TB and malaria programs and health systems.

Annex 2 – Relevant Past Documents & Reference Materials

The Global Fund Strategy 2017-2022: Investing to End Epidemics
The Global Fund Strategy 2023 – 2028: Fighting Pandemics and Building a Healthier and More Equitable World (December 2021)
Executive Summary of the Global Fund Strategy 2023 – 2028: Fighting Pandemics and Building a Healthier and More Equitable World - Global Fund Strategy (2023-2028)
Advisory Paper on Resilient and Sustainable Systems for Health Technical Review Panel October 2021

Technical Review Panel Advisory Paper on Resilient and Sustainable Systems for Health, (October 2021)

Focus on building Resilient and Sustainable Systems of Health

Technical Evaluation Reference Group: Thematic Review on Sustainability, Transition and Co-financing (STC) Policy, (January 2020).

The Global Fund Sustainability, Transition and Co-financing Policy, GF/B35/04: The Global Fund (2016) 35th Board Meeting: The Global Fund Sustainability, Transition, and Co-financing Policy

GF/B35/04 – Revision 1: The Global Fund Sustainability, Transition and Co-financing Policy

The Global Fund, 'The Impact of COVID-19 on HIV, TB and Malaria Services and Systems for Health: a snapshot from 502 health facilities across Africa and Asia' (The Global Fund COVID-19 Disruption report)" (2021): https://www.theglobalfund.org/media/10776/covid-19_2020-disruption-impact_report_en.pdf.

Annex 3 – List of Abbreviations

Acronyms	
AIDS	Acquired Immune Deficiency Syndrome
COVID-19	Coronavirus disease 2019
DP	Development Partners
EU	European Union
FR	Funding Request
GAC	Grant Approval Committee
GF	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GMD	Grant Management Division
HMIS	Health Management Information Systems
HIV	Human Immunodeficiency Virus

HRH	Human Resources for Health
HSS	Health Systems Strengthening
HSSEC	Health Systems Strengthening Evaluation Collaborative
NFM	New Funding Model
NHA	National Health Accounts
NSP	National Strategic Plans
OECD	Organization for Economic Co-operation and Development
OIG	Office of the Inspector General
PR	Principal Recipient
PUDR	Progress Update Disbursement Request
RSSH	Resilient and Sustainable Systems for Health
SC	Strategy Committee
SHA	System of Health Accounts
TA	Technical Assistance
TAP	Technical Advice and Partnerships
TB	Tuberculosis
TERG	Technical Evaluation Reference Group
TOSSD	Total Official Support for Sustainable Development
ToR	Terms of Reference
WHO	World Health Organization

Annex 4: Terminology, Methods, and Mapping Framework

To avoid any misunderstanding from different terminology used in the Global Health field that denotes investments in health system the report differentiates following to aid understanding of the findings and recommendations.

Term	Definition
RSSH investments	Term used mostly to describe (planned i.e., budgeted) funding and (expected) spending through RSSH modules. However, given that RSSH investments are the subject of this mapping, the term is used somewhat flexibly.
RSSH funding	RSSH modules in the Grant Approvals Committee (GAC) budget.
RSSH spending	RSSH modules in the expenditure report provided for this mapping study.
RSSH Direct	This term is taken from the Secretariat methodology for calculating direct RSSH investments that is equivalent to RSSH Modules in the GAC budget.
RSSH Contributory	This term is taken from the Secretariat methodology for calculating RSSH contributory investments based on applying the methodology to non-RSSH modules in the GAC budget.
RSSH modules	The specific RSSH modules as defined in the Global Fund modular framework.
Cross-cutting investments	Used in this report to describe 'system-level investments,' as set out in the Terms of Reference (ToR): those that have cross-cutting benefits beyond a single disease, strengthen relationships between building blocks and promote permanent system impact beyond a disease programme.
Health system strengthening (HSS)	HSS is used to describe the investments into health systems which the Global Fund, other DPs and governments are making, which broadly align with World Health Organization (WHO) definition and building blocks. There is no standard definition of HSS (See Annex 1 of main report).

This study developed and applied methodologies to answer the various mapping questions under each of the three objectives. These methodologies were reviewed and revised together with Technical Evaluation Reference Group (TERG) and WHO focal points and signed off at inception. Below we summarise the main methodologies that have been applied for this RSSH mapping by mapping objective.

Objective 1: Critically evaluate the RSSH tracking methods/tools and expenditure data categorisation used by the Global Fund Secretariat and what exactly differentiates investments in RSSH from other Global Fund areas of investment.

The main methodology used for this objective was a comparative analysis of the RSSH tracking methods/tools and expenditure data categorisation used by the Global Fund Secretariat. The team reviewed in detail the method and tools used, identifying the key strengths and weaknesses of these approaches, as well as interviewing stakeholders in other DP organisations to map out similarities and differences in approaches used as well as key challenges faced.

Objective 2: Estimate the magnitude of the Global Fund's investment into the health system (1) globally and (2) at country level.

The method used to address the questions under Objective 2 was to classify and categorise data extracted from a representative sample of global and country-level data sets against precise definitional categories of HSS. The starting point for this approach was a definition of HSS that was jointly agreed between the Global Fund TERG, WHO and the consultant team at the inception period of this

assignment. This definition (see above) required the team to focus on mapping those investments that have been specifically identified as designed to deliver '*cross-cutting*' benefits beyond a single disease.

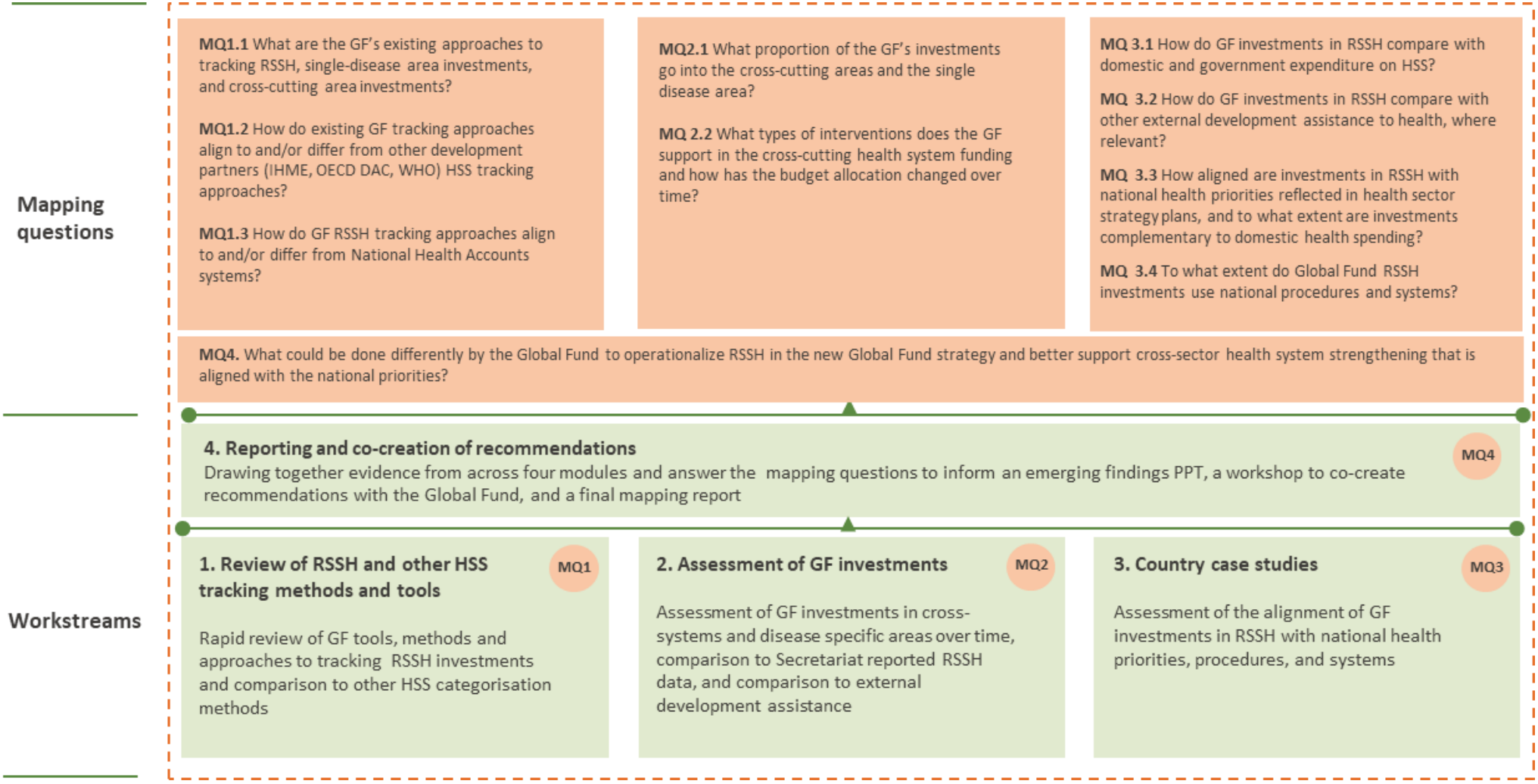
To generate the estimates of the magnitude of the Global Fund investment at the *global level*, the mapping exercise was undertaken through a stepwise process as outlined below. The main data source for the global analysis was the GAC budget data. The analysis was carried out over three phases. The first focused on unpacking cross-cutting and disease specific investments, the second focused on classifying the cross-cutting investment into 'system strengthening' and 'system support' investments, and the final phase looked at cross-cutting investments in terms of expenditure.

To generate estimates of the magnitude of the Global Fund investment at the *country level*, two ratios were calculated as requested in the ToR for this assignment, namely (1) Global Fund expenditure on RSSH as a proportion of government domestic HSS expenditure and (2) Global Fund expenditure on RSSH as a proportion of total externally funded HSS expenditure. Based on findings from the global-level analysis, the mapping team developed the methodology for calculating these ratios with full consideration of the comparability issues and data limitations. This methodology is based on clear definitions of the numerator and denominator to derive these ratios. Ratios were calculated (where data was available) for the 15 country case studies identified under Objective 3 (see below).

Objective 3: Understand how Global Fund RSSH investments align with domestic and government investments and national health priorities.

The main method used to address this objective was the undertaking of country case study analysis. We carried out in-depth analyses of a purposively selected sample of 15 country case studies and analysed both secondary data (document review and analysis on quantitative data) and qualitative data (collected through undertaking of a large number of Key Informant Interviews (KIIs) within the case study countries). Data and information collected were entered into a matrix database for each country.

A rubric scoring system was used to assess the level of alignment of RSSH investments and use of national systems. A strength of evidence estimate was developed in our synthesis of findings across countries; this included three dimensions the assessing strength of evidence o alignment (i) within countries, (ii) across countries and (iii) across the quantitative and qualitative data.

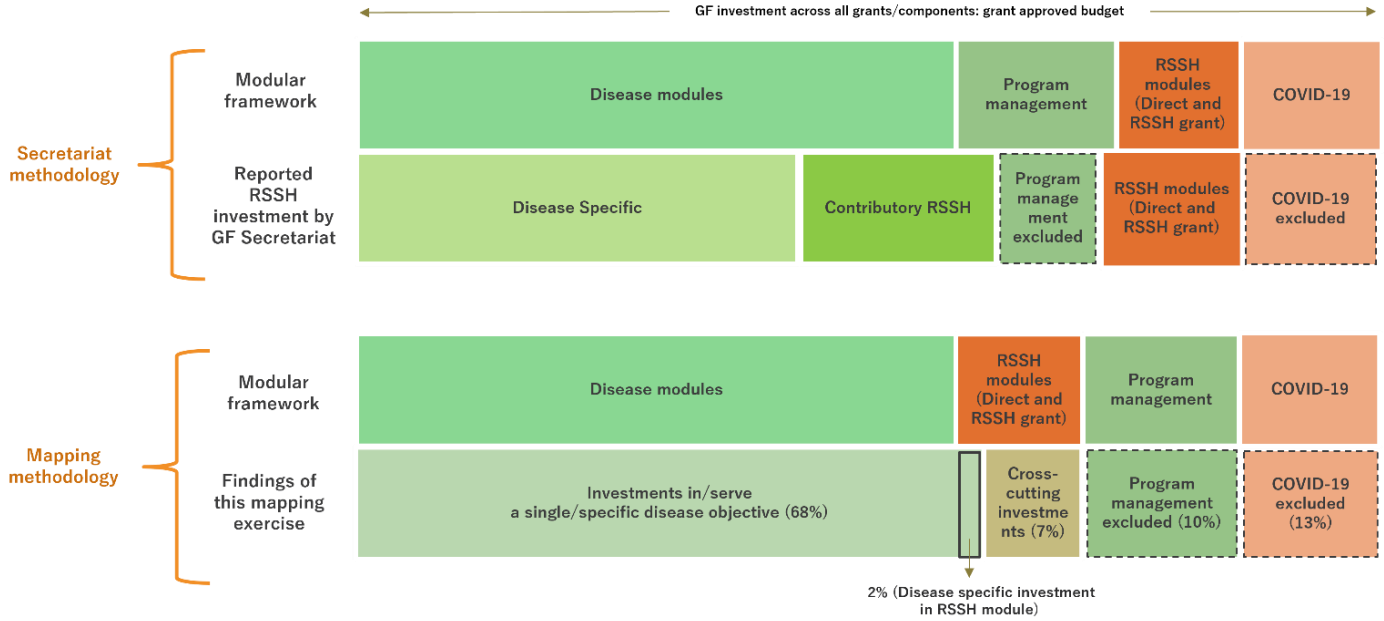

Mapping questions
MQ1.1 What are the GF's existing approaches to tracking RSSH, single-disease area investments, and cross-cutting area investments?
MQ1.2 How do existing GF tracking approaches align to and/or differ from other development partners (IHME, OECD DAC, WHO) HSS tracking approaches?
MQ1.3 How do GF RSSH tracking approaches align to and/or differ from National Health Accounts systems?
MQ2.1 What proportion of the GF's investments go into the cross-cutting areas and the single disease area?
MQ 2.2 What types of interventions does the GF support in the cross-cutting health system funding and how has the budget allocation changed over time?
MQ 3.1 How do GF investments in RSSH compare with domestic and government expenditure on HSS?
MQ 3.2 How do GF investments in RSSH compare with other external development assistance to health, where relevant?
MQ 3.3 How aligned are investments in RSSH with national health priorities reflected in health sector strategy plans, and to what extent are investments complementary to domestic health spending?
MQ 3.4 To what extent do Global Fund RSSH investments use national procedures and systems?
MQ4. What could be done differently by the Global Fund to operationalize RSSH in the new Global Fund strategy and better support cross-sector health system strengthening that is aligned with the national priorities?
Workstreams
4. Reporting and co-creation of recommendations
Drawing together evidence from across four modules and answer the mapping questions to inform an emerging findings PPT, a workshop to co-create recommendations with the Global Fund, and a final mapping report
MQ4
1. Review of RSSH and other HSS tracking methods and tools
MQ1
Rapid review of GF tools, methods and approaches to tracking RSSH investments and comparison to other HSS categorisation methods
2. Assessment of GF investments
MQ2
Assessment of GF investments in cross-systems and disease specific areas over time, comparison to Secretariat reported RSSH data, and comparison to external development assistance
3. Country case studies
MQ3
Assessment of the alignment of GF investments in RSSH with national health priorities, procedures, and systems

Box 1. Comparison of secretariat RSSH methodology and methodology used for this study.

The figure below shows results of this mapping study alongside the results of the Secretariat methodology for tracking investments in RSSH. They are both presented against the budget categories of the modular framework.

The results from the mapping study and Secretariat methodology are not directly comparable as they use different methodologies, but both can be compared against the modular framework.

Figure 1: Visual comparison between Secretariat methodology for tracking HSS and methodology used for this study (not to scale)



The top two rows show the Secretariat methodology for reporting RSSH which aggregates:

(1) Direct RSSH which is all RSSH modules in RSSH only and disease specific grants. It includes programme management modules in RSSH only grants and excludes COVID-19 modules.

(2) Contributory RSSH which includes disease specific modules where the investment is primarily for disease specific outcomes but are assumed to also have health system benefits. This includes one of the interventions under the programme management modules in disease specific grants and excludes COVID-19 modules.

The bottom two rows show the results of this mapping study which suggests 1) A large proportion of investments made through RSSH modules are cross-cutting and 2) Some of the investments made through RSSH modules are disease specific.

The study methodology excludes investments in programme management and COVID-19 modules.

Secretariat Management Response

Mapping Health Systems Strengthening (HSS) Component of the Resilient and Sustainable Systems for Health (RSSH) Investments

Introduction

The Technical Evaluation Reference Group (TERG) is a critical component of the Global Partnership, providing independent evaluations of the Global Fund's business model, investments, and impact to the Global Fund Board through its Strategy Committee. The Global Fund values transparency and publishes TERG reports according to the TERG Documents Procedure approved by the Strategy Committee.

The Strategy Committee (SC) at its 17th Meeting requested the TERG to commission a country-level mapping of Resilient & Sustainable Systems for Health (RSSH) investments, with a particular emphasis on the health system strengthening investments, to investigate how these are aligned with country priorities and national strategic plans and how funding in this area could be better operationalized in the new strategy period (2023-2028).

The review was focused on 1) evaluating RSSH tracking methods/tools and expenditure data categorization used by the Secretariat, 2) estimating the magnitude of Global Fund investments in health systems globally and at country level and 3) understanding how RSSH investments align to domestic and government investments and national health priorities.

The mapping exercise reviewed the RSSH investment tracking methodology that was presented and endorsed by the SC at its 8th Meeting in October 2018. At its 9th Meeting in

March 2019, the SC was presented with the RSSH roadmap which noted that the RSSH Roadmap *"Considers 'direct' and 'contributory' RSSH investments as defined through the agreed investment tracking methodology, and how these investments relate in a synergistic manner to disease-focused investment*", and a further update was provided in March 2021. At the pre-Board retreat in May 2022, the Secretariat reiterated that RSSH investments include direct and contributory investments that build systems to accelerate achieving HIV, TB and malaria goals.

The Secretariat acknowledges and appreciates the work of the TERG and the evaluators in undertaking this mapping exercise. However, the Secretariat is not able to fully endorse all key findings, high-level conclusions, and recommendations from the report and the TERG's position paper. Main concerns include the different definitions used to measure cross-cutting HSS interventions and recommendations on contributory RSSH, expenditure tracking and resource tracking exercises.

Additionally, the Secretariat feels that the report contains several serious limitations, particularly with respect to how some of the data analysis is presented. While the report provides some useful analysis, insights, and recommendations, several of the recommendations will be difficult to action due to a lack of a cost-benefit analysis and/or mandate of the Global Fund.

Areas of agreement

The Secretariat partially or fully agrees with several of the recommendations. The Secretariat is in partial agreement with **recommendation 1**[1]. Development and technical partners should work to align individual institutional expenditure tracking and systems of health accounts (SHA). The Secretariat does not lead technical guidance and operational support to implementing systems of National Health Accounts (NHA) but can support these efforts at the country-level.

The Secretariat (via its Principal Recipients) already shares budget data with country level NHA teams and will work to further systematize this, for example through better mapping, resources permitting. Budgeting categories are also being updated for grant cycle 7 (GC7) which will better respond to NHA data requirements.

Regarding the specific recommended actions to update frameworks for health expenditure tracking (standardized mapping, integration of Global Fund data, developing IT solutions and operational guidelines for standardized resource tracking across development partners, as noted in Box 7 of the report), the Secretariat sees these as partner and government responsibilities, and not the responsibility or the remit of the Global Fund. That noted, the

[1] Recommendation 1: The Global Fund (GF) Secretariat and development partners (DPs) should work towards making explicit the contents of the RSSH/HSS composition in their resource tracking. This implies that health expenditure tracking frameworks reflect relevant RSSH spending from the GF and other partners. The mapping should match both the GF and the system of health accounts (SHA) categories to have a one-to-one relation. In practice this is challenging, as category content in both systems is based on different taxonomies. In fact, RSSH interventions may overlap several SHA categories and classifications. The GF can work in a number of ways towards updating frameworks for health expenditure tracking. These are outlined in the full report (Box 7). (High Priority/Strategic)

Secretariat will continue to participate in resource alignment work, for example with a network of global partners who work on resource tracking, including around HIV together with PEPFAR and UNAIDs. The Global Fund can support this work at the country level through grants if countries prioritize this in their funding requests. For the 2020-2022 allocation period, funding has been provided to WHO to support countries to implement NHAs through the Sustainability, Transition and Efficiency Strategic Initiative which will end in December 2023.

The Secretariat mostly agrees with **recommendation 2**[2]. While the Global Fund can collaborate on strengthening greater standardization and categorization with partners, as resources permit, it is not within its mandate to lead this work. Instead, partners are the entities that provide normative and technical guidance and are best placed to convene and lead these discussions. These include the Health Systems Strengthening Evaluation Collaborative, Total Official Support for Sustainable Development, and the WHO, OECD and EU, as suggested by the TERG. The Secretariat recognizes the value of disease programs and their important contributions to health systems, and judges that removing these investments by using a narrower definition of HSS is inappropriate and unnecessarily limiting.

The Secretariat mostly agrees with **recommendation 5**[3]. The Secretariat's tracking methodology can be shared with NHA teams at the country level, and the Secretariat will continue to share budget and expenditure data at the aggregate level. Given the need for more granular data, the Secretariat will continue to encourage Principal and Sub-recipients to share more disaggregated grant budget data as required.

Technical agencies should continue to take the lead in bringing together various development partners (DPs), including the Global Fund, to update and develop tracking methodologies, guidelines and tools as this is not within the Secretariat's remit. For example, the Secretariat has taken part in discussions convened by the Bill and Melinda Gates Foundation, together with PEPFAR and UNAIDs, to harmonize data to facilitate resource tracking activities, including for National AIDS Spending Assessments, NHA and related initiatives.

The Secretariat agrees with **recommendation 6**[4]. Efforts are currently being made to support innovative ways to contribute to innovative financing mechanisms, including through program based and results-based budgeting and pooled donor mechanisms. The

[2] The GF should work together with DPs to ensure greater standardisation of definition and categorisation of HSS building on ongoing work with the Health Systems Strengthening Evaluation Collaborative (HSSEC), Total Official Support for Sustainable Development (TOSSD) and working groups on resource tracking and development finance statistics. (High Priority/Strategic)

[3] The resource tracking system of the GF should be shared with country NHA teams to facilitate proper visibility of RSSH investments. Cooperation between the GF, resource tracking teams at national level and other resource tracking associated organisations should be encouraged in order to ensure a better mix of modules/interventions/cost categories and cost inputs for RSSH tracking (High Priority/Operational)

[4] The GF should continue to support alignment through the existing country-led process for preparing funding requests (FRs) and should support and engage in national alignment frameworks led by the government. The FR preparation process should include assessment and dialogue on opportunities to manage GF investments in RSSH that include budgets, use of programme-based budgeting and/or integration with pooled donor funding mechanisms as relevant and appropriate to the country context. (High Priority/Operational)

Secretariat will continue to support alignment of Funding Requests (FRs) and resulting programming with country-led processes and national policies and frameworks together with technical partners. For example, it has developed the RSSH annex to the FR to facilitate assessment, prioritization and financial gap analyses for potential RSSH investments.

The Secretariat agrees with **recommendation 7**[5] to continue to move towards supporting and using national reporting systems and appropriate national structures that have a formal mandate to implement health systems interventions, in cooperation with the country coordinating mechanisms (CCMs) who select Principal Recipients. The Global Fund is also putting considerable efforts towards strengthening community systems including community health worker programs, as well as supporting community-based and community-led organizations and ensuring their active participation in the funding request and grant implementation process.

The Secretariat fully agrees with **recommendation 8**[6] and will continue to encourage Principal Recipients to provide timely data on all Global Fund investments to NHA teams in a comprehensive, disaggregated and timely manner. It is also possible for countries to prioritize funding for financial management systems through their RSSH investments.

Observations on other recommendations

The Secretariat disagrees or partially disagrees with two of the recommendations.

Regarding **recommendation 3**[7], the Secretariat is not in agreement with removing reporting on contributory RSSH to the Board and the Strategy Committee. The Secretariat notes that the RSSH tracking methodology was developed together with WHO, and this was reviewed and accepted by the Global Fund Strategy Committee and Board in 2018. Since then, the Secretariat has consistently reported on both direct and contributory RSSH to the Board and the Strategy Committee, as they have requested to know how much the Global Fund contributes directly to RSSH, and how much the disease investments likely contribute to RSSH. Removing the Contributory RSSH from the RSSH investment estimate methodology can lead to the loss of the important opportunities to improve the systems strengthening

[5] Over time, the GF should move towards use of national systems for reporting as countries' capacities in reporting increase and should (where appropriate) continue to strengthen such systems. RSSH grants should be implemented by the national structures that have a formal mandate to implement the health system interventions, but adequate consideration of community health systems needs to be built into the FR preparation process and grant implementation. (Medium Priority/Strategic)

[6] The principal recipients (PRs) of the GF should ensure that the data they provide to the NHA team in MOH is comprehensive, disaggregated and submitted in a timely manner. The GF should work with MOH and WHO to enable regular access to relevant disaggregated data from the NHA database to track investments in HSS. Given that accounting efforts are not produced every year and given the time lag, the GF can direct investments to facilitate routine reporting to financial management systems (interoperable with Health Management Information Systems (HMIS)) which are accessible to the Health Accounts team.
(Medium Priority/Operational)

[7] Given that existing reporting to the Board is based only on planned investments in RSSH and that RSSH Contributory is not aligned with the way that other DPs defined HSS, a potentially more accurate, low-cost and timely measure of GF investments in RSSH (budget and expenditure) is to track investments through the existing RSSH modules. This can be complemented by a review of disease specific modules by the Secretariat for purposes of detailed mapping so as to identify and propose approaches to increase cross-cutting effects and efficiencies. (High Priority/Strategic)

contributions of the disease programs which contribute to the overall strengthening of in-country health systems.

The Secretariat accepts the recommendation to continue to track direct RSSH investments using the RSSH modules. The Secretariat also accepts the recommendation to review the contributory tracking methodology to ensure that the components selected (modules/interventions/cost categories/cost inputs) can better contribute to RSSH, and will consider doing a review of these components in a sample of countries to identify areas where improvements can be made to the cross-cutting effects of RSSH investments embedded within disease-specific modules.

The Secretariat disagrees with **recommendation 4**[8]. While it agrees in principle that it would be important to be able to report on expenditure in more granular detail, in practice this involves restructuring the Secretariat's financial management information system which has significant cost implications and changes for the next grant cycle (GC7) have already been implemented. In the short- to medium-term, the Secretariat has concluded the costs outweigh the benefits given that the changes will not add substantive value to the design and operationalization of the grants, and the current DP environment currently lacks clear definitions and classification conventions. The Secretariat would like to see these systems strengthened - for example by countries prioritizing their allocated funding towards this, complemented by increased and strengthened technical partner support - to facilitate countries to better track expenditure for HSS/RSSH. In the meantime, the Secretariat commits to having discussions during GC7 on how to improve expenditure reporting for Grant Cycle 8 (GC8), including for RSSH.

Conclusions

The Secretariat appreciates the work of the TERG and evaluation consultants in undertaking a complex review and partially or fully agrees with several of the recommendations, including those related to improving the Secretariat's resource tracking methodology, the need to better align to global and national resource tracking methodologies, working with technical agencies and development partners to harmonize definitions and classification systems and support the development and use of National Health Accounts systems as resources permit.

The Secretariat disagrees with two of the recommendations, highlighting four main issues:

1. *Different definitions of HSS & RSSH.* The mapping exercise used a narrow HSS definition to review RSSH. This led to lower estimates of cross-cutting investments than the Global Fund's estimates and the Secretariat disagrees with the report's conclusion that only 7% of the Global Fund investments are cross-cutting HSS investments. This finding is misleading as it is based on a very narrow definition of "cross-cutting HSS"

[8] The Global Fund Secretariat should explore the feasibility of extending performance update and disbursement request (PUDR) expenditure reporting to enable cross-tabulation of module, intervention, cost category and cost input by budget line item. Cross-tabulation would allow for the level of granularity in analysis based on strategic priorities such as disease specific vs cross-cutting (High Priority/Operational)

investments and ignores counter examples that have clear cross-cutting effects (e.g., community health workers, M&E functions, and polyvalent diagnostics for TB, Covid19 and other diseases).

2. *Removal of contributory RSSH.* The Secretariat was requested by Strategy Committee and the Board to report on both direct and contributory RSSH when estimating how much is being budgeted to support cross-cutting interventions that directly aim to strengthen the health system, and how much of the disease investments are likely contributing to strengthening the health system. Also, making HIV/TB/malaria investments contribute to systems strengthening is a unique potentially significant contribution of the Global Fund. Therefore, the Secretariat disagrees with removing contributory RSSH from the tracking of RSSH investments. The Secretariat agrees that it's useful to review the contributory RSSH investments with a view to strengthen the impact of these investments.

3. *Expenditure tracking*. While the Secretariat agrees that it would be useful to be able to report on expenditures using more granular data, this would require substantive changes to the Secretariat's financial management systems, and it considers that currently the costs outweigh the benefits. However, the Secretariat will continue to discuss how to improve its expenditure tracking in preparation for the next cycle (GC8), including for RSSH.

4. *Strengthening Systems of National Health Accounts (NHAs).* The Secretariat does not have the mandate nor the resources to convene partners at the global level to drive the resource tracking agenda and will continue to rely on technical and development partners to drive this initiative. However, the Secretariat is fully supportive of strengthening the use of NHAs and can support this by continuing to encourage PRs to provide timely data to NHA processes at country-level, and through country grants (for example by strengthening public financial management systems).

Overall, the Secretariat partially endorses the overall findings, conclusions, and recommendations. The Secretariat endorses the report's publication, along with the TERG Position Paper and the Secretariat management response.

Summary of Recommendations

Recommendation	Level of Agreement	Level of Control
1. The Global Fund (GF) Secretariat and development partners (DPs) should work towards making explicit the contents of the RSSH/HSS composition in their resource tracking. This implies that health expenditure tracking frameworks reflect relevant RSSH spending from the GF and other partners. The mapping should match both the GF and the system of health accounts (SHA) categories to have a one-to-one relation. In practice this is challenging, as category content in both systems is based on different taxonomies. In fact, RSSH interventions may overlap several SHA categories and classifications. The GF can work in a number of ways towards updating frameworks for health expenditure tracking. These are outlined in the full report (Box 7). (High Priority/Strategic)	Partially agree	Low
2. The GF should work together with DPs to ensure greater standardisation of definition and categorisation of HSS building on ongoing work with the Health Systems Strengthening Evaluation Collaborative (HSSEC), Total Official Support for Sustainable Development (TOSSD) and working groups on resource tracking and development finance statistics. (High Priority/Strategic)	Mostly agree	Medium
3. Given that existing reporting to the Board is based only on planned investments in RSSH and that RSSH Contributory is not aligned with the way that other DPs defined HSS, a potentially more accurate, low-cost and timely measure of GF investments in RSSH (budget and expenditure) is to track investments through the existing RSSH modules. This can be complemented by a review of disease specific modules by the Secretariat for purposes of detailed mapping so as to identify and propose approaches to increase cross-cutting effects and efficiencies. (High Priority/Strategic)	Low agreement	Significant

4. The Global Fund Secretariat should explore the feasibility of extending performance update and disbursement request (PUDR) expenditure reporting to enable cross-tabulation of module, intervention, cost category and cost input by budget line item. Cross-tabulation would allow for the level of granularity in analysis based on strategic priorities such as disease specific vs cross-cutting (High Priority/Operational)	Low agreement	Full
5. The resource tracking system of the GF should be shared with country NHA teams to facilitate proper visibility of RSSH investments. Cooperation between the GF, resource tracking teams at national level and other resource tracking associated organisations should be encouraged in order to ensure a better mix of modules/interventions/cost categories and cost inputs for RSSH tracking (High Priority/Operational)	Mostly agree	Significant
6. The GF should continue to support alignment through the existing country-led process for preparing funding requests (FRs) and should support and engage in national alignment frameworks led by the government. The FR preparation process should include assessment and dialogue on opportunities to manage GF investments in RSSH that include budgets, use of programme-based budgeting and/or integration with pooled donor funding mechanisms as relevant and appropriate to the country context. (High Priority/Operational)	Fully agree	Significant
7. Over time, the GF should move towards use of national systems for reporting as countries' capacities in reporting increase and should (where appropriate) continue to strengthen such systems. RSSH grants should be implemented by the national structures that have a formal mandate to implement the health system interventions, but adequate consideration of community health systems needs to be built into the FR preparation process and grant implementation. (Medium Priority/Strategic)	Fully agree	Significant

8. The principal recipients (PRs) of the GF should ensure that the data they provide to the NHA team in MOH is comprehensive, disaggregated and submitted in a timely manner. The GF should work with MOH and WHO to enable regular access to relevant disaggregated data from the NHA database to track investments in HSS. Given that accounting efforts are not produced every year and given the time lag, the GF can direct investments to facilitate routine reporting to financial management systems (interoperable with Health Management Information Systems (HMIS)) which are accessible to the Health Accounts team. (Medium Priority/Operational)	Fully agree	Significant

Final Report

Global Fund on Mapping Health Systems Strengthening (HSS) Component of the Resilient and Sustainable Systems for Health (RSSH) Investments

Date: 5 June 2023

Disclaimer

The views expressed in this report are those of the mapping team. They do not represent those of the Global Fund or of any of the individuals and organisations referred to in this report.

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Contents

Figures iv

Tables iv

Acronyms and abbreviations v

Executive summary 8

- Objectives 8
- Definitions 8
- Methods 9
- Conclusions 11
- Recommendations 15

Main Technical Report 18

Background 18

- Definitions 19

Methods 21

- Limitations and assumptions 25

Findings 27

- Objective 1: Findings 27
- Objective 2: Findings 31
- Objective 3: Findings 37

Conclusions 44

Recommendations 48

Annex 1: Objective 1 detailed methodology note 50

Annex 2: Objective 1 findings 55

Annex 3: Objective 2 global analysis detailed methodology note 63

Annex 4: Detailed review of databases for tracking investments at country level 73

Annex 5: Mapping of modules and interventions by SHA 2011 coding 93

Annex 6: Objective 2 (country-level analysis) detailed methodology note with illustrative analysis in Eswatini 97

Annex 7: Objective 3 detailed methodology note 111

Annex 8: Bibliography 118

Figures

Figure 1: Visual comparison between Secretariat methodology for tracking HSS and methodology used for this study (not to scale) 17
Figure 2: Results of the mapping exercise 32
Figure 3: Cross-cutting investments disaggregated by RSSH module and allocation cycle in 38 countries . 33
Figure 4: Cross-cutting investment as a proportion of total grant for the grant components in NFM 2 and NFM 3 34
Figure 5: Cross-cutting investment in each grant component as a percentage of total cross-cutting investment for NFM 2 and NFM 3 34
Figure 6: 2S categorisation for 3 RSSH modules in country case studies 35
Figure 7: Total planned investment in the GAC budget and actual expenditure excluding COVID-19 and programme management for NFM 2 (total investment in all countries in NFM 2) 35
Figure 8: Types of RSSH investments 53
Figure 9: Comparison of GF Secretariat, TRP, and PCE approaches; and estimates of RSSH 57
Figure 10 Alignment of RSSH modules with WHO building blocks 60
Figure 11: Overview of methodology 65
Figure 12: Country Sample 111

Tables

Table 1: Definitions of key terms used in this report 9
Table 2: Limitations and mitigation of limitations 10
Table 3: Definitions of key terms used in this report 19
Table 4: Classification framework 23
Table 5: Summary of main limitations and mitigation actions for this study 26
Table 6: Distribution of Global Fund investment across investment areas in NFM 2 and NFM 3 in 38 countries (80% of investments) 31
Table 7: Ratios resulting from proposed mapping study indicators (3.1 and 3.2) 36
Table 8: Strength of Evidence explanation 38
Table 9: Overview of budgeting and financing mechanisms 39
Table 10: WS1 document review and key stakeholder interviews 50
Table 11: Working definitions for the various DPs in HSS 51
Table 12: Example comparison of development partner approach to categorising and tracking investments in health systems 62
Table 13: Parameters used to determine system support or system strengthening 64
Table 14: Global-level analysis countries 67
Table 15: Data sources considered for WS2 analysis 68
Table 16: Examples of activities reviewed and categorised in Objective 2 global analysis 70
Table 17: Domestic Health Expenditure (DOM) as % of Current Health Expenditure (CHE) 80
Table 18: External Health Expenditure (EXT) as % of Current Health Expenditure (CHE) 81
Table 19: OECD/DAC investments on HSS ($ million) 85
Table 20: GF investments on HSS ($ million) 91
Table 21: MFH modules mapped to SHA2011 by intervention component 94
Table 22: Indicators generated with NHA to support country analysis 97
Table 23: Ratios resulting of the indicators proposed 105
Table 24: Characteristics of the 15 case studies countries 112
Table 25: Rubric scoring criteria for alignment 113
Table 26: Rubric scoring criteria for integration 114
Table 27: Strength of evidence explanation 115

Acronyms and abbreviations

ARV	Antiretroviral
CCM	Country Coordination Mechanism
CHE	Country Health Expenditure
CHW	Community Health Worker
CRS	Creditor Reporting System
DAC	Development Assistance Committee (of OECD)
DAH	Development Assistance for Health
DFH	Domestic Financing for Health
DP	Development Partner
EECA	Eastern European and Central Asia
FCDO	Foreign, Commonwealth & Development Office
FP	Factor of Provision
FPM	Fund Portfolio Manager
FR	Funding Request
GAB	Grant Approved Budget
GAC	Grant Approvals Committee
Gavi	Gavi, the Vaccine Alliance
GDP	Gross Domestic Product
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GFF	Global Financing Facility for Women, Children and Adolescents
GFS	Government Financial Statistics
GHED	Global Health Expenditure Database
HANSA	Health and Nutrition Services Access
HAPT	Health Accounts Production Tool
HMIS	Health Management Information Systems
HRH	Human Resources for Health
HRTT	Health Resource Tracking Tool
HSS	Health Systems Strengthening
HSSEC	Health Systems Strengthening Evaluation Collaborative
HSP	Health Sector Plans
IBBS	Integrated Biological and Behavioural Surveillance
IEC	Information, Education and Communication
J2SR	Journey to Self-Reliance
KII	Key Informant Interview
LFA	Local Funding Agent
LI	Low-Income

LLIN	Long-Lasting Insecticidal Net
LMI	Lower-Middle Income
M&E	Monitoring and Evaluation
MDR	Multidrug Resistant
MOF	Ministry of Finance
MOH	Ministry of Health
MQ	Mapping Question
MSM	Men who have Sex with Men
MTSS	Medium-Term Sector Strategy
NCA	North Central Asia
NERCHA	National Emergency Response Council on HIV and AIDS
NFM	New Funding Model
NGO	Non-Governmental Organisation
NHA	National Health Accounts
NPC	National Planning Commission
NSP	National Strategic Plan
OECD	Organisation for Economic Co-operation and Development
OIG	Office of the Inspector General
OOP	Out of Pocket
PBB	Programme-Based Budgeting
PCE	Prospective Country Evaluation
PEPFAR	President's Emergency Plan for AIDS Relief
PFM	Public Financial Management
PHC	Primary Health Care
PPP	Public–Private Partnership
PR	Principal Recipient
PUDR	Progress Update Disbursement Request
QC	Quality Control
RDT	Rapid Diagnostic Tests
RMET	Resource Mapping and Expenditure Tracking
RSSH	Resilient and Sustainable Systems for Health
SDG	Sustainable Development Goal
SEA	Southeast Asia
SHA	System of Health Accounts
SoA	South America
SoE	Strength of Evidence
SoW	Statement of Work

STD	Sexually Transmitted Disease
SSA	Sub-Saharan Africa
SWAp	Sector-Wide Approach
TA	Technical Assistance
TB	Tuberculosis
TERG	Technical Evaluation Reference Group
ToR	Terms of Reference
TOSSD	Total Official Support for Sustainable Development
TRP	Technical Review Panel
UHC	Universal Health Coverage
UMI	Upper-Middle Income
UNAIDS	Joint United Nations Programme on HIV and AIDS
USAID	United States Agency for International Development
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization

Executive summary

Objectives

Since inception, The Global Fund to Fight AIDS, Tuberculosis and Malaria has recognised the need for cross-cutting support for the health system as an enabler for disease specific programming. In the GF Strategy 2017–2022, Health Systems Strengthening (HSS) was reconceptualised as Resilient and Sustainable Systems for Health (RSSH), which encompasses not just the national health system but also services provided by communities, the private sector and other providers, which together should ensure that individuals' health needs are met wherever they seek care. The GF 2023–2028 Strategy aims to maximise people-centred, integrated systems for health to deliver impact, resilience and sustainability in support of its primary goal of ending AIDS, TB and malaria.

This mapping exercise of GF investments in RSSH has three objectives:

Objective 1: Critically evaluate the RSSH tracking methods/tools and expenditure data categorisation used by the GF Secretariat and what differentiates investments in RSSH from other GF investments.

Objective 2: Estimate the magnitude of GF investments in health systems globally and at country level.

Objective 3: Understand how GF RSSH investments align to domestic and government investments and national health priorities.

Definitions

As has been well documented, there are significant definitional issues surrounding HSS, and indeed this is one of the main findings from this study. In order to ensure clarity around the approach taken and the findings and conclusions generated, it is important to lay out up front the definitions used to help frame the analysis that was undertaken here. Table 1 provides an overview of key terms used in this study.

Readers of this report need to be aware of the different ways in which RSSH is used within the Global Fund and within this report and that external analysis we are assuming investment via RSSH modules is a proxy for HSS when comparing with other development partners (DPs) and country-level investments in HSS. For example, RSSH is used to refer to the following: a component of the GF Strategy; RSSH interventions within the modular framework; RSSH funding in line with the modular framework – RSSH modules within the Grant Approved Budget (GAB) and subsequent expenditure. The Secretariat also tracks and reports investments in RSSH using a specific methodology which identifies RSSH investments as 'RSSH Direct' (these map to RSSH modules within RSSH grants and disease specific grants) and 'RSSH Contributory' (these are investments through disease specific modules in disease specific grants which meet criteria in the RSSH methodology for having cross-cutting benefits).

Box 1 at the end of this Executive Summary provides an visual overview of how these definitions have been used to frame the mapping exercise undertaken as part of this assignment and compares it with the way the GF reports RSSH.

Table 1: Definitions of key terms used in this report

Term	Definition
RSSH investments	Term used mostly to describe (planned) funding and (expected) spending through RSSH modules. However, given that RSSH investments are the subject of this mapping, the term is used somewhat flexibly.
RSSH funding	RSSH modules in the budget approved by the Grant Approvals Committee (GAC).
RSSH spending	RSSH modules in the expenditure report provided for this mapping study; includes NFM 2.
RSSH Direct	This term is taken from the Secretariat methodology for calculating RSSH. RSSH Direct is the equivalent to RSSH Modules in the GAC approved budget.
RSSH Contributory	This term is taken from the Secretariat methodology for calculating RSSH. RSSH Contributory is calculated based on applying the methodology to non-RSSH modules in the GAC approved budget.
RSSH modules	The specific RSSH modules as defined in the GF modular framework.
Cross-cutting investments	Used in this report to describe 'system-level investments', as set out in the Terms of Reference (ToR): those that have cross-cutting benefits beyond a single disease, strengthen relationships between building blocks and promote permanent system impact beyond a disease programme.
Health system strengthening	HSS is used to describe the investments into health systems which the GF, other DPs and governments are making, which broadly align with World Health Organization (WHO) definition and building blocks. There is no standard definition of HSS (See Annex 1).

Methods

This study developed and applied methodologies to answer the various mapping questions under each of the three objectives. These methodologies were reviewed and revised together with Technical Evaluation Reference Group (TERG) and WHO focal points and signed off by TERG at inception. Below we summarise the main methodologies that have been applied for this RSSH mapping by mapping objective.

Objective 1: Critically evaluate the RSSH tracking methods/tools and expenditure data categorisation used by the GF Secretariat and what exactly differentiates investments in RSSH from other GF areas of investment.

The main methodology used for this objective was a comparative analysis of the RSSH tracking methods/tools and expenditure data categorisation used by the GF Secretariat. The team reviewed in detail the method and tools used, identifying the key strengths and weaknesses of these approaches, as well as interviewing stakeholders in other DP organisations to map out similarities and differences in approaches used as well as key challenges faced.

Objective 2: Estimate the magnitude of the GF's investment into the health system (1) globally and (2) at country level.

The method used to address the questions under Objective 2 was to classify and categorise data extracted from a representative sample of global and country-level data sets against precise definitional categories of HSS. The starting point for this approach was a definition of HSS that was jointly agreed between the GF TERG, WHO and the consultant team at the inception period of this assignment. This definition (see Table 1 above) required the team to

focus on mapping those investments that have been specifically identified as designed to deliver '*cross-cutting*' benefits beyond a single disease.

To generate the estimates of the magnitude of the GF investment at the *global level*, the mapping exercise was undertaken through a stepwise process as outlined below. The main data source for the global analysis was the GAC budget data. The analysis was carried out over three phases. The first focused on unpacking cross-cutting and disease specific investments, the second focused on classifying the cross-cutting investment into 'system strengthening' and 'system support' investments, and the final phase looked at cross-cutting investments in terms of expenditure.

To generate estimates of the magnitude of the GF investment at the *country level*, two ratios were calculated as requested in the ToR for this assignment, namely (1) GF expenditure on RSSH as a proportion of government domestic HSS expenditure and (2) GF expenditure on RSSH as a proportion of total externally funded HSS expenditure. Based on findings from the global-level analysis, the mapping team developed the methodology for calculating these ratios with full consideration of the comparability issues and data limitations. This methodology is based on clear definitions of the numerator and denominator to derive these ratios. Ratios were calculated (where data was available) for the 15 country case studies identified under Objective 3 (see below).

Objective 3: Understand how GF RSSH investments align with domestic and government investments and national health priorities.

The main method used to address this objective was the undertaking of country case study analysis. We carried out in-depth analyses of a purposively selected sample of 15 country case studies and analysed both secondary data (document review and analysis on quantitative data) and qualitative data (collected through undertaking of a large number of Key Informant Interviews (KIIs) within the case study countries). Data and information collected were entered into a matrix database for each country.

A rubric scoring system was used to assess the level of alignment of RSSH investments and use of national systems. A strength of evidence estimate was developed in our synthesis of findings across countries; this included three dimensions the assessing strength of evidence o alignment (i) within countries, (ii) across countries and (iii) across the quantitative and qualitative data.

Limitations

The analysis presented in this report is based on robust and systematic application of the above methodology. However, it has a number of limitations, many of which are common to other approaches deployed by other global institutions to track their investments.

Table 2: Limitations and mitigation of limitations

Limitation	Mitigation
1. There are varied definitions and interpretations of key terms used in the RSSH mapping. RSSH is a term used by the GF but not commonly used by other DPs and countries. This can lead to confusion when referring to GF investments in RSSH in an external context. In addition, the lack of commonly agreed definitions around HSS means that the terminology used is open to interpretation.	While this mapping did not set out to develop or create agreement around key definitions, we have sought to clarify the uses of terms (see Table 1 in the Executive Summary and a more complete Table 3 in the main report). In addition, as highlighted in the methods section, we have set out definitions of HSS and cross-cutting investments which were agreed with the TERG and WHO at the outset, and we have used this to frame to the analysis presented in this report.

2. The definition of RSSH that was used for the mapping exercise in Objective 2 framed the way in which we approached the analysis and – in full agreement with the TERG – promoted a major focus on mapping those investments that have been specifically identified as designed to deliver 'cross-cutting' benefits. However, the data used to inform this analysis does not allow for assessment of benefit.	It is important to emphasise that the data sources for this analysis were budget and expenditure data and, as such, could not provide information of the extent to which actual benefits were achieved from these investments. This is a mapping exercise and not an evaluation. To determine if activities in disease specific modules have cross-cutting benefit beyond the single disease area for which they had been curated, the activities and interventions will require more details and even some evaluation at the country level, which is beyond the scope of this mapping exercise.
3. The time-consuming nature of the categorisation exercise under Objective 2 global analysis (which involved a line-by-line review of all GF investments under RSSH and disease specific modules – see Annex 3) means the analysis was only conducted in a sub-sample of countries.	In order to maximise the coverage of this study, the mapping methodology was scaled up to 38 countries, representing 80% of the GF's total investment portfolio for NFM 2 & NFM 3 respectively. These 38 countries include the 15 case study countries, representing 30% of the total investment.
4. The mapping project faced a series of logistical challenges around timing and access to key stakeholders. Accessing country-level stakeholders was a lengthy process, requiring permissions from both WHO and GF. These delays compressed the period in which data collection and analyses were conducted.	In total, 74 KIIs were conducted, which is equal to an average of five KIIs per country (a range of 3–10 per country). While the number of KIIs conducted presents some limitations in terms of generalising findings from the country case studies, a process of validation and triangulation through extensive desk review and country-level quantitative analysis was undertaken. We applied a strength of evidence rating to findings to highlight where issues arise.

Conclusions

We generated a number of specific findings that address the three objectives of the study and detailed response to the specific sub questions outlined in the ToR. These are provided in the full report. On the basis of these findings we identified thirteen headline conclusions which are outlined below. They have been categorised according to those that relate to (1) the definition and categorisation of HSS, (2) tracking of RSSH investments, (3) the magnitude and nature of GF RSSH investments and (4) operations of the current GF business model.

Conclusions related to the definition and categorisation of HSS

1. **The lack of a standard definition of HSS, together with the limited comparability of 'HSS' interventions, leads to inconsistency between agencies in defining and targeting investments for systems strengthening, including between those that focus on disease specific areas and those that focus on cross-cutting outcomes.** The definition of RSSH and its relation to HSS continues to elicit differences in interpretation**.** RSSH is not equivalent to HSS; it is based on the definition set out in the Global Fund Strategy 2017- 2022 on Strategic Objective 2 -Build Resilient and Sustainable Systems of Health (RSSH) , which includes WHO building blocks as well as community systems. There is no standard definition of HSS (Annex 1 Table 11). Other DPs – e.g. Gavi, United States Agency for International Development (USAID), the Global Financing Facility for Women, Children and Adolescents (GFF) – also have an RSSH-type category of investments. The definition is

largely based on the WHO definition and the building blocks; however, it is common for DPs to adopt a definition of HSS-type investments which relates to the specific organisational strategies or programme objectives.

2. **For the GF, issues relating to misclassification, subjectivity, and rigidity of budget codes hinder the effective categorisation and definition of RSSH investments, reducing the ability to use financial data to answer strategic questions on how RSSH investments are used – even as the new Global Fund Strategy proposes to make RSSH a mutually reinforcing contributory objective to the overall goal of ending AIDS, TB and malaria.** These limitations are not unique to GF. Other DPs confirmed there are issues with internal and external reporting, including misclassification, subjectivity, and rigidity of budget codes.

3. **The GF methodology for measuring RSSH investments uses a definition which does not correlate with what most stakeholders consider to be HSS (and this mapping analysis of cross-cutting investments); definitions vary on the extent to which HSS includes disease specific vs a focus on cross-cutting.** The main point of departure is the inclusion of RSSH Contributory in the measure of RSSH, which assumes that some investments in disease specific interventions may contribute to cross-cutting outcomes. Although these assumptions may be theoretically valid, the extent to which they hold true across all GF countries is unclear and will require further country-level evaluation to be able to reach a better conclusion as to the cross-cutting benefits of the interventions/activities.

Conclusions related to tracking of RSSH investments

4. **Analysis of the available GF global data sets provides limited visibility of what happens to RSSH grants post-budget approval stage, which means it is hard to answer questions about how strategic priorities on RSSH are operationalised. Specifically, this means that RSSH spending cannot be tracked at sufficiently granular level to address questions around type of RSSH spend (contributory, cross-cutting, support vs strengthening, etc.).** GAC budgets allow for RSSH planned investments to be tracked in detail by module, intervention, cost category and cost input alongside description of each budget line. In using information from Progress Update Disbursement Request (PUDR) forms to assess GF RSSH spending, this mapping exercise observed that the level of granularity in analysis of RSSH investments is lost, as PUDR reports do not allow for cross-tabulation of costs. In addition, the analysis of health accounts needs to identify what constitutes RSSH expenditure in a standard way. Expenditure detail by module, intervention, cost category and cost input would allow for more specific tracking of the RSSH spending and greater potential to influence health systems decisions.

5. **In order to better track relevant RSSH spending from the GF in alignment with other partners, it is theoretically possible to improve the approaches to track RSSH and cross-cutting investments at country level. However, this requires both an investment in developing standardised monitoring frameworks and a focus on accessing detailed information through national study databases.** Most health expenditure tracking exercises are guided by the System of Health Accounts (SHA). While the conceptualisation of health systems has evolved over time, health expenditure tracking frameworks have not kept pace. While it is technically possible to track GF investments at the country level, this would require two key actions. Firstly, there needs to be an investment in developing standardised mapping of health expenditure tracking frameworks. Secondly, there needs to be a a focus on accessing detailed information through national study databases and improving those databases. It is important to highlight that while in theory such improvements can be implemented, there will still be significant limitations, such as lack of access to disaggregated data in the country National Health Accounts (NHA) database. The

time lag in NHA reporting also constrains the use of NHA to inform financing gap analysis, limiting the ability of countries to clearly identify current RSSH or HSS gaps.

6. **The current approach for tracking RSSH investments has limitations, and routinely evaluating health system strengthening outcomes comes with significant challenges and costs. However, a more accurate, low-cost and timely measure of GF investments in RSSH is to track investments (budget and expenditure); this may be possible through a greater emphasis on tracking RSSH modules.** A focus on inputs will, by definition, provide only a partial view of RSSH investments. However, getting insights on outcomes requires significant investments in evaluation and will only ever provide a partial view. Tracking GF RSSH investments through existing modules of RSSH could provide a potentially lower cost way of partially addressing this challenge and may provide a better way of generating a baseline assessment of RSSH spend on which to measure future investments.

Conclusions related to the magnitude and nature of GF RSSH investments

7. **The magnitude of RSSH investment (direct and contributory) estimated using the current GF Secretariat approach to tracking these investments is significantly higher than the cross-cutting investment estimated in this mapping exercise. This is because the GF Secretariat approach uses a broader definition and set of assumptions than the methodology for this mapping exercise.** The definition used for the global analysis in this mapping exercise aims to estimate the proportion of GF investments that are primarily for cross-cutting rather than disease specific objectives. It is designed to provide a baseline for mapping of GF investments which aim to strengthen the health system. It does not seek to evaluate whether these investments have resulted in cross-cutting benefits. It is a much higher standard against which to measure GF investments in health system strengthening, so we would expect the proportion of investments falling into this category to be much smaller than for other measures.

   The GF Secretariat approach tags all investments labelled 'RSSH' as cross-cutting systems strengthening, whereas our analysis found that some investments under RSSH modules did not meet this criteria. The Secretariat methodology also assumes that some disease specific modules and interventions in the programme management module have HSS benefits. Although these assumptions may be theoretically valid, the extent to which they hold true across all GF countries is unclear and will require further country-level evaluation to be able to reach a better conclusion as to the cross-cutting benefits of the disease specific and programme management interventions/activities.

8. **At budget level, about 7% of the GF's total investments in NFM 2 & NFM 3 are cross-cutting investments, and these are found within RSSH modules and not in disease modules.** This estimate was reached by applying the definition of investments in cross-cutting health systems, as agreed with the TERG and WHO for this mapping study. The cross-cutting investments make up about 77% of the investments in the RSSH modules (7% overall). The GF's investment was categorised into cross-cutting investments, single disease investment (based on a line-by-line mapping of activity descriptions under the disease specific modules and RSSH modules across all grant types), programme management and COVID-19-related investment. Applying the definition and methodology for this mapping exercise and reviewing all the investments in the disease specific modules, no cross-cutting investments were identified in these modules (see Box 1).

9. **Mapping interventions into system support and strengthening can be highly subjective, and accurate tracking of the balance between HSS *support* and *strengthening* is extremely difficult. Our analysis was able to generate some limited insights into the way RSSH investments have been divided across these two areas in the GF, but they necessarily need to be interpreted with these limitations in mind. Currently, GF systems**

are not set up to track this routinely; as such, decisions about the optimal balance between these types of investment are not well informed. The classification of some interventions into support and strengthening are highly dependent on how the intervention is planned and delivered, for example capacity building/training depending on the area of focus and the target group. Performance-based initiatives delivered at the service delivery/health facility level will differ from incentives provided to deliver systems strengthening interventions. As a result, mapping interventions into system support and strengthening can be highly subjective, and mapping should be done with adequate knowledge of the programme implementation and nuances.

Our analysis identified some important trends. For example, distributions of health systems support and strengthening investments varied by specific RSSH module, with a high proportion of support investments in Human Resources for Health (HRH) and a high proportion of strengthening investments in health sector governance and planning.

The debate on what constitutes strengthening and systems support is ongoing and it is not appropriate to label one as desirable and the other undesirable. Country health systems differ in maturity/progression and weaknesses; as such, systems support and strengthening interventions should be tailored according to country-specific constraints and opportunities.

Although supporting the system alone can improve performance in the short term, only activities that go beyond strengthening the system can improve the system's (resilience) ability to respond to future challenges. Support investments are necessary, but there is a need to strike the right balance between these investments, and this decision is a policy/strategic decision that is highly country-specific. The process of mapping and categorising these investments to support and strengthening can be helpful in helping to frame the decision around what the optimal balance should be. Currently, GF systems are not set up to track this routinely; as such, decisions about the optimal balance between these types of investment are not well informed.

Conclusions related to operations of the current GF business model

10. **Our analysis at country level highlighted that stakeholders in countries widely perceive GF investments in RSSH to be well aligned with national priorities, health sector strategies and disease specific plans. However, we also found that alignment of disease grants with disease national strategic plans (NSPs) is stronger than the alignment of RSSH investments with national health priorities and sector plans, indicating that there may be ways to improve alignment.** The strong stakeholder agreement on alignment is a testament to the robust and consultative GF funding request process, which provides a critical foundation and starting point for ensuring alignment of RSSH investments with government HSS priorities. RSSH continues to feature more prominently in recent NSPs, albeit still largely in the context of health system needs required for the delivery of HIV, TB and malaria programmes.

    As the GF targets continuing to complement other financers on key HSS functions, alignment of GF investments in RSSH can be further enhanced – and can support integration/use of national systems – by identifying opportunities to use appropriate national budgeting and financing mechanisms for grant implementation. Participating in pooled financing mechanisms, such as in Lao People's Democratic Republic (Lao PDR), may strengthen alignment of GF RSSH investments if such arrangements are implemented in a way that satisfies GF reporting requirements and links financing with health outcomes.

11. **Our analysis highlighted some key insights around the ways in which RSSH investments are being used at country level. In other cases it was noted across a number of case study countries that insufficient attention has been given to subnational resource**

allocation and decision-making processes, and that community-level health systems should be given more priority. The case studies also generated a number of recommendations (from in-country stakeholders) that could be leveraged to help improve future alignment. Key insights included the fact that countries reported that reprogramming of GF grants had enabled them to shift funds from disease specific investments to RSSH investments. Others highlighted an opportunity for the GF to increase the impact of its RSSH investments by expanding its engagement with subnational governments and processes, especially in countries where decentralisation is advanced. This is already practiced in disease grants through differentiated delivery, subnational tailoring, etc. Other opportunities include for the GF to work with the Ministry of Health (MOH) and other partners to strengthen its focus on community needs and community health systems as well as leveraging its RSSH and disease specific grants to highlight broader sector and health system issues of relevance to GF grant implementation.

12. **Countries continue to face significant challenges in reporting spending towards health from their domestic financial commitments. In addition, lack of data on co-financing commitments and expenditure in RSSH spend is evident.** With the devastating effects of the COVID-19 pandemic on public spending – which has implications for health and health spending – countries are facing a wide range of challenges in reporting spending towards health from their domestic financial commitments. As the GF operationalises its new Global Fund Strategy – which places a focus on more and better integrated and aligned funding of HSS through domestic resource mobilization – availability of country level data on co-financing commitments in RSSH should be prioritized.
13. **Country stakeholders confirmed that GF RSSH investments generally use national systems at the central level which are associated with greater alignment.** Some countries generate data and information from national public financial management (PFM) and health information systems for financial and programmatic reporting to the GF, while in other countries separate systems have been set up. The implementation of most RSSH funding (RSSH modules) is managed by government institutions, and in these cases management of this was generally associated with increased integration and use of national systems.

Recommendations

Based on the analysis done in this report and the discussions held with internal and external stakeholders, the following recommendations – categorised as strategic or operational – are prioritised. We have identified four strategic recommendations and four operational recommendations. There are six high priority recommendations that we believe, if well addressed, can help address the issues of measurement, comparability, magnitude and alignment of RSSH investments at the global, Secretariat and national level going forward.

Recommendations related to the definition and categorisation of HSS

Recommendation 1 (High Priority/Strategic): The Global Fund and DPs should work towards making explicit the contents of the RSSH/HSS composition in their resource tracking. This implies that health expenditure tracking frameworks reflect relevant RSSH spending from the GF and other partners. The mapping should match both the GF and SHA categories to have a one-to-one relation. In practice this is challenging, as category content in both systems is based on different taxonomies. In fact, RSSH interventions may overlap several SHA categories and classifications. The GF can work in a number of ways towards updating frameworks for health expenditure tracking. These are outlined in the full report.

Recommendation 2 (High Priority/Strategic): The GF should work together with DPs to ensure greater standardisation of definition and categorisation of HSS building on ongoing work with the Health Systems Strengthening Evaluation Collaborative (HSSEC), Total Official Support for Sustainable Development (TOSSD) and working groups on resource tracking and development finance statistics.

Recommendation 3 (High Priority/Strategic): Given that existing reporting to the Board is based only on planned investments in RSSH and that RSSH Contributory is not aligned with the way that other DPs defined HSS, a potentially more accurate, low-cost and timely measure of GF investments in RSSH (budget and expenditure) is to track investments through the existing RSSH modules. This can be complemented by a review of disease specific modules by the Secretariat for purposes of detailed mapping so as to identify and propose approaches to increase cross-cutting effects and efficiencies.

Recommendations related to tracking of RSSH investments

Recommendation 4 (High Priority/Operational): The Global Fund Secretariat should explore the feasibility of extending PUDR expenditure reporting to enable cross-tabulation of module, intervention, cost category and cost input by budget line item. Cross-tabulation would allow for the level of granularity in analysis based on strategic priorities such as disease specific vs cross-cutting.

Recommendation 5 (High Priority/Operational): The resource tracking system of the GF should be shared with country NHA teams so as to facilitate proper visibility of RSSH investments. Cooperation between the GF, resource tracking teams at national level and other resource tracking associated organisations should be encouraged in order to ensure a better mix of modules/interventions/cost categories and cost inputs for RSSH tracking.

Recommendations related to the magnitude and nature of GF RSSH investments

Recommendation 6 (High Priority/Operational): The GF should continue to support alignment through the existing country-led process for preparing funding requests (FRs) and should support and engage in national alignment frameworks led by the government. The FR preparation process should include assessment and dialogue on opportunities to manage GF investments in RSSH that include use of programme-based budgeting and/or integration with pooled donor funding mechanisms as relevant and appropriate to the country context.

Recommendation 7 (Medium Priority/Strategic): Over time, the GF should move towards use of national systems for reporting as countries' capacities in reporting increase, and should (where appropriate) continue to strengthen such systems. RSSH grants should be implemented by the national structures that have a formal mandate to implement the health system interventions, but adequate consideration of community health systems needs to be built into the FR preparation process and grant implementation.

Recommendations related to operations of the current GF business model

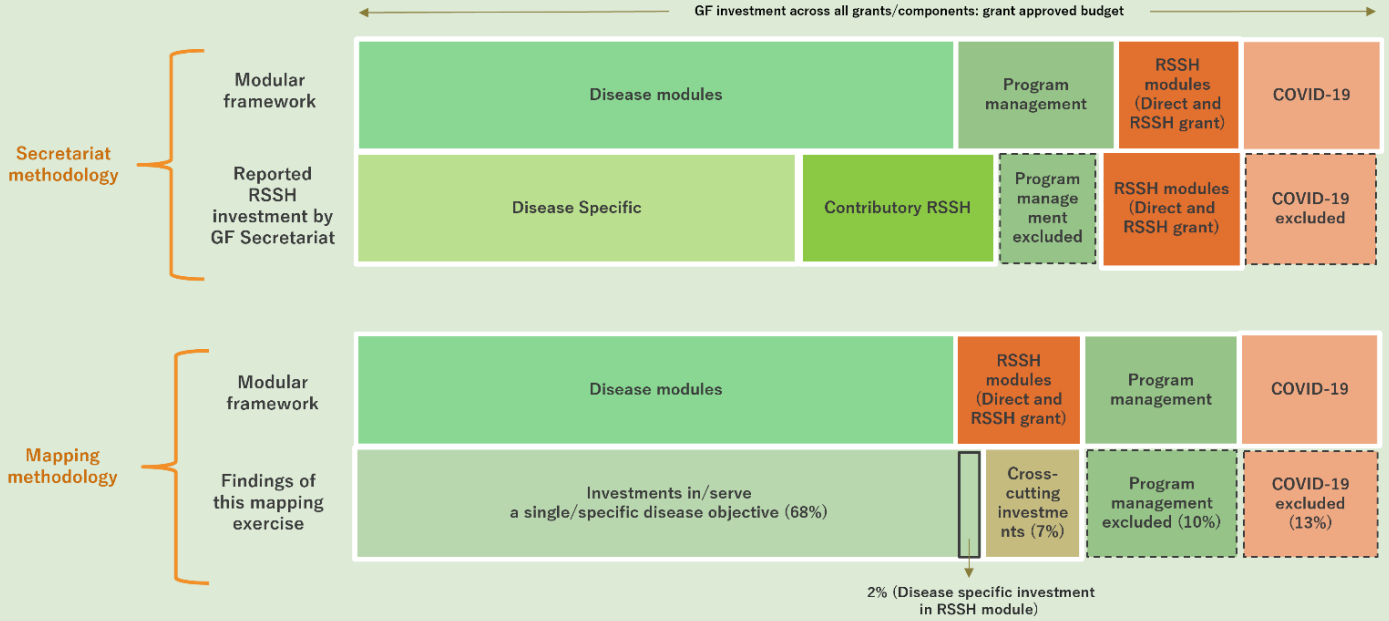
Recommendation 8 (Medium Priority/Operational): The principal recipients (PRs) of the GF should ensure that the data they provide to the NHA team in MOH is comprehensive, disaggregated and submitted in a timely manner. The GF should work with MOH and WHO to enable regular access to relevant disaggregated data from the NHA database to track investments in HSS. Given that accounting efforts are not produced every year and given the time lag, the GF can direct investments to facilitate routine reporting to financial management systems (interoperable with Health Management Information Systems (HMIS)) which are accessible to the Health Accounts team.

Box 1. Comparison of secretariat RSSH methodology and methodology used for this study

The figure below shows results of this mapping study alongside the results of the Secretariat methodology for tracking investments in RSSH. They are both presented against the budget categories of the modular framework.

The results from the mapping study and Secretariat methodology are not directly comparable as they use different methodologies, but both can be compared against the modular framework.

Figure 1: Visual comparison between Secretariat methodology for tracking HSS and methodology used for this study (not to scale)



The top two rows show the Secretariat methodology for reporting RSSH which aggregates:

(1) Direct RSSH which is all RSSH modules in RSSH only and disease specific grants. It includes programme management modules in RSSH only grants and excludes COVID-19 modules.

(2) Contributory RSSH which includes disease specific modules where the investment is primarily for disease specific outcomes but are assumed to also have health system benefits. This includes one of the interventions under the programme management modules in disease specific grants and excludes COVID-19 modules.

The bottom two rows show the results of this mapping study which suggests 1) A large proportion of investments made through RSSH modules are cross-cutting and 2) Some of the investments made through RSSH modules are disease specific.

The study methodology excludes investments in programme management and COVID-19 modules.

Main Technical Report

Background

The Global Fund Strategy (2023-2028): Fighting Pandemics and Building a Healthier and More Equitable World (2023–2028 Strategy) notably aims to maximise people-centred, integrated systems for health to support its primary goal of ending the three diseases. A critical part of this Strategy is the intention to strengthen health systems and make them more people-centred through a series of sub-objectives. Since inception, GF recognised the need for cross-cutting support for the health system as an enabler for disease specific programming. In the Global Fund Strategy (2017-2022): Investing to End Epidemics), health systems strengthening (HSS) was reconceptualised as Resilient and Sustainable Systems for Health (RSSH), which encompasses not just the national health system but also services provided by communities, the private sector and other providers, which together should ensure that individuals' health needs are met wherever they seek care.

Given the complexities in defining and categorising HSS investments, and despite previous efforts, and to present investments in resilient and sustainable health systems in different ways, this category of investments remains of particular interest to the GF Board.

Itad and LAMP Development have been commissioned by the GF to conduct a mapping to inform how the GF can align and harmonise HSS efforts with national priorities and to inform how these investments could be monitored.

Mapping its investments in RSSH will provide a critical learning opportunity for the GF, as it seeks to step back and better understand the nature of its investments and its overall contribution to the HSS of countries, relative to domestic and other funders' investments, with a particular focus on the grant implementation phase. It will play an important role in shaping future RSSH investments in terms of (i) planning for and designing of HSS/RSSH interventions and (ii) practices of monitoring RSSH investments under the new GF strategy.

The primary intended users of the mapping will be GF's Board and its Strategy Committee, the Technical Evaluation Reference Group (TERG) and key Secretariat staff involved in RSSH. Secondary intended users will include principal recipients (PRs), country teams, partners and country-level implementers who may also be sub-recipients (SRs).

Three objectives for the RSSH mapping were identified in consultation with the GF TERG and World Health Organization (WHO) stakeholders, and are noted below:

Objective 1: Critically evaluate the RSSH tracking methods/tools and expenditure data categorisation used by the GF Secretariat and what exactly differentiates investments in RSSH from other GF areas of investment.

Objective 2: Estimate the magnitude of GF's investment into the health system globally and at country level.

Objective 3: Understand how GF RSSH investments align with domestic and government investments and national health priorities.

This report is the final deliverable of the RSSH mapping assignment. It presents key findings from across objectives. The report is structured into seven sections. Section 1 provides background information on the mapping and its intended audiences. Section 2 presents a summary of the structure of the mapping approach, highlighting workstreams and mapping questions (MQs). Section 3 summarises challenges and limitations of our mapping. Section 4 presents key findings by workstream, and Section 5 and Section 6 present conclusions and recommendations respectively.

This report also includes several detailed annexes, referenced throughout the report, for additional details on methodologies, analyses and findings.

Definitions

As has been well documented, there are significant definitional issues surrounding HSS, and indeed this is one of the main findings from this study. In order to ensure clarity around the approach taken and the findings and conclusions generated, it is important to lay out up front the definitions used to help firm the analysis that was undertaken here. Table 3 provides an overview of key terms used in this study.

Readers of this report need to be aware of the different ways in which RSSH is used internally and within this report and that externally we are assuming that investment via RSSH modules is a proxy for HSS when comparing with other development partners (DPs) and country-level investments in HSS. For example, RSSH is used to refer to the following: a component of the GF Strategy; RSSH interventions within the modular framework; RSSH funding in line with the modular framework – RSSH modules within the Grant Approvals Committee (GAC) budget and subsequent expenditure. The RSSH team within the Secretariat also tracks investments in RSSH using a specific methodology which identifies RSSH investments as 'RSSH Direct' (these map to RSSH modules within RSSH grants and disease specific grants) and 'RSSH Contributory' (these are investments through disease specific modules in disease specific grants which meet criteria in the RSSH methodology for having cross-cutting benefits).

Table 3: Definitions of key terms used in this report

Term	Definition	Use in the report
RSSH investments	Term used mostly to describe (planned) funding and (expected) spending through RSSH modules. However, given that RSSH investments are the subject of this mapping, the term is used somewhat flexibly.	Used throughout the report to describe the RSSH GF investments, this study seeks to map (All objectives)
RSSH funding	RSSH modules in the Grant Approval Committee (GAC) approved budgets	Estimating magnitude of cross-cutting investment (Objective 2) Denominator for budget expenditure analysis - NFM 2 only (Objective 2) Subject of discussion in CCS KIIs (Objective 3)
RSSH spending	RSSH modules in the expenditure report provided for this mapping study includes NFM 2.	Numerator for budget expenditure analysis (Objective 2) Numerator for country level ratios (Objective 2)
RSSH Direct	This term is taken from the Secretariat methodology for calculating RSSH (Box 8 Annex 1). RSSH Direct is the equivalent to RSSH Modules in the GAC budget.	Review of existing systems to track investments in RSSH (Objective 1)
RSSH Contributory	This term is taken from the Secretariat methodology for calculating RSSH (Box 8 Annex 1). RSSH Contributory is calculated based on applying the methodology to non-RSSH modules in the GAC approved budget.	Review of existing systems to track investments in RSSH (Objective 1)
RSSH grants	RSSH grants are standalone grants specifically for RSSH investments. RSSH funding is also	CCS description of RSSH investments in each country (Objective 3)

	channelled through RSSH modules in disease and multi-component grants.	
RSSH modules	The specific RSSH modules as defined in the GF modular framework.	Review of existing systems to track investments in RSSH (Objective 1) Analysis of cross-cutting by RSSH module (Objective 2)
Cross-cutting investments	Used in this report to describe 'system-level investments', as set out in the Terms of Reference (ToR): those that have cross-cutting benefits beyond a single disease, strengthen relationships between building blocks and promote permanent system impact beyond a disease programme.	Used to estimate the magnitude of GF Investments at global level (Objective 2)
Health system strengthening	HSS is used to describe the investments into health systems which the GF, other DPs and governments are making, which broadly align with the WHO definition and building blocks. There is no standard definition of HSS (See Annex 1).	Subject of discussion in KIIs (Objectives 2 & 3)
System strengthening investments	Investments that seek comprehensive changes to policies and regulations, organisational structures and relationships across the health system building blocks that motivate changes in behaviour and/or allow more effective use of resources to improve multiple health services. Systems strengthening investments include performance drivers such as changes in policies and regulations, organisational structures and relationships within the health system.	Categorization of GF investments as health systems support or health systems strengthening. (Objective 2)
System supporting investments	Investments that improve the system's functionality, primarily by increasing inputs, and can be short-term and narrowly focused.2 Examples of system support investments include payment of salaries and procurement of IT equipment.	Categorization of GF investments as health systems support or health systems strengthening. (Objective 2)

Methods

This study developed and applied methodologies to answer the various mapping questions under each of the three objectives. These methodologies were reviewed and revised together with Technical Evaluation Reference Group (TERG) and WHO focal points and signed off during at inception completion. Summaries of the methodologies applied for this RSSH mapping are presented below by mapping objective. Detailed methodology notes are available in Annexes 1, 3, 6 and 7.

Objective 1: Critically evaluate the RSSH tracking methods/tools and expenditure data categorisation used by the GF Secretariat and what exactly differentiates investments in RSSH from other GF areas of investment.

The main methodology used for this objective was a comparative analysis of the RSSH tracking methods/tools and expenditure data categorisation used by the GF Secretariat. The team reviewed in detail the method and tools used, identifying the key strengths and weaknesses of these approaches as well as interviewing stakeholders in other DP organisations to map out similarities and differences in approaches used as well as key challenges faced.

19 key stakeholder interviews, across three teams at the GF and five DP organisations, were conducted under this objective. Documents were reviewed to understand definitions, methodologies, scope of analyses, financial data used and the levels of analysis routinely conducted. Where comparisons in approaches to tracking HSS were needed, we also reviewed publicly available information on the definitions used by DPs and built on the work of the Health Systems Strengthening Evaluation Collaborative (HSSEC).

Objective 2: Estimate the magnitude of the GF's investment into the health system (1) globally and (2) at country level.

The method used to address the questions under Objective 2 was to classify and categorise data extracted from a representative sample of global and country-level data sets against precise definitional categories of HSS. The starting point for this approach was a definition of HSS that was jointly agreed between the GF TERG, WHO and the consultant team at the inception period of this assignment. This definition (see Table 3) required the team to focus on mapping those investments that have been specifically identified as designed to deliver '*cross-cutting*' benefits beyond a single disease.

To generate the estimates of the magnitude of the GF investment at the *global level*, the mapping exercise was undertaken through a stepwise process as outlined below. The main data source for the global analysis was the GAC budget data. The analysis was carried out over three phases. The first focused on unpacking cross-cutting and disease specific investments, the second focused on classifying the cross-cutting investment into 'system strengthening' and 'system support' investments, and the final phase looked at cross-cutting investments in terms of expenditure.

To generate estimates of the magnitude of the GF investment at the country level, two ratios were calculated, as requested in the terms of reference (ToR) for this assignment, namely: (1) Global Fund expenditure on RSSH as a proportion of government domestic HSS expenditure; (2) Global Fund expenditure on RSSH as a proportion of total externally funded HSS expenditure. Based on findings from the global-level analysis, the mapping team developed the methodology for calculating these ratios with full consideration of the comparability issues and data limitations. This methodology is based on clear definitions of the numerator and denominator to derive these ratios.

1. *Estimate the magnitude of the GF's investment into the health system: global analysis*

Below we detail the steps that were undertaken as part of the global analysis which are divided into three phases. The main data source for the global analysis was the Grant Approvals Committee (GAC) budget data (see Box 2).

Annex 3 provides a detailed methodology note for this Objective.

Box 2. Grant Approvals Committee Approved and Committed Budget data

The Global Fund Grant Approvals Committee (GAC) approved and committed budget data was used for our analysis of global magnitude analysis as it contains line-by-line descriptions of activities and module and intervention descriptions. We analysed data from **38 GF countries**, representing about **80% of the total portfolio for New Funding Model (NFM) 2 & NFM 3** (see list of 38 countries in Annex 3). Relevant modules were the disease-specific modules and the RSSH modules. COVID-19 and the programme management modules were excluded, although the total investment in these modules was used **within the denominator** to estimate the proportion of the GF's investment in the different investment area.

Phase 1: Analysis of cross-cutting and disease specific investments

The first phase of the analysis focused on unpacking cross-cutting and disease specific investments. For this we applied a 'scope' parameter to all the activities contained in the disease specific modules and RSSH modules of all the grant types as below. The stepwise process for our analysis was as follows:

Step 1: Separate the activities into cross-cutting activities and activities focused on single disease. The key question was whether the activity in the GAC budget is identified as potentially delivering primarily a cross-cutting benefit beyond a single disease. This process separated the activities (and, by extension, the GF's investments) into cross-cutting investments and single disease investments.

Step 2: The cross-cutting and single disease investments were **also classified based on the type of grant,** i.e. whether the activity/investment sits in the RSSH stand-alone grant or the RSSH portion of the single disease grant.

Step 3: The cross-cutting investments were **classified according to the component of the health system they are affecting** – for example human resource for health, data/information system, supply chain system management, etc. Those investments that do not have a direct effect on the health system, e.g. programme management investments, were excluded.

All activities were reviewed from a programme planning perspective, and activities were interpreted with the intent described in the GAC budget. Activities were categorised as cross-cutting only if the activity description and intervention pair had clear descriptions and key words that aligned with the mapping cross-cutting definition. No activity was categorised based on its *potential* for cross-cutting contribution unless this information was provided in the activity description and intervention pair.

The above analysis was double-checked through our data validation protocol (see Box 3).

Box 3.Data validation protocol

- All analyses were conducted by trained data analysts with backgrounds and knowledge of HSS, and quality checks were carried out by the team lead and co-lead.
- To minimise the magnitude and impact of misclassification, activities with the highest costs were sorted using Excel filters and double-checked to ensure they were properly mapped.
- In cases where it was unclear from the activity description, the detailed budgets and project implementation plans of some countries were also reviewed to ensure activities were properly categorised.

Phase 2: Classification into system strengthening and system support investments

The second type of analysis applied an 'approach' and 'longevity' parameter to the cross-cutting investments in order to categorise them into 'system support' investments and 'system strengthening' investments. Table 4 below provides the framework used for this classification.

Table 4: Classification framework

Parameter	System Support	System Strengthening
Longevity	Effects limited to period of funding	Effects will continue after funded activities end
Approach	Provide inputs to address identified system gaps	Revise policies and institutional relationships to change behaviours and resource use to address identified constraints in a more sustainable manner

Note: The definitions of scope, longevity and approach included in the table above were used at different stages to determine whether an activity is systems support or systems strengthening.

Cross-cutting investments (from the first phase of the analysis) were classified into **system strengthening and system support investments**. The approach and longevity parameters and activities/intervention pairs were categorised into 'support' and 'strengthening'. **This analysis was implemented across 15 case study countries for the RSSH modules – Human Resources for Health (HRH), health sector governance and financial management systems.**

Phase 3: Estimate cross-cutting investments in terms of expenditure

The final stage of the global-level analysis was to estimate cross-cutting investments in terms of expenditure. Since the expenditure reports available do not have detailed activity descriptions, it was not possible to conduct the line-by-line analysis as described above. Therefore, actual investment was estimated by **analysing the total budget and expenditure data for RSSH and disease specific modules for NFM 2**. The budget implementation rate calculated was applied to the cross-cutting investment estimated above.

2. Estimate the magnitude of the GF's investment into the health system: country level

The methodology applied for the *country level analysis* was derived from the calculation of the two ratios described in the ToR for this study, namely:

1) GF expenditure on RSSH as a proportion of government domestic HSS expenditure

2) GF expenditure on RSSH as a proportion of total externally funded HSS expenditure.

There are comparability issues with the data available to compute these ratios; these are discussed in detail in Annex 4. Based on findings from the global-level analysis, the mapping team developed the methodology for calculating these ratios with full consideration of the comparability issues and data limitations. This methodology is based on clear definitions of the

numerator and denominator to derive these ratios and identification of key data sources, as outlined in Box 4.

The sample for this analysis was the 15 country case studies identified under Objective 3 (see below).

Box 4. Definitions of numerator and denominator for country-level ratio calculations

GF expenditure on RSSH as a proportion of government domestic HSS expenditure

a. **Numerator** refers to total GF RSSH spending, taken from the Progress Update Disbursement Request (PUDR) and annualised for ratio generation, which is taken as a proxy for GF investments in HSS to compare with country-level investments in HSS.

b. **Denominator** is government domestic HSS, which is taken to be equivalent to expenditure on governance and administration. This denominator can be sourced from existing National Health Accounts (NHA) databases as country reports and the Global Health Expenditure Database (GHED).

GF expenditure on RSSH as a proportion of total externally funded HSS expenditure

c. **Numerator** refers to total GF RSSH spending and was taken from PUDR and annualised for ratio generation.

d. **Denominator** is externally funded HSS, which is taken to be equivalent to expenditure on governance and administration. This denominator can be obtained from NHA reports.

Objective 3: Understand how GF RSSH investments align with domestic and government investments and national health priorities.

The main method used to address this objective was the undertaking of country case study analysis. We carried out in-depth analyses of a purposively selected sample of **15 country case studies** and analysed both secondary data (document review and analysis on quantitative data) and qualitative data (collected through undertaking of a large number of key informant interviews (KIIs) within the case study countries). Data and information collected were entered into a matrix database for each country. A rubric scoring system was used to assess the level of alignment of RSSH investments and use of national systems. A strength of evidence (SoE) estimate was developed in our synthesis of findings across countries, and included three dimensions, assessing alignment (i) within countries, (ii) across countries and (iii) across the quantitative and qualitative data.

Country selection

Fifteen countries were purposefully selected for the RSSH mapping. Sampling criteria included income level, geographic region, burden of disease, data on GF investment in RSSH, and availability of NHA data. Table 24 in Annex 7 shows that the country selection process yielded a balanced set of 15 countries from different regions, income levels, disease burden and magnitude of RSSH investments. Health expenditure data were available for all 15 countries (see Table 24 in Annex 7 for the characteristics of the 15 case studies).

Data collection

Quantitative data on the GF RSSH investments were sourced from the GF Grant Approvals Committee (GAC) Approved and Committed Budgets for NFM 2 and NFM 3. NFM 2 and NFM 3 for RSSH under funding module classification (2022) were triangulated with data from WHO/GHED and NHA, using the expenditure on governance and health systems administration by source of funding as the best proxy to the RSSH aggregate, noting limitations in

comparability. Data on domestic and external expenditure and total health expenditure for RSSH (denominator) were obtained through the NHA reports and the GHED (see Annex 4).

Qualitative data were collected through desk review and KIIs. Documents were identified using online searches and advice from WHO country offices and key informants. Documents reviewed included peer-reviewed journal publications, grey literature, GF documents and reports, national health sector strategies, disease programme plans, health systems reviews, and health sector evaluations.

A total of 74 KIIs were conducted: 59 with country stakeholders (including 30 with government officials/PRs, 3 Country Coordination Mechanism (CCM) Secretariat members, 9 bilaterals and 17 multilaterals) and 15 with Global Fund Portfolio Managers (FPMs). Some interviews included multiple key informants; a total of 102 individuals participated in the interviews, which were guided by a set of interview questions (Annex 7 Box 10).

Data analysis

Data and information collected were entered into a matrix database for each country. A rubric scoring system was used to assess the level of alignment of RSSH investments and use of national systems. Four scoring categories were applied to the rubric matrix data: (1) emerging, (2) progressing, (3) established, and (4) advanced. The scoring criteria for each component of the analysis are presented in Annex 7.

Quantitative data were analysed to produce indicators for alignment and integration. Analysis of quantitative data was also used to triangulate findings from the qualitative analysis. The quantitative indicator under alignment measured the cross-cutting HSS as a proportion of GF expenditure on RSSH. The numerator was cross-cutting investments identified as part of Objective 2. The denominator was the total GF GAC approved budget for RSSH modules. This indicator is a proxy measure of the extent of RSSH investments' alignment with national HSS interventions and national needs/priorities. See Annex 7 for detailed methodological notes on other quantitative indicators.

Strength of Evidence (SoE)

An SoE indication was developed in our synthesis of findings across countries, and included three dimensions:

a. SoE across countries: This dimension assesses the number of countries supporting a specific finding. A country was considered to support a finding if the SoE within that country (see paragraph on 'SoE within country' below) was 33% or higher.
b. SoE within country: This dimension was assessed by dividing the number of interviews within a country that supported a specific finding by the total number of interviews in that country.
c. Alignment of the qualitative and quantitative findings: This dimension assesses the degree to which qualitative and quantitative (country-level) findings support each other. This SoE dimension was applicable to findings 3.1, 3.7, 3.9 and 3.10.

Limitations and assumptions

The RSSH mapping has a series of limitations and assumptions which it is important to consider in the interpretation of the findings. Table 5 provides a summary of the main limitations and mitigation actions that were taken for this study.

Table 5: Summary of main limitations and mitigation actions for this study

Limitation	Mitigation
1. There are varied definitions and interpretations of key terms used in the RSSH mapping. RSSH is a term used by the GF but not commonly used by other DPs and countries. This can lead to confusion when referring to GF investments in RSSH in an external context. In addition, the lack of commonly agreed definitions around HSS means that the terminology used is open to interpretation.	While this mapping did not set out to develop or create agreement around key definitions, we have sought to clarify the uses of terms (see Table 1 in the Executive Summary and a more complete Table 3 in the main report). In addition, as highlighted in the methods section, we have set out definitions of HSS and cross-cutting investments which were agreed with the TERG and WHO at the outset, and we have used this to frame to the analysis presented in this report.
2. The definition of RSSH that was used for the mapping exercise in Objective 2 framed the way in which we approached the analysis and – in full agreement with the TERG – promoted a major focus on mapping those investments that have been specifically identified as designed to deliver 'cross-cutting' benefits. However, the data used to inform this analysis does not allow for assessment of benefit.	It is important to emphasise that the data sources for this analysis were budget and expenditure data and, as such, could not provide information of the extent to which actual benefits were achieved from these investments. This is a mapping exercise and not an evaluation. To determine if activities in disease specific modules have cross-cutting benefit beyond the single disease area for which they had been curated, the activities and interventions will require more details and even some evaluation at the country level, which is beyond the scope of this mapping exercise.
3. The time-consuming nature of the categorisation exercise under Objective 2 global analysis (which involved a line-by-line review of all GF investments under RSSH and disease specific modules) means the analysis was only conducted in a sub-sample of countries	In order to maximise the coverage of this study, the mapping methodology was scaled up to 38 countries, representing 80% of the GF's total investment portfolio for NFM 2 & NFM 3. These 38 countries include the 15 case study countries, representing 30% of total investment.
4. The mapping project faced a series of logistical challenges around timing and access to key stakeholders. Accessing country-level stakeholders was a lengthy process requiring permissions from both WHO and GF. These delays compressed the period in which data collection and analyses were conducted.	A total of 74 KIIs were conducted, which is equal to an average of five KIIs per country (a range of 3–10 per country). While the number of KIIs conducted presents some limitations in terms of generalising findings from the country case studies, a process of validation and triangulation through extensive desk review and country-level quantitative analysis was undertaken. We applied a strength of evidence rating to findings to highlight where issues arise

Findings

This section presents key findings from the RSSH mapping, structured against the three objectives. Under Objective 1 findings, we present results from a critical review of the GF's approaches to defining, categorising and tracking HSS investments. Under Objective 2, we present results from our quantitative analysis of the magnitude and nature of GF investments, globally and at the country level. Objective 3 findings present results from the country case studies, structured under the topics of 'alignment' and 'use of national systems'.

Objective 1: Findings

Below we present the main findings that were derived from our critical evaluation of the RSSH tracking methods/tools and expenditure data categorisation used by the GF Secretariat.

Finding 1.1: GF systems allow for partial identification, differentiation and analysis of RSSH investments. Grant budgets allow for RSSH planned investments to be tracked in detail by module (e.g. community systems strengthening, health management information systems (HMIS) and monitoring and evaluation (M&E), HRH, including community health workers (CHWs)), intervention, cost category and cost input, alongside a description of each budget line. Expenditure data is available at the level of RSSH modules and interventions. This enables meaningful analysis of RSSH investments. For example, the country case studies present budget and expenditure by RSSH module, showing increased investments in community systems and laboratory systems in many countries between NFM 2 and NFM 3.

Grant budgets also provide information to estimate investments in support vs strengthening type activities and estimate RSSH Contributory (See Annex 1 Figure 8). However, this level of granularity is lost in grant reporting of budget against expenditure through the PUDR, which does not allow for cross-tabulation of these costs. This means that the GF has limited visibility of what happens to RSSH grants post-budget approval (e.g. in terms of cross-cutting vs disease specific and support vs strengthening).

Finding 1.2: The definition of RSSH and its relation to HSS continue to elicit differences in interpretation. RSSH is not equivalent to HSS; it is based on the definition set out in the RSSH Information Note, which includes WHO building blocks as well as community systems. There is no standard definition of HSS (see Annex 1 Table 12). Other DPs – e.g. Gavi, the United States Agency for International Development (USAID), the World Bank (WB) – also have an RSSH-type category of investments. The definition is largely based on the WHO definition and the building blocks; however, DPs tend to have a specific focus (disease specific vs cross-cutting).

'RSSH' is a term used by the GF, whereas other DPs use 'HSS' or similar terms to describe these types of investments. Like the GF, most other DPs we looked at include other areas of investment, such as community systems pandemic preparedness, within this HSS-type of investment category. They also use the term 'HSS', with some adding specific terms such as 'Health System and Immunisation Strengthening' (Gavi), 'Governance and Health Systems' (the Joint United Nations Programme on HIV and AIDS (UNAIDS)) and 'health systems strengthening for global health security and universal health coverage' (the Foreign, Commonwealth & Development Office (FCDO)).

It is common for DPs to adopt a definition of HSS-type investments which relates to the specific organisational strategies or programme objectives. For example, the President's Emergency Plan for AIDS Relief (PEPFAR) has a focus on laboratory strengthening, and the World Bank Global Financing Facility (WB GFF) focuses on health financing. There is recognition among DPs that greater standardisation is needed, and ongoing work includes HSSEC, Total Official Support for Sustainable Development (TOSSD) – a new statistical

framework to measure official support to sustainable development in developing countries, focusing on the sustainable development goals (SDGs) – and working groups on resource tracking and development finance statistics.

We found the organisations and programmes varied in the extent to which their HSS-type investments focused on strengthening health systems for disease specific outcomes compared to placing more emphasis on cross-cutting health outcomes. We also found different interpretations of cross-cutting, with some organisations interpreting this to mean investments across multiple WHO building blocks (cross-system investments) and others interpreting it at the cross-cutting health outcomes (health benefits beyond specific disease outcomes).

Finding 1.3: The Secretariat methodology for estimating GF RSSH investments applies a broad definition of HSS investments, while the definition used for this mapping study defines HSS investments as cross-cutting, as agreed with the TERG and WHO. This is a key reason for the lower estimates of RSSH investments identified in this study – see Objective 2. In order to categorise and track investments in RSSH, the GF Secretariat has developed a methodology (see Box 5 below) which adopts a broad definition of HSS that includes activities to support as well as strengthen systems to achieve both disease specific (RSSH Contributory) and cross-cutting (RSSH Direct) health outcomes. It includes RSSH Contributory which are primarily disease specific investments judged to also generate HSS effects. Our analysis of GF investments, driven by the definition of system-level investments in the Statement of Work (SoW) for this assignment (See Box 5), found that some of the investments categorised under the RSSH modules (RSSH Direct) are not cross-cutting; rather, they contribute primarily to achieving disease specific objectives. Some common examples of disease specific strengthening investment include one which would be categorised as RSSH Contributory, e.g. HIV recency surveillance, and one which would be categorised as RSSH Direct, e.g. assessments and development of national legislation, strategies, policies, regulations, protocols and guidelines for specific diseases. Based on the information available in the GAC budget, our mapping did not find any cross-cutting investments within disease specific modules (RSSH Contributory) since they are described under their disease specific, primary purpose.

Box 5. The GF methodology for estimating RSSH

The GF Secretariat RSSH methodology for estimating investments in RSSH is focused on the module and intervention level. All RSSH modules in RSSH stand-alone grants and disease specific and multi-component grants (RSSH Direct) are included in the estimate of RSSH investments. In addition, interventions within disease specific modules and programme management modules that have been categorised as contributing to systems strengthening (RSSH Contributory) are included based on their description and type of input. Our review of these investments at activity level found that some RSSH Direct and all RSSH Contributory investments are focused on single disease areas. The mapping methodology excluded programme management modules in the measure of cross-cutting investments.

Finding 1.4: The magnitude of investment in RSSH cannot be estimated accurately. This is due to different definitions being used, systems in place to track investments and limitations in the methodologies used. Estimates therefore vary due to the following:

1. The definition applied in the methodology. For example, the Secretariat methodology for estimating investments in RSSH applies a broader definition of HSS investments than the definition of investments in cross-cutting health systems used for this study. Unsurprisingly, applying different definitions means estimates can vary from between 6% to 24% of total GF investments in a given funding period.

2. Systems are not set up to track expenditure at the level of activity, so estimates are based on what is planned at the stage of the GAC budget. Expenditure data is not available routinely and is usually lagging. It also does not contain enough operational detail to enable the granular analysis that is possible with the budget data.

Limitations in the methodologies may lead to misclassification of activities if they are not properly coded. For example, the top-to-bottom approach taken by the Secretariat focuses on the modules and interventions. This approach is a quick and practical way to estimate RSSH investment, but it is prone to misclassification if the activities are not properly coded. In addition, it relies on some high-level assumptions that may be difficult to validate.

Finding 1.5: These limitations are not unique to the GF. Other DPs confirmed there are issues with internal and external reporting, including misclassification, subjectivity, and rigidity of budget codes – limiting ability to answer stakeholder questions.

From the examples of reporting we have seen (which are limited to publicly available data and descriptions through KIIs), we note the following findings. Estimates of the magnitude of investments range from around 5% to 35%, but the definition which is applied to generate this estimate varies by programme, and therefore they are not comparable. For example, a 2021 evaluation of UNAIDS investments in HSS[1] found that what was reported as having benefits beyond the specific outcomes of the programme mandate was not equivalent to actions designed to strengthen RSSH.

At least two of the seven organisations we looked at are reporting externally on HSS to the Organisation for Economic Co-operation and Development's Development Assistance Committee (OECD/DAC), and others may use tools at country level such as Resource Mapping and Expenditure Tracking (RMET) and country-specific expenditure tracking. However, a number of limitations were raised in relation to the categorisation and tracking of HSS-type investments.

1. These include misclassification of investments when budgetary codes are misapplied to activities which are not health system strengthening; for example, the 2019 audit of USAID HSS investments found some programmes with a majority of HSS activities focusing on a single primary health goal. Another stakeholder raised the issue of subjectivity in classification of investments as cross-cutting as opposed to single disease when classifying investments for external reporting to the OECD/DAC Creditor Reporting System (CRS).
2. OECD noted that the purpose code which maps most directly to HSS (12110 Health policy and administrative management) is not used exclusively for HSS. OECD also noted that although multiple purpose codes can be used to disaggregate investments into those with a disease focus and those which are more cross-cutting system strengthening, the use of multiple purpose codes makes reporting more complex and so was not being encouraged.
3. Finally, stakeholders highlighted limitations in their organisations' systems to track financial resources for HSS as they were not always set up to track against strategic priorities: '*[organisation] theme codes don't lend themselves very well to answering important questions stakeholders have*'. There is some use of 'policy markers' to address this. However, as one stakeholder noted, although there are policy markers set up in the CRS database, there is still inconsistency in how these are applied, e.g. primary health care (PHC).

Finding 1.6: Externally, the GF reports only a small percentage of investments in HSS to OECD/DAC. Reporting is based on disbursements of RSSH stand-alone grants only, so RSSH

[1] UNAIDS Evaluation Office. UNAIDS Contribution To Resilient and Sustainable Systems for Health Systems for Health (RSSH): Evidence Review. Geneva, Switzerland; 2021 Apr.

modules within disease specific grants are not included in the figures reported. Although there is no specific category for HSS investments within the OECD/DAC CRS database, the purpose code which maps most closely is 'Health policy and administrative management'. Table 12 in Annex 2 is an extract of data from the CRS database with the most recent data; only three of the 15 countries selected for our country-level analysis – Ethiopia, Senegal and Nigeria – record investments in this category for 2018 and 2019. Assuming this category is used to analyse GF and compare HSS investments with others (DPs and government), then this will lead to an underestimation of GF investments in HSS.

Finding 1.7: It is possible to use other approaches to track RSSH and cross-cutting investments at country level. However, this relies on detailed information being available through national study databases. The main approach for tracking external financing of health is the System of Health Accounts (SHA). RSSH investments can be tracked at an aggregated level both in the NHA report and in the GHED. The category of expenditure which maps most closely is 'Governance, and health system and financing administration'. However, as shown in the detailed mapping against SHA categories (Annex 5) and illustrative case of Eswatini, RSSH investments are likely to also be reported in other categories when the contributions have detail (see Box 6). For example, capital spending is separated as well as other purposes, such as programme disease control. Details exist in Health Accounts national study databases, especially when produced with the Health Accounts Production Tool (HAPT). Data can also be obtained through the WHO GHED when reported by the country. However, this relies on the information being recorded and released.

Box 6. Findings from GF expenditure tracking at country-level NHA, including illustration using Eswatini Health Accounts (See Annex 5)

RSSH does not have a specific code in SHA, but services funded are reported mainly as ancillary services (notably laboratory), preventive care, information, education and communication (IEC) in health, programme disease control with planning and management, M&E and procurement. These same services were provided at system level, identified as 'HC.7 Governance, and health system and financing administration'.

In the case of Eswatini, RSSH could include: a large part of ancillary services, not classified as detection or testing; most of the HC.6.5 (Epidemiological surveillance and risk and disease control programmes) related to planning and management; M&E and procurement. Spending on these same services (planning and management; M&E and procurement) at systems level, is reported as 'HC.7 Governance, and health system and financing administration'. In the case of Eswatini, **governance and administration could be doubled if it included preventive spending on disease control programmes (potential HSS) and would be increased tenfold if it included contributions at laboratory level (potential HSS).** Given that the GF RSSH investments are related to disease programme control activities, this is likely to be the case in other countries.

With the more detailed information from HAPT, we could identify that GF RSSH investments are going through not only governance and administration but also preventive care, capital, and laboratory. Governance is related e.g. to coordination and regulation; administration is related e.g. to procurement. But the disease specific investments are related to epidemiology and administration at programme level. However, at the NHA reporting level, the only overarching code that can be mapped to RSSH is governance and administration.

Finding 1.8: While it is technically possible to track GF investments at the country level, there are several limitations. Most notable of these are: (i) the categorisation of GF RSSH within NHA; (ii) insufficient description of the spending across the years of the project; (iii) the fact that accounting efforts not produced every year; (iv) the effect of time lag.

Lack of access to disaggregated data in the country NHA database prevents robust and systematic tracking of GF investments in HSS to inform monitoring and planning for future grants. The time lag in the NHA reporting also constrains the use of NHA to inform financing gap analysis, limiting the ability of countries to clearly identify current RSSH or HSS gaps.

Objective 2: Findings

Given the issues with estimating RSSH and health systems investments highlighted by Objective 1, any analysis comes with significant limitations, and findings should be interpreted with these in mind.

The definition used for the global analysis in this mapping exercise aims to estimate the proportion of GF investments that are primarily for cross-cutting rather than disease specific objectives. It is designed to provide a baseline for mapping of GF investments which aim to strengthen the health system. It does not seek to evaluate whether these investments have resulted in cross-cutting benefits. It is a much higher standard against which to measure GF investments in health system strengthening, so we would expect the proportion of investments falling into this category to be much smaller than for other measures.

Magnitude and nature of GF cross-cutting investments at global level

Finding 2.1: At budget level, about 7% of GF's total investments in NFM 2 & NFM 3 are cross-cutting investments, and these are found within RSSH modules and not in disease modules. GF's investment was categorised into cross-cutting investments, single disease investment (based on a line-by-line mapping of activity descriptions under the disease specific modules and RSSH modules across all grant types), programme management and COVID-19-related investments. The proportion of each category is as outlined in Table 6 below.

The proportion of cross-cutting investments in the total NFM 2 budget was 7%, and there was a slight drop to 6% by NFM 3, although in terms of the magnitude of investment there is an increase in the dollar amount invested in NFM 3 compared to that invested in NFM 2. The proportion of the single disease investment also dropped from 75% to 66% between NFM 2 and NFM 3; and, as with the cross-cutting investment, there is also an increase in the magnitude of investment between NFM 2 and NFM 3. The reduction in the proportion of investment for both cross-cutting and single disease investment observed between NFM 2 and NFM 3 is largely related to the introduction of COVID-19-related investment to both the NFM 2 and NFM 3 budgets. For NFM 2, the COVID-19-related investments were, mainly, reprogrammed budgets from other investment areas, while for NFM 3 additional investments were raised for COVID-19-related matters and were embedded from the onset of the grant making process.

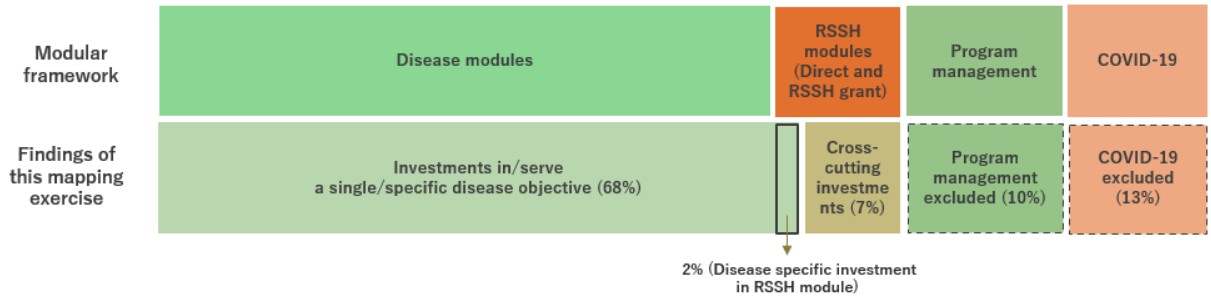
Table 6: Distribution of Global Fund investment across investment areas in NFM 2 and NFM 3 in 38 countries (80% of investments)

Investment area	NFM 2 (2017–2019) ($)	%	NFM 3 (2020–2022) ($)	%	Total ($)	%
Single disease	7,389,179,804	75%	8,741,183,678	66%	16,130,363,482	70%
Cross-cutting	731,199,083	7%	825,511,821	6%	1,556,710,904	7%
COVID-19	688,731,574	7%	2,526,969,782	19%	3,215,701,356	13%
Programme management	1,039,386,277	11%	1,218,317,895	9%	2,257,704,172	10%

Total	9,848,496,738	100%	13,311,983,176	100%	23,160,479,914	100%

Based on the mapping exercise, the single disease investment makes up about 70% of the total GF budget in NFM 2 and NFM 3, and about 2% of this was found in RSSH modules. These proportions are illustrated in Figure 2 below. For example, activities such as the Integrated Biological and Behavioural Surveillance (IBBS) survey among key populations, the development of an HIV information system, software development to strengthen antiretroviral (ARV) quantification, a TB mortality survey and an advocacy workshop for police on HIV/AIDS, although captured within RSSH modules, were eventually classified as single disease investments because the intervention and activity descriptions point the mapping analysis towards the single disease nature of the investment. It is noted that although these activities are single disease-focused, they meet the other system strengthening investment parameter of approach and longevity.

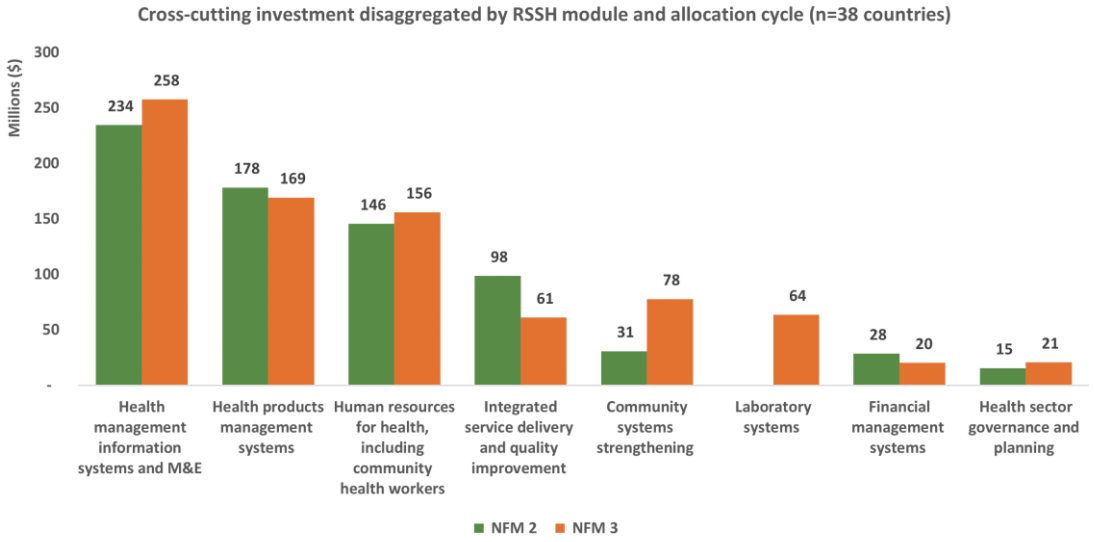
Figure 2: Results of the mapping exercise



The mapping exercise also reviewed all the investments in the disease modules and did not identify any cross-cutting investments in these modules. This was because the mapping did not assume that investments listed in these modules had cross-cutting benefits except where the text describing the investment clearly indicated this. For example, under the comprehensive prevention programmes for men who have sex with men (MSM), the HIV testing interventions are considered as having cross-cutting benefits to the health systems based on the GF Secretariat methodology and are classified as contributory RSSH investments.

Finding 2.2a: Cross-cutting investments are mostly made in RSSH modules for HMIS and M&E, health product management systems, and HRH. Across the two funding cycles, HMIS/M&E received the highest investment. This is followed by health product management systems and HRH, including CHWs. Financial management systems and health sector governance and planning received the least allocation across the funding cycles. These are illustrated in Figure 3 below.

Figure 3: Cross-cutting investments disaggregated by RSSH module and allocation cycle in 38 countries



The magnitude of the investment in the various areas changed between NFM 2 and NFM 3. The cross-cutting investments in HMIS and M&E, HRH, community systems strengthening and health sector governance and planning increased, while investment in health products management systems, integrated service delivery and quality improvement and financial management systems decreased. Specifically, cross-cutting investment in community systems strengthening more than doubled between NFM 2 and NFM 3, and the laboratory systems (a new RSSH module added to the modular framework in NFM 3) had investment of about $64 million in NFM 3.

Finding 2.2b: There are more RSSH investments in single disease and multi-component grants than RSSH stand-alone grants, and most of the cross-cutting investments are in the RSSH modules of the malaria grant. The GF provides grants across five separate components: HIV/AIDS, HIV/TB, TB, malaria and stand-alone RSSH. The cross-cutting investments are distributed across the grant components as illustrated in Figure 4. The proportion of the cross-cutting investment relative to the total investment in the different grant component is illustrated in Figure 5. The proportion of the cross-cutting investment found in the RSSH grant represents 31% of the total stand-alone RSSH grant, while the proportion of the cross-cutting investment found in the malaria grant represents 7% of the total malaria grant. However, due to the size of the disease grants, more RSSH investments are channelled through these grants than the RSSH stand-alone grants. For example, RSSH modules of the malaria grant have the highest cross-cutting investment (31%). This is followed by HIV/AIDS and HIV/TB. The stand-alone RSSH grant has 13% of the total cross-cutting investment (see Figure 5).

Figure 4: Cross-cutting investment as a proportion of total grant for the grant components in NFM 2 and NFM 3

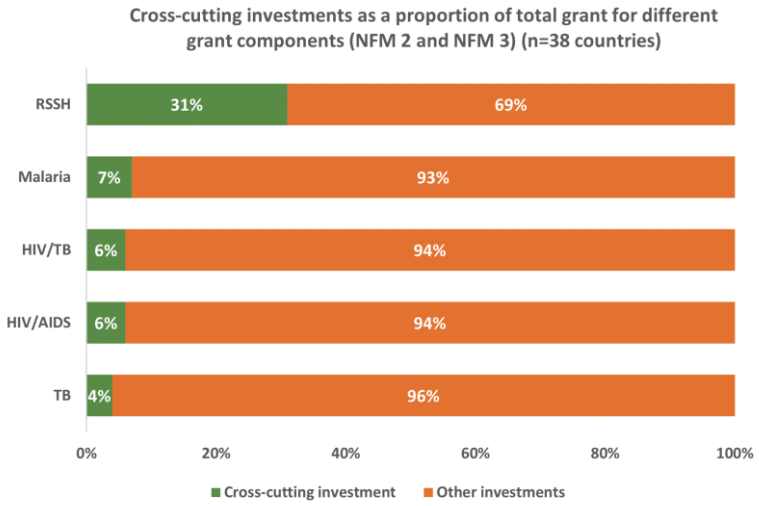
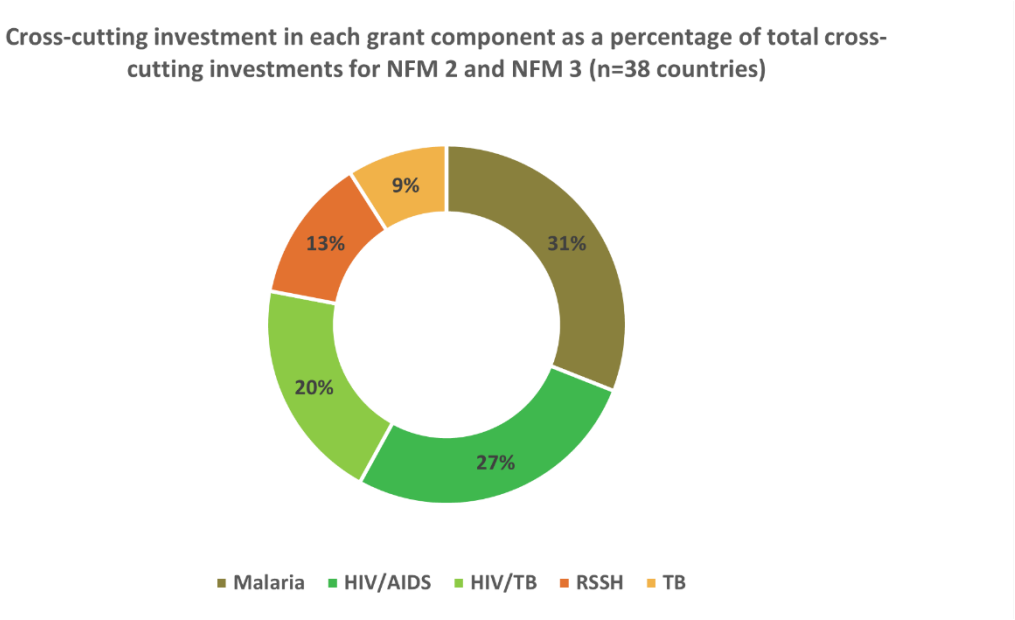
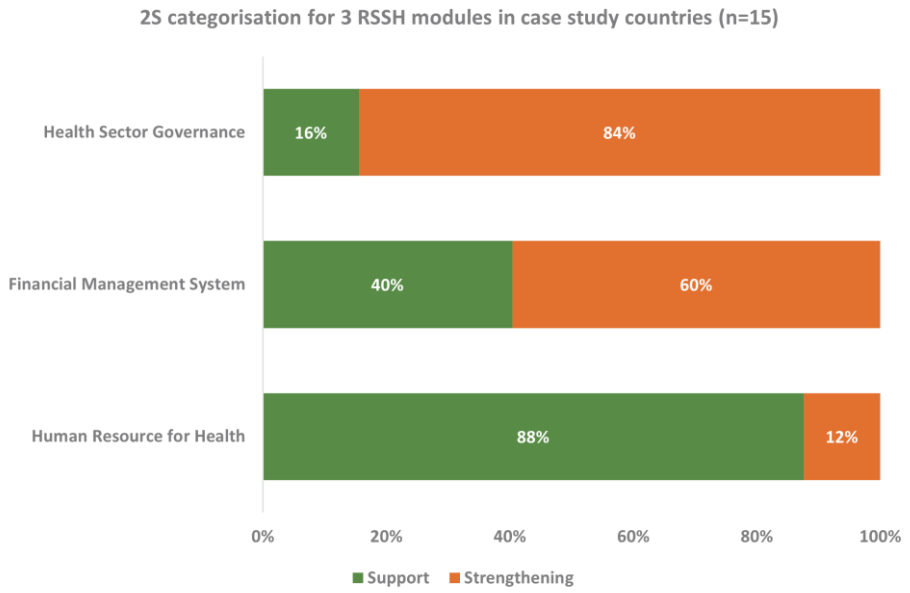


Figure 5: Cross-cutting investment in each grant component as a percentage of total cross-cutting investment for NFM 2 and NFM 3



Finding 2.2c: Distributions of health systems support and HSS investments varied by specific RSSH module, with a high proportion of support investments in HRH and a high proportion of strengthening investments in health sector governance and planning.

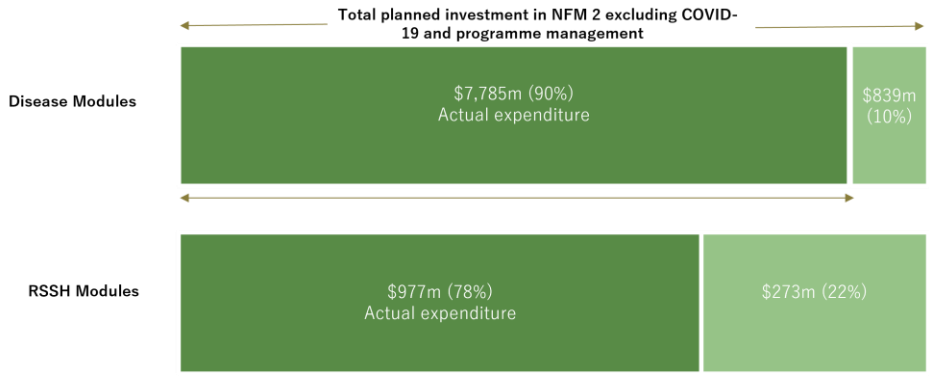
Figure 6: 2S categorisation for 3 RSSH modules in country case studies



About 88% of the amount budgeted for cross-cutting HRH investment was for support-related activities such as salaries and payment for results, delivered as incentives to health workers, while 12% was for strengthening activities such as trainings and other capacity building activities, development of HRH policies and guidelines, and development of national health workforce registries. For the health sector governance and planning module, the majority (84%) of investment was in strengthening, while 16% was budgeted for support-related activities. 60% of cross-cutting investment in the financial management modules was budgeted for strengthening activities, compared to 40% in support-related activities.

Finding 2.3: Given budget absorption rates for RSSH are lower than for disease specific grants, the estimate of cross-cutting investments is likely to be between 5% and 6% of total GF investments. A budget and expenditure analysis was done at the module level to compare total planned investment in single disease modules and RSSH modules to actual expenditure. Overall, the GF spent 11% less than was planned in NFM 2. As shown in Figure 7 below, this was 10% less than planned for single disease investment and 22% less than planned for RSSH modules. Assuming similar budget implementation rates, actual cross-cutting investments are likely to be between 5% and 6% of total GF investments.

Figure 7: Total planned investment in the GAC budget and actual expenditure excluding COVID-19 and programme management for NFM 2 (total investment in all countries in NFM 2)



Magnitude and nature of GF cross-cutting investments at country level

Comparison of GF investments compared to domestic and external investments at country level

Definitions and assumptions for the country-level analysis under this objective mean the ratios computed need to be interpreted alongside the limitations. For example, we have taken RSSH expenditure as a proxy for GF HSS investments, sourced from GF financial reports. Likewise, we are using the closest category in NHA to map to HSS, Governance, and health system and financing administration to estimate government and development partner investments. This was informed by the finding from detailed mapping of the GF modular framework to SHA categories.

Finding 2.4: In the 15 sample countries, governments are the main source of funding of HSS (51%), followed by DPs (35%). In these countries, the reliance on external funding is around a quarter of total current health expenditure (CHE), with exceptions such as Mozambique (60%) and Uganda (40%). GF RSSH investment (expenditure through RSSH modules) appears to be around a third of total HSS externally funded. Comparing GF investments with domestic and external spending is not a straightforward exercise and relies on assumptions. However, they can be used to provide a general overview of the situation of GF contributions vs those potentially associated resources of national and other DPs' organisations.

The full list of indicators proposed (Annex 6) is valuable to provide a general overview of the situation of GF contributions vs those potentially associated resources of national and other DPs' organisations. However, RSSH is not always understood as one single code and can hardly concentrate resources with multiple purposes in a single category of the various resource tracking systems.

A detailed mapping of the GF modular framework was conducted (Annex 5). Coding the modular framework handbook (MFH) intervention components showed that the category most frequently coded refers to governance and administration, followed by prevention. When considering the spending, capital on infrastructure is the single code with more spending. The grants for M&E are those with the largest amount of coding diversity (capital and current), followed by laboratory improvement and human resources, which also impact curative care.

For interpretation of the ratios in Table 7, it becomes clear that more detailed and specific content is needed for a more accurate tracking.

Table 7: Ratios resulting from proposed mapping study indicators (3.1 and 3.2)

Indicator % Country	HSS in CHE	GF expenditure on RSSH as % of domestic government HSS expenditure	GF expenditure on RSSH as % of total externally funded HSS expenditure	Government expenditure on governance and administration as % of total governance and administration expenditure	Externally funded HSS expenditure as % of total HSS expenditure	External as share of CHE
Armenia	0.0	**1.6**	**96.0**	98.2	1.6	1.0
Ethiopia	9.8	**7.4**	**8.1**	51.3	46.6	34.1
Eswatini	14.5	**3.8**	**10.0**	66.1	25.1	26.1

Guyana	5.3	**2.0**	**4.0**	58.8	32.4	2.7
Lao PDR	26.8	**0.2**	**0.2**	48.4	51.6	21.3
Mali	17.6	**2.7**	**100.0**	93.9	2.5	33.5
Mongolia	NA	**NA**	**NA**	NA	NA	5.1
Mozambique	30.4	**4.9**	**4.7**	48.8	51.2	62.8
Nigeria	0.1	**5.9**	**2.9**	33.2	66.7	12.7
Philippines	7.2	**NA**	**NA**	NA	NA	0.4
Rwanda	11.5	**54.2**	**64.1**	25.8	21.8	33.8
Senegal	6.6	**7.1**	**32.0**	71.4	15.9	17.9
Uganda	13.6	**7.8**	**2.1**	17.1	77.4	42.0
Vietnam	5.0	**0.2**	**100.0**	68.8	0.1	1.0
Zimbabwe	13.6	**38.5**	**23.0**	25.7	43.0	29.6

In this sample, HSS is a share of CHE, which is double the global average (6%). Governments are the main source of funding of HSS (51%, ranging from 17.1% to 98.2%), followed by DPs (35%, ranging from 0.1% to 77.4%). In these countries, the reliance on external funding is around a quarter of total CHE, with exceptions such as Mozambique (60%) and Uganda (42%). GF RSSH appears to be around a third of total HSS externally funded; however, in countries such as Armenia, Mali and Viet Nam, the relative importance is more than 90%. In Armenia and Viet Nam the reported external funding in CHE is relatively very low.

Rwanda is also worth mentioning as the support received by the GF RSSH appears to be important (60% of externally funded HSS). The GF RSSH represent an average of 10% of total domestic governmental contributions to HSS, with the exceptions of Rwanda (54%) and Zimbabwe (38%). The challenges in compiling these indicators are described in Annex 5, and relate to an operational definition of RSSH (equivalent as governance and health systems administration-HSS in GHED), data availability (e.g. GF expenditure amounts by intervention and by year; GHED updated up to 2019) and lack of detail (e.g. to make current vs capital analysis consistent or by type of contribution).

The uses of these ratios need to be explored further, as with use comes improved quality. Ratios need to be interpreted alongside the limitations. For example, disbursements do not always convert into spending, so monitoring the difference in amounts can be of value for a specific analysis. There are also many big differences between the positions of the GF in the various indicators, which are not easy to explain based only on the economic and health situation in the country.

Objective 3: Findings

Each finding in this section is followed by a table which illustrates the SoE of the finding. This includes SoE across countries (column 1), SoE within countries (column 2) and the alignment of qualitative and quantitative findings (column 3). Table 8 below provides an explanation of each of these categories as well as the colour coding key.[2]

[2] For more information on Strength of Evidence, please refer to Annex 7 (Objective 3 detailed methodology note)

Table 8: Strength of Evidence explanation

SoE across countries How many countries support the finding?	SoE within country How many interviews support the finding?	Alignment of qualitative and quantitative findings
>10 countries	>66%	Full
5–10 countries	33%–66%	Partial
<5 countries	<33%	Limited

Alignment with national priorities and plans

Finding 3.1: Stakeholders in countries widely perceive GF investments in RSSH to be well aligned with national priorities, health sector strategies and disease specific plans. Government officials and DPs explained that the process in place to develop funding requests (FRs) is robust and inclusive, which provides an essential foundation for alignment of GF investments. There was wide consensus that GF investments are informed by national health sector strategies and disease programme plans. Desk review and KIIs confirmed that most plans are costed, especially national disease programme plans, which is critical to informing analysis of financing gaps and ensuring that RSSH investments are complementary to investments by the government and other DPs. The SoE of this finding based on KIIs was strong: 15 countries and 93% of KIIs supported the finding. For example, in Eswatini stakeholders highlighted that all components of GF RSSH are mentioned in the National Health Sector Strategic Plan (NHSSP), and in Rwanda all country stakeholders agreed that GF investments in RSSH are aligned with the National Health Sector Plans through the use of the Single Project Coordination Unit.

In general, the quantitative analysis confirms the finding that RSSH investments are aligned with national health sector plans and priorities. Alignment from a quantitative perspective was measured by the proportion of investments in RSSH that are cross-cutting – a proxy measure for being aligned to broader health sector plans and priorities – rather than focusing only on disease specific outcomes. Our global analysis of 38 countries, representing 80% of GF investments in NFM 2 and NFM 3 (Objective 2 global analysis), found the proportion of cross-cutting investments within RSSH modules is higher than the global average (77%) in 10 of the 15 sampled countries. On average, in the 15 countries sampled, cross-cutting investments accounted for 79% of RSSH funding (ranging from 52% in Armenia to 97% in Zimbabwe).

Strength of evidence for finding 3.1

Across countries	Within country	Quant./qual.
15 countries	93%	Full

Finding 3.2: **A country's type of budgeting system matters to alignment.** Country stakeholders highlighted the impact of their budgeting systems on alignment of RSSH investments by the GF and other donors. Stakeholders in more than half of the 15 countries reported that GF RSSH investments are managed on budget (see Table 9), which means that financial flows are managed and reported on through government systems (Armenia, Ethiopia, Guyana, Lao PDR, Mozambique, Rwanda, Senegal and Uganda). Stakeholders in Eswatini and the Philippines reported that GF RSSH investments are not managed on budget. There was consensus among country stakeholders that donor funds managed on budget are more favourable to alignment than those managed off budget and that they strengthen integration and use of national systems.

Table 9: Overview of budgeting and financing mechanisms

Country	On budget	Programme-based budgeting	Pooled donor funding mechanism
Armenia	Yes	Yes	No
Eswatini	No	No	No
Ethiopia	Yes	Yes	No
Guyana	Yes	Yes	No
Lao PDR	Yes	No	Yes
Mali	No	Yes	No
Mongolia	Yes	No	No
Mozambique	Yes	Yes	No
Nigeria	No	Yes	No
Philippines	No	Yes	No
Rwanda	Yes	Yes	No
Senegal	Yes	Yes	No
Uganda	Yes	Yes	No
Viet Nam	No	Yes	No
Zimbabwe	No	No	No

Country stakeholders felt that programme-based budgeting (PBB) is more conducive to alignment, transparency and accountability than traditional line item or input-based budgeting by focusing on programme goals and outputs. Some countries had introduced or were in the process of introducing PBB (Ethiopia, Mozambique, Nigeria, Senegal and Uganda), with positive results. Some country stakeholders requested support from GF to support introduction of strengthening of existing PBB systems.

Stakeholders in Lao PDR and Uganda suggested that participation in pooled donor funding mechanisms may increase alignment of GF investments. For example in Lao PDR, GF RSSH funding is channelled through the WB-managed Health and Nutrition Services Access (HANSA) project, which also includes financing from the Australian government. There was consensus among key informants in Lao PDR that participation in this mechanism had helped alignment of RSSH investments and visibility of GF investments in the broader health system.

The SoE of this finding was relatively strong: 11 countries and 57% of KIIs supported the finding.

Strength of evidence for finding 3.2

Across countries	Within country
11 countries	57%

Finding 3.3: **Alignment of disease grants with disease national strategic plans (NSPs) is stronger than the alignment of RSSH investments with national health priorities and sector plans.** Country stakeholders provided different reasons for this finding. In Eswatini, Ethiopia and the Philippines, stakeholders pointed out that national disease programmes tend to have more senior representation and a stronger voice on the CCM. For example, one stakeholder

suggested '*the need for the CCM to shift to a more RSSH mindset and skillset*'. Stakeholders also suggested that it is easier to align investments when the FR is based on a costed plan, which is available for national disease programmes in all 15 countries. In contrast, it is more challenging to identify specific HSS investments in national health sector plans, especially in countries with input-based budgeting. For example, country stakeholders in Eswatini highlighted that HMIS properly costed, activity-based strategic plans for HMIS and the central medical store would have enabled the identification of financing gaps that GF RSSH funding could have filled.

This finding was supported by six countries and 38% of KIIs.

Strength of evidence for finding 3.3

Across countries	Within country
6 countries	38%

Finding 3.4: Country stakeholders suggested that while the CCM functions effectively overall and provides leadership to the development of FRs and implementation of grants, more attention needs to be given to HSS investment priorities and challenges. There are natural champions for the disease programmes among CCM members, who are often specialists in these areas, while it may be less evident who will elevate health systems discussions on the CCM agenda. Country stakeholders suggested that CCMs could contribute to improved alignment of GF investments in HSS by allocating more time and focus to health systems issues and that the Ministry of Health (MOH) can do more to signal that RSSH investments are a priority by appointing senior officials on the CCM to help elevate and drive the RSSH agenda. They also suggested that this may contribute to raising the visibility of GF RSSH investments, which are not always well understood by actors in the broader health sector. These findings align with the GF Office of the Inspector General (OIG) 2019 Audit of Managing investments in RSSH, which stated that:

'Most in-country grant implementation structures, including coordination mechanisms, are set up with little emphasis on cross-cutting health systems. This affects countries' ability to design and implement strategies to strengthen health systems. Therefore structures, policies and processes for the management of RSSH investments are rated as needing significant improvement'.

This finding was supported by six countries and 38% of KIIs.

Strength of evidence for finding 3.4

Across countries	Within country
6 countries	38%

Finding 3.5: There were some examples of countries which reported that reprogramming of GF grants had enabled them to shift funds from disease specific investments to RSSH investments. This finding was reported by key informants in Armenia, Guyana, the Philippines, Uganda and Zimbabwe. Examples of RSSH investments supported by reprogramming included surveillance and information systems, patient-based electronic records systems, electronic logistics management systems, laboratory networks, and the warehouse function of the supply chain. In Armenia, MOH has submitted a reprogramming request to support the introduction of comprehensive medical insurance, the establishment of a human resource testing and certification centre at the National Institute of Health, and the development of telemedicine.

In Eswatini the reprogramming process was leveraged by GF to co-finance connectivity through a local mobile company provider, which led to large savings and discussions on expanding support in this area. Country stakeholders in Lao PDR suggested that there was less need for reprogramming of GF grants since the HANSA project's pooled funding mechanism provides more flexibility to shift funding to achieve targets.

Some stakeholders also suggested that reprogramming from the disease specific grants was accelerated by the COVID-19 pandemic, which increased the need to strengthen health systems components such as health facilities, laboratory networks and surveillance systems. For example, key informants in Mongolia reported that the COVID-19 pandemic had brought several challenges to the health system and that the reprogramming process should be more flexible to enable to grants to be responsive to the changing needs on the ground.

This finding was supported by seven countries and 48% of KIIs.

Strength of evidence for finding 3.5

Across countries	Within country
7 countries	48%

Finding 3.6: Reprogramming of GF grants improves budget absorption rates. Analysis of RSSH module expenditure as a share of budget (see also analysis in Workstream 2) found that the 15 countries had a higher rate of RSSH budget absorption than the average (70%) for the 38 of countries analysed. Some country stakeholders suggested that the GF has shown flexibility to facilitate the reprogramming process. For example, in Viet Nam one stakeholder reported that the GF had demonstrated flexibility in the reprogramming of a grant to keep patients on ARVs when there was a stock out. In Lao PDR, country stakeholders explained that the GF had facilitated the reprogramming process through open dialogue and willingness to explore different options. On the other hand, others felt that the efficiency and the effectiveness of reprogramming would benefit from more flexibility. For example, in Mongolia stakeholders noted that the GF should consider greater flexibility in the reprogramming of funds: reprogramming is perceived as a time-consuming process, constraining the ability to leverage reprogramming to respond to emerging needs on the ground.

There are also other factors that influence budget absorption rates. The OIG 2019 Audit of Managing investments in RSSH found that a lack of engagement of disease programmes in discussions of RSSH activities can lead to delays in implementation and gaps in coordination of RSSH activities, which in turn can have a negative impact on absorption rates for RSSH modules in stand-alone grants (56%, reported by the OIG audit) and for RSSH modules within disease grants (67%) compared to disease grants (75%). This was also supported by qualitative evidence; for example, in Ethiopia it was noted that RSSH components are managed by different autonomous entities, thereby affecting the speed of implementation and absorption of the grant as opposed to disease specific grants.

Finding 3.7: Governments are facing challenges in reporting on GF co-financing commitments. Country stakeholders agreed with the premise underpinning GF co-financing, which is to promote ownership and sustainability by encouraging greater government investments in health systems and disease programmes. In practice, interviews with government officials and DPs revealed that countries face significant challenges in reporting spending towards co-financing commitments, especially estimating the value of commitments that are expressed in kind (for example, accounting for a share of government-financed salaries of health workers who are involved in implementation of GF-financed activities).

There is a lack of RSSH co-financing commitments data for seven countries. Zimbabwe, on the other hand, has been exempted from co-financing due to economic challenges in the country. There appear to have been increases and reductions in the RSSH co-financing commitments across most of the countries. These changes could be attributed to epidemiological, programmatic, systems-related, governance, human rights, community systems, and political contexts which are not reported in this assignment. They also depend heavily on a specific country or regional contexts, including the epidemiological situation, macro-fiscal context, reliance on external financing for the health sector and the structure of the overall health system.

The SoE of this finding was relatively strong: 11 countries and 51% of KIIs supported the finding.

Strength of evidence for finding 3.7

Across countries	Within country	Quant./qual.
11 countries	51%	Full

Use of national systems to support grant implementation and reporting

Finding 3.8: Country stakeholders confirmed GF RSSH investments generally use national systems at the central level. However, some noted that insufficient attention is given to subnational resource allocation and decision-making processes and that community health systems should be given more priority. Key informants in Ethiopia, Mozambique and Uganda felt that subnational functions and relevant capacity are often forgotten in the design of and support to national health systems. These key informants stated that the ability of regional and local authorities to plan, allocate and coordinate resources, processes and systems is critical. Country stakeholders in Ethiopia, Mozambique and Uganda highlighted that additional attention, representation (of community organisation on the CCM), and financial and technical support are needed to strengthen community health systems through GF RSSH investments. In Ethiopia, GF RSSH investments provided support to the Health Extension Programme, including CHWs and service delivery packages at grass roots level. In Uganda, country stakeholders suggested that identifying the needs of communities is critical to ensuring successful service delivery and that GF could push forward this agenda in collaboration with MOH.

The finding on use of national systems was supported by 15 countries and 89% of KIIs. The finding on subnational systems was supported by four countries (Ethiopia, Mozambique, Nigeria and Uganda.

Strength of evidence for finding 3.8

Across countries	Within country
15 / 4 countries	89%

Finding 3.9: Some countries generate data and information from national public financial management (PFM) and health information systems for financial and programmatic reporting to GF, while in other countries separate systems have been set up. Countries that use national systems for grant implementation and reporting include Eswatini, Ethiopia, Lao PDR, Rwanda, Viet Nam and Zimbabwe. Countries where separate systems have been set up include Armenia and the Philippines. For example in the Philippines, given that the PRs are not

government agencies but non-governmental organisations, the HSS investments do not use national systems for financial management and reporting.

The implementation of most RSSH funding (RSSH modules) is managed by government institutions. Management of RSSH funding by government institutions should generally lead to increased integration and use of national systems. In 15 case study countries, government PRs – including MOH, the Ministry of Finance (MOF) and national disease programmes – manage, on average, 80% of grant budgets. The median was even higher at 92% because of outliers in the Philippines (0%), Nigeria (35%) and Mali (47%). Many governments have also installed project management units, which further strengthen integration and use of national systems.

The SoE of this finding was relatively strong: eight countries and 73% of KIIs supported the finding.

Strength of evidence for finding 3.9

Across countries	Within country	Quant./qual.
8 countries	73%	Full

Finding 3.10: Stakeholders consider NHAs to be the primary tool for resource tracking and they can be used to track GF RSSH investments. Most countries reviewed reported they can track health expenditure through NHAs, although some countries (such as Nigeria and Viet Nam) highlighted that this is not done routinely. One country (the Philippines) noted that it was not possible to track GF RSSH investments through NHAs, while another country, Rwanda, has also set up national tools – such as the Health Resource Tracking Tool (HRTT) – to track public, private and donor expenditures in health.

Although the detail needed to track GF investments is not displayed in an NHA report, it is likely to exist within underlying data presented in the NHA study database. An agreement is needed to make available such details for GF tracking needs. However, there are limitations of using NHA data to track investments including time lag, although the T-2 production (e.g. producing NHA 2018 in 2020) is under revision to reach T-1. As expenditure reports are never available on T, an agreement can also be reached to get preliminary/expected aggregates. The strength of expenditure analysis is to be close to reality. However, in reality it is challenging to access disaggregated data for such analysis (because governments are sometimes reluctant to share the NHA database), and there are often considerable time lags because financial data can take a long time to be released by governments and because of the time involved in carrying out data collection, validation and analysis for NHA. This has greatly limited the utility of pursuing such analysis for this exercise.

A recent report by OIG confirmed some of the challenges of using NHAs to track RSSH investments. The 2022 OIG Advisory on the Global Fund's Role and Approach to Domestic Financing for Health (DFH) found that '*the issuance of most health financing results on key indicators are [sic] delayed by several years*' and that the NHAs are delayed because they rely on '*audited governmental financial data which are often two years after the period end, inhibiting prompt corrective actions*'.

The SoE of this finding was strong: 14 countries and 71% of KIIs supported the finding. Quantitative analysis also supported this finding.

Strength of evidence for finding 3.10

Across countries	Within country	Quant./qual.
14 countries	71%	Full

Conclusions

We have identified thirteen conclusions from this study, outlined below. They have been categorised according to those that relate to (1) the definition and categorisation of HSS, (2) tracking of RSSH investments, (3) the magnitude and nature of GF RSSH investments and (4) operations of the current GF business model.

Conclusions related to the definition and categorisation of HSS

1. **The lack of a standard definition of HSS, together with the limited comparability of 'HSS' interventions, leads to inconsistency between agencies in defining and targeting investments for systems strengthening, including between those that focus on disease specific areas and those that focus on cross-cutting outcomes.** The definition of RSSH and its relation to HSS continues to elicit differences in interpretation**.** RSSH is not equivalent to HSS; it is based on the definition set out in the RSSH Information Note which includes WHO building blocks as well as community systems. There is no standard definition of HSS (Annex 1 Table 11). Other DPs – e.g. Gavi, United States Agency for International Development (USAID), the Global Financing Facility for Women, Children and Adolescents (GFF) – also have an RSSH-type category of investments. The definition is largely based on the WHO definition and the building blocks; however, it is common for DPs to adopt a definition of HSS-type investments which relates to the specific organisational strategies or programme objectives.
2. **For the GF, issues relating to misclassification, subjectivity, and rigidity of budget codes hinder the effective categorisation and definition of RSSH investments, reducing the ability to use financial data to answer strategic questions on how RSSH investments are used – even as the new Global Fund Strategy proposes to make RSSH a mutually reinforcing contributory objective to the overall goal of ending AIDS, TB and malaria.** These limitations are not unique to GF. Other DPs confirmed there are issues with internal and external reporting, including misclassification, subjectivity, and rigidity of budget codes.
3. **The GF methodology for measuring RSSH investments uses a definition which does not correlate with what most stakeholders consider to be HSS (and this mapping analysis of cross-cutting investments); definitions vary on the extent to which HSS includes disease specific vs a focus on cross-cutting.** The main point of departure is the inclusion of RSSH Contributory in the measure of RSSH, which assumes that some investments in disease specific interventions may contribute to cross-cutting outcomes. Although these assumptions may be theoretically valid, the extent to which they hold true across all GF countries is unclear and will require further country-level evaluation to be able to reach a better conclusion as to the cross-cutting benefits of the interventions/activities.

Conclusions related to tracking of RSSH investments

4. **Analysis of the available GF global data sets provides limited visibility of what happens to RSSH grants post-budget approval stage, which means it is hard to answer questions about how strategic priorities on RSSH is operationalized. Specifically, this means that RSSH spending cannot be tracked at sufficiently granular level to address questions around type of RSSH spend (contributory, cross-cutting, support vs strengthening, etc.).** GAC budgets allow for RSSH planned investments to be tracked in detail by module, intervention, cost category and cost input alongside description of each budget line. In using information from Progress Update Disbursement Request (PUDR) forms to assess GF RSSH spending, this mapping exercise observed that the level of granularity in analysis of RSSH investments is lost, as PUDR reports do not allow for cross-tabulation of costs. In

addition, the analysis of health accounts needs to identify what constitutes RSSH expenditure in a standard way. Expenditure detail by module, intervention, cost category and cost input would allow for more specific tracking of the RSSH spending and greater potential to influence in health systems decisions.

5. **In order to better track relevant RSSH spending from the GF in alignment with other partners, it is theoretically possible to improve the approaches to track RSSH and cross-cutting investments at country level. However, this requires both an investment in developing standardised monitoring frameworks and a focus on accessing detailed information being through national study databases.** Most health expenditure tracking exercises are guided by the System of Health Accounts (SHA). While the conceptualization of health systems has evolved over time, health expenditure tracking frameworks have not kept pace. While it is technically possible to track GF investments at the country level, this would require two key actions. Firstly, there needs to be an investment in developing standardised mapping of health expenditure tracking frameworks. Secondly, there needs to be a a focus on accessing detailed information through national study databases and improving those databases. It is important to highlight that while in theory such improvements can be implemented, there will still be significant limitations, such as lack of access to disaggregated data in the country National Health Accounts (NHA) database. The time lag in NHA reporting also constrains the use of NHA to inform financing gap analysis, limiting the ability of countries to clearly identify current RSSH or HSS gaps

6. **The current approach for tracking RSSH investments has limitations, and routinely evaluating health system strengthening outcomes comes with significant challenges and costs. However, a more accurate, low-cost and timely measure of GF investments in RSSH is to track investments (budget and expenditure); this may be possible through a greater emphasis on tracking RSSH modules.** A focus on inputs will, by definition, provide only a partial view of RSSH investments. However, getting insights on outcomes requires significant investments in evaluation and will only ever provide a partial view. Tracking GF RSSH investments through existing modules of RSSH could provide a potentially lower cost way of partially addressing this challenge and may provide a better way of generating a baseline assessment of RSSH spend on which to measure future investments.

Conclusions related to the magnitude and nature of GF RSSH investments

7. **The magnitude of RSSH investment (direct and contributory) estimated using the current GF Secretariat approach to tracking these investments is significantly higher than the cross-cutting investment estimated in this mapping exercise. This is because the GF Secretariat approach uses a broader definition and set of assumptions than the methodology for this mapping exercise.** The definition used for the global analysis in this mapping exercise aims to estimate the proportion of GF investments that are primarily for cross-cutting rather than disease specific objectives. It is designed to provide a baseline for mapping of GF investments which aim to strengthen the health system. It does not seek to evaluate whether these investments have resulted in cross-cutting benefits. It is a much higher standard against which to measure GF investments in health system strengthening, so we would expect the proportion of investments falling into this category to be much smaller than for other measures.

   The GF Secretariat approach tags all investments labelled ‘RSSH’ as cross-cutting systems strengthening, whereas our analysis found that some investments under RSSH modules did not meet this criteria. The Secretariat methodology also assumes that some disease specific modules and interventions in the programme management module have HSS benefits. Although these assumptions may be theoretically valid, the extent to which they hold true across all GF countries is unclear and will require further country-level evaluation

to be able to reach a better conclusion as to the cross-cutting benefits of the disease specific and programme management interventions/activities.

8. **At budget level, about 7% of the GF's total investments in NFM 2 & NFM 3 are cross-cutting investments, and these are found within RSSH modules and not in disease modules.** This estimate was reached by applying the definition of investments in cross-cutting health systems, as agreed with the TERG and WHO for this mapping study. The cross-cutting investments make up about 77% of the investments in the RSSH modules (7% overall). The GF's investment was categorized into cross-cutting investments, single disease investment (based on a line-by-line mapping of activity descriptions under the disease specific modules and RSSH modules across all grant types), programme management and COVID-19-related investment. Applying the definition and methodology for this mapping exercise and reviewing all the investments in the disease-specific modules, no cross-cutting investments were identified in these modules.

9. **Mapping interventions into system support and strengthening can be highly subjective, and accurate tracking of the balance between HSS *support* and *strengthening* is extremely difficult. Our analysis was able to generate some limited insights into the way RSSH investments have been divided across these two areas in the GF, but they necessarily need to be interpreted with these limitations in mind. Currently, GF systems are not set up to track this routinely; as such, decisions about the optimal balance between these types of investment are not well informed.** The classification of some interventions into support and strengthening are highly dependent on how the intervention is planned and delivered, for example capacity building/training depending on the area of focus and the target group. Performance-based initiatives delivered at the service delivery/health facility level will differ from incentives provided to deliver systems strengthening interventions. As a result, mapping interventions into system support and strengthening can be highly subjective, and mapping should be done with adequate knowledge of the programme implementation and nuances.

   Our analysis identified some important trends. For example, distributions of health systems support and HSS investments varied by specific RSSH module, with a high proportion of support investments in Human Resources for Health (HRH) and a high proportion of strengthening investments in health sector governance and planning.

   The debate on what constitutes strengthening and systems support is ongoing and it is not appropriate to label one as desirable and the other undesirable. Country health systems differ in maturity/progression and weaknesses; as such, systems support and strengthening interventions should be tailored according to country-specific constraints and opportunities.

   Although supporting the system alone can improve performance in the short term, only activities that go beyond strengthening the system can improve the system's (resilience) ability to respond to future challenges. Support investments are necessary, but there is a need to strike the right balance between these investments, and this decision is a policy/strategic decision that is highly country-specific. The process of mapping and categorising these investments to support and strengthening can be helpful in helping to frame the decision around what the optimal balance should be. Currently, GF systems are not set up to track this routinely; as such, decisions about the optimal balance between these types of investment are not well informed.

Conclusions related to operations of the current GF business model

10. **Our analysis at country level highlighted that stakeholders in countries widely perceive GF investments in RSSH to be well aligned with national priorities, health sector strategies, and disease-specific plans. However we also found that alignment of disease**

grants with disease national strategic plans (NSPs) is stronger than the alignment of RSSH investments with national health priorities and sector plans, indicating that there may be ways to improve alignment. The strong stakeholder agreement on alignment is a testament to the robust and consultative GF funding request process which provides a critical foundation and starting point for ensuring alignment of RSSH investments with government HSS priorities. RSSH continues to feature more prominently in recent NSPs, albeit still largely in the context of health system needs required for the delivery of HIV, TB and malaria programmes.

As the GF targets continuing to complement other financers on key HSS functions, alignment of GF investments in RSSH can be further enhanced – and can support integration/use of national systems – by identifying opportunities to use appropriate national budgeting and financing mechanisms for grant implementation. Participating in pooled financing mechanisms, such as in Lao People's Democratic Republic (Lao PDR), may strengthen alignment of GF RSSH investments if such arrangements are implemented in a way that satisfies GF reporting requirements and links financing with health outcomes.

11. **Our analysis highlighted some key insights around the ways in which RSSH investments are being used at country level. In other cases it was noted across a number of case study countries that insufficient attention has been given to subnational resource allocation and decision-making processes, and that community-level health systems should be given more priority. The case studies also generated a number of recommendations (from in-country stakeholders) that could be leveraged to help improve future alignment.** Key insights included the fact that countries reported that reprogramming of GF grants had enabled them to shift funds from disease specific investments to RSSH investments. Others highlighted an opportunity for the GF to increase the impact of its RSSH investments by expanding its engagement with subnational governments and processes, especially in countries where decentralization is advanced. This is already practiced in disease grants through differentiated delivery, subnational tailoring, etc. Other opportunities include for the GF to work with the Ministry of Health (MOH) and other partners to strengthen its focus on community needs and community health systems as well as leveraging its RSSH and disease specific grants to highlight broader sector and health system issues of relevance to GF grant implementation.

12. **Countries continue to face significant challenges in reporting spending towards health from their domestic financial commitments. In addition, lack of data on co-financing commitments and expenditure in RSSH spend is evident.** With the devastating effects of the COVID-19 pandemic on public spending – which has implications for health and health spending – countries are facing a wide range of challenges in reporting spending towards health from their domestic financial commitments. As the GF operationalizes its new Global Fund Strategy – which places a focus on more and better integrated and aligned funding of HSS through domestic resource mobilization – availability of country level data on co-financing commitments in RSSH should be prioritized.

13. **Country stakeholders confirmed that GF RSSH investments generally use national systems at the central level which are associated with greater alignment.** Some countries generate data and information from national public financial management (PFM) and health information systems for financial and programmatic reporting to the GF, while in other countries separate systems have been set up. The implementation of most RSSH funding (RSSH modules) is managed by government institutions, and in these cases management of this was generally associated with increased integration and use of national systems.

Recommendations

Based on the analysis done in this report and the discussions held with internal and external stakeholders, the following recommendations – categorised as strategic or operational – are prioritised. We have identified four strategic recommendations and four operational recommendations. There are six high priority recommendations that we believe, if well addressed, can help address the issues of measurement, comparability, magnitude and alignment of RSSH investments at the global, Secretariat and national level going forward.

Recommendations related to the definition and categorisation of HSS

Recommendation 1 (High Priority/Strategic): The Global Fund Secretariat and DPs should work towards making explicit the contents of the RSSH/HSS composition in their resource tracking. This implies that health expenditure tracking frameworks reflect relevant RSSH spending from the GF and other partners. The mapping should match both the GF and SHA categories to have a one-to-one relation. In practice this is challenging, as category content in both systems is based on different taxonomies. In fact, RSSH interventions may overlap several SHA categories and classifications (see Annex 5). The GF can work in a number of ways towards updating frameworks for health expenditure tracking (see Box 7).

Box 7. Actions to update frameworks for health expenditure tracking

a) Take a decision on the convenient level of detail to be used for the standardised mapping. Accordingly, the labels to be used should preferably be concise and additionally provide a clear description of its content, e.g. capital and current, and identify whether the resource is directed to health care provider level or to the governance and management of the health system.

b) The integration of GF monitoring could, ideally, be part of an SHA-compatible health financing information system. This could progressively include IT solutions for a more accurate, detailed, integrated retrieval of desired reporting by all domestic and foreign sources. It could also be possible to assess the GF investments and the related domestic co-financing, which in SHA could represent a memorandum item.

c) Although general guidelines exist for a standardised monitoring (SHA2011), additional resource tracking operational guidelines are needed to support the process at country level. At the moment, a guide on administration and governance is lacking. An effort on this area specifically is doable in a relatively short time and would have positive benefits.

d) Finally, notifying the NHA teams of the potential use of GF RSSH aggregates and detail would facilitate a proper visibility. This can be done during the preparation of the Health Accounts.

Recommendation 2 (High Priority/Strategic): The GF should work together with DPs to ensure greater standardisation of definition and categorisation of HSS building on ongoing work with the Health Systems Strengthening Evaluation Collaborative (HSSEC), Total Official Support for Sustainable Development (TOSSD) and working groups on resource tracking and development finance statistics.

Recommendation 3 (High Priority/Strategic): Given that existing reporting to the board is based only on planned investments in RSSH and that RSSH Contributory is not aligned with the way that other DPs defined HSS, a potentially more accurate, low-cost and timely measure of GF investments in RSSH (budget and expenditure) is to track investments through the existing RSSH modules. This can be complemented by a review of disease specific modules by the Secretariat for purposes of detailed mapping so as to identify and propose approaches to increase cross-cutting effects and efficiencies.

Recommendations related to tracking of RSSH investments

Recommendation 4 (High Priority/Operational): The Global Fund Secretariat should explore the feasibility of extending PUDR expenditure reporting to enable cross-tabulation of module, intervention, cost category and cost input by budget line item. Cross-tabulation would allow for the level of granularity in analysis based on strategic priorities such as disease specific vs cross-cutting.

Recommendation 5 (High Priority/Operational): The resource tracking system of the GF should be shared with country NHA teams so as to facilitate proper visibility of RSSH investments. Cooperation between the GF, resource tracking teams at national level and other resource tracking associated organisations should be encouraged in order to ensure a better mix of modules/interventions/cost categories and cost inputs for RSSH tracking.

Recommendations related to the magnitude and nature of GF RSSH investments

Recommendation 6 (High Priority/Operational): The GF should continue to support alignment through the existing country-led process for preparing funding requests (FRs) and should support and engage in national alignment frameworks led by the government. The FR preparation process should include assessment and dialogue on opportunities to manage GF investments in RSSH that include use of programme-based budgeting and/or integration with pooled donor funding mechanisms as relevant and appropriate to the country context.

Recommendation 7 (Medium Priority/Strategic): Over time, the GF should move towards use of national systems for reporting as countries' capacities in reporting increase, and should (where appropriate) continue to strengthen such systems. RSSH grants should be implemented by the national structures that have a formal mandate to implement the health system interventions, but adequate consideration of community health systems needs to be built into the FR preparation process and grant implementation.

Recommendations related to operations of the current GF business model

Recommendation 8 (Medium Priority/Operational): The principal recipients (PRs) of the GF should ensure that the data they provide to the NHA team in MOH is comprehensive, disaggregated and submitted in a timely manner. The GF should work with MOH and WHO to enable regular access to relevant disaggregated data from the NHA database to track investments in HSS. Given that accounting efforts are not produced every year and given the time lag, the GF can direct investments to facilitate routine reporting to financial management systems (interoperable with Health Management Information Systems (HMIS)) which are accessible to the Health Accounts team.

Annex 1: Objective 1 detailed methodology note

Objective 1: Review of RSSH and other HSS tracking methods and tools

Objective 1 aims to provide an overview of GF's approaches to RSSH tracking and categorisation methods and tools and compare this to other categorisation schemes used to track HSS investments. To respond to this objective, the following mapping questions (MQs) were explored:

MQ1.1 What are the GF's existing approaches to tracking RSSH, single disease area investments and cross-cutting area investments?

MQ1.2 How do existing GF tracking approaches align to and/or differ from other development partners' (DP) HSS tracking approaches?

MQ1.3 How do GF RSSH tracking approaches align to and/or differ from National Health Accounts systems?

Methodology

Document reviews and key stakeholder interviews were used to answer each of the WS1 mapping sub-questions. Table 10 presents an overview of documentation reviewed and teams/organisations of key stakeholders interviewed for each of the mapping questions. Documents were reviewed to understand definitions, methodologies, scope of analyses, financial data uses and the levels of analysis routinely conducted. For the comparative analysis under MQ1.2, we also reviewed publicly available information on the definitions used by DPs and built on the work of the Health Systems Strengthening Evaluation Collaborative.

Table 10: WS1 document review and key stakeholder interviews

Workstream 1: Mapping question	Documents reviewed	KIIs
MQ1.1 What are the GF's existing approaches to tracking RSSH, single disease area investments and cross-cutting area investments?	GF Secretariat methodology note on RSSH The Technical Review Panel (TRP) methodology The prospective country evaluation methodology	GF Secretariat – RSSH Team GF health financing GF management oversight and reporting
MQ1.2 How do existing GF tracking approaches align with and/or differ from other development partners' HSS tracking approaches?	PEPFAR USAID Gavi PMI OECD DAC WHO FCDO UNAIDS	USAID GFF FCDO OECD DAC
MQ1.3 How do GF RSSH tracking approaches align with and/or differ from National Health Accounts systems?	The System of Health Accounts (SHA) National Health Sector Plans Government Financial Statistics (GFS)	OECD

	Databases (including NHA, GHED, OECD DAC CRS)	

Definitions of Health Systems Strengthening

The World Health Organization (WHO) defines health system strengthening as an array of initiatives and strategies that lead to better health through improvements in one or more of the health system's building blocks (WHO, 2007). The WHO framework for health systems strengthening identifies six attributes of a health system: a health workforce; health services; health financing; governance and leadership; medical products, vaccines and technologies; and health information (Nutley & Reynolds, 2013).

As part of the work of the Health Systems Strengthening Evaluation Collaborative (HSSEC), Itad reviewed working definitions of HSS for each of the development partners (DP) involved in the Collaborative. Table 11 below sets out working definitions for each partner. DP definitions are varied and focus on different aspects of the system. In some cases they are also a work in progress, pending or under debate.

Table 11: Working definitions for the various DPs in HSS

Stakeholder	Definition
BMGF	PHC is 'a package of preventative, curative, and promotive health services and the system that delivers those services. It is important to underline that PHC is a set of services, not a place'.
FCDO	FCDO has no working definition of HSS, and follows the WHO definition(s). FCDO launched a position paper on Health Systems Strengthening that outlines their approach in December 2021 Health systems strengthening for global health security and universal health coverage – GOV.UK (www.gov.uk)
Gavi	Definition for 5.0 is pending.
GF	'The Global Fund is the largest multilateral investor in health systems investing US$1 billion a year to build resilient and sustainable systems for health. This includes: improving procurement and supply chains; strengthening data systems and data use; building an adequate health workforce; strengthening community responses and systems; and promoting more integrated service delivery so people can receive comprehensive care throughout their lives.' 'The Global Fund's work to build stronger systems for health aligns with the priorities of governments by supporting National Health strategies and disease specific national plans.'[3]
GFF	Main targets are stated around strengthening systems for achieving UHC.
UNICEF	'UNICEF defines HSS as actions that establish sustained improvements in the provision, utilisation, quality and efficiency of health services, including both preventive and curative care, as well as the resilience of the system as a whole.'[4]
USAID	'Health system strengthening comprises the strategies, responses, and activities that are designed to sustainably improve country health system performance. Health system strengthening aims to make comprehensive changes in how the system functions through changes to policies, regulations, organisational structures, and relationships across the system. Health system strengthening has benefits which cut

[3] The Global Fund. Focus on Building Resilient and Sustainable Systems for Health. 2019.
[4] UNICEF. The UNICEF Health Systems Strengthening Approach. 2016. New York.

	across all programmes to support and contribute to the improvement of health system outcomes, including equity, quality, and resource optimisation, and ultimately to improved health outcomes. A high-performing health system is made up of a constellation of high-performing public and private health institutions that deliver high-quality health and comprehensive integrated care that is accountable, affordable, accessible and reliable.'[5]
WHO	'Any array of initiatives that improves one or more of the functions of the health systems and that leads to better health through improvements in access, coverage, quality or efficiency.'[6]
World Bank	'The World Bank Group supports countries' efforts towards achieving Universal Health Coverage (UHC) and to provide quality, affordable health services to everyone —regardless of their ability to pay — by strengthening primary health care systems and reducing the financial risks associated with ill health and increasing equity.'[7] One of World Bank Group's areas of focus for helping countries achieve UHC is 'strengthening health systems and health financing'.

Box 8. GF Secretariat methodology for RSSH tracking

The Global Fund is the major multilateral investor in low/middle-income countries' national HIV, TB and malaria programmes, and also provides substantial contributions to building resilient and sustainable systems for health (RSSH). Support to RSSH is provided through three types of investments:

RSSH grants: these grants support cross-cutting health system strengthening interventions that benefit multiple disease-control programmes and reinforce countries' national systems. For example: scaling up DHIS-2, developing national HRH strategy, scaling up laboratory capacity at primary care facilities, revising clinical guidelines for improving quality of health services, etc.

Direct RSSH investments: these are cross-cutting RSSH/HSS modules and interventions within disease grants. Programmatic content is the same as RSSH grants. The only difference is in the grant architecture: when countries want to avoid extra grant management costs, they include cross-cutting modules in disease grant(s) as opposed to creating a separate RSSH grant. The benefit of these interventions is always systemwide and goes beyond the disease programme which 'hosts' the cross-cutting module(s).

Contributory RSSH investments: these are investments in HIV, TB and malaria programmes that also provide benefits to systems for health. These investments are primarily focused on a single disease programme and they help enable the health system to catalyse the delivery of the respective national disease programme. A few illustrative examples include:

(Under the malaria module Case Management) Intervention: Ensuring drug and other health product quality for malaria

(Under the HIV module Reducing human rights-related barriers to HIV services) Intervention: Improving laws, regulations and polices relating to HIV and HIV/TB

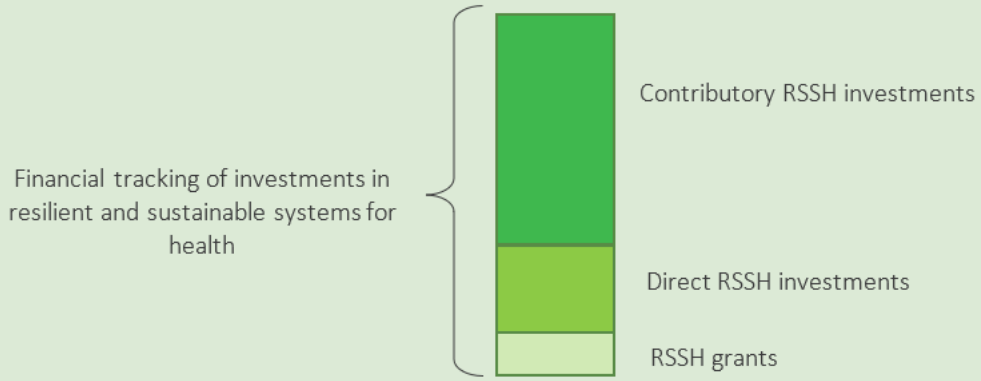
[5] USAID. U.S. Agency for International Development Report to Congress on Health Systems Strengthening for Fiscal Year 2020. 2020.
[6] World Health Organization. Health Systems Strengthening Glossary. Accessed: 27 May 2021.
[7] The World Bank. Health Overview. Last updated: 2 April 2020, Accessed: 27 May 2021

(Under the TB module TB care and prevention) Intervention: Collaborative activities with other programmes and sectors.

The Global Fund's modular framework provides standard definitions for each intervention, based on which countries categorise programmatic content (i.e. specific activities) under standard sets of interventions, which in turn are included under respective modules. These definitions provide space for system-relevant activities under disease specific interventions, for example in the HIV modular framework, the intervention diagnosis and treatment of sexually transmitted diseases (STDs) and other sexual health services for MSM, which is listed under the module comprehensive prevention programmes for MSM, in addition to the disease specific/key population-specific activities also includes system-relevant activities, e.g. training health personnel in STDs.

The Global Fund encourages countries to place high focus on cross-cutting investments, either through RSSH grants or direct RSSH interventions (i.e. types 1 and 2 listed above). To ensure a comprehensive financial tracking, all three above types are taken into consideration, with some limitations attached to the third type, in order to exclude the non-system-relevant content. More details are explained in the following section.

Figure 8: Types of RSSH investments



Methodology

To track investments in cross-cutting interventions, the Global Fund uses the modular framework, based on which countries develop their funding requests. There are four modular frameworks: one for each disease and one for RSSH. The RSSH modular framework is composed of seven modules, plus a module on programme management for RSSH grants. The Global Fund guides countries to include only cross-cutting HSS activities/interventions under RSSH modules and provides lists of interventions for each RSSH module. Within interventions, countries have flexibility to propose country-specific activities, but these activities should also be cross-cutting (i.e. benefiting more than one disease programme). Any activity/intervention that is specific to a single disease programme must be included under disease modules.

Countries' funding requests are approved with detailed budgets. The detailed budget indicates costs of each cross-cutting RSSH intervention. The tracking methodology aggregates costs of cross-cutting HSS interventions to calculate the cost of RSSH modules. Depending on the grant architecture, the aggregated cost of all RSSH modules gives the sum of RSSH grants or direct RSSH investments included in disease grants.

To track disease specific investments that contribute to health systems, the Secretariat designed a two-pronged process as follows.

First, we selected several interventions from disease specific modular frameworks, with the main selection criterion being the relevance of these interventions to systems for health, having mapped the interventions for both New Funding Model (NFM) 1 and 2. For example, interventions focused on disease prevention through behavioural change communication, provision of preventive, diagnostic or curative care, provision of social support, grant management (for disease grants); and others have been excluded. As a result of this differentiation, only 85 interventions out of 180 total interventions in the three disease modular frameworks for both funding cycles have been retained for tracking.[8]

Secondly, the Secretariat acknowledged that not all activities within these interventions might be relevant to systems. Therefore, for each selected intervention, the Secretariat identified the cost inputs that make the intervention system-relevant. Out of the standard list of 63 cost inputs, grouped under 13 cost categories, the Secretariat selected 32 cost inputs. For example, cost inputs such as all pharmaceutical health products, single-use/single disease specific equipment (e.g. RDT's communication material and publications were excluded).

Similarly, interventions under the programme management – namely: grant management; policy, planning, coordination and management of national disease control programme; and other programme management intervention(s) – were considered as contributing towards systems, with the exception of costs going into programme administration and communications and publications costs.

[8] These numbers are based on combined lists of all interventions in the two funding cycles.

Annex 2: Objective 1 findings

GF RSSH tracking approaches: comparison of methodologies

There are four primary methodologies which have been, or are being used, by the GF to analyse, track and report RSSH investment internally and externally. The GF Secretariat methodology on RSSH (See Annex 1 Box 8) is used to report to the Strategy Committee and Board on a routine basis. This methodology is also used to respond to requests for current information on GF investments in RSSH from funders who are champions of health system strengthening. The Technical Review Panel (TRP) conducted a 4S analysis of investments in health systems and this methodology was used as the basis for prospective country evaluation (PCE) 2S analysis. Externally, the GF also reports RSSH investments to OECD/DAC under health policy and administrative management. **Error! Reference source not found.** compares the GF Secretariat, PCE and TRP methodologies and presents estimates of RSSH across the approaches. Although the approaches provide different estimates, these are not in conflict, given that each applies a specific definition to provide different insights into RSSH investments.

The GF Secretariat methodology on RSSH relies on the modular framework, based on which countries developed their funding request and employ a top to bottom approach in the categorisation of the RSSH investments. The tracking methodology as approved by the Board classified the RSSH investment into three broad categories, based on the modules where they are located and the type of grant used to deliver them. The first category is the RSSH investments found within the RSSH modules of the RSSH stand-alone grant. The second category is the RSSH investments found within the RSSH modules of the disease specific grants. The aggregation of these two categories gives the direct RSSH investments. The third category is the contributory RSSH investment. These are investments in TB/HIV/malaria programmes that also provide benefits to enable the health system to catalyse the delivery of the respective national disease programme. These investments are located within the disease specific modules in the TB/HIV/malaria grants. To identify the contributory RSSH investments, the Secretariat reviewed interventions in each disease specific module and selects interventions relevant to the health system that will '*enable the health system to catalyse the delivery of the respective national disease programme*'. These interventions are mapped to specific cost categories and inputs that indicate they are contributing to the health system. This approach is largely based on assumptions about what happens in-country during programme implementation. The aggregate of these cost inputs for the different interventions makes up the total estimate of GF investments in RSSH (RSSH modules and specific cost categories and inputs in disease specific modules). The result of the Secretariat's analysis showed that 24% of the total budget was invested in RSSH in NFM 1 and 25% in NFM 2.[9]

The TRP approach was based on the HSS building blocks, which were expanded to include private sector engagement, community systems and responses and review of RSSH programme implementation. The TRP analysed RSSH investment (RSSH modules) in 16 countries along the health system development continuum of 4S (start-up, support, strengthening and sustainability). Performance indicator analysis was conducted by comparing indicators in the funding requests to those in the modular framework. In addition, 50 case study funding requests were reviewed to determine the extent to which RSSH issues were addressed and proposed investment across the health systems development continuum. TRP analysis showed that about 66% of RSSH investments (in the RSSH modules sampled) focus on systems support rather than system strengthening and system sustainability efforts.[10]

[9] Global Fund 8th Strategy Committee Meeting October 2018, Geneva.
[10] Technical Review Panel (TRP) report on RSSH investments in the 2017–2019 funding cycle, Available at: https://www.theglobalfund.org/media/8093/trp_rssh2017-2019fundingcycle_report_en.pdf (accessed 12/7/2022)

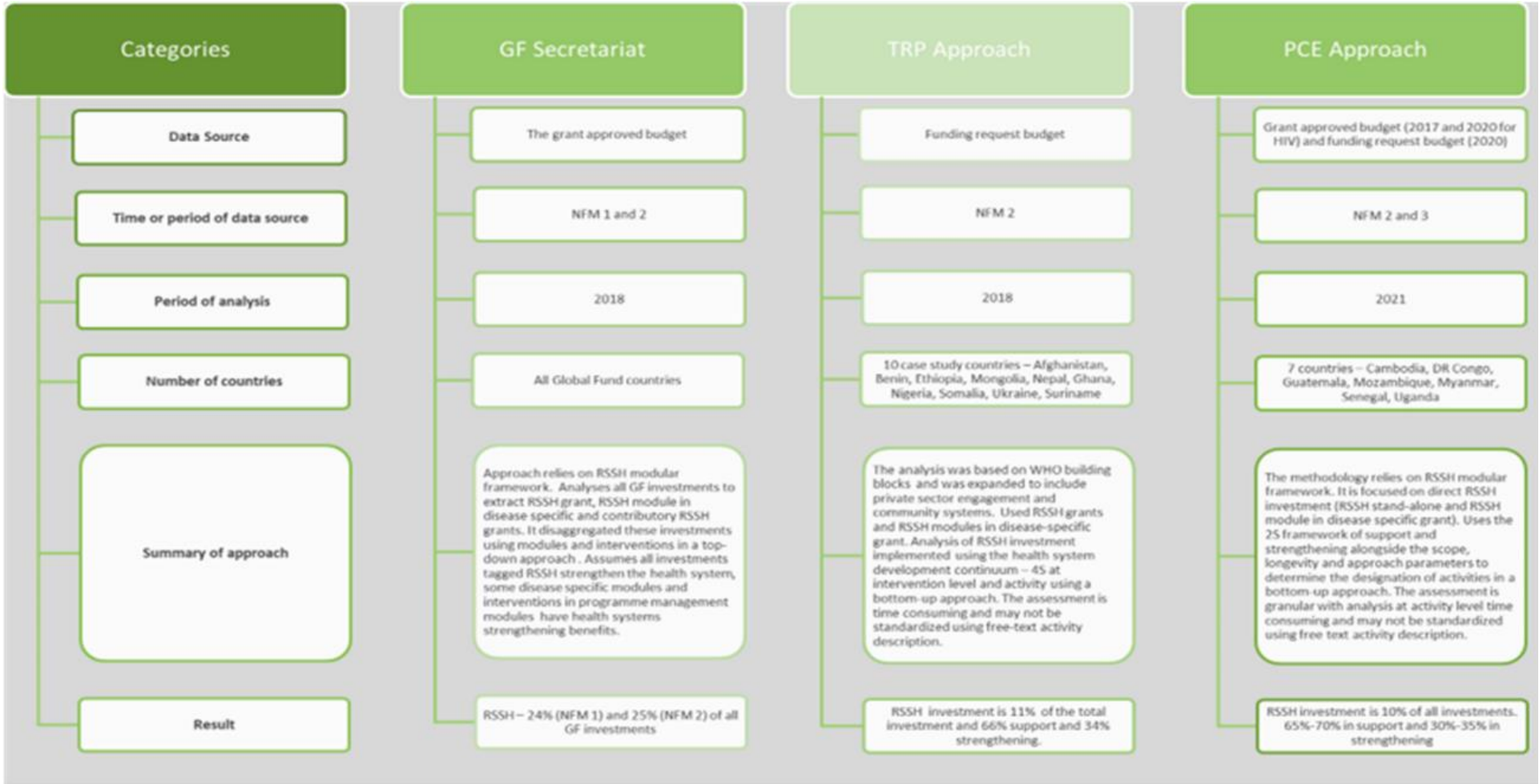
The PCE approach built on the TRP methodology to apply a 2S framework for analysis.[11] This noted that start-up and sustainability (outer 2S) categories of the 4S were not applied very often, so most GF investments were either in the support or strengthening categories (middle 2S) within the 4S continuum. The data sources for the PCE analysis were the final approved budget following grant-making (2017), funding request budgets submitted to TRP (2020) and final approved budget following grant-making (2020) for HIV. These data sources were reviewed and coded independently by two evaluators using the 2S approach and compared to review any inconsistencies. In addition, funding request narratives of RSSH investments were used to triangulate with budget information when examining interventions or activities and applying the 2S framework.

Like the TRP analysis, PCE considered the scope (impact of activity across health services and outcomes), longevity (continuity of effect after the activity ends) and approach (policy revision and institutional relationships to change behaviour or resource use), along with cost input categories to determine the designation of interventions (activities) in the financial documents as health systems support or strengthening. Once the final designations were determined and agreed upon, the PCE quantified the proportion of RSSH funds allocated to supporting and strengthening investments. PCE analysis showed that about 65%–70% of RSSH investments (in the RSSH modules sampled) focus on systems support rather than system strengthening and system sustainability efforts. PCE analysis further showed that around 40%–45% of RSSH investments (of the four-country review sample) focus on a single disease, with the remainder designed to have an impact across services and outcomes.[12]

[11] Chee G, Pielemeier N, Lion A, Connor C. (2013). Why differentiating between health system support and health system strengthening is needed. *Int J Health Plann Manage*, 28(1), 85-94. doi: 10.1002/hpm.2122.

[12] https://www.theglobalfund.org/media/11081/terg_2021-pce-synthesis_report_en.pdf

Figure 9: Comparison of GF Secretariat, TRP, and PCE approaches; and estimates of RSSH



The GF Secretariat RSSH methodology for estimating investments in RSSH is focused on the module and intervention level. All RSSH modules in RSSH only and disease specific and multi-component grants (RSSH Direct) are included in the estimate of RSSH investments. In addition, interventions within disease specific modules that have been categorised as contributing to systems strengthening (RSSH Contributory) are included based on their description and type of input. Our review of these investments at activity level found that some RSSH Direct and Contributory investments are focused on single disease areas and therefore estimates of RSSH investments may be inflated. This is because some RSSH activities can be implemented to strengthen a single disease area without necessarily strengthening the overall health system. The extent to which the estimates of RSSH are 'inflated' will be explored further in WS2. WS2 will estimate the proportion of GF investments which are cross-cutting and the proportion which are disease specific. WS3 will review the alignment of RSSH investments with National Health system priorities.

All four approaches rely on the modular framework. However, the approaches use different data sources for analysis. The GF Secretariat RSSH methodology uses grant approved budget data from the Grant Operating System. This draws on the latest budget data which has been loaded into the system. The TRP approach uses the funding request budget, and the PCE used the funding request (2020) and grant approved budgets. None of the approaches we reviewed use expenditure data for analysis – the PCE sought to do this but was not able to obtain sufficiently granular expenditure data to conduct the analysis. However, RSSH absorption rates are tracked and reported by grant management and reporting unit. These are based on RSSH modules and so include stand-alone and direct RSSH, but 'contributory' investments in RSSH cannot be tracked based on expenditure.

All approaches have applied a slightly different interpretation of what constitutes health system strengthening. Therefore, where the 'line' is drawn between investments that are used to improve disease specific health outcomes and those contributing to broader outcomes (e.g. strengthened health systems or multiple health outcomes) varies. However, as we see in the next section, this is not uncommon among other DPs and reflects debates within the literature and between DPs on where the 'line' is between investing in strengthening systems which serve single disease area investments – which have defined objectives and in which interventions are specifically targeted to those areas, e.g. HIV, tuberculosis and malaria – and investments in health systems which benefit health outcomes beyond specific diseases.

GF reports HSS investments externally to OECD/DAC at grant (component) level and is based on disbursements. All investments are categorised either as general healthcare (health policy and administrative management), basic healthcare, disease specific or population health. Reporting is also based on the modular framework, with RSSH stand-alone grants reported under general healthcare (health policy and administrative management) and disease specific and multi-component grants reported under disease specific or population health categories. This approach differs to the other internal approaches because tracking is at component level not module level. This means that the GF reports RSSH investments under health policy and administrative management but only includes RSSH stand-alone grants. GF investments in RSSH modules within disease specific grants are reported under OECD/DAC disease specific or population health categories. This is illustrated further in limitations noted in calculating the ratio in MQ3.2. The way other DPs report HSS investments to OECD/DAC is described in the next section.

Limitations of the approaches

The current approaches to track and analyse RSSH investments have several limitations. Some of these are general and others are more specific to the approach.

General limitations

- Data source: The expenditure data would have been the data source of choice for all the tracking approaches because it contains information on actual cost of activities implemented in the different countries. However, it could not be used in all the tracking approaches because it does not have the same level of detail as the Grant Approved Budget.
- Data availability: Non-availability of the data required for analysis during the tracking period because of lag in production of the data sources due to internal processes such as in-country grant making process, grant budget review and approval.
- Data completeness: May be some limitation in using grant approved budget data here given OIG 2020 finding budget revisions not being reflected in GOS (Audit of the Global Fund's Grant Operating System June 2020).
- Sample size: The country selection and sample size for the different methodologies is linked to the objectives of the assignment and based on available data. However, they are not large enough to provide a reliable estimate of the proportion of the Global Fund's investment in the cross-cutting and single disease areas.

GF Secretariat approach to tracking RSSH

- The GF Secretariat approach was a top-down approach, analysing the bigger blocks of investment at the modular level and using the cost input and other high assumptions to separate the GF's investment into RSSH investment (direct and contributory) and single disease investment. While this is a more pragmatic approach, especially if the plan is to carry out the analysis on a routine basis, the chance of misclassification is higher, especially if the activities are not properly coded into the respective modules.
- A key assumption for the GF Secretariat's methodology is that some single disease investments have the potential to also strengthen the health system, and hence are regarded as contributory RSSH. This assumption is based on what is theoretically possible and what is expected to happen at implementation, and not what is happening in-country. This assumption needs to be tested to check whether it holds true most of the time.

PCE approach

- The PCE approach is a bottom-up approach which analysed investments at the activity and intervention level. This is difficult to implement on a routine basis because it is resource-intensive and time-consuming.

TRP approach

- Like the PCE, the TRP approach is a bottom-up approach which analysed investments at the activity and intervention level but used the funding request budget. This is difficult to implement on a routine basis because it is resource-intensive and time-consuming.
- The TRP approach used the funding request budget for its analysis. This data source is used by the TRP to conduct the pre-assessment of investments, and the grant amount is susceptible to changes by the time the Grant Approved Budget is finalised. As a result, this data source may not reflect the final grant amount approved for the country.

Development partners' approach to tracking investment in health systems

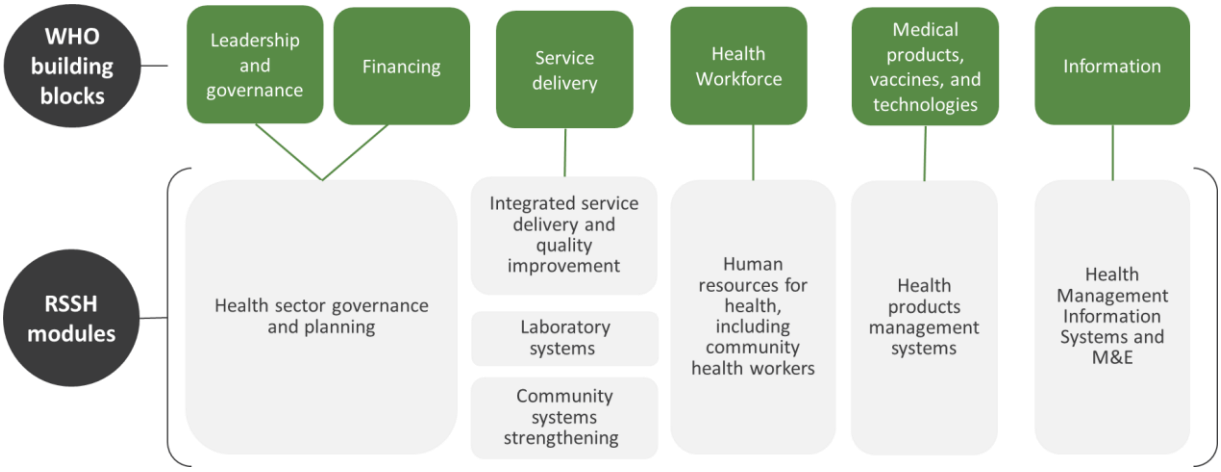
There is a common practice of DPs investing in health systems, which is understood as being critical to the success of outcomes or objective-based programmes, supporting achievement of

sustainable development goals (SDGs) and mitigating the downsides of investing in siloed functions/programmes. A number of different **terms** are used for this type of investment, e.g. Governance and Health Systems, Health Systems Strengthening. Annex 1 presents definitions of HSS used by various DPs, building on the work of the Health Systems Strengthening Evaluation Collaborative.

The definition and interpretation of these investments vary to some degree, but overall **there is alignment to WHO building blocks**. Definitions and interpretations when tracking investments reflect organisational mandates and priorities, e.g. Gavi has Health Systems and Immunisation Strengthening; PEPFAR includes laboratory strengthening.

There are some differences between organisations in which areas of investments are classified under health systems when it comes to reporting. For example, the World Bank takes a cross-cutting approach to HSS; applying their definition, it would include general budget support which is allocated for health. Among development partners, it is common to see inclusion of community systems and community engagement in descriptions of categories under HSS.

Figure 10 Alignment of RSSH modules with WHO building blocks



Error! Reference source not found. shows that there is alignment between RSSH interventions and HSS building blocks definitions of health system strengthening. There are two areas of interventions under the RSSH which are categorised under separate modules: 'community systems strengthening' and 'laboratory systems'. Although these are not specific building blocks, they can be categorised under service delivery and align with the overall WHO definition of HSS.

Comparison of development partners' approaches to tracking health systems investment

Across the seven organisations and programmes we reviewed, all have a specific strategy on health systems strengthening, apart from GFF which has embedded an HSS approach in their main strategy to improve RMNCAH and Nutrition outcomes through targeted strengthening of service delivery systems. The terminology used is similar, with most using health systems strengthening (HSS) and some adding specific terms such as Health System and Immunisation Strengthening (GAVI), Governance and Health Systems (UNAIDS) and health systems strengthening for global health security and universal health coverage (FCDO).

All of the programme strategies are loosely aligned with the WHO building blocks and have programme structures and budgets which allocate resources along these lines. However, most also have specific areas of focus which align with the programme or organisations' priorities. For example, PEPFAR has a focus on laboratory strengthening, GFF focuses on health financing

and FCDO focuses on data for decision making. These areas of focus were noted as being part of organisations' 'competitive advantage' and also reflect the use of HSS investments to address specific bottlenecks to deliver their respective programme mandates. In over half of the programme strategies there was a specific inclusion of strengthening community systems as well as community engagement, although it was not always a specific area of investment.

We found that the organisations and programmes varied in the extent to which their HSS-type investments focused on strengthening health systems for disease specific outcomes compared to placing more emphasis on cross-cutting health outcomes. We also found different interpretations of cross-cutting, with some organisations interpreting this to mean investments across multiple WHO building blocks (cross-system investments) and others interpreting it at the cross-cutting health outcomes (health benefits beyond specific disease outcomes).

Programmes are reporting on their HSS investments, and internal systems are set up to track this, either as HSS plus one or two areas of focus or aligned to their selected HSS strategy pillars. For example, PEPFAR tracks HSS (leadership or governance, health workforce, medical products and technologies, health financing, information and research, and service delivery) and then Laboratory Systems and Strategic Information separately. GFF tracks Health Service Delivery, Health Systems Strengthening, and Health Financing, Pandemic Response (though these are not mutually exclusive).

Reporting is done using budgets or commitments, apart from FCDO, which tracks based on disbursements. One stakeholder noted, describing the efforts to address the limitation of tracking investments based on commitments: '*[the programme is] working towards tracking spending by intervention and activity; however, without a detailed accounting of these activities, mere commitments of funding to programme areas do not necessarily mean critical services will continue*'.

From the examples of reporting we have seen (which are limited to publicly available data and descriptions through KIIs), we note the following findings. Estimates of the magnitude of investments range from around 5% to 35%, but the definition which is applied to generate this estimate varies by programme, and therefore they are not comparable. For example, a study of UNAIDS investments in HSS [add reference] 2019 audit of USAID HSS investments found that what was reported as having benefits beyond the specific outcomes of the programme mandate was not equivalent to actions designed to strengthen resilient and sustainable systems for health. At least two of the seven organisations are reporting externally on HSS to OECD/DAC, and others may use tools at country level such as RMET and country-specific expenditure tracking.

A number of limitations were raised in relation to the categorisation and tracking of health system strengthening type investments.

- These include misclassification of investments when budgetary codes are misapplied to activities which are not health system strengthening; for example, the 2019 audit of USAID HSS investments found some programmes with a majority of HSS activities focusing on a single primary health goal. Another stakeholder raised the issue of subjectivity in classification of investments as cross-cutting as opposed to single disease when classifying investments for external reporting to the OECD/DAC CRS.
- OECD noted that the purpose code which maps most directly to HSS (12110 Health policy and administrative management) is not used exclusively for HSS. OECD also noted that although multiple purpose codes can be used to disaggregate investments into those with a disease focus and those which are more cross-cutting system strengthening, the use of multiple purpose codes makes reporting more complex and so was not being encouraged.

- Finally, stakeholders highlight limitations in their organisations' systems to track financial resources for HSS as they were not always set up to track against strategic priorities: '*[organisation] theme codes don't lend themselves very well to answering important questions stakeholders have*'. There is some use of 'policy markers' to address this. However, as one stakeholder noted, although there are policy markers set up in the CRS database, there is still inconsistency in how these are applied (e.g. PHC).

Table 12: Example comparison of development partner approach to categorising and tracking investments in health systems

Feature	PEPFAR (2014)	Gavi	USAID
Strategy for HSS	Governance and health systems	Health Systems and Immunisation Strengthening	Health Systems Strengthening
Reporting	PEPFAR investments in governance and health systems were one-fifth of countries' budgeted funds, 2004–2014.	Reporting to OECD/DAC.	Typically, missions use between 6% and 12% of their non-HIV/AIDS GHP budget to co-fund cross-cutting HSS, with some missions using more than 20%.
Categories included	PEPFAR tracks investments in health systems through cost categories: HSS (leadership or governance, health workforce, medical products and technologies, health financing, information and research, and service delivery); laboratory infrastructure; strategic information.	Advocacy, communications and social mobilisation. Capacity building of human resources for health (including community). Health financing. Health information systems. Improve public financial management. Legal, policy and regulatory environment. Other. Procurement and supply. Service delivery (to improve accessibility and quality, including through campaigns). Programme management.	Building sustainable health financing systems. Improving health equity through social accountability and behaviour change. Strengthening public financial management. Improving the management of national resources. Promoting the role of the private sector in healthcare. Addressing inefficiencies in healthcare. Improving quality. Investing in human resources. Strengthening community health systems. Improving the collection and use of data and information. Building resilient healthcare. Strengthening pharmaceutical systems.

Annex 3: Objective 2 global analysis detailed methodology note

Introduction

Objective 2 of the mapping study is to estimate the magnitude of the GF's investment into the health system globally and at country level. This objective aims to analyse the GF's investments in cross-cutting and disease specific areas over time and to determine what areas the GF supports in cross-cutting funding.

Two sub-questions provide the framing for the analyses under WS2:

MQ2.1 What proportion of the GF's investments go into the cross-cutting areas and the single disease area?

MQ 2.2 What types of interventions does the GF support in the cross-cutting health system funding and how has the budget allocation changed over time?

To answer the mapping questions, the GF's investment for NFM 2 and NFM 3 was mapped using the HSS definition in the SoW for this assignment. According to the SoW, HSS investments are defined as investments that have **cross-cutting benefits beyond a single disease, strengthen relationships between building blocks, and promote permanent system impact beyond a disease programme**. Other definitions and literatures that influenced this mapping exercise were the previous work of the Global Fund Secretariat (Shakarishvili *et al.*) to develop a common classification and framework for Health Systems Strengthening (HSS) investment analysis, and the broader literature (notably Grace Chee *et al.*, and as utilised by the TRP and PCE)[13] around a 4S framework (start-up, support, strengthening, sustainability).

Data source, review and extraction

The data source for the mapping was the GF Approved and Committed Budget. Other sources of data were considered for the analysis; however, the GAC budget was used for the analysis because it contains the line-by-line descriptions of activities carried out by the grant recipients, in addition to the module and intervention descriptions. See Annex 6, which has a table highlighting the different types of financial data, availability and the pros and cons of using them for the analysis. The GAC budget was obtained as an Excel spreadsheet and it contained the grant budget for both the disease specific grants and RSSH grants for NFM 2 and NFM 3 for all the countries receiving the GF's support. The mapping exercise was implemented for 38 GF countries, representing about 80% of the total portfolio for NFM 2 and NFM 3. The relevant budget data was extracted for the 38 countries using the grant approved budget format. The modules relevant to this analysis were the disease specific modules and the RSSH modules. The COVID-19 and the programme management modules were excluded from the mapping exercise, although the total investment in these modules was used to estimate the proportion of the GF's investment in the different investment areas. The columns that were included in the budget data include Grant, Grant Period, Module, Intervention, Activity Description, Activity type, Cost Input, and Amount.

Mapping of the Global Fund's investment for NFM 2 and NFM 3

The approach to the mapping exercise was bottom-up, i.e. the mapping of the investments was carried out at the activity level and the line-by-line review of all the budget items was carried out. The activity descriptions, together with other parameters such as modules,

[13] Chee G, Pielemeier N, Lion A, Connor C. (2013). Why differentiating between health system support and health system strengthening is needed. *Int J Health Plann Manage*, 28(1), 85-94. doi: 10.1002/hpm.2122.

interventions and cost input, provided the more reliable information for delineating investments into cross-cutting and single disease investment.

Like the PCE approach, the mapping was operationalised using the parameters of scope, approach and longevity as coined from the definition of system-level investment in the SoW for this assignment and described by Grace Chee *et al.*[14] However, for this analysis, a two-stage mapping was carried out. The first stage applied the 'scope' parameter to all the activities contained in the disease specific modules and RSSH modules of all the grant types. This separated all the investments into cross-cutting and single disease investment. The second stage of the analysis applied the 'approach' and 'longevity' parameter to the cross-cutting investments, only to categorise them into 'system support' investments and system strengthening investments. Between stages 1 and 2 of the analysis, other analysis was carried out, for example categorisation of the cross-cutting investment based on the type of grant and the component of the health system they are affecting. Steps 1 to 5 below describe the detailed approach to this mapping.

Table 13: Parameters used to determine system support or system strengthening

Parameter	System Support	System Strengthening
Scope	May be focused on a single disease or intervention	Activities have impact across health services and outcomes; and systems may be integrated into the overall health sector
Longevity	Effects limited to period of funding	Effects will continue after funded activities end
Approach	Provide inputs to address identified system gaps	Revise policies and institutional relationships to change behaviours and resource use to address identified constraints in a more sustainable manner

Note: The definitions of scope, longevity and approach included in the table above were used at different stages to determine whether an activity is systems support or systems strengthening.

Step 1: The focus of this step is to **separate the activities into cross-cutting activities and activities focused on single disease.** The key question here is whether the activity in the GAC budget affords cross-cutting benefit beyond a single disease. This separates the activities (and, by extension, GF's investments) into cross-cutting investments and single disease investments. Two filters, representing the two categories identified, were created in an Excel spreadsheet used for the analysis. See Table 17 for examples of activities in the single disease category.

Step 2: The cross-cutting and single disease investments were **also classified based on the type of grant,** i.e. whether the activity/investment sits in the RSSH stand-alone grant or in the RSSH portion of the single disease grant.

Step 3: The cross-cutting investments were **classified according to the component of the health system they are affecting** – for example human resource for health, data/information system, supply chain system management, etc. Those investments that do not have a direct effect on the health system, e.g. programme management investments, were excluded.

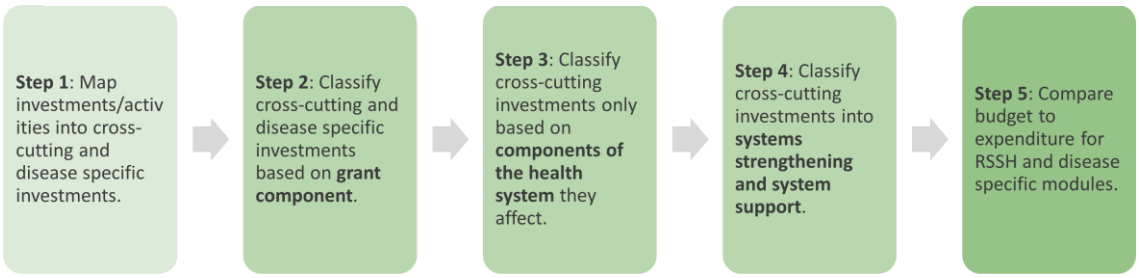
Step 4: In this step, cross-cutting investments were classified into **system strengthening and system support investments**. System strengthening investments lead to more comprehensive changes to policies and regulations, organisational structures and relationships across the health system building blocks that motivate changes in behaviour and/or allow more effective use of resources to improve multiple health services. System supporting investments, on the

[14] Ibid

other hand, include any investments that improve the system's functionality primarily by increasing inputs, and can be short-term and narrowly focused.[15] [16] Using the PCE 2S methodology, the approach and longevity parameters and activities/intervention pairs were categorised into support and strengthening. This analysis was implemented as a pilot across 15 case study countries for the RSSH modules – HRH, health sector governance and financial management systems.

Step 5: The focus of this step is to estimate budget implementation rate by **comparing the budget and expenditure data for RSSH and disease specific modules**.

Figure 11: Overview of methodology



Mapping assumptions and justifications

All activities were reviewed from a programme planning perspective, and activities were interpreted with the intent described in the grant approved budget of the different countries. See examples of activities reviewed in **Error! Reference source not found.**. The activities were categorised as cross-cutting only if the activity description and intervention pair had clear descriptions and key words that aligned with mapping cross-cutting definitions outlined in the methodology. No activity was categorised based on its potential for cross-cutting contribution unless this information was provided in the activity description and intervention pair.

To determine if activities in disease specific modules have cross-cutting effect beyond the single disease area which they had been curated, the activities and interventions will require more details and even some evaluation at the country level, which is beyond the scope of this mapping exercise.

Quality checks

The budget information obtained in other languages such as French and Portuguese was translated using Google's translation web-based application and was reviewed by French and Portuguese native speakers and writers to ensure consistency. In addition, the mapping exercise was carried out by trained data analysts with background and knowledge of implementing HSS projects, and quality checks were carried out by the WS2 lead and co-lead. To minimise the magnitude and impact of misclassification, activities with the highest costs were sorted using Excel filters and double-checked to ensure they are properly mapped. In cases where it was unclear from the activity description, the detailed budgets and project implementation plans of some countries were also reviewed to ensure activities were properly categorised.

[15] Piatti-Funfkirchen, M., Hashim, A., Alkenbrack, S., & Gurazada, S. (2021). Following the Government Playbook? Channelling Development Assistance for Health through Country Systems.
[16] Phrases in the definition of system strengthening and support investments (step 2c) implies the longevity characteristics of the investment. For example, system strengthening investments were described as motivating behavioural changes (long-term effect), while system support investment increases the functionality of the system in the short term.

Limitations

Use of budget vs expenditure data: The GAC Budget was used because of the availability of activity description column, which is a key variable for categorisation of the GF's investment, while for the expenditure data this variable is not available. Table 15 highlights the types of financial data, availability and the pros and cons of using them for the analysis.

Unclear description of activities in the grant-approved budget and risk of misclassification. For example, some of the Global Fund's investments are channelled through Technical Assistance (TA) providers at the country level. These interventions contain ballpark amounts, with a single line of activity description. The activity description is not sufficient to classify the investment into cross-cutting and single disease investments. These are classified as 'unclear' and are subject for further discussions. Another implication of the 'unclear' or 'incomplete activity' description is the challenge of the classification of the cross-cutting investment into system strengthening or system support investment. Both challenges highlighted above can be resolved by obtaining clear and complete activity descriptions from the in-country programme managers for NFM 2 and NFM 3 and providing further guidance for describing activities in the grant approved budget going forward.

Potential for scaling up this approach: The time-consuming nature of the categorisation exercise in this workstream means that the analysis can be conducted in only a sub-sample of countries. However, the mapping exercise was scaled up to 38 countries, representing 80% of Global Fund's portfolio for NFM 2 and NFM 3. These 38 countries include the 15 case study countries.

Table 14: Global-level analysis countries

S/N	Country	RSSH Grant NFM 2 &NFM 3 ($)	Disease Grants NFM 2 & NFM 3 ($)	Total ($)
1	Nigeria	325,505,664	1,477,555,849	1,803,061,513
2	Mozambique		1,510,831,658	1,510,831,658
3	Congo (Democratic Republic)	52,173,277	1,435,920,726	1,488,094,003
4	Tanzania (United Republic)		1,328,336,335	1,328,336,335
5	Uganda		1,303,242,854	1,303,242,854
6	Zimbabwe		1,203,996,551	1,203,996,551
7	Malawi		1,130,910,457	1,130,910,457
8	India		1,091,432,963	1,091,432,963
9	South Africa		1,034,494,250	1,034,494,250
10	Kenya		1,005,252,715	1,005,252,715
11	Ethiopia	100,574,016	892,821,411	993,395,427
12	Zambia		751,188,612	751,188,612
13	Indonesia		699,579,045	699,579,045
14	Pakistan		604,408,331	604,408,331
15	Cameroon		587,121,408	587,121,408
16	Côte d'Ivoire	65,122,244	489,891,264	555,013,508
17	Ghana		551,187,804	551,187,804
18	Rwanda		519,306,633	519,306,633
19	Burkina Faso		473,634,526	473,634,526
20	Myanmar		451,887,509	451,887,509
21	Bangladesh		388,547,335	388,547,335
22	Sudan		362,588,918	362,588,918
23	Mali	61,000,027	292,473,294	353,473,321
24	Ukraine		344,903,201	344,903,201
25	Philippines		340,349,569	340,349,569
26	Niger		292,631,950	292,631,950
27	Guinea		282,988,908	282,988,908
28	Viet Nam		281,022,404	281,022,404
29	Chad		279,310,840	279,310,840
30	Central African Republic		259,959,637	259,959,637
31	Haiti	23,460,622	236,071,985	259,532,607
32	South Sudan		258,663,858	258,663,858

33	Senegal		185,246,968	185,246,968
34	Eswatini		130,855,687	130,855,687
35	Lao (People's Democratic Republic)		41,384,650	41,384,650
36	Mongolia		30,596,765	30,596,765
37	Armenia		24,208,162	24,208,162
38	Guyana		12,483,327	12,483,327

Table 15: Data sources considered for WS2 analysis

S/N	Financial documents	Source of data	Data provider	Users	Quality of data *(completeness, reliability)*	Pros of using the data for WS2 analysis	Cons of using the data for WS2 analysis
1	Funding request budget	Country funding request form	Grant recipient	Technical Review Panel			
2	GF Approved and Committed Budgets for NFM 2 and NFM 3	Detailed budget submission to board by GAC	Grant recipient, LFA, GAC	Global Fund Finance Team, GF Secretariat	Data contains variables relevant for analysis, such as allocation period, components, implementation date, module, intervention, detailed budget activity, cost category, cost input, and amount.	Most complete data set received so far. Data can be analysed across funding periods by module and intervention to answer mapping questions.	Represents the planned spending but not the actual expenditure. It may not give the full picture of the GF's investment, especially of budget revisions and issues around absorption of investment and repurposing of investment at the country level.
3	Global Fund disbursement				Variables available are grant name, component, programme start and end date, disbursement amount, disbursement year and date.	None.	Data is not available by funding periods (NFM 2 and NFM 3), no modules and interventions. This level of detail will not support the analysis required to

							answer the WS2 questions.
4	Country-level expenditure	Progress Update and Disbursement Report (PUDR)	Grant recipient/LFA review	Global Fund Finance Team	Contains all data variables in the grant-making budget except the detailed activity description, which is the variable required for categorising investments into cross-cutting and single disease areas.	Can be used for estimating absorption rates for NFM 2 period.	Data is only available for NFM 2. The data is incomplete because of non-availability of the activity description.

Table 16: Examples of activities reviewed and categorised in Objective 2 global analysis

S/N	Grant component	Module	Intervention	Activity	Scope	Approach	Longevity
1	HIV/TB	Prevention programmes for other vulnerable populations	HIV testing services for other vulnerable populations	OST provision and HIV testing among prisoners, training for prison personnel	Single disease	Provides inputs to address gaps	Effect limited to the funding period
2	HIV/TB	TB care and prevention	Collaborative activities with other programmes and sectors (TB care and prevention)	Trainings of TB doctors and lab staff for new treatment guidelines	Single disease	Provides inputs to address gaps	Effect lasts beyond the programme
3	HIV/AIDS	PMTCT	Prong 3: Preventing vertical HIV transmission	Contribute to the development of an eMTCT strategic plan taking into account syphilis and hepatitis	Single disease	Revise policies and institutional relationship to change behaviour and resource use to address identified constraints in a more sustainable manner	Effect lasts beyond the programme
4	Malaria	Vector control	Long-lasting insecticidal nets (LLIN) – mass campaign – universal	Organise a three-day workshop for the training of facilitators for the preparation of Micro plans (35 facilitators)	Single disease	Provides inputs to address gaps	Effect limited to the funding period
5	HIV/AIDS	Reducing human rights-related barriers to HIV/TB services	Community mobilisation and advocacy (HIV/TB)	Conduction of advocacy/sensitisation meetings with local police, RAB, DNC officials, community leaders, religious leaders, and civil society on drug use, harm reduction and HIV	Single disease	Provides inputs to address gaps	Effect limited to the funding period

6	Tuberculosis	TB/HIV	Collaborative activities with other programmes and sectors (TB/HIV)	Advocacy meeting in district level as part of coordination with the Ministry of Labour and BPJS ketenagakerjaan to enable access to social protection for TB and HIV patients	Single disease	Provides inputs to address gaps	Effect limited to the funding period
7	HIV/AIDS	Reducing human rights-related barriers to HIV/TB services	Community mobilisation and advocacy (HIV/TB)	Regular meeting for district task force (Paralegal, CBMF Officer, Advocacy Officer, DHO, law enforcement agencies, religious leaders, public leaders, media, etc.)	Single disease	Provides inputs to address gaps	Effect limited to the funding period
8	HIV/AIDS	Reducing human rights-related barriers to HIV/TB services	Community mobilisation and advocacy (HIV/TB)	Communication and Advocacy Strategy for HIV and Key Populations – validation workshop with NACP, PACPs, key populations and other key stakeholders for National Advocacy and Communications Strategy	Single disease	Revise policies and institutional relationship to change behaviour and resource use to address identified constraints in a more sustainable manner	Effect lasts beyond the programme
9	HIV/AIDS	Reducing human rights-related barriers to HIV/TB services	Community mobilisation and advocacy (HIV/TB)	Strengthen community-based monitoring system on human rights and HIV to include mechanism for data utilisation that will be used for advocacy and monitoring government accountability VAT	Single disease	Provides inputs to address gaps	Effect limited to the funding period
10	Malaria	Case management	Ensuring drug quality	Train 30 executives from 6 DPs for 5 days in the rational use and pharmacovigilance of antimalarial drugs	Single disease	Provides inputs to address gaps	Effect limited to the funding period

11	Malaria	Case management	Ensuring drug quality	Training of National Core Group in malaria microscopy competencies and quality assurance procedures (Only NMEC, CHAZ, TDRC, UNZA school of medicine, Lusaka province and UTH); the provinces will be trained by PAMO (8) and PATH (2 PHOs)	Single disease	Provides inputs to address gaps	Effect lasts beyond the programme

Annex 4: Detailed review of databases for tracking investments at country level

This annex presents a detailed review of databases for tracking investments at country level, guided by MQ1.3 and informing the approach for MQ3.1 and 3.2. The first section provides a background to resource tracking. The second section presents a summary of the tracking tools and databases together with limitations and alignment with GF resource tracking system. The third section presents tables showing the current focus of different sources of health funds. The fourth section presents current discussions on the effectiveness of the method of the health system components financing, and Section 5 presents recommendations for aligning health financing sources with the goals of financing health systems.

Background

The emergence of global attention to health systems strengthening has led to different kinds of innovations to ensure quality improvement in healthcare service delivery. The World Health Organization (WHO) defines health system strengthening as an array of initiatives and strategies that lead to better health through improvements in one or more of the health system's building blocks (WHO, 2007). The WHO framework for health systems strengthening identifies six attributes of a health system: a health workforce; health services; health financing; governance and leadership; medical products, vaccines and technologies; and health information (Nutley & Reynolds, 2013).

One of the health system functions refers to the financial resources used to ensure that the health needs can be covered adequately. It deals with the mobilisation, pooling and efficient and effective allocation of funds to cover the health needs of the people individually and collectively. It makes funding available and sets the right financial incentives for providers to ensure that all individuals access effective public health and personal health care. Besides, it is an enabling factor in the ability of countries to achieve universal health coverage by improving service access and offering financial risk protection (Kutzin, 2013). Effective tracking of such health finances is important for policy. Among financial tracking approaches, health accounts and international aid statistics produce estimates including external resource flows into a country's health system.

Description of tools and databases

Health Accounts

Health Accounts (HA) is a policy tool for the health system which provides integrated and detailed information on the health financing landscape. The standardised framework, the System of Health Accounts (SHA2011 Rev 2017), 'tracks all health spending in a given country over a defined period of time regardless of the entity or institution that financed and managed that spending'. It consists of a series of standardised classifications allowing spending to be tracked along their flow, from when resources reach the health system until they are used in final consumption among beneficiary population. It is an essential source of information to drive health financing policy reforms and strategy development. Moreover, the SHA framework offers focused expenditure reviews on policy concerns such as programmes/diseases relating to e.g. HIV/AIDS, TB, reproductive health, malaria, etc.

HA contributes to evaluate progress toward universal health coverage by providing essential data for optimising health resource mobilisation, pooling and allocation, and also contributes towards assessing equity and efficiency in a dynamic health system environment. However, there are limitations.

The **planning** phase starts with countries' customisation of the framework. Each country decides the detail and the classifications to be included. There is a specific code assigned that can be used to identify grants from the GF. Additional analysis can cover, among other classifications: factors of provision; institutions providing the funds, financing agents; diseases/health conditions; location; age and sex.

The **data collection** process begins with the identification of actors of the health system and their role, to include them in the accounts (any agency involved in the health care provision and administration and financing), and a focal point is identified for each agency. Development partners (e.g. the GF/CCM) are included within the financing process as *revenue sources* – modalities of contribution – and as *institutional units* providing revenue. In some cases, DPs also run/execute programmes.

All actors are informed of the process, timing and data needs. The data collection relies extensively on secondary and primary data. Data obtained is used to estimate and project expenditures, for triangulation and to generate health expenditure indicators. Primary data is collected from questionnaires. Records and reports are used as secondary data. Specific actors include the Ministry of Health (central and subnational level), other ministries, social security, employer firms, insurance firms, non-governmental organisations and development partners. The data is then reviewed and validated for consistency (e.g. the origin and destination of the foreign funds are expected to identify not only the GF flows but also whether there is multiple intermediation and to avoid double counting). Once totals and subtotals are verified, a database is generated.

GF/CCM country offices are approached for that purpose. A survey is regularly sent to DPs, notably asking for the origin and destination of resources and detail on agreed uses. When no GF/CCM exists or does not report, the principal recipients (PRs) are expected to offer the information of the revenue received by the donor agency.

During the **analysis** process, the expenditure amounts are mapped to the SHA classifications: a code for each amount is identified and each classification included in the analysis is assigned to track full financing flows. The detail of each classification can be adjusted to country needs, respecting the internationally agreed categories. The coding of the RSSH can involve, depending on the desired level of detail, one category in one classification (*governance and health system administration*) or a multitude of standard categories (around thirty within three classifications: *functions, capital* and *factors of provision*) and further detail as per country interest. Descriptive fields in the database are also available to refine tracking. This process implies a quality control (QC), embedded in the health accounts production tool (HAPT, an IT specific software tool), usually used in low income countries (LICs) and low and low middle income countries (LMICs). Additional QC is also performed through key categories in the classifications.

The advantage of the generation of a full expenditure flow is that a cross-tabulation can be made which expands the analytical use of the data in detail. There is a set of standard tables and charts, which are used to produce the report. Once the mapping is made using the HAPT, these tables are generated quite easily and without errors. The HAPT can generate multi-variated tables to enhance a particular analysis, e.g. the detail can involve how much was spent on HIV in preventive care in ambulatory facilities in a specific region by the social security and how this spending was financed.

In general, there are no LICs and MICS with an information system ideal and complete for HA. Thus the fragmented pieces of information are interpreted and used to complement the mapping. Distributions, either documented and/or estimated, are to be verified internally with QC measures (e.g. triangulating various sources and reports such as GF and PR data). The cross-tabulation allows not only analysis but also the identification of errors. A good practice is

to discuss preliminary results with the various groups of counterparts, including GF/CCM and PR officers, to explain the process and the results. At this point, additional reports and advice can be given in order to improve/refine data and estimates. Errors and inconsistencies can be avoided during this validation.

Reports are disseminated electronically in the country websites and shared with WHO, and these are used to generate the GHED updates. WHO staff have discussions with each country to validate the data to be made public. GHED allows an updated information set to be maintained by country, which is as consistent as possible and which allows for comparison in time and across countries.

Limitations, challenges and opportunities of the SHA and NHA

In summary, NHA track GF contributions at country level spent in the accounting period, which may not be equivalent to the disbursements. The main strength of this monitoring is that it can inform where the resources were used, by whom, with what purpose, to benefit which population, etc. In order to achieve this purpose, detailed information is required on the flow, such as PRs, content and purposes.

The SHA framework. This is an internationally agreed framework. Its main purpose is not 'financing accounting' but management – useful for decision making, not for auditing. Thus, data handling needs to be properly understood and adjusted to fit the agreed framework. Indeed, evolving systems, evolving uses and experience in accounting also allow unforeseen complexities in the framework to be identified. Several areas remain a challenge for standardisation (e.g. medicines). The manual, although revised twice – the main revision being in 2011, with a minor revision in 2017 – may require a further enhancement to reduce minor inconsistencies which can confuse users. Specific challenges are treated subsequently in guidelines prepared by WHO and OECD, notably as per priority and feasibility of solutions.

Information system. The quality of the results of a NHA is linked to the quality of the data included and the way it is used in the production of the account. Information is managed by different departments, in different stages of execution and at different moments in time. Thus, apparent inconsistencies can be erased with a proper data knowledge and source. However, data gaps and problems are expected to be reduced through the continuous operation and use of the management information system. A routine provision of the data required for NHA can ensure better quality and usability of results. Experience shows that the need for guides, trained personnel, etc. is universal for the various statistical systems, including GFS and SNA.

Limitations of using NHA data to track investments include time lag, although the T-2 production (i.e. producing NHA for 2018 in 2020) is under revision to reach T-1. As expenditure reports are never available on T, an agreement can also be reached to get preliminary/expected aggregates. There are often considerable time lags because financial data can take a long time to be released by governments and because of the time involved in carrying out data collection, validation and analysis for NHA.

Health systems are complex and differently organised, and their related health information systems need to be created, tested, operated and maintained to ensure usability along the financing evolution in countries. However, current IT advances can open new opportunities to facilitate the process, to improve both the statistical structure and automatic information flows to nourish the reporting needs.

Key to the process of such implementation is to keep an integral overview of such systems, in order to ensure the compatibility and complementarity of the components. A basic and strategic principle is to ensure the inclusion of all governmental information. The Public Finance Management (PFM) system covers a segment of information not reflected in SHA, which initiates the analysis once the resources are allocated within the health system.

Compatibility can help to identify discrepancies or adjustments that happen from disbursements to spending. The development of PFM at country level can, ideally, be SHA-compatible, using the agreed international categories, and considered policy relevant. Additionally, the experience gained with SHA can identify the emerging information needs, adjustments and inclusions.

A detailed analysis of the expected information system and the strategies to be developed between the key agencies (e.g. WHO and the GF) is required to ensure compatibility and a simplified process through the ongoing Public Financial Management reform. This may be more strategic and could yield the information with less duplication of effort, and it relates to:

creating a unified classification schedule with unique codes for equivalent financing agencies;

disaggregating allocations and spending by budgetary item (when available), capital investments acquired, services performed with the resources, entities executing them, the targeted disease component (HIV, TB, malaria, RMNCAH, vaccination, nutrition, RSSH, etc.), regional location of the transactions, etc. in an integrated financial management information system benefiting from the SHA experience;

enforcing quarterly[1] reporting during the budget cycle as required by PFM law in many countries. The Global Fund should support these processes as part of the planned Health Financing systems strengthening interventions during 2022–2025.

Identification and data gathering of related private entities, to ensure a comprehensive overview of financing – notably given that the GF specifically funds private sector entities such as communities and non-governmental organisations (NGOs).

Data coverage

The GF/CCM may offer detailed information either as survey response or as reports shared. However, PRs may be partially covered, e.g. some countries do not cover all NGOs receiving external aid. Funds offered via budget support may not be easy to identify in amount, source and purpose without a knowledgeable report/informant (e.g. MOF). It is also important to ensure an expanded coverage of actors, including the subnational level and private sectors. It is important to make health accountants aware of the level of detail to be expected and used, and to display it along the process until reported.

Data mapping

Data with complex labels, including e.g. capital and current spending, can be difficult to classify unless additional information of the components exists. In their absence, an estimate needs to be done. SHA proposes distribution based on keys, considering services, diseases or human resources involved. PRs may not be particularly informed about/interested in tracking each donor and purpose. If GF/CCM officers participate in validation meetings, they may be aware of biases or data problems. If the GF tracks in their system, data of detailed disbursements, NHA can integrate those numbers and use them for triangulation with expenditure data.

Dissemination and use

Details displayed in reports are not standard, and published results are hardly updated once new information is available. Reports are often presented as univariate tables, while bivariate tables, displayed as annexes, may lack a complete interpretation in the report. Limited dissemination results in a lack of use. Data use allows the quality of the results to be improved, with a continuous cycle of increased production, attention, quality and usability.

Lack of continuity

HA studies are not developed by all countries, and when they are developed they can be produced intermittently for several years. The rotation of responsible personnel makes continuous training necessary in order to reduce mistakes and increase understanding of the framework. Metadata ensures the proper documentation of the accounts to replicate, correct and update them. It is important to institutionalise the process.

Lack of IT support

Experience shows that IT is needed, notably to speed up processing of surveys and for database maintenance. The database is key to generating proper analysis. Countries not using the HAPT may produce a reduced range of classifications and may face inconsistencies in the various tables, particularly because the flows generated increase the number of data points exponentially. It is expected that the HAPT or a similar tool can facilitate the accounting process.

Diversity of NHA uses

HA results are often underutilised, and it is important to illustrate their analytical potential and uses, which vary from academia to policymakers in the system or the press, e.g. on productivity, how to contribute to assess efficiency of a health system and to monitor existing policies.

Global Health Expenditure Database (GHED)

This is a database of countries' Health Accounts exercises compiled by WHO. It covers 192 countries over the past 20 years (from 2000 to 2019). WHO works collaboratively with Member States to make updated and comparable health expenditure figures publicly available. Every year WHO collects new results from partial or complete NHA studies from countries. In contrast to GHED, NHA reports are static and are hardly ever updated. The updating process allows for integrating expenditure tracking under other frameworks (e.g. satellite accounts); GHED translates their results into the SHA framework.

In the absence of new NHA reports, GHED generates partial or full updated estimates based on health accounts data, government expenditure records and official statistics. Where necessary, adjustments, interpolation, extrapolation and other estimates are made to ensure the comprehensiveness and consistency of the data across countries and years. Data is displayed in various modalities, such as absolute values and indicators by country, year and disease category. Data released is consulted and validated with country focal points. The initial monitoring covered financing and progressively has expanded the results to functions, diseases and special reporting, e.g. for PHC and COVID-19.

Data from NHA and GHED displays separately spending on capital formation investments, such as hospital construction, and medical equipment, reported through a different classification. Health worker education and training (pre-job formation) and research and development (e.g. linked to patent creation) are partially segregated as non-health expenditure, unless they relate to actual health systems personnel and current medical activities. However, they can be monitored and reported as 'below the line' items.

Limitations of WHO-GHED

Health Accounts (HA) exercises are the backbone of a solid understanding of sources of expenditure flows at the country level. The accuracy of data reported in the GHED varies on a country-to-country basis. Some countries have completed NHA exercises multiple times, and others are yet to conduct them. Also, most countries publish audited expenditure data, but

others provide only executed budget data. The release of verified data at country level may take years, and GHED may benefit from data improvements at country level when updating the series. Not all countries share their complete reports with WHO, and sometimes they share the databases. Given the sensitivity of financial records, confidentiality is a request from certain partners, limiting the possibilities to disseminate the full databases. However, specific agreements, mainly with national teams and WHO, may facilitate the sharing of selected components of the database, such as the GF resource tracking.

OECD Development Assistance for Health (DAH)

Overseas Development Assistance through grants has been crucial in the health sector funding in general and for HIV, TB and malaria specifically. The reduction of the donor commitment to these programmes has elevated the push to increase domestic resources for direct allocations and indirect commitments. Several on and off-budget development partners have exerted the need for counterpart financing. The Global Fund to fight AIDS, TB and malaria implements a Transition, Co-financing and Sustainability Policy requiring incremental counterpart financing. In the same vein, the push for Journey to Self-Reliance (J2SR) by PEPFAR and the requirement for matching funds by UNICEF progressively increase the proportion of domestic funding.

OECD DAH CRS

To track DAH, data from the Organisation for Economic Co-operation and Development (OECD) Creditor Reporting System is used. The OECD DAH estimates track disbursements from the originating donor (called the source) to the development agency responsible for disbursing the funds to the recipient country (called the channel) and to the recipient country. In addition to reporting the source, channel and recipient of DAH, reported disbursements are disaggregated into nine major health focus areas (as well as more detailed programme areas). Health focus areas include: HIV/AIDS; malaria; tuberculosis; reproductive and maternal health; newborn and child health; non-communicable diseases; other infectious diseases; sector-wide approaches and health system strengthening; and other. The 'Other' category captures projects such as general support for a conference on the Sustainable Development Goals that are not allocated to any of the eight specific health focus areas, and remaining funds for which no project descriptions are available and classified as 'unallocable'. This is also the case when resources are offered to cover several countries. The OECD/DAC category used for reporting GF investments in RSSH is Health policy and administrative management (12110).

Limitations of the OECD DAC database

The OECD DAC database does not cover all donors, and gaps are not filled by OECD DAC. Also important is that the classification codes available are more aggregated than those used in the GF, which, as in the case of SHA, makes the labelling important to properly code GF categories. The available data does not always follow the accounting rules proposed by CRS. Disbursements in OECD DAC are not expected to be integrated with expenditure data in SHA2011. However, OECD DAC data is useful for triangulation purposes and analysis of SHA data and can facilitate the analysis of disbursed but not executed amounts and their characteristics.

As per the experiences with country-specific exercises in this study, the GF and OECD DAC may apply a different coding to the reported disbursements, which can explain some of the differences between GF-reported RSSH amounts and OECD DAC-integrated administration disbursements.

The current focus of different sources of health funds

The tables below outline the analysis of the contribution of different funding sources to current health expenditure (CHE) over 20 years, using data from the WHO global health expenditure database. Several issues emerge from these analyses. First, private sources, including households out of pocket expenditure (OOP), contribute the highest proportion of total health expenditure, and have on average decreased from 51% in 2000 to 46% in 2019. Second, public sources remain a substantial contributor to total health expenditure – approximately 38% of CHE in 2000 but declining to 33% in 2019. Third, donor funding increased between 2000 and 2013 but has stagnated at around 22%.

Table 17: Domestic Health Expenditure (DOM) as % of Current Health Expenditure (CHE)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Armenia	87.22	81.99	92.07	94.77	94.54	88.32	88.43	87.78	94.11	95.41	96.27	96.85	97.04	97.93	98.47	98.92	98.13	98.71	98.78	99.00
Eswatini	95.86	88.90	84.18	81.77	79.50	81.17	74.04	76.56	75.69	76.82	74.45	67.96	69.04	70.05	63.28	67.33	67.35	76.25	70.48	73.88
Ethiopia	83.74	82.93	87.30	85.80	70.35	77.76	67.64	66.65	53.24	66.41	65.56	62.47	72.06	76.73	76.57	81.74	79.77	64.64	63.90	65.90
Guyana	99.86	99.36	98.15	94.70	90.99	85.10	80.38	75.19	78.73	78.92	80.89	86.43	90.74	90.92	94.18	95.24	95.55	95.99	96.84	97.31
Lao PDP	90.17	79.48	84.36	86.10	77.64	79.79	72.15	76.45	78.02	80.41	83.28	72.40	72.98	81.00	83.21	83.04	81.88	83.33	87.55	78.79
Mali	94.21	93.14	85.81	91.08	87.91	85.80	80.93	82.15	79.36	76.45	72.65	67.46	58.33	57.93	55.66	58.68	69.77	71.37	65.00	66.55
Mongolia	98.88	96.38	95.14	96.12	93.48	96.14	95.75	97.24	94.15	94.31	95.65	93.83	94.22	94.87	93.92	95.60	94.33	97.16	94.64	94.89
Mozambique	90.41	74.04	65.23	58.00	47.97	46.75	42.34	43.97	41.51	34.81	32.00	33.86	41.61	41.44	46.03	45.32	40.06	37.31	37.70	37.28
Nigeria	83.03	93.28	92.70	94.28	93.78	94.55	94.59	94.10	93.94	93.78	93.74	92.14	91.58	87.56	87.72	90.08	89.68	92.08	92.62	87.25
Philippines	96.47	96.21	97.17	96.63	96.09	95.79	96.17	98.05	98.52	97.67	98.21	99.04	98.97	98.26	98.51	98.56	97.73	97.81	99.69	99.59
Rwanda	53.43	59.17	64.79	57.56	52.76	49.73	42.95	44.68	46.98	47.08	48.07	50.58	46.67	55.74	52.91	57.81	56.74	60.66	60.67	66.21
Senegal	96.01	96.40	94.99	97.07	97.85	93.39	94.57	94.18	93.52	93.21	87.68	91.47	90.66	90.58	81.65	82.02	82.67	83.82	78.40	82.07
Uganda	68.46	70.60	75.80	81.07	69.14	67.42	70.19	71.02	70.71	58.23	54.36	49.81	53.99	62.57	64.03	57.07	58.74	56.86	56.49	57.98
Viet Nam	95.75	96.08	95.31	95.11	94.50	95.99	95.99	96.40	97.80	97.54	97.76	97.64	97.58	97.76	96.81	97.84	97.70	98.92	98.98	99.03
Zimbabwe	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	72.52	80.79	84.66	79.87	79.78	75.74	72.09	69.30	74.83	70.45

Table 18: External Health Expenditure (EXT) as % of Current Health Expenditure (CHE)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Armenia	12.78	18.01	7.93	5.23	5.46	11.68	11.57	12.22	5.89	4.59	3.73	3.15	2.96	2.07	1.53	1.08	1.87	1.29	1.22	1.00
Eswatini	4.14	11.10	15.82	18.23	20.50	18.83	25.96	23.44	24.31	23.18	25.55	32.04	30.96	29.95	36.72	32.67	32.65	23.75	29.52	26.12
Ethiopia	16.26	17.07	12.70	14.20	29.65	22.24	32.36	33.35	46.76	33.59	34.44	37.53	27.94	23.27	23.43	18.26	20.23	35.36	36.10	34.10
Guyana	0.14	0.64	1.85	5.30	9.01	14.90	19.62	24.81	21.27	21.08	19.11	13.57	9.26	9.08	5.82	4.76	4.45	4.01	3.16	2.69
Lao PDP	9.83	20.52	15.64	13.90	22.36	20.21	27.85	23.55	21.98	19.59	16.72	27.60	27.02	19.00	16.79	16.96	18.12	16.67	12.45	21.21
Mali	5.79	6.86	14.19	8.92	12.09	14.20	19.07	17.85	20.64	23.55	27.35	32.54	41.67	42.07	44.34	41.32	30.23	28.63	35.00	33.45
Mongolia	1.12	3.62	4.86	3.88	6.52	3.86	4.25	2.76	5.85	5.69	4.35	6.17	5.78	5.13	6.08	4.40	5.67	2.84	5.36	5.11
Mozambique	9.59	25.96	34.77	42.00	52.03	53.25	57.66	56.03	58.49	65.19	68.00	66.14	58.39	58.56	53.97	54.68	59.94	62.69	62.30	62.72
Nigeria	16.97	6.72	7.30	5.72	6.22	5.45	5.41	5.90	6.06	6.22	6.26	7.86	8.42	12.44	12.28	9.92	10.32	7.92	7.38	12.75
Philippines	3.53	3.79	2.83	3.37	3.91	4.21	3.83	1.95	1.48	2.33	1.79	0.96	1.03	1.74	1.49	1.44	2.27	2.19	0.31	0.41
Rwanda	46.57	40.83	35.21	42.44	47.24	50.27	57.05	55.32	53.02	52.92	51.93	49.42	53.33	44.26	47.09	42.19	43.26	39.34	39.33	33.79
Senegal	3.99	3.60	5.01	2.93	2.15	6.61	5.43	5.82	6.48	6.79	12.32	8.53	9.34	9.42	18.35	17.98	17.33	16.18	21.60	17.93
Uganda	31.54	29.40	24.20	18.93	30.86	32.58	29.81	28.98	29.29	41.77	45.64	50.19	46.01	37.43	35.97	42.93	41.26	43.14	43.51	42.02
Viet Nam	4.25	3.92	4.69	4.89	5.50	4.01	4.01	3.60	2.20	2.46	2.24	2.36	2.42	2.24	3.19	2.16	2.30	1.08	1.02	0.97
Zimbabwe	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	27.48	19.21	15.34	20.13	20.22	24.26	27.91	30.70	25.17	29.55

The effectiveness of the method of the health system components financing

Government funding

There is consensus that public expenditure on health is a key determinant of the achievement of UHC (Mcintyre D, 2014). It has been proposed that for countries to achieve UHC, their public spending on health, as a share of their gross domestic product (GDP), will need to be at least 5% (Di McIntyre *et al.*, 2017) or 6% (WHO/PAHO, 2019). Countries must raise sufficient funds and reduce the reliance on direct payments to finance services in order to improve efficiency and equity. The extent to which public spending on health aligns with health system goals is dependent on the financing arrangements.

External funding

Beyond the positive impact on expanding access to care, external funding has been characterised by several attributes of concern. First, external funding has predominantly been channelled to vertical programmes (Desai *et al.*, 2010; Ejughemre, 2013; Mounier-jack *et al.*, 2010; Rudge *et al.*, 2010). While there is evidence that verticalisation has contributed to the success of specific disease programmes (malaria, HIV/AIDS, TB, immunisation), it has had unintended effects, with implications for the efficiency of health systems (Mwisongo & Nabyonga-orem, 2016). Vertical programmes have compromised the coordination of overall health systems because they have typically not been well integrated with the rest of the system (Desai *et al.*, 2010; Mounier-jack *et al.*, 2010; Mwisongo & Nabyonga-orem, 2016; Rudge *et al.*, 2010), resulting in duplication of functions such as procurement, monitoring and evaluation, and information systems, and the draining of health workers from other services because of added financial incentives for health workers in these donor-funded programmes (Yu *et al.*, 2008). The fragmented and vertical funding arrangements are exacerbated challenges by governments to track their resources (Mwisongo & Nabyonga-orem, 2016). The terms of external funding also often mean that donors influence public health priorities, sometime at odds with local priorities (Mwisongo & Nabyonga-orem, 2016). For instance, an assessment of GF round 1–7 funding found that investments in human resources or health were not coordinated with the rest of the system (Bowser *et al.*, 2014). Further, external funding has been fragmented, with little coordination across different donors. While there have been efforts to coordinate donor funding at the country level through the sector-wide approaches (SWAPS) (Sweeney & Mortimer, 2016), and at the global level through initiatives such as the Health Systems Funding Platform, the extent to which these initiatives have been successful is debatable (Brown *et al.*, 2013; Hill *et al.*, 2011; Moucheraud *et al.*, 2016; Stierman *et al.*, 2013). The narrow focus, combined with the poor integration and coordination of external funding, has therefore compromised the efficiency of health systems (Bowser *et al.*, 2014; Moucheraud *et al.*, 2016).

Further, there is evidence that when external funds are concentrated in urban areas, they have contributed to maldistribution of health workers. Financing salaries and incentives of health workers has, in some cases, made an important contribution to country efforts to increase staffing and improve retention. However, health workers, attracted by financial (allowances) and non-financial (training) incentives, move to health facilities in urban areas that are donor funded, resulting in inequities in the distribution of health workers (Brugha *et al.*, 2010). For example, countries employed a variety of mechanisms, including salary top-ups, performance incentives, extra compensation and contracting of workers for part-time work, to pay health workers using Global Fund financing (Bowser *et al.*, 2014).

There are also concerns about the sustainability of external funding. While historically external funding has played a significant role in financing LMIC health systems, there are plans by major

donors such as Gavi and PEPFAR to progressively exit as countries graduate to middle-income status (Gilbert *et al.*, 2019). This means that donor funding cannot be considered sustainable in the long term.

Finally, donor funding has been shown to have a displacement effect on public expenditure on health. An analysis of financial flows data spanning 119 countries and 16 years showed that a $1 year-on-year increase in development assistance for health channelled to governments leads to a $0.62 decrease in domestic government spending on healthcare (J. L. Dieleman & Hanlon, 2014).

Recommendations (WS4)

We make several proposals for aligning health financing sources with the goals of financing health systems:

Updating frameworks for health expenditure tracking: Health expenditure tracking aims to empower actors and increase accountability, transparency and responsiveness in health systems in support of progress towards universal health coverage. Most health expenditure tracking exercises are guided by the system of health accounts (SHA). While the conceptualisation of health systems has evolved over time, health expenditure tracking frameworks have not kept pace. We recommend that health expenditure tracking frameworks reflect relevant RSSH spending from the Global Fund and other partners.

Improved coordination of sources of funding: Evidence shows that global efforts have mostly failed, and gaps exist with national efforts. There is a need for the coordination of donor funding at both these levels and for alignment of these funding approaches with local priorities. Roadmaps to UHC should consider the complex and changing needs of different contexts. Tailored, country-specific plans and coordination mechanisms that aim to build and finance health systems that are adaptable for unforeseen changes such as global pandemics will help accelerate progress along the path towards UHC.

Integration: The case for integration is even stronger now, given plans by donors to transition. Donors and LMICs will need to make concrete plans for integrating vertical programmes into the broader health system to improve efficiency and ensure the sustainability of these service delivery areas. Moreover, social determinants of health are vital for the equitable pursuit of healthy lives and health services delivery for all. There is a need to expressly incorporate social determinants of health into the framework for monitoring UHC through integration. Integration disaggregates UHC indicators to reflect the social gradient and the complexity of social stratification. Also, through integration we can connect health indicators, both outcomes and coverage, with the social determinants of health and policies within and outside of the health sector. Failure to integrate health services increases the risk of going down a narrow route that limits the right to health to coverage of services and financial risk protection.

Donor transition plans: Related to integration, LMICs will need to develop pragmatic and feasible donor transition plans. These plans must be anchored on three broad principles that guide health financing reforms to accelerate progress towards universal health coverage (UHC). The first is to move towards a predominant reliance on public funding sources. The second is to reduce fragmentation in pooling to enhance the redistribution capacity of these prepaid funds. The third is the move towards strategic purchasing, which seeks to align funding and incentives with promised health services. Such plans will need to be country-driven, pragmatically aligned to country fiscal capacity, and accompanied by efficiency measures such as integration and feasible co-financing commitments. Countries will need to honour these commitments to avoid disruption of gains made.

Also, emergency programming has short funding cycles that do not facilitate medium to long-term strategic planning. This complicates efforts to build programme ownership and capacity among the affected populations and prolongs the use of expensive emergency-oriented programme strategies. Consequently, there is a need to focus on resilience programming that links emergency and development responses under the framework of supporting programme that will enable communities to withstand future shocks.

Table 19: OECD/DAC investments on HSS ($ million)

Recipient	Sector	Channel	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Mongolia	12110: Health policy and administrative management	All Channels	3.94	4.64	7.68	11.90	0.74	1.60	1.89	2.65	2.02	3.86	1.49
		Public Sector	3.91	4.45	7.26	11.58	0.39	1.32	1.52	2.17	1.72	3.37	1.33
		NGOs & Civil Society	0.04	0.19	0.42	0.32	0.26	0.23	0.33	0.24	0.30	0.49	0.12
		Public–Private Partnerships (PPPs)	..	..	..	..	0.01	..	..	..	..	..	..
		Multilateral Organisations	..	..	..	..	..	0.04	0.04	0.23	..	..	..
		Teaching institutions, research institutes or think tanks	..	..	..	..	..	0.01	..	..	..	..	..
		Other	..	..	..	0.01	0.08	..	..	..	..	..	0.04
Mali	12110: Health policy and administrative management	All Channels	9.92	6.38	2.91	14.49	13.06	1.76	3.19	0.30	5.27	4.51	4.47
		Public Sector	7.49	3.59	0.76	6.96	0.14	0.08	1.84	0.07	2.35	1.05	0.33
		NGOs & Civil Society	1.59	2.42	1.50	1.30	2.29	0.95	1.35	0.23	2.25	1.71	1.83
		Public–Private Partnerships (PPP)	..	..	..	..	..	..	..	..	0.47	..	..
		Multilateral Organisations	0.00	0.02	0.04	5.31	9.96	0.03	..	..	..	..	0.73
		Teaching institutions, research institutes or think tanks	..	0.04	0.17	0.65	0.65	0.45	..	..	0.10	0.32	0.18
		Private Sector Institutions	..	..	..	..	..	..	0.00	..	0.11	1.43	1.40
		Other	0.84	0.31	0.45	0.27	0.03	0.25	..	..	..	..	..

Rwanda	12110: Health policy and administrative management	All Channels	17.35	24.94	11.11	21.43	6.99	2.66	6.13	14.48	8.59	1.80	1.85
		Public Sector	17.01	24.78	10.38	21.28	6.27	2.16	6.10	14.00	8.29	1.16	1.73
		NGOs & Civil Society	0.33	0.16	0.73	0.11	0.71	0.46	0.03	0.37	0.06	0.22	0.09
		Public–Private Partnerships (PPPs)	..	..	..	0.01	..	..	..	..	0.12	..	..
		Multilateral Organisations	..	..	..	0.04	..	..	..	..	..	..	..
		Teaching institutions, research institutes or think tanks	..	..	..	..	..	..	..	..	0.04	0.37	0.02
		Private Sector Institutions	..	..	..	..	..	..	..	0.10	0.09	0.05	0.00
		Other	..	..	..	..	0.01	0.04	..	..	..	..	..
Eswatini	12110: Health policy and administrative management	All Channels	0.06	0.03	0.16	0.09	0.03	0.02	1.84	0.00	0.18	0.06	0.49
		Public Sector	0.06	0.02	0.16	0.09	0.03	0.02	1.80	0.00	0.18	0.06	0.48
		NGOs & Civil Society	..	0.01	..	..	..	..	0.04	..	..	0.01	0.00
		Other	..	..	..	..	..	..	..	..	..	..	0.01
Ethiopia	12110: Health policy and administrative management	All Channels	10.42	16.49	15.60	19.29	26.07	28.36	17.31	11.62	13.20	16.13	27.55
		Public Sector	10.26	15.59	14.94	17.16	22.62	25.28	16.24	8.48	9.20	11.22	23.20
		NGOs & Civil Society	0.05	0.10	0.48	0.90	0.16	0.25	0.13	1.41	1.29	1.70	0.54
		Public–Private Partnerships (PPPs)	..	..	..	..	..	..	..	..	0.08	..	..
		Multilateral Organisations	..	0.72	..	0.86	3.20	..	0.35	1.54	0.24	1.18	0.05
		Teaching institutions, research institutes or think tanks	0.05	..	0.15	0.15	..	2.82	0.42	..	0.91	0.31	0.30

		Private Sector Institutions	..	..	..	..	..	..	0.01	0.11	1.40	1.73	3.46
		Other	0.06	0.09	0.02	0.22	0.10	0.02	0.17	0.08	0.08	..	0.01
Guyana	12110: Health policy and administrative management	All Channels	0.22	0.04	0.47	0.28	0.07	0.05	0.48	0.03	0.03	0.01	0.00
		Public Sector	0.07	0.04	0.47	0.28	0.07	0.05	0.44	0.01	0.01	..	..
		NGOs & Civil Society	..	..	..	..	..	..	..	..	..	0.00	0.00
		Multilateral Organisations	..	..	..	..	..	..	0.04	0.01	0.02	0.00	..
		Other	0.15	..	..	..	..	..	..	..	..	..	..
Lao People's Democratic Republic	12110: Health policy and administrative management	All Channels	3.25	5.02	6.71	4.76	3.71	3.95	4.99	7.58	8.77	9.18	6.85
		Public Sector	2.20	2.73	3.69	2.12	3.52	3.42	4.44	7.31	8.75	9.11	6.06
		NGOs & Civil Society	0.16	0.02	0.45	0.25	0.19	0.19	0.41	0.09	0.01	0.06	0.07
		Multilateral Organisations	0.84	2.27	2.57	2.39	..	0.06	0.14	0.18	..	..	0.65
		Teaching institutions, research institutes or think tanks	..	..	..	..	..	0.28	..	..	..	..	..
		Private Sector Institutions	..	..	..	..	..	..	..	..	..	..	0.04
		Other	0.05	..	..	..	..	..	..	0.01	0.01	0.00	0.04
Mozambique	12110: Health policy and administrative management	All Channels	78.47	65.08	45.43	40.37	39.30	38.50	31.45	29.31	38.89	24.56	29.64
		Public Sector	75.16	62.39	41.99	36.23	34.71	33.35	29.29	23.21	24.28	13.69	14.62
		NGOs & Civil Society	2.75	0.91	1.95	2.05	1.65	1.61	0.53	2.16	3.05	1.70	3.27
		Public–Private Partnerships (PPPs)	..	0.41	..	..	0.02	..	..	..	0.06	..	..
		Multilateral Organisations	-0.01	0.61	0.25	0.36	0.79	0.13	..	1.66	8.66	6.96	9.56

		Teaching institutions, research institutes or think tanks	..	0.09	0.92	1.55	1.82	3.12	1.11	0.68	0.58	0.48	0.09
		Private Sector Institutions	..	..	..	..	..	..	0.45	1.57	2.19	1.62	1.89
		Other	0.57	0.66	0.32	0.19	0.31	0.30	0.07	0.04	0.07	0.12	0.21
Senegal	12110: Health policy and administrative management	All Channels	7.85	21.04	10.76	4.73	5.18	6.58	7.74	82.29	11.88	14.00	7.44
		Public Sector	7.05	20.23	9.96	4.03	2.57	6.23	7.52	81.63	8.98	13.70	6.43
		NGOs & Civil Society	0.77	0.76	0.77	0.54	0.28	0.29	0.23	0.30	1.68	0.28	0.35
		Public–Private Partnerships (PPPs)	..	..	..	..	..	..	..	..	0.18	..	..
		Multilateral Organisations	..	..	..	0.13	2.34	0.06	..	0.36	0.12	..	0.40
		Teaching institutions, research institutes or think tanks	..	0.05	0.04	0.02	..	..	..	..	0.92	0.03	0.18
		Private Sector Institutions	..	..	..	..	..	..	..	..	..	..	0.08
		Other	0.03	..	..	..	..	..	..	..	..	..	0.00
Armenia	12110: Health policy and administrative management	All Channels	0.05	0.34	0.01	0.01	0.04	0.03	0.03	0.01	..	..	0.04
		Public Sector	0.02	0.01	0.01	0.01	0.02	0.03	0.02	0.01	..	..	..
		NGOs & Civil Society	0.02	0.33	..	..	..	..	..	..	..	..	0.04
		Multilateral Organisations	..	..	..	..	0.03	..	0.01	..	..	..	..
		Other	0.00	0.00	..	..	..	..	..	..	..	..	..
Viet Nam	12110: Health policy and	All Channels	10.12	15.16	5.78	5.67	4.72	13.51	29.25	7.93	8.74	8.39	3.92
		Public Sector	5.40	6.86	4.54	3.01	3.81	12.56	27.11	7.16	6.38	7.66	3.56

	administrative management	NGOs & Civil Society	0.35	0.12	0.74	0.35	0.49	0.76	0.32	0.32	1.16	0.39	0.11
		Public–Private Partnerships (PPPs)	..	..	..	..	..	..	..	0.26	0.37	0.10	..
		Multilateral Organisations	4.13	7.74	..	1.33	..	0.14	0.13	0.15	..	..	..
		Teaching institutions, research institutes or think tanks	0.00	0.44	0.48	0.98	..	0.06	1.70	..	0.79	0.23	..
		Private Sector Institutions	..	..	..	..	..	..	..	..	0.04	..	0.15
		Other	0.23	..	0.03	..	0.42	..	..	0.04	0.01	0.01	0.10
		Not reported	..	..	..	..	0.00	..	..	..	..	..	..
Uganda	12110: Health policy and administrative management	All Channels	13.14	15.10	24.91	8.17	16.03	6.32	12.70	3.78	10.52	4.76	8.64
		Public Sector	10.92	13.14	22.74	6.14	12.23	3.82	11.18	1.82	5.90	3.22	5.99
		NGOs & Civil Society	1.75	1.34	1.79	1.34	3.37	2.10	1.39	1.64	1.24	1.37	1.45
		Public–Private Partnerships (PPPs)	..	..	..	0.01	0.05	..	..	..	0.89	..	..
		Multilateral Organisations	0.09	0.04	..	..	..	..	..	..	0.14	..	..
		Teaching institutions, research institutes or think tanks	0.38	0.39	0.38	0.68	0.16	0.23	0.13	0.32	2.24	0.06	..
		Private Sector Institutions	..	..	..	..	..	..	..	0.00	0.11	0.11	1.20
		Other	0.02	0.18	..	..	0.22	0.18	0.01	..	..	..	0.00
Zimbabwe	12110: Health policy and administrative management	All Channels	3.49	5.34	0.69	2.18	1.32	0.86	5.18	4.89	6.36	7.33	8.90
		Public Sector	0.11	0.09	0.30	1.02	0.99	0.69	5.17	0.10	0.90	1.75	2.78
		NGOs & Civil Society	0.06	0.05	0.00	0.78	0.11	0.08	0.01	0.41	0.95	0.87	0.50

		Public–Private Partnerships (PPPs)	..	..	..	0.01	0.02	..	..	..	..	..	..
		Multilateral Organisations	..	..	0.05	0.06	..	..	..	4.36	4.50	3.73	5.41
		Teaching institutions, research institutes or think tanks	..	..	0.11	0.12	..	..	..	..	..	0.88	..
		Private Sector Institutions	..	..	..	..	..	..	..	0.01	..	0.01	0.21
		Other	3.32	5.20	0.24	0.20	0.19	0.10	..	0.00	..	0.09	..
Philippines	12110: Health policy and administrative management	All Channels	6.24	2.92	6.08	8.28	6.09	3.56	6.18	3.23	2.66	1.51	2.99
		Public Sector	2.81	2.81	5.56	8.04	5.19	3.20	5.57	2.31	2.46	0.99	0.78
		NGOs & Civil Society	0.15	0.12	0.19	0.09	0.72	0.20	0.45	0.43	0.19	0.25	0.23
		Multilateral Organisations	3.21	..	..	..	0.19	0.15	0.15	0.30	..	..	1.85
		Teaching institutions, research institutes or think tanks	..	..	0.34	0.15	..	..	..	..	..	0.26	0.12
		Private Sector Institutions	..	..	..	..	..	..	..	0.18	..	..	..
		Other	0.07	..	..	..	..	..	..	0.01	0.01	0.01	0.02
Nigeria	12110: Health policy and administrative management	All Channels	42.74	55.81	75.73	56.23	36.12	25.46	20.42	5.47	9.25	5.47	7.11
		Public Sector	3.78	4.39	3.87	2.67	0.71	1.05	10.21	0.06	2.28	2.23	3.61
		NGOs & Civil Society	0.09	0.26	2.62	1.23	2.53	3.96	0.96	0.26	0.64	0.28	0.19
		Public–Private Partnerships (PPPs)	7.28	17.80	..	0.10	0.77	0.34	..	..	1.26	..	..
		Multilateral Organisations	4.83	3.41	0.70	0.68	2.04	1.65	0.88	0.39	0.38	..	0.48

		Teaching institutions, research institutes or think tanks	..	..	0.01	..	..	..	..	0.31	0.58	0.04	0.84
		Private Sector Institutions	..	..	..	..	..	..	..	4.45	4.11	2.91	2.00
		Other	26.76	29.96	68.53	51.54	30.07	18.46	8.36	..	..	..	..

Source: OECD.Stat

Table 20: GF investments on HSS ($ million)

Recipient	Sector	Channel	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Rwanda	12110: Health policy and administrative management	All Channels	..	..	..	..	..	..	..	1.95	..	..	..
		Multilateral Organisations	..	..	..	..	..	..	..	1.95	..	..	..
Eswatini	12110: Health policy and administrative management	All Channels	..	..	..	..	0.59	..	..	..	..	..	..
		Public Sector	..	..	..	..	0.59	..	..	..	..	..	..
Ethiopia	12110: Health policy and administrative management	All Channels	..	..	..	..	..	..	13.82	21.24	10.27	9.92	11.51
		Public Sector	..	..	..	..	..	..	13.82	21.24	10.27	9.92	11.51
Lao People's Democratic Republic	12110: Health policy and administrative management	All Channels	..	..	..	..	..	..	1.88	0.72	..	..	..
		Public Sector	..	..	..	..	..	..	1.88	0.72	..	..	..
Mozambique	12110: Health policy and administrative management	All Channels	..	..	..	..	8.27	0.51	1.24	3.01	0.52	..	..
		Public Sector	..	..	..	..	8.27	0.51	1.24	3.01	0.52	..	..
Senegal	12110: Health policy and administrative management	All Channels	..	..	..	..	..	..	1.82	2.71	4.34	4.52	4.64
		Public Sector	..	..	..	..	..	..	1.82	2.71	4.34	4.52	4.64

Viet Nam	12110: Health policy and administrative management	All Channels	..	..	..	..	8.87	11.84	9.00	..	..	..	..
		Public Sector	..	..	..	..	8.87	11.84	9.00	..	..	..	..
Uganda	12110: Health policy and administrative management	All Channels	..	..	..	..	..	..	4.31	10.35	1.45	..	..
		Public Sector	..	..	..	..	..	..	2.81	7.61	1.45	..	..
		NGOs & Civil Society	..	..	..	..	..	..	1.50	2.74	..	..	..
Zimbabwe	12110: Health policy and administrative management	All Channels	..	..	..	..	0.73	1.05	..	..	..	..	..
		Multilateral Organisations	..	..	..	..	0.73	1.05	..	..	..	..	..
Nigeria	12110: Health policy and administrative management	All Channels	..	..	..	..	..	..	..	..	..	5.66	27.15
		NGOs & Civil Society	..	..	..	..	..	..	..	..	..	5.66	27.15
Guyana													
Mongolia													
Philippines													
Mali													
Armenia													

Annex 5: Mapping of modules and interventions by SHA 2011 coding

Background

As 'what is measured is performed' and 'to measure is to know', the specific expenditure on RSSH tracking is mutually beneficial for the GF and the country. It is advisable to be done in a standardised way. In principle, a standard monitoring of GF RSSH expenditure becomes comparable in time and with other similar spending from domestic and other donor origins.

SHA composition and procedures

A standard for monitoring health expenditure is SHA. The composition and detail of NHA reports is optional to a country. It is expected, however, that the data should be cross-classified among the various classifications, e.g. including the funding origin. The GF has a special entry in the funding origin.

The expenditure tracking, although complementary to DAC, can lead to different results from the disbursements due to e.g. absorption capacity and administrative reasons.

SHA classifications and categories are agreed to be policy relevant; however, SHA includes the possibility to disaggregate and to add further subcategories for refinement. Thus, it is possible to adjust to a particular country's analytical needs.

Mapping GF RSSH flows to SHA

The level of detail of the GF RSSH information to be mapped modifies the granularity of the result. Greater detail allows for a more specific monitoring of the spending and its potential influence in health systems decisions. SHA coding can be applied to any expenditure composition. To analyse the GF grants, this can be made at module, intervention or component level.

The mapping of GF RSSH by 'module' to SHA directly suggests the Governance and Administration category. In most of the NHA reports this category is available. This amount would reflect a country-level total, and a cross-tabulation by type of originating source could allow identification of the domestic and each donor's RSSH expenditure totals. The data in the GF system of spending would constitute a useful reference source.

The next level of detail, 'intervention' level, allows for identification of the basic SHA grouping of current and capital spending. Given that SHA promotes this separate reporting, this is a more appropriate level of mapping.

The third level of detail, the 'scope of the interventions', as presented in the GF Modular Framework Handbook (29 July 2022), allows for the detailed definition of the SHA categories. This means the identification of the type of capital (HK), the type of governance and administration categories, the preventive content (e.g. emergency preparedness, risk and disease control management programmes, and information to the population) and those for service provision (e.g. personal care).

Table 21: MFH modules mapped to SHA2011 by intervention component

SHA2011 Code	Concept	RSSH: Health Sector Planning & Governance for Integrated People-centered Services	RSSH: Community Systems Strengthening	RSSH: Health Financing Systems	RSSH: Health Products Management Systems	RSSH/PP: Human Resources for Health (HRH) and Quality of Care	RSSH/PP: Laboratory Systems (including national and peripheral)	RSSH/PP: Medical Oxygen and Respiratory Care System	RSSH: Monitoring and Evaluation Systems	Tal
HC.7.1	Governance & HS admin	18	25	23	51	61	51	10	147	386
HC.6.5	Epid. Surv & disease control	1					4		28	33
HC.6.5/HC.6.6	Epid surv/disaster preparedness						1		12	13
HC.7.2	Financing admin			12						12
HK.1.1.2.3	Computer software & databases					2	4		2	8
HK.1.1.2.1	Medical Equipment						2	5	1	8
HC.6.6	Disaster preparedness					4	2		2	8
HC.1-HC.7	Health care system				2	4				6
HK.1.1.1.1	Infrastructure	1	1		2		1	1		6
HK.1.1.3.1	ICT equipment		1		2				2	5

HC.1-HC.3	Curative care							3	1	4
HK.R	Capital related investments					3	1			4
HC.6.1	IEC		2						1	3
HC.6.4	Healthy population care					2			1	3
HC.1-HC.6	Health care						2			2
HC.1-HC.4-HC.6.5	Personal care & disease control						2			2
HC.R	Health care related							1		1
HC.1/HC.6.4	Disease Testing								1	1
HK.1.1.1.1; HK.1.1.2.4	Infrastructure & equipment				1					1
HC.6.4/HC.6.5	Healthy population care& disease control						1			1
HK.1.1.2.4	Other Equipment				1					1
Total		20	29	35	59	76	71	20	198	508

Coding the MFH intervention components shows that the category most frequently coded refers to governance and administration, followed by prevention. When considering the spending, capital on infrastructure is the single code with more spending. The grants for monitoring and evaluation are those with the largest number of coding diversity (capital and current wise), followed by laboratory improvement and human resources, which also impact curative care. The level of detail to generate the mapping can be reduced if it is performed only at intervention or module level, but then the nature of the impact is too aggregated to capture the level of importance in the various interventions. This detail is important for the evaluation and assessment of the grants and for the amount and time required to achieve the expected results.

The mapping should match both the GF and SHA categories to have a one-to-one relation. In practice this is challenging, as category content in both systems is based on different taxonomies. In fact, RSSH interventions may overlap several SHA categories and classifications. Table 21 has summarised the SHA2011 coding based on the MFH, at module level, but accounted for as component of intervention. The 508 in total represents the code points by module component. Multiple coding was avoided as far as possible, but when a code can be multiple, each code counts; thus 508 is a larger number than the list of interventions by component across the modules.

Recommendations

- Take decision on the convenient level of detail to be used for the standardised mapping. Accordingly, the labels to be used should preferably be concise and additionally provide a clear description of its content, e.g. capital and current, and identify whether the resource is directed to health care provider level or to the governance and management of the health system.
- The integration of GF monitoring could, ideally, be part of an SHA-compatible health financing information system. This could progressively include IT solutions for a more accurate, detailed, integrated retrieval of desired reporting by all domestic and foreign sources. It could also be possible to assess the GF investments and the related domestic co-financing, which in SHA could represent a memorandum item.
- Although a general guideline exists for a standardised monitoring (SHA2011), additional resource tracking operational guidelines are needed to support the process at country level. At the moment, a guide on administration and governance is lacking. An effort on this area specifically is doable in a relatively short time and would have positive benefits.
- Finally, notifying the NHA teams of the potential use of GF RSSH aggregates and detail would facilitate a proper visibility. This can be done during the preparation of the Health Accounts.

Annex 6: Objective 2 (country-level analysis) detailed methodology note with illustrative analysis in Eswatini

This Annex presents the technical notes for computing indicators for mapping questions 3.1 and 3.2.

MQ 3.1 How do GF investments in RSSH compare with domestic and government expenditure on HSS?

MQ 3.2 How do GF investments in RSSH compare with other external development assistance to health, where relevant?

The first section includes **Error! Reference source not found.**, which provides the indicator definitions, limitations and recommendations to strengthen these indicators. This is followed by a detailed description for each of the indicators and notes on their strength. The second section presents a summary of the limitations and challenges in computing these ratios, exemplified in three country cases. The third section provides an interpretation of the ratios. The fourth section presents recommendations on the use of the indicators for resource tracking. Finally, the fifth section presents the illustrative analysis of computing the indicators, including use and the limitations, for Eswatini.

Technical notes of the indicators for comparing GF investments with domestic, government and external health expenditure

Table 22: Indicators generated with NHA to support country analysis

Data points	Step for calculation	Possible limitations found	Criteria for weakness by indicator	Recommendations	Comment
Global Fund expenditure on RSSH as a proportion of domestic current health expenditure	Numerator ***Global Fund expenditure on RSSH*** is taken from GF PUDR annualised – as close to expenditure on RSSH as possible.	GF website may display total RSSH as disbursement; expenditure only as internal information in PUDR (here was the basic source); OECD DAC has this information as disbursements. In a few cases there was a partial reporting of disbursements or mismatch in years (time lag?). HA include GF data but reports do not make details	No data = 100% weak Detail on capital data = 50%	GF disbursements should separate current and capital and indicate detailed RSSH content for a proper classification or give % of spending or allocation by purpose of RSSH. Standardise definition of RSSH and HSS, content and coding. Standardise time lag handling. Promote timely updates of HA. Promote display of capital spending in NHA and GHED. Intervention name should separate content or give %	This indicator gives the idea of relevance of GF RSSH investments in total health spending.

	Denominator ***domestic current health expenditure*** is taken from GHED for calculations.	visible, although it is feasible to access these flows. GHED may have a database with country NHA details but their availability is not known. Detail on capital and current content in GF flows is available only in detailed descriptions. Annualised spending may not correspond to spending made in 2019. GHED was the main source. This denominator can be obtained from any NHA study. HA may lack availability of the recent years, given lack of yearly NHA updates (available T-2). Capital and current expenditure should be made consistent in numerator and denominator.		of spending /allocation by purpose, including RSSH and current and capital purposes; and distributional channel. Promote QC on reported amounts (e.g. OECD DAC total and GF totals by year); harmonise exchange rates with DPs and GHED. Agree GF reporting needed with HA.	
Global Fund expenditure on RSSH as a proportion of domestic government	Same numerator as above. Denominator is taken from GHED.	If GF disbursements cover only private sector, this indicator is not appropriate.	No data = 100% weak No capital data = 50% weak	Ideally numerator and denominator should be made consistent for governmental spending.	This indicator allows to establish the relevance of GF funds specifically in governmental

current health expenditure		Ideally current and capital components should be separated. Detail on GF government current RSSH spending is likely to be in GHED and in country NHA reports. Capital RSSH is not frequently reported.			spending. Relevant when allocations are made through government.
Global Fund expenditure on RSSH as a proportion of government domestic health systems strengthening (HSS) expenditure	Numerator same as above. Denominator taken from GHED and can be also available in NHA country reports (HC.7 HSS by source).	HA data often report HSS domestically funded (HC.7 by FS) but less likely to report domestic capital spending on HSS. Studies may not be produced annually. GHED reports are T-2. Denominator could be incomplete if not all HSS is considered.	No data = 100% weak Missing capital data = 50% weak	Ideally both numerator and denominators should be consistent in content and coding, e.g. standardised at intervention level. - Promote nowcasting of NHA aggregates data for T-1, and preliminary spending data - Promote separation of RSSH and HSS current and capital disbursements. - Agree on detail and periodicity of GF ad hoc NHA reporting.	This detail is relevant to track relevance of GF in HSS, e.g. for additionality, mainly when detailed. HAPT (or similar tools) facilitates availability.
Global Fund expenditure on RSSH as a proportion of Total externally funded HSS expenditure	Denominator taken from GHED.	Ideally numerator and denominators should be consistent (e.g. on HSS interventions and current and capital). OECD DAC may display lower amount of disbursements given partial donor	No data = 100% weak No capital data = 50%	Definition and reporting on RSSH and HSS should be standardised by component. Also important to standardise time lag reporting.	This indicator shows the relevance of GF among all DPs on HSS in the country. Ideally the group of interventions should be consistent.

		coverage. Time lag of execution may affect consistency of denominator and numerator. Data is often displayed as HSS current spending in NHA reports and in GHED. Detail on capital HSS external has potential lacunae in country reports and in GHED.				
Government expenditure on governance and administration as a proportion of total governance and administration expenditure	Numerator has been described above. Denominator taken from GHED: HSS spending, including all sources.	Likely to be found but potential lacunae present for domestic capital spending by purpose. The numerator and denominator should be made consistent. Main problem is standardisation and understanding of HSS as the coding based on the detail of the descriptive accessible information varies. Thus denominator may be undervalued if only includes HSS at health system level.	No data = 100% weak Missing capital data = 50% weak		Detailed description of HSS by group of intervention should be available and standardised. Promote nowcasting of NHA aggregates data for T-1 or preliminary spending data.	This indicator informs on the relevance of HSS at country level and under government responsibility.

Externally funded HSS expenditure as a proportion of total HSS expenditure	Numerator and denominator have been discussed above.	These are basic NHA components but as mentioned above, the key quality is in having a standardised definition and detail for classification so that numerator and denominator are consistent.	No data = 100% weak Missing capital data = 50% weak	The level of detail to be analysed and classification of HSS content should be agreed. Promote nowcasting of NHA aggregates data for T-1 or preliminary data.	This indicator informs the reliance of HSS on external funding.

The ratios in MQs 3.1 and 3.2 are not routinely quantified health finance statistics, and there are major limitations in comparability that affect their robustness/strength. The use of these ratios is likely to improve their production and quality.

Box 9.Definitions of numerator and denominator for country-level ratio calculations

3.1a Global Fund expenditure on RSSH as a proportion of domestic current health expenditure

3.1a **Numerator refers to total GF RSSH spending** and was taken from PUDR and annualised for ratio generation. However, this information can be derived from GF website and annual spending reports, OECD DAC (disbursements) and NHA (spending) databases.

- There are comparability issues to consider, e.g. between disbursements and expenditure, which may involve a different purpose.
- Disbursement records may need to be distributed among the years covered, to be made comparable to expenditure. For this process, information is required on the absorption capacity, the grants received and the length of projects or annual reported spending in PUDR.
- GF expenditure can be obtained mainly from resource user agencies and GF disbursements are analysed for triangulation purposes: to verify completeness, consistency and complement records when needed.
- A better quality and comparability of this denominator will be reached if RSSH and HSS are standardised in definition, on how to reflect them by classifications and categories, and in the detail to be handled, e.g. at intervention level.
- NHA databases are available at country and GHED level. To access them, an agreement can be made for making GF RSSH funds visible, including their use by purpose.

3.1.a **Denominator is total domestic current spending** (public and private excluding external contributions). This denominator can be sourced from existing NHA (spending), either in country report or GHED (GHED may be more updated). It is widely available, although quality and update may vary (e.g. on completeness of private spending). A compatibility challenge is identifying whether GF funds include capital spending. If that is the case, denominator should also include capital spending.

3.1.b Global Fund expenditure on RSSH as a proportion of domestic government current health expenditure

3.1b **Numerator is the same as 3.1.a: refers to total GF RSSH spending.**

3.1b **Denominator is domestic government current spending**. This denominator can be sourced from existing NHA databases as country reports and GHED. It is widely available, although it can also vary in quality (e.g. related to subnational governmental spending). A consistency challenge is the existing capital spending in GF funds, in which case the denominator should also include capital spending.

3.1.c Global Fund expenditure on RSSH as a proportion of government domestic health systems strengthening (HSS) expenditure

3.1.c **Numerator is the same as 3.1.a: refers to total GF RSSH spending.**

3.1c **Denominator is domestic HSS, which is taken to be equivalent to expenditure on governance and administration**. This denominator can be sourced from existing NHA databases as country reports and GHED. It is widely available. A comparability challenge refers to: (a) the existing of capital spending by GF funds, in which case the denominator should also include capital spending; (b) the definition and classification of HSS. Some of the functions, such as planning, administration, monitoring and procurement, in SHA are classified differently when referring to a disease programme control or to the health system as a total. Both challenges can be solved when the definition, detail and the way of handling are agreed.

3.1.d Global Fund expenditure on RSSH as a proportion of total externally funded HSS expenditure

3.1.d **Numerator is the same as 3.1.a: refers to total GF RSSH spending.**

3.1.d **Denominator is externally funded HSS, which is taken to be equivalent to expenditure on governance and administration**. This denominator can be obtained from NHA reports. It presents the same classification challenge. When referred as HSS equivalent to health systems governance and management, it is widely available. The strength of the data can vary (e.g. when NGOs receiving resources are not fully covered), and depend on whether the numerator and denominator are consistent regarding capital content, given that NHA report current and capital spending separately.

3.1.e Government expenditure on governance and administration as a proportion of total governance and administration expenditure

3.1.e **Numerator is government expenditure on governance and administration**, which is the same as denominator 3.1.c.

3.1.e **Denominator is total governance and administration expenditure**, which refers to all sources of funding. As in other indicators, this aggregate is widely available in NHA and the consistency relies on the completeness and regarding capital and current HSS spending in numerator and denominator.

3.1.f Externally funded HSS expenditure as a proportion of total HSS expenditure

3.1.f **Denominator is externally funded HSS, which is taken to be equivalent to expenditure on governance and administration**, same as denominator of 3.1.d.

3.1.f **Denominator is total governance and administration expenditure**, which refers to all sources of funding. As with other indicators, this aggregate is widely available in NHA and the consistency relies in the completeness and regarding capital and current HSS spending in numerator and denominator.

Summary of the limitations and challenges in computing these ratios, exemplified in three country cases

GF disbursements include current and capital spending, which in NHA are analysed separately, given the different nature of the spending: long-lasting, future impact, often relatively large amounts involved. For the ratios, given that GF RSSH reports mix current and capital, both current and capital need to be included both in numerators and denominators. It is convenient that GF disbursements are separately reported on current and capital.

In order to explore more detailed data, the information from PUDR was obtained and analysed. In this case it is possible to identify spending on capital. Module reports do not allow identification of details, while interventions do. However, often some intervention names suggest unclear content, e.g. 'National costed supply chain master plan, and implementation' or 'Supply chain infrastructure and development of tools' – where it is not certain that capital spending was made and whether the complete intervention was capital or not. The PUDR information includes details of the channel, either governmental or private agencies.

Depending on the detail of data provided to HAs, coding can modify the location of HSS, to be included as disease programme control or even curative care. Thus, a clear agreement on definition and detail is needed for standardised reporting.

In the illustrative analysis, Ethiopia, Nigeria and Lao PDR were selected using data for 2019, the last year available in GHED. The GF RSSH investments were sourced from the GF website and denominators from HA, GHED.

Generation of indicators for Ethiopia

Once the definition of indicators was made, data to generate them was compiled for every country. GF contributions were explored initially through the data reported to OECD DAC. It appears convenient to monitor disbursements through a disbursement framework. However, in OECD DAC records a discrepancy was often found, specifically in the reporting of GF disbursements on administration (12110: Health policy and administrative management) and the amounts displayed as totals from all sources on this purpose. In general, the total amount was lower, which **suggests that the criteria or definition of RSSH used by GF and that used by OECD DAC may be different**. A discrepancy was also found on the years of reporting. This lag time for total disbursements could be associated with the method of handling fiscal years, among other reasons. For Ethiopia, there was a year in which the GF reported that amounts to OECD DAC were higher than disbursements on the same purpose by all sources.

Disbursements monitored as expenditure with NHA can offer the possibility to identify the compliance of uses, compared to agreements.

Data directly taken from the GF website was also compiled. For Ethiopia, the amount of disbursements on RSSH were reported for 2018, 2019 and 2020. The contributions were made through the government, but they were grouped without detail.

Given that the PUDR was accessed, information on spending was extracted. Data was available at intervention level, which clarifies to a large extent the type of spending, notably as current or capital. There are several categories, however, the nature of which is difficult to identify, e.g. 'Other service delivery intervention(s)', 'Laboratory systems for disease prevention, control, treatment and disease surveillance' and 'National costed supply chain master plan, and implementation'. All of them are health services, but it is not clear to what extent they are e.g. preventive or curative, current or capital spending.

Expenditure data can be more consistently monitored through HA. In this case, amounts in NHA and PUDR are expected to be equivalent or similar. This becomes relevant because in NHA each purpose has a specific code.

To make the amounts with NHA comparable, the reported data by year of spending is appropriate. As the extracted data was reflecting the cumulative total, which is understandable from a multi-year grant perspective, the accumulated data had to be 'annualised'. This estimation considered the years of the grant. In theory this is not accurate, given that the rate of spending may not necessarily be equivalent every year. Given the lack of a full understanding of the content of the RSSH intervention, a separation of capital was not possible.

Denominators were obtained from HA. However, the last report on the WHO website is for 2019–2020. Monitoring includes community and public financing by disease. The report, however, focuses on COVID, and although GF contributions are included, these are not explicitly displayed. Details in the NHA database are available on request and can be extracted, but were not requested for this analysis. Denominators were taken from the GHED database, which is displayed in a more aggregated level. The SHA code used for most RSSH is expected to be governance and administration. This code was available specifically for funding from government and external sources (the difference can be used to estimate private funding). This source also has data on domestic and external funding of current and capital spending. However, Ethiopia has not reported capital spending for the years after 2017.

The results obtained indicate that RSSH in the country is 50% funded by government and 40% by external resources. In total, HSS is around 10% of CHE and the reliance on external funding is around 30% (see table of indicators).

Generation of indicators for Nigeria

As in the case of Ethiopia, OECD DAC was initially explored. For 2019, data on health policy and administrative management was reported by the GF to be provided to NGOs and civil society, not to government. However, in the table including all sources, the spending on health policy and administrative management was reported for NGOs to be lower than the amount reported by the GF and mostly received by governments. The disbursements reported on the GF website indicated RSSH amounts for 2019, 2020 and 2021 for civil society and, in 2021, through the government. The data on PUDR includes spending and identifies module and intervention level. At module level it is not possible to identify capital spending. At intervention level this is feasible, although also some labels are not clear and would require definition or clarification to be classified certainly.

The denominator was taken from HA. The report for 2017 table B7 includes disease by funding origin, with GF information; however, it is not displayed, due to the size of the table. WHO-GHED includes aggregates up to 2019, with current, capital and the HSS spending by source; thus it is possible to identify public and external sources independently.

The results obtained indicate that RSSH in the country is funded mainly by external funds (67%), followed by government (33%). In total, HSS is around 13% of CHE and also 13% for external funding of CHE (see table of indicators).

Generation of indicators for Lao PDR

OECD DAC had data for 2016 and 2017 on GF disbursements allocated through government. In the total sources table, data appears much larger than the GF resources and was allocated for government and NGOs. Disbursements on the GF website showed data for 2019. PUDR allowed access to cumulative spending to be annualised, also displaying the governmental channel and the modules and interventions. Cumulative spending was annualised to generate the ratios. Apparently, no interventions with a clear content of capital were funded.

Denominators were generated with HA. A report was accessed for 2015–2016, with data for diseases and subnational level. However, the database is not accessible except by request.

Such a request was not made for this analysis. Updated data was used from GHED, with data up to 2019 as for all other countries and containing current, capital and governance and administration by sources (government and external).

Interpretation of ratios

Table 23: Ratios resulting of the indicators proposed

Indicator % Country	HSS in CHE	Global Fund expenditure on RSSH as a proportion of domestic current health expenditure	Global Fund expenditure on RSSH as a proportion of domestic government current health expenditure	Global Fund expenditure on RSSH as a proportion of domestic government health systems strengthening (HSS) expenditure	Global Fund expenditure on RSSH as a proportion of total externally funded HSS expenditure	Government expenditure on governance and administration as a proportion of total governance and administration expenditure	Externally funded HSS expenditure as a proportion of total HSS expenditure	External as share of CHE
Armenia	0.0	0.0	0.0	1.6	96.0	98.2	1.6	1.0
Ethiopia	9.8	0.6	1.6	7.4	8.1	51.3	46.6	34.1
Eswatini	14.5	0.5	0.7	3.8	10.0	66.1	25.1	26.1
Guyana	5.3	0.1	0.1	2.0	4.0	58.8	32.4	2.7
Lao	26.8	0.0	0.1	0.2	0.2	48.4	51.6	21.3
Mali	17.6	0.7	1.8	2.7	100.0	93.9	2.5	33.5
Mongolia	NA	0.1	0.2	NA	NA	NA	NA	5.1
Moz	30.4	1.5	2.7	4.9	4.7	48.8	51.2	62.8
Nigeria	0.1	0.3	1.8	5.9	2.9	33.2	66.7	12.7
Philippines	7.2	0.0	0.0	NA	NA	NA	NA	0.4
Rwanda	11.5	2.7	6.4	54.2	64.1	25.8	21.8	33.8
Senegal	6.6	0.4	1.6	7.1	32.0	71.4	15.9	17.9
Uganda	13.6	0.4	1.4	7.8	2.1	17.1	77.4	42.0
Vietnam	5.0	0.0	0.1	0.2	100.0	68.8	0.1	1.0

Zimbabwe	13.6	1.9	7.7	38.5	23.0	25.7	43.0	29.6

The list of indicators proposed is valuable to provide a general overview of the situation of GF contributions vs those potentially associated resources of national and other DPs' organisations. However, RSSH is not always understood as one single code and can hardly concentrate resources with multiple purposes in a single category of the various resource tracking systems. For the interpretation of the ratios, it becomes clear that more detailed and specific content is needed for a more accurate tracking.

There are no straightforward descriptions making the coding on NHA and OECD DAC (or any other resource tracking) direct to GF budget categories. For GF's own tracking purposes, it is valuable to be compatible in their own taxonomy with those of WHO. This also is valuable to facilitate monitoring yearly, as multi-year grants may vary in an active period. This includes, but is not limited to, current and capital, preventive care vs admin, etc.

In this sample, HSS is a share of current health expenditure (CHE), which is double the global average (6%). Governments are the main source of funding of HSS (50%), followed by DPs (35%). In these countries, the reliance on external funding is around a quarter of total CHE, with exceptions such as Mozambique (60%) and Uganda (40%). GF RSSH appears to be around a third of total HSS externally funded; however, in countries such as Armenia, Mali and Viet Nam, the relative importance is more than 90%. In Armenia and Viet Nam the reported external funding in CHE is relatively very low. Rwanda is also worth mentioning as the support received by GF RSSH appears to be important (60% of externally funded HSS). The GF RSSH represent an average of 10% of total domestic governmental contributions to HSS, with the exceptions of Rwanda (50%) and Zimbabwe (40%). The challenges in compiling these indicators relate to an operational definition of RSSH (equivalent as governance and health systems administration-HSS in GHED), data availability (e.g. GF expenditure amounts by intervention and by year; GHED updated up to 2019) and lack of detail (e.g. to make current vs capital analysis consistent or by type of contribution).

Ratios therefore need to be interpreted alongside the limitations. For example, disbursements do not always convert into spending, so monitoring the difference in amounts can be of value for a specific analysis. There are also many big differences between the positions of the GF in the various indicators, which are not easy to explain based only on the economic and health situation in the country.

Recommendations

The resource tracking system of GF has much useful information and many advantages. It should be shared with NHA teams and other resource tracking processes to ensure a progressive compatibility and mutual enrichment.

- A further recommendation is that GF should cooperate at national and international level with the resource tracking national teams and associated organisations.

Illustration of GF expenditure tracking using Eswatini Health Accounts

Overview

Health expenditure tracking tools provide evidence on the use of resources entering the health system. The health accounts framework displays standardised classifications and categories that have been agreed to be policy relevant and useful to guide decision making within the health systems. Using the illustrative example of Eswatini, this RSSH mapping exercise

attempts to answer the question of how GF RSSH investments are tracked and how this process can be improved. It also brings to light the need for accurate, detailed, integrated retrieval of desired expenditure reporting by all domestic and foreign sources to allow for more specific monitoring of the spending in RSSH and its potential influence in health systems strengthening decisions.

Introduction

How much is spent on health and how is it spent? The internationally agreed standard for expenditure tracking is the System of Health Accounts 2011 Rev 2017 (SHA 2011), with the objective of informing decision making in the health system. The framework aims at reflecting the resources as a flow once they enter the health system until they are used in services provided to the population. Health accounts analyse the key areas of the money flow to document their amount and how they are used in detail. The framework begins by setting a clear boundary of what is considered a health spending and by standardising the classifications and categories to reflect the resource flows. The classifications follow the rule of analysing a single axis or purpose and both classifications, as well as their categories, have been internationally agreed to be policy relevant in 2011.

The SHA analysis covers three dimensions: consumption, provision and financing of health care. As it refers to a flow, the amount of resources measured during the accounting period is considered to be the same, and thus equivalent in the three dimensions. Each of these dimensions has a group of classifications to fully analyse the various perspectives of the same amount of resources, with a focus on final consumption expenditure. That is, by convention the analysis offers the perspective of the resources used on health services by the population. The system of classifications illustrates the financing flows: who provides the resources, under which modality, who manages the resources and what the rules of their use are. Regarding provision, information indicates the type of provider of health services, the inputs used and the investments made in that period. For consumption, the classifications indicate the health services, the diseases/health conditions and the characteristics of the beneficiary, such as age, sex and geographic location. Additional classifications may be added, as well as detail to the categories, keeping those standards unchanged for comparison in time and internationally.

SHA2011 is operationalised at country level. The National Health Accounts (NHA) is a key policy tool for the health system which provides integrated and detailed information on the health financing landscape. The accounts have become an essential source of information to drive health financing policy reforms and strategy development. The framework, which can be adjusted to country needs, includes a customisation of the classifications to be used and their relevant categories. In order to properly track resources and inform decisions, they are expected to be produced every year. Their results become part of the statistical system of the country. They are not expected to reflect specific agencies – except e.g. those of government, such as MOH and Social Security – but to present a complete overview of the flows and their characteristics in an aggregated way. It can even be requested that records are handled confidentially (e.g. not to be published by enterprise and household).

Global Fund contributions are expected to be part of every health account performed when they are part of the revenue of the health system in the accounting period. As the accounts are expected to register all resources used, they are expected to integrate information of all agencies involved in health services financing or provision, and notably those with higher levels of spending. They also will cover off-budget flows, but there is not a specific category to

analyse them. A prerequisite for good compliance of their completion is collaboration and political support.

NHA are based on data collection of both secondary and primary data. The first choice in data collection is the use of available records of transaction involved on the expenditure flows, notably in executed budgets, expenditure records and various published reports. However, given that the information system is usually fragmented, there may be a need to complement it with primary data. Primary data is collected through questionnaires administered to governmental agencies (e.g. at subnational level), employer firms (offering health benefits to their employees), insurance firms, non-governmental organisations and development partners (donor survey). Information on expenditure is collected exhaustively to identify the origin and destination of resources and for triangulation purposes. Data on expenditure is used in the accounting process, and so is non-expenditure data, especially in the estimation of missing data cells and indicators.

The standard process is ensured with the use of the health accounts production tool (HAPT) or its principles employed in other software applications. HAPT is an application that facilitates the NHA generation and supports the progressive advances, with fewer errors, with high-level quality controls and data and metadata reporting, without programming needs by the NHA teams. This is a great advantage as the expenditure distribution using multiple classifications hugely increases the number of data points and potential errors. HAPT prevents these errors. Also very important is that data can be analysed through the generated flows, which gives the feasibility to produce bivariated and even multivariated tables, enriching the potential usability of the results. A database is integrated by the application, which can be extracted from the tool with the detailed metadata. These databases are not openly distributed, due to confidentiality requirements of some agencies, but they can be selectively used for ad hoc analysis.

An overview of the NHA GF RSSH resource tracking in Eswatini

Eswatini produced NHA reports after the SHA2011 framework was released. Although reports are not listed in GHED, a Health Accounts study 2017–2018 was obtained and it is taken to illustrate the GF RSSH expenditure tracking. The NHA study covers 1 April 2017 to 31 March 2018. It was produced through the Health Accounts Production Tool (HAPT), an IT tool to concentrate data, organise it and map it to the SHA classifications and categories, in order to reflect the financing flows – in this case, those of the GF contributions. The HAPT generates a database which can be downloaded or used within the tool to generate specific reports at any aggregation level available. The tool displays both expenditure data as well as metadata, as descriptive information to facilitate the interpretation of the content. We have both extracted the database and used it to follow the path of the GF resources. These options are standard for NHA generated within the HAPT.

As in any other NHA, GF data is included and processed within the classifications selected by the country, and the identification of GF resources can be made through the report of the GF, containing disbursements, or via the report of the recipient agencies using the resources. For an expenditure tracking system, the closer the data is to the expenditure the better, because it contains details and provides the real amount used.

In the case of Eswatini, the report lacked information from the GF response to the donor survey. However, the GF resources were reported by the recipient agencies, based on the resources used that year. In this case, the government provided information on the funds reaching the National Emergency Response Council on HIV and AIDS (NERCHA), as well as

through a multilateral organisation (the World Food Programme (WFP)) executing funds themselves and through an NGO (Wellness Centre). Thus the GF contributions are acknowledged and reconstructed using the specific code for the GF as a multilateral donor (FS.RI.1.5.28).

According to the classifications used, capital and recurrent spending are reported separately. Services funded by GF include curative care (inpatient and outpatient, both general and specialised). The health care providers involved are both hospitals and ambulatory centres. Although SHA lacks a code for primary health care, the additional notes reported in the metadata allow for indicating that PHC centres were funded, related to the HIV population.

RSSH does not have a specific code in SHA, but services funded are mainly reported as ancillary services (notably laboratory), preventive care, information, education and communication (IEC) in health, programme disease control with planning and management, M&E and procurement. These same services were provided at system level, identified as HC.7 Governance, and health system and financing administration.

The resource flow on NHA reporting of GF RSSH contributions to Eswatini

In the case of Eswatini, RSSH could include: a large part of ancillary services, not classified as detection or testing; most of the HC.6.5 (Epidemiological surveillance and risk and disease control programmes) related to planning and management; monitoring and evaluation and procurement. Spending on these same services (planning and management; monitoring and evaluation and procurement) at systems level is reported as HC.7 Governance, and health system and financing administration. In the case of Eswatini, governance and administration could be doubled if it included preventive spending on disease control programmes (potential HSS) and would be increased tenfold if it included contributions at laboratory level (potential HSS). Given that the GF RSSH investments are related to disease programme control activities, this is likely to be the case in other countries.

Limitations to consider

Health Accounts (HA) monitors resources of all actors in the health system. GF RSSH resource flows are expected to be tracked at country level. Data compiled from each actor is integrated in resource flows using standardised classifications and categories that allow the relevant movements to be seen, since the resources enter the health system according to their use. NHA results allow expenditure comparison in time and internationally. Although increasing, in practice not all countries perform HA and not all perform them yearly. The idea behind institutionalisation of NHA is to ensure countries provide annual estimates to support decision making. This has not been adopted in Eswatini, because of low country capacity, low support by the entities providing data and even the low level of financing. For instance, the government only provides staff Thematic Working Groups (TWG) for the estimation, whereas the training, data collection, analysis and even report printing are usually supported by DPs (WHO, United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), UNAIDs and Clinton Health Access Initiative (CHAI)).

The specificities of each flow can be reflected through eight or more classifications, each using up to seven categories, and each category having standardised codes at 3–4-digit level (around 170 options in total). When needed, additional classifications, categories and descriptive information can be used. In practice, not all countries use all the relevant classifications, e.g. by factors of provision and by disease. Both classifications were available in Eswatini: the expenditure distribution by disease is promoted by WHO and is expected to be comprehensive, with at least 75% of spending. Eswatini has complied with this requirement in this study and a complete tracking was generated for the GF contributions. In Eswatini the

classification of Factors of Provision (FPs) was also used and allowed to identify the higher spending categories, e.g. remunerations and medicines and other medical goods. Frequently other FP items are estimated, because minor components are not always disaggregated.

A usual concern is to ensure coverage of main actors, including those in the private sector and related to external funds. In this case, the Eswatini report has not included GF donor data; however, it was possible to track GF resources through data from the users of such resources. Lack of records and reporting may lead to displaying incomplete flows and bias results. Most countries reach a response rate of over 80%, which is statistically significant. The TWG ensures they capture data from the entities with larger spending.

Different to any database, where variables are coded on an ad hoc basis, NHA are standardised in coding, allowing anybody to understand the results. However, the processing requires an effort because GF and SHA categories are not similar and easily linked, as they are generated with different purposes. NHA focuses on the analysis of the expenditure landscape of a country while the GF focuses on fighting a specific scope of diseases. RSSH categories are wider in nature, and they refer to several NHA purposes (mainly to SHA categories of prevention and administration and governance) and include current and capital spending. This lack of direct correspondence makes it necessary to standardise the reporting. A definition and clear understanding of content of RSSH categories increases the accuracy of the monitoring and results.

A comparison of GF RSSH disbursements and the reported spending is not feasible, due to lack of access to disbursements in the same period. NFM 2 was initiated in October 2018.

Recommendations

- There is an opportunity for the GF to join hands with other players in the estimation of NHA. The RSSH funds could be utilised for this purpose, which will make it easy and make data available during grant-making.
- The Health Accounts framework (SHA2011) could include an annex defining RSSH and main criteria to facilitate a standardised monitoring by NHAs (just like the methodological note now developed for the estimation of PHC).
- Active cooperation and supporting the NHA process at country level can facilitate the NHA updated generation and increase their quality of results.

Annex 7: Objective 3 detailed methodology note

Introduction

Fifteen country case studies were conducted to inform the assessment of: (i) the alignment of Resilient and Sustainable Systems for Health (RSSH) investments with national health priorities and plans and (ii) the extent of integration with national systems. The case studies include the following countries: Armenia, Eswatini, Ethiopia, Guyana, Lao PDR, Mali, Mongolia, Mozambique, Nigeria, Philippines, Rwanda, Senegal, Uganda, Viet Nam and Zimbabwe.

Findings from across the case studies were analysed to respond to the two mapping questions under this objective:

MQ 3.3 How aligned are investments in RSSH with National Health priorities reflected in health sector strategy plans, and to what extent are investments additional and complementary to domestic health spending?

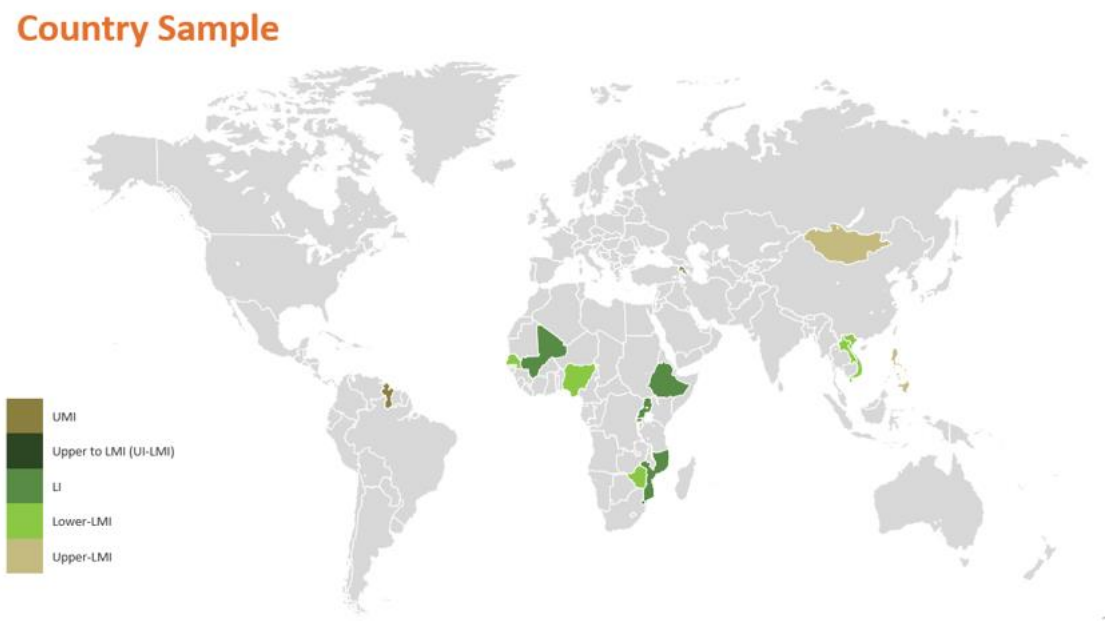
MQ 3.4 To what extent do GF RSSH investments use national procedures and systems (for budget execution, financial reporting, auditing, procurement, etc.)?

Methodology

The country case studies were conducted using a mixed methods approach that included the collection and triangulation of quantitative and qualitative evidence.

Country selection

Figure 12: Country Sample



Fifteen countries were purposefully selected for the RSSH mapping. Sampling criteria included income level, geographic region, burden of disease, data on GF investment in RSSH, and availability of NHA data. **Error! Reference source not found.** shows that the country selection process yielded a balanced set of 15 countries from different regions, income levels, disease

burden and magnitude of RSSH investments. Health expenditure data was available for all 15 countries. See **Error! Reference source not found.** for a summary of the characteristics.

Table 24: Characteristics of the 15 case studies countries

Country	Region	Income level	Disease burden			Total planned investment GF RSSH modules NFM 2 and NFM 3 ($)	Availability of NHA data
			HIV	TB	Malaria		
Armenia	EECA	UMI	Not high	High	Not high	704,981	Yes
Eswatini	SSA	Upper-LMI	High	High	Not high	9,100,519	Yes
Ethiopia	SSA	LI	High	High	High	94,054,645	Yes
Guyana	SoA	UMI	High	High	Not high	1,625,338	Yes
Lao PDR	SEA	Lower-LMI	Not high	High	High	391,373	Yes
Mali	SSA	LI	High	High	High	44,248,148	Yes
Mongolia	NCA	Upper-LMI	High	High	Not high	4,632,131	Yes
Mozambique	SSA	LI	High	High	High	99,779,202	Yes
Nigeria	SSA	Lower-LMI	High	High	High	140,824,325	Yes
Philippines	SEA	Upper-LMI	High	High	Not high	19,322,194	Yes
Rwanda	SSA	LI	High	High	High	46,324,487	No*
Senegal	SSA	Lower-LMI	High	High	High	25,465,285	Yes
Uganda	SSA	LI	High	High	High	41,552,391	Yes
Viet Nam	SEA	Lower-LMI	High	High	High	14,246,495	Yes
Zimbabwe	SSA	Lower-LMI	High	High	High	148,832,415	Yes

Source: Global Fund 2022 Eligibility List.

Notes

Region: EECA = Eastern European and Central Asia, NCA = North Central Asia, SoA = South America, SEA = Southeast Asia, SSA = Sub-Saharan Africa, Income level: LI = low-income, LMI = lower middle-income, UMI = upper middle-income.

* Rwanda has not produced NHAs in a long time, but it has developed its own tool to track health expenditure data.

RSSH Stand-alone grants: Mali, Ethiopia and Nigeria have RSSH stand-alone grants.
15 countries represent 30% of total planned GF investment in NFM 2 and NFM 3.

Data collection

Data collection included both quantitative and qualitative data as follows:

- **Data collection – quantitative**: quantitative data on the Global Fund RSSH investments was sourced from the Global Fund GAC Approved and Committed Budgets for New Funding Model (NFM) 2 and NFM 3. NFM 2 and NFM 3 for RSSH under funding module classification (2022) was triangulated with data from WHO/Global Health Expenditure Database (GHED) and National Health Accounts (NHA), using the expenditure on governance and health systems administration by source of funding as the best proxy to the RSSH aggregate. Data on domestic and external expenditure (comparison numerators for M3.1 and M3.2) and total health expenditure for RSSH (denominator) was obtained through the NHA reports and GHED.
- **Data collection – qualitative**: qualitative data and information was collected through two main methods:
    - *Desk review of core documents* – this included: (i) national documents such as National Health Sector Strategies and Plans, national disease specific sector plans for HIV/AIDS, TB and malaria, other health sector documents on universal health care (UHC), health systems reviews and evaluations; (ii) Global Fund documents such as Funding Requests (FRs), Allocation Letters, Secretariat Briefing Notes, and Funding Request Review and Recommendation Forms; (iii) other peer-reviewed journal publications and grey literature. National documents were identified through online search and advice/sharing from key informants and WHO country offices. Global Fund documents were obtained from the Global Fund.
    - *Key informant interviews* – in total, 74 KIIs were conducted as follows: (i) 59 with country stakeholders (including 30 with government officials/PRs, three with Country Coordinating Mechanism (CCM) Secretariat members, nine bilaterals and 17 multilaterals) and (ii) 15 with Global Fund Portfolio Managers (FPMs). Some interviews included multiple key informants; a total of 102 individuals participated in the interviews, which were guided by a set of interview questions (see Box 10).

Data analysis

Data and information collected from both the desk review and the KIIs was entered into an Excel matrix database for each country. This was used as the basis for the triangulation of the evidence and the write-up of the case studies.

A rubric scoring system was then used to assess the level of alignment of RSSH investments and use of national systems. Four scoring categories were applied to the rubric matrix data: (1) emerging, (2) progressing, (3) established and (4) advanced. The scoring criteria for each component of the analysis are presented in ***Error! Reference source not found.*** and ***Error! Reference source not found.*** below. The assessment of the score was based on an analysis of achievements and areas for improvement with respect to alignment and integration of Global Fund RSSH investments.

Table 25: Rubric scoring criteria for alignment

Topic	Emerging – 1	Progressing – 2	Established – 3	Advanced – 4

Alignment of Global Fund RSSH investments with national health priorities, health sector plans, and national health budgets.	Global Fund RSSH investments are not aligned with national health priorities as articulated in policy documents (or national health priorities are poorly defined and not used to inform planning and investment decisions), and Global Fund RSSH investments have not contributed to increased overall health systems strengthening (HSS) investment and there is evidence of overlaps with government HSS investment.	Some Global Fund RSSH investments are aligned with national health priorities, and Global Fund RSSH investments have contributed to some increases overall HSS investment, but there is evidence of overlaps with government HSS investment.	Most Global Fund RSSH investments are aligned with national health priorities, and Global Fund RSSH investments are complementary to government HSS investments and based on a systematic and joint planning process with the government and other key stakeholders.	All Global Fund RSSH investments are informed by national health priorities and the health sector plan, and Global Fund RSSH investments are complementary to government HSS investments and are based on a systematic and joint planning process with the government and other key stakeholders.

Table 26: Rubric scoring criteria for integration

Topic	Emerging – 1	Progressing – 2	Established – 3	Advanced – 4
Integration and use of national systems for planning, budgeting, implementation, financial management, health expenditure tracking, and reporting on Global Fund RSSH grants.	Global Fund RSSH investments do not use national systems for planning, budgeting, procurement, and financial management, investments are managed off budget, there is weak capacity to track health expenditure, and there is no process to track co-financing targets.	Global Fund RSSH investments are partially managed using national systems for planning, budgeting, procurement, and financial management, investments are managed off budget, there is some capacity to track health expenditure, but data are not used to inform policy and planning, and there is no process to track co-financing targets.	Global Fund RSSH investments are partially managed using national systems for planning, budgeting, procurement, and financial management, investments are managed on budget, there is some capacity to track health expenditure and data are partially used to inform policy and planning, there is a process in place to track co-financing targets,	Global Fund RSSH investments are fully managed using national systems for planning, budgeting, procurement, and financial management, investments are managed on budget, there is strong capacity to track health expenditure and data used routinely to inform policy and planning, and results are used to inform policy dialogue.

			but results are not used to inform policy dialogue.	

Quantitative data was analysed to produce one indicator for alignment and for integration:

The quantitative indicator under alignment measures the cross-cutting HSS as a proportion of the Global Fund expenditure on RSSH. The numerator was cross-cutting investments identified in WS2 of this mapping study. The denominator was the total Global Fund grant approved budget for RSSH modules. This indicator is a proxy measure of extent of RSSH investments aligning with national HSS interventions and national needs/priorities.

The quantitative indicator under integration measures the share of Global Fund grants managed by a government principal recipient (PR). The indicator is a proxy measure for the degree to which Global Fund investments are integrated in and use national systems as, in principle, it could be argued that having government institutions manage Global Fund grants as PRs should increase the integration and use of those funds. Whether that assumption holds in practice is an empirical question which it was not possible to analyse within the scope of this country case study. There may also be valid reasons why non-government institutions serve as PRs in a country.

Analysis of these two quantitative indicators was also used to triangulate findings from the qualitative analysis.

The findings of each case study are presented in a separate report and were used as supporting evidence for the development of WS3 findings in the main report.

Strength of evidence

The strength of evidence (SoE) underpinning the findings of the country case studies was assessed along three dimensions (**Error! Reference source not found.**):

- SoE across countries: This dimension assesses the number of countries supporting a specific finding. A country was considered to support a finding if the SoE within that country (see 'SoE within country' paragraph below) was 33% or higher.
- SoE within country: This dimension was assessed by dividing the number of interviews within a country that supported a specific finding by the total number of interviews in that country.
- Alignment of the qualitative and quantitative findings: This dimension assesses the degree to which qualitative and quantitative (country-level) findings support each other. This SoE dimension was applicable to findings 3.1, 3.7, 3.9 and 3.10.

Table 27: Strength of evidence explanation

SoE across countries How many countries support the finding?	SoE within country How many interviews support the finding?	Alignment of qualitative and quantitative findings
>10 countries	>66%	Full
5–10 countries	33%–66%	Partial
<5 countries	<33%	Limited

Limitations

The country case studies faced the following limitations:

- **Limitations in the quality and comprehensiveness of quantitative data,** including unavailability of data/incomplete data.
- **Non-responses and/or unavailability of consultees**: for some countries only a limited number of KIIs were consulted, due to the non-response and/or lack of availability of stakeholders. As a result, the qualitative evidence for these countries relied on a more limited number of KIIs.

Box 10. Questions for Key Informant Interviews with Country Stakeholders

Alignment

1. Are Global Fund investments in health systems strengthening (HSS) aligned with national health priorities and health sector plans?
2. Are Global Fund investments in HSS based on costed plans?
3. Are Global Fund investments in HSS complementary to government health spending on HSS?
4. Are mechanisms for managing Global Fund grants (CCM, PCU, PRs, etc.) effectively represented in national platforms for health sector coordination?

Additionality

5. Are Global Fund RSSH investments additional to government health spending on HSS?

Integration and Use of Health System

6. Are Global Fund investments in HSS integrated into national budgeting processes?
7. Are Global Fund grants on budget or off budget?
8. Does your country use program-based budgeting?
9. Can data on Global Fund investments in HSS be obtained from national health expenditure tracking?
10. Does Global Fund RSSH investments use national systems for planning, monitoring, financial reporting, auditing, procurement, etc.?
11. How does your country monitor and report on Global Fund investments in HSS?
12. Do data for financial reports to Global Fund come from a national public financial management system?
13. Is your country on track to meet its Global Fund co-financing requirements?
14. What is the process for reprogramming Global Fund RSSH funds?
15. Are there plans for donor transition in your country and how is this process managed?

Recommendations

16. What should the Global Fund do to support increased alignment, integration and use of national systems?
17. What capacities and processes need to be strengthened by the MOH and other government institutions?

Other

18. Please suggest other persons or organisations that you think we should talk to.
19. Please share documents and websites that can inform analysis of the issues we discussed today.

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Itad.com @ItadLtd mail@itad.com

Itad Ltd
Preece House
Davigdor Road Hove,
East Sussex UK
BN3 1RE

+44 (0) 1273 765250

Itad Inc
c/o Open Gov Hub
1100 13th St NW, Suite 800
Washington, DC, 20005
United States

+1 (301) 814 1492