30 JUNE 2021

Prospective Country Evaluation

Senegal

2021 EXTENSION REPORT

Commissioned by the Technical Evaluation Reference Group (TERG) of the Global Fund

DISCLAIMER

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

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ACRONYMS

ACTs	Artemisinin-based combination therapy
ANCS	National AIDS Council
C19RM	COVID-19 Response Mechanism
CCM	Country Coordinating Mechanism
CNLS	National Council for the Fight against AIDS
CSIH-RSS	Strategic Plan for Harmonized Interventions for Health System Strengthening
CT	Global Fund Country Team
DAGE	Directorate of General Administration and Equipment
DGS	Direction Générale de la Santé
GAC	Grants Approval Committee
GDF	Global Drug Facility
IHME	Institute for Health Metrics and Evaluation
ISED	Institut de Santé et Développement
KII	Key informant interviews
MoH	Ministry of Health
MSAS	Ministry of Health and Social Affairs
NFM2	New Funding Model 2 (Global Fund 2017-2019 allocation cycle)
NFM3	New Funding Model 3 (Global Fund 2020-2022 allocation cycle)
NSP	National Strategic Plan
PCE	Prospective Country Evaluation
PFs	Performance Frameworks
PNA	National supply pharmacy
PNDSS	Plan National de Développement Sanitaire et Social
PNLP	National Malaria Control Program
PR	Principal Recipient
PSM	Procurement and supply management
PTF	Financial partners
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RSSH	Resilient and sustainable systems for health
TERG	Technical Evaluation Reference Group

TRP	Technical Review Panel
USAID	United States Agency for International Development

1. Introduction and methods

Building from the Global Fund Prospective Country Evaluation (PCE) 2020/21 Senegal country report, a three month extension phase (April-June 2021) was commissioned by the Technical Evaluation Reference Group (TERG) to focus on a deeper analysis of several areas within the grant cycle analysis. The overall objective of the grant cycle analysis was to understand what, when, why and how grant investments change over time, including significant factors that influenced the implementation of and changes to the original grant. The extension phase timing in 2021 allowed for additional analyses of New Funded Model 3 (NFM3) awarded grants, which had not been available for the prior report. Key areas explored during the extension phase included:

- The understanding and use at the country level by Country Coordinator Mechanisms (CCM's), government and stakeholders of the terms health systems support and health systems strengthening.
- Reasons for the limited uptake of Resilient and sustainable systems for health (RSSH) coverage indicators in the NFM3 grant performance frameworks (PFs);
- NFM3 grant making, including drivers of budgetary shifts for RSSH and equity-related investments; and
- New Funding Model 2 (NFM2) grant revision issues and any relevant lessons learnt from the Global Fund's response to COVID-19.

The findings from the extension phase complement the 2020/21 annual country report findings related to grant design and implementation considerations, and therefore, recommendations have been revised and updated.

1.1 Data collection

During the extension phase, additional primary data were collected through document review, key informant interviews (KIIs), and meeting observations in order to more deeply examine the questions. Budgetary analyses were updated to include NFM3 grant award budgets, which enabled analysis of module and intervention-level shifts during grant making.

Documents reviewed included the NFM3 funding requests, meeting notes, National Strategic Plans (NSPs), and strategic documents referenced by the key informants interviewed.

When key informants were unavailable, e-mails were exchanged in order to obtain written responses and opinions about certain questions and analyses that required rapid fact-checking in order to ensure the reliability of the data collected. Triangulation therefore occurred through the use of several complementary techniques: document review, by varying sources and resource persons, and through interviews and observations.

2. Findings

2.1 NFM2 Grant Cycle - grant revisions

2.1.1 NFM2 revision processes

Grant revisions were viewed as administratively burdensome and complex, as a result of various factors which contributed to lengthy approval processes.

In the 2020/2021 Senegal annual report, we found that two budget revisions were planned by the National Malaria Control Program (PNLP) but only one was implemented, taking 18 months to complete due to challenges in gathering required financial data. In contrast, the National Council for the Fight against AIDS (CNLS) and the National AIDS Council (ANCS) were able to implement revision within 5 months, due to stronger financial management, and the TB/RSSH principal recipient (PR) decided to hold off on revisions to see whether efforts to strengthen coordination would improve absorption. Key informants consulted about their experience with the grant revision process pointed to major constraints related to the slowness of the process. Among the factors that contributed to the burdensome nature of the process were:

1. The same teams involved in grant implementation must also dedicate a lot of time to revisions;
2. The Global Fund is often late in making the required templates available (with the programs having already completed older templates before receiving the new ones);
3. For some actors, the answers to certain questions asked by the Global Fund are already found in the funding request, resulting in stakeholders having the impression of responding to the same questions multiple times;
4. The transfer of data from the Tempro platform to the templates is done manually with great risk of error;
5. There is much back and forth between the Global Fund and PRs related to Global Fund feedback, and the reaction time is often long (3 to 9 months); and
6. Grants Approval Committee (GAC) procedures and CCM endorsement also take a lot of time.

2.1.2 Introduction of NFM2 grant flexibilities in response to COVID-19

In contrast to prior revisions, COVID-related revisions were perceived as faster and more flexible.

During NFM2, the Global Fund introduced a range of ‘flexibilities’ to improve responsiveness to the COVID-19 pandemic. For grant revisions, these flexibilities included lightening requirements to improve the speed and efficiency of revision processes. In Senegal, USD $2.2 million in savings and reprogramming from the NFM2 grants was approved for COVID-19

response, in addition to the $4.9 million in additional funds through the COVID-19 Response Mechanism (C19RM). (1) The grant flexibilities allowed the Global Fund to rapidly make these resources available to PRs in order to implement the COVID contingency plan. These revisions occurred rapidly unlike other grant revisions.

Key informants noted that these flexibilities enabled faster and more flexible grant revisions for the following reasons:

1. Submission forms were streamlined;

2. The coordination of the submission was centralized for all the programs and led by the RSSH team under the supervision of the General Direction of Health (DGS);

3. The possibility to anticipate the availability of 5-10% of NFM2 funds helped simplify the process of mobilizing funds;

4. The sustained support of the consultants made it possible to mobilize various expertise (e.g., procurement and supply management (PSM), finance, etc.) and the contribution and increased responsiveness of the Global Fund made it possible to accelerate the pace.

5. The elimination of the requirement for CCM and GAC endorsement.

Due to the urgency of the COVID-19 situation, Global Fund responses came more quickly compared to normal revisions, which, according to key informants, can entail significant back and forth. Some key informants noted a certain level of redundancy in the types of requests received from the Secretariat, and noted that they had to interact with different point persons in every exchange. This leads to lost time spent re-explaining elements that have already been explained, which delays the process.

Efforts were made by all (CCM, PR, Ministry of Health (MoH), other stakeholders involved in Funding Request and Grant Making) to dedicate more time to meeting on the various communication platforms used (such as the CCM platform and others). The availability of actors who no longer went into the field due to COVID-19 also played a role in the quality of the exchanges and responsiveness from all parties.

Furthermore, the trust that was given to local teams to use NFM2 savings and reprogramming for activities that would accelerate the response to the pandemic was also significant. In normal times, it seems that actors could not redistribute resources in response to emergencies. However, the revisions are themselves a mechanism introducing important flexibility to multi-year funding which allows for a change in direction when the situation changes.

The question of trust has also been raised with regard to the Global Fund's more limited involvement in micro-managing operational details during this period, which are seen as needlessly delaying the normal revision process. Stakeholders noted that the operational details (micro-plan) should be more often left to national expertise.

2.2 NFM2 Grant Cycle - RSSH investments

2.2.1 RSSH landscape

Despite a clear desire on the part of the Global Fund to have an exhaustive view of the contributions of financial partners to inform the RSSH funding request, there remain major challenges with alignment between the Global Fund and Country priorities.

Along with the Global Fund, the other main funders of investments in health systems strengthening in Senegal are LuxDev, United States Agency for International Development (USAID), the Belgian government, and World Bank. The Global Fund, contrary to other donors that fund specific programs, has a gap-financing model, supporting activities that are not being addressed by other donors or the government. Nevertheless, creating an exhaustive and comprehensive mapping of Financial Partner (PTF) interventions at the national level was a challenging task for the Directorate of General Administration and Equipment (DAGE) because information is incomplete. Capturing all activities and their financial implications from all actors is always an issue. Although DAGE leverages the contributions of the primary PTFs, certain interventions at the subnational level or activities for which the DAGE is not financially or programmatically involved are not captured. To counter this problem when developing the NFM3 funding request, the MoH designated a focal point to centralize the required information. It should also be noted that the available information is aggregated and does not allow for the identification of redundancies in donor contributions.

At the country level, decisions regarding RSSH investments are guided primarily by the national strategic plans, such as the Plan National de Développement Sanitaire et Social (PNDSS). In 2015, efforts were invested in comprehensively analyzing RSSH financing and programmatic gaps, and outlining national priorities for health systems strengthening. This resulted in the 2015-2018 Strategic Plan for Harmonized Interventions for Health System Strengthening (CSIH-RSS) which was used to develop the NFM2 RSSH interventions. The document, however, was never updated and there has been little uptake and ownership of the CSIH-RSS by the Ministry of Health and Social Affairs (MSAS). Instead, preference has been given to the PNDSS, the Sector Investment Plan, and the Health Funding Plan. The NFM3 funding request's RSSH components were therefore developed based on an analysis of transversal gaps between the NSPs for HIV, TB, malaria, Community Health, the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH), the PNDSS, and the Strategic Health Funding Plan.

The absence of an up-to-date national plan for guiding RSSH investments, presents a barrier to successful planning of the country's RSSH needs as well as its gaps and priorities. There are still no clear references and directions to guide the gap definition process and the development of a relevant and effective RSSH strategy. This is further compounded by the fact that the RSSH platform within MSAS, which is composed of representatives from various divisions within MSAS, as well as donors, civil society, private sector, has not functioned properly during the entire NFM2 process even if some feeble efforts have been made recently, as confirmed by the coordinating team.

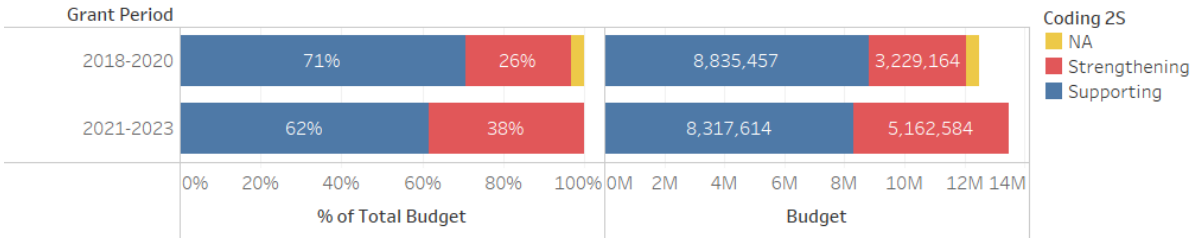
In this context, it is crucial for optimizing the impact of Global Fund and other donor investments in RSSH to have a RSSH NSP. Otherwise, RSSH investments will be fragmented as they pertain to the strategic plans for different programmatic components (e.g., human resources, Medicine, Lab, CS, RMNCAH Funding, etc.) which lack consistency between them. For this, Global Fund support and momentum are required.

2.2.2 RSSH support vs. strengthening

The difference between the concepts of 'strengthening' and 'supporting' is not always clear to actors and has not strongly influenced the development or design of RSSH interventions in NFM3.

The updated 2S analysis of NFM3 final grant award budgets shows that RSSH investments categorized as strengthening the health system grew from 26% to 38% of total investments in RSSH between NFM2 and NFM3 (Figure 1). Nonetheless, RSSH investments continue to be largely providing support to health systems rather than strengthening.

Figure 1. RSSH funds tied to health system strengthening or support



Source: Direct RSSH funds in NFM2 and NFM3 approved grant budgets.

According to key informants, PRs are not necessarily focusing on aspects of support vs. strengthening during the development of the funding request, but rather on the country priorities and program or technical elements that are helpful in reaching disease program objectives and performance. PRs seek to balance the types of investments but ultimately the country's needs, which are not systematically expressed in these terms, often take precedence. Compared to NFM2, we noted an effort to move toward more health system strengthening investments in NFM3, such as by building human resource capacity through the return of contractual agents and the integration of the community health unit. Involvement by the Directorate of Human Resources and members of the Ministry Cabinet during funding request development helped facilitate these developments.

Otherwise, additional factors impacting the choice of RSSH interventions are grant duration and activity eligibility, as determined by the Global Fund. Because of the three-year duration of the grants, actors set priorities on immediate needs to achieve indicators and attain objectives during the grant period, which explains the strong preference for continuing to prioritize 'support' interventions. According to key informants, directing Global Fund investments toward support funding responds to two principles: 1) country priorities and 2)

operational needs related to the Global Fund PF. With the grant implementation time being rather short, the country tends to identify actions that are urgent and have a high impact on reaching the grant objectives. Emphasis is placed on attaining results and good short-term performance (in accordance with Global Fund requirements) rather than building long-term capacity. According to a consultant, this explains why several opportunities to build system capacity are not sufficiently utilized by the PR.

Regarding activity eligibility, some key informants cited challenges with interventions proposed with the RSSH budget that were considered ineligible by the Global Fund, as demonstrated by the quote below. An example of this was with RSSH investments proposed for human resources, which are crucial in the PNDSS, but were limited or even rejected in NFM3.

"If the Global Fund refers exclusively to the programmatic gap table and the financial landscape (which are incomplete) to determine activities that are 'eligible', then it follows that several interventions proposed in the funding request are automatically deemed 'ineligible' because the referential framework is not the same. They should also, as the country does, use the PNDSS as reference to determine the eligible activities and finance gaps from there." - Quote from a key informant

In NFM3, there was a substantial financial investment in the supply system. However, despite an approach that was recognized as inclusive and transparent, some actors believe that there has been a lack of alignment between the RSSH allocation and the real priorities of the country.

During NFM3 grant making, the Global Fund highlighted three priority investment areas for RSSH investments: 1) supply chain, 2) human resources, and 3) the health information system. Stakeholders cited the added value of RSSH investments, such as the significant increase in budget to reinforce the storage and distribution capacities of the National Supply Pharmacy (PNA) (increase of 84% between the Funding Request and the final budget after Grant Making) is expressive of the Global Fund's strong vision and will to strengthen and sustain the RSSH. However, key informants also cited issues with decisions that were influenced by the Global Fund Secretariat which run counter to country priorities and could actually undermine efforts aimed at strengthening the health system.

In particular, the Global Fund's choice to use Wambo and the Global Drug Facility (GDF) platform during NFM3 was not perceived as relevant by country stakeholders because it does not facilitate capacity building, especially in procurement, of the PNA and national laboratories in the long term. Although the Global Fund continues to use the PNA for storage and distribution of drugs, opinions remain divided on this topic of procurement. The Global Fund's argument is that this decision is justified given the need for security in supply and quality (considering the challenges encountered under previous grants), however country stakeholders consider it a move that will weaken the system (e.g., sustainability), as demonstrated by the quote below.

"At this rate, you will see us forced, in the near future, to only buy from their platform, which will further weaken the national medicine supply system." - Quote from a key informant

Another example was within the framework of the PNLP, the failure to better strengthen the National Drug Control Laboratory was perceived "as a slap in the face for the country" (to use the expression of the key informant).

The issues raised by key informants urgently require reflection on the Global Fund's choices regarding platforms and providers over which the country (and its PRs) have no control and for which they are asked to be accountable and responsible. The situation risks undermining the sustainability of interventions, particularly in the event that the country decides to change directions at the end of the grant. Entities such as the national laboratories and the PNA cannot be fully and sustainably strengthened.

2.2.3 RSSH indicators in NFM3 grants

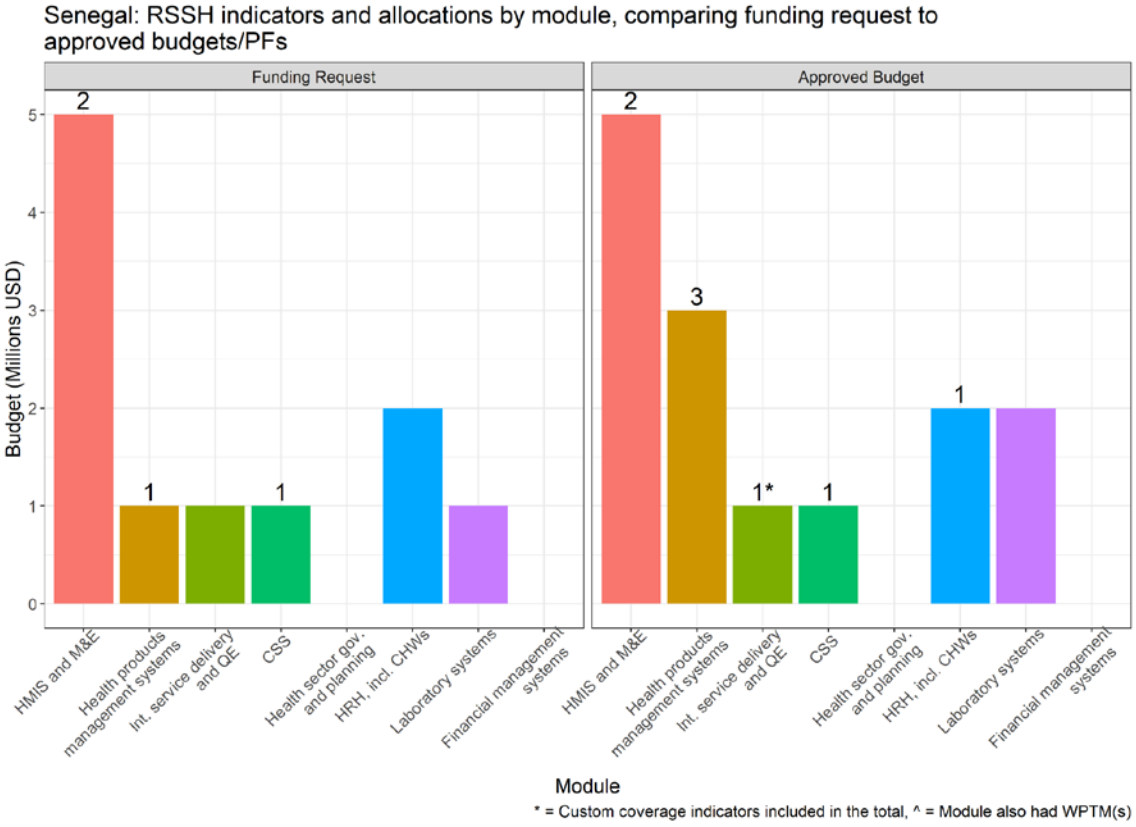
The total number of RSSH indicators increased from four in NFM2 to ten in NFM3, including five PSM indicators that were requested by the Technical Review Panel (TRP).

While in most PCE countries NFM3 grant PFs did not include many new RSSH indicators, Senegal is an exception. The total number of RSSH indicators increased from four in NFM2 to ten in NFM3 (Figure 2)[1]. An enabling factor that supported the inclusion of RSSH indicators in Senegal was the TRP's review which identified gaps in measurement of PSM system strengthening results. As a result, the TRP requested that the PR add RSSH indicators PSM 3-7 in the TB-RSSH grant. During grant making negotiations, it was decided with the Country Team (CT) that three of the five PSM indicators would be added (PSM3, PSM4 and PSM7) for the SEN-Z-MoH grant agreement and two indicators (PSM3 and PSM4) for the SEN-H-CNLS agreement. The FM therefore opted to take into account the indicators suggested by the TPR except for the PSM5 and PSM6 indicators which did not have the country's support.

Although the addition of RSSH indicators could lead to greater accountability and monitoring of RSSH investments, the country's disagreement with the addition of PSM indicators poses a risk for country ownership and alignment with national systems. According to key informants, in previous funding cycles, the Global Fund aligned itself with country indicators. However, for NFM3, country stakeholders disagreed with the addition of PSM indicators because they are not appropriate since the country has no control of purchases through the WAMBO platform. Also, stakeholders reported that certain indicators can only be collected by making a reasoned request to the Global Fund in order to release funds in this regard. The MSAS sent a formal letter to express its position although, while exchanges are still ongoing, key informants noted that the situation may negatively impact the NFM3 implementation of RSSH interventions. It should also be noted that when the grant agreements were signed, the FM took into account the reservations expressed by the country concerning the PSM5 and PSM6 indicators.

[1] Two of the ten new RSSH indicators have yet to be added to the approved NFM3 PF but TRP sign-off was conditional upon them being added during grant implementation.

Figure 2. Graphic of RSSH indicators used/available



2.3 NFM3 Grant Cycle - grant making

Key informants considered the NFM3 grant making process inclusive and transparent, although PCE analysis revealed various changes in the RSSH and HRG-equity budgets during grant making that could not be explained by key informants interviewed.

The NFM3 country dialog process was done in an inclusive and participatory manner, uniting all parties involved in implementing the interventions, including involvement from the public sector, technical leaders, MSAS programs and services, civil society including key population associations, and technical and financial partners.

The procedure for establishing the NFM3 grants relied on the lessons learned from previous funding cycles so as to establish quality grants in cooperation with all partners. During the funding request development, the CCM, stakeholders, and disease program writing groups were involved. This involvement by different parties encouraged proactiveness and timeliness for funding request submissions despite the COVID-19 context.

"We have involved all stakeholders and none of them should be left out, everyone's ideas, all innovations should be considered in terms of the objectives we would like to achieve in terms of pre-eradication, even eradication, of the three diseases funded by the Global Fund." - Quote from a key informant

The PCE identified various changes in the RSSH and HRG-equity budgets during grant making which included an 18% increase in the RSSH budget (from €11.4 million to €13.5 million) and 2.5% decrease in the budget for HRG-equity related investments (from €12.2 million to €11.9 million) (Figures 3 and 4). These changes are explained in part by the fact that funding request budgets are developed long before grant making and before there is clarity about the PRship architecture for implementing the grant. As such, at grant making, changes in grant architecture make it necessary for the PRs to review the entire internal organization and, consequently, redistribute activities between SRs (PNLP vs. International Plan, mainly). Furthermore, for NFM3, the PNLP delegated everything RSSH-related to the DGS. Changes in the architecture did not therefore have a direct impact on the amounts allocated by the PNLP under the RSSH modules. Other aspects tied to human resources and community activities were, however, affected.

Other reasons for the budget shifts at grant making included removal of certain budgeted items by the Global Fund because they are funded by other partners. In the case of the malaria grant, for example, this included monitoring the effectiveness of artemisinin-based combination therapy (ACTs).

Figure 3. Most RSSH modules saw an increase in funds between the funding request and grant award.

Module	Funding Request 2020	Approved	Percent Change
Community systems strengthening	1,363,842	1,282,503	-5.96%
Financial management systems	36,007	147,332	309.18%
Health management information system and monitoring and evaluation	4,742,346	4,829,592	1.84%
Health products management systems	1,329,879	2,590,721	94.81%
Health sector governance and planning	192,331	129,310	-32.77%
Human resources for health, including community health workers	1,600,755	1,919,852	19.93%
Integrated service delivery and quality improvement	669,145	878,270	31.25%
Laboratory systems	1,480,392	1,702,619	15.01%
Grand Total	11,414,698	13,480,198	18.10%

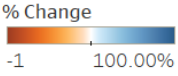
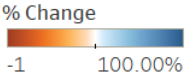


Figure 4. The total HRG-Equity budget remains very similar between the funding request and grant award (decrease of 2.5%, or 300,000 EUR).

Module	Funding Request 2020	Approved	Percent Change
Case management	1,404,930	1,372,329	-2.32%
Community systems strengthening	815,928	765,030	-6.24%
Differentiated HIV Testing Services	2,266,320	1,480,674	-34.67%
MDR-TB	3,506	3,506	0.00%
PMTCT	1,207,170	1,200,110	-0.58%
Prevention	3,351,653	3,379,417	0.83%
Reducing human rights-related barriers to HIV/TB services	815,347	632,283	-22.45%
Removing human rights and gender related barriers to TB services	1,012,471	1,031,776	1.91%
Specific prevention interventions (SPI)	865,855	1,528,021	76.48%
TB care and prevention	493,210	437,909	-11.21%
Treatment, care and support	0	95,281	
Grand Total	12,236,391	11,926,337	-2.53%



Within certain modules, such as the “Reducing human rights-related barriers to HIV/TB services”, we noticed that some interventions, such as the intervention for “reducing HIV-related gender discrimination, harmful gender norms, and violence against women and girls” were removed during grant making (Figure 5). The stakeholders interviewed could not provide a specific rationale for the change or did not recall the details. The fact that the explanation for these changes and their rationale are not well-documented (for example, they were not discussed in the Grant-making Final Review Form), poses risks to the overall transparency of the grant making process.

Figure 5. The module for reducing barriers to access to TB/HIV coinfection care services saw a decrease of 183,000 EUR.

Module	Intervention	Funding Request 2020	Approved	Percent Change
Reducing human rights-related barriers to HIV/TB services	HIV and HIV/TB related legal services	178,081	169,354	-5%
	Human rights and medical ethics related to HIV and HIV/TB for health care providers	112,968	113,310	0%
	Improving laws, regulations, and policies relating to HIV and HIV/TB	20,318	20,063	-1%
	Legal Literacy (”Know Your Rights”)	158,803	216,745	36%
	Reducing HIV-related gender discrimination, harmful gender norms, and violence against women and girls in..	228,674	0	-100%
	Sensitization of law-makers and law-enforcement agents	116,504	112,811	-3%
Grand Total		815,347	632,283	-22%

3. Conclusions

The Global Fund’s approach seeks to accelerate progress in fighting the three diseases (HIV, TB, Malaria) and better anchor RSSH. In the context of the COVID-19 pandemic, an effective initiative was implemented to facilitate efforts at the level of beneficiary countries such as Senegal to allow for a redirection of available funds to address urgent priorities for mitigating the impact of COVID-19. These strategies show the Global Fund’s ability to organize and mobilize when faced with pandemics and catastrophes by interacting with countries and mobilizing experts.

Despite the Global Fund’s clear intention of compiling a comprehensive view of technical and financial contributions to RSSH during the funding request phase, the Global Fund tools (e.g., programmatic gaps and funding landscape tables) and current national strategies do not facilitate a comprehensive analysis and planning of RSSH investments. Upon further analysis, it has proven difficult to gain visibility on all levels of the health pyramid.

The key findings and recommendations from the PCE extension phase, which complement the findings and recommendations from the 2020/2021 annual report are summarized in the table below.

Table 1. Summary of key findings and recommendations

Key findings	Recommendations
NFM2 Grant Cycle – grant revisions 1. Grant revisions were viewed as administratively burdensome and complex, as a result of various factors which contributed to lengthy approval processes. 2. In contrast to prior revisions, COVID-related revisions were perceived as faster and more flexible.	1. Grant revisions conducted in response to COVID-19 showed that revision procedures can be relaxed to facilitate quicker processing while reserving more time for grant implementation. Lessons learned suggest that: ● Global Fund should allow budget carry-over from one grant cycle to another (as was done with COVID-19 resources between NFM2 and NFM3) could help avoid the challenges associated with the first 3-6 months of implementing a new grant. ● The Secretariat should give clearer guidance to PRs so that they can take rapid ownership of the tools and guidelines, saving time in the processes of formulating requests, revising and implementing. ● The Global Fund should establish clear timelines for review and response to help lighten the significant time commitment required by country stakeholders.

Key findings	Recommendations
NFM2 Grant Cycle – RSSH investments 1. Despite a clear desire on the part of the Global Fund to have an exhaustive view of the contributions of financial partners to inform the RSSH funding request, there remain major challenges with alignment between the Global Fund and Country priorities. 2. The difference between the concepts of 'strengthening' and 'supporting' is not always clear to actors and has not strongly influenced the development or design of RSSH interventions in NFM3. 3. In NFM3, there was a substantial financial investment in the supply system. However, some actors believe that there has been a lack of alignment between the RSSH allocation and the real priorities of the country. 4. The total number of RSSH indicators increased from 4 in NFM2 to 10 in NFM3, including 5 procurement and supply management (PSM) indicators that were requested by the Technical Review Panel.	1. There is a need to better define the CT role so that decisions regarding operational and technical matters are driven by national experts, and for country stakeholders to be empowered to lead grant design and implementation. Micro-planning issues should be delegated to the country, which would allow the CT to advise on more strategic issues. The experience of having recruited technical assistance to support the country, as needed, should be sustained. 2. In line with the Global Fund principle of alignment with national systems, there is a need to let countries choose performance indicators that are readily available through the country's existing health information system, for example taking advantage of the flexibility to develop custom RSSH indicators.
NFM3 Grant Cycle – grant making 1. Key informants considered the NFM3 grant making process inclusive and transparent, although PCE analysis revealed various changes in the RSSH and HRG-equity budgets during grant making that could not be explained by key informants interviewed.	1. The CCM and Global Fund could improve the transparency of the grant making process by: ● Discussing and deciding on PRship earlier in the funding request development process to avoid confusion and frustration during later stages. ● Clarifying the roles and responsibilities of national program teams from the beginning of the process to improve trust and motivation. ● Better planning the work calendar to allow greater stakeholder participation in developing the Funding Request budget and technical components.

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