# Response to Reviewer comments

We are grateful to both reviewers for their careful and constructive engagement with the manuscript. Their comments have meaningfully strengthened the paper's methodological transparency and analytical rigor, and we have addressed each point below.

**General comment:** We suggest that you conduct language editing to meet the standards for academic publishing.

**Response:** Thank you for this note. The manuscript has undergone full language editing for grammar and syntax to ensure it meets the standards expected for academic publishing.

**Reviewer 1**

**Comment 1:** The only areas where it could be strengthened is to better describe how the TA agenda was set with the ministry prior to embedding the TA providers. Often what the government wants to focus on for TA may not be what will help move the forward - agreeing on the TA agenda and scope is a key first step to buy in and I feel that was not clearly explained and could strengthen the methodology.

**Response:** We thank the reviewer for flagging this gap. We have added the Memorandum of Understanding signed with the Ministry of Health and Public Hygiene (2023) as the governing instrument, specifying that it set out the objectives of the collaboration, the principles governing the advisors' role, and an explicit mandate for progressive transfer of analytical and coordination functions to identified government counterparts. We also note that the engagement was anchored to jointly agreed objectives, which we hope clarifies how the TA agenda was established from the outset.

**Comment 2:** In the conclusion, more could be discussed on the risk of conflicting agendas between government and TA advisors, and how embedded TA experts navigate long-term outcomes that may conflict with government priorities.

**Response**: We appreciate this suggestion, as it points to a real and underexplored tension in embedded models. We have added a fourth risk category: governments may prioritize urgent deliverables and visible results, while embedded TA targets systems and capabilities that sustain performance over time. We describe mitigation in terms of jointly agreed objectives and capability transfer retained as a core measure of success alongside immediate deliverables. We now have ensured that the conclusion also discusses this more explicitly.

**Reviewer 2**

**Comment 1:** The article is written from the perspective of the organization providing the technical assistance (FAH), introducing a clear confirmation bias. Successes (the USD 50 million grant, the 7-month formulation) are attributed primarily to the presence of the two embedded advisors, with no clear methodology for isolating this effect from other macroeconomic or policy variables.

**Response:** We agree with this important observation, which is a limitation of practitioner-authored case studies. We have added an explicit disclaimer following the USD 50 million result, stating that the grant outcome is not proof of what the model contributed. The Introduction now states clearly that the paper does not claim causal attribution and instead uses Senegal to identify mechanisms through which embedded TA can complement conventional approaches. We also note explicitly that the arguments are supported by existing literature, in addition to practitioners' experiences.

**Comment 2:** The manuscript does not specify how the data for the claims in Table 1 were collected. Were interviews, focus groups, or perception surveys conducted with ministry counterparts? This omission compromises the internal validity of the qualitative analysis.

**Response:** We thank the reviewer for raising this. As this is a perspective article based on practitioners' own experiences rather than direct focus groups or surveys, the comparative table drew on practical experience, literature, and multi-country evaluations on technical assistance without independent data collection. To avoid overstating the evidence base and to strengthen internal validity, we have removed the table and clarified in the Introduction that the analysis is grounded in direct experience and documentary outputs, interpreted alongside the broader literature.

**Comment 3:** Key concepts such as relational trust, institutional literacy, and reduced transaction costs are presented abstractly. The lack of proposed indicators to measure success or capacity transfer, beyond the final grant outcome, weakens the reproducible value expected from a methodological perspective.

**Response:** We agree that these concepts required an operational basis beyond the final grant outcome. We have added a paragraph to Section 4 proposing measurable diagnostics, each mapped to a specific risk identified in Section 3: the share of advisory functions with a named counterpart and the outputs that counterpart leads over time (substitution); the balance of advisor time between agreed objectives and unplanned requests (accountability drift); the proportion of bottlenecks resolved between reporting periods (implementation risk); and whether performance is maintained through leadership transitions (priority conflict). Following Richardson & de la Peza (2019), we frame these explicitly as diagnostics rather than proof of contribution, since progress in complex systems cannot be attributed to a single advisor, though its absence reliably signals where a reform is stuck. Tracked through advisor workplans and reviewed at each reporting cycle, these indicators give the concepts the reviewer flagged an operational, trackable basis.

**Comment 4:** The manuscript compares the current process with the evaluation of the previous community health plan (delayed by a year with external consultants) without methodologically analyzing whether budgets, political stability, or post-pandemic context were comparable across both periods. The comparison is asymmetrical and methodologically unfair.

**Response:** We agree that the framing implied a controlled contrast that the evidence could not support without accounting for differences in budget, political continuity, and post-pandemic conditions across the two periods. To keep the paper's reasoning clear and defensible, rather than reframe the comparison with caveats, we have removed the illustrative case entirely from Section 1 and closed the section instead with a synthesis of the three structural weaknesses (discontinuity, fragmentation, distance), supported by the existing literature. This comparison was also part of the data presented in Table 1, which has been removed in response to Comment 2; the paper's argument for embedded TA now does not rely on this comparison, or on the table, at any point.

**Comment 5:** Formalize the case study approach by explicitly stating, in a brief Methodological Approach section, how the experience was systematized. If meeting minutes, milestone reports, or external evaluations existed, they should be cited as documentary sources of validation.

**Response:** We thank the reviewer for this suggestion. We have added statements in the Introduction specifying that the analysis draws on direct experience of embedded advisors in the reform process, interpreted alongside the broader TA literature and an independent multi-country evaluation of Global Fund advisors (Richardson & de la Peza, 2019).

**Comment 6:** Incorporate the voices of the Ministry and donors; add brief qualitative quotes or documented insights from counterparts within the Senegalese Ministry of Health to validate the objective existence of relational trust and reduce corporate bias.

**Response:** We agree that direct quotes or documented insights from ministry counterparts would strengthen the paper's credibility and help mitigate the corporate bias the reviewer rightly identifies. As this data was not systematically collected during the engagement, we are unable to add it retroactively without risking the same lack of methodological rigor flagged in Comment 2. We have therefore acknowledged this explicitly as a limitation in the Introduction and flagged the collection of independent counterpart perspectives as a priority for future research on embedded TA models.
**Comment 7:** Propose an evaluation framework and expand Section 4 or Table 1 with qualitative and quantitative KPIs, for example, the proportion of technical reports led by the government counterpart versus the advisor over time.

**Response:** We thank the reviewer for this suggestion, which is closely aligned with our response to Comment 3. Section 4 now closes with a proposed set of diagnostics, including the specific example the reviewer raises (the share of advisory functions with a named counterpart and the proportion of outputs that counterpart leads over time). Following Richardson & de la Peza (2019), we present these as a starting set to be

adapted to the terms of each engagement rather than a uniform framework, since a single fixed set of indicators applied across all embedded advisors was found to be neither useful nor fair, given how substantially advisor roles vary by context.

**Comment 8:** Nuance causal assertions and explicitly acknowledge exogenous factors, such as the prior technical maturity of Senegal's malaria/HIV programme staff and the Global Fund's geopolitical priorities in the region, which may have acted as enabling variables.

**Response:** We agree, and this point is closely connected to Comment 1. We have named these exogenous factors explicitly in Section 2, immediately following the account of the GC7 outcome: Senegal's status as an established Global Fund implementer, its technically strong HIV, tuberculosis, and malaria programs, favorable regional funding priorities, and relative continuity of ministry leadership. We now attribute to the advisory model only a specific, bounded contribution - consistency across cross-disease budget assumptions and continuity through the transition from grant-making to implementation - rather than the underlying programmatic strength or funding decision itself.