Health Resource Tracking Partner Alignment and Cross-Country Learning Exchange Summary Report

December 2022

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Acronyms

BMGF	Bill and Melinda Gates Foundation
CHAI	Clinton Health Access Initiative
DRC	The Democratic Republic of Congo
GAVI	Global Alliance for Vaccines and Immunisation
HA	Health Accounts
HRT	Health Resource Tracking
IFMIS	Integrated Financial Management Information System
MDS	Minimum data set
MOH	Ministry of Health
MOF	Ministry of Finance
OGAC	Office of the U.S. Global AIDS Coordinator
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PFM	Public Financial Management
NASA	National AIDS Spending Assessment
RMET	Resource Mapping and Expenditure Tracking
SHA	System of Health Accounts
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

Governments continue to experience challenges in accessing and using quality near real-time health financing data to inform key health sector policy questions. This makes it difficult to develop, resource, and track health sector priorities. Governments are often unable to link budget and expenditure data to results, and they may not have a complete picture of resources available from the private sector or outside donors. Without these data, planning, forecasting, and identifying opportunities for efficiency remain elusive. However, governments have expressed renewed interest and demand in support for strengthening health resource tracking (HRT) systems and data use. At the same time, development partners are interested in understanding how these needs can be met while leveraging existing investments in health resource tracking tools and initiatives.

Governments and partners met in person for the first time in over two years to coalesce around the next phase of a global health resource tracking agenda that is actionable at the country level. The Health Resource Tracking Partner Alignment and Cross-Country Learning Exchange Workshop took place in Kigali, Rwanda December 6-8, 2022, and was hosted by the Government of Rwanda and the Health Resource Implementation Partners Group (a group of multilateral, bilateral, and implementing partner agencies). Country representatives from Ministries of Health and Finance from Burkina Faso, the Democratic Republic of Congo, Ghana, Kenya, Malawi, Nigeria, Rwanda, Tanzania, and Uganda attended the workshop.

The proposed agenda and discussion topics aimed to help articulate country needs, surface persistent pain points, and align incentives around HRT. The ultimate goal of the workshop was to take steps toward maximizing the value of HRT data while minimizing the burden of capturing it and applying it for policy and decision-making.

Several core themes and challenges, and proposed solutions, emerged from the workshop.

Core themes and challenges

1. **Countries have a clear vision and expectations for how they want to use HRT data anchored on the premise of "collect once, use many times."** Country participants expressed a strong desire for solutions that allow them to track, analyze, and visualize government and donor / implementing partner budget and expenditure information, as well as routine health data. Country representatives articulated a need to leverage approaches and tools that consolidate fragmented government and partner information, giving them access and allowing them to both visualize and analyze HRT data. An ideal end-state, as articulated by participants, would allow countries to leverage these data for both their own decision-making and global reporting. As an example of how these data could be used, decision-makers could better understand how resources are allocated across high disease-burdened areas, which human resource cadre should be advocated for, and improve program efficiency. These insights would in turn help governments to alter their budgets faster, more efficiently, and more equitably to ensure that key priorities are met. Governments could also draw upon their routine data to contribute to cross-country assessments through Health Accounts (HA) or to global agencies for grant-making purposes.

2. **HRT data systems and processes should be fit-for-purpose.** There is not a one-size-fits-all solution for HRT and investments in HRT systems and processes must be country-specific. HRT system design should rely on heavy consultation with local decision-makers to ensure that the system is fit-for-purpose for those entering and using the data. The data available in the system should also be needs-based and relevant to country policy and programmatic decisions. While development partners provide support to different systems or system components, countries suggested that partners coordinate to develop and strengthen HRT systems more holistically to ensure that the system meets country needs.

3. **Existing local processes and capabilities for reporting financial information do not match global requests for financial data.** Participating countries reported frequent inability to use the routine data they collect to report financial information at the donor or global level. As a result, countries create separate data collection processes to report financial information to donors. This process produces significant duplication for the often small team in the Ministry of Health (MOH) who collect data. This inefficiency results in frustration, poor compliance, and inconsistency during data collection efforts.

4. **Countries expressed difficulty in using Health Accounts data for near real-time decision-making.** Countries expressed the need to have near real-time data available to them for budgeting and planning purposes. However, many countries do not have HRT systems in place to provide near real-time data and rely on HA data, which may have a lag of one to two years. While the HA produces valuable information that can be used at the national level for longer-term planning, and at the global level for cross-country comparison, it has limited utility for near real-time (annual) planning.

5. **The lack of standardization of data reporting requirements across development partners creates a challenge for governments in streamlining data collection and reporting processes.** Currently, each development partner has unique reporting needs, making it difficult for countries to collect data just once and use the data for the various reports required of countries. Countries consequently often create separate data analysis and reporting processes for each development partner. Better coordination and integration between development partners would make the data collection process more efficient and improve the use and value of the results from each reporting activity.

Proposed solutions

1. **A minimum data set (MDS) is needed to harmonize data requirements between countries and development partners.** Countries and partners can jointly develop an MDS – the minimum data elements and details needed to address key stakeholder data needs. This can be done by articulating the use cases or data needs of each stakeholder (e.g., MOH planning unit, district planning, development partner, etc.), focusing first on country priorities, policies, and needs. Once the needs are identified, countries can then identify key data sources that can be used to meet these needs. Timing is also critical for stakeholders to consider, ensuring that data is aligned with country budget cycles. An MDS enables countries to collect data once and use it many times. It is a starting point for countries that are beginning their journey towards a more

interoperable and functional system, decreasing system fragmentation. It also ensures that governments can track their priorities, policies, and implementation. The MDS would include:

    a. **a crosswalk of metadata, international standards, and national priorities/objectives** to enable streamlined data capture and use for many purposes.

    b. **alignment** of categories used for capturing available resources (health **budgets**) with executed resources (health **expenditures**) for full continuum analysis.

With the appropriate HRT information systems in place and agreed-upon harmonization of data with relevant stakeholders, information can be linked from various data sources in a given country and reporting automated to produce consistent results with minimal effort at the country level.

2. **Continue to align understanding of technical terms** to promote exchange and common guidelines. Some technical terms have a generic single meaning, whereas other terms may have multiple meanings. It is important to ensure a common understanding of technical terms among key stakeholders, such as "health resources" or "health financing." As noted during the workshop, the HRT field brings together technical experts from across disciplines, backgrounds, and experiences. As this global agenda moves forward and starts to explore opportunities for leveraging technology, ensuring a common understanding of new technical terms such as: "interoperability," "minimum data set," and "use cases," will be critical.

3. **HRT systems should be fit-for-purpose and should capture data useful for country-level decision-making.** Countries recognize that there is not a one-size-fits-all solution and that investments in HRT systems must be country-specific. System design, therefore, should center on consultation with local decision-makers to ensure that the system is fit-for-purpose for those entering and using the data. Additionally, while development partners can provide support to different systems or system components, countries suggested that partners coordinate to develop and strengthen HRT systems more holistically to ensure that the HRT system meets country needs. Countries and partners suggested a user-centered approach to identify tools, existing or new, to address any gaps in information. First, countries could identify key HRT policy and programmatic decisions and articulate the data needed to make those decisions. Second, countries and partners could then work together to determine whether an existing or new tool can address the country's specific need.

4. **Countries request better engagement with development partners to align data to key policy and programmatic decisions countries are making.** The data needed for these HRT decisions should form the basis of the MDS. Specifically, workshop participants suggested the following possible solutions to help align incentives and data to key policy decisions:

    a. Document and understand each actor's **key decisions**. Ensure that data collected are relevant to those key decisions.

    b. **Optimize data and data systems** to align with those decisions, focusing on why the data are collected and how they align with identified key decisions.

    c. Understand **incentives for data use** and the political economy around those incentives.

    d. Countries could **use existing mechanisms**, such as, memoranda of understanding or compacts **to compel partners to report off-budget data**. Governments could consider linking registration or operational licenses of private international organizations to their reporting to increase accountability and remain in good standing with local leadership.

Doing so would help ensure that donors and their recipients report relevant, needed financial data.

    e. Develop better indicators as part of country M&E frameworks to monitor country objectives and reforms so that data is useful for policymaking and decisionmakers, thereby incentivizing data use.

5. **Existing country systems should be leveraged and enhanced to fulfill reporting requirements rather than creating parallel systems/tools.** Leveraging existing systems – rather than introducing new tools – will reduce duplication of data collection, improve the efficiency of systems investments, and improve continuity and uptake of digital technologies. Country participants expressed a desire to focus on building local skills and leverage existing systems to increase the chances of developing sustainable systems and processes. By linking available programmatic and financial data sources, countries can leverage information for more data-informed decision-making.

6. **Revisit the functionality of Integrated Financial Management Information Systems (IFMIS)** to better capture fit-for-purpose health financing/expenditure data in country systems. Financial management for health is a cooperative effort across multiple sectors. In most settings, the Ministry of Finance (MOF) tracks and accounts for health resources. MOFs leverage IFMIS, and solutions to improve HRT should consider IFMIS data.

7. **Invest in sustainable, country-led training and capacity building efforts.** Countries rely on development partners to support training. For instance, data collection for formal surveys (e.g., National AIDS Spending Assessment - NASA, Health Accounts) is costly and could be heavily dependent on donor support to implement it. Some governments are decentralized with many reporting entities, making it difficult and costly to provide capacity building to all entities. Participants agreed that discussions alone around resourcing have not been effective in increasing staff skills and capacity. Workshop participants suggested several actions which could help build the skills and capacity of the HRT-related health workforce:

    a) Evaluate and support **multiple models in country contexts** for different capacity needs. Countries should focus on capacity building models that address institutional barriers and build a culture of data use.

    b) Leverage **local, non-government institutions** (e.g., universities, centers of excellence) to create an on-ramp for skilled professionals and bolster HRT data use in key health sector roles.

    c) Pool development partner resources and coordinate an approach to **target high-value opportunities** and provide more efficient delivery of capacity building.

At the workshop closing, participants made individual commitments to move the HRT agenda forward within their respective countries and organizations and to carry out the recommendations that emerged through workshop discussions. Participants agreed to pursue the following goals: focused harmonization between partner requirements and across country processes; building capacity to institutionalize HRT; and enhanced use of health financing data for decision-making.

Background

Governments continue to experience challenges in accessing and using quality near real-time health financing data to inform key health sector policy questions. This makes it difficult to develop, resource, and track health sector priorities. Governments are often unable to link budget and expenditure data to results, and they may not have a complete picture of resources available from the private sector or outside donors. Without these data, planning, forecasting, and identifying opportunities for efficiency remain elusive. However, governments have expressed renewed interest and demand in support for strengthening health resource tracking (HRT) systems and data use. At the same time, development partners are interested in understanding how these needs can be met while leveraging existing investments in health resource tracking tools and initiatives.

HRT is the collection and use of health budget and/or expenditure data to inform health plans and policies. HRT encompasses many activities, methodologies, and processes. These vary across sources of funding (domestic, donor aid, private), breadth of scope (disease specific, health sector, multi-sectoral), and focus (budget, expenditure, or both, and national, subnational, or facility-level). Activities are often complementary and provide a better picture of resource levels and flows that help governments prioritize and align health sector investments and improve efficiency and equity in health investments and outcomes. Furthermore, each distinct activity often requires different segments of information from the same stakeholders and data sources.

HRT activities may be implemented in parallel and without adequate coordination across departments. Insufficient country capacity, processes, and guidance for capturing and analyzing HRT data often lead to inefficiencies and suboptimal data quality. There are also difficulties in aligning health policy priorities to budget and expenditure data, which can result in not being able to effectively track resources across the continuum, limiting visibility and accountability. In many cases data exists or a system is available to capture this information; however, countries' capacity to extract the right data or retrofit an existing system is limited.

To move towards institutionalized health resource tracking, countries are eager to better understand and share their technical experiences. Partners are also eager to learn and better understand how they can support country efforts in a coordinated approach. To help facilitate these goals, the Health Resource Tracking Partner Alignment and Cross-Country Learning Exchange Workshop held December 6-8, 2022, in Kigali, Rwanda was an opportunity for countries to share their experiences with HRT and for development partners to listen and plan for support of country efforts in a coordinated approach.

Workshop Objectives

The objectives of the workshop were to:

1. Assess and discuss the current state of HRT to raise awareness and provide space for cross-country learning and sharing of experiences and use cases for conducting, aligning/harmonizing, using, and institutionalizing health resource tracking efforts. This included:

a. Discussing objectives, incentives, and demands that shape HRT (policy questions, global mandates, donor requirements).
b. Sharing country HRT landscapes (mapping of tools, HRT exercises underway, and relevant stakeholders/institutions/leadership).
c. Sharing use cases and experiences in using resource tracking data in policy, decision-making, and policy dialogue.
d. Sharing country challenges/areas for improvement and solutions/opportunities (what works and doesn't work).

2. Determine how to move forward together and co-create a vision and good practices for resource-tracking institutionalization. This included:
a. Discussing what institutionalization looks like – country examples and challenges.
b. Co-creating a joint statement or principles for moving forward and creating a learning agenda on institutionalization of country HRT.
c. Identifying country-specific capacity needs and roadmaps for next steps.
d. Identifying and developing consensus amongst development partners on how to better align their HRT efforts and build country capacity.

Expected Outcomes

This gathering was intended to move beyond sharing experiences, challenges, and best practices. The proposed agenda and discussion topics were designed to translate information into action by helping articulate country needs, surface persistent pain points, align incentives, and ultimately take steps toward maximizing the value of HRT data while minimizing the burden of capturing it and applying it for policy and decision-making.

Workshop activities and discussions focused on identifying:

- Country use cases, pain points, vision, and support needs.
- Core principles of HRT.
- An inventory of current HRT technology, tools, and support available to countries.
- A common vision for a future state of HRT.

Participants

The workshop brought together:

1. Technical and policy maker representatives from the following governments: Burkina Faso, the Democratic Republic of Congo (DRC), Ghana, Kenya, Malawi, Nigeria, Rwanda, Tanzania, and Uganda.
2. Country-specific bilateral and multilateral institutions: Global Financing Facility (GFF) Liaison Officers, United States Agency for International Development (USAID) / Rwanda, World Bank/Rwanda, and World Health Organization (WHO) country representatives.
3. Global and regional development partner representatives from bilateral and multilateral institutions: Bill and Melinda Gates Foundation (BMGF), Global Alliance for Vaccines and

Immunisation (Gavi), GFF, The Global Fund, U.S. President's Emergency Plan for AIDS Relief (PEPFAR)'s Office of the Global AIDS Coordinator (OGAC), Joint United Nations Programme on HIV/AIDS (UNAIDS), WHO.

4. Organizational and freelance technical experts with previous/ongoing experience supporting HRT efforts globally and within partner countries: Abt Associates, Clinton Health Access Initiative (CHAI), Cooper/Smith, and consultant Teresa Guthrie.

This workshop was made possible with support from the Health Resource Implementation Partners Group, a group of multilateral, bilateral, and implementing partner agencies. Aimee Mukunde of the GFF and Cooper/Smith facilitated the workshop.

A full list of participants can be found in Annex 4.

Workshop Activities

This three-day workshop consisted of guided discussions, panels, posters, and group activities, grounded in country experiences and needs. It was designed to systematically catalog and document HRT user needs; decisions the user makes; the data, systems, and tools used for decision-making; and opportunities to improve HRT processes.

Breakout and group presentation sessions were accompanied by documentation materials intended to capture the ideas and feedback generated by this group of experts. Country representatives participated in panels to discuss common challenges for efficiency and streamlining, institutionalization and governance, data sharing and collaboration, and best practices in their respective countries. Development partners gave short 'lightning talks' on the support they provide to countries, how they use health financing data, and gaps and barriers to effective data use. Some participants created posters to spotlight promising examples of HRT technology, tools, and support that countries could potentially adopt (Annex 5).

Across the three days, a "User Journey" exercise took place where country groups systematically documented how health financing data are used to support key decisions in-country through a full "user journey," which included pain points, data systems interactions, stakeholder touchpoints, and key outcomes. This activity served as a frame to identify high-value improvements to data, process, coordination, and decision-making within countries. Development partners had the opportunity to separately discuss HRT guiding principles and the global future state of HRT. After each session and activity, plenary discussions were held to report back and have wider discussions on key topics.

Throughout the workshop, participants discussed their current resource tracking successes and challenges; identified gaps in HRT processes, limitations of existing tools, and opportunities to improve; and articulated a desired future state that enables data-driven HRT decisions and partner coordination.

A detailed agenda is found in Annex 1.

User Journeys

To contextualize workshop conversations, participants from each country were asked to document their experience with health resource tracking in the form of a "user journey." Prior to attending the workshop, each country representative identified 1-3 of the most important HRT-related policy and service delivery decisions that they make. These goals were formulated as "use cases." Country use cases focused on planning and budgeting processes, increasing domestic resources, ensuring equity and efficiency in resource allocation, and implementing universal health care.

> **Use Case**: A use case is a description of how someone performs a task. Each use case represents a sequence of simple steps, ending when the goal is fulfilled.
>
> **User Journey**: A user journey documents the experience of an actor / person in completing the use case or task.

At the workshop, country representatives then undertook a "user journey" exercise to document their experience in completing each use case. Participants considered the questions in Figure 1 to identify the process they currently take to achieve each use case and to consider pain points and ways to improve the process. The user journeys served as a frame through which to identify potential high-value improvements to data, process, coordination, and decision-making. The user journeys were digitized (Annex 3) and presented by countries in a plenary session. Figure 2 is an example of a user journey from Uganda.

FIGURE 1 - QUESTIONS CONSIDERED FOR THE USER JOURNEY EXERCISE

Process / Steps	What steps do you take to achieve this goal or reach this decision?
Triggers	What initiates the process of moving toward this goal or answering this decision?
Key Decisions	What other key decisions do you make to achieve your end goal or ultimate decision?
Data Needs	What data do you need to make these decisions? Where do you access these data? What systems or tools are used?
Touchpoints	What people / groups are involved in this step and how are they involved?
Pain Points	What are the problems or negative experiences that are faced in achieving this goal and by whom? What challenges prevent the best use of these data?
Improvement Opportunities	What would you change to improve how you achieve the goal or reach the decision? Who needs access to data, when, and in what format?
Solutions	What efficiencies or opportunities are gained by improving how you address the objective? What are the cost / opportunities savings?
Support Needs	What support do you need to be able to achieve this ideal state?

While the use cases differed across most countries, there were many similarities in the types of pain points that countries experience. Country representatives acknowledged that internal processes can be pain points; health system complexity and misalignment among country stakeholders present challenges in achieving use cases. Countries also identified data availability, quality, and timing as a key pain point. Specifically, population data is inaccurate, there are gaps in data, and system fragmentation makes it difficult for countries to access data. Many user journeys require data beyond resource tracking data,

especially data for near real-time country programmatic and budgeting purposes. Partners recognized the need for countries to have near real-time data in relation to their specific national priorities.

FIGURE 2 - UGANDA USER JOURNEY

UGANDA   **USE CASE**: Resource Allocation: To ensure efficient and equitable resource allocation

	(1) Consultative Meetings	(2) Apply the resource allocation formula	(3) Seek approval and endorsement	(4) Communication of allocation to all entities/beneficiaries	(5) Budget Execution	(6) Monitoring and reporting
Decision	-Stakeholder mapping -Agenda setting, convening -Documentation of meeting resolutions -Approach	Review and agree on RAF	-Submit to MOH and top management -Submit to MOFPED -Submit to health committee of PAH -Approval of all allocations	-Prepare and distribute -Publish on website – MOFPED	-Develop work plans -Activity implementation -Decisions: Budget use & possible reprogramming	-Compile monitoring report (Monthly, quarterly, annually) by H/F and submit to district for review and onward submission to MOFPED with copy to MOH - Approval of report to inform the next quarter's financial release
Data	-Budget data, past years -Indictive Planning Figures (IPF) -Performance Assessment -Macro Data -Resource Tracking Data (NHA, NASA, PER, etc.)	-Epi data -Demographic data -Equity– distance/hard to reach	-Budget data, past years -IPF -Performance Assessment -Macro Data -Resource Tracking Data (NHA, NASA, PER, etc.)		-Financial data -Epidemiological data (esp for epidemics)	MOH MTEF Health Sector Reports
Touch Points	-MOH, MOFPED, DPs, CSO, NPA, Parliament	MOH, LGs, DPs, NPA, Parliament, MOFPED	MOH, MOFPED, Parliament	MOH, LGs, Agencies	MOH, MOFPED, LGs, HUMCs	MOH, MOFPED, HUMCs
Pain Points		Reaching consensus on parameters inside	Reaching consensus on final allocation	Delays in communication	-Inflexibility in reprogramming and reporting -limited capacity and inadequate funds	-lack of good quality, accurate data -delays in reporting -lack of feedback from higher levels -inadequate capacity -Internet connection

Solutions	Data quality and availability Digitization Interoperability	PM reform to allow flexibility Institutional Capacity Building Use multiple & accessible communication platforms
Benefits	Efficient use of resources Equitable resource allocation Timely and accurate data/reports	Effective communication Improved health data
Support Needs	Adequate and sustainable resources Effective and functional governance Technical assistance to build capacity	Management information systems (IFMIS, DHIS) Improved, efficient and interoperable

Through discussing each user journey, country representatives and development partners were able to come to a better shared understanding of country priorities and moved the discussion towards committing to create a realistic, achievable solution that addresses country needs.

Key Themes

The workshop generated consensus across all participants around the need for better systems, tools, and processes to fully track, analyze, and visualize government, donor, and implementing partner budget and expenditure information, as well as routine programmatic health data. An opportunity exists for development partners and countries to coordinate in moving the global HRT agenda forward and achieving an ideal state in which countries would be able to better leverage data that they collect for both their decision-making and donor and global reporting. These data, if brought together, could help countries address challenges identified during the user journey exercise.

Countries articulated a need to have a system that consolidates fragmented government and partner information in one place, improving access to relevant data and allowing countries to visualize and analyze these data. As an example of how these data could be used, decision-makers could better understand how resources are allocated across high disease-burdened areas, which human resource

cadre should be advocated for, and improve program efficiency. These insights would in turn help governments to alter their budgets faster, more efficiently, and more equitably to ensure that key priorities are met.

Throughout the group discussions, presentations, and panels held among participants, five key themes emerged as critical in moving this agenda forward:

1. Harmonization and alignment of data needs
2. Efficiency and sustainability of data systems
3. Data use: align incentives and data to decisions
4. Data quality and timeliness
5. Skills and capacity

1. Harmonization and alignment of data needs

Local processes for reporting financial information do not match donor, continental, or global requests for financial data. Country-level data often do not have the required level of detail nor the appropriate timing to adequately address global needs. This means that countries cannot adequately use the routine data they collect to report financial information at the donor, continental, or global level. Additionally, routine health financing data is often not aligned with globally standardized reporting, such as the Health Accounts (HA) or National AIDS Spending Assessment (NASA). As a result, countries create separate data collection processes to report financial information to donors. This produces significant duplication for those who collect data. This inefficiency results in frustration, poor compliance, and inconsistency during data collection efforts.

Countries expressed difficulty in using Health Accounts data for near real-time decision-making. Countries expressed the need to have near real-time data available to them for budgeting and planning purposes. However, many countries do not have HRT systems in place to provide near real-time data. Other countries may have an Integrated Financial Management Information System (IFMIS) that provides some near real-time data, but still has gaps. As a result, countries rely on HA data for routine planning, which may have a lag of one or even two years. While the HA produces valuable information that can be used at the national level for longer-term planning and at the global level for cross-country comparison, it has limited utility for routine (annual) planning.

Alignment of development partner data needs remains a challenge. Each development partner has unique reporting needs. Because of this, countries are unable to collect data one time and use it for each unique donor reporting requirement. Countries create separate data analysis and reporting processes for each development partner. Better coordination and harmonisation between development partners can make the data collection process more efficient and improve the understanding and use of the results from each activity.

A minimum data set (MDS) is needed to harmonize data requirements between countries and development partners and to ensure that country priorities are tracked. Countries and partners can jointly develop an MDS – the minimum data elements and details needed to address key stakeholder data needs. This can be done by articulating each stakeholder's use cases or data needs, focusing first on country priorities, policies, and needs. Once the needs are identified, countries can then identify key data sources that can be used to meet these needs. Timing is also critical for stakeholders to consider, ensuring that data is aligned with country budget cycles. An MDS enables countries to collect data once and use it many times. It also ensures that governments can track their priorities, policies, and implementation.

Workshop participants noted that the following activities could improve harmonization and alignment:

- **Document current HRT priorities,** policy questions, and country landscapes. This includes identifying priority policies, programs, data systems, and governance mechanisms. The documentation can be standardized to allow partners to more easily understand country needs and priorities and compare across countries.
- Countries and partners jointly **develop a minimum data set.** The MDS would include a **crosswalk of metadata, international standards, and national priorities/objectives** to enable streamlined data capture and use for many purposes. The MDS should include **alignment** of categories used for capturing available resources (health **budgets**) with executed resources (health **expenditures**) for full continuum analysis. With the appropriate HRT information systems in place and agreed-upon harmonization of data with relevant stakeholders, information could then be linked from various data sources in a country and reporting could be automated to produce consistent, regular results with minimal effort at the country level.
- Strengthen **country mechanisms for coordinating** and aligning tools/processes for HRT. Partners can consider strengthening HRT systems and tools more holistically instead of supporting individual tools or specific system components. This type of support will enable countries to better adapt HRT tools to their specific needs.
- Continue to **align understanding of technical terms** to promote exchange and common guidelines. Some technical terms have a generic single meaning, whereas other terms may have multiple meanings. It is important to ensure a common understanding of technical terms among key stakeholders. Please see Annex 2 for common terminology used during the workshop.

2. Efficiency and sustainability of systems

An efficient data system captures data once and uses it many times. Countries highlighted the desire to have efficiency in data collection, especially for larger, routine tools. It was noted that HRT information systems can also be designed to capture data once and use multiple times. Countries would like to use data within their existing HRT systems for government and development partner reporting. With a MDS in place, countries can link routine data together and automate reports, thus collecting data one time and using it for multiple purposes.

Multiple data systems often exist at the country level but are rarely comprehensive nor well-linked. This makes it difficult for decision-makers to find the data they need for decision-making, as they must access multiple, fragmented systems for the relevant information. Once the relevant data are accessed, countries then must download the data from each system and merge datasets to manually analyze the data. Governments may also be using multiple resource tracking tools with similar purposes, creating complexity in countries. Interoperability and better integration of systems would help enable countries to access and use their data more efficiently.

Existing country systems should be leveraged and enhanced to fulfill reporting requirements rather than creating parallel systems/tools. Leveraging existing systems – rather than introducing new tools – will reduce duplication of data collection, improve efficiency of systems investments, and improve continuity and uptake of digital technologies. Country participants expressed a desire to focus on building local skills and leverage existing systems to increase the chances of developing sustainable systems and processes. By linking available programmatic and financial data sources, countries can leverage information for more data-informed decision-making.

HRT data systems and processes should be fit-for-purpose. There is not a one-size-fits-all solution for HRT and investments in HRT systems and processes must be country-specific. HRT system design should rely on heavy consultation with local decision-makers to ensure that the system is fit-for-purpose for those entering and using the data. The data available in the system should also be needs-based and relevant to country policy and programmatic decisions. While development partners provide support to different systems or system components, countries suggested that partners coordinate to develop and strengthen HRT systems more holistically to ensure that the system meets country needs.

Workshop participants highlighted that the following could improve the efficiency and sustainability of data systems:

- Optimize **country information systems** to capture data once and use multiple times. Once data are linked between HRT systems, data capture, cleaning, and analysis can be automated and exported to match international standards. This will allow countries to use their routine data for various reporting requirements.
- Leverage **technology** for more efficient data capture and interoperability. Digital systems enable countries to receive more timely data and provide opportunities for data to be linked together. If an HRT tool is in place but not scaled nationally, countries could look at ways to expand the existing technology instead of developing new systems or tools. Leveraging existing systems could improve the uptake of digital technologies.
- Revisit the functionality of **IFMIS** to better capture fit-for-purpose health financing data in country systems. Financial management for health is a cooperative effort across multiple sectors. In most settings, it is the Ministry of Finance (MOF) that tracks and accounts for health resources. MOFs leverage IFMIS, and solutions to improve HRT should consider the data collected in the IFMIS.

3. Data use: align incentives and data to decisions

Existing HRT data do not meet country needs. Countries need HRT data to make health sector policy and program decisions. Countries reported that they do not have all the data they need to make these decisions. Countries also need to be able to link HRT with information describing utilization and efficiency for more informed decision-making. Participants highlighted that there is no overarching tool or technological platform that routinely links health resources to results, outcomes, and key decisions. In most cases, health data and financial information are not integrated and exist instead in silos. In some cases, these data are housed across fragmented systems, making it difficult to access the data for analysis. Sometimes ministries of health (MOHs) are required to coordinate with other ministries to get access to the data that they need for decision-making.

HRT tools should capture data that is useful for decision-making. Countries highlighted that some HRT tools (often introduced by partners) do not capture the information needed to inform relevant decisions at the country level. Countries and partners suggested a user centered approach to identify tools to address any gaps in information. First, countries can identify what HRT policy and programmatic decisions they are making. Second, countries can articulate the data needed to make those decisions. Third, countries and partners can work together to identify if an existing or new tool can address the country's specific need.

Countries struggle to use Health Accounts data for near real-time decision-making. Countries reported experiencing challenges in using HA data for near real-time decision-making but recognize its use in longer-term health financing strategies and at the global level. Additionally, they noted that most countries rely on partners to provide support to produce Health Accounts. Countries requested that globally standardized data (e.g., HA, NASA) be reported in an easier to digest format to use for decision-making. For instance,

data can be tagged in a way that allows for faster extraction and aggregation. Partners and countries could further discuss what format would enable better data use. Additionally, knowledge sharing (i.e., countries sharing successful ways they use the data) could also facilitate the use of these data sources.

Countries reported being more incentivized to use data when they own the HRT process. This sense of ownership includes being able to articulate data requirements effectively. Countries face challenges in obtaining high-quality financial information from partners. Off-budget[1] data has been particularly difficult for countries to collect from partners but is needed to inform planning. In the absence of off-budget data, countries have been using household expenditure surveys and the HA to fill the information gap. However, these sources are not near real-time, and policymakers do not use them to monitor financial trends.

Workshop participants shared the following suggestions for aligning incentives and data with key policy and programming decisions:

- Document and understand **key decisions** that are being made by each actor. Ensure that data collected is relevant to the key decisions being made. **Optimize data and data systems** to align with those decisions, focusing on why the data are collected and how they align with the key decisions.
- Streamline tools and processes to **create "space" (i.e., time, workforce capacity) for data use.**
- Understand **incentives for data use** and the political economy. Develop better indicators to monitor country objectives and reforms so that data are useful for policymaking and decision-makers, incentivizing data use.
- Leverage existing mechanisms such as memoranda of understanding to **compel partners to report** and empower countries to collect off-budget data. Governments can consider linking registration or operational licenses of private international organizations to their reporting responses to increase accountability. Doing so would ensure that donors and their recipients must report financial data to remain in good standing with local regulatory bodies.

4. Data quality and timeliness

Gaps in HRT data quality and timeliness impede decision-making. Poor data availability and quality make it difficult for countries to determine what financial gaps they may have and how to bridge them. In some instances, countries are using outdated or paper-based tools and systems that cannot produce the near real-time data needed for decision-making. As a result, countries use outdated data for decision-making out of necessity. Some countries reported regularly using data up to five years old for budgeting and planning.

Perceived low data use weakens data quality. HRT data is often captured across multiple data systems. These data systems may also be owned by different ministries within the government, making data access challenging. Because the systems are fragmented, it is difficult for decision-makers to access the data in an optimal way. Countries reported generating data in a "one size fits all" approach for decisions, when greater specificity and granularity is needed. As a result, data collectors feel that data are not used and so collectors are not incentivized to collect better quality data. Countries want to ensure data are being used and are relevant to country priorities to incentivize the collection of better-quality data.

Workshop participants suggested the following ideas to help improve data quality and timeliness:

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[1] Off-budget funding is funding that does not go through the government national bank account and/or is earmarked.

- **Better incentivize off-budget resource data provision.** Weak incentives to share health finance data result in suboptimal reporting rates, incomplete data, and limited use of financial information for planning.
- Better leverage technology, existing data systems, and novel methods to **increase the timeliness** of HRT data and **reduce the cost** of data capture.

5. Skills and capacity

Managing data systems and using data effectively requires sufficient country capacity, yet countries reported varying levels of capacity and skills to conduct HRT activities. Some countries reported a general lack of skills and capacity to assess existing HRT system infrastructure, understand overall needs, and interoperate systems where possible. Other countries articulated that staff do not have the necessary data analysis skills to use the data. In other cases, there is capacity but a high level of staff turnover. For example, staff may receive training on a survey or system, and then change jobs shortly thereafter. This turnover contributes to dependency on technical partners to ensure continuity in skills and knowledge.

Training is a long-term and expensive investment. Countries rely on development partners to support training. For instance, data collection for formal surveys (e.g., NASA, HA) is costly and could be heavily dependent on donor support to implement it. Some governments are decentralized with many reporting entities, making it difficult and costly to provide capacity building to all entities.

Workshop participants suggested that various actions could build the skills and capacity of the HRT-related health workforce:

- Evaluate and support **multiple models in country contexts** for different capacity needs. Participants agreed that discussions alone around resourcing have not been effective in increasing staff skills and capacity. Countries should focus on capacity-building models that address institutional barriers and build a culture of data use.
- Leverage **local, non-government institutions** (i.e., universities, centers of excellence) to create an on-ramp for skilled professionals and bolster HRT data use in key health sector roles.
- Pool resources and coordinate an approach to **target high-value opportunities** and provide more efficient delivery of capacity building.

Commitments

Participants learned from each other as they shared their technical experiences and perspectives on best practices in HRT throughout the workshop. After reflecting on these learnings, country and partner participants shared commitments they would make to move the HRT agenda forward. The below points summarize commitments from participants:

- **Advocate** to mainstream HRT priorities across other government units, showcase data to policymakers to generate demand for HRT data, be an HRT champion, and involve additional stakeholders in-country.
- **Build capacity** to generate and utilize HRT data and to institutionalize HRT.
- **Strengthen coordination** between governments and development partners to minimize fragmentation of data collection and ensure efficiency in the technical and financial support provided to countries.

- **Develop a minimum data set** as countries and development partners that addresses country decisions and priorities.
- **Harmonize** country and development partner needs, including reducing fragmentation and data collection burden between the resource mapping and expenditure tracking (RMET), HA, and NASA.
- Move from reporting to focusing on analysis and **use of data for decision-making**.
- **Share workshop learnings** with others in their respective country or organization and continue to exchange experiences and best practices.
- **Improve data quality** of Public Financial Management (PFM) systems.
- **Develop country-specific HRT systems** that allow for a one-stop shop for health financing data. This would be fit-for-purpose for each country, leveraging existing HRT data systems where able.
- **Prepare timely budget information** so it is available at the time it is needed for planning.

Beyond the actions that participants committed to do, participants also provided recommendations of actions that the collective group could do to move the HRT agenda forward. The discussion included recommendations to:

- **Build on and integrate existing country systems** instead of developing new HRT tools.
- **Share exemplar HRT tools** and best practices between countries.
- **Strengthen local institutions' capacity** to conduct and institutionalize HRT for sustainability.
- **Pool resources** to institutionalize HRT and avoid duplication of efforts.
- Strive for HRT data to be available in near **real-time** from the country, continental, and global levels.
- Improve **data use for decision-making** by 1) ensuring the appropriate level of data granularity and disaggregation, 2) using country estimates instead of global estimates for more accuracy, 3) effectively disseminating data in an easy-to-understand format (targeted dissemination using multiple dissemination products).
- **Harmonize donor requirements** for countries.
- **Institute a collect once, use many times approach** to collect data that can be used for country and global needs and reporting.
- **Focus on country needs** and country-specific use cases, recognizing that there may not be a one-size-fits-all approach.

There is a great opportunity for countries and development partners to move towards more country-owned, institutionalized HRT. Improved country HRT systems would support increased resource accountability, domestic health financing, and donor coordination while yielding greater technical and allocative efficiencies in the design and implementation of health sector priorities.

Annex 1 - Agenda

Health Resource Tracking (HRT) Partner Alignment and Cross-Country Learning Exchange Workshop
Kigali, Rwanda | December 6-8, 2022

AGENDA DAY 1

TIME	ACTIVITY
9:00 AM – 9:15 AM	**1. Greeting** We will introduce ourselves and set the stage for this workshop.
9:15 AM – 9:30 AM	**2. Welcome to Rwanda** The Rwanda Minister of Health will welcome participants to the workshop and highlight Rwanda's experience with HRT.
9:30 AM – 10:00 AM	**3. Introductions** We will get to know the countries and organizations present, facilitators, and individuals which we will collaborate with over the next 3 days.
10:00 AM – 10:30 AM	**4. Setting the Scene - Context** We will discuss how the HRT landscape, objectives, and data systems have changed over time and the factors that are currently influencing the HRT agenda.
10:30 AM – 10:45 AM	**Coffee, Tea, and Networking Break**
10:45 AM – 11:30 AM	**5. Setting the Scene – Terminology** We will coalesce around operational definitions for key terms and set "ground rules" to frame workshop discussion.
11:30 AM – 1:15 PM (Concurrent)	**6. Country Activity: Defining Country User Journeys** Country delegations will break out into groups to describe systematically how health financing data are used to support key decisions. They will document full "user journeys," typical "pain points," data systems interactions, stakeholder touchpoints, and key outcomes. User journeys will serve as a frame to identify high-value improvements to data, process, coordination, and decision-making.
11:30 AM – 1:00 PM (Concurrent)	**7. Partner Activity: Review HRT Principles** Development and technical partners will convene to refine HRT guiding principles that can be endorsed globally, identify sticking points that may hinder widespread adoption, and discuss appropriate fora for sharing and promotion.
1:00 PM – 2:00 PM	**Lunch**
2:00 PM – 3:00 PM	**8.1 Panel: Country Perspectives on HRT** Country representatives will discuss common challenges in 4 thematic areas: efficiency and streamlining, institutionalization and governance, data sharing and collaboration, and best practices.
3:00 PM – 3:15 PM	**Coffee, Tea, and Networking Break**
3:15 PM – 4:15 PM	**8.2 Panel: Country Perspectives on HRT** Country representatives will discuss common challenges in 4 thematic areas: efficiency and streamlining, institutionalization and governance, data sharing and collaboration, and best practices.
4:15 PM – 4:30 PM	**9. Summary and Closing**

Health Resource Tracking (HRT) Partner Alignment and Cross-Country Learning Exchange Workshop
Kigali, Rwanda | December 6-8, 2022

AGENDA DAY 2

TIME	ACTIVITY
9:00 AM – 9:15 AM	**10. Day 2 Overview** We will introduce the agenda and logistics for the day.
9:15 AM – 10:30 AM	**11. Panel: Development Partner Perspectives on HRT** Development partner participants will give short "lightning talks" on health financing data use cases across countries. We will discuss why HRT data are needed for specific uses, the gaps and barriers to effective data use, and how these issues are currently being addressed. Presenters will be available for Q&A and discussion.
10:30 AM – 10:45 AM	**Coffee, Tea, and Networking Break**
10:45 AM – 11:30 AM	**12. Posters: HRT Technology, Tools, Support, and Promising Examples** Presenters will have the opportunity to spotlight specific work that demonstrates an advance in HRT technology or approach. Posters will be displayed simultaneously and participants may interact with presenters to advance learning or explore partnerships.
11:30 AM - 1:00 PM	**13. Country Activity: Defining Country User Journeys** Country delegations and partners will break out into groups to continue documenting full "user journeys," typical "pain points," data systems interactions, stakeholder touchpoints, and key outcomes.
1:00 PM – 2:00 PM	**Lunch**
2:00 PM – 2:15 PM	**14. Thinking Future State** We will introduce a frame for identifying improvements to HRT that focuses on the future and helps to crystalize a shared vision.
2:15 PM - 3:45 PM (Concurrent)	**15.1 Country Activity: Defining Country User Journeys, Continued** Country delegations and partners will break out into groups to describe an improved future state for HRT and potential next steps.
2:15 PM - 3:45 PM (Concurrent)	**15.2 Partner Activity: Global Future State** Development and technical partners will break out into groups to describe a future state for HRT for the global community.
3:45 PM - 4:00 PM	**Coffee, Tea, and Networking Break**
4:00 PM – 5:00 PM	**16. Discussion: Global Future State** Development and technical partners will report back on what a global future state for HRT might look like and what steps are needed to achieve it.
5:00 PM – 5:15 PM	**17. Summary and Closing**

AGENDA DAY 3

TIME	ACTIVITY
9:00 AM – 9:15 AM	**18. Day 3 Overview** We will introduce the agenda and logistics for the day.
9:15 AM – 10:45 AM	**19. Panel: Country User Journeys Report Out** Representatives from country delegations will discuss their user journeys; ideal future states; critical data sources, systems, and governance mechanisms; pain points; and technical support needs.
10:45 AM – 11:00 AM	**Coffee, Tea, and Networking Break**
11:00 AM – 12:45 PM	**20. Reflections and Recommendations** Participants will reflect on salient themes from the workshop and recommend steps to realize goals for the future state of HRT.
12:45 PM – 1:00 PM	**21. Summary and Closing**
1:00 PM – 2:00 PM	**Lunch**

Annex 2 – Terminology List

Some health financing terms have a generic single meaning, whereas other terms can mean something different to different audiences. It was important to coalesce around operational definitions for key terms during the workshop to ensure a common understanding among participants. At the beginning of the workshop, participants participated in an online survey to vote on the definition of common health financing terms. Participants could select multiple definitions which they felt represented each term. The percentages in the graphs below show what percentage of respondents agreed that the definition is associated with the term. The results showed that there are differences in how terminology is understood and used.

HEALTH RESOURCE TRACKING

DEFINITION | % RESPONDENTS WHO AGREE

Comparing health budgets and health expenditures over time — 84%

Estimating health expenditures for services, programs, or outputs — 78%

Monitoring transactions and financial flows at each level of the system — 72%

Collecting and describing data about health resources available to a country — 91%

HEALTH RESOURCE MAPPING

DEFINITION | % RESPONDENTS WHO AGREE

Aligning available health resources to country priorities — 78%

Collecting data on health resources that may be available in future years — 73%

Identifying gaps between estimated costs and available resources — 60%

Estimating health program budgets — 65%

HEALTH FINANCE DATA

DEFINITION | % RESPONDENTS WHO AGREE

Qualitative health budget information	88%
Quantitative health accounting information	78%
Information about future available resources	66%
Estimated costs for health services, inputs, or outputs	80%

HEALTH EXPENDITURE

DEFINITION | % RESPONDENTS WHO AGREE

Amount of a health budget that has been allocated to specific activities	56%
Amount paid for goods and services at point of care	87%
Difference between budget at beginning of the year and resources remaining at the end of the year	52%

ON BUDGET RESOURCES

DEFINITION | % RESPONDENTS WHO AGREE

Financial allocation to health programs or activities according to agreed upon plan	60%
Accounting line items approved by financial controller	40%
Health resources that are monitored using country financial accounting tools and standards	83%
Health resources that originate from internal country financing sources (i.e. not external donor or lending sources)	60%
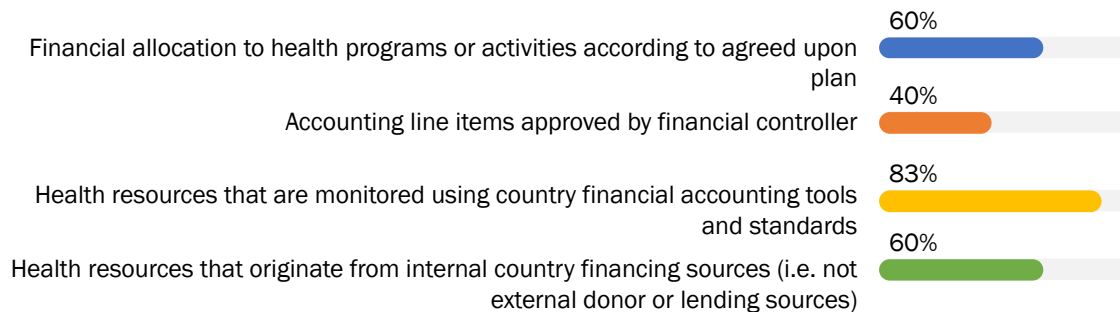
USE CASE

DEFINITION | % RESPONDENTS WHO AGREE

A list of actions or events defining the interactions between an actor and a system to achieve a goal
49%

Description of a desired outcome/end-state of how certain data and/or technology will be used
46%

Description of how a person or group uses information to make a decision
65%

A legal brief detailing a particular actor's perspective on a series of events
24%
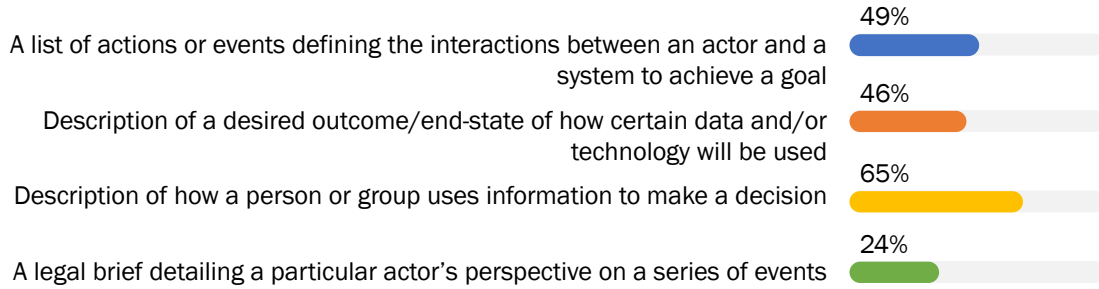
USER JOURNEY

DEFINITION | % RESPONDENTS WHO AGREE

A person's experience while using a website or application
26%

A series of actions performed by a person to achieve a particular goal
53%

Description of a user experience while completing a task
76%

INTEROPERABILITY

DEFINITION | % RESPONDENTS WHO AGREE

Merging data system into a single solution
50%

An alignment of data definitions and standards that results in increased relatability of information
61%

Two or more data systems that automatically exchange information routinely
81%

The ability to analyze data from multiple systems
58%

INFORMATION SYSTEM

DEFINITION | % RESPONDENTS WHO AGREE

A software application for storing and accessing quantitative statistics
75%

A set of predefined paper tools and processes for gathering and storing information
75%

Registers or ledgers used in health facilities and management offices
63%

DATA HARMONIZATION

DEFINITION | % RESPONDENTS WHO AGREE

Using a unified software to capture information from different sources
50%

Aligning operational definitions to better interpret information from different systems
83%

Aligning metadata (time period, location codes, element types, etc.) to jointly analyze data from different systems
83%

Developing guidelines for data collection that promote standardization
67%

Annex 3 – User Journeys

Burkina Faso

BURKINA FASO   **USE CASE:** Subvention fonctionnement F.S.

	(1) Clé Initial de répartition	(2) Projet distribution du montant	(3) Arbitrage budget	(4) Transmission assemblee nationale
Decision	Atelier de consensus national (2014)	Circulaire avant projet budget	Rencontre nationale	Approbation et execution
Data	-Données de routines de F.S -Historique de donnée financières -Annuaire statistiques -Plan triennial de financement	CDMT	-Revue -Rapports de performance -Données due context national insécuriité	-Programme d'urgence transition -PDI
Touch Points	MOH	DGESS, DGF, Santé	-Disposable Programme budgetaire, F.S. -Niveau central	Govt Deputés
Pain Points	-Non respect des criteres de repartition	-Non prise en compte du context -Regulation budgetaire	Méconnaissance de la cié	

Solutions		-Comité de suivi et d'orientation -Actualisation et respect des critères -Digitalisation de tout de processus -Site web du MS	-Budget citoyen -Tableaux de bord -Rapports -Donnees a telecharger	
Benefits				
Support Needs		Mettre en place une procedure de partagte et de centralisation		

Figure 4 - Burkina Faso User Journey 2

BURKINA FASO   **CAS D'UTILISATION**: Allocations tiers payant Gratuité

	(1) Estimation du montant	(2) Calcul de la clé de distributeur	(3) Génération des montants par formation sanitaire	(4) Transmission des etat de paiement aux formations sanitaires
Decision		-Arbitrage ST-RFS -DGF		
Data	-Contrôle de l'effectivité rapport ONG	-Liste des FS fermées -CORUS	Facture de F.S.	-Situation des dettes de la central d'achat des médicaments
Touch Points	-DGF (Directeur en charge des finances)	-ST-RFS	DG de hôpitaux et CNTS	-Les ONG en charge du contrôle des FS -Médicins chefs de district
Pain Points	-Re mise en cause de la cié de repartition	-Fraude -Surfacturation	-Disponibilité des fonds à temps	-Ruptures des medicaments

Solutions	-Engagement des partenaires -AMU en cours de déploiement			
Benefits				
Support Needs	-Digitalisation -Education de la population et des actuers -Immatriculation de beneficiaries			

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FIGURE 5 - BURKINA FASO USER JOURNEY 3

BURKINA FASO **CAS D'UTILISATION**: Allocation des ressources pour les gardes couchées

	(1) Estimation du montant	(2) Calcul de la clé de distributeur	(3) Génération des montants par formation sanitaire	(4) Transmission des etat de paiement aux formations sanitaires
Decision	-Attestation de service fait			
Data	-Fiche de services faits	Rapport de contrôle de l'inspection		
Touch Points	-DG de hôpitaux	-DG AGSP -DRH	Superieur hierarchique immediate	
Pain Points	-Fraudes			

Solutions	-Priorité du gouvernement			
Benefits				
Support Needs	-Digitalisation -Contrôle de l'effectivité			

Democratic Republic of Congo

FIGURE 6 - DRC USER JOURNEY 1

Democratic Republic of the Congo   **USE CASE**: Mise en oeuvre de la Gratuite

	Dans la prise en charge du nouveau	Dans la prise en charge de la femme enceinte	De l'accouchement
Decision	Connaitre ressources mobilises	Allocation de ressources	
Data	-Donnes enq. menages -Etude des coûts	Paiement direct des menages (NHAPI) Outil de quantification des MEG ESB Chaine de la defense Rapport CNS m-1 RAP Suivi Finance	DHIS2 (utilisation sante) Rapports des programmes specializes Min budget; Min Finance
Touch Points		PTF Secteur prive (OAC / ONG) Min budget politique sect. CBMT-CDMT Ministre sectorial PLF, N&D	
Pain Points	-Faible mobilisation de ressources -Insuffisance des donneés DIENQ -Charge commune (paiyoment des soins)	-Faible qualité des données de routine -Suivi financement au niveau opérationnel -Decentralisation DPS	-Mauvaise affectation des ressources -Inefficacite du SNIS -Disponibilite des defenses

Solutions	Respect des engagements Mise en place de régimes assurantiels Responsabilité des IT/CS dans la gestion de ressources Mise en place du budget programme Achat strategique	Production des CNS par module Appui de LHSS a la DAF Lien entre les CHS la carto Rapport de suivi de financement de la santé production
Benefits	Accroissement des ressources Amélioration du taux d'exécution Suivi de flux financier Protection financière pour les ménages	Amélioration de la qualité des données Projection des ressources Alignement des ressources pour les priorités du secteur Déconcentration de l'ordonnancement
Support Needs	Harmonisation des CNS & la carto des ressources Production des CNS par module appui financier Développer un outil de collecte des données ess → ETS soins de santé	

Kenya

Figure 7 - Kenya User Journey 1

KENYA   **USE CASE**: Bridge the gap between donor funding and domestic resources

	(1) Update resource mapping tool	(2) Ensure partners fill out RM tool	(3) Analyze RM data	(4) Conduct a gap analysis	(5) Disseminate the gap analysis	(6) Increase domestic financing
Decision	Determine the available domestic resources	Determine off budget resources		Determine how much to allocate to specific sectoral priorities		
Data			-Donors & Ips in country -Budget info by FY -Budget info by area -Budget by geographic area -Budget by duration	-Govt expenditure reports -Programmatic trends -Programmatic areas	-Program Performance Report -What was allocated -What was utilized -Resource source	-HSSP Priorities
Touch Points		DPHK HENNET FBOs KHF	National and County governments			
Pain Points	Complexity of devolved health care system (1 national 47 governments)	-Nonresponse by partners -Double reporting between donor and implementing agencies				-Administrative costs versus actual authority costs

Solutions	Leverage technology for mapping tools (real-time data) Improve partner coordination through the KHSPCF towards one plan, one budget, one implementation, one M&E Improve data sharing and use dissemination with relevant stakeholders and publication frequent Integration/harmonization on interoperability of data tools/platforms
Benefits	Timely data for decision making, Ease of data collection Equity in allocation of resources Eliminate duplication and improve efficiency in use of resources Transparency and accountability improved among all stakeholders
Support Needs	Technical assistance for digital platform operationalization Training and capacity building (skills transfer) Resource for dissemination and publications Technical assistance for RMET harmonization Political buy-in

FIGURE 8 - KENYA USER JOURNEY 2

KENYA   **USE CASE**: Equity and efficiency in health financing

	(1) Analyze health resource allocation & expenditure data from previous year	(2) Disseminate analysis findings with health sector colleagues	(3) Root cause analysis	(4) Identify priority areas to reallocate resources	(5) Review the resource allocation criteria/formula	(6) Reinforce the PFM act
Decision				Determine priority areas for funding	Determine how to update the resource allocation formula	
Data	-IFMIS- resource allocation and expenditure data -resource mapping data	-KNBS Census Data analytic reports -DHIS2 Annual Performance Review Report	MOH MTEF Health Sector Reports	-IFMIS- resource allocation and expenditure data -resource mapping data	-KNBS Census Data analytic reports -DHIS2 Annual Performance Review Report	MOH MTEF Health Sector Reports
Touch Points	-National govt -Treasury -MOH	-Parliament Health Committees -National Assembly & Senate	-DPHK -Hennet -KHF -FBO		County governments	
Pain Points	Availability of off-budget data (allocation & expenditure)	Actual population data is available every 10 years				Complexity of the government system in Kenya

Solutions	Revise/update the allocative efficiency criteria and formula Leverage technology (see other use case) Improve partner coordination through the KHSPCF
Benefits	Reduced out of pocket expenditure Equity in allocation of resources Ease in prioritization of health sector needs
Support Needs	Political buy-in Resources for training and capacity building Technical assistance

Malawi

FIGURE 9 - MALAWI USER JOURNEY 2

MALAWI   USE CASE: Revise the national resource allocation (national health budget) formula inputs

	(1) Literature review & stakeholder engagement on needs assessment	(2) Select the variables	(3) Develop the new formula using the new variables	(4) Dissemination & adoption of the new formula
Decision	ID who will be involved	Pick variables to include and exclude	Finalize selected variables	Where? How? (Different modes targeting different stakeholders)
Data	Current HRT Reports, Existing resource allocation formula, other countries formulae		Variable list	
Touch Points	-N2GFC, Treasury, MOH, Parliamentary committee on health, district councils -Development Partners (UN Family, CHAM/IHAM, HSJF, GAVI, GF, PEPFAR, WB, CHAI)			
Pain Points	-Misalignment amongst stakeholders -Political will	Convincing different stakeholders at different levels	Stakeholder availability	

Solutions	Dissemination of strategic documents with all stakeholders
Benefits	Unitary interest in improved health resource allocation
Support Needs	Resources to hold different stakeholders' engagement

FIGURE 10 - MALAWI USER JOURNEY 2

MALAWI   USE CASE: Directing external resources when people come to districts

	(1) Capacity building at DHMT	(2) District health needs assessment using known tools	(3) District resource mapping
Decision	-Who to train -Nature of training	-Formulate district implementation plan	-Resources earmarked for the health sector
Data	DHMT Members	DHIS2 Data	Resource Tracking tool
Touch Points	Planning directorate	-DHMT, Extended DHMT (coordinators) -Implementing partners -Community	DHMT, District
Pain Points	-Financial resources -Commitment -Unpredictable funding	-Data gaps, data quality issues (incomplete, inactive, timeliness)	Hesitancy by some DPs to provide resource information

Solutions	Increase predictability of funding Capacity building at all levels in quality data generation and use for decision Digitalization and harmonization of data collecting Capacity building on the DPS to provide necessary resource information
Benefits	Better planning, engagement, implementation and better results Improved data quality for use at district level Improved reporting rates and timely submission of HRT data in decision making
Support Needs	Adequate funding for capacity building ICT expertise and equipment Committed DHMT members Regulatory framework/authority/law to report on time

Nigeria

FIGURE 11 - NIGERIA USER JOURNEY 1

■ ■NIGERIA   **USE CASE:** Increase domestic resource mobilization for health | **TRIGGER:** Data off track with regards to guiding UHC

	(1) Assessment to identify financing/ performance gaps	**(2) Calculate VFM & DEV Inv. Case**	**(3) Call a meeting with relevant stakeholders**	**(4) Design strategies to increase the fiscal space**	**(5) Health requests $**	**(6) Annual budget inc.**	**(7) Contingency fund deployed for emergency**
Decision			Incentivize states to allocate more for performance-based budgeting	Set up performance monitoring units at Federal and State ministries of health			
Data		Targets/performance health stats, Health expenditure data (NHA), OOP Expenditure % GCHE from Gov Exp/P Health insurance coverage		Service delivery coverage Disease-specific program spec (multi-source			
Touch Points		Other relevant ministries, office of the account general Civil society, private sector, academia Ministry of health (national/state), ministry of finance, budget, National Planning					
Pain Points	Poor timing of data availability and use for decision making	Low fiscal space for health due to competing priorities	Engagement between the MOF and MOH is sub-optimal	Poor efficiency in use of funds as against health outcomes			

Solutions	Timely conduct of RT linked to health systems performance with appropriate dissemination · Create budget line and prioritize govt · Increase fiscal space by removal of subsidy, prohealth taxes, rationalize MDAs; Schedule quarterly performance reviews between MOF and MOH · Tie resource allocation to performance · Improve performance monitoring systems · Tracking internally generated revenue from the health sector
Benefits	Increased confidence in health sector from ministry of finance · Increased resource allocation to health · Improved health system performance Improved access to healthcare services · Increased revenue generation from the health sector
Support Needs	Institutionalization of PFM in for reforms at federal and state levels · Capacity building for key stakeholders in MOH and MOF · Performance tracking and performance improvement

Rwanda

FIGURE 12 - RWANDA USER JOURNEY 1

RWANDA USE CASE: Increased Revenue towards UHC | **TRIGGER:** Global, Regional, Country emerging pandemic + Health Commitment

	(1) Understand policy context of the country	(2) Resource Needs Analysis	(3) Resource mapping + identify potential source	(4) Develop resource mobilization plan	(5) Resource mobilization implementation	(6) M&E of resource mobilization
Decision	Tech consultation approved	Establish functional resource mapping	-Structure -Tool -Dedicating a team	Approved Plan	Approved Plan	-Conduct regular review -Approval
Data		Assess available data source / systems		Policy documents and reports, Reports from MINECOFIN DHS, Global health expenditure data, Census, Health insurance data, Health (HRTT, HMIS Information Reports)		
Touch Points	GOR (central & district), DPs, Private Sector Civil Society, Academia, Health Insurance			Civil Society, Academia, Health Insurance GOR (central & district), DPs, Private Sector		
Pain Points	-MOH Skills -Over hiring -Staffing	-Fragmented HRT data sources -Inadequate HRT tools -Users/admins		-MOH Skills -Over hiring -Staffing	-Quality of data -Capacity (tech) -HMIS/IFMIS/HRTT	

Solutions	HRT dedicated team Regular trainings and staff exposure (retention) Harmonization of HRT data services Systems interoperability Enforce reporting Methodology harmonization across stakeholders	DQ Audits - Data Validations - Sessions at central and district Design an HRT feedback systems HRT SOPs Data Security	
Benefits	Timely reports and accurate data Data completeness and accuracy Increased staff productivity and efficiency Increase of quality data analysis	One stop center Cost reduction Transparency Country owned data	
Support Needs	HRT financing and capacity building Salaries, office space, equipment, Study visits, conference and knowledge exchange	Technical expertise Encourage publications Data security	

Tanzania

FIGURE 13 - TANZANIA USER JOURNEY 1

TANZANIA **USE CASE**: Obtain Co-financing

	(1) Ceiling allocation from the Global Fund	(2) Programs identifying priority area for funding after situation assessment	(3) Convening a meeting within a ministry	(4) Meeting with TN MJM
Decision	Joint identification of the sector priorities	Costing of the verified priorities	Proposal writing	Submission to Global Fund
Data	Malaria spending, HIV spending, TB & Leprosy spending, analyzed the government co-financing			
Touch Points		-MOH to identify the priority area funding -MOFP signing of the contract between global fund and govt -TB & MOFP negotiating with the Global Fund -Technical team for co-financing		
Pain Points		-Inconsistent program data and NHA data for co-financing -Lack of analysis capacity at program level -Deductions of fund allocation -Delay of the approval for grants to start		
Solutions	Timely inform actions from the patterns To strengthen the system from MOFP for budget preparation Create awareness during the preparations of budget between DPs and IPs			
Benefits	They have a harmonized system which looks between both parties - DPs and IPs Improved data quality Increase access of data			
Support Needs	Capacity building within MOH staff Funding for the harmonization of system in department Capacity building at facility level vs. national level.			

FIGURE 14 - TANZANIA USER JOURNEY 2

TANZANIA   USE CASE: Planning and Budgeting

	(1) Budget review- convene meeting & review previous spending	(2) Priority setting – link to national priorities, NHA to help link sector priority	(3) Discuss priorities with stakeholders	(4) Finalization of planning with ministry
Decision	Budget negotiations with MOFP – present justification based on previous allocation	Ceiling allocation to address priority intervention		
Data		-Spending by disease (NHA, PQR) -Spending by geography (NHA, geography) -Spending by function (NHA)		
Touch Points		-Head of department and programs -Internal MOH meetings -Budget secretariat team during MOH review meetings -MOFP through budget negotiation -DPs and IPs – joint review meeting		
Pain Points		-Inconsistent program data and NHA data for co-financing -Lack of analysis capacity at program level -Deductions of fund allocation -Delay of the approval for grants to start		

Solutions	Dissemination of strategic documents with all stakeholders
Benefits	Unitary interest in improved health resource allocation
Support Needs	Resources to hold different stakeholders' engagement

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Uganda

FIGURE 15 - UGANDA USER JOURNEY 1

UGANDA   **USE CASE**: Resource Allocation: To ensure efficient and equitable resource allocation

	(1) Consultative Meetings	(2) Apply the resource allocation formula	(3) Seek approval and endorsement	(4) Communication of allocation to all entities/beneficiaries	(5) Budget Execution	(6) Monitoring and reporting
Decision	-Stakeholder mapping -Agenda setting, convening -Documentation of meeting resolutions -Approach	Review and agree on RAF	-Submit to MOH and top management -Submit to MOFPED -Submit to health committee of PAH -Approval of all allocations	-Prepare and distribute -Publish on website – MOFPED	-Develop work plans -Activity implementation -Decisions: Budget use & possible reprogramming	-Compile monitoring report (Monthly, quarterly, annually) by H/F and submit to district for review and onward submission to MOFPED with copy to MOH - Approval of report to inform the next quarter's financial release
Data	-Budget data, past years -Indictive Planning Figures (IPF) -Performance Assessment -Macro Data -Resource Tracking Data (NHA, NASA, PER, etc.)	-Epi data -Demographic data -Equity– distance/hard to reach	-Budget data, past years -IPF -Performance Assessment -Macro Data -Resource Tracking Data (NHA, NASA, PER, etc.)		-Financial data -Epidemiological data (esp for epidemics)	MOH MTEF Health Sector Reports
Touch Points	-MOH, MOFPED, DPs, CSO, NPA, Parliament	MOH, LGs, DPs, NPA, Parliament, MOFPED	MOH, MOFPED, Parliament	MOH, LGs, Agencies	MOH, MOFPED, LGs, HUMCs	MOH, MOFPED, HUMCs
Pain Points		Reaching consensus on parameters inside	Reaching consensus on final allocation	Delays in communication	-Inflexibility in reprogramming and reporting -limited capacity and inadequate funds	-lack of good quality, accurate data -delays in reporting -lack of feedback from higher levels -inadequate capacity -Internet connection

Solutions	Data quality and availability Digitization Interoperability	PM reform to allow flexibility Institutional Capacity Building Use multiple & accessible communication platforms
Benefits	Efficient use of resources Equitable resource allocation Timely and accurate data/reports	Effective communication Improved health data
Support Needs	Adequate and sustainable resources Effective and functional governance Technical assistance to build capacity	Management information systems (IFMIS, DHIS) Improved, efficient and interoperable

Annex 4 – Participant Registry

HRT Workshop December 2022 Participant Registry

Christabel Abewe NPO, Health Financing, WHO, Uganda abewec@who.int	Christabell is a health economist working with WHO Uganda Office. She has a strong commitment to enhancing equity, efficiency and sustainability on the path to Universal Health Coverage. She has experience in research and implementation in health economics, health financing and health systems strengthening in Uganda and other countries within the African Region. She is a graduate of a BA in Economics (Makerere University) and Master of Public Health (Health Economics) from University of Cape Town. She is currently undertaking her doctoral studies at the University of Cape Town focusing on the cost effectiveness of early detection methods for breast cancer in low- and middle-income countries.
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Samson Awudanjong Financial Monitoring and Reporting Officer, Ghana jerry4gh@gmail.com	Samson Awudanjong works at the Financial Reporting and Montoring Unit – MOH Head Quarters Accra. His roles include validating financial management records and preparation of the quarterly and annual Financial Reports of the Ministry, consolidating same for Financial Audit by the Ghana Audit Service and the Private External Audit Firm as per Common Management Arrangements with Donor Partners. He also leads in coordination and taking part in Financial Monitoring activities within the Ministry of Health and its Agencies eg. Teaching Hospitals, Ghana Health Services and other agencies under the Ministry of Health. He holds a BBA from the Valley View University Accra and an MBA in Accounting from the Kwame Kkrumah University of Science and Technology.
Dr. Francis Ayomoh Deputy Country Lead, Healthcare Financing, Equity, & Investments, Nigeria francisayomoh@gmail.com	Dr. Francis Ayomoh is the Deputy Country Lead for Healthcare Financing, Equity, & Investments at the Federal Ministry of Health in Nigeria. He is a Health Systems and Policy Expert and a DPhil candidate in the Nuffield Department of Primary Care Health Sciences at the University of Oxford. He has a medical degree and a Maste rs (distinction) in Health Policy, Planning, and Financing jointly awarded by the London School of Economics and Political Science and the London School of Hygiene and Tropical Medicine. Francis is a member of the Nigeria National Health Accounts Core Team and the Country Core Group of the Joint Learning Network for UHC.
Nadine Tamboura Bamogo Officier de Liaison, Burkina Faso ntambourabamogo@worldbank.org	Je suis titulaire d'un double master en finances , relations internationales et master en intelligence économique. J'ai travaillé dans la coopération au développement pour le compte du ministère en charge des finances au poste de chargée de programme de coopération puis directrice, ou j'étais chargée de coordonner et promouvoir les relations avec les PTF bilatéraux et multilatéraux. J'ai rejoint le Ministère de la santé en 2018 en tant que secrétaire technique chargée de la coopération ou j'ai contribué à la mobilisation des ressources des PTF pour les projets du secteurs. Depuis 2021, j(occupe la fonction d'officier de liaison du GFF au Burkina Faso, chargée d'assurer le lien entre le gouvernement et le GFF ainsi que du suivi des engagements du GFF.

Kashu Bekuretsion Senior Country Advisor, MoH Rwanda Kbekuretsion@stbfoundation.org	I'm a public health professional working at the Ministry of Health, Rwanda, as a Senior Country Advisor seconded by The Susan Thompson Buffett Foundation.
Alexander Birikorang Head of Grant Finance, The Global Fund alexander.birikorang@theglobalfund.org	Alexander is the Head of Grant Finance of the Global Fund to fight Tuberculosis, HIV and Malaria, leading the Grant Finance Team. He has overall responsibility for the direction, management and oversight of the grant financial management, grant fiduciary risks and portfolio level optimization of approved grant resources. He has over eighteen years experience in financial management, reporting, a internal controls and in fiduciary risk management, having worked in multilateral organizations, government departments, INGOs, and Big4 accounting firms to deliver results in health and in social sector projects. Alexander is a Chartered Accountant and holds an MBA in Finance.
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Dr. Faustin M. Chenge GFF Liaison, DRC fchenge@worldbank.org	I am a Medical Doctor, Master in Public Health and Doctor in Public Health (PhD). During my career, I have benefited from many capacity building trainings (PHC, health policies, UHC and health financing, strategic health management, evidence-based decision making.). In my professional career, I have succeeded in combining teaching, research and community service, and worked at all levels of the health pyramid of the DRC. Over the last few years, I have actively participated (sometimes coordinated) in a context of pluralism of actors and interests, in the reflections and strategic work on reforms within the Ministry of Health, the drafting of the Investment Case 2019-2022, the health financing strategy for UHC, roadmap of the UHC in DRC. From January 14th, 2021 to date, I am the GFF Liaison Officer in support to the DRC GFF Government Focal point in implementing the Investment Case.
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Hannah Cooper CEO & Co-founder, Cooper/Smith hannah@coopersmith.org	Hannah Cooper is the co-founder and CEO of Cooper/Smith a global organization focused on using hard data to improve the efficiency and effectiveness of development programs worldwide. Over the past 20 years, Hannah has advised governments on using data and technology to improve their citizens' lives. Hannah has worked at the World Bank, the United Nations, served as a policy advisor to several Canadian Cabinet Ministers, and led the Monitoring, Evaluation, and Quality team at the Office of the U.S. Global AIDS Coordinator, President's Emergency Plan for AIDS Relief (PEPFAR), U.S. Department of State. Hannah is a Visiting Scholar at the University of Texas at Austin's Center for Innovations in Peace and Development and is an affiliate of Georgetown University's Center for Innovation in Global Health. She is fluent in English, French, and Italian and lives in Austin, Texas with her husband and their three children, dog, and cat
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Ermias Dessie NPO/Health Financing and Economics Analyst, WHO, Ethiopia dessiee@who.int	I am working in the WHO-Ethiopia country office (second to the MoH). I work as an NPO/Health Financing and Economic Analyst and provide technical assistance in the fields of health financing and economics. I've also been a technical lead for conducting the 8th, 7th, and 6th rounds of National Health Account (NHA) studies in Ethiopia, and now I'm hoping that this workshop will help boost the Health Resource Tracking (HRT) institutionalization process at the country level.
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Kingsley is a Health Economist at the WHO Ghana Country Office, coordinating health financing and health workforce interventions and working at the intersection of policy, research and implementation to advance UHC objectives. Since December 2021, he has been supporting the Health Financing and Investment Unit at the WHO African Region Offices in Congo Brazzaville. He has a Master of Public Health, is a member of the Institute of Chartered Economists of Ghana, ICEG; Associate Member of the Association of Certified Chartered Health Economists (ACCE® – USA) and the Association of Chartered Certified Accountants (ACCA, UK) with over 22 years of experience in public financial management, health system strengthening, institutional reforms, change management, strategy and operations within the context of organizational efficiency and effectiveness.

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Teresa is a health economist with twenty years in the health financing space, mostly in East and Southern Africa: costing, budgeting, financing & expenditure tracking for health, HIV, TB, hepatitis, immunisation, nutrition (with experience in SHA, NASA, PETS, other tools, and combined SHA-NASA) at national and sub-national levels, and working with African public health finance systems as well as PEPFAR and Global Fund funding systems, investment cases, value-for-money analysis and fiscal space analysis. She is committed to improving access to accurate financial data to inform health planning, allocative decisions and improve efficiencies.

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Mr. HABINSHUTI Michel is the Single Project Implementation Unit (SPIU) Coordinator in the Ministry of Health since December 2020. He has been working in the health sector for 14 years. Before joining the Ministry of health, he was the Director of Planning in Rwanda Biomedical Centre for 8 years. He actively participated in various successful grant applications like global fund (HIV, TB, and Malaria), World Bank, GAVI, Bill and Melinda Gates, CDC CoAg, and others. He led the COVID 19 preparedness and response interventions planning during the pandemic period. Michel is a Public Health expert with a master's degree from the University of Rwanda.

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Sara Hyde is a monitoring and evaluation and health information systems specialist. She has experience designing and strengthening data collection systems to improve the availability and use of data. She has supported governments and organizations to develop monitoring frameworks and systems, use data to better design programs, and strengthen the monitoring of health systems to ensure that programs are focused on identified needs. Sara has experience in portfolio and performance management, program development and implementation, health financing, and monitoring, evaluation, accountability, and learning.

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Pearl Opoku-Youngmann is a Liaison Officer with Global Financing Facility (GFF) in Ghana. She holds a Masters in Research and Public Policy. She has worked with the health sector for the past 10 years facilitating policy dialogue, project coordination, stakeholder management and human resource management. She seeks to strengthen health systems for increased access to health and social inclusion particularly for women, children, adolescents and vulnerable populations. She aims to continue supporting governments and clients to work collaboratively to achieve desired program results.

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Daniel Osei started his career as a national service personnel in 1990 as a finance officer for the National Traditional Birth Attendant project and the Health Research Unit funded by the USAID and DFID respectively. Throughout his career, he has managed projects funded by Gavi Alliance, DFID, UNICEF, UNFPA, WB, USAID, CDC, WHO and Global Fund.He moved to the Ministry of Health, headquarters where he managed the budget and financial analysis portfolio for both the planning and finance divisions. During this period, he was a member of the Ghana health sector reforms team. He was a member of one or more committees that implemented government financial management system. (PUFMARP, GIFMIS, PBB). For twelve years, led the planning and budget team as a Deputy Director at the Policy Planning Monitoring and Evaluation Division of Ghana Health Service.

Maria Patyna
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Over the past 15 years, Maria has led policy design, programme implementation and partner engagement to address some of the world's most pressing health challenges. Currently at Gavi, she oversees partner engagement and investments on health and immunization financing-related issues. In previous roles at Gavi, she has led the country team, designed strategies and policies, and led the monitoring, reporting and evaluation of Gavi's immunisation financing work. Prior to Gavi, she has worked at the Stop TB Partnership and at the WHO Immunization Department supporting countries in accessing essential health technologies.

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20 years of professional experience, within the health and development arena. In the last 10 years, played a central role in operationalizing and implementing previous and current Global Fund policies for 'Sustainability, Transition and Co-Financing. Previous experience has been within the United Nations System and Global Health Initiatives, (WHO, UNAIDS UNITAID). Lisa has led efforts to standardized data on disease expenditures, and developed systems to better track resources.

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Mr. Reuben is a global health and development economist with a passion to optimize alignment, efficiency, and accountability of HIV/health resources. He has extensive experience leading and managing portfolio of activities incl. economic evaluations, resource tracking, costing, and use of data for strategic planning. He currently leads the financial sustainability portfolio at PEPFAR HQ and serves as the chief representative leading the multilateral resource alignment collaboration with Global Fund, UNAIDS and other partners. He holds MA degrees in Economics & Finance.

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Siguire Salif
Directeur des ressources humaines,
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Directeur des ressources humaines du ministère de la santé depuis 2019. Avant cela j'ai travaillé pendant 6 ans au ministère de la fonction publique à la direction générale de la fonction publique. Je suis gestionnaire des ressources humaines mais aussi juriste. Je suis titulaire d'un Master en gestion des ressources et d'une maîtrise en droit obtenu à l'Université de Ouagadougou. Dans ma carrière j'ai participé à plusieurs travaux sur les outils de gestion des ressources humaines publiques. J'ai aussi animé plusieurs sessions de formation au profit des acteurs du public que du privé. J'accompagne aussi les jeunes étudiants dans leur préparation pour la recherche de l'emploi. Notons aussi que j'ai été lauréat du prix de meilleur directeur des ressources humaines du Burkina Faso pour les RH Awards en septembre dernier.

Brian Sampram
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For the past eleven years Brian Sampram has been employed by the Ministry of Health in the Planning and Budget Unit of the Policy Planning Monitoring and Evaluation Directorate. He has a Bachelor of Arts (Hons) in Economics and is currently studying to complete a Master of Health Economics. He has certified trainings in Health Economics and Performance and Programme Budget (Crown Agents). His current position is Senior Health planner. As part of his job duties, he is responsible for the following: 1. Development of a Ministry of Health Work Program document; 2. Budget execution, tracking, and trend analysis on the flow of funds for Compensation, Goods and Services, and Capital Expenditures on the Ghana Integrated Financial Management Information System (GIFMIS); 3. Coordination of the Ministry of Health's Program-Based Budget development and training; 4. Resource Mapping. His areas of interest are Budget Development and Health financing.

Nuhu Mahmud Sani
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My Name is Nuhu Mahmud Sani, I have Masters in Development Studies and Bsc Economics, Male, from Nigeria, 46 years, Married, presently the Budget Manager (Budget Office of the Federation)

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Health economist with 15 years of supporting bilateral, multilateral, NGO, and country government programs with data systems, analysis, and decision tools for better health resource allocation. Co-founder for Cooper/Smith, residing in Lilongwe, Malawi.

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Serena Sonderegger provides support to multi-country projects and strategic advice to CHAI's technical advisors embedded in Ministries of Health, Finance, and insurance agencies, with a focus on aid coordination, strengthening and institutionalizing resource tracking, and provider payment reform. Ms. Sonderegger has 8 years of experience providing technical assistance to NGOs and governments in Sub-Saharan Africa, Asia, and Latin America.

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Cicely leads the GFF's portfolio of work supporting health resource mapping and expenditure tracking. She also provides technical support to GFF countries in developing and implementing health financing strategies in support of universal health coverage (UHC). Cicely is the GFF Focal Point for Ghana. She lives in Washington, DC.

Dr. Francis Nwachukwu Ukwujie
Health Economics and Health Financing,
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Francis Nwachukwu Ukwuije is a Medical Doctor and a Health Economist with the World Health Organization Nigeria. He holds a degree in Medicine and Surgery from Nnamdi Azikiwe University Awka, Nigeria, a Masters in Health Policy Planning and Financing (HPPF) from the London School of Hygiene and Tropical Medicine (LSHTM) and London School of Economics (LSE), and Advanced Health Economics Certificates from Oxford University, United Kingdom, and Harvard T.H Chan School of Public Health. Prior to joining the WHO, Dr. Ukwuije was the Senior Health Economist and Pioneer Head, Healthcare Financing Equity and Investment Branch, FMOH. He also led Health Economics Research for 2 years at the Population Council from 2012 to 2014. A recipient of the UK Chevening Scholarship and the Nigerian President's Honours Award, he specializes in setting up and successfully managing complex country health financing systems, including decentralized pro-poor financial risk protection mechanisms in developing countries. Dr. Ukwuije has significantly contributed to the progress so far made by Nigeria towards Universal Health Coverage (UHC).

Dr. Elisabeth Uwanyiligira
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Ellen leads the Health Financing work program in the GFF. Before joining the GFF she was an associate professor of Health Economics at Erasmus University Rotterdam, Netherlands. She holds a PhD from the same university (2009).

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Pierre Yameogo
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Dr Pierre Yaméogo est Médecin Spécialiste en santé publique avec 17 ans d'expérience professionnelle dans le secteur de la santé publique. Il a occupé entre 2017 et 2022, le poste cumulé de Secrétaire Technique en charge de la couverture sanitaire universelle et de One Health. Depuis 2016 il assure la coordination nationale de la politique de gratuité des soins pour les femmes et les enfants de moins de 5ans. Récemment en juin 2022, il occupe le poste de secrétaire technique des réformes sur le financement de la santé dans le cabinet du ministre chargé de la santé. Dr Pierre est titulaire d'un Master en Santé Publique de l'Université de Genève (2013) ; son mémoire était axé sur la gratuité des soins au profit des femmes et des enfants pour plus d'équité d'accès aux soins de santé de base. Il est titulaire de Doctorat d'Etat en Médecine de l'Université de Ouagadougou, Burkina Faso (2005).

Saudatu Umma Yaradua
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Throughout her career in medicine and research, Umma Yaradua's greatest aspiration has been to combine her unique skills as a gynecologist and obstetrician with her interest in public policy. She employs her extensive clinical training and experience in women's health as to identify areas of gender inequality and to manage health risks particular to women, including maternal mortality. Since 2016, Dr. Yaradua has been serving as the Global Financing Facility Liaison Officer with the World Bank where she provides support to the Nigerian government as it implements its RMNCAH+N Investment Case. She has also worked as a consultant with the Health in Africa Initiative of the International Finance Corporation of the World Bank Group. Dr. Yaradua trained at the University of Ibadan. She graduated with a Master of Science in Public Health and a Diploma in Reproductive and Sexual Health from the London School of Hygiene and Tropical Medicine in 2006.

Annex 5 – Posters

Poster 1: Abt Associates Expertise in Health Resource Tracking

Implementation: Using Data to Inform Decision-Making

In **Benin**, data on immunization expenditure was **packaged in a policy brief** to inform discussions on sustainability of immunization financing, and the related issue of spending on routine versus campaign immunization efforts.

FIGURE 3. PERCENT GOVERNMENT CONTRIBUTION TO IMMUNIZATION SPENDING IN BENIN AND NEIGHBORING COUNTRIES[3]

Country	Percent of government contribution
Côte d'Ivoire 2013	56%
Benin 2015	32%
Sierra Leone 2013	28%
Niger 2014	27%
Burkina Faso 2013	19%
Liberia 2011	16%
DRCongo 2014	6%

FIGURE 5. IMMUNIZATION EXPENDITURE IN BENIN —ROUTINE AND CAMPAIGN, USD

$13,860,265 2014
$8,135,484 2015
ROUTINE

$1,866,345 2015
$875,624 2014
CAMPAIGN/ SUPPLEMENTAL

Impact: Using Data to Inform Decision-Making

- Raise Funds for Health

- Allocate Resources to Priority Health Services

- Reduce Financial Risk for those Seeking Care

- Inform Health Planning

TRACKING HEALTH EXPENDITURES FOR SUSTAINABLE DATA-DRIVEN HEALTH FINANCING
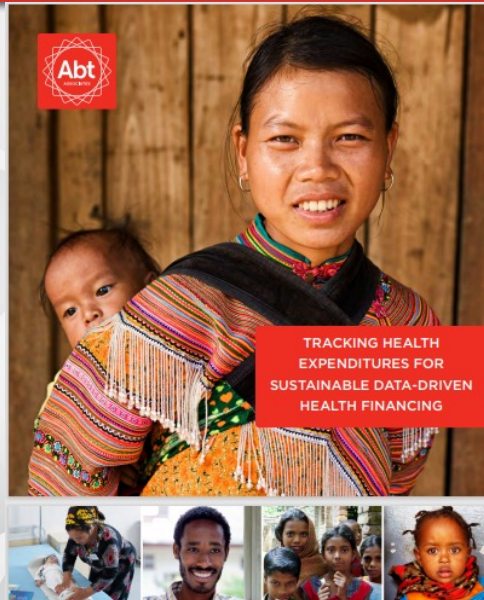
HA data in **Ethiopia** showed low spending on primary health care, which contributed to the decision to introduce user fee retention in health facilities, and also catalyzed the development of community-based health insurance schemes.

In **Namibia**, a comparison of spending on reproductive health and HIV/AIDS, vis-à-vis national health priorities, led to reallocation of additional resources for reproductive health, to better align with the national health strategy.

Lessons: Using Data to Inform Decision-Making

To promote the use of resource tracking data for decision-making:

- Ensure **data is demand-driven**: involve policymakers prior to data collection to understand policy priorities

- Co-develop concise, **user-friendly materials tailored to the audience**, to ensure relevance to policy needs

- **Use champions** to help instill a culture of daily use of data for decision-making

- Prioritize and adequately resource **dissemination of HA data** at appropriate venues

- **Institutionalize** not just data production but also data dissemination and use

Collaboration: Using Data to Inform Decision-Making

Abt Associates has supported resource tracking around the globe in partnership with USAID, the Global Fund, Bill & Melinda Gates Foundation, WHO, and others.

Current efforts include:

- **Global Fund-**funded activity to strengthen local capacity to use Health Accounts data to inform health policy and planning decisions in Kenya, Uganda and Tanzania

- **USAID-**funded global activity on the Local Health System Sustainability Project (LHSS), in collaboration with Medicines, Technologies and Pharmaceuticals Program (MTaPS), to increase the accuracy of pharmaceutical expenditure tracking (also in collaboration with WHO)

**Improving lives knows no boundaries.
When others say it can't be done, we say it can.**

From advancing positive health outcomes and just environmental and social policy to crafting digital, data-centric solutions and bolstering economic security, Abt Associates partners with clients and communities to tackle their most complex challenges.

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RÉTRO INFORMATION SUR LA GRATUITÉ DES SOINS
Bulletin n°7- de janvier à mars 2022

La Rétro Information Sanitaire participe au processus de formation continue et d'amélioration des services de santé. Dans cette dynamique, le Secrétaire Technique en charge de la marche vers Couverture Sanitaire Universelle (ST-CSU) produit mensuellement un bulletin à l'intention des acteurs du programme national de Gratuité des soins pour la prise de décision. Les données proviennent de la plate-forme eGratuité et des rapports des organisations non gouvernementales (ONG) en charge du contrôle de l'effectivité de la gratuité. Ce septième numéro présente l'évolution des indicateurs de janvier à mars 2022.

👍 Taux de complétude satisfaisant des factures transmises des CSPS/CM avec un niveau national de 89,2% (Figures 2-3)

👍 Stabilité des coûts moyens mensuels des prestations au cours du premier trimestre 2022 (Figures 9-19)

👍 Transmission des données de commandes et de péremptions MEG des CSPS/CM/CMA en plus des données des DRD (Figures 19)

👎 Faible complétude dans la transmission des factures des CMA/CHR/CHU ainsi que celle de la région du Sahel (Figures 1-4)

👎 Faible taux de complétude dans la transmission des données sur les commandes et les livraisons de MEG ainsi que sur les péremptions de MEG (Figures 16-19)

👎 Régression de la complétude dans la transmission des données sur les dettes CAMEG (Figure 20-21)

SUIVI DES INTERRUPTIONS DE LA PLATEFORME EGRATUITE

La plateforme egratuite constitue la base de données de la stratégie nationale de la gratuité des soins. Elle est hébergée au Burkina Faso dans le cloud national qui est géré par l'Agence Nationale de promotion des TIC (ANPTIC). Des interruptions de service interviennent par moment rendant inaccessible la plateforme egratuite. Cette section du bulletin présente l'évolution hebdomadaire du nombre de jours d'inaccessibilité de la plateforme. De la première à la vingt-deuxième semaine de l'année 2022, la plateforme a été indisponible sur huit (08) jours répartis sur 5 semaines.

Figure 1 : Nombre de jours d'interruption de la plateforme egratuité par semaine

THINK
WELL
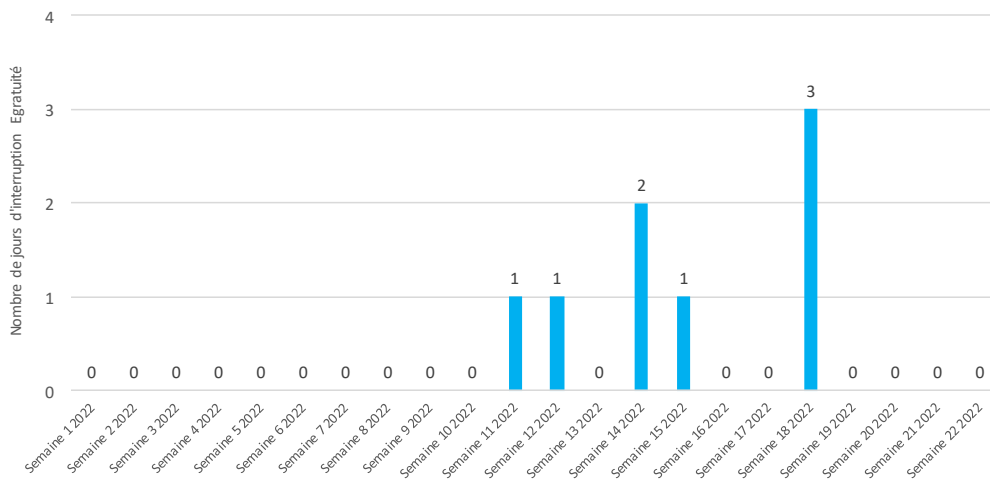
FACTURATION

Afin de justifier l'utilisation des fonds reçus et bénéficier de nouveaux fonds pour la mise en œuvre de la gratuité des soins, les formations sanitaires produisent chaque mois des rapports mensuels d'activités (RMA). Ces RMA constituent les factures de la gratuité. Ils recapitulent le volume et le coût des prestations offertes aux cibles. Le taux de transmission des rapports des CSPS/CM au niveau national a oscillé entre 87,5% et 90% au cours de janvier à mars 2022. Huit régions ont enregistré des taux plus élevés que la moyenne nationale et les cinq autres se situent en deçà. Les régions du Centre-Ouest, du Plateau-Central et du Centre-Sud enregistrent les taux les plus élevés. La région du Sahel enregistre le plus faible taux de complétude (30,7%) sur la période de janvier à mars 2022.

Figure 2 : Complétude dans la transmission des RMA Gratuité des CSPS/CM par région
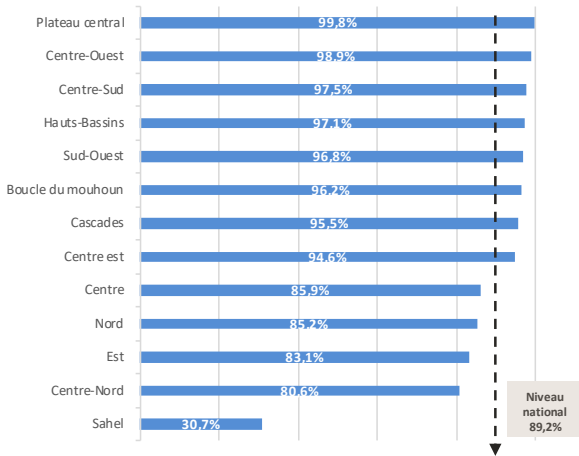
Figure 3 : Evolution mensuelle des RMA Gratuité des CSPS/CM
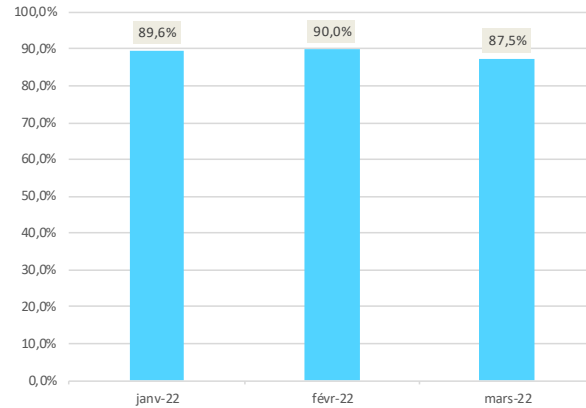
Le taux de complétude des rapports des CMA/CHR/CHU est relativement plus bas que celui des structures de soins primaires, oscillant entre 72,3% et 79,2% de janvier à mars 2022. Huit régions enregistrent un taux de complétude au-delà du niveau national et 5 régions sont en deçà du niveau national. Les régions du Sahel, de l'Est et du Nord sont celles qui enregistrent les plus faibles taux de complétude.

Figure 4 : Complétude dans la transmission des RMA Gratuité des CMA/CHR/CHU par région
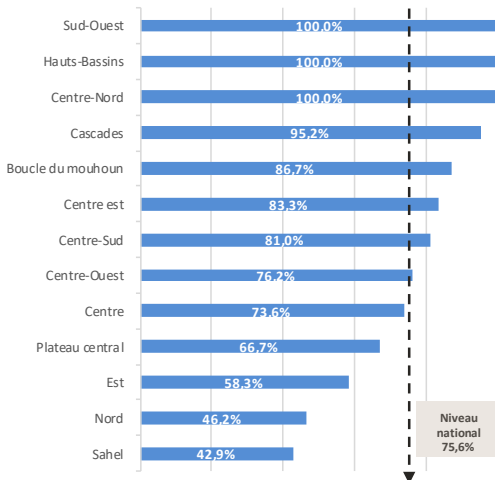
Figure 5 : Evolution mensuelle de la transmission des RMA Gratuité des CMA/CHR/CHU
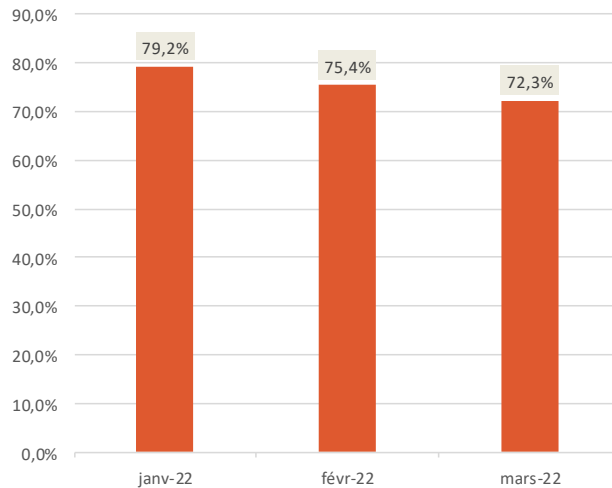
ACHAT DE SERVICE

La politique de gratuité des soins est financée principalement sur le budget de l'Etat qui prend en charge les coûts des prestations offertes gratuitement aux bénéficiaires dans les formations sanitaires. Le paiement des prestations s'effectue par des virements dans les comptes Trésor « gratuité » des districts sanitaires et des établissements de santé. Le virement du premier trimestre 2022 a couvert à 92% les factures transmises par les formations sanitaires. Les arriérés de paiement s'élèvent à 32 960 339 013 en fin mars 2022.

Figure 6 : Paiement des factures
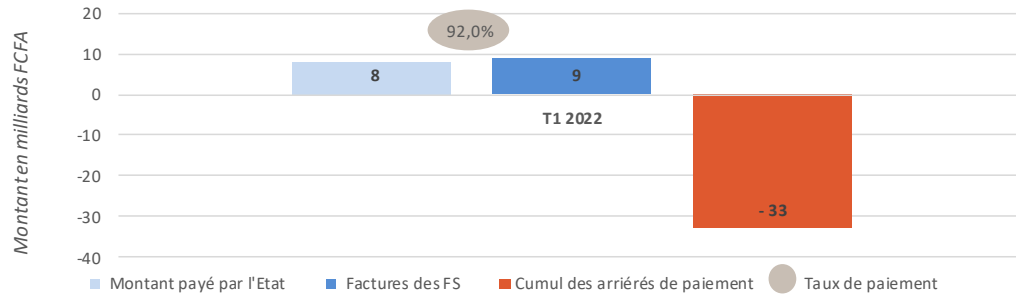
Le suivi de l'évolution des prestations permet de s'assurer de l'effectivité des recours aux soins, d'estimer les tendances d'utilisation des différents types de prestations selon les périodes en vue d'une meilleure organisation des services et la planification des besoins des structures sanitaires. En fin mars 2022, l'ensemble des groupes homogènes de prestations de soins gratuits a connu une baisse sauf le groupe du dépistage et de traitement des lésions précancéreuses du col de l'utérus qui a légèrement haussé. Cela peut être dû au niveau de complétude de mars qui était 3% inférieur aux taux des mois de janvier et de février.

Figure 7 : Suivi des prestations réalisées au niveau national
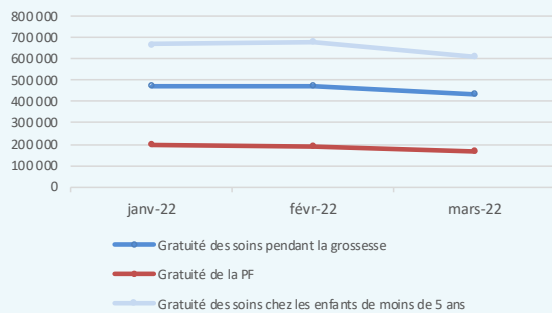
Figure 8 : Suivi des prestations réalisées au niveau national (suite et fin)
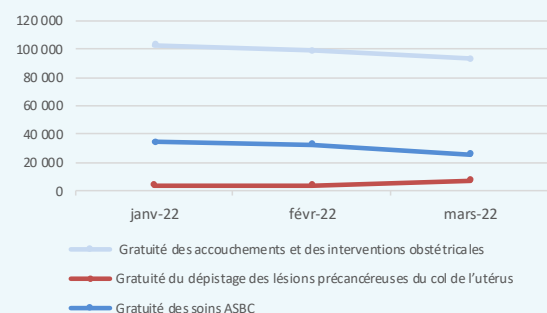
Le coût moyen est obtenu en divisant le coût total d'une prestation par sa quantité. Le suivi des coûts moyens permet de s'assurer de la stabilité et de la soutenabilité financière du programme de gratuité des soins. De janvier à mars 2022, il est constaté une quasi stabilité des coûts moyens des prestations. Les accouchements par voie basse (normaux et ceux assistés à l'aide d'instrument et/ou de produits) ont coûté en moyenne respectivement 5 000F, 22 000F et 49 500F au CSPS/CM, CMA et CHR/CHU.

Figure 9 : Coûts moyens accouchements par voie basse au CSPS/CM
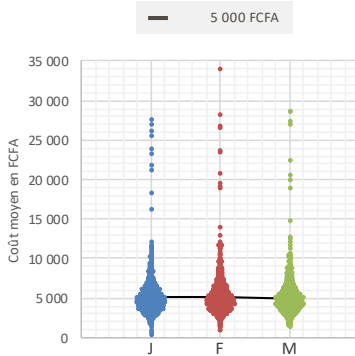
Figure 10 : Coûts moyens accouchements par voie basse au CMA
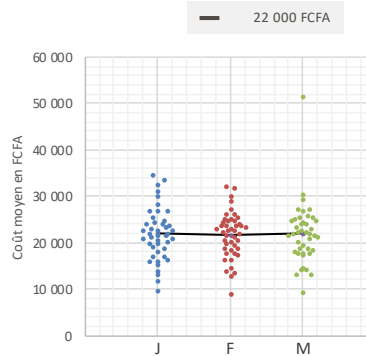
Figure 11 : Coûts moyens accouchements par voie basse au CHR/CHU
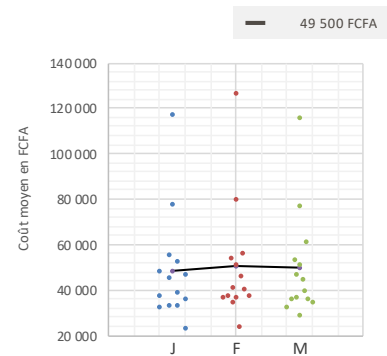
La césarienne a coûté 86 000F au CMA et 127 500 F dans les CHR/CHU. Les soins au profit des enfants ont coûté en moyenne 1 000 FCFA, 10 500 FCFA et 29 800 FCFA au CSPS/CM, CMA et CHR/CHU. Les soins et services de planification familiale ont coûté 1000 F au niveau CSPS/CM et 2 400 F au niveau CMA/CHR/CHU. Enfin, les soins par les ASBC ont coûté en moyenne 190 F.

Figure 12: Coûts moyens de la Césarienne au CMA
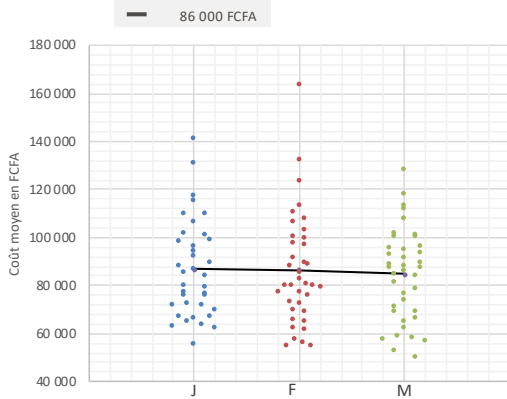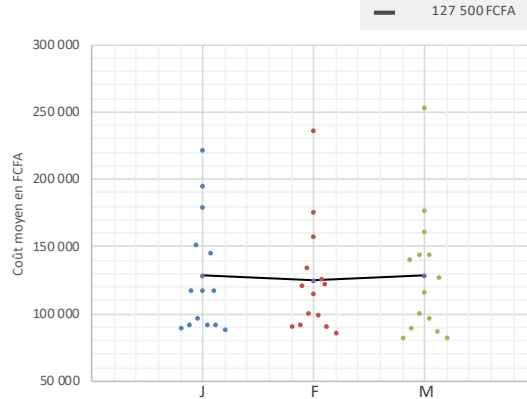

Figure 13 : Coûts moyens de la césarienne au CHR/CHU

Figure 14 : Coûts moyens soins enfants au CSPS/CM
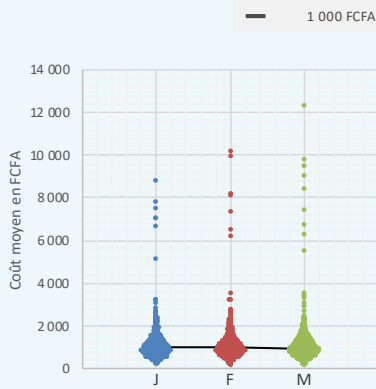
Figure 15 : Coûts moyens soins enfants au CMA
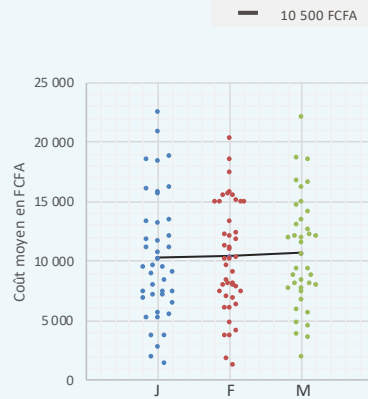
Figure 16 : Coûts moyens soins enfants au CHR/CHU
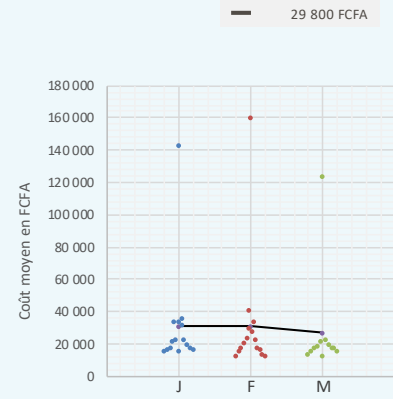
Figure 17 : Coûts moyens PF au CSPS/CM
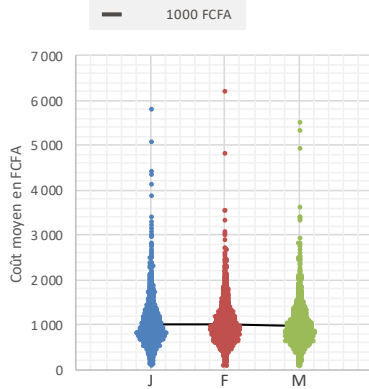
Figure 18 : Coûts moyens PF au CMA/CHR/CHU
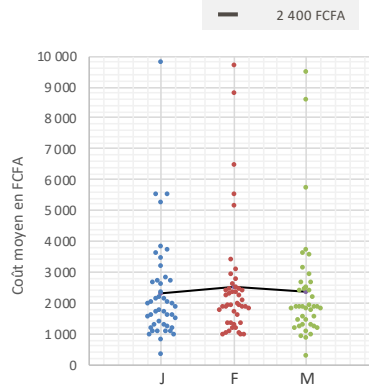
Figure 19 : Coûts moyens soins ASBC
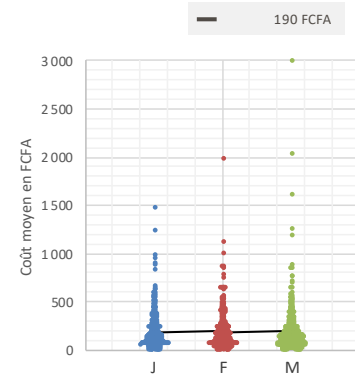
*Les données sur les commandes et les péremptions de MEG, les dettes CAMEG ne sont pas spécifiques à la Gratuité des soins. Cependant, leur suivi est nécessaire à la bonne marche de la stratégie de Gratuité des soins.

De janvier à mars 2022, en moyenne 16 districts sanitaires sur 70 ont transmis des données sur les commandes MEG. Comparativement à l'année 2021, cette moyenne est en baisse passant de 26 districts à 16. Le faible taux de transmission est également affecté par une mauvaise qualité des données transmises. En moyenne 17% des données transmises sont non exploitables de janvier à mars 2022. A l'instar de 2021, l'index de satisfaction globale (ISG) des commandes MEG est resté faible de janvier à mars 2022 et n'a pas atteint le seuil minimal souhaité de 80%.

Figure 20: Evolution de la répartition des districts selon la disponibilité des données sur les commandes MEG
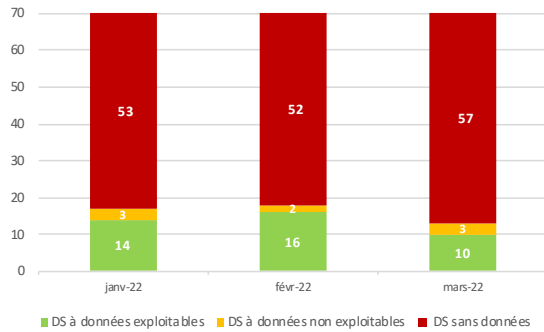
Figure 21 : Evolution mensuelle de l'Index de satisfaction globale (ISG) des commandes MEG
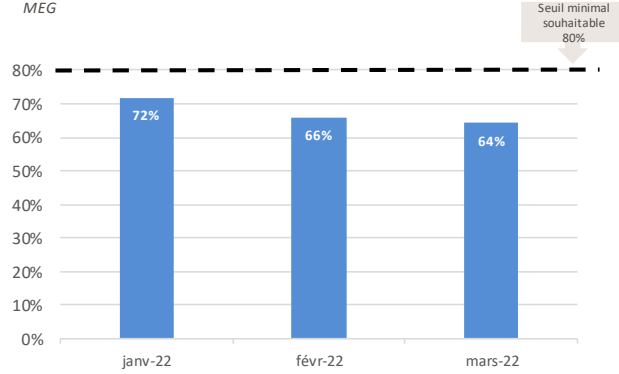
Le faible rapportage sur les données MEG est également constaté sur la notification des péremptions de médicaments. De 2021 au premier trimestre 2022, 2022, le nombre moyen de DRD transmettant des données mensuelles de péremption est passé de 11 à 9. Quatre districts transmettent également des données de péremption MEG des dépôts de leurs formations sanitaires. De janvier à mars 2022, la valeur des péremptions s'élève à 7 410 775 FCFA au niveau des DRD et 893 598 FCFA dans 39 CSPS/CM des quatre districts sanitaires.

Figure 22 : Valeur mensuelle (FCFA) des péremptions dans les DRD
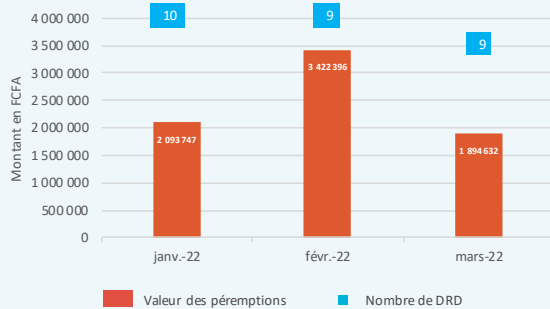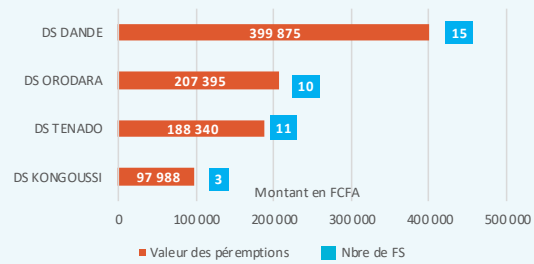

Figure 23: Valeur mensuelle (FCFA) des péremptions dans les dépôts MEG des CSPS/CM/CMA

La complétude des données transmises par la CAMEG sur les dettes des districts sanitaires et des hôpitaux va toujours décroissant. Le nombre de régions n'ayant aucune donnée est passée de trois (3) en 2021 à sept (7) au premier trimestre 2022. Le taux de complétude nationale s'élève à 7,5% en fin mars 2022. La dette totale quant à elle se chiffre à 6 443 050 504 FCFA en février au compte de 19 structures.

Figure 24: Complétude de la transmission des données sur les dettes CAMEG des DS et des hôpitaux
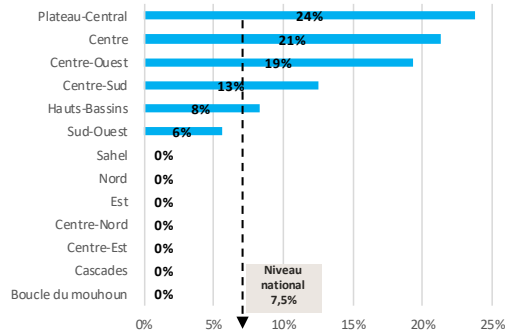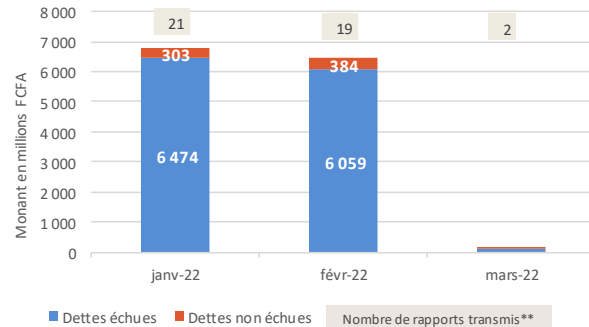

*Figure 25 : Dettes totales des DS et des hôpitaux envers la CAMEG*

**Nombre de rapports attendus = 85, soit 15 CHR/CHU + 70 DS

PRODUITS SANGUINS LABILES (PSL)

Les fonds de la gratuité servent également au paiement des coûts de production des poches de sang au profit des cibles de la gratuité. Ces fonds sont virés dans le compte Trésor Gratuité du Centre national de transfusion sanguine (CNTS) qui regroupe les centres régionaux de transfusion sanguine (CRTS) et les Dépôts préleveurs distributeurs de produits sanguins (DPD/PS). De janvier à mars 2022, la complétude des données transmises est de 100% pour tous les centres sauf pour le CRTS de Ouagadougou qui n'a transmis aucun rapport.

Figure 26 : Complétude dans la transmission des rapports par CRTS
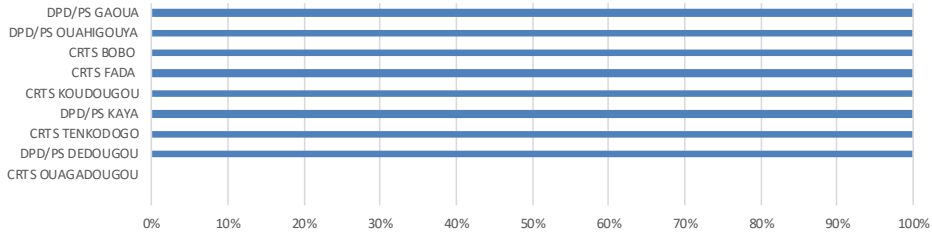
De janvier à mars 2022, le nombre total de PSL distribué est de 8898. Comparativement à 2021, le CRTS de Koudougou a surpassé celui de Bobo dans la distribution avec un besoin plus élevé des cibles femmes sur la période.
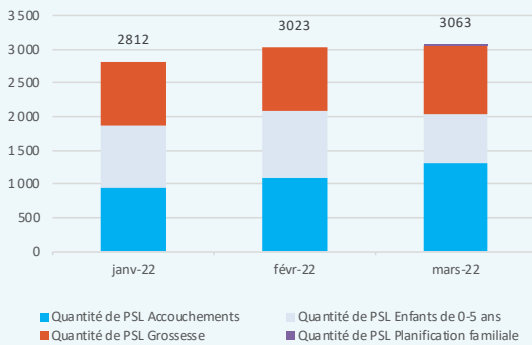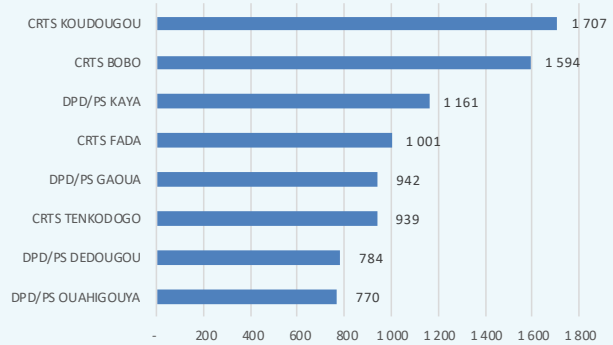
Figure 27 : Nombre de PSL distribués par mois

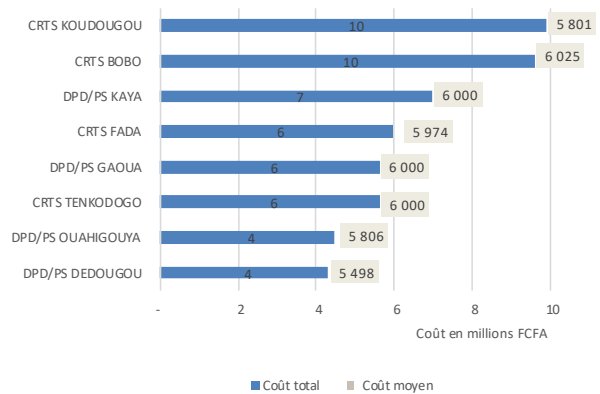*Figure 28: Nombre de PSL distribués par CRTS*

De janvier à mars 2022, les concentrés de globules rouges et les plasmas frais congelés ont été principalement les plus distribués par le CNTS. Le coût total des PSL distribués s'élève à 52 520 500 FCFA au niveau national avec le CRTS de Koudougou en tête et le DPD/PS de Dédougou enregistrant le plus faible montant. En terme de coût moyen de production, le DPD/PS de Bobo coûte le plus cher et celui de Dédougou le moins cher.

Figure 29 : Type de PSL distribués
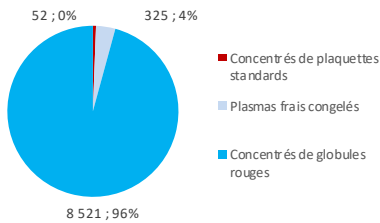
Type de PSL	Quantité totale	Coût total (FCFA)	Coût moyen de production (FCFA)
Concentrés de globules rouges	52	390 000	7 500
Plasma frais congelé	325	1 771 500	5 451
Concentrés de plaquettes standards	8 521	46 719 000	5 483
Examen pré-transfusionnels	7 280	3 640 000	500
Total PSL	8 898	52 520 500	5 903

Figure 30 : Coût total des PSL distribués

Poster 3: PEPFAR-Global Fund-UNAIDS-HIV Resource Alignment Collaboration

What is Resource Alignment?

- PEPFAR-Global Fund **bilateral** collaboration **established in 2017** and **trilateral** along with **UNAIDS in 2021**
- **Strengthens HIV resource tracking, harmonization** and **alignment** allowing for **sharing timely, consistent,** and **high-quality data** on the **totality of HIV investments**
- Informs **program planning**, **decision-making**, **efficiency**, and **sustainability** of the HIV response
- Harmonizes data across **all funding sources (PEPFAR, GF, Government** and **Other Funders)** to give a view of **totality of HIV investments** in a country
- Provides data at a **granular level** across two largest HIV donors
- Includes budgets, expenditures, epi, macro-econ, and sustainability data
- Covers **52 countries*** with joint GF and PEPFAR investments 2018 forward
- Tracks approximately **US$11bn+** in annual HIV investments
- **Routine** and **timely** data to inform planning and decision-making

* PEPFAR has presence in 55 countries, three of those countries (Brazil, Barbados, and Trinidad and Tobago) don't have GF

What is Resource Alignment? continued

- Global Fund and PEPFAR currently have a **bilateral data sharing and use MOU** in place for this collaboration
- Work ongoing to establish a **trilateral MOU** to include UNAIDS
- Initiative has **strong support across the three entities**, involves relatively **minimal LOE**, and **high ROI**
- Serves as a *"Global Good"*, not meant to replace existing HIV resource tracking efforts; instead, it strengthens the interoperability of sytems e.g., PEPFAR and Global Fund financial reporting, NASAs, GAM, etc. to harmonize data and make it available routinely to program planners and decision-makers
- Additionally, this collaboration also **does not expect partner country governments to make changes to their existing financial systems** to track disease specific data in a specific format

PEPFAR   The Global Fund   **UNAIDS**

Use Case

Improved Data Quality and Harmonization	Alignment and Efficiency between Funding Sources	Effective Planning and Decision-Making

- **DPs/Donors:**
  - GF-PEPFAR classifications fully harmonized
- **Multilateral:**
  - GF-PEPFAR classification harmonized with UNAIDS GAM followed by NASA
- **National:**
  - Feeding into HIV resource tracking and resource planning activities
- **Cross organization**
  - w/ WHO, WBG/GFF
- **Private Sector HIV landscape**
	- Provides **totality of HIV funding landscape** for a country
	- Improves visibility on **Domestic Government HIV financing**
	- Routine granular data allows for **trends** and conduct **deep-dives**:
	  - Commodities
	  - HRH
	  - Health Systems
	  - Beneficiary Populations
	  - Service Delivery Modalities
	- Enables **integrated analytics**
	  - Program data/outputs
	  - Macro-fiscal
	  - Cost analysis
		- **DPs/Donors planning cycles**
		  - GF grant cycle, TRP
		  - PEPFAR C/ROP
		- **Joint national planning and coordination**
		  - National planning NSP, Health Sector, Resource Needs, Investment Case, Resource Allocation
		  - Sustainability of the national HIV response
		  - Increasing domestic leadership and resource mobilization

PEPFAR   The Global Fund   **UNAIDS**

Trends in Budget Allocation and Expenditures

Figure D1: Trends in Total Budget Distribution by Funder (Millions)

Distribution of 2020 Total Budget
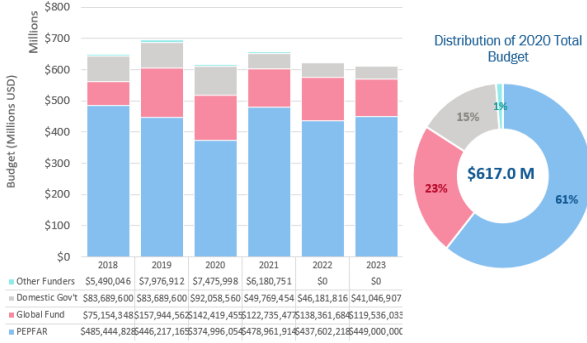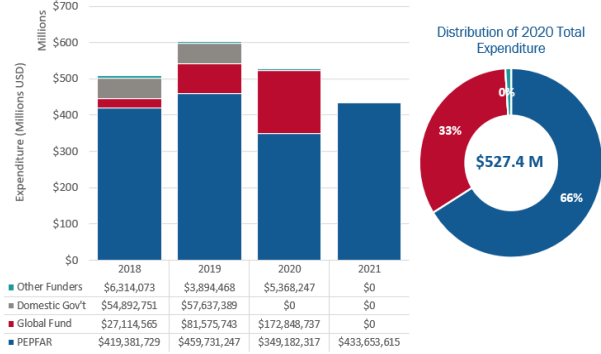
$617.0 M

- 61%
- 23%
- 15%
- 1%

	2018	2019	2020	2021	2022	2023
Other Funders	$5,490,046	$7,976,912	$7,475,998	$6,180,751	$0	$0
Domestic Gov't	$83,689,600	$83,689,600	$92,058,560	$49,769,454	$46,181,816	$41,046,907
Global Fund	$75,154,348	$157,944,562	$142,419,455	$122,735,477	$138,361,684	$119,536,033
PEPFAR	$485,444,828	$446,217,165	$374,996,054	$478,961,914	$437,602,218	$449,000,000

Figure D2: Trends in Total Expenditure Distribution by Funder (Millions)

Distribution of 2020 Total Expenditure

$527.4 M

- 66%
- 33%
- 0%

	2018	2019	2020	2021
Other Funders	$6,314,073	$3,894,468	$5,368,247	$0
Domestic Gov't	$54,892,751	$57,637,389	$0	$0
Global Fund	$27,114,565	$81,575,743	$172,848,737	$0
PEPFAR	$419,381,729	$459,731,247	$349,182,317	$433,653,615

HIV Funding by Source and Elements

Figure C1: Budget Distribution by Program Areas and Funder, 2022

	Program Management	Above Site Programs	Programs
PEPFAR	$37,694,754	$27,650,955	$372,256,509
Global Fund	$5,704,035	$3,708,904	$128,948,745
Domestic Gov't	$-	$23,685,148	$22,496,668
Other Funders	$-	$-	$-
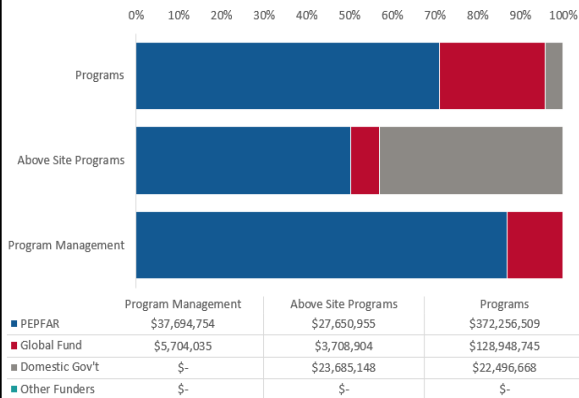
Figure C2: Budget Allocation by Funder, 2022

	Other Funders	Domestic Gov't	Global Fund	PEPFAR
Care and Treatment	$-	$8,176,590	$92,084,906	$233,867,356
HIV Testing Services	$-	$1,412,960	$17,989,985	$36,041,057
Prevention	$-	$12,907,118	$10,961,815	$75,940,144
Socio-economic (incl. OVC)	$-	$-	$7,912,039	$26,407,952
Above Site Programs	$-	$23,685,148	$3,708,904	$27,650,955
Program Management	$-	$-	$5,704,035	$37,694,754
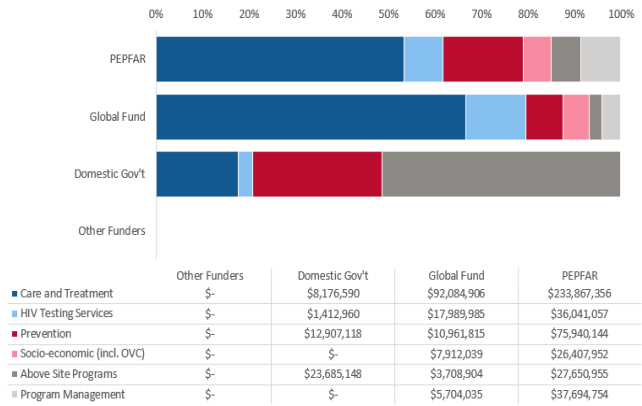
Granularity on Commodities and Systems Investments

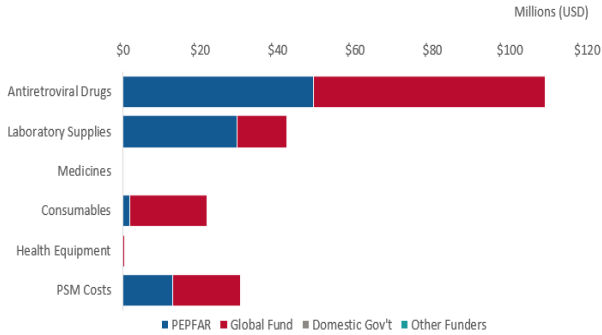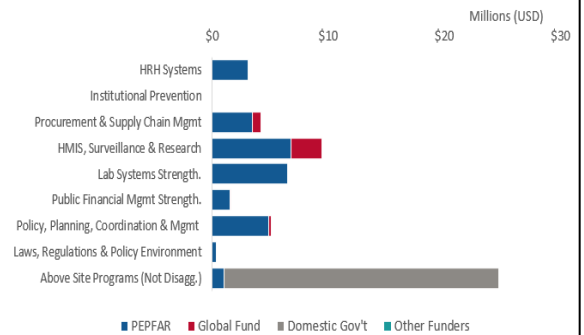Figure C7: Commodity Budget by Funder, 2022

Figure C8: Above Site Budget by Funder, 2022

Understanding Budget Allocation vs Expenditures

Figure D3: Total Budget Allocation vs Expenditure by Funder, 2020
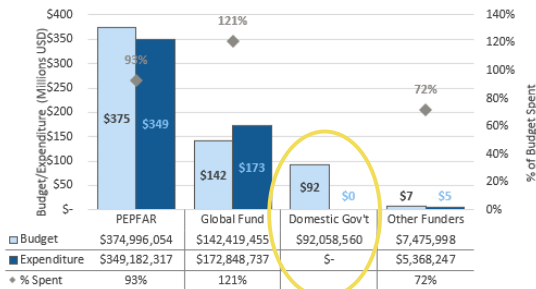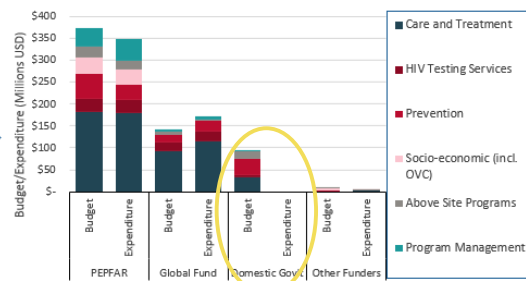
Figure D4: Total Detailed Budget Allocation vs Expenditure by Funder, 2020

Note: Figure D3 and D4 will populate for Domestic Gov't and Other Funders only when disaggregated budget and expenditure data are available

Use Case

Improved Data Quality and Harmonization	Alignment and Efficiency between Funding Sources	Effective Planning and Decision-Making

- **Donors:**
  - GF-PEPFAR classifications fully harmonized
- **Multilateral:**
  - GF-PEPFAR classification harmonized with UNAIDS GAM followed by NASA
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  - Feeding into HIV resource tracking and resource planning activities
- **Cross organization**
  - w/ WHO, GFF, World Bank,
- **Private Sector HIV landscape**
	- Provides **totality of HIV funding landscape** for a country
	- Improves visibility on **Domestic Government HIV financing**
	- Routine and granular data allows to view **trends** and conduct **deep-dives**:
	  - Commodities
	  - HRH
	  - Health Systems
	- Enables **integrated analytics**
	  - Program data/outputs
	  - Macro-fiscal
	  - Cost analysis
		- **Donor planning cycles**
		  - GF grant cycle, TRP
		  - PEPFAR C/ROP
		- **Joint national planning and coordination**
		  - National planning NSP, Health Sector, Resource Needs and Investment Case
		  - Sustainability of the national HIV response
		  - Increasing domestic leadership and resource mobilization

PEPFAR · The Global Fund · UNAIDS

Harmonizing resource tracking exercises

Experiences from the Governments of Malawi and Zimbabwe

About Clinton Health Access Initiative (CHAI)

- The Clinton Health Access Initiative (CHAI)'s Health Financing Program provides technical assistance to governments in low- and middle-income countries to strengthen health financing systems and implement reforms to move towards universal health coverage

- Since 2011, CHAI has worked at the invitation of governments in 12+ governments in strengthening and institutionalizing resource tracking, including:
    - Technical assistance for resource mapping and expenditure tracking (RMET) processes
    - Harmonization and institutionalization of joint RMET-HA process in Malawi, Zimbabwe, and Ethiopia (in progress)

- CHAI collaborates with governments, WHO, and GFF/World Bank on RMET and harmonization efforts, including documenting harmonization processes in Malawi and Zimbabwe
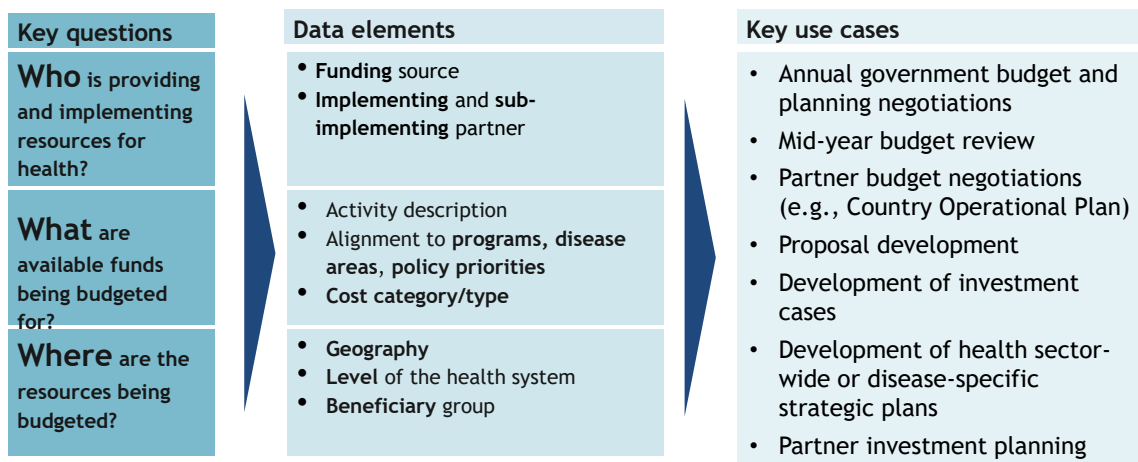
Contact information:

- Serena Sonderegger
  (ssonderegger@clintonhealthaccess.org)

- Meg McCarty (mmcarty@clintonhealthaccess.org)

Countries where CHAI has supported government-led RMET and RMET-HA harmonization

- ■ Country where CHAI has supported RMET-HA harmonization
- ■ Other countries where CHAI has supported RMET
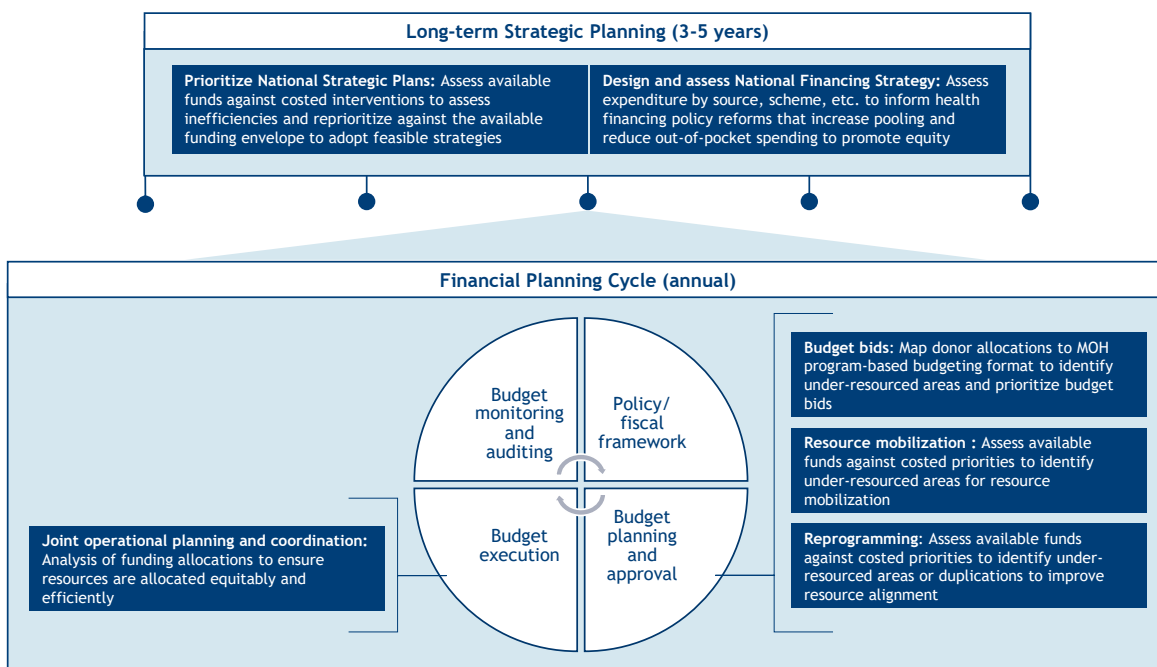- ■ Other countries where CHAI has offices
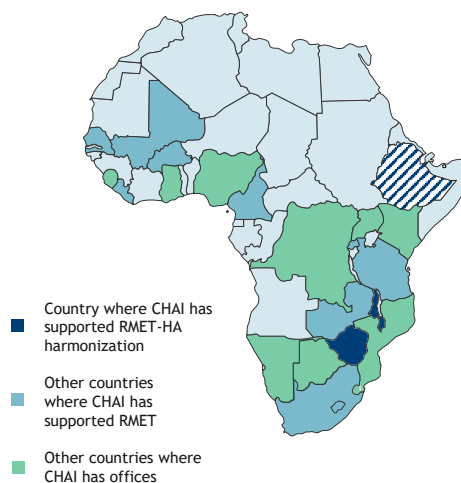
Process: Resource Mapping and Expenditure Tracking

- CHAI has supported governments to strengthen routine resource mapping exercises that generate financial data used for joint planning, aid alignment, and resource mobilization. These are typically:
  - Focused on forward-looking budget data (sometimes expenditure data) from government and development partners
  - Tailored to a country's fiscal year and strategic planning processes and categories
  - Can be sector-wide or focused on specific disease/program area depending on needs/use cases

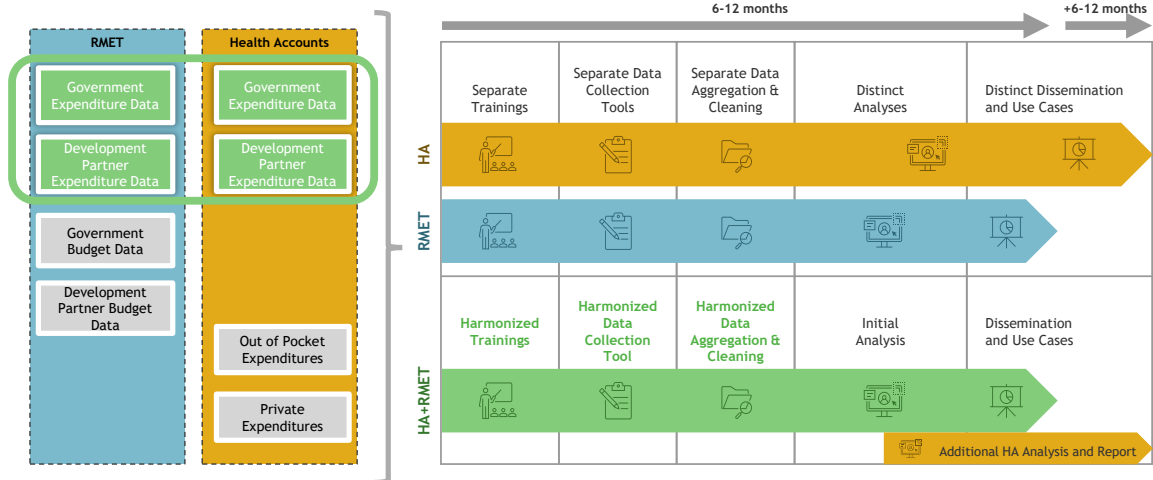- RMET maps information on who, where, and what health investments are budgeted for, e.g.,:

Key questions	Data elements	Key use cases
Who is providing and implementing resources for health?	• **Funding** source • **Implementing** and **sub-implementing** partner	• Annual government budget and planning negotiations • Mid-year budget review • Partner budget negotiations (e.g., Country Operational Plan) • Proposal development • Development of investment cases • Development of health sector-wide or disease-specific strategic plans • Partner investment planning
What are available funds being budgeted for?	• Activity description • Alignment to **programs, disease areas**, **policy priorities** • **Cost category/type**	
Where are the resources being budgeted?	• **Geography** • **Level** of the health system • **Beneficiary** group	

Use Cases of Resource Mapping and Expenditure Tracking

Long-term Strategic Planning (3-5 years)

Prioritize National Strategic Plans: Assess available funds against costed interventions to assess inefficiencies and reprioritize against the available funding envelope to adopt feasible strategies

Design and assess National Financing Strategy: Assess expenditure by source, scheme, etc. to inform health financing policy reforms that increase pooling and reduce out-of-pocket spending to promote equity

Financial Planning Cycle (annual)

Budget monitoring and auditing

Policy/ fiscal framework

Budget execution

Budget planning and approval

Joint operational planning and coordination: Analysis of funding allocations to ensure resources are allocated equitably and efficiently

Budget bids: Map donor allocations to MOH program-based budgeting format to identify under-resourced areas and prioritize budget bids

Resource mobilization : Assess available funds against costed priorities to identify under-resourced areas for resource mobilization

Reprogramming: Assess available funds against costed priorities to identify under-resourced areas or duplications to improve resource alignment

Promising Practice: Harmonization of Resource Tracking Exercises

In Malawi and Zimbabwe, and in process in Ethiopia, harmonization has involved combined **trainings** and **data collection, aggregation,** and **cleaning** for overlapping government and partner budget and expenditure data required from RMET and Health Account (HA) exercises, as well as the National Aids Spending Assessment (NASA) in Malawi.

Overview of Harmonization Process Undertaken by Governments of Malawi and Zimbabwe

1	2	3	4	5
Stage 1: Assess data use cases and landscape resource tracking	Stage 2: Determine the scope and objectives for harmonization	Stage 3: Define data elements to meet use cases	Stage 4: Adapt resource tracking process to meet objectives	Stage 5: Test, iterate, and improve approach over time

Continuous Stakeholder Engagement and Optimization of Use Cases
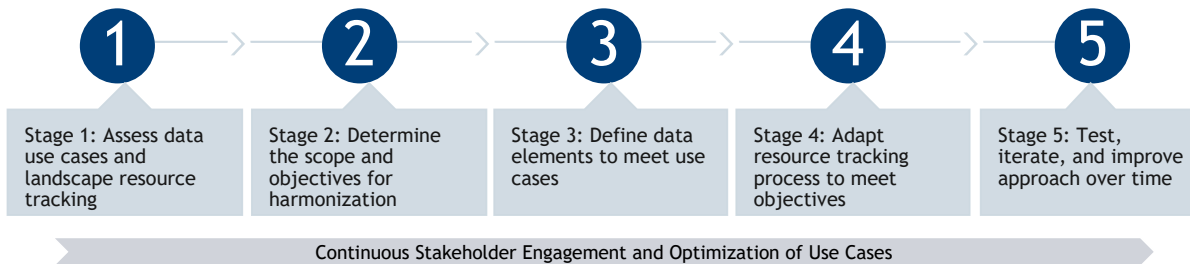
Stage 1. MOH described existing processes; and where and by whom budget and expenditure data was used in policy, planning and management.

Stage 2. Assessed if harmonization could create efficiencies and advance institutionalization; and whether harmonization would be feasible and desirable for all stakeholders.

Stages 3 and 4. With input from technical partners (e.g., WHO, PEPFAR, WB, CHAI), prepared the tools and processes for the implementation of harmonized resource tracking, ensuring the data collected would be relevant for use cases and easy to provide; and aligned timelines, teams, and tools for data collection, analysis, and use.

Stage 5. Routine implementation and improvement of resource tracking to ensure continued relevance and integration with other financial processes.

This process is described in a forthcoming Resource Guide developed in collaboration with the Governments of Malawi and Zimbabwe as well as GFF and WHO-AFRO

Harmonizing Resource Tracking
A RESOURCE GUIDE FOR COUNTRY IMPLEMENTATION

Malawi's Harmonized RMET-HA-NASA Data Collection Tool

Malawi tool available [here](#)

Zimbabwe tool available [here](#)
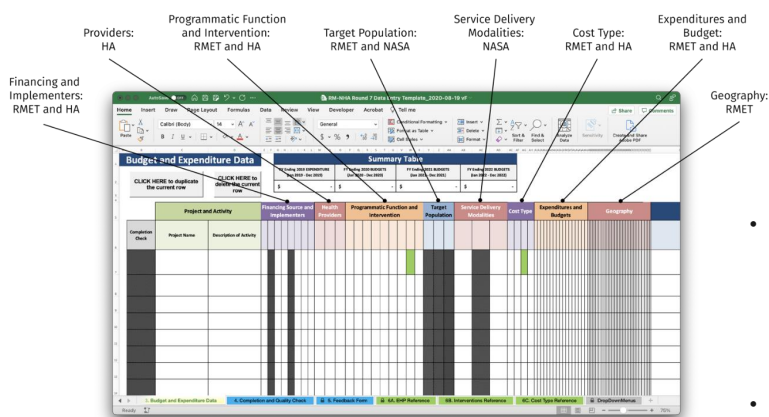
- **Data entry**: The harmonized tool has a single data entry sheet that collects budget and expenditure data elements for government and development partners for all exercises, using the RMET format aligned to Malawi's programmatic function and interventions, cost types, etc.

- **Quality check**: An additional sheet displays a preliminary summary and visualization of data entered in the tool to serve as a quality check, so data providers can review data entered.

- **Mapping for HA and NASA**: Data collected in the RMET format on the main data entry sheet are automatically mapped to HA and NASA classification systems in separate sheets.

- *Private spending data: Out-of-pocket and private sector data are collected separately for the NASA and HA exercises.*

Example 'cross-walk'/mappings in Zimbabwe of RM to HA classifications

RM Disease and Intervention Classifications (aligned to National Health Strategy) mapped to relevant SHA Healthcare Function and Disease Classification

RM	NHA	
Disease and Intervention	**HC**	**DIS**
Malaria Malaria Prevention	HC.6.4 Healthy condition monitoring programmes	DIS.1.3 Malaria
HIV Including STIs Treatment/Care - ART	HC.5.1.1 Prescribed medicines	DIS.1.1.1.1 HIV/AIDS
HIV Including STIs Treatment/Care - ART	HC.5.1.1 Prescribed medicines	DIS.1.1.1.1 HIV/AIDS
Tuberculosis, excluding HIV/TB TB Screening and diagnosis	HC.1.3.1 General outpatient curative care	DIS.1.2.1.1 Drug-Sensitive Tuberculosis (DS-TB)
Health Systems Strengthening Community Health System Strengthening	HC.7.1.3 Procurement & supply management	DIS.nec Other and unspecified diseases/conditions (n.e.c.)
Health Systems Strengthening Health Financing	HC.7.2 Administration of health financing	DIS.nec Other and unspecified diseases/conditions (n.e.c.)
Health Systems Strengthening Health Financing	HC.7.2 Administration of health financing	DIS.nec Other and unspecified diseases/conditions (n.e.c.)

RM Cost Categories (aligned with MOHCC accounting classifications) mapped to relevant SHA Factors of Provision and Capital Expenditure

RM	NHA	
Cost Category	**FP**	**HK**
Administration & Management (incl. salaries)	FP.5.2 Other items of spending	
Drugs, Medical Supplies and Other Health Commodities	FP.3.2.1.nec Other pharmaceuticals (n.e.c.)	
Administration & Management (incl. salaries)	FP.5.2 Other items of spending	
Health Worker Training - In-service	FP.3.3.1 Training	
Health Worker Salaries/Benefits	FP.1.1 Wages and salaries	
Infrastructure - Rehabilitation		HK.1.1.1.1 Residential and non-residential buildings
Infrastructure - Rehabilitation		HK.1.1.1.1 Residential and non-residential buildings

Note: this process requires extensive collaboration between government entities and technical partners (e.g., WHO, PEPFAR, and World Bank) involved in conducting the exercises being harmonized.

8

Example 'cross-walk'/mapping in Malawi of RM and HA classifications

RMET Programmatic Functions and Programmatic Interventions collected by the MOH for planning purposes (aligned to national classifications) are mapped to relevant SHA Health Care Functions and Disease Classifications

Programmatic Function	Programmatic Intervention	Health Care Function	SHA Code	Disease Classification
Environmental Health and Diarrheal Diseases	Disease Surveillance - Disease surveillance and vector control	Preventive care - Epidemiological surveillance and risk and disease control programmes	HC 6.5	Non-disease specific
Malaria	Prevention - ITNs/LLIN (Nets)	Prevention and public health services - Prevention of communicable diseases	HC.RI.3.3	Infectious and parasitic diseases - Malaria
Malaria	Prevention - Indoor Residual Spray (IRS)	Prevention and public health services - Prevention of communicable diseases	HC.RI.3.3	Infectious and parasitic diseases - Malaria
Malaria	Larvicides	Prevention and public health services - Prevention of communicable diseases	HC.RI.3.3	Infectious and parasitic diseases - Malaria
HIV Including Viral Hepatitis and other STIs	Prevention - Condoms	Medical goods (non-specified by function)	HC 5.1.3	Reproductive health - Contraceptive management
HIV Including Viral Hepatitis and other STIs	Prevention - Behaviour Change Communication/Community Mobilisation	Preventive care - Information, education and counselling programs	HC 6.1	Infectious and parasitic diseases - HIV/AIDS and other STDs
HIV Including Viral Hepatitis and other STIs	Treatment/Care - ART	Long-term care - Outpatient long-term care (health)	HC 3.3	Infectious and parasitic diseases - HIV/AIDS and other STDs
HIV Including Viral Hepatitis and other STIs	Prevention - Cotrimoxazole (Opportunistic Infections)	Curative care - Outpatient curative care	HC 1.3.1	Infectious and parasitic diseases - HIV/AIDS and other STDs
HIV Including Viral Hepatitis and other STIs	Lab Services - Screening and testing	Preventive care - Early disease detection programs	HC 6.3	Infectious and parasitic diseases - HIV/AIDS and other STDs
Neglected Tropical Diseases	Trypanosomiasis - Diagnosis and treatment of Trypanosomiasis	Preventive care - Early disease detection programs	HC 6.3	Infectious and parasitic diseases - Neglected tropical diseases
Non-Communicable Diseases	Non-Communicable Disease - Cancer	Preventive care - Early disease detection programs	HC 6.3	Noncommunicable diseases - neoplasms

Example mapping: The Programmatic Function/Intervention and the SHA Health Care Function align 1:1

Example mapping: Multiple Programmatic Interventions within one Programmatic Function align with the same SHA Health Care Function and Disease Classification

Example mapping: Multiple Programmatic Interventions within one Programmatic Function align with different SHA Health Care Functions and Disease Classifications

Example mapping: Multiple Programmatic Functions and Interventions align with the same SHA Health Care Function and multiple Disease Classifications

9

Advantages and Challenges Related to Harmonization

Complementarity in Data Use

Results are used by similar stakeholders that use both forward looking and expenditure data to enhance decision making

Reduced Workload for Ministry Personnel

Similar departments and personnel within the Ministry responsible for both resource mapping and Health Accounts, building ownership and accountability

Benefits of Harmonization in Malawi and Zimbabwe

Cost Saving

Combined HA and RMET data collection exercises has significant cost advantages from combined staffing and training

Reduced Burden of Data Submission

Partners receive numerous requests for same/similar data, combining data collection processes and tools reduces data requests on partners

Centralised Data Collection

A streamlined resource tracking process can create data demand and ensure consistency in outputs to inform multiple exercises and processes (e.g. partner and Government budgeting)

Drawbacks and ongoing challenges:

- Requires compromises in the types of data and level of detail that can be collected, particularly for HA exercise. It is important to focus on use cases and capacity to right-size the amount and granularity of data collected.
- Increases complexity of the exercise by adding additional classification systems, particularly as more exercises are harmonized
- Requires careful stakeholder management to juggle multiple funding streams, priorities, and timelines

10

Enabling a Digital Health Resource Tracking Platform in Liberia

MINISTRY OF HEALTH
Republic of Liberia

COOPER/SMITH

GLOBAL FINANCING FACILITY

BILL & MELINDA GATES *foundation*

ORGANIZATIONAL INFORMATION

COOPER/SMITH

Cooper/Smith works with governments, ministries of health, and international partners, helping them build, scale, and sustain digital health initiatives. We focus on data-driven solutions that harness science and research to design programs owned and institutionalized by government partners.

Our goal is improving the efficiency and efficacy of programs, resulting in healthier, more equitable lives. We have experience in strategic planning, evidenced-based resource allocation and planning, and empirical analysis

PERFORMANCE MANAGEMENT
- Metrics
- Monitoring
- Adaptive Learning

RESEARCH
- Design
- Ops approaches
- Evaluation
- Novel field methods

ANALYTICS
- Stats
- Data science
- Modeling
- Machine learning
- Geospatial

ECONOMICS AND HEALTH FINANCING
- Costing
- Efficiency analysis
- Cost-effectiveness
- Projections

DATA SYSTEMS
- Design
- Integration Architecture
- Mobile

Decision Support

ADDITIVE EXPERTISE
- Epidemiology
- HIV/TB
- Malaria
- RMNCH
- Policy development
- Tech deployment

Please see our website for more information or email us: contact@coopersmith.org

1

IMPLEMENTATION

Since 2019, Cooper/Smith, with support from GFF and the Gates Foundation, has provided support to the Health Financing Unit (HFU) at the Ministry of Health (MOH) in Liberia in three key areas:

1 Documented how to digitize the resource tracking process

To accomplish this, we:

Worked with key stakeholders to identify opportunities and pain points with the current system and process

Documented existing systems and technology that could be leveraged as part of a digital solution
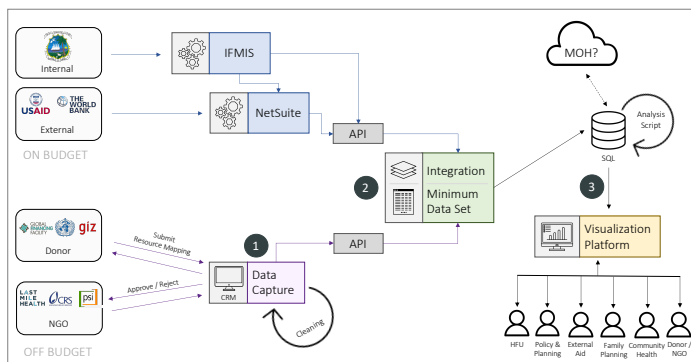
Figure 1. High-level schematic of a digital health resource tracking tool that leveraged existing systems and processes where possible, which was subsequently approved by key stakeholders within the MOH

2

TOOL, TECHNOLOGY AND SUPPORT

2 Developed a digital based resource tracking tool (Figure 2) based on the high-level schematic to track budget allocation, by activity down to sub-national levels bi-annually, which:

Supports the following units:

- Health Financing Unit
- Policy and Planning
- External Aid
- Community Health
- Nutrition
  + Donors & Implementing Partners

Addresses the following needs:

- Activity level budget allocation at district level
- Mapping to priority areas and key strategies (government and donors)
- Resource Mobilization
- Automated reporting

Figure 2. Landing page of the digital resource mapping platform currently in use by the HFU at the MOH in Liberia.

3

TOOL, TECHNOLOGY AND SUPPORT

(3) Created pre-determined reports that dynamically builds information (as it is submitted) into dashboards and reports so the HFU can easily respond to reporting requests from the government or external funders

> Pre-developed visuals were developed and can be filtered, reviewed, and easily exported for use in reports

Data for illustration purposes only

4

ADVANTAGES AND LIMITATIONS

Advantages

- Online platform allows for easy information flow between the MOH and Donors/Implementing Partners
- Minimum data set established on the back-end makes it easier to respond to MOH and donor reporting requirements
- Harmonization across activities within the MOH allows the information to be collected once and used many times
- Allows for automatic integration of existing systems (e.g., IFMIS or HMIS)
- Additional modules, such as expenditure tracking, can be added to the existing system

Limitations

- Off-the-shelf product, therefore, requires a small licensing fee
- Back-end customization needed; therefore, MOH needs a unit with necessary skillset for sustainability
- Platform optimized for web interface, therefore, offline functionality is limited

5

SUCCESS AND LESSONS LEARNED

MINISTRY OF HEALTH
Republic of Liberia   COOPER/SMITH   GLOBAL FINANCING FACILITY   BILL&MELINDA GATES foundation

Successes

Seamless workflow that allows Donors/IPs and MOH to seamlessly send health resource information back and forth

MOH capacitated to conduct their own resource mapping with limited intervention

Endorsement from key departments within the MOH along with Donor and IPs

Lessons Learned

Stakeholders across the MOH, MOF, Donors and IP need to be consulted before developing a digital solution

Collecting once and using many times not only creates efficiencies in the MOH but reduces Donor/IP reporting burden

Deploy systems that can readily interoperate with existing infrastructure to reduce technical debt in countries

For more information about our approach or how we can support your country, please reach out:
contact@coopersmith.org

6

Health Resource Tracking Tool Output report
FY 2017-2018 | 2018-2019 | 2019-2020

Introduction

- Resource tracking activities involves tracing financial flows from the sources to the ultimate use of these funds. Information generated allows countries to assess how well resources are allocated to country's priorities.

- The HRTT was developed to address challenges of producing up-to-date health expenditure estimates routinely and relevant for policy decision.

- 9 rounds conducted up to date: from 2010-2011 to 2019-2020 with exception of the FY 2012-2013.

- Overtime, HRTT has been able to include the private sector and better capture household expenditures.

- In the long term, the objective is to build interoperability features to allow data exchange between HRTT and other digital tools such as EMR and IFMIS.

1

Methodology

Data collection:

- Data entry directly into an excel template, done by individuals working in each institution/ organization and supported by a team of trained data collectors.
- Relied on secondary data as well reported through different data systems: HMIS, IFMIS
  - Private sector data (pharmacies and clinics) collected through HMIS.
  - Health facilities data (budget and expenditures) reported in the IFMIS.

Data cleaning:

- Harmonization of funding sources, agents, implementers, input categories across all levels of stakeholders and comparing reporting across funding sources and agents to identify double-counting.

2

Findings

THE vs THE as a share of GDP

Total Health Expenditures (in millions RWF):
- 2010-2011: 266,628 (6.5%)
- 2011-2012: 305,839 (6.5%)
- 2013-2014: 328,257 (5.8%)
- 2014-2015: 345,332 (5.6%)
- 2015-2016: 404,923 (5.9%)
- 2016-2017: 414,167 (5.4%)
- 2017-2018: 461,423 (5.6%)
- 2018-2019: 596,979 (6.4%)
- 2019-2020: 652,484 (6.7%)

Legend: Total Health Expenditures (in millions RWF) — THE as a % of GDP

3

Findings

Trends in the share of domestic and external sources, 2010-2020

Legend: Domestic sources as % of THE — External sources as % of THE

Trends in the share of Public, Private and External sources, 2010-2020

Legend: Public sources as a % of THE — Private sources as a % of THE — External sources as a % of THE

Domestic sources increased over the years; this increase is led by the increase in public sources

4

Findings

Domains of intervention by type of funding source, FY 2017-2018, 2018-2019 and 2019-2020

Legend:
- Administrative and support services
- Disease prevention and control
- Financial and geographical health accessibility
- Health Human resources
- Health sector planning and information
- Health Service Delivery
- MCH
- Policy development and health service regulation

5

78
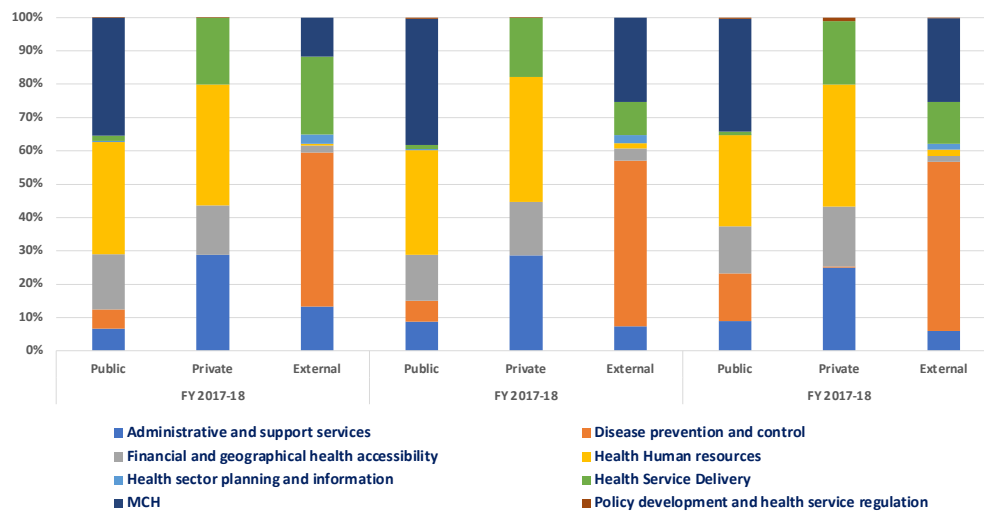
Limitations and Challenges

The introduction of HRTT allowed routine data collection of health expenditure estimates. Over the years, the tool evolved, however, there are still challenges to producing comprehensive and timely health expenditure to inform policy decisions.

1. **Data completeness and timely reporting:** it is essential that stakeholders report complete data and on time, and the reporting structure allows a detailed breakdown of information to allow a thorough analysis of expenditure data from the source to the final use/health service consumed.

2. **Staff turnover and capacity:** RT activities require dedicated staff to undertake regular training of respondents, supervision of data collection, cleaning, and validation of data, data analysis, and timely production of annual reports.

3. **Interoperability challenges:** the ability to exchange information between different systems (IFMIS, EMR, HMIS) is very limited and should be explored to simplify data collection and allow routine production of health expenditures.

6

Recommendations

Apply a thorough methodology for collecting and analyzing health expenditures: a consistent framework for measuring, tracking and monitoring resource flows will improve quality and comparison over the years.

Redesign the HRTT system and processes: review and adapt data collection templates to reflect data needs, strengthen data entry training & continuously engage the leadership of stakeholder's organizations to improve ownership and accountability of the reporting.

Improve staff retention and continuously build capacity

Explore the opportunity for interoperability across existing data systems.

7
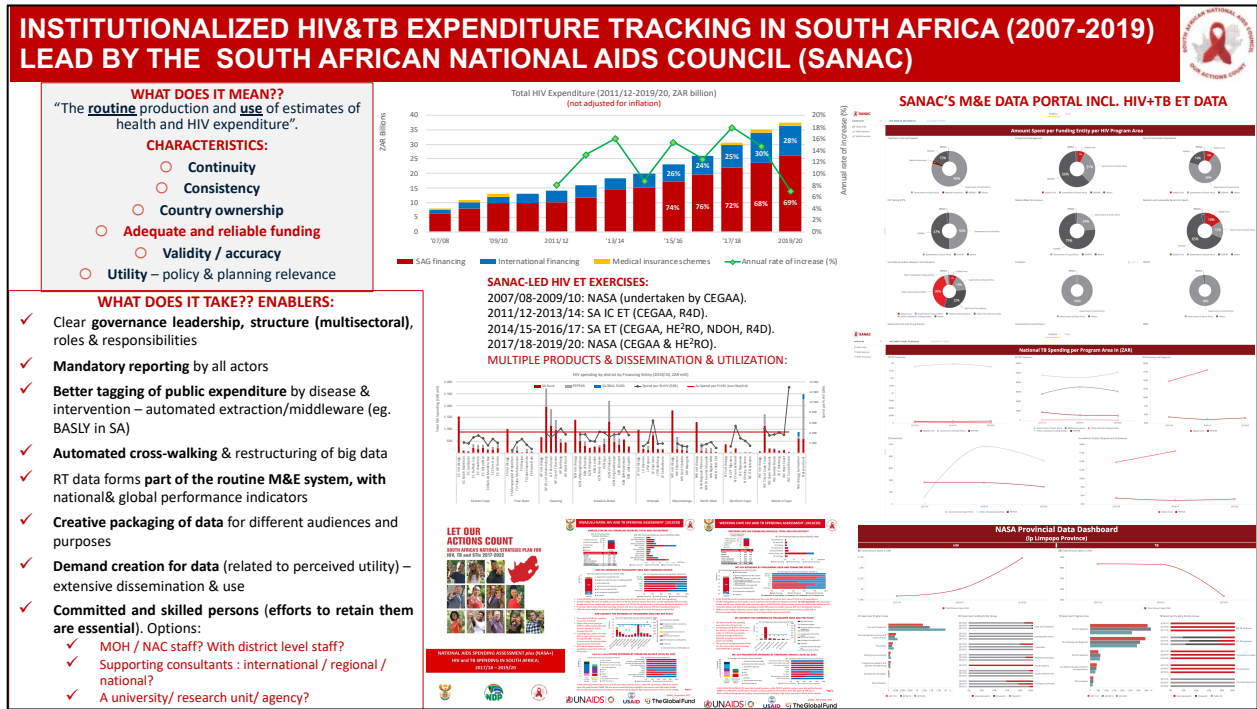
WHAT DOES IT MEAN??

"The **routine** production and **use** of estimates of health and HIV expenditure".

CHARACTERISTICS:
○ **Continuity**
○ **Consistency**
○ **Country ownership**
○ **Adequate and reliable funding**
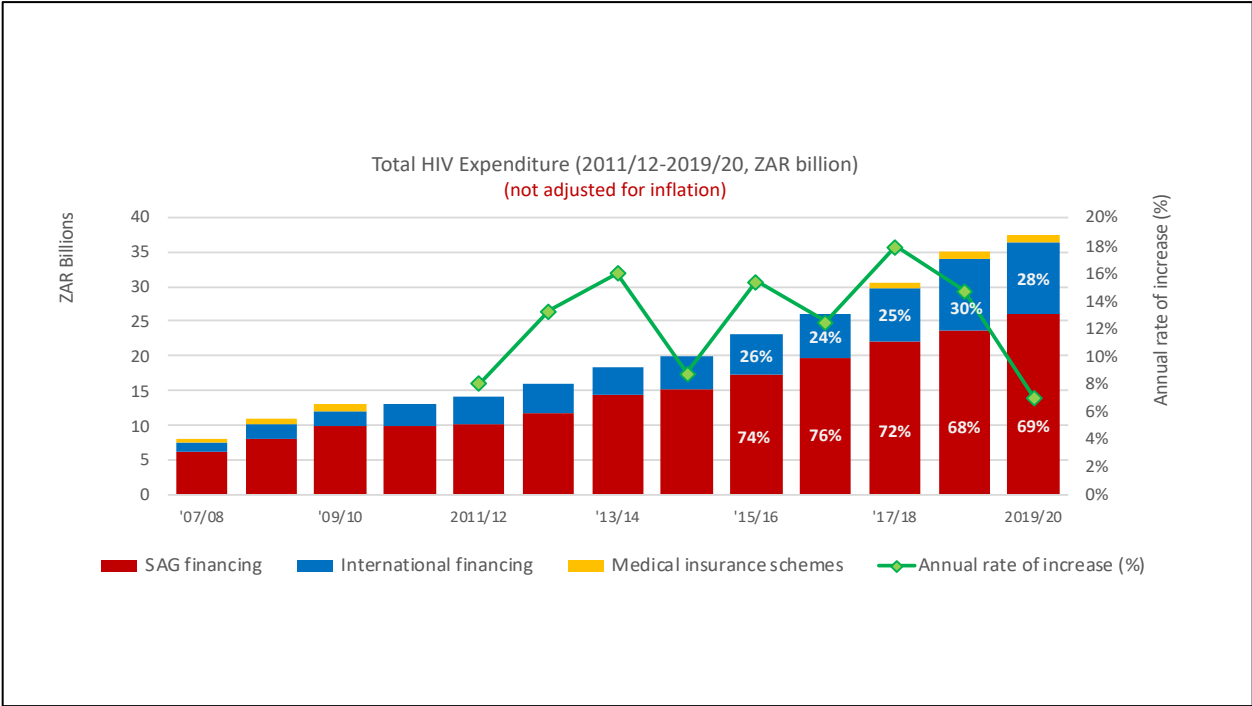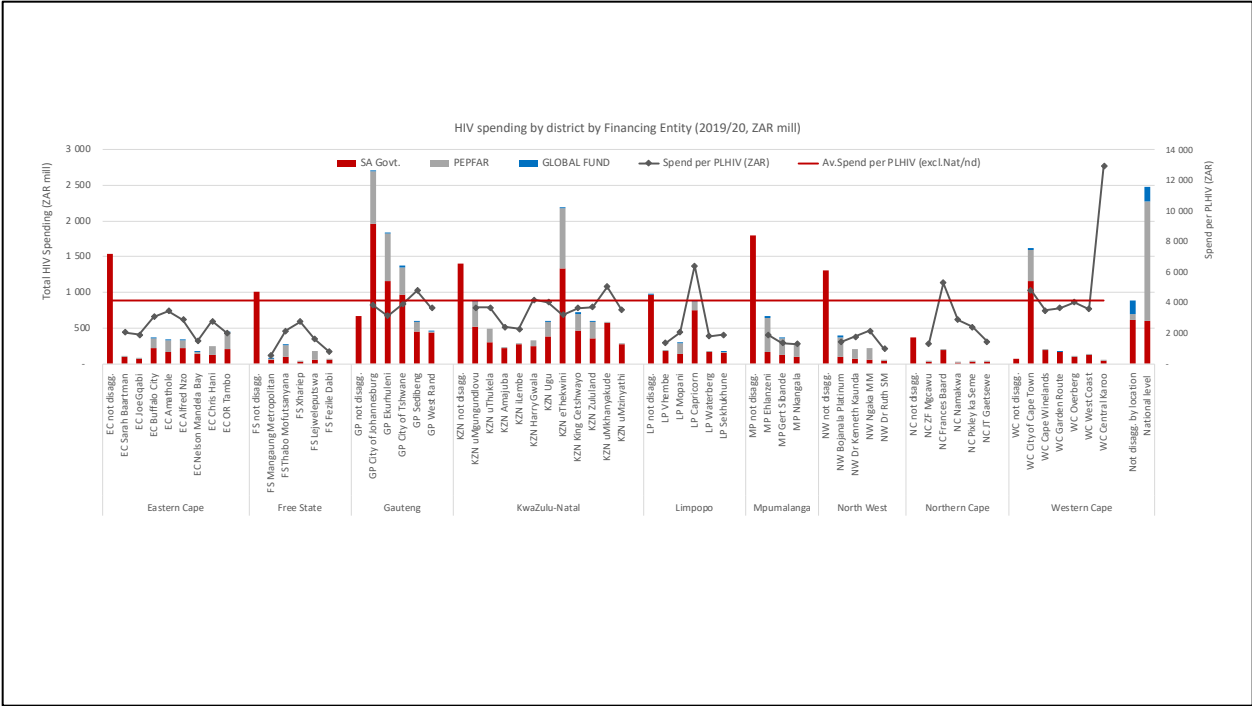○ **Validity / accuracy**
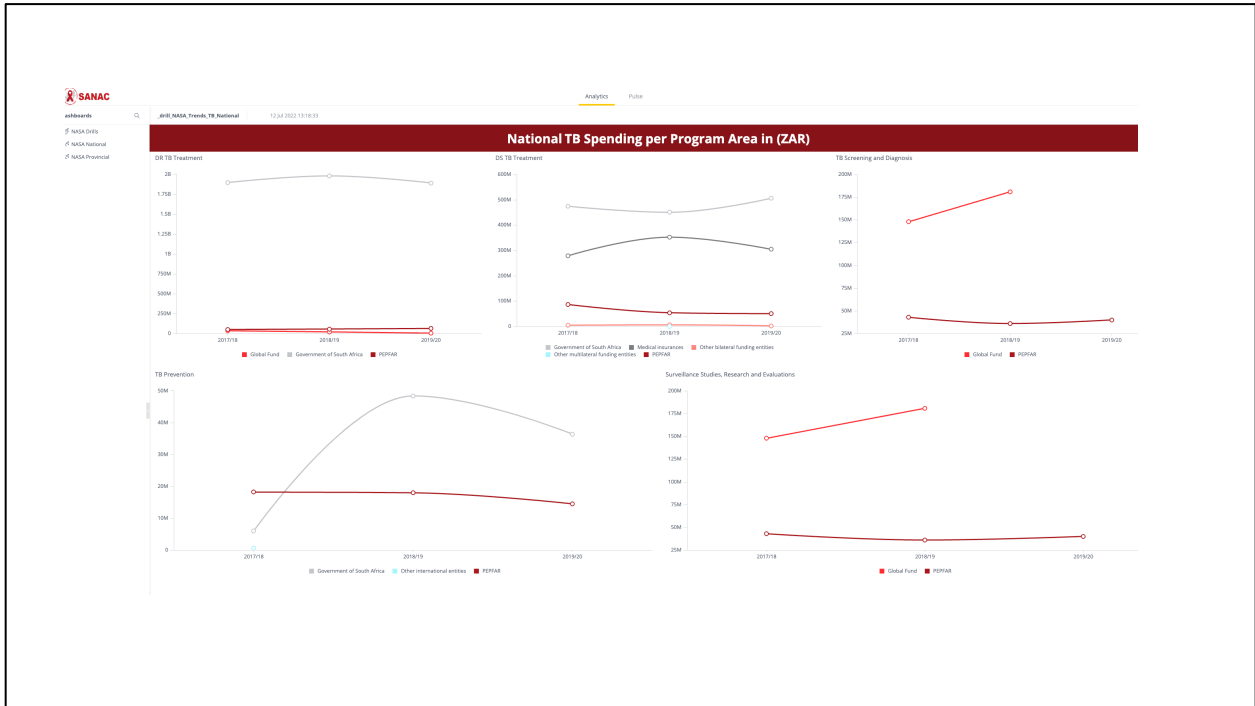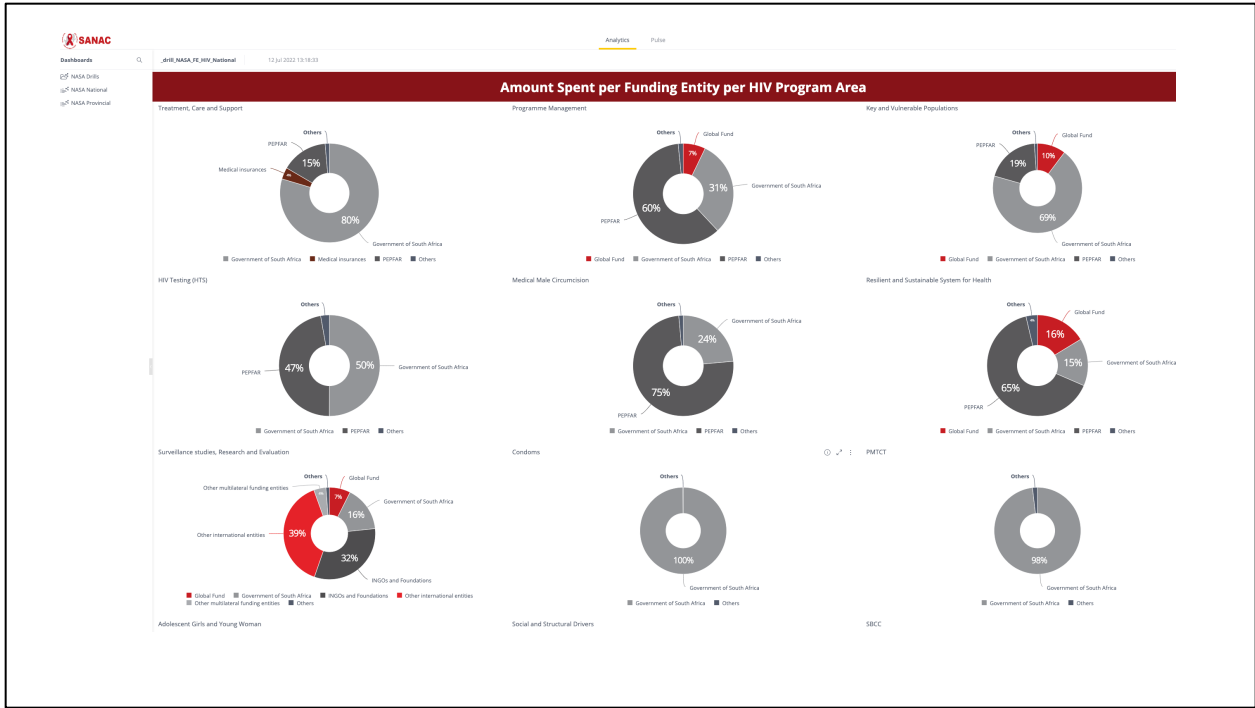○ **Utility** – policy & planning relevance

WHAT DOES IT TAKE?? ENABLERS:

✓ Clear **governance leadership, structure (multisectoral)**, roles & responsibilities

✓ **Mandatory reporting** by all actors

✓ **Better tagging of public expenditure** by disease & intervention – automated extraction/middleware (eg. BASLY in SA)

✓ **Automated cross-walking** & restructuring of big data

✓ RT data forms **part of the routine M&E system, with** national& global performance indicators

✓ **Creative packaging of data** for different audiences and purposes

✓ **Demand creation for data** (related to perceived utility) – extensive dissemination & use

✓ **Committed and skilled persons** (**efforts to retain them are essential**). Options:
  ✓ MOH / NAC staff? With district level staff?
  ✓ Supporting consultants : international / regional / national?
  ✓ A university/ research unit/ agency?

SANAC-LED HIV ET EXERCISES:

- 2007/08-2009/10: NASA (undertaken by CEGAA).
- 2011/12-2013/14: SA IC ET (CEGAA, R4D).
- 2014/15-2016/17: SA ET (CEGAA, HE^{2}RO, NDOH, R4D).
- 2017/18-2019/20: NASA (CEGAA & HE^{2}RO).
- MULTIPLE PRODUCTS & DISSEMINATION & UTILIZATION

HIV spending by district by Financing Entity (2019/20, ZAR mill)

Total HIV Expenditure (2011/12-2019/20, ZAR billion)
(not adjusted for inflation)
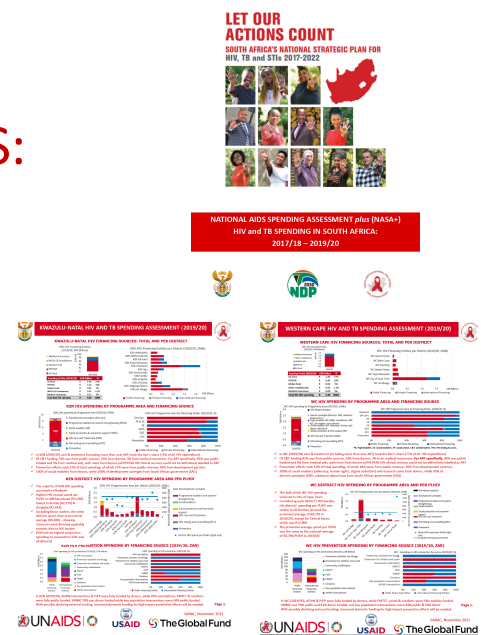
NASA Provincial Data Dashboard
(lp Limpopo Province)

| HIV | TB |

HIV Total Amount Spent in ZAR

2.75B
2.5B
2.25B
2B
1.75B

2017/18   2018/19   2019/20

■ Total Amount spent ZAR

TB Total Amount Spent in ZAR

85M
80M
75M
70M
65M

2017/18   2018/19   2019/20

■ Total Amount spent ZAR

HIV Spent per Program Area

Care and Treatment
Social protection services and social services
Prevention
Testing and counselling
Programme enablers and systems strengthening
Development synergies
Social Enablers

0   250M 500M 750M 1B 1.25B 1.5B 1.75B 2B 2...

■ 2017/18 ■ 2018/19 ■ 2019/20

HIV Spent per Funding Entity Group

Care and Treatment
Development syner...
Prevention
Programme enabler...
Social Enablers
Social protection ser...
Testing and counsell...

0%   20%   40%   60%   80% 100%

■ International FE ■ Private FE ■ Public FE

TB Spent per Program Area

DS TB treatment
TB screening and diagnosis
DR TB treatment
Surveillance studies, research and evaluations
TB Prevention

0   5M 10M 15M 20M 25M 30M 35M 4...

■ 2017/18 ■ 2018/19 ■ 2019/20

TB Spent per Funding Entity Group

DR TB treatment
DS TB treatment
Surveillance studies.
TB Prevention
TB screening and di..

0%   20%   40%   60%   80% 100%

■ International FE ■ Private FE ■ Public FE

Harmonized SHA/NASA resource tracking approaches and experiences in Botswana & Namibia

Results for Development
African Collaborative for Health Financing Solutions aimed to:

Support to countries to advance their UHC agenda
- ‣ Social, political and technical levers
- ‣ Focus on African expertise embedded in regional ecosystem, cross-country learning, better use and contextualization of evidence

Harmonize SHA/NASA resource tracking approaches and share experiences in Botswana & Namibia
- ‣ In order to improve financial management and resource utilization

Teresa Guthrie, R4D Senior fellow:
guthriehealthfinancingconsult@gmail.com

USAID RESULTS FOR DEVELOPMENT Duke GLOBAL HEALTH Innovation Center FEED THE CHILDREN. amref health africa SYNERGOS RESADE CERRHUD COTONOU UHF UGANDA HEALTHCARE FEDERATION

PROMISING PRACTICE – HARMONIZING SHA-NASA

'**Harmonized resource tracking**' definition:

- Efforts to *synchronize or merge* aspects of different resource tracking approaches, by bringing them together into *one joint process*, instead of conducting separate and often duplicative processes.

- For the harmonization of SHA and NASA, this implies the merging of these two methodologies to *simultaneously generate estimates* of spending on *both health and HIV* respectively with the level of detail required by relevant stakeholders.

- Countries can adopt **different degrees** of harmonization in line with country needs and data context. Options;
  - ‣ Full harmonization of all stages of RT from data collection to reporting
  - ‣ Harmonization of data collection only (e.g. Botswana)
  - ‣ Harmonization of analysis and reporting (e.g. Namibia)

1

SHA-NASA Data Collection Approach used in Namibia & Botswana

- Used SHA questionnaires as basis, but **customized significantly** to incorporate all NASA data requirements
- Combined data collection for both SHA and NASA simultaneously, including non-health HIV actors (noting self-administered tools had poor response rate)
- **All HIV data were collected according to NASA disaggregation and classifications** - for HIV-related spending, the NASA frameworks and classifications became available to select. For all other health spending, the SHA classifications became available.
- Drop-down lists using descriptions as per cross-walk to ensure consistency in responses
- Incorporated automated SHA and NASA worksheets (hidden from respondent) that automatically map each transaction against both sets of classifications and codes based on the cross-walk
- Incorporated hidden sheets that allow for direct importation into HAPT and RTT
- Some respondents provided raw data instead of completed questionnaires → team converted data to allow for HAPT & RTT import
- Data cleaning: Strenuous efforts to ensure any changes were applied to both HAPT & RTT datasets - to produce consistent estimates of HIV expenditures with level of detail required for NASA purposes
- Mapping of raw data and application of distribution keys required some fine-tuning to ensure that detailed NASA classifications are captured when applied in HAPT
- Analysis undertaken separately but ensuring consistency between the HIV (health-related) totals.
- Report options: two separate HA and NASA reports (Bots), or joint (HA type) report with detailed HIV section (Namibia).

2

SHA-NASA Lessons learnt from Botswana & Namibia

- ➤ Government commitment and leadership (both in the MOH and NAHPA), including multi-stakeholder partnership and collaboration are key to buy-in and success for country ownership (institutionalization) and sustainable routine resource tracking.
- ➤ The joint RT process requires the team to have both SHA and NASA expertise, and the entire team to be thoroughly trained in both SHA and NASA frameworks.
- ➤ But redeployment and failure to retain HRT-empowered personnel (within public, private and parastatal sectors as well as in the RT-TWG & representatives of respondents) undermined RT team's capacity.
- ➤ The harmonized SHA-NASA data collection yielded some efficiency gains through a single data collection process – shared resources. But the SHA, by nature of its scale, still requires significant $$.
- ➤ The duration of the two components' aspects (analysis, presentation & validation) vary such that ultimate outputs, including alignment and complementarity, cannot be achieved without delaying the finalization of the NASA report.
    - ➤ Also has a bearing on the regularity of assessments to be undertaken (annual would probably not be feasible).
- ➤ Collaboration between the government, WHO, UNAIDS, partners and other stakeholders demonstrated that aligned and coordinated partner technical assistance can improve the efficiency of support to countries.
- ➤ A joint SHA-NASA is not suitable in all situations – country context, needs, resources, data and capacity must be taken into account

3

Requirements for successful harmonization of SHA-NASA

- **Data collected with the disaggregation required for NASA,** and applying transaction principle
- Ensuring adequate inclusion of non-health actors
- Allocative keys and assumptions should not be used to estimate HIV spending, but only actual HIV expenditure
- Comprehensive cross-walk of SHA and NASA classifications and codes
- SHA and NASA technical expertise and support on the RT team
- Capacity building, training and continuous mentoring
- Political commitment
- Financial and human resources
- Support from WHO, UNAIDS and USAID (financial and technical) was essential and will continue to be needed, even if "institutionalized"

4

Suggestions for SHA-NASA efforts

- ✓ Government to consider options, their data needs & tradeoffs (benefits vs losses) if undertaking a SHA-NASA regarding incomplete (without the SHA shared contributions) annual HIV reports to GAM. Or delayed reporting to GAM to accommodate completion of SHA and therefore comprehensive NASA reporting every two years.

- ✓ A standalone NASA might remain more appropriate in countries with high HIV burden of disease and complex response (many actors and resources)

- ✓ In countries with a low HIV burden, a standalone SHA with some disease-specific data, might be sufficient.

- ✓ In countries with strong teams experienced in **both SHA and NASA,** a joint SHA-NASA would have greater chances of delivering the required health and HIV data.

- ✓ Move towards routine (mandatory?) reporting of all stakeholders including service providers, according to an agreed set of categories (a common classification system).

- ✓ Improve the coding of public health expenditures (requisitions to be labelled, perhaps by ICD-11 codes).

- ✓ Design ways to restructure and crosswalk large datasets in a more automated way, to enable the country teams to repeat the process more efficiently (middleware software options?).

- ✓ Govt to augment the HRT expenditure analysis with periodic consumption analyses to estimate more realistic unit costs to inform planning and budgeting.

- ✓ Governments to continue to mobilize development partners' support to augment governments' capacity for sustained HRT institutionalization.

5

LESSONS FOR HEALTH RESOURCE TRACKING EFFORTS

Every resource tracking effort is undermined by the available expenditure data (especially public accounting system outputs)– particularly regarding how detailed and accurate the coding of interventions has been done from the level of requisitioning (to allow the allocation of expenditures to the correct 'cost centres'). This would enhance their extraction from large datasets.

Just one or two additional variables, perhaps reflecting the ICD-11 disease codes (for the MOH expenditures), could be added to 'tag' every transaction/ payment, and then a middleware software that extracts, aggregates and summarises the public expenditures would be extremely beneficial. And would enable the generation of different reports, as needed by stakeholders.

A comprehensive, standardized classification system to code all the expenditures under study is essential to ensure the correct labelling, aggregation & comparison of expenditures.

For further information, please contact:
Allison Kelley, R4D Program Director: akelley@r4d.org
Teresa Guthrie, R4D Senior fellow: guthriehealthfinancingconsult@gmail.com
R4D materials: https://r4d.org/acs-harmonizing-resource-tracking-for-better-decision-making/

6

UNAIDS NATIONAL AIDS SPENDING ASSESSMENT (NASA) APPROACH TO HIV/AIDS RESOURCE TRACKING

UNAIDS and partners have developed and enhanced the NASA approach & classifications over many years, with the following objectives:

- ✓ To measure HIV expenditures in the country during a given year and comparing them over time.
- ✓ To quantify the contributions from foreign and domestic financial sources to HIV/AIDS financing schemes.
- ✓ To reconstruct the flows from sources to purchasing agents and service providers, and then reaching beneficiaries through different service modalities.
- ✓ To compare expenditure levels by HIV/AIDS spending categories and resources needed to implement the national strategic plan for the year under analysis.
- ✓ To provide valid and sound answers on policy relevant to decision makers.

For more information, contact:
Contact: Deepak Mattur, UNAIDS: matturd@unaids.org
Teresa Guthrie: guthriehealthfinancingconsult@gmail.com
UNAIDS programme area on resources and financing:
https://www.unaids.org/en/topic/resources
UNAIDS financial dashboard on HIV:
https://www.unaids.org/en/topic/resources
NASA country reports:
https://www.unaids.org/en/dataanalysis/knowyourresponse/nasacountryreports

NASA data can answer the following questions:

- ✓ **Total** HIV in-country expenditures - **Adequacy? Trends over time? Changing priorities?**
- ✓ **Financing**: Who pays and who purchase?

Financial Entities (Sources) - **dependency (sustainability?)**
Financial Agents - **strategic purchasing?**
Revenue - **What mechanisms are used to finance the schemes? Pooling / insurances / direct transfers?**
Financing scheme - **What modalities are used through which beneficiaries access services?**

- ✓ **Provision**

What cost components? (*Production Factors*) - **technical efficiency? Drivers of units of expenditure?**
Who provides the services? (*Providers*) - **response actors/ mapping / role of CLOs?**
Service Delivery Modality - **What are the service delivery models?**

- ✓ **Utilization**

Who benefits? (*Beneficiary Populations*) - **focus on KPs / equity?**
What was provided? (*Aids Spending Categories*) - **allocative efficiency?**

Following are a few examples of where NASA data add value:

0

NASA PROVIDES SUB-NATIONAL EXPENDITURE & SPEND PER PLHIV: Equitable distribution of resources to meet need? Partners focus?
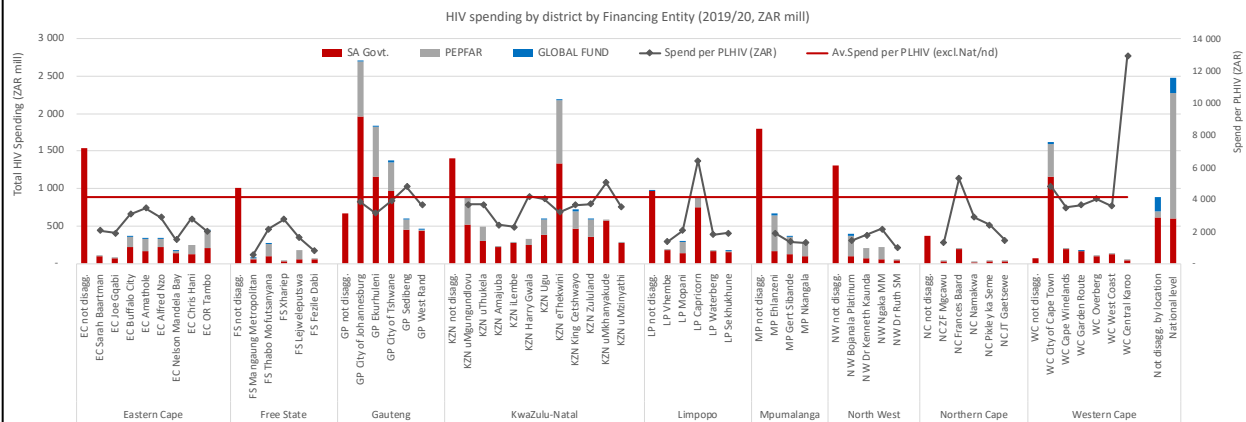
Source: South African NASA+ (SANAC, 2021).

1

NASA PROVIDES INDEPTH UNDERSTANDING OF CROSS-SECTORAL HIV INTERVENTIONS – Optimal investments? Prevention impact?

Source: South African NASA+ (SANAC, 2021).
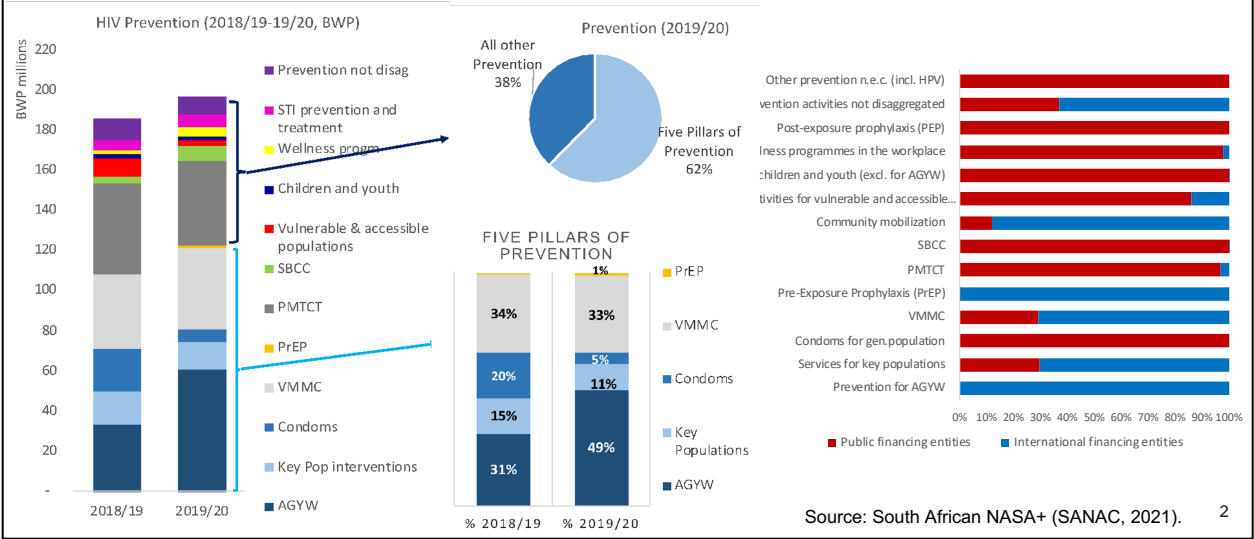
NASA MATCHES THE NSP GOALS & INTERVENTIONS AND SHOWS SUSTAINABILITY / VULNERABILITY / FUNDING GAPS

Sources: Botswana NASA, (NAHPA & MOH, 2021).
South African NASA+ (SANAC, 2021).
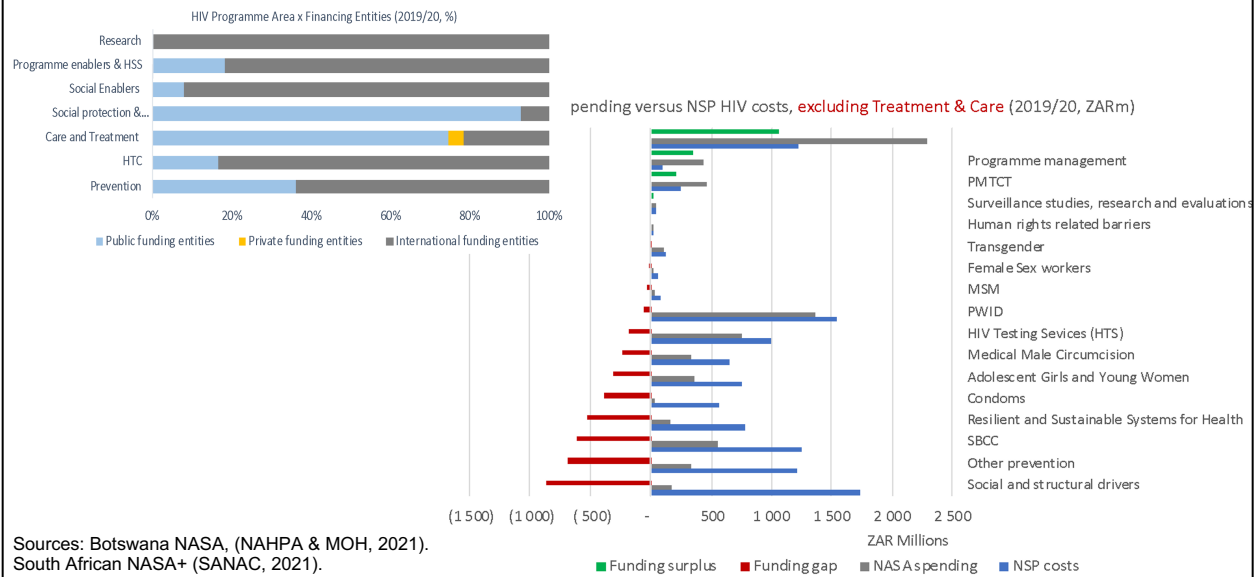
NASA DATA CAN MEASURE TECHNICAL EFFICIENCIES:
e.g. Spending per ART client by cost component over time – Optimal economies of scale? ARV price savings? Differentiated delivery savings? Regional variations?

Regional annual ART unit cost comparison, USD (various years)

SA DOH Annual ART spending per ART pt by production factor/ cost Item (ZAR)
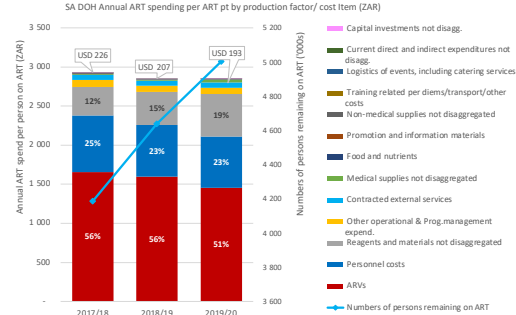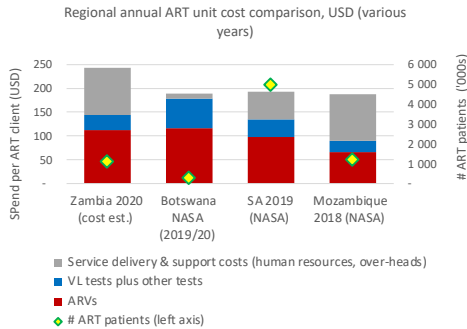
Sources: Country NASA reports or NSP costing.
• Botswana unit spend missing MOHW shared HIV personnel & over-head costs (pending HA report).

SA C&T spending by PFs per FE (ZARb, 2019/20)
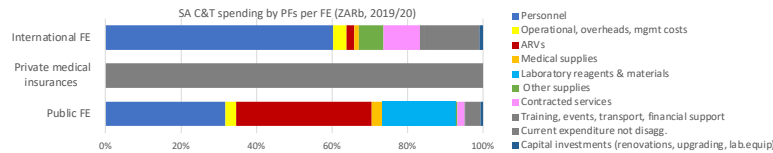
Source: South African NASA+ (SANAC, 2021).

4

NASA PROVIDES VALUABLE INSIGHTS INTO THE SERVICE PROVIDERS and MODALITIES of DELIVERY: e.g. what funds are consumed by community-based organisations, from whom and for which services?

SA NGOs Pgm.Areas (2019/20)

HIV Service Providers in SA (2017/18-2019/20, ZAR bn)

SA NGOs/CSOs SDMs (2019/20,%)

Source: South African NASA+ (SANAC, 2021).

SA NASA+ TB ASSESSMENT AT SUB-NATIONAL LEVEL – production factors (cost drivers) & intervention (burden of MDR-TB)

Provincial TB spend/ PTB case - public funds only (2019/20, ZAR)

Provincial TB spend per TB patient - public funds only (2019/20, ZAR'000s)
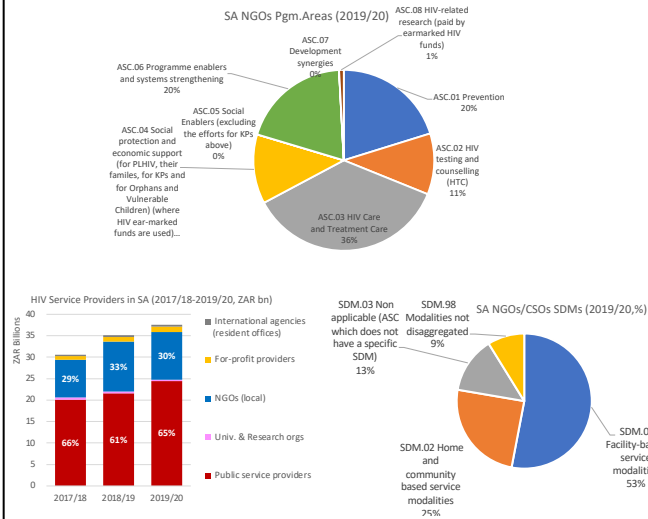
Interested countries can contact UNAIDS and access NASA materials: matturd@unaids.org
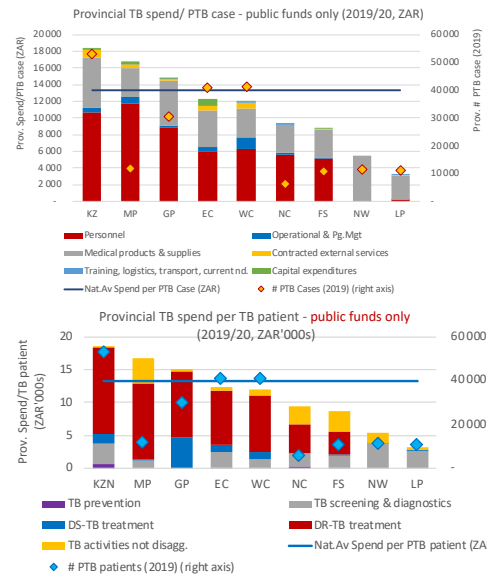
Health Resource Tracking Partner Alignment and Cross-country Learning Exchange Meeting

HRT landscape : Setting the scene

Dr Hapsa Touré and Dr Juliet Nabyonga
on behalf of WHO

Kigali, December 7, 2022

World Health Organization

How much should a country spend on health?

Tracking changes in health financing patterns across time and benchmarking against global trends is vital to:
- addressing missed opportunities,
- ensuring access to medicines and high-quality services,
- and pursuing UHC.

World Health Organization

2014 — 5% GDP; $86 pc
2010 — $44-80 per capita
2009 — $54 per capita
2001 — $34 per capita
2001 — 15% Gov. Spending
1993 — $12-22 per capita

2

How much on specific topics/diseases?

PubMed.gov
US National Library of Medicine
National Institutes of Health

Nar Zdrav. 1954; 0(5):154-8.

[Expenditures for treatment and prevention of diseases in Yugoslavia].

[Article in Undetermined Language]
ANDELKOVIC D.

(HIV)   (MCH)   (Immun.)

World Health
Organization

3

How much on specific topics/diseases?

PubMed.gov
US National Library of Medicine
National Institutes of Health

Nar Zdrav. 1954; 0(5):154-8.

[Expenditures for treatment and prevention of diseases in Yugoslavia].

[Article in Undetermined Language]
ANDELKOVIC D.

- Demand for more detail information continue growing
  - For program management and M&E purposes,
  - In addition to the policy, strategic planning & resource allocation purposes

World Health
Organization

4

Health Resource Tracking

- Health expenditure accounts that can help track resource flows **from sources to uses**.

- Enhances the coherence and comparability of health care expenditure statistics **over time** and **across countries**.

World Health Organization
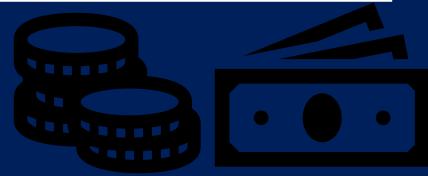
Global Health Expenditure Database (From Year 2000)

https://apps.who.int/nha/database/Home/Index/en

Global Spending on Health Reports

(Yearly Publication)

7

Global Spending on Health Reports

95

Methodological Challenges

- International Framework

https://...t/publica...

Tracking Family Planning-related Expenditures
Using the System of Health Accounts Framework

Table of Content:

World Health Organization

Tracking COVID-19 health expenditure using
the System of Health Accounts Framework
Technical note, version June 2022

Measuring primary
health care
expenditure under
SHA 2011

Technical note, December 2021

World Health
Organization

Implementation Challenges

≥ 6 years | 4-5 years | 2-3 years | 1 year | Not HA study

| 16 34.04% | 14 29.79% | 5 10.64% | 5 10.64% | 7 14.89% |

World Health
Organization

Implementation challenges

- Despite a long history – still adhoc and donor driven
- Sub optimal capacity with reliance on consultants; high turn over of trained staff
- Have not harnessed available opportunities
  - Mainstream in data/information systems
  - Digital technologies
- Limited uptake of results in decision making
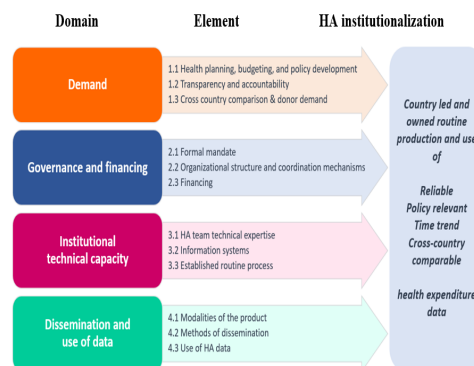- Poorly coordinated partner support

World Health Organization

11

- *"….**Institutionalization of expenditure tracking remains (an) incomplete (journey) as some aspects such as technical capacity, financing and even governance of the process have not been fully taken over by government"***
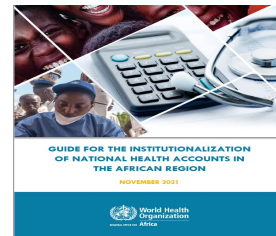
Framework for assessing the maturity of HA institutionalization

What should governments do?

Governance, Capacity & Financing

#Own

1. Review & strengthen institutional arrangements for generation & dissemination NHA
2. Generate interest and awareness beyond technocrats
3. Greater collaboration across all responsible ministries, agencies & academia
4. Sustain capacity for production (in-service & pre-service training)
5. Commit & Allocate resources to the production and dissemination

Demand and Use

#Generate Demand

1. Map policy needs and generate data relevant to your questions
2. Build a common understanding on policy utility of the accounts
3. Inbuild the use within routine programming needs (project design & success monitoring)

Production & Dissemination

#Optimise Use

1. Integrate NHA indicators into national dashboards
2. Combine NHA data with other data sets for deeper analysis
3. Mainstream NHA data collection into routine data collection process (non survey)
4. Produce audience targeted communication products , explore all channels
5. Map out recommended actions based on results and create a group to follow up
6. Sub-national analysis (if possible) especially in devolved/heavily decentralized settings

...What about partners?

Governance, Capacity & Financing

#Convene

1. "Maturity" assessment – support countries to move from step 1 to next in terms of institutionalization (context specific)- Not one size fits all approach to institutionalization
2. Have a shared vision for sustainability/institutionalization (e.g. encouraging co-financing)

Demand and Use

#Collate

1. Improve coordination of resource tracking/expenditure tracking activities
2. Strengthen collaborations across partners on the implementation of NHA

Production & Dissemination

#Catalyse

1. Link programming diagnostics and implementation monitoring to updated (good quality) health accounts data
2. Support regional studies and sharing of best practices on the content (NHAs) but also the process (implementation)