



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

December 2022

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# Acronyms

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

# Executive Summary

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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

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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

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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

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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

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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

<b>Process / Steps</b>	What steps do you take to achieve this goal or reach this decision?
<b>Triggers</b>	What initiates the process of moving toward this goal or answering this decision?
<b>Key Decisions</b>	What other key decisions do you make to achieve your end goal or ultimate decision?
<b>Data Needs</b>	What data do you need to make these decisions? Where do you access these data? What systems or tools are used?
<b>Touchpoints</b>	What people / groups are involved in this step and how are they involved?
<b>Pain Points</b>	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?
<b>Improvement Opportunities</b>	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?
<b>Solutions</b>	What efficiencies or opportunities are gained by improving how you address the objective? What are the cost / opportunities savings?
<b>Support Needs</b>	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
<b>Decision</b>	-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
<b>Data</b>	-Budget data, past years -Indicative 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
<b>Touch Points</b>	-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
<b>Pain Points</b>		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
<b>Solutions</b>	Data quality and availability Digitization Interoperability			PM reform to allow flexibility Institutional Capacity Building Use multiple & accessible communication platforms		
<b>Benefits</b>	Efficient use of resources Equitable resource allocation Timely and accurate data/reports			Effective communication Improved health data		
<b>Support Needs</b>	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<sup>1</sup> 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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<sup>1</sup> 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

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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	<b>1. Greeting</b> We will introduce ourselves and set the stage for this workshop.
9:15 AM – 9:30 AM	<b>2. Welcome to Rwanda</b> The Rwanda Minister of Health will welcome participants to the workshop and highlight Rwanda’s experience with HRT.
9:30 AM – 10:00 AM	<b>3. Introductions</b> 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	<b>4. Setting the Scene - Context</b> 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	<b>Coffee, Tea, and Networking Break</b>
10:45 AM – 11:30 AM	<b>5. Setting the Scene – Terminology</b> We will coalesce around operational definitions for key terms and set “ground rules” to frame workshop discussion.
11:30 AM – 1:15 PM (Concurrent)	<b>6. Country Activity: Defining Country User Journeys</b> 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)	<b>7. Partner Activity: Review HRT Principles</b> 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	<b>Lunch</b>
2:00 PM – 3:00 PM	<b>8.1 Panel: Country Perspectives on HRT</b> 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	<b>Coffee, Tea, and Networking Break</b>
3:15 PM – 4:15 PM	<b>8.2 Panel: Country Perspectives on HRT</b> 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	<b>9. Summary and Closing</b>

## AGENDA DAY 2

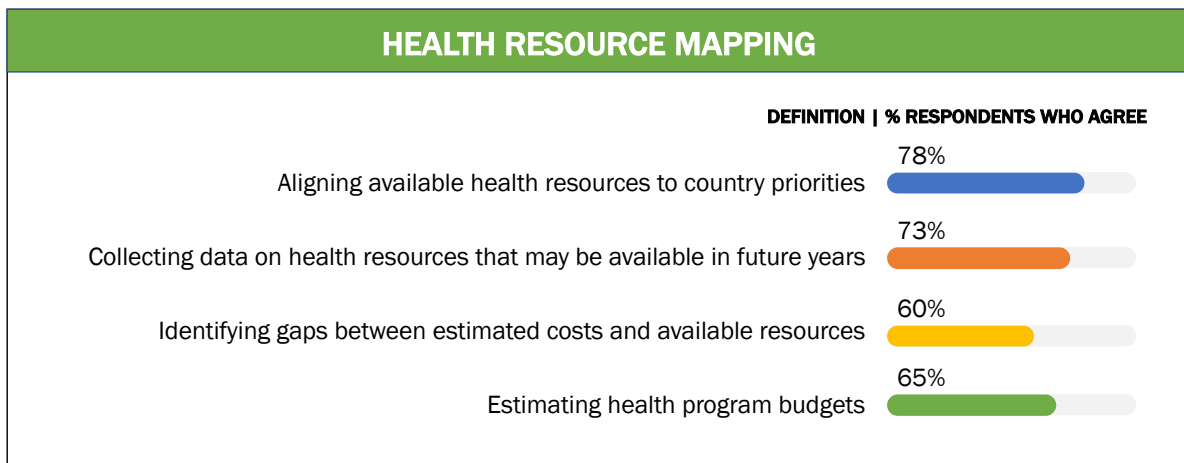
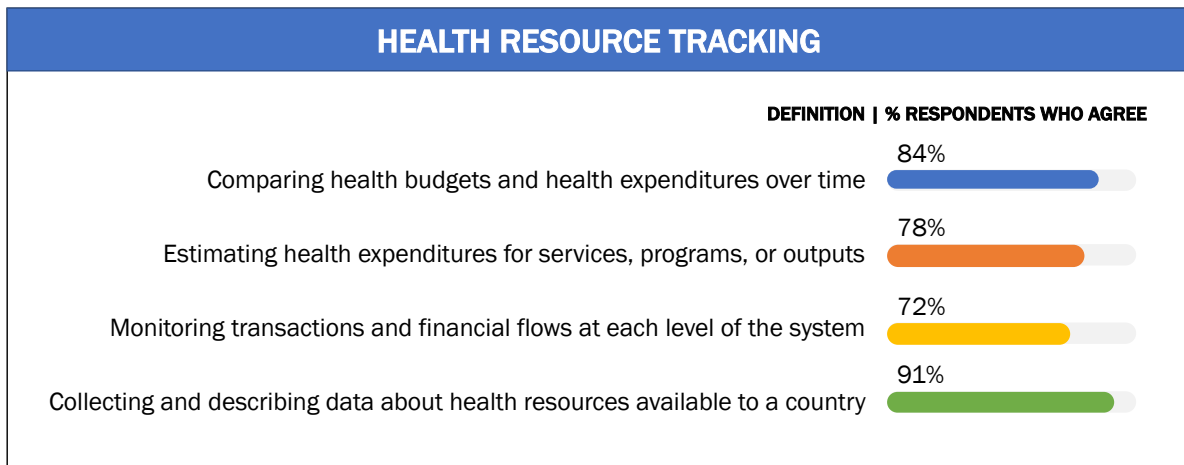
TIME	ACTIVITY
9:00 AM – 9:15 AM	<b>10. Day 2 Overview</b> We will introduce the agenda and logistics for the day.
9:15 AM – 10:30 AM	<b>11. Panel: Development Partner Perspectives on HRT</b> Development partner participants will give short “lightning talks” on health financing data use cases across countries. 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	<b>Coffee, Tea, and Networking Break</b>
10:45 AM – 11:30 AM	<b>12. Posters: HRT Technology, Tools, Support, and Promising Examples</b> 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	<b>13. Country Activity: Defining Country User Journeys</b> 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	<b>Lunch</b>
2:00 PM – 2:15 PM	<b>14. Thinking Future State</b> 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)	<b>15.1 Country Activity: Defining Country User Journeys, Continued</b> 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)	<b>15.2 Partner Activity: Global Future State</b> 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	<b>Coffee, Tea, and Networking Break</b>
4:00 PM – 5:00 PM	<b>16. Discussion: Global Future State</b> 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	<b>17. Summary and Closing</b>

## AGENDA DAY 3

TIME	ACTIVITY
9:00 AM – 9:15 AM	<b>18. Day 3 Overview</b> We will introduce the agenda and logistics for the day.
9:15 AM – 10:45 AM	<b>19. Panel: Country User Journeys Report Out</b> 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	<b>Coffee, Tea, and Networking Break</b>
11:00 AM – 12:45 PM	<b>20. Reflections and Recommendations</b> 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	<b>21. Summary and Closing</b>
1:00 PM – 2:00 PM	<b>Lunch</b>

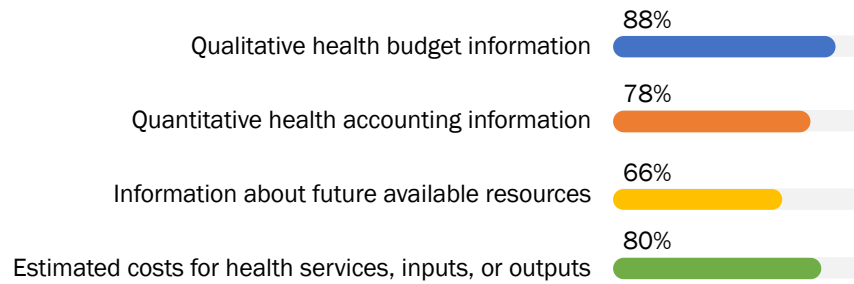
# Annex 2 – Terminology List

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.



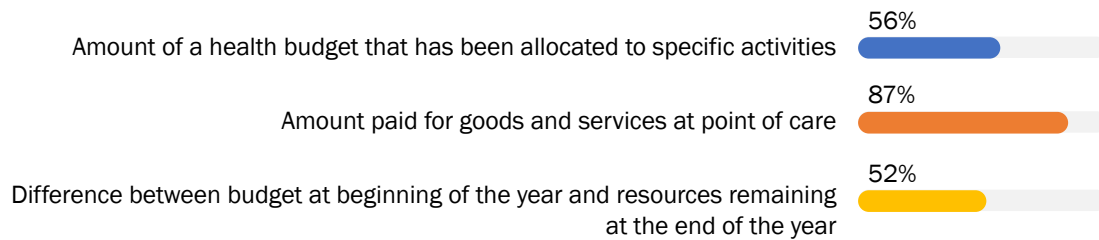
## HEALTH FINANCE DATA

### DEFINITION | % RESPONDENTS WHO AGREE



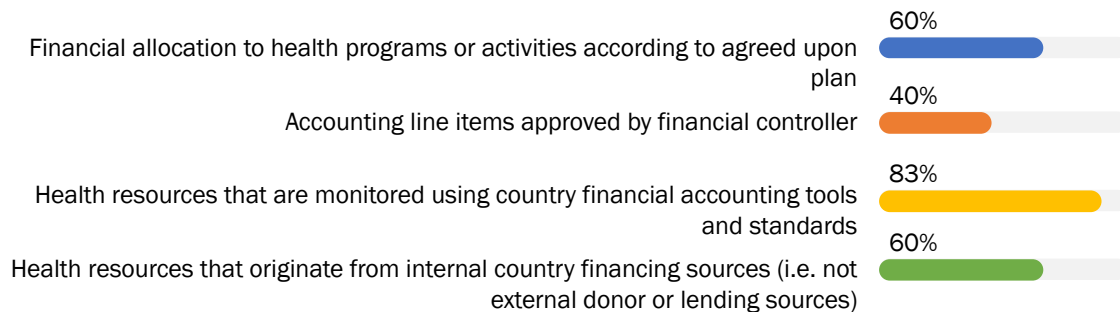
## HEALTH EXPENDITURE

### DEFINITION | % RESPONDENTS WHO AGREE



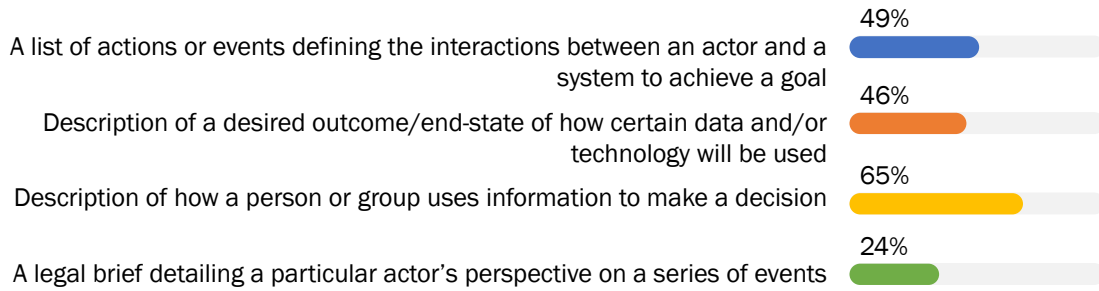
## ON BUDGET RESOURCES

### DEFINITION | % RESPONDENTS WHO AGREE



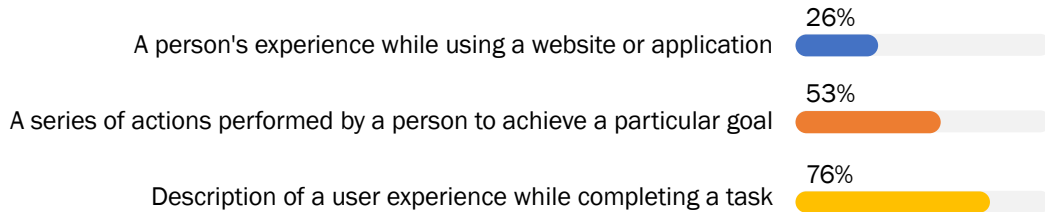
## USE CASE

### DEFINITION | % RESPONDENTS WHO AGREE



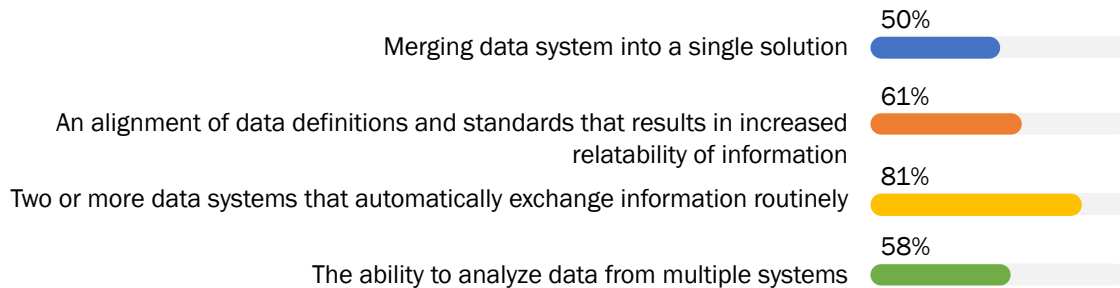
## USER JOURNEY

### DEFINITION | % RESPONDENTS WHO AGREE



## INTEROPERABILITY

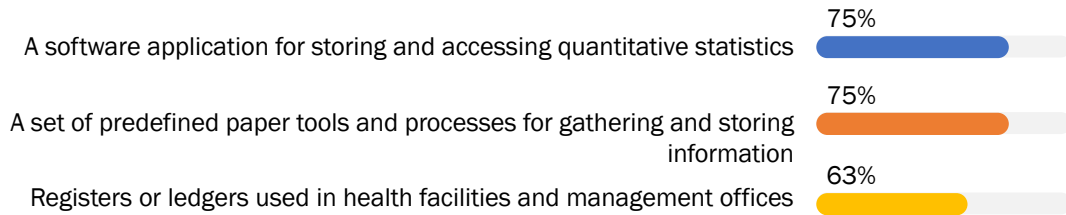
### DEFINITION | % RESPONDENTS WHO AGREE





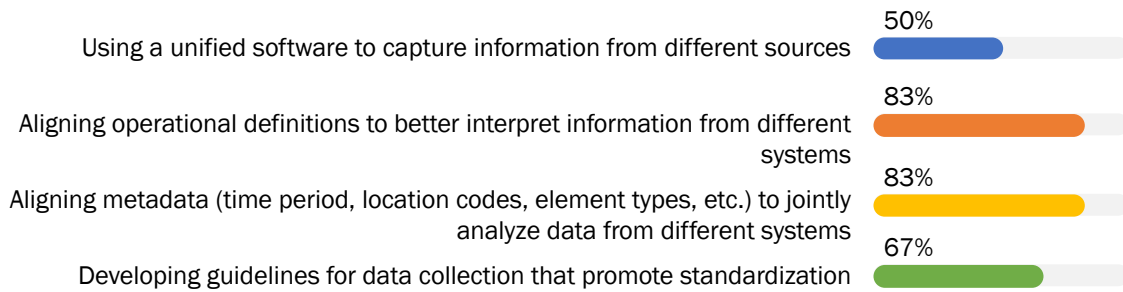
## INFORMATION SYSTEM

### DEFINITION | % RESPONDENTS WHO AGREE



## DATA HARMONIZATION

### DEFINITION | % RESPONDENTS WHO AGREE



# Annex 3 – User Journeys

## Burkina Faso

FIGURE 3 - BURKINA FASO USER JOURNEY 1



**BURKINA FASO**

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








	(1) Clé Initial de répartition	(2) Projet distribution du montant	(3) Arbitrage budget	(4) Transmission assemblée nationale
 <b>Decision</b>	Atelier de consensus national (2014)	Circulaire avant projet budget	Rencontre nationale	Approbation et execution
 <b>Data</b>	-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 insécurité	-Programme d'urgence transition -PDI
 <b>Touch Points</b>	MOH	DGESS, DGF, Santé	-Disposable Programme budgetaire, F.S. -Niveau central	Govt Deputés
 <b>Pain Points</b>	-Non respect des criteres de repartition	-Non prise en compte du context -Regulation budgetaire	Méconnaissance de la clé	
 <b>Solutions</b>		-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	
 <b>Benefits</b>				
 <b>Support Needs</b>		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
 <b>Decision</b>		-Arbitrage ST-RFS -DGF		
 <b>Data</b>	-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
 <b>Touch Points</b>	-DGF (Directeur en charge des finances)	-ST-RFS	DG de hôpitaux et CNTS	-Les ONG en charge du contrôle des FS -Médecins chefs de district
 <b>Pain Points</b>	-Re mise en cause de la clé de repartition	-Fraude -Surfacturation	-Disponibilité des fonds à temps	-Ruptures des médicaments
 <b>Solutions</b>	-Engagement des partenaires -AMU en cours de déploiement			
 <b>Benefits</b>				
 <b>Support Needs</b>	-Digitalisation -Education de la population et des acteurs -Immatriculation de beneficiaries			

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
 <b>Decision</b>	-Attestation de service fait			
 <b>Data</b>	-Fiche de services faits	Rapport de contrôle de l'inspection		
 <b>Touch Points</b>	-DG de hôpitaux	-DG AGSP -DRH	Superieur hierarchique immediate	
 <b>Pain Points</b>	-Fraudes			
 <b>Solutions</b>	-Priorité du gouvernement			
 <b>Benefits</b>				
 <b>Support Needs</b>	-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
 <b>Decision</b>	Connaitre ressources mobilises	Allocation de ressources	
 <b>Data</b>	-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
 <b>Touch Points</b>		PTF Secteur prive (OAC / ONG) Min budget politique sect. CBMT-CDMT Ministre sectorial PLF, N&D	
 <b>Pain Points</b>	-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
 <b>Solutions</b>	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
 <b>Benefits</b>	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
 <b>Support Needs</b>	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		

# Ghana

FIGURE 8 - GHANA USER JOURNEY 1



**GHANA**

**USE CASE:** To influence resource allocation policy across disease areas.

	(1) Advocate from MoH for full deployment of GIFMIS to sector	(2) Provide equipment, logistics and capacity building	(3) Review programme based budget structure and link to the chart of accounts	(4) Define analytical work necessary to influence health policy and managerial decision making at all levels
<b>Decision</b>	Approval for Management of GIFMIS by the Health Sector	Carry out rollout plan for deployment	Engage MoH and CAGD for the review of the CoA	Narrow down analytical work needed and any additional systems to be employed for this
<b>Data</b>	Financial, HR, Expenditure	Inventory of logistics needed	Review and update selected segments of the CoA	GIFMIS Data
<b>Touch Points</b>	Leadership of MoH, Ministry of Finance, Parliament of Ghana, Office of the President	Government and DPs	BDU of MoF, GIFMIS Sec, MoH, DP	MoH Leadership and agencies of the MoH, MoFEP Leadership, Technical and DPs
<b>Pain Points</b>	-Political will	Funding, procurement delays, financial clearance for recruitment of additional staff	Possible rigidity of the CoA, government Bureaucracy	Funding
<b>Solutions</b>	Advocate for MOH for full deployment of GMIS to sector, System to generate and visualize the analytical outputs needed to communicate to policy makers and government agencies			
<b>Benefits</b>	<ul style="list-style-type: none"> <li>Track resources at lower levels</li> <li>Generate data for analysis</li> <li>Equitable resource allocation/resource allocation across disease area and across geographic area</li> <li>Long-term cost saving from automated processes</li> <li>Better data quality and availability</li> </ul>			
<b>Support Needs</b>	<ul style="list-style-type: none"> <li>Political Will - Approval for Management of GIFMIS by health sector</li> <li>Funding</li> <li>Procurement</li> <li>Financial clearance for recruitment of additional staff</li> <li>Enhanced flexibility of the COA</li> <li>Engage ministry of finance and CAGD for the review of COA</li> <li>Technical capacity</li> <li>Data visualization system</li> </ul>			

# Kenya

FIGURE 8 - 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
<b>Decision</b>	Determine the available domestic resources	Determine off budget resources		Determine how much to allocate to specific sectoral priorities		
<b>Data</b>			-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
<b>Touch Points</b>		DPHK HENNET FBOs KHF	National and County governments			
<b>Pain Points</b>	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
<b>Solutions</b>	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					
<b>Benefits</b>	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					
<b>Support Needs</b>	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 9 - 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
<b>Decision</b>				Determine priority areas for funding	Determine how to update the resource allocation formula	
<b>Data</b>	-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
<b>Touch Points</b>	-National govt -Treasury -MOH	-Parliament Health Committees -National Assembly & Senate	-DPHK -Hennet -KHF -FBO		County governments	
<b>Pain Points</b>	Availability of off-budget data (allocation & expenditure)	Actual population data is available every 10 years				Complexity of the government system in Kenya
<b>Solutions</b>	Revise/update the allocative efficiency criteria and formula Leverage technology (see other use case) Improve partner coordination through the KHSPCF					
<b>Benefits</b>	Reduced out of pocket expenditure Equity in allocation of resources Ease in prioritization of health sector needs					
<b>Support Needs</b>	Political buy-in Resources for training and capacity building Technical assistance					



# Malawi

FIGURE 10 - MALAWI USER JOURNEY 1



**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
 <b>Decision</b>	ID who will be involved	Pick variables to include and exclude	Finalize selected variables	Where? How? (Different modes targeting different stakeholders)
 <b>Data</b>	Current HRT Reports, Existing resource allocation formula, other countries formulae		Variable list	
 <b>Touch Points</b>	-N2GFC, Treasury, MOH, Parliamentary committee on health, district councils -Development Partners (UN Family, CHAM/IHAM, HSJF, GAVI, GF, PEPFAR, WB, CHAI)			
 <b>Pain Points</b>	-Misalignment amongst stakeholders -Political will	Convincing different stakeholders at different levels	Stakeholder availability	
 <b>Solutions</b>	Dissemination of strategic documents with all stakeholders			
 <b>Benefits</b>	Unitary interest in improved health resource allocation			
 <b>Support Needs</b>	Resources to hold different stakeholders' engagement			

FIGURE 11 - 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
<b>Decision</b>	-Who to train -Nature of training	-Formulate district implementation plan	-Resources earmarked for the health sector
<b>Data</b>	DHMT Members	DHIS2 Data	Resource Tracking tool
<b>Touch Points</b>	Planning directorate	-DHMT, Extended DHMT (coordinators) -Implementing partners -Community	DHMT, District
<b>Pain Points</b>	-Financial resources -Commitment -Unpredictable funding	-Data gaps, data quality issues (incomplete, inactive, timeliness)	Hesitancy by some DPs to provide resource information
<b>Solutions</b>	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		
<b>Benefits</b>	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		
<b>Support Needs</b>	Adequate funding for capacity building ICT expertise and equipment Committed DHMT members Regulatory framework/authority/law to report on time		

# Nigeria

FIGURE 12 - 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
 <b>Decision</b>			Incentivize states to allocate more for performance-based budgeting	Set up performance monitoring units at Federal and State ministries of health			
 <b>Data</b>	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)				
 <b>Touch Points</b>	Other relevant ministries, office of the account general Civil society, private sector, academia Ministry of health (national/state), ministry of finance, budget, National Planning						
 <b>Pain Points</b>	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			
 <b>Solutions</b>	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			
 <b>Benefits</b>	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			
 <b>Support Needs</b>	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 13 - 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 14 - TANZANIA USER JOURNEY 1



	(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
<b>Decision</b>	Joint identification of the sector priorities	Costing of the verified priorities	Proposal writing	Submission to Global Fund
<b>Data</b>	Malaria spending, HIV spending, TB & Leprosy spending, analyzed the government co-financing			
<b>Touch Points</b>	<ul style="list-style-type: none"> <li>-MOH to identify the priority area funding</li> <li>-MOFP signing of the contract between global fund and govt</li> <li>-TB &amp; MOFP negotiating with the Global Fund</li> <li>-Technical team for co-financing</li> </ul>			
<b>Pain Points</b>	<ul style="list-style-type: none"> <li>-Inconsistent program data and NHA data for co-financing</li> <li>-Lack of analysis capacity at program level</li> <li>-Deductions of fund allocation</li> <li>-Delay of the approval for grants to start</li> </ul>			
<b>Solutions</b>	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			
<b>Benefits</b>	They have a harmonized system which looks between both parties - DPs and IPs Improved data quality Increase access of data			
<b>Support Needs</b>	Capacity building within MOH staff Funding for the harmonization of system in department Capacity building at facility level vs. national level.			

FIGURE 15 - 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
 <b>Decision</b>	Budget negotiations with MOFP – present justification based on previous allocation	Ceiling allocation to address priority intervention		
 <b>Data</b>		<ul style="list-style-type: none"> <li>-Spending by disease (NHA, PQR)</li> <li>-Spending by geography (NHA, geography)</li> <li>-Spending by function (NHA)</li> </ul>		
 <b>Touch Points</b>		<ul style="list-style-type: none"> <li>-Head of department and programs</li> <li>-Internal MOH meetings</li> <li>-Budget secretariat team during MOH review meetings</li> <li>-MOFP through budget negotiation</li> <li>-DPs and IPs – joint review meeting</li> </ul>		
 <b>Pain Points</b>		<ul style="list-style-type: none"> <li>-Inconsistent program data and NHA data for co-financing</li> <li>-Lack of analysis capacity at program level</li> <li>-Deductions of fund allocation</li> <li>-Delay of the approval for grants to start</li> </ul>		
 <b>Solutions</b>	Dissemination of strategic documents with all stakeholders			
 <b>Benefits</b>	Unitary interest in improved health resource allocation			
 <b>Support Needs</b>	Resources to hold different stakeholders' engagement			

# Uganda

FIGURE 16 - 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
<b>Decision</b>	-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
<b>Data</b>	-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
<b>Touch Points</b>	-MOH, MOFPED, DPs, CSO, NPA, Parliament	MOH, LGs, DPs, NPA, Parliaments, MOFPED	MOH, MOFPED, Parliament	MOH, LGs, Agencies	MOH, MOFPED, LGs, HUMCs	MOH, MOFPED, HUMCs
<b>Pain Points</b>		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
<b>Solutions</b>	Data quality and availability Digitization Interoperability			PM reform to allow flexibility Institutional Capacity Building Use multiple & accessible communication platforms		
<b>Benefits</b>	Efficient use of resources Equitable resource allocation Timely and accurate data/reports			Effective communication Improved health data		
<b>Support Needs</b>	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**  
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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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Health Financing Expert. Currently Director of health finance on the USAID Rwanda Integrated Health System Activity (RIHSA)

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**Samson Awudanjong**  
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Samson Awudanjong works at the Financial Reporting and Monitoring 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 Nkrumah University of Science and Technology.



**Dr. Francis Ayomoh**  
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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 Masters (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  
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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.



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**Kashu Bekuretsion**  
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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**  
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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. Change**  
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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 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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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.



**Fanny Lubala Gidoa**  
Head of Division, MoPHHP, DRC  
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I am the head of division in charge of preparation and budget monitoring in the administration and financial department of the Ministry of Public Health, Hygiene and Prevention. I am in charge of drawing up the health financing map.



**Teresa Guthrie**  
Consultant  
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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.



**Mike Habinshuti**  
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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**  
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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.



**Julius Kabusere**  
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Julius Kabusere is the Principal Policy Analyst at the Ministry of Health, Uganda. He has previously worked at Plan International Uganda, Family Life Education Program, Iganga General Hospital as a Senior Hospital Administrator, and the Ministry of Foreign Affairs as a Principal Policy Analyst. He holds a Bachelor of Social work and Social Administration, Master of Social Sector Planning and Management, and a Certificate in Administrative Law all from Makerere University. His hobbies include listening to gospel music, gym, and sauna.

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Dr. Alinafe Kalanga is a youthful result driven District Manager with 6 years of work experience in Public Health Sector. She currently holds a Post of Director of health & Social services, whose main role is to oversee, plan and coordinate the implementation of health and social services in Mulanje District Council. One of her area of interest is to partner and coordinate with different stakeholders in order to help in advocacy and resource mobilization for provision of quality health services. She holds a Medical Degree as well as a postgraduate Diploma in Health Systems Management for Regional and District Managers.

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I am Health Management Specialist with over 15 years of experience managing healthcare programs in Kenya and South Sudan. Currently working as the GFF Liaison Officer for Kenya, supporting effective and inclusive government-led partnership and coordination processes for RMNCAH-N in the country.

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**Happy Emilio Kapanga**  
Economist  
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**Dr. Isaac M. Kimani**  
Transforming Health Systems for Universal  
Care Project Manager, Kenya  
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Dr. Isaac M. Kimani is a Medical Doctor with experience in Public Health and Health Systems Management. He is currently managing the Transforming Health Systems for Universal Care project at the Ministry of Health, Kenya. The project finance the 47 County Governments activities geared towards improving utilization, access and quality of primary health care services with emphasis on RMNCAH and emergency

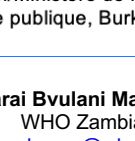


**Brandon Klyn**  
Director of Analytics & Decision Support,  
Cooper/Smith  
[brandon@coopersmith.org](mailto:brandon@coopersmith.org)

My personal mandate is to ensure that data is at the forefront of complex problem solving, distilled in a way that can be easily understood by decision-makers, and inclusive of the many voices impacted by it.



**Sandhya Krishnan**  
Administrative Logistics Support  
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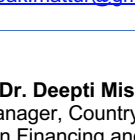


**Dr Tassemedo Mahamadi**  
Directeur du suivi de l'évaluation et la capitalisation/Ministère de la santé et de l'hygiène publique, Burkina Faso

Dr Tassemedo est spécialiste en suivi et évaluation et en renforcement du système de santé. Il a travaillé aux différents niveaux du système de santé, avec 15 ans d'expériences dans les soins de santé primaires il s'intéresse particulièrement au suivi des ressources financières. Depuis 2020, il fait partie de l'équipe technique de la cartographie dynamique des ressources du Burkina et des comptes nationaux de la santé.



**Sarai Bvulani Malumo**  
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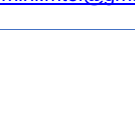
**Deepak Mattur**  
Senior Advisor, Resource Tracking;  
Equitable Financing Practice, UNAIDS  
[deepak.mattur@gmail.com](mailto:deepak.mattur@gmail.com)

Deepak is a senior Health economist at UNAIDS with more than 13 years of experience in Global Health. At UNAIDS, Deepak leads the portfolio of Global and National level Resource tracking, estimation of global financial resources, modelling of future needs, strategic information on HIV Financing and price monitoring of HIV products.



**Dr. Deepti Mishra**  
Senior Manager, Country Focal Point,  
Immunization Financing and Sustainability,  
GAVI  
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Deepti is a senior programme manager, immunisation financing and sustainability at Gavi. She is responsible for providing technical support to Gavi countries in developing and implementing immunisation and health financing strategies, as well as ensuring the application of Gavi's eligibility, transition and co-financing policies. Deepti is a clinician, and a health economist by training and based at the Gavi secretariat in Geneva.



**Gemini Mtei**  
Senior Director, Public Finance Systems,  
Abt Associates  
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Gemini is an Economist working as Senior Director, Public Finance Systems at Abt Associates. He is currently working under USAID Public Sector Systems Strengthening Plus (PS3+) project in Tanzania. He is leading implementation of systems strengthening interventions in the areas of public financial management, provider payment, Resource Tracking, Direct Facility Financing and facility level planning, budgeting and accounting across local government authorities.



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Directeur Adjoint au Programme National  
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**Thulasoni Msuku**  
Principal Health Economist, Planning  
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Thulasoni Msuku holds an MSc in Health Economics and is working in Malawi's Ministry of Health. He has over 20 years of work experience in civil service which include nine years of primary school teaching, five in revenue policy analysis in the Ministry of Finance and eight in health policy analysis.

He is currently working in the Health Financing Division where he is involved in NHA data collection, analysis and report writing. His interest are in research. Mental health and welfare in old age are his favorite research fields.

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**Chris Mugarura**  
Assistant Commissioner, MoH Uganda  
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**Diane Karenzi Muhongerwa**  
Health Financing Technical Officer, WHO  
AFRO  
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Diane is an economist with MSc Economics; MPH; and is a PhD Candidate in Governance and Leadership (PhD Research: "Sustaining financial access to health services for all in Rwanda: Governance responses through Community Based Health Insurance."). She is the Health Financing Technical Officer in WHO-AFRO, with over 17-year experience in Regional Health Financing guiding documents development and review, Health Sector and Health Financing policy, strategies and reforms development, implementation and review. Contributed to Rwanda and different other African countries' health financing systems development and reforms towards UHC within the national development agenda and poverty reduction processes; Decentralized health strategic plans development and review; and Multisectoral program management including managing partnerships and coordination for developmental policies.



**Dr. Stephen K. Muleshe**  
Deputy Director of Medical Services, Kenya  
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Dr. Stephen Muleshe is a Public Health Specialist with more than 20 years of experience in Public Health administration and practice. He holds a Master's Degree in Public Health (MPH) and a Bachelor's Degree in Medicine (MBCHB) from the University of Nairobi. He also holds a Postgraduate Diploma in the management & Control of HIV/AIDS & other Sexually Transmitted Diseases from the same University. Currently, he is a Deputy Director of Medical Services in the Division of Health Care Financing supporting the UHC program at the Ministry of Health Headquarters Nairobi. He has previously worked with USAID projects in Kenya as the service Delivery Advisor for HIV/AIDS/TB/Malaria & Maternal and Child Health.



**Grace Nyerwanire Murindwa**  
GFF Liaison, Uganda  
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I am a medical doctor with additional training in health planning, management and policy. I have worked at various levels of the Ugandan health systems for over 30 years, starting working at a rural hospital, then as a District Medical Officer and then a Ministry of Health Headquarters. I have supported the planning, management and supervision of health service delivery and technical backstopping to districts. I have provided capacity building processes for district and health sub-districts teams in planning, management and supervision of health service delivery. I have worked with various Development partners at national and global levels and with Global Health Initiatives such as Global Fund and GAVI on their technical review panels.



**Patrice Mwitende**  
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Development and Public Health Professional with over 18 years of progressive work experience in health and nutrition in Rwanda, Niger and Cote d'Ivoire. Patrice's career spans government institutions, international NGOs, as well as multilateral and bilateral development agencies. He is currently working in the capacity of Senior Health Specialist at the World Bank, Rwanda Office. As part of his work at the World Bank, he has been engaged in a number of public health and nutrition policy dialogue events and reforms, program/project design, negotiations, implementation support, advisory services and analytics, as well as performance and results measurement.

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Rwanda's health sector bilateral, multilateral, and civil society health Cooperation, participated in the 2019 HRT in Geneva.



**Miyu Niwa**  
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Miyu is a Research & Data Analyst at Cooper/Smith. She has research experience in health systems strengthening, priority setting, and equity modeling, as well as previous experience working for the World Bank Development Impact Evaluation, Socios En Salud (Partners in Health Peru), Harvard Ministerial Leadership Program, and the Health and Global Policy Institute in Tokyo. She is originally from Tokyo, Japan.



**Pearl Adwoa Opoku-Youngmann**  
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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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**Ebunoluwa Okunuga**

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**Daniel Osei**  
Coordinator, Resource Mobilization, Ghana  
Health Service  
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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**  
Senior Manager, Strategic Partnerships,  
Immunisation Financing and Sustainability,  
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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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**Pamela Rao**  
BMGF

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**Lisa Regis**

Specialist, Health Finance, The Global Fund  
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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.



**Elan Reuben**  
Director for Financial Sustainability,  
PEPFAR  
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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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**Enock Rwamuza**  
USAID RIHSA  
[Enock.rwamuza@thepalladiumgroup.com](mailto:Enock.rwamuza@thepalladiumgroup.com)

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**Siguire Salif**  
Directeur des ressources humaines,  
Burkina Faso  
[drhsantebf@gmail.com](mailto:drhsantebf@gmail.com)

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**  
Planning and Budget Officer, MoH, Ghana  
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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**  
Budget Manager, Budget Office of the  
Federation, Nigeria  
[nuhmah@gmail.com](mailto:nuhmah@gmail.com)

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)



**Tyler Smith**  
CTO & Co-founder, Cooper/Smith  
[tyler@coopersmith.org](mailto:tyler@coopersmith.org)

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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**Dr. Hakiba Solange**  
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[Solange.hakiba@thepalladiumgroup.com](mailto:Solange.hakiba@thepalladiumgroup.com)

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**Serena Sonderegger**  
Senior Associate, CHAI Global Health  
Financing  
[ssonderegger@clintonhealthaccess.org](mailto:ssonderegger@clintonhealthaccess.org)

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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**Nertila Tavanxhi**

Manager, Health Financing High Impact  
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**Cicely Thomas**  
Health Economist, GFF  
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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,  
WHO, Nigeria  
[ukwujief@who.int](mailto:ukwujief@who.int)

Francis Nwachukwu Ukwujie 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. Ukwujie 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. Ukwujie has significantly contributed to the progress so far made by Nigeria towards Universal Health Coverage (UHC).

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**Dr. Parfait Uwaliraye**

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**Dr. Elisabeth Uwanyiligira**  
HSS Advisor, USAID Rwanda  
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**Ellen Van de Poel**  
Health Financing Lead, GFF  
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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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**David Wilson**

Senior Program Officer, BMGF  
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**Pierre Yameogo**

Médecin, secrétaire technique des réformes  
sur le financement de la santé, Burkina  
Faso

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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**

GFF Liaison, Nigeria


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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



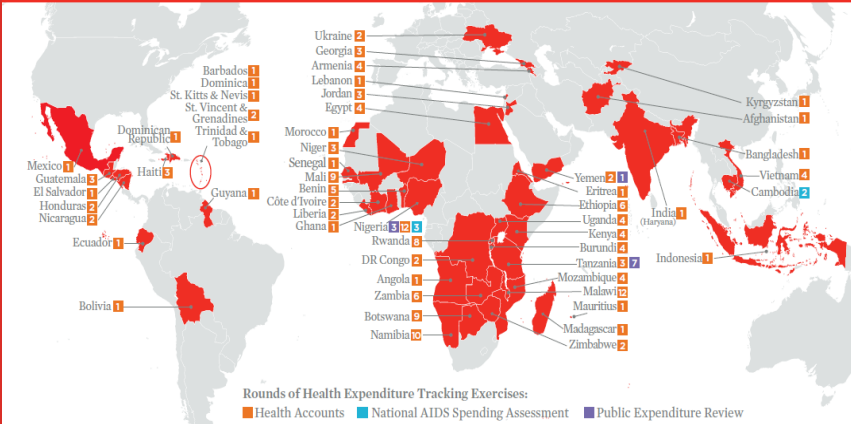
**BOLD THINKERS  
DRIVING  
REAL-WORLD  
IMPACT**

Abt Associates is a global consulting and research firm, with staff in over 50 countries

We have supported over **180 rounds** of expenditure tracking exercises in **more than 55 countries**



## Abt's Expertise in Health Resource Tracking

**COUNTRIES WHERE ABT HAS SUPPORTED HEALTH EXPENDITURE TRACKING**



Rounds of Health Expenditure Tracking Exercises:  
■ Health Accounts    ■ National AIDS Spending Assessment    ■ Public Expenditure Review

## Spotlight: Using Data to Inform Decision-Making

How have Health Accounts data been used to influence policy?

In addition to production of RT data, Abt Associates supports countries to:

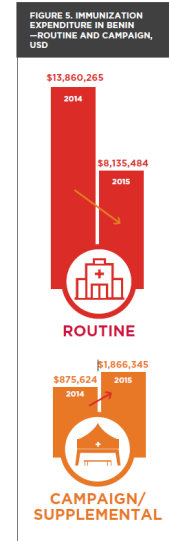
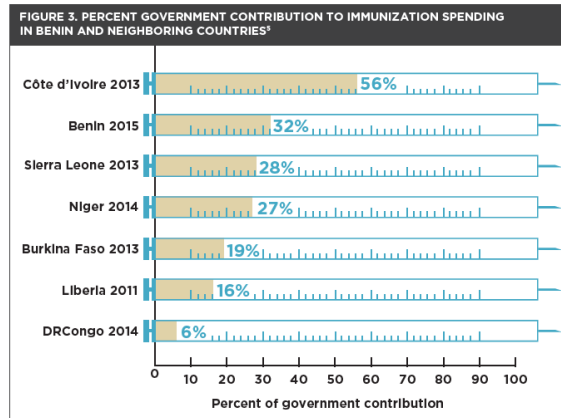
- **Analyze, package and use** resource tracking data to inform policy and planning decisions
- **Ensure alignment of data analysis to country policy priorities** (such as sustainability, efficiency, resource allocation for priority health services, etc)

For over two decades, Abt has supported the development of numerous policy briefs, media releases and white papers targeted to decision-makers, to highlight key policy-relevant data in a digestible format.

<https://www.hfgproject.org/resources/publications/resource-tracking-nha-sha/>

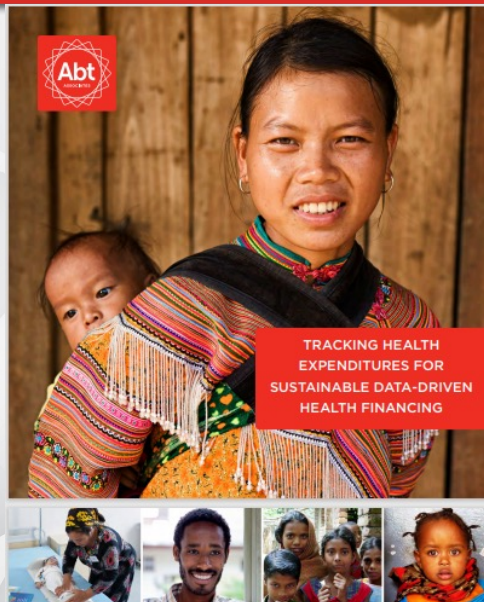
## Implementation: Using Data to Inform Decision-Making

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.



## 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



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)

For more information, please contact:  
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 Shipra Srihari ([Shipra\\_Srihari@abtassoc.com](mailto:Shipra_Srihari@abtassoc.com))  
 Paul Smithson ([Paul.Smithson@abtbritain.co.uk](mailto:Paul.Smithson@abtbritain.co.uk))

Poster 2: Burkina Faso's Gratuité Program



## 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)



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



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



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)



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



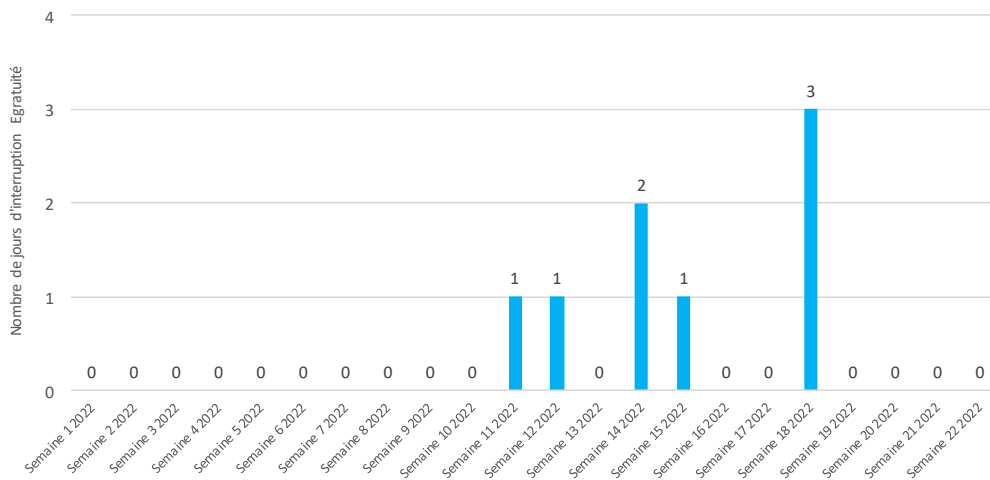
Régression de la complétude dans la transmission des données sur les dettes CAMEG (Figure 20-21)



## 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 egratuite par semaine



# 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

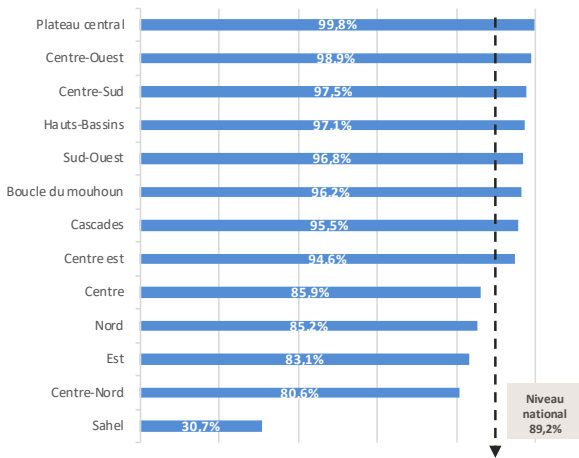
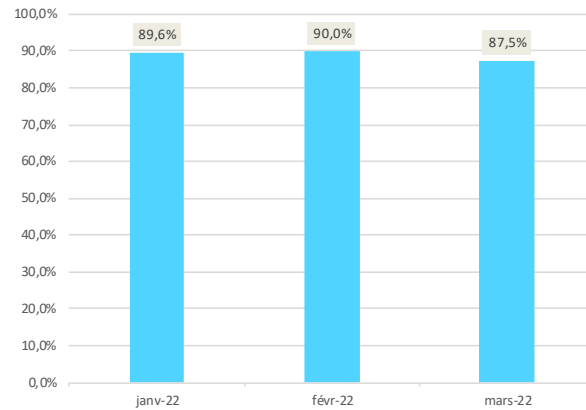


Figure 3 : Evolution mensuelle des RMA Gratuité des CSPS/CM



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

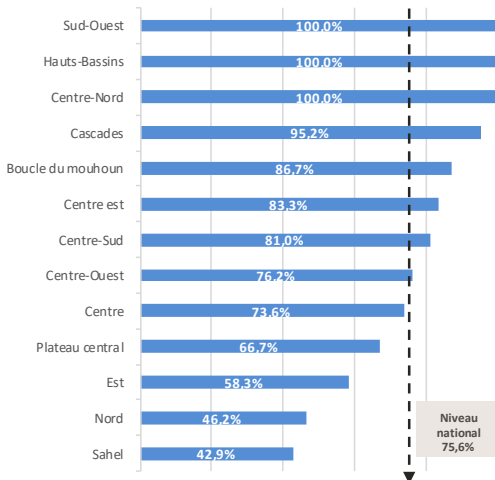
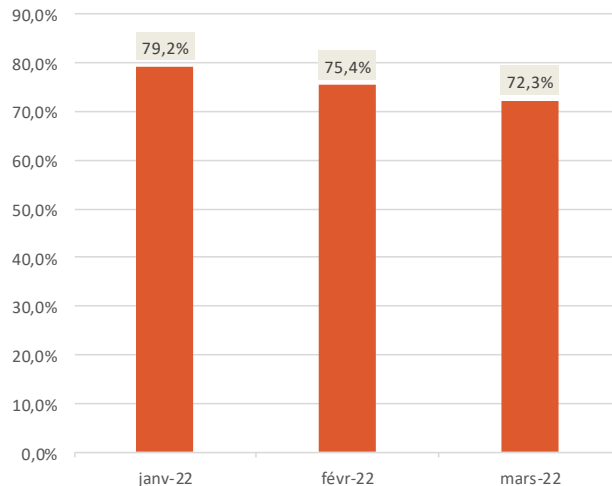


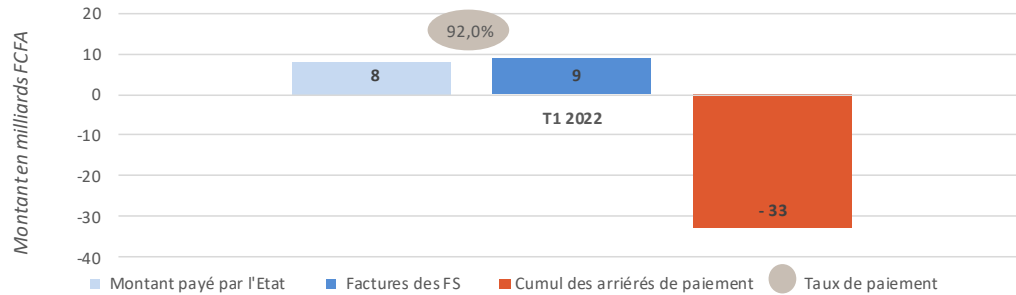
Figure 5 : Evolution mensuelle de la transmission des RMA Gratuité des CMA/CHR/CHU



# 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

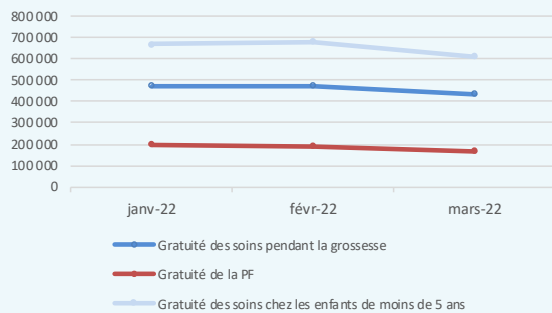
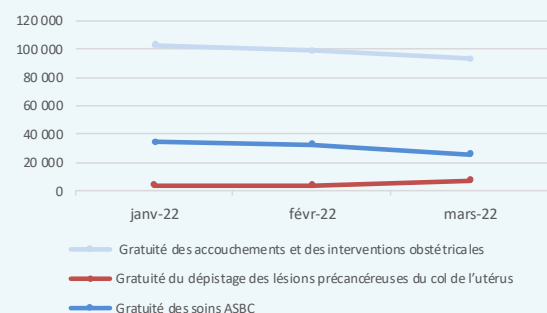


Figure 8 : Suivi des prestations réalisées au niveau national (suite et fin)



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

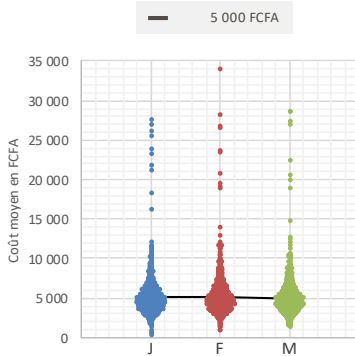


Figure 10 : Coûts moyens accouchements par voie basse au CMA

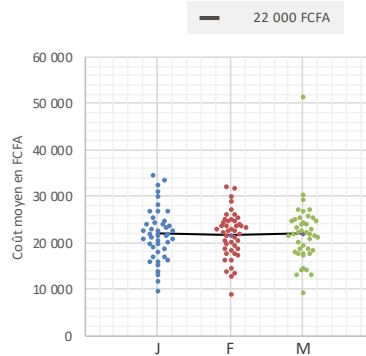
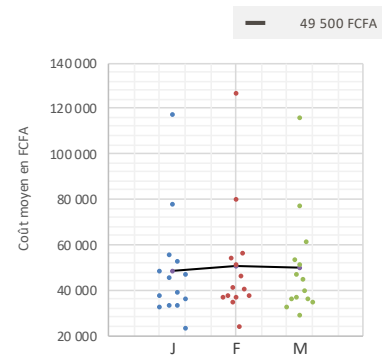


Figure 11 : Coûts moyens accouchements par voie basse au CHR/CHU





# ACHAT DE SERVICE

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

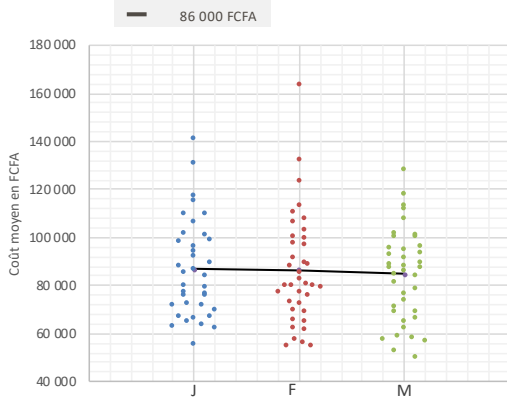


Figure 13: Coûts moyens de la césarienne au CHR/CHU

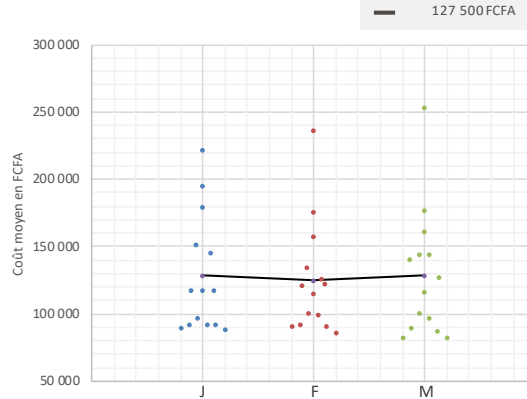


Figure 14: Coûts moyens soins enfants au CSPS/CM

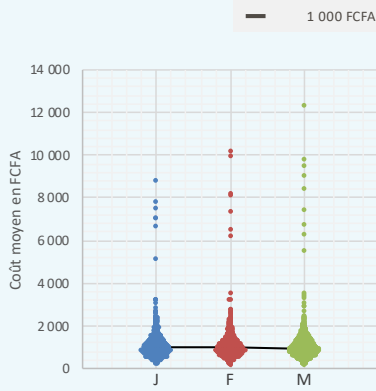


Figure 15: Coûts moyens soins enfants au CMA

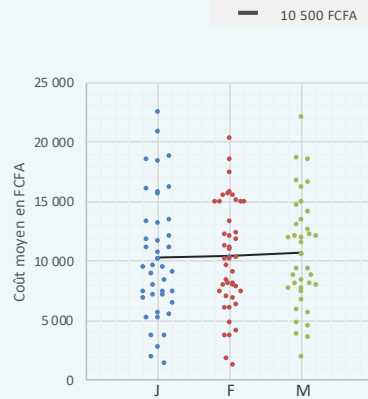


Figure 16 : Coûts moyens soins enfants au CHR/CHU

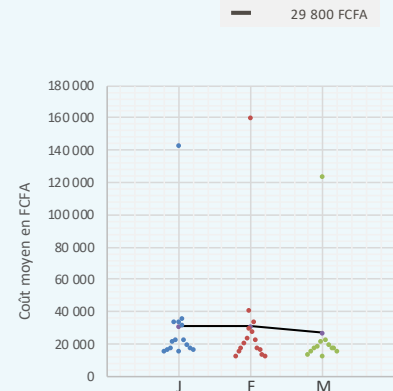


Figure 17: Coûts moyens PF au CSPS/CM

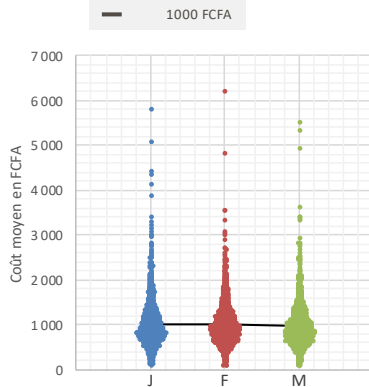


Figure 18: Coûts moyens PF au CMA/CHR/CHU

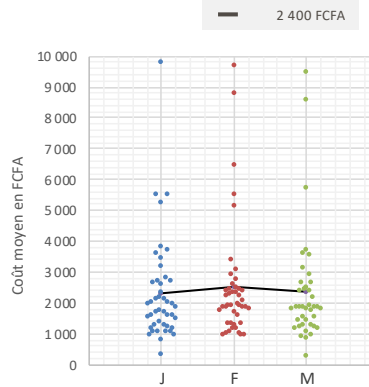
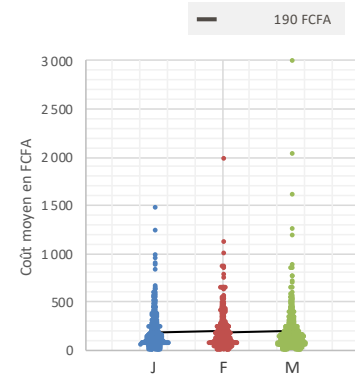


Figure 19: Coûts moyens soins ASBC





# MÉDICAMENTS ESSENTIELS ET GÉNÉRIQUES\*

\*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

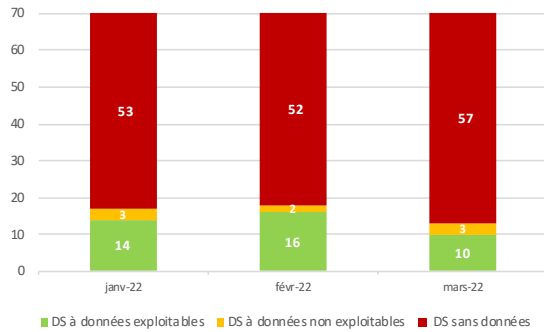
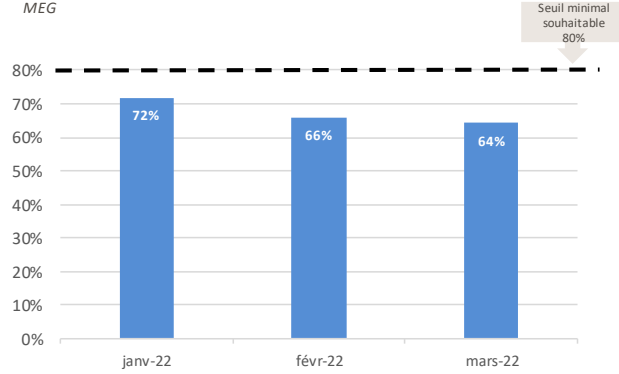


Figure 21: Evolution mensuelle de l'Index de satisfaction globale (ISG) des commandes MEG



Le faible rapportage sur les données MEG est également constaté sur la notification des péremptions de médicaments. De 2021 au premier trimestre 2022, 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

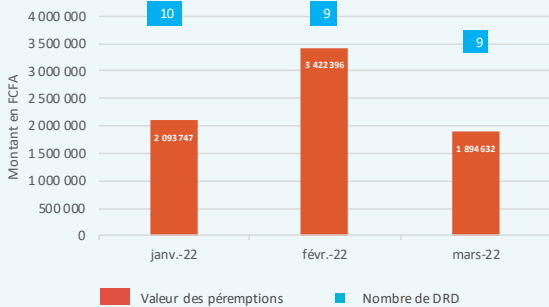
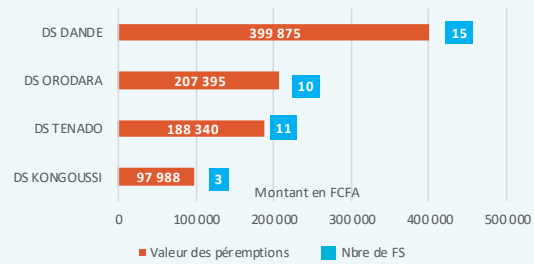


Figure 23: Valeur mensuelle (FCFA) des péremptions dans les dépôts MEG des CSPS/CM/CMA



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

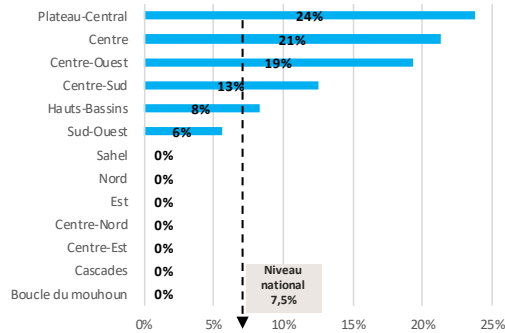
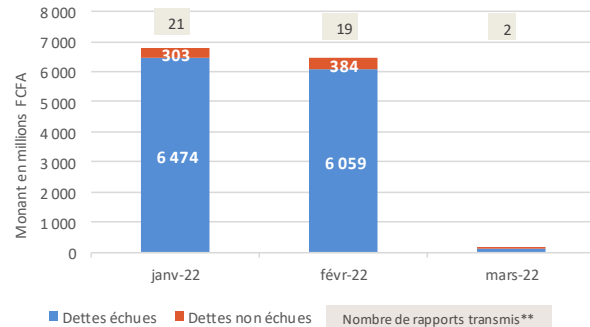


Figure 25: Dettes totales des DS et des hôpitaux envers la CAMEG



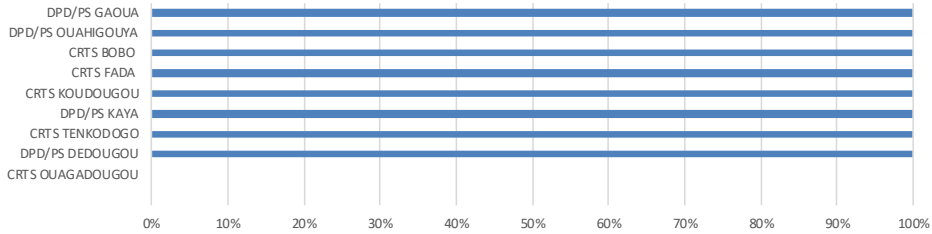
\*\*Nombre de rapports attendus = 85, soit 15 CHR/CHU + 70 DS



# 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

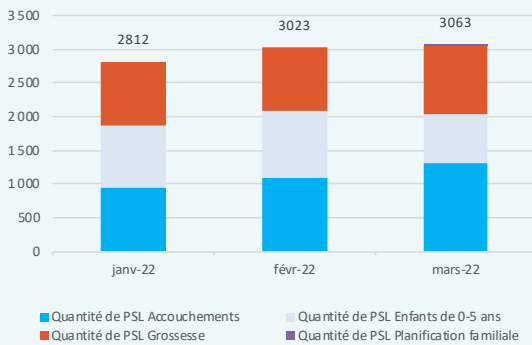
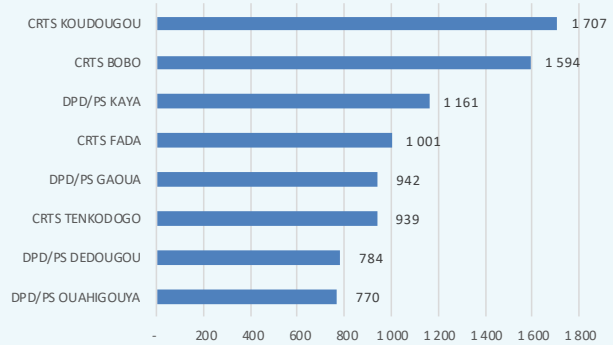
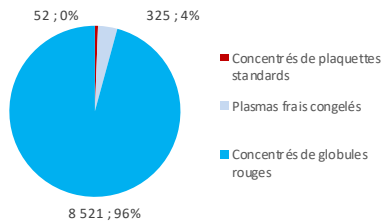


Figure 28 : Nombre de PSL distribués par CRTS



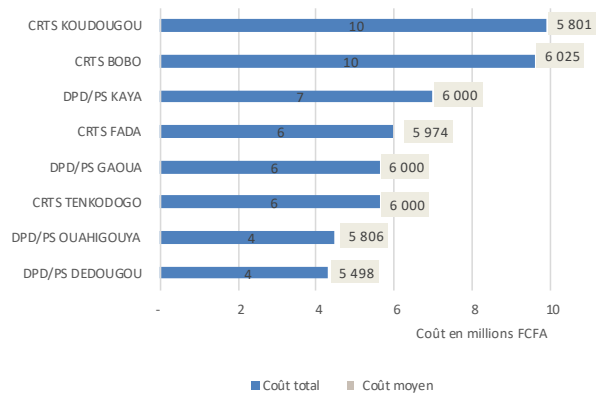
De janvier à mars 2022, les concentrés de globules rouges et les plasmas frais congelés ont été principalement les plus distribués par le CNTS. Le coût total des PSL distribués s'élève à 52 520 500 FCFA au niveau national avec le CRTS de Koudougou en tête et le DPD/PS de Dédougou enregistrant le plus 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
<b>Total PSL</b>	<b>8 898</b>	<b>52 520 500</b>	<b>5 903</b>

Figure 30 : Coût total des PSL distribués





The poster features a dark background with a world map and a large red ribbon graphic. At the top, the logos for PEPFAR (U.S. President's Emergency Plan for AIDS Relief), The Global Fund, and UNAIDS are displayed. The main title is 'PEPFAR-Global Fund-UNAIDS HIV Resource Alignment Collaboration'. Below the title is the subtitle: 'Advancing Strategic Alignment and Maximizing Value of Partner Country, Global Fund, PEPFAR, and Other Donor Investments for a Sustainable HIV/AIDS Response'. The dates '6-8 December 2022' and the event name 'Global Health Resource Tracking Workshop' are listed, along with the location 'Kigali, Rwanda'.

## 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 systems 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



## Use Case

Improved Data Quality and Harmonization	Alignment and Efficiency between Funding Sources	Effective Planning and Decision-Making
<ul style="list-style-type: none"> <li>- <b>DPs/Donors:</b> <ul style="list-style-type: none"> <li>- GF-PEPFAR classifications fully harmonized</li> </ul> </li> <li>- <b>Multilateral:</b> <ul style="list-style-type: none"> <li>- GF-PEPFAR classification harmonized with UNAIDS GAM followed by NASA</li> </ul> </li> <li>- <b>National:</b> <ul style="list-style-type: none"> <li>- Feeding into HIV resource tracking and resource planning activities</li> </ul> </li> <li>- <b>Cross organization</b> <ul style="list-style-type: none"> <li>- w/ WHO, WBG/GFF</li> </ul> </li> <li>- <b>Private Sector HIV landscape</b></li> </ul>	<ul style="list-style-type: none"> <li>- Provides <b>totality of HIV funding landscape</b> for a country</li> <li>- Improves visibility on <b>Domestic Government HIV financing</b></li> <li>- Routine granular data allows for <b>trends</b> and conduct <b>deep-dives:</b> <ul style="list-style-type: none"> <li>- Commodities</li> <li>- HRH</li> <li>- Health Systems</li> <li>- Beneficiary Populations</li> <li>- Service Delivery Modalities</li> </ul> </li> <li>- Enables <b>integrated analytics</b> <ul style="list-style-type: none"> <li>- Program data/outputs</li> <li>- Macro-fiscal</li> <li>- Cost analysis</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>- <b>DPs/Donors planning cycles</b> <ul style="list-style-type: none"> <li>- GF grant cycle, TRP</li> <li>- PEPFAR C/ROP</li> </ul> </li> <li>- <b>Joint national planning and coordination</b> <ul style="list-style-type: none"> <li>- National planning NSP, Health Sector, Resource Needs, Investment Case, Resource Allocation</li> <li>- Sustainability of the national HIV response</li> <li>- Increasing domestic leadership and resource mobilization</li> </ul> </li> </ul>



## Trends in Budget Allocation and Expenditures

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

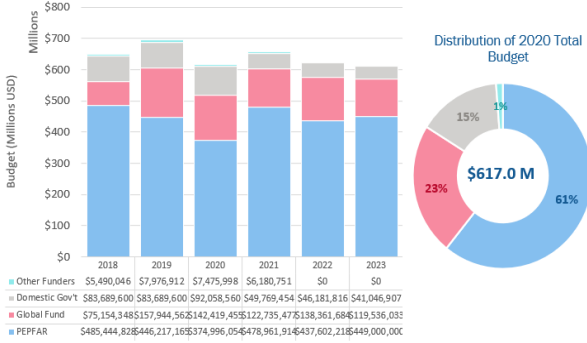
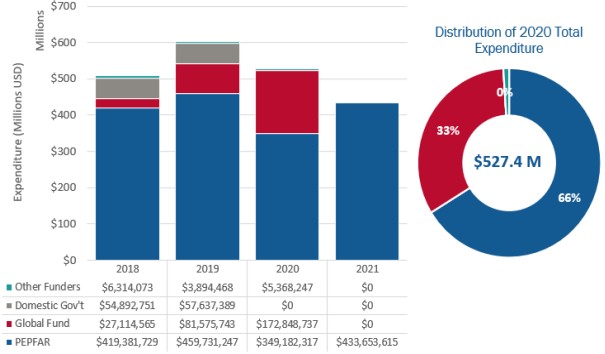


Figure D2: Trends in Total Expenditure Distribution by Funder (Millions)



## HIV Funding by Source and Elements

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

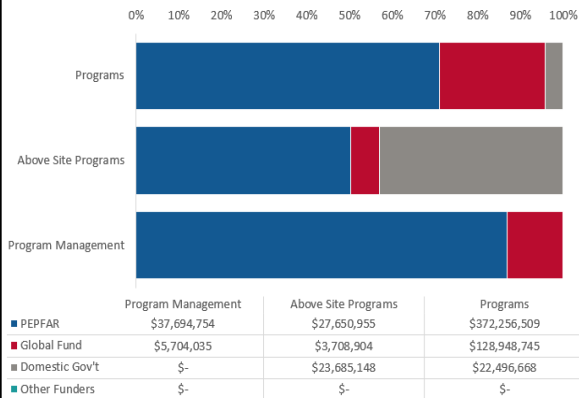
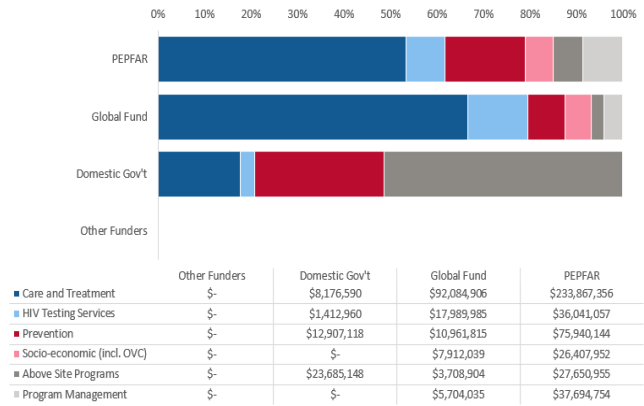


Figure C2: Budget Allocation by Funder, 2022



## Granularity on Commodities and Systems Investments

Figure C7: Commodity Budget by Funder, 2022

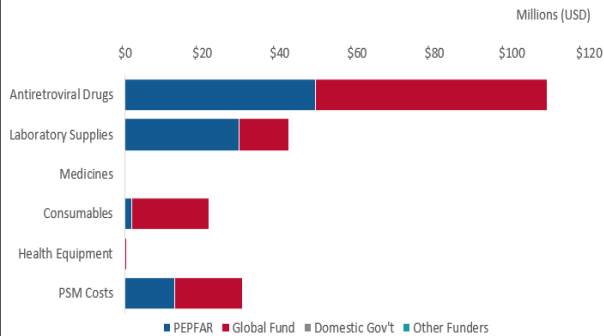
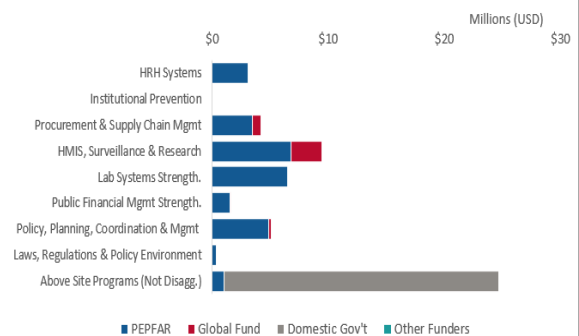


Figure C8: Above Site Budget by Funder, 2022



## Understanding Budget Allocation vs Expenditures

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

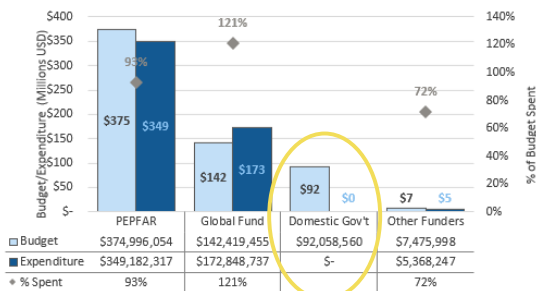
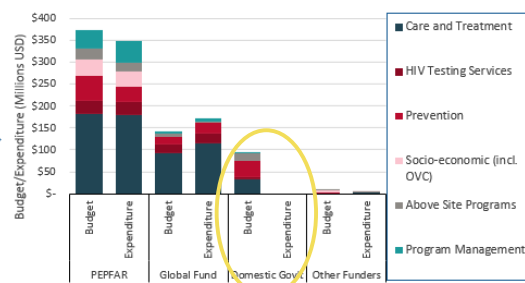


Figure D4: Total Detailed Budget Allocation vs Expenditure by Funder, 2020



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
<ul style="list-style-type: none"> <li>- <b>Donors:</b> <ul style="list-style-type: none"> <li>- GF-PEPFAR classifications fully harmonized</li> </ul> </li> <li>- <b>Multilateral:</b> <ul style="list-style-type: none"> <li>- GF-PEPFAR classification harmonized with UNAIDS GAM followed by NASA</li> </ul> </li> <li>- <b>National:</b> <ul style="list-style-type: none"> <li>- Feeding into HIV resource tracking and resource planning activities</li> </ul> </li> <li>- <b>Cross organization</b> <ul style="list-style-type: none"> <li>- w/ WHO, GFF, World Bank,</li> </ul> </li> <li>- <b>Private Sector HIV landscape</b></li> </ul>	<ul style="list-style-type: none"> <li>- Provides <b>totality of HIV funding landscape</b> for a country</li> <li>- Improves visibility on <b>Domestic Government HIV financing</b></li> <li>- Routine and granular data allows to view <b>trends</b> and conduct <b>deep-dives</b>:               <ul style="list-style-type: none"> <li>- Commodities</li> <li>- HRH</li> <li>- Health Systems</li> </ul> </li> <li>- Enables <b>integrated analytics</b> <ul style="list-style-type: none"> <li>- Program data/outputs</li> <li>- Macro-fiscal</li> <li>- Cost analysis</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>- <b>Donor planning cycles</b> <ul style="list-style-type: none"> <li>- GF grant cycle, TRP</li> <li>- PEPFAR C/ROP</li> </ul> </li> <li>- <b>Joint national planning and coordination</b> <ul style="list-style-type: none"> <li>- National planning NSP, Health Sector, Resource Needs and Investment Case</li> <li>- Sustainability of the national HIV response</li> <li>- Increasing domestic leadership and resource mobilization</li> </ul> </li> </ul>





# Harmonizing resource tracking exercises

Experiences from the Governments of Malawi and Zimbabwe

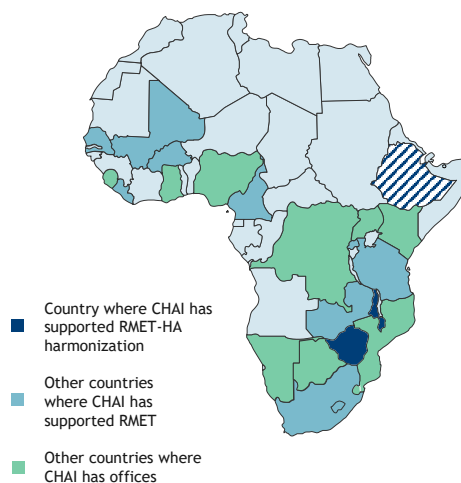
## About Clinton Health Access Initiative (CHAI)

- 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:

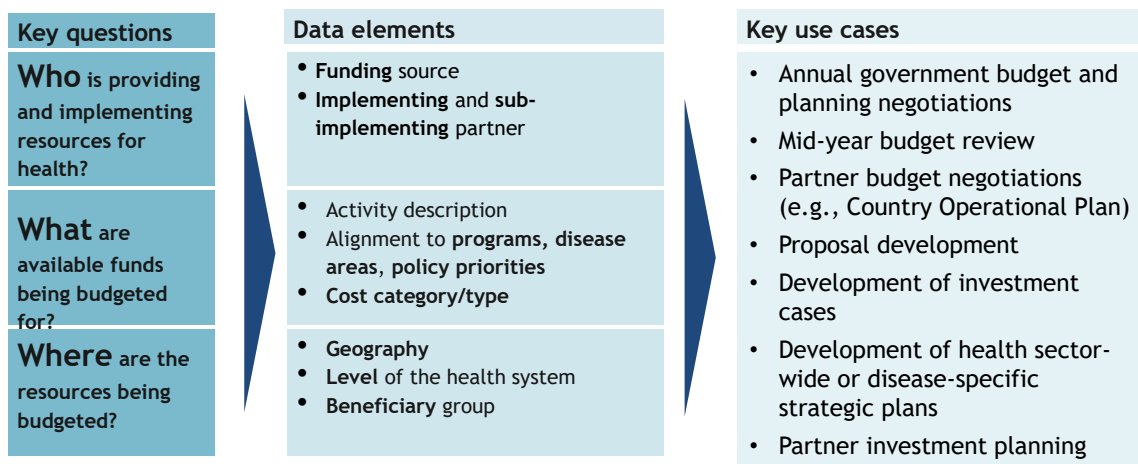
- Serena Sonderegger ([ssonderegger@clintonhealthaccess.org](mailto:ssonderegger@clintonhealthaccess.org))
- Meg McCarty ([mmcarty@clintonhealthaccess.org](mailto:mmcarty@clintonhealthaccess.org))

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

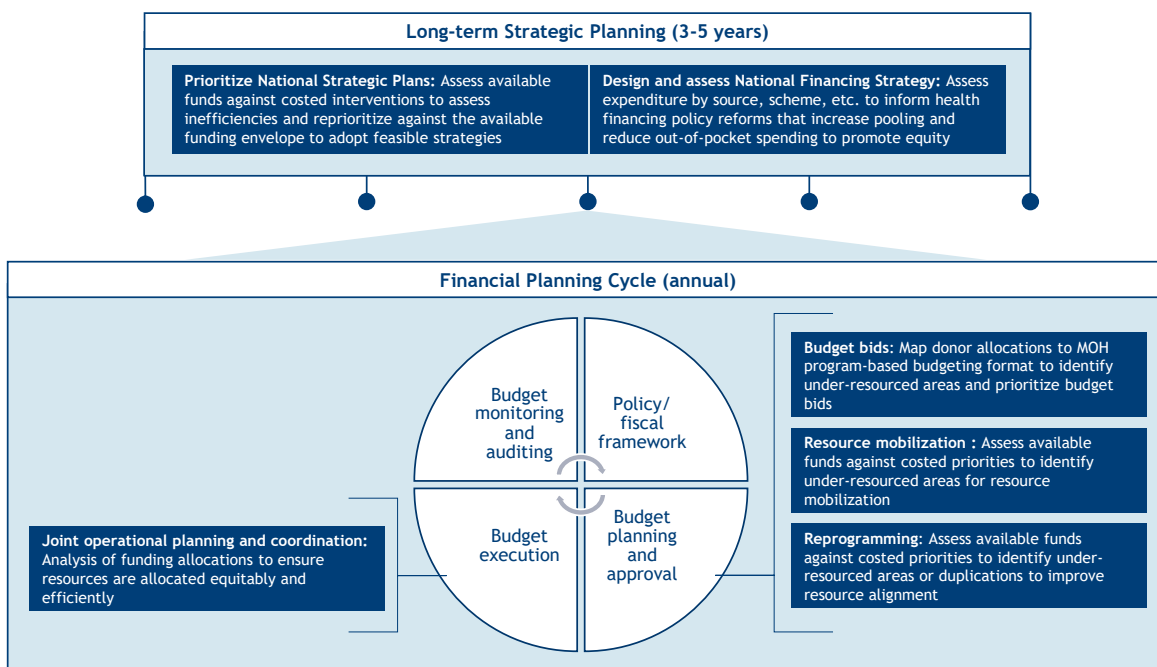


## Process: Resource Mapping and Expenditure Tracking

- 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.,:

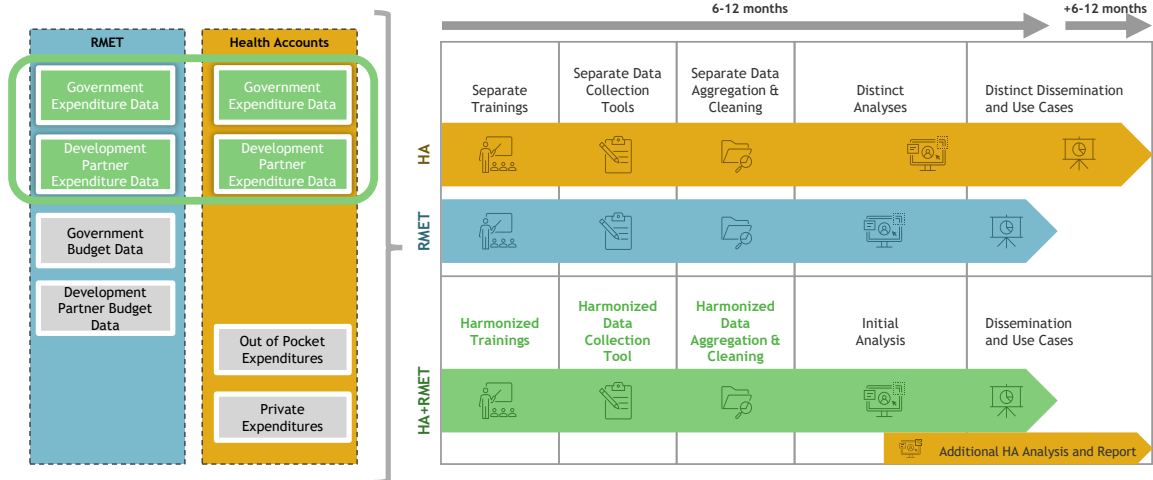


## Use Cases of Resource Mapping and Expenditure Tracking

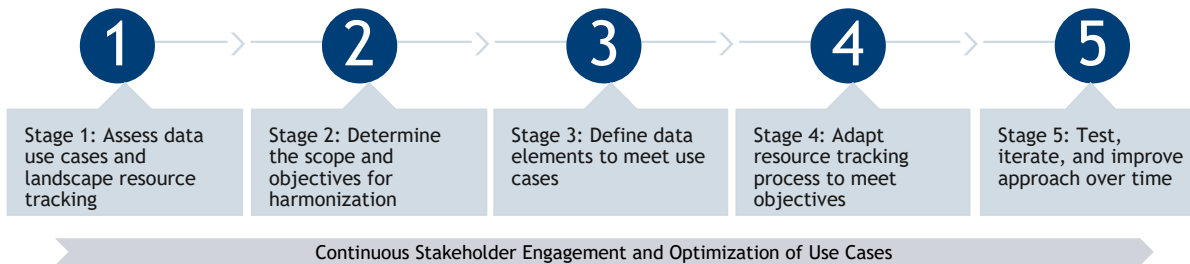


## Promising Practice: Harmonization of Resource Tracking Exercises

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



**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.

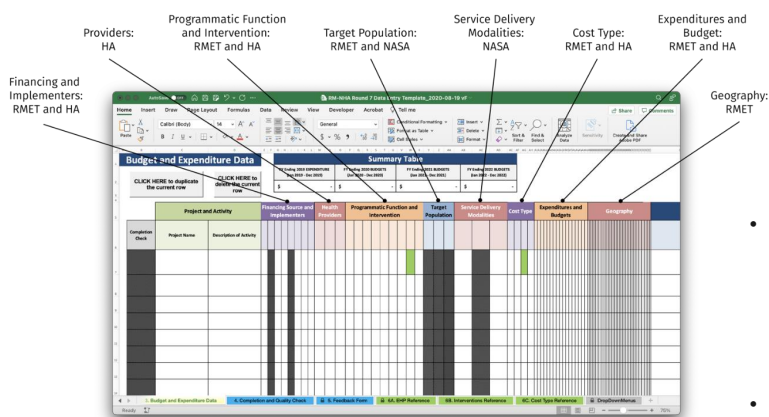
**Stage 5.** Routine implementation and improvement of resource tracking to ensure continued relevance and integration with other financial processes.

*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



- **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.*

Malawi tool available [here](#)

Zimbabwe tool available [here](#)



## 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

F	G	H
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

I	J	K
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.

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## 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

## 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

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Poster 5: Cooper/Smith Enabling a Digital HRT Platform in Liberia



## Enabling a Digital Health Resource Tracking Platform in Liberia

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**MINISTRY OF HEALTH**  
Republic of Liberia

**BILL & MELINDA GATES foundation**

### ORGANIZATIONAL INFORMATION

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

**ADDITIVE EXPERTISE**

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

Please see [our website](#) for more information or email us: [contact@coopersmith.org](mailto:contact@coopersmith.org)

1

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## 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

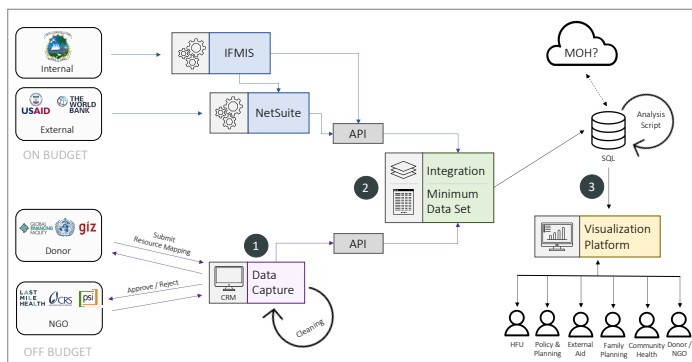


Figure 1. High-level schematic of a digital health resource tracking tool that leveraged existing systems and processes where possible, which was subsequently approved by key stakeholders within the MOH

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

All Organizations						
Organization Name	Email	Position	Phone	Name	View Activities	Users
Ministry of Health		Accountant			View Activities	
Christian Aid Ministries		Official Business and PRD			View Activities	
John Hopkins University		Senior Finance Officer			View Activities	
United States Pharmaceutical		Finance & Operations Manager			View Activities	

All Activities							
ID	Project Name	Organization Name	Donor	Project Start D.	Project End D.	Status	View
294514500000723094	Strengthen Health in Liberia	Christian Aid Ministries	Methodist Churches	2020-01-01	2023-12-31	Draft	View
294514500000723042	Gender Sensible Development of Health Workforce	GIZ	Germany	2020-09-20	2023-09-30	Draft	View
294514500000729083	Mental Health	Center Center Mental Health Program	Center Center USA	2023-01-01	2023-09-30	Draft	View
294514500000722083	Support COVID-19 Response in Liberia	World Health Organization (WHO)	USAID	2023-01-01	2023-01-31	Draft	View
294514500000721108	Promoting Quality Medicines Plus	United States Pharmaceutical	USAID			Under Review	View

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



MINISTRY OF HEALTH  
Republic of Liberia

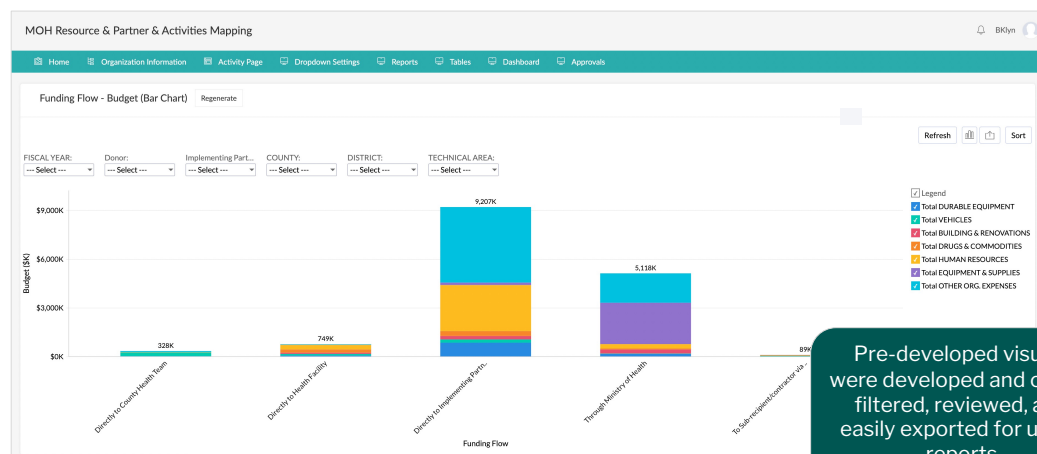
COOPER / SMITH

GLOBAL FINANCING FACILITY

BILL & MELINDA GATES Foundation

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



MINISTRY OF HEALTH  
Republic of Liberia

COOPER / SMITH

GLOBAL FINANCING FACILITY

BILL & MELINDA GATES Foundation

### 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](mailto: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.

## 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:

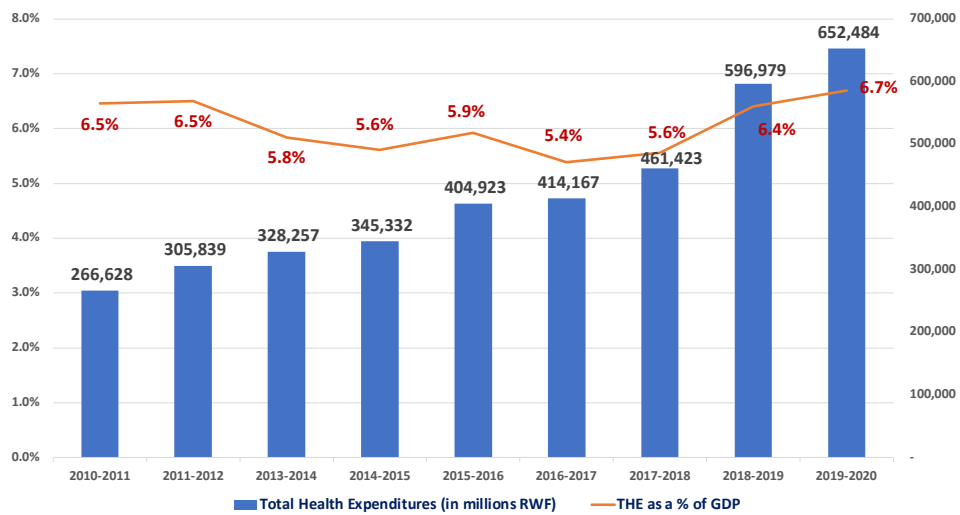
- Harmonization of funding sources, agents, implementers, input categories across all levels of stakeholders and comparing reporting across funding sources and agents to identify double-counting.

2

## Findings



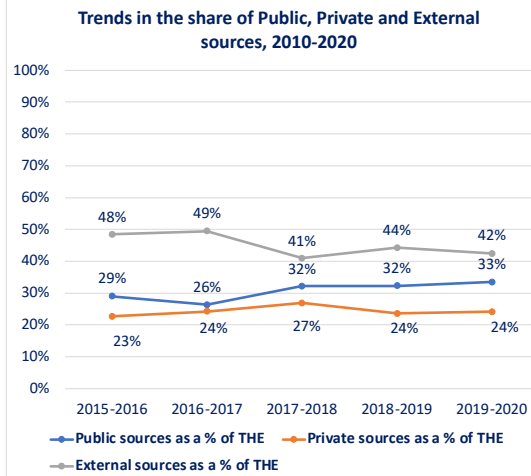
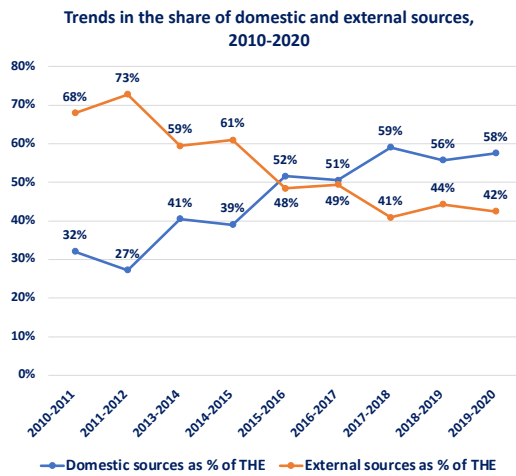
THE vs THE as a share of GDP



3



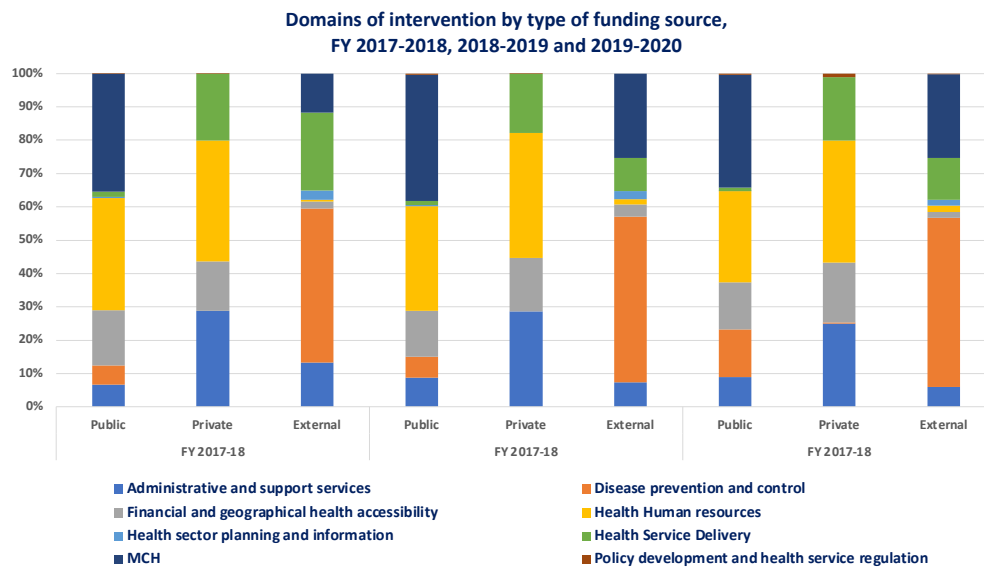
## Findings



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

4

## Findings



5

## 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.

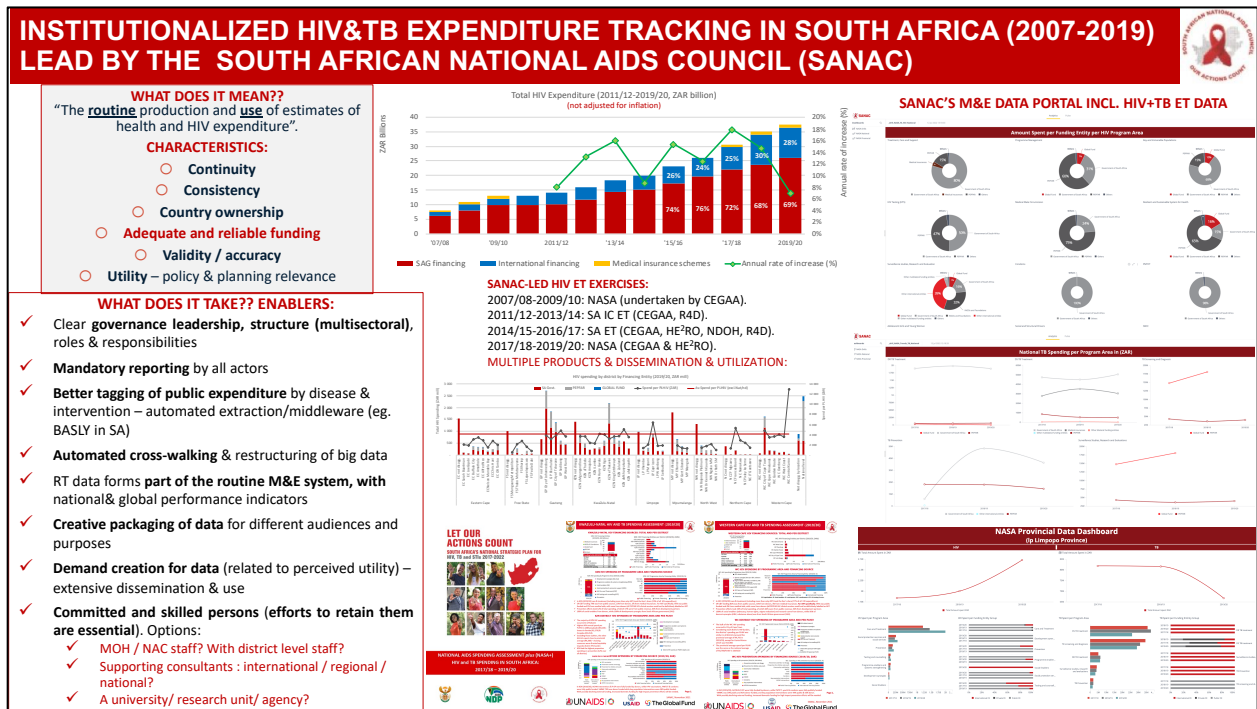
Redesign the HRTT system and processes: review and adapt data collection templates to reflect data needs, strengthen data entry training & continuously engage the leadership of stakeholder organizations to improve ownership and accountability of the reporting.

Improve staff retention and continuously build capacity

Explore the opportunity for interoperability across existing data systems.

7

Poster 7: Institutionalized HIV & TB Expenditure Tracking In South Africa (2007-2019) Led By The South African National Aids Council (Sanac)



## WHAT DOES IT MEAN??

“The routinized production and use of estimates of health and HIV expenditure”.

### CHARACTERISTICS:

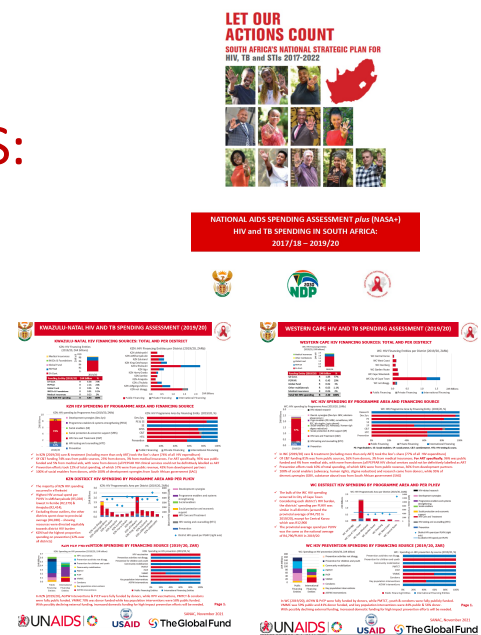
- Continuity
- Consistency
- Country ownership
- Adequate and reliable funding
- Validity / accuracy
- Utility – policy & planning relevance

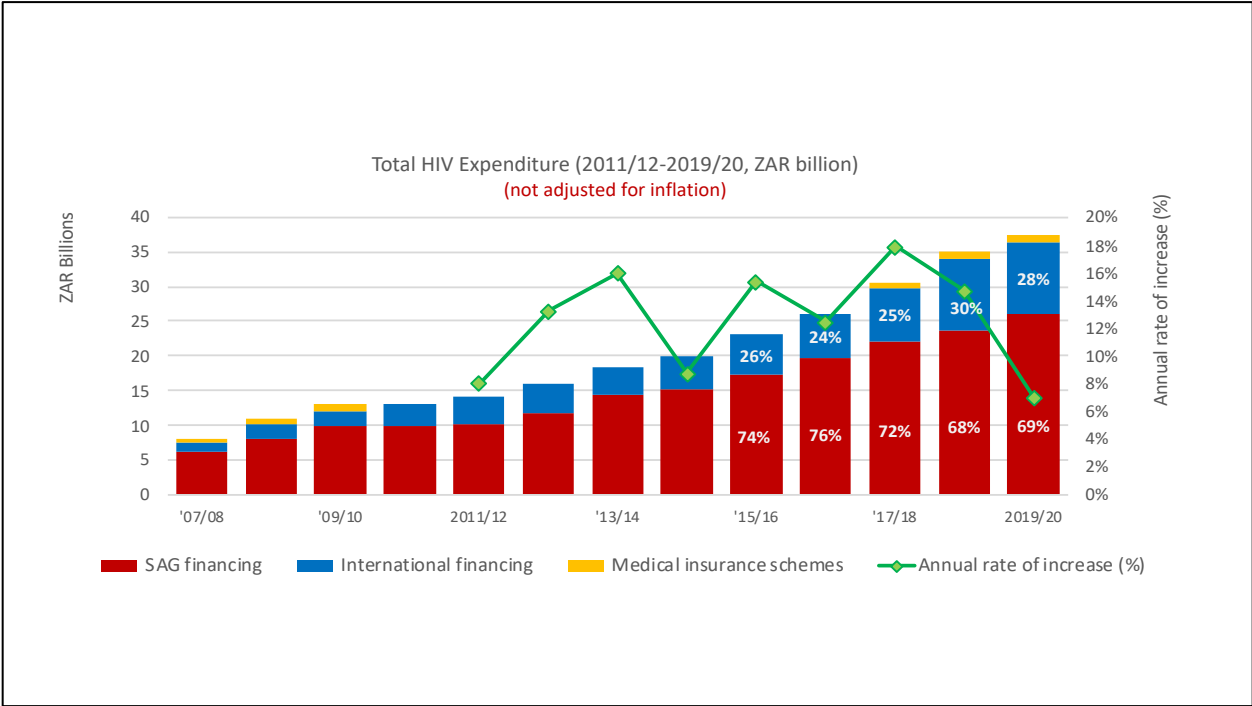
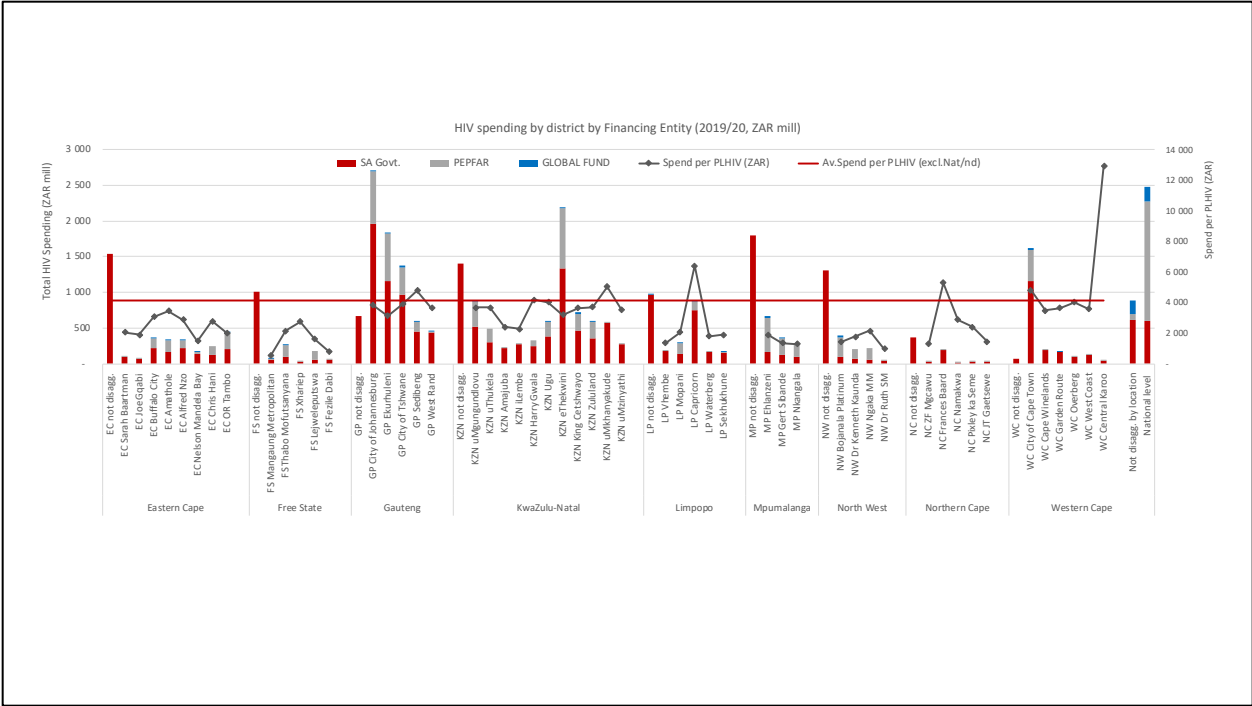
## WHAT DOES IT TAKE?? ENABLERS:

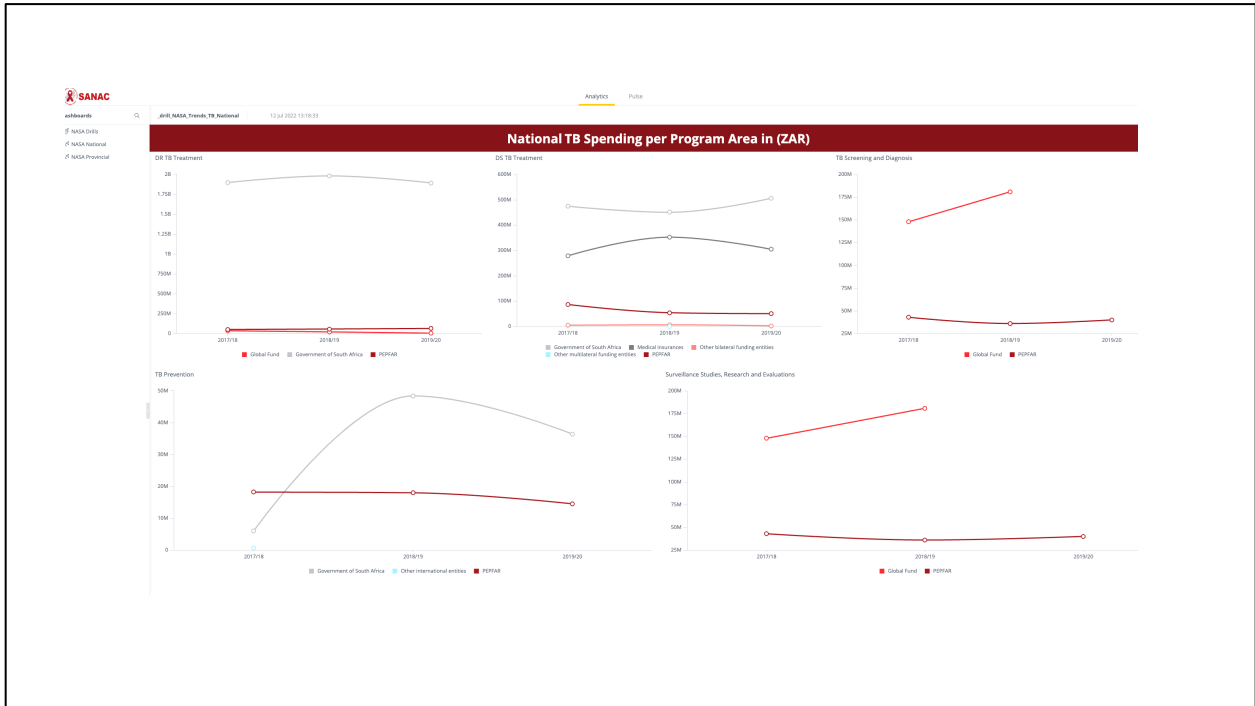
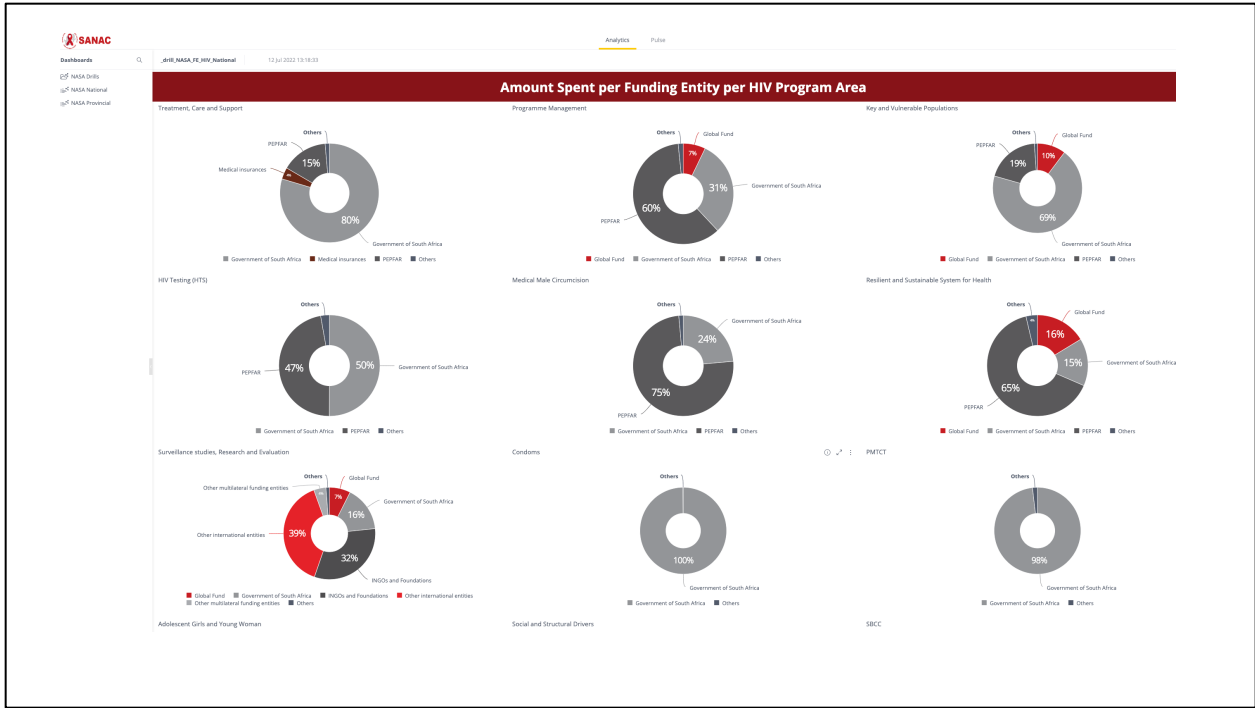
- ✓ Clear **governance leadership, structure (multisectoral)**, roles & responsibilities
- ✓ **Mandatory reporting** by all actors
- ✓ **Better tagging of public expenditure** by disease & intervention – automated extraction/middleware (eg. BASLY in SA)
- ✓ **Automated cross-walking** & restructuring 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<sup>2</sup>RO, NDOH, R4D).
- 2017/18-2019/20: NASA (CEGAA & HE<sup>2</sup>RO).
- **MULTIPLE PRODUCTS & DISSEMINATION & UTILIZATION**







# NASA Provincial Data Dashboard (Ip Limpopo Province)



## 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](mailto:guthriehealthfinancingconsult@gmail.com)



### 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](mailto:akelley@r4d.org)

Teresa Guthrie, R4D Senior fellow: [guthriehealthfinancingconsult@gmail.com](mailto: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:

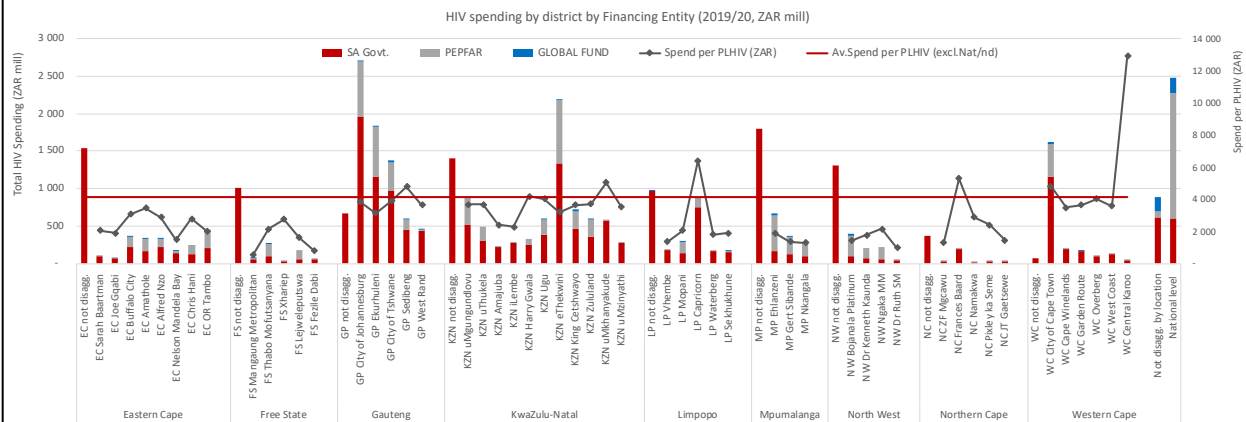
Contact: Deepak Mattur, UNAIDS: [matturd@unaids.org](mailto:matturd@unaids.org)  
 Teresa Guthrie: [guthriehealthfinancingconsult@gmail.com](mailto:guthriehealthfinancingconsult@gmail.com)  
 UNAIDS programme area on resources and financing:  
<https://www.unaids.org/en/topic/resources>  
 UNAIDS financial 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

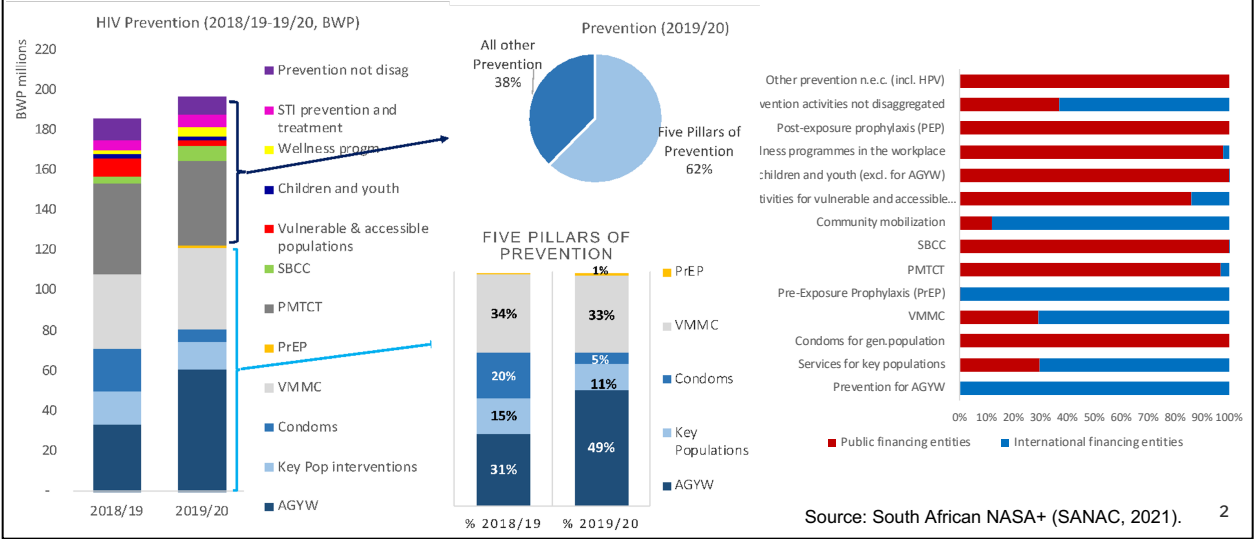
## NASA PROVIDES SUB-NATIONAL EXPENDITURE & SPEND PER PLHIV: Equitable distribution of resources to meet need? Partners focus?



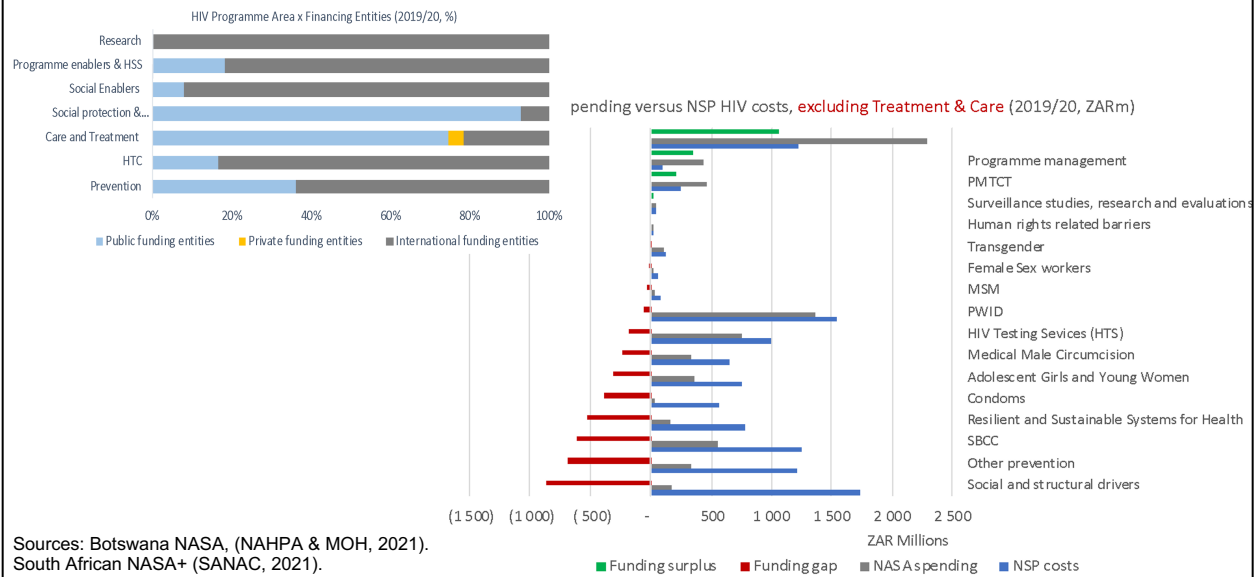
Source: South African NASA+ (SANAC, 2021).

1

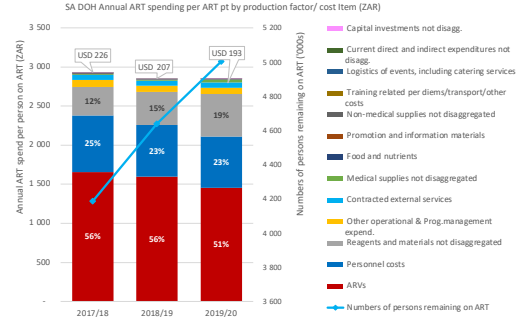
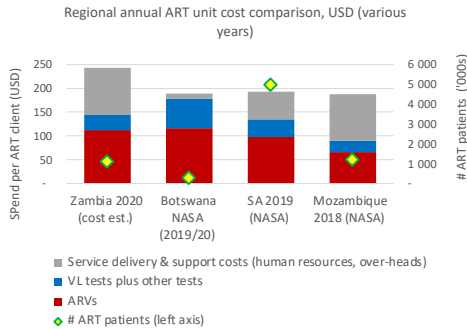
# NASA PROVIDES INDEPTH UNDERSTANDING OF CROSS-SECTORAL HIV INTERVENTIONS – Optimal investments? Prevention impact?



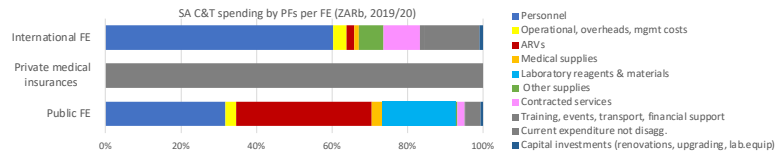
# NASA MATCHES THE NSP GOALS & INTERVENTIONS AND SHOWS SUSTAINABILITY / VULNERABILITY / FUNDING GAPS



# 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?



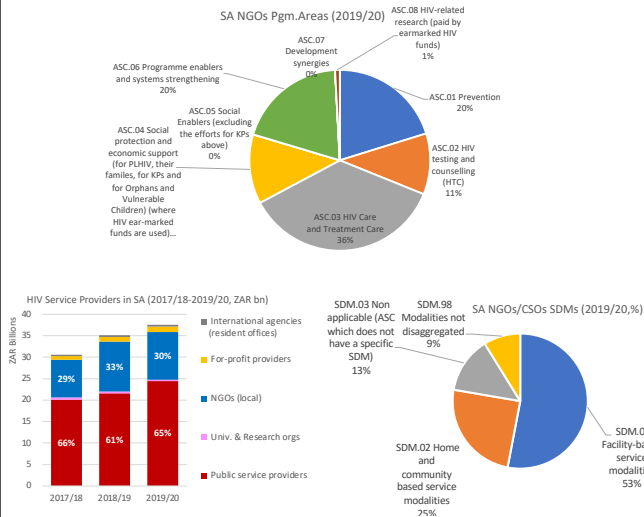
Sources: Country NASA reports or NSP costing.  
• Botswana unit spend missing MOHW shared HIV personnel & over-head costs (pending HA report).



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

4

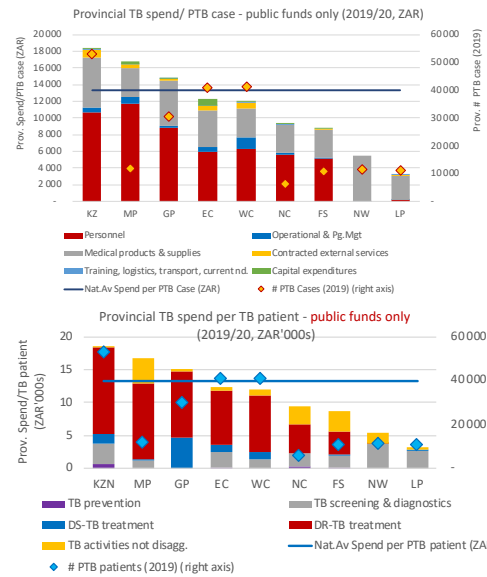
## NASA PROVIDES VALUABLE INSIGHTS INTO THE SERVICE PROVIDERS and MODALITIES of DELIVERY: e.g. what funds are consumed by community-based organisations, from whom and for which services?



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

Interested countries can contact UNAIDS and access NASA materials: [mattur@unaids.org](mailto:mattur@unaids.org)

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



# 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



## 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.



## How much on specific topics/diseases?

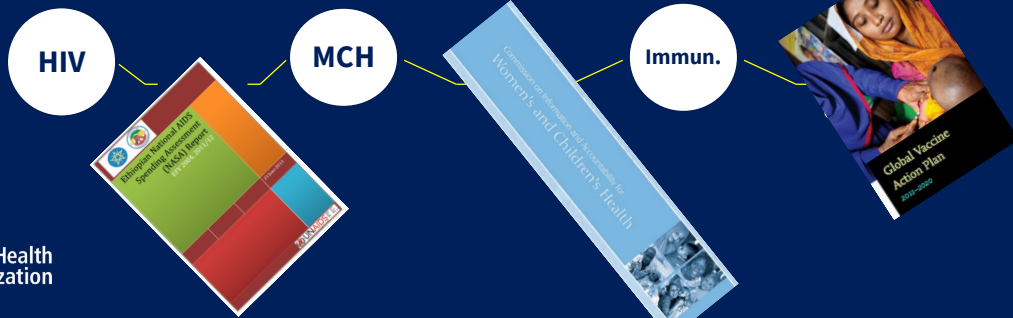
PubMed.gov  
US National Library of Medicine  
National Institutes of Health

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

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

[Article in Undetermined Language]

ANDELKOVIC D.



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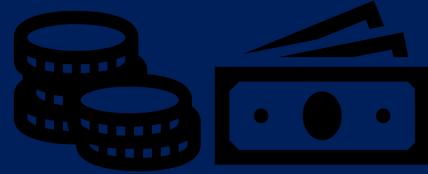
- Demand for more detail information continue growing
  - For program management and M&E purposes,
  - In addition to the policy, strategic planning & resource allocation purposes

World Health Organization



# 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**.



# Global Health Expenditure Database (From Year 2000)



**World Health Organization**

## Global Health Expenditure Database

العربية 中文 English

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

**Select**

- Indicators and data**  
0 of 152 selected  
Reset x
- Countries**  
0 of 193 selected  
Reset x
- Years**  
0 of 17 selected  
Reset x
- Units of expenditures**  
Million NCU

**Indicators and data**

Quick filter

- INDICATORS
- HEALTH EXPENDITURE DATA
- MACRO DATA



**World Health Organization**

### Global Health Expenditure Database

The Global Health Expenditure Database (GHED) provides comparable data on health expenditure for 192 countries over the past 20 years. Health spending indicators are key guides for monitoring resource, provision of transparency and supporting the accountability of health financing systems. The present time series, from 2000 to 2019, up to the COVID-19 pandemic period, provide a basis for assessing future changes in health systems. They also support the goal of Universal Health Coverage (UHC) by helping monitor the availability of resources for health. The published data stimulate further research and discussion of health policy at the global, regional and national levels, as well as improving the data availability and quality. The database is open access and contributes to a better understanding of:

- How much do countries spend on health?
- How much do government, insurance companies, households and donors contribute to health spending?
- How much money is spent on primary health care (PHC)?
- How much is spent on specific health services?
- How much money is spent to fight different diseases and conditions?

WHO works collaboratively with Member States and updates the data base (Explore the Data) annually using available information such as health accounts data, government expenditure records and official statistics. Where necessary, modifications and estimates are made to ensure the comprehensiveness and consistency of the data across countries and years.



# Global Spending on Health Reports

[www.who.int/teams/health-systems-governance-and-financing/global-spending-on-health-report](http://www.who.int/teams/health-systems-governance-and-financing/global-spending-on-health-report)



(Yearly Publication)



7

# Global Spending on Health Reports

[www.who.int/teams/health-systems-governance-and-financing/global-spending-on-health-report](http://www.who.int/teams/health-systems-governance-and-financing/global-spending-on-health-report)



■ **Thursday December 8, 2022** ■

2.00 - 3.30 pm CET • 8.00 - 9.30 am EST

# Methodological Challenges

- International Framework

<https://.../publica>



## Measuring primary health care expenditure under SHA 2011

Technical note, December 2021

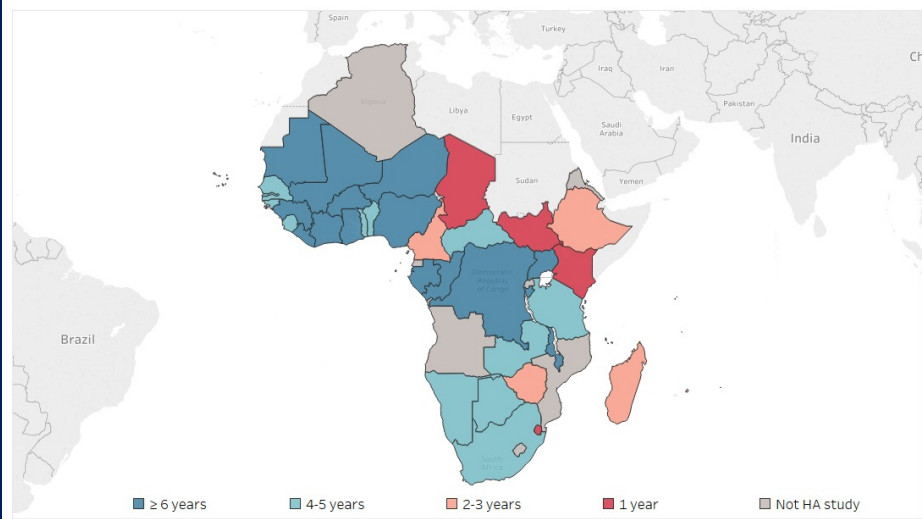


World Health Organization  
Tracking COVID-19 health expenditure using the System of Health Accounts Framework  
Technical note, version June 2022

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# Implementation Challenges



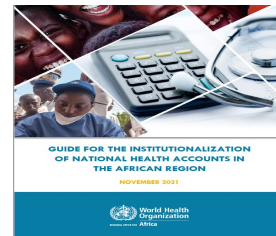
# Implementation challenges

- 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

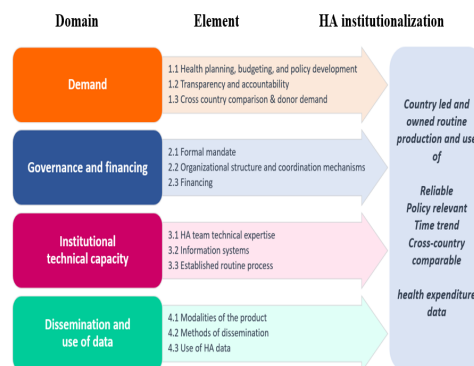


11

**“...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)