An Aidspan Report

# Data For Decision Making Roundtable

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Independent observer
of the Global Fund
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# Preface

**Aidspan** (www.aidspan.org) is an international NGO based in Nairobi, Kenya, whose mission is to be an effective watchdog of the Global Fund at global and country levels, by providing information, critical analysis and commentary on developments at the Fund. Aidspan is an indispensable resource for a broad range of stakeholders – from policy makers seeking independent critique and guidance on the Fund's processes, investments and progress; to grassroots organizations seeking access to Global Fund's resources.

Aidspan provides information, targeted analyses and independent commentary via its official website, Global Fund Observer (GFO) newsletter, social media, and other communication channels. To receive the GFO Newsletter, go to www.aidspan.org and click on the "Subscribe to GFO Newsletter" link. To follow Aidspan on Facebook and Twitter, click here and here.
Other reports recently published by Aidspan include:

- Value for money of Global Fund investments in HIV, TB and malaria in selected sub-Saharan countries
- Impact of Global Fund withdrawal on programs and service delivery in Bosnia and Herzegovina
- Accountability for Global Fund grants in Malawi
- Asia Pacific Report
- Transitions from donor funding domestic reliance on HIV responses – Recommendations for transitioning countries

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# Executive Summary

Aidspan convened a round-table discussion on data for decision-making in Global Fund against HIV/AIDS, TB and malaria grants in seven African countries – Cameroon, Kenya, Malawi, Nigeria, Rwanda, Uganda and Zambia. The three-day meeting that took place from 14th to 16th March, 2018 in Nairobi, Kenya, drew over 50 participants representing Country Coordinating Mechanisms (CCM), State and non-State implementers, Civil Society Organizations (CSOs) and Local Fund Agent (LFA).

The roundtable pursued shared solutions to the challenges of data collection and use in Global Fund operations in these seven countries. Discussions focused on data for: (a) appropriate decision-making in programming, (b) optimal absorption of grants, (c) efficient health product and commodity procurement, and (d) demonstrating and influencing domestic and co-financing.

The roundtable discussions centered on how strengthening data systems impacts forecasting, planning and implementation. Participants noted the importance of data generators and users working well together to ensure that the data collected are analyzed and utilized to improve grant efficiency.

A vibrant exchange of ideas led to countries verbally affirming their commitment to test best practices within their own contexts. One such practice is the assignment of a focal point to proactively monitor procurement expenditure, especially those conducted offshore. Thus, savings can be timely reallocated to improve grant absorption. Another valuable lesson was the timely use of data for better planning, implementation and accounting for country co-financing. Participants affirmed the importance of reliable and routine systems such as health information systems and annual national health accounts. In addition, participants encouraged the LFAs to invest in M&E capacity within their teams in order to strengthen the use of data for improved programming.

It is clear that there is an ardent need for similar, regular roundtables where different country PR and SR, CCM, LFA and Global Fund secretariat can interact, listen and learn from one another in an independent setting.

This report lays out in greater detail the presentations, discussions and recommendations from this learning and exchange roundtable.

## Abbreviations

ACB: Africa Constituency Bureau
CCM: Country Coordinating Mechanism
CHAZ: Christian Health Association of Zambia
CSO: Civil Society Organization
KCM: Kenya's Country Coordinating Mechanism
KEMSA: Kenya Medical Supplies Authority
LFA: Local Fund Agent
MoH: Ministry of Health
OIG: Office of the Inspector General
PET: Performance Evaluation Tool
PF: Performance Framework
PU/DR: Progress Update and Disbursement Requests
PR: Principal Recipient
SR: Sub Recipients
SSR: Sub Sub Recipient or Service Provider
SIIC: Strategy, Investment and Impact Committee of the Board
VOI: Verification of Investment

# Introduction

Aidspan convened a round-table discussion on data for decision-making in Global Fund against HIV/AIDS, TB and malaria (hereafter Global Fund) grants in seven African countries – Kenya, Zambia, Cameroon, Rwanda, Malawi, Nigeria and Uganda. The three-day meeting that took place on 14th to 16th March, 2018 at the Southern Sun Hotel in Nairobi, Kenya drew over 50 participants representing Country Coordinating Mechanisms (CCM), principal and sub-recipients (PRs and SRs), civil society organizations (CSOs) and Ministry of Health officials (MoH) leading the fight against HIV/AIDS, TB and malaria in these seven countries.

## Roundtable Objectives

The roundtable aimed to generate knowledge and share participant experiences on data collection and use for key performance indicators as well as data related issues of absorption capacity and domestic financing. The consultation was intended to be pragmatic, results-oriented, and directed toward the search for mutual solutions to the challenges of data collection and analysis in Global Fund operations in these seven countries.

Data is central to: (a) appropriate decision-making in programming (design, implementation and evaluation), (b) optimal absorption of grants through re-programming, (c) efficient health product and commodity procurement, and (d) demonstrating and influencing domestic and co-financing. Improving the quality of data collection and analysis is therefore central to the improvement of the Global Fund's grant efficiency.

## Roundtable Report

This report provides a brief overview of the conference presentations and key issues that emerged during discussions before concluding with the recommended next steps for action by the Global Fund secretariat, CCMs, PRs and Aidspan.

## Conference Opening

*Ida HAKINZINKA, Aidspan's Executive Director*

Aidspan provides analysis and reporting for more effective use of Global Fund grants. To illustrate the importance of data for grant absorption, Ida explained that out of USD 3.6 billion budgeted for these seven countries, an estimated USD 828 million had not been used by October 2017. Indeed, it is unlikely that countries would absorb that amount in the last three months of 2017. Therefore, it can be concluded that at least USD 800 million that were previously allocated to countries has not been used in those countries due to poor grants governance leading to poor programmatic and financing performance.

## Contribution of Country Data to the Global Fund Key Performance Indicators (KPI)

*Daniel Ngamije, Individual consultant and Conference Facilitator (on behalf of the Global Fund secretariat)*

The Global Fund's framework for data use for action and improvement has five components that are aligned with the Global Fund strategy:

1) sustainable national M&E systems and fostering country ownership and alignment;
2) disaggregation, data quality, analysis and use of data for program improvement;
3) country support for institutionalizing review of progress through regular reviews and evaluations;
4) implementation through partnership approaches, including outcome-based agreements, and;
5) continuous learning, feedback loops, adaptation, and improvement of approach.

The Global Fund has invested in country data systems through provision of technical support to strengthen M&E systems and analytical capacity. In the 2018-2020 grant period, $3M is allocated to creating a pool of certified consultants for technical support. During the implementation phase, data is used for program monitoring, specifically in measuring grant performance; it forms the basis for routine grant rating and thereby, grant disbursements. Data collected from countries and other sources also contributes to measuring progress against Global Fund strategic objectives and related KPIs.

***Discussion***

- **Discussions revolved around how to achieve health objectives if stakeholders do not use the data available and how to better use resources coming from the Global Fund.**
- Reinforcing country data systems is vital for health system sustainability. The greatest challenge is inclusive collaboration with all in-country partners to create a single, unified system and reduce parallel systems leading to discrepancies.
- **Data has to make sense to countries**. There is a need to encourage countries to put resources into developing their KPIs so that indicators are owned by the nation, and data is comparable across different diseases and donors. Indicators thus obtained are contextually relevant and useful.
- Implement the country's vision elaborated in its national strategic plans, which inevitably strengthens national ownership.
- CCMs should increase data use at all levels of evaluations, especially while assuring their grant oversight function. The use of data is especially significant also at the time of concept note development and when re-programming.

**Key points of Country Data for Key Performance Indicators (KPI)**

- The Global Fund is supporting improved data collection and use.
- Countries should reinforce data systems in order to generate contextually relevant data for use by all stakeholders including implementers and CCM.
- Data that makes sense to countries and implementation of country strategic plans leads to better country ownership.

## Typical Data Quality Challenges in Routine Reporting and Lessons Learnt - Perspectives of the Local Fund Agent (LFA)

*Rita Motlana, Director of DevPart Consult (LFA Monitoring & Evaluation (M&E) support)*

The presentation touched on the role of LFA professionals (M&E, Public Health and Programmatic), the importance of data in a Global Fund grant, the LFA assessment of routine performance, examples of good practices in the Progress Update (PU) preparation and verification processes, and the use of data to influence performance and programmatic delivery (absorption).

Data issues can often be traced to:

- absence of SOPs/Reporting guidelines with SRs and implementers;
- absence of templates;
- unspecified reporting deadlines;
- absence of indicator protocols that specify how data is to be reported (units and disaggregation e.g. what is a minimum service package?) and data sources.

Global Fund data is used to develop the Progress Update and Disbursement Requests (PU/DR). This data determines the indicator rating which determines the next disbursement. **Therefore, data is key to accessing funding.**

**Typical Progress Update (PU) shortcomings can be avoided when:**

- CCMs oversee PR in a proactive and practical manner;
- CCM secretariats have M&E specialists to enhance capacity;
- CCM secretariats monitor submissions of PU/DR reports to the Global Fund;
- LFAs provide CCM with high-level feedback on risks identified during verification of investments (VOI).

Program performance can be enhanced in the short-term by enhancing the PU/DR preparation and verification process and in the longer-term through addressing systemic data quality and reporting issues.

| **Performance rating** | | **Indicator rating** | **Cumulative budget amount** (including current funding request) |
|---|---|---|---|
| A1 | >100% | Exceeding expectations | Between 90-100% of cumulative budget through the next reporting period |
| A2 | 90-100% | Meet expectations | |
| B1 | 60-89% | Adequate | Between 60-89% of cumulative budget through the next reporting period |
| B2 | 30-59% | Inadequate but potential demonstrated | Between 30-59% of cumulative budget through the next reporting period |
| C | <30% | Unacceptable | To be discussed individually |

## Discussions

- Participants widely acknowledged **the importance of not just providing information but analysis**; good analyses address quantitative performance, grant investments and provide contextual perspective.
- **Enhancing LFA relationships positively impacts grant implementation**. Country examples include: LFA participation in the CCM secretariat meetings as an ex-officio member, like other partners (WHO and UNAIDS); regular meetings between the CCM chair and LFA team leads; and, continuous engagement with LFA in mission visits and debrief meetings.
- Good relationship management between CCMs, PRs and their SRs/SSRs as well as keeping updated on Global Fund policies and operating procedures is key.
- The LFA's focus on finance rather than M&E is of great concern; most LFAs do not have in country M&E experts and are therefore only able to provide financial expertise. Going forward, **LFAs must strengthen their M&E expertise** so that the entire data system is strengthened.
- Funding health system strengthening efforts reinforces the data system. In the current funding period, several health system strengthening requests have been rejected despite the health system being a strategic focus of the Global Fund**.**

## Systemic Issues that Affect Data Quality and Tips to Address them

*Rita Motlana, Director of DevPart Consult (LFA Monitoring & Evaluation (M&E) support)*

The presentation provided examples of systemic data issues, suggestions for tackling them and practical tips to improve grant management. Quality data is vital for reprogramming and for more useful indicators. Thus, **indicators must be reviewed in order to determine if the data is measuring what it is intended to measure**. One good practice is to establish ahead or time a regular system of revising reporting formats so that new indicator data is captured in time for Global Fund reporting.

**Discussions**

***Service Providers vs. Sub Recipients***

*When appropriate, countries can consider deploying service providers (cheaper, faster contracting for service or product provision) instead of sub recipients (costlier, slower contracting and must be closely monitored).*

*For example, if a grant is running behind and rated at B2, it is better not to tender for a sub recipient (SR) contract that may take a year to conclude but rather get several service providers and get the work done in a timely manner. Service providers are commissioned like a consultancy and do not own the data they collect.*

- **Robust contract management systems counter the possible abuse of service providers**. However, balancing issues of ownership and accountability requires coordinated and harmonized reporting.
- Detailed SR manuals are needed to provide guidelines on timely supervision by the PRs.
- CCMs are response for diligently identifying solutions that work best for their context. Below are two examples of contextually-relevant SR/SSR experiences:
    - Cameroon had a challenge in recruiting SRs for the new implementing period; the country negotiated with Global Fund to continue services with the existing SR for the first semester. For this first semester, no programmatic target was set, thus improving budget absorption that year.
    - Malawi used service providers to deliver TB health services in the mines for a contract time of 2 or 3 years.

## Country Findings: Case Study on Global Fund Data Collection, Analysis and Use

*Djesika Amendah, Aidspan*

Aidspan undertook a multi-country case study in: Cameroon, Kenya, Malawi, Rwanda and Zambia, funded by GIZ. This qualitative case study is the second of two phases that examines: (1) the data collection and use in-country and (2) the perception of Key Performance Indicators (KPI). Aidspan carried out a desk review of existing publications, grant agreements etc., and then reached out to key informants in these countries representing the CCM, PR, SR, Global Fund secretariat.

The case study found that there was general compliance in data collection and use for Global Fund reporting. Data flowed from implementers to the Global Fund and back through PR reporting every 6 months. However, the use of data in many cases stopped there. The study emphasized the **need for more data ownership especially at lower levels of governance**. Of central importance in the future, is improving the quality of data, and its subsequent use and analysis, as a pillar in the strengthening country health systems.

**Discussion**

- The Global Fund grant is performance-based; there is heavy focus on achieving targets. Thus, LFAs look for value for money to verify reports. In the current grant implementation model, **there is little motivation to stop and analyze the data collected or reflect and learn from the already implemented activities.**
- **Include data and M&E requirements in MOUs/contracts** between the PR and SR to improve data collection and use. Furthermore, the quarterly SR reports to PR that generate data should be analyzed and recommendations shared with CCM timely.
- CCMs are better able to assess and reinforce efficient grant implementation when supported by an independent M&E team within their CCM secretariat.

***An example of M&E support to CCM Secretariat*** *In Uganda, seven staff members support CCM oversight by working closely with other government M&E teams and furnishing CCM with well-synthesized information.*

# Data for Responsible--and Responsive--Decision Making Examples from Sub Saharan Africa (SSA)

*Danielle Doughman, Africa Population Health Research Center (APHRC)*

Good-quality data are essential for country governments, international institutions, and donors to accurately plan, budget, and evaluate development activities. Without basic development metrics, it is not possible to get an accurate picture of a country's development status or improve social services, achieve the Sustainable Development Goals, and improve prosperity for all. Providing evidence for long-term rather than one-off investment in data systems is imperative to Africa's data revolution.

**Barriers to decision-makers use of evidence include:**

- Availability and access to research,
- Reliability and relevance of research findings,
- Policy-maker's research skills
- Cost and timing of undertaking robust scientific research.

**Factors facilitating the decision-makers use of evidence include:**

- Improved dissemination,
- Collaboration on research
- Quality relationship with researchers

**Discussions**

- The availability of reliable data at the local level is a challenge to most countries. One example is the African Constituency Bureau (ACB) efforts to understand country absorption challenge. The ACB asked both countries and the Secretariat about unabsorbed funds from the Global Fund grants and discovered that the country's figures did not match the Global Fund's records. Such faulty figures hinder country-level decision-making process and present **a strong case for increased, re-focused investment in the country health management information systems**.
- **Political will is vital to implementing any data-decisions** and strengthening data systems.

**An example of evidence-informed decision-making within the Global Fund**

- In 2014, the Strategy Investment and Impact Committee (SIIC) of the Global Fund board was asked to consider if the Global Fund should invest in hepatitis C treatment because of high rates of HIV/AIDS co-infection
- Research from Africa and other constituencies prompted the board to defer its decision so that it might consider a wider mandate for contextual responses to a range of co-morbidities.

## The Africa Constituency Bureau (ACB) Update

*Dr. Fred Muwanga, Executive Director*

The Africa Constituency Bureau (ACB), based in Addis Ababa, supports the board and committee representatives to present the African constituency's views. In the Global Fund, the donor and implementer blocks each have 10 seats on the board. The 47 African countries funded by the Global Fund are divided into two constituencies. The East and Southern Africa (ESA) constituency and West and Central Africa (WCA) constituency each have one voting representative on the board. Each constituency is also represented in the strategy, ethics & governance and finance committees that report to the board.

In the past one year of its existence, the ACB has built systems to collect and feedback country views to the ACB board representatives in order to ensure that Africa has a clear position and country concerns are well articulated. It is important that countries participate in selecting board representatives who should be held accountable for their representation.

## Importance of Accurate Data for Grant Performance according to the Office of the Inspector General (OIG)

*Ann Ithibu, Aidspan*

The presentation summarized findings of an OIG audit on in-country supply chain processes in 15 countries, among them Kenya, Malawi, Nigeria, Rwanda, Uganda and Zambia, published in April 2017. The audit found that lack of reliable consumption data negatively impacts decision making within the supply chain process. In fact, **only one of the 15 countries, i.e. Rwanda uses real time consumption data.** Even where the data exists, countries rarely analyze and use it to inform program planning and implementation.

There is need for a proactive approach where countries use the issues identified in OIG audit to inform grant implementation. For example, countries facing challenges in getting health systems investments funded can start discussions amongst the different stakeholders in order to bring these issues into the limelight. There is also need for more research and analysis so that countries are able to provide stronger evidence-based arguments to their decision makers.

## The Oversight Role of the Country Coordinating Mechanisms (CCMs)

*Margaret Mundia, CCM chair, Kenya*

Kenya's presentation focused on the successes and challenges of dashboard use by the Kenya Coordinating Mechanism (KCM), which is Kenya's CCM. The KCM oversight committee holds quarterly sittings to receive updates and discuss challenges with each PR and other stakeholders in order to identify problems and find solutions in a timely manner. KCM adopted the use of dashboards in 2012; they are Excel based tools that use color-coding to show performance in all programmatic, management and financial areas. PRs are responsible for completing the dashboards. Then disease specific sub-committees review the dashboards and send their recommendations to the KCM oversight committee which reviews and validates them. Each PR is required to carry out corrective measures.

**Advantages of Dashboards**

- Dashboards enable the KCM oversight committee to review grant performance at a glance.
- They save time since they are available in advance before oversight committee meetings and thus their reviews do not take up precious meeting time.
- Using dashboards, the KCM is able to flag areas of concern in a manner that all participating can easily understand.

**Drawbacks of Dashboards**

- Dashboards do not cover all the indicators in the Performance Framework (PF). Sometimes, the review process is so long that if meetings between sub-committees and KCM are not synchronized, then the dashboards may not be reviewed.
- Dashboards duplicate the PU/DR every six months. Frequent engagement between CCM and the PRs, programs, stakeholders, and beneficiaries ensure that challenges are identified early and resolved.

**Discussions**

- Countries exchanged lessons learned **on strengthening CCM expertise, composition and managing conflict of interest.**
- To address conflict of interest, in all countries represented, **the CCM chair is not an implementing partne**r. But countries have different approaches.

    - In Cameroon, the MoH is a member of CCM as a health authority and as PR, although MoH does not vote.
    - In Kenya, the chair of CCM is the MoH permanent secretary while in Uganda, the CCM chair position rotates between public and non-public sector, although the CCM chair cannot be from an implementing institution whether state or non-state PR. However, Ugandan MoH has more CCM seats than any other constituency which results in better ownership of CCM decisions.
- Civil society representation is of great interest.
    - In Kenya and Zambia, CSOs are free to bring the people they select or elect on board.
    - In Cameroon, the CCM approves after the CSOs elect their representative.
- In regards to post-transition planning for Global Fund activities, countries concluded that CCMs must continue to **encourage their MoH to prioritize managing this transition well,** while considering conflict of interest.

## Data for Health Products and Commodities within Global Fund Grants

*Kenya Medical Supplies Authority (KEMSA) Representative, John Kabuchi;*
*Cameroon M&E Chief of Section for HIV, Dr Serge Billong;*
*Zambia CHAZ representative, Catherine Mulikita*

Kenya, Cameroon and Zambia provided an overview of Global Fund procurement systems in their countries.

- The Kenya Medical Supplies Authority (KEMSA) is incorporated through an act of parliament that allows the rendering of both non-profit and commercial services through partnerships with other institutions
- In Cameroon, there is a central procurement and distribution location where data storage records are also centralized.
- In Zambia, the government handles most of the procurement while the Christian Health Association of Zambia (CHAZ) provides health products and commodities to mission healthcare institutions in Zambia.

**In Kenya**, KEMSA purchases mosquito nets, condoms and ARVs. Upon selection and quantification, KEMSA verifies the sources of funds and procures in line with the budget. KEMSA charges Global Fund an 8% fee for its procurement, sourcing and distribution. However, the Kenyan procurement institution has outsourced distribution to third-party partners who deliver to the doorstep of each facility, covering 5000 health facilities and 7000 testing sites and even providing cold chain delivery services. KEMSA oversees the distribution through vehicle tracking systems connected to the central KEMSA system. These third-party distribution partners are contracted for three years so that they have time to put in necessary infrastructure and get their return on investment.

KEMSA works closely with various programs in the MoH and holds monthly commodity security meetings with programs to minimize stock outs. As a policy, KEMSA maintains a nine-month inventory, with three months in stock, three months on order and three months in transit. KEMSA procures using generic names not originator brands. However, institutions can order brand names at competitive prices. KEMSA has an online ordering tool, which captures previous, current and three-month inventories. Facilities are able to log in online and update their orders; those without internet can use standard excel formats that are updated offline and then uploaded when internet becomes available. The order management team's key task is to validate data and call back facilities where inconsistencies are noted. From the comfort of their offices, all facilities can therefore see what is in the KEMSA warehouse and place their orders online without needing a physical visit to KEMSA.

**In Zambia**, the CHAZ budget only caters for mission health, and the majority distribution is by the MoH. CHAZ has an MoU with the government and is more of a

warehousing facility, only distributing to mission health facilities (around 15% of the countries facilities) to the last mile. CHAZ utilizes manual registers and then compiles; depending on the level, facilities are given two to three months buffer stock. CHAZ mainly works with ARVs, RDTs, laboratory reagents and anti-malaria medications.

**Cameroon** has various distribution branches in the regions and inventory invoices are sent to the central commodity location of the Global Fund that caters for all three diseases. The central and regional level warehouses were set up after a cost-benefit analysis carried out by the Global Fund. Key populations and adolescent girls and young women (AGYW) have their own warehouse and differentiated distribution system

All three countries acknowledged that changes in treatment guidelines are the key challenge leading to expiries. Within a health sector supply chain, it is difficult to eradicate expiries 100% but efforts can be made to minimize by managing transition from one treatment guideline to another.

Whereas Global Fund policies aim to strengthen health systems, countries must seize available opportunities to build their capacity, for instance, through timely negotiation for reallocation of savings towards health information system strengthening.

**Discussion**

- **Accessing real-time information on country procurement expenditure, especially conducted offshore is a great challenge for many countries.** Countries gave examples of receiving bill and order information from country teams only towards the end of the grant, making it impossible to take advantage of any savings. CCMs are encouraged to require PRs to always request

**Lessons Learned**

- Collecting data regularly allows the CCM to identify and adapt to more efficient procurement models.
- Documenting and regularly sharing challenges with various procurement models with the ACB and the Global Fund Country teams.
- Reallocating timely commodity savings improves grant implementation, absorption, and saves lives. Two good practices help towards that objective
    - Requiring Principal Recipients to monitor spending on a real-time basis.
    - Assigning a staff focal point to monitor procurement and invoicing.

invoices and monitor what is being spent on the country's behalf. Furthermore, PR should analyze information on pharmaceuticals and health products spending and when appropriate apply for reprogramming.

- A best-practice shared: the importance of assigning a staff focal point to monitor procurement paperwork and saving especially those done offshore by the Secretariat on behalf of countries. Such staff structuring will help keep updated information grant expenditure.
    - For example, Rwanda through PPM procured for $18m instead of $22m allocated; because they followed up on their procurement, they were aware of the savings and subsequently reprogram in good time.

# Data for Improved Budget Absorption – Lessons from Nigeria and Uganda

*Tajudeen Ibrahim, Nigeria*
*Syson Namaganda, Uganda*

Poor country absorption of allocated Global Fund grants is a perennial challenge across majority of the 47 sub Saharan African countries. The roundtable discussion drew out lessons by comparing and contrasting Nigerian and Ugandan experiences by discussing a series of three questions.

**1. How is budget execution monitored in your country?**

**Nigeria** benchmarks its budget and reviews disbursement on a quarterly basis; each quarter, the PR presents to the CCM activities undertaken and associated expenditures. The resource mobilization committee of the CCM, headed by the WHO, uses its action plan to monitor program expenditure. Thus, the CCM can monitor the effectiveness of different service delivery areas. Unfortunately, there is a struggle for real-time budget tracking information from SRs and SSRs despite quarterly budget reviews; the CCM sometimes directly requests information from the Secretariat country team. Last year, because of improved grant forecasting efforts, Nigeria was able to underpin some SRs not spending resources in commodity procurement timely and the PR was then able to reprogram the savings.

**Uganda** has both state and non-state PRs and its budget tracking differs slightly from that of Nigeria. The State PR uses IFMIS that is inbuilt to track budget execution while the non-state PR presents quarterly reports and bank compilations to establish the execution rate. In addition, the CCM and two SRs use dashboards but there are challenges getting information from the SRs. Nevertheless, there are quarterly CCM meetings of the finance and procurement sub-committees, where PRs present pre-analysis, keep track of achievements and attention areas. Subsequently, budget execution results are presented at finance & procurement committee CCM meetings. The CCM's program oversight committee focuses on achievements based on workplan measures and coordinates with finance committee. Red flags on the program side are then shared with finance sub-committee and vice versa. A third CCM sub-committee on resource mobilization focuses on reprogramming.

The CCM secretariat staff includes an M&E technical advisor, which is of a great importance. In addition, each of the three committees has a dedicated secretariat member who liaises with PRs to ensure the conformity of CCM executed budgets and PR dashboards. Thus, the CCM team is able to combine both PRs reports and have full picture. The CCM also compares the Global Fund and PR reports focusing on committed funds, pending reimbursements and funds that the PR has not yet requisitioned to fund spending accountability.

**2. What budget lines are most difficult to engage in your countries?**

**In Nigeria**, three important factors affect the executing of budget lines.

1. The Secretariat's frequent travels to Nigeria, and the subsequent need for CCM members to accompany them during the visit, negatively affects supervision. Almost every week since 2015, there has been a Global Fund country team or a member of the Secretariat visiting one PR or SR. Whenever possible, the CCM is part of the delegation. Even, as the roundtable was going on, a Fund Portfolio Manager (FPM) was visiting PRs and state officials in Imo state. These **repeated visits take time away from oversight and other coordination activities** that could help improve grant implementation.
2. Country team validation of procurement of non-health commodities (e.g. consultant recruitments) leads to long delays. Indeed, 60% of Nigeria's Global Fund resources go to commodities. In Nigeria, **quantification is based on morbidity data; yet in grant making, resources are allocated based on prevalence rates.** This discrepancy results in a lengthy back and forth between the Country Team and PR/CCM in order to agree on information needed for order purchasing.
3. Key population modules are barely able to spend $16m out of $30m allocated as most **key populations are hard to find** and the grant design has restricted activities to only nine states. This results in lower grant absorption.

**In Uganda,** some budget lines perennially underperform. There was a time when a PPM delay of nearly 2 years led to loss of a grant; since then, CCM oversight has improved burn rates on pharmaceutical products.

1. **Procurement of non-pharmaceutical products** especially for the State PR. Sometimes the delays are due to a late start to the bureaucratic, lengthy public procurement process.
2. **Training activities**: Uganda PRs experiences low budget execution rates on training as a result of not planning in advance. The Ugandan CCM has also faced issues of over-budgeting or under-absorption: when implementation does not start on time, planned trainings are delayed.
3. **Budgets managed by semi-autonomous government departments** e.g. districts authorities also experience low absorption of funds due to delays in implementation. Those semi-autonomous government departments are devolved government entities which do not answer to the central government. Thus, they cannot be "dictated to" by the CCM.
4. **Delays in initiating the grant result in delay in recruitment;** Note that staff recruitment is already a lengthy process for a state PR. Also, the difference in the government and Global Fund fiscal year affects spending cycles.

In the NFM grant, Uganda received HSS funding to construct a warehouse and distribute long lasting insecticide nets. Despite CCM follow-up, it took three years to initiate the process; construction only started a few months before the end of the

grant. The CCM managed to negotiate two extensions for the construction of a warehouse and completion of distribution of long lasting insecticide nets because the two projects had already began.

**3. What initiatives have you put in place to improve grant absorption?**
Innovation is needed in order to stop Nigeria's poor absorption. Four innovations are worth mentioning here.

1. The first innovation is towards **making available good data**. To this end, a $100m budget - $20m from Global Fund and $80m from PEPFAR/CDC - has been set aside for a study on HIV/AIDS prevalence and key population size estimates; the study findings are expected in October 2018.
2. A progressive scale-up associated with an integrated supply management; Already, a state specific study estimated the prevalence rate of HIV/AIDS in Lagos State at 1.2%. This prevalence was used to set the targets for putting 65% of HIV positive people on ARV in the State. In the past, the State used the national estimate of 3.4% and it consistently missed targets. This prevalence of 1.2% is now used in three more states.this means that **HIV/AIDS and malaria treatments commodities move at same time, from the State, down to the zone and health facility levels**.
3. Each state now has a management team with a representative beyond the program; **the team includes all relevant ministry representatives** (e.g. ministry of energy and water so they can deal with need for electricity and water supply).
4. Lastly, all local governments have logistic management coordination units that replicate similar units at state level; thus, **the local government is engaged and given responsibility**

**Uganda's Lessons Learned on Budget Absorption**

1. **Early contracting** facilitates timely absorption.
2. **Timely and realistic planning** of activities (e.g. put in time to recruit staff before activities begin) and continuous review of grant budget performance (especially offshore expenditures) has helped identify savings that are then redirected to cover critical gap areas.
3. **Procurement through PPM** has helped improve absorption and is cheaper than purchasing as a country.
4. **Continuous engagement with the LFA** helps mitigate procurement management risks and delays that would have affected approval process.
5. **Early identification of savings and timely submission of reprogramming requests**. Last year, Uganda reallocated over $30 million to cover ARTs and TP where more resources were needed.
6. Ultimately, **securing financing from government and other funders** has helped speed up Global Fund activities. For example, community health management trainings funded by another donor helped in implementation and grant absorption.
7. Finally**, integrating Global Fund into wider program workplans** (e.g. national TB, malaria, HIV/AIDS programs) funded by government and its partners ensured harmonized workplans and fewer activities falling through the cracks.

## Data for co-financing – *Definition, implementation and related challenges and Lessons from Nigeria, Kenya and Cameroon*

*Nigeria: Tajudeen Ibrahim*
*Kenya: Margaret Ndubi (National Treasury)*
*Kenya: Stephen Mutuku (NACC)*
*Serge Billong: Cameroon Delegate*
*Aidspan: Djesika Amendah*

Since 2015, all Global Fund country grants require national co-funding. The panel sought to define and understand co-financing and how it is measured and financed.

**What is your definition of co-financing and how do you persuade the Global Fund team in your reporting?**

For all countries, **co-financing has two aspects**

1. Percentage of government expenditure towards those three diseases or the health system
2. Regular increase of that proportion for these three diseases or the health system.

- *Nigeria* – Co financing includes any and all spending on health including expenditures conducted at the state and local government levels. Most local governments' health expenditure goes to immunization; the expenditure of 474 local governments is aggregated and combined with the federal health sector response. Between 2014 and 2016, the Nigerian government spending was estimated at $478m. Beyond that, human resource and renovation of health facilities are also included, where data is available.

- *Kenya* - Health in Kenya is devolved to 47 counties and they develop their own health budgets. Before 2015, it was very difficult to know how much was spent on health, especially on the three diseases. Since 2015, the national government agreed to allocate a specific amount as co-financing and the funds are managed by the state PR (National Treasury). The national government's allocation goes only to procurement and therefore funds allocated do not leave the national treasury and are easy to track. In addition, health sector spending reporting is done per disease and overall. At the beginning of a grant, there is usually a commitment from national government indicating the amount the government is going to add for each county.
- *Cameroon* – Co-financing is not defined by the government but the Global Fund, which has placed this requirement. After a debate about what should be counted as government co-financing, for instance on-the-job training (e.g. workshops), Cameroon agreed on cash rather than other contributions to the health sector.

The amount is availed in a bank account at the "Caisse autonome d'amortisation" which keeps the Global Fund monies. Nonetheless the debate continues because programs like Malaria, TB, HIV/AIDS operational costs (staff, utility, space etc.) are not considered but many believe they should.

- *Uganda* – Co-financing is any money spent on health including human resource (example salaries of the person registering and measuring weight, testing lab etc.), space, utility etc. Based on that definition, it appears that the government covers the biggest proportion of heath expenditures.

**Who takes leadership on negotiating co-financing?**

- *Nigeria* – Nigeria has not been very successful in its co-financing discussions in the recent past. The country has not been able to document its spending on those three diseases mainly because the federal configuration of the country does not provide for a compulsory repository of state and local government data. Thus expenses at the State and local government levels where the bulk of care is provided are not documented. For instance, in 2016,
    - **HIV/AIDS**: out of $84m to be spent Nigeria was only able to get documentation for $9.5m
    - **TB:** out of $19.6m, Nigeria could not provide any support documentation on the country's spending; Nigeria's co-financing was to be spent on TB drug procurement, which did not take place in 2016
    - **Malaria**: out of $170m, Nigeria provided supporting documents for $134m. In Nigeria, malaria cases are the baseline for the National Health Insurance Scheme (NHIS); NHIS expenditure and supportive documents are used to document national expenditures.
- Many of **the data challenges emanate from the disjointed participation of key government agencies in the CCM**. For example, the Federal ministries of health, finance and national planning are CCM members but do not actively participate in grant negotiation; only the federal MoH representatives are fully involved. There is also a weakness in CCM composition and feedback mechanisms, which means that there is always a gap between participation of government agencies and feedback to their ministry leadership. To address these challenges, **the federal MoH presents quarterly reports to the national meeting of all federal government ministries in an effort to improve buy-in from all sectors**, whether they are directly involved in the health sector and Global Fund grant implementation or not.
- *Kenya* - Kenya's grant negotiation involves PRs, program heads and the procurement agent but is led by the MoH.
- *Cameroon* - In Cameroon, the CCM leads the process of grant negotiation along with the PRs, ministries of planning, finance and health. Based on presentations made and agreed upon, a MoU is signed.

Participants reiterated the need of guidance to use in the discussion on co-financing. They suggested that Aidspan writes on report or a guide on that topic.

***Aidspan Input on Co-financing***

**Global Fund defines co-financing as all expenses incurred by the State on health for those three diseases and/or health systems**; such definition covers not only commodities but also human resource, space, utility, etc. In order to calculate those in a way acceptable by all donors, it is useful to **carry out national health accounts yearly following the current System of Health Accounts endorsed by the World Health Organization.**

The health accounts recap in one document all the sources of funding (government, partners, and households), for all the diseases and conditions, all providers of health care and determine each entity's contribution for each disease and the health system. The government financing for each disease and for health system can be clearly highlighted Such health accounts can be used for all donors, saving time and funding. Otherwise, each donor uses its own method (including data) rendering results incomparable.

## Round Table on Data for Decision-Making Recommendations

*The workshop concluded with a review and agreement on the following recommendations on improving the quality of data for programming, absorption capacity, domestic and co-financing, and health products and commodities.*

| **RECOMMENDATIONS** | |
|---|---|
| Principal Recipient | • Timely planning, implementation, reallocation and reprogramming (*start early*)<br>• Closer follow-up on indicators by PR leadership, grant managers and heads of programs (*regular data review meetings involving in country stakeholders e.g. Pepfar, UN agencies, Civil Society, government ministries*)<br>• Submit PU/DR with detailed, documented explanations to inform grant direction and reprogramming<br>• Joint Pre–review of PU/DR by CCM and PRs and endorsement before submission<br>• Dedicate staff for PU/DR and offshore procurement (keep updated on *paperwork and amounts*)<br>• Improve timely feedback mechanism to SR (covering both program & finance, capture SR data)<br>• Engage private sector for data collection and quality assurance for the CCM oversight activities |
| Country Coordinating Mechanism | • Improve working relationships amongst the CCM, LFA and Global Fund country team<br>• Make better use of electronic data reporting and dashboards (complementing paper-based systems)<br>• Develop clear strategies for moving toward a single, harmonized data reporting system, culminating in regular national health accounts<br>• Ensure effective oversight of PRs in all their grant managerial functions<br>• Engage ministries of finance/treasury in calculating co-financing and setting strong data systems for national health accounts and public expenditure tracking surveys<br>• Engage relevant national government institutions towards increasing domestic & co-financing beyond three diseases<br>• Strengthen CCM secretariat (HR, M&E systems) for effective data analysis |

| | |
|---|---|
| Global Fund Secretariat | • Improve relationship between and amongst LFA, PR & CCM<br>• Provide focused continuous mentoring and capacity strengthening on Global Fund requested documents, reporting tools and forms to CCM & PR by the country team and Local Fund Agent<br>• Strengthen collaboration with CCM, PRs, LFA at all stages while preparing and conducting onsite data verification<br>• Provide flexibility and support as countries transition to new data systems<br>• Emphasize country ownership and priorities<br>• Prioritize investments in RSSH to address weaknesses in M&E systems |
| Aidspan | • Create regular roundtables for PR, CCM, LFA, partners and Global Fund secretariat interaction and learning (Such roundtable will document learning and share with countries in an independent setting)<br>• Avail more and deeper analysis on prevailing issues (e.g. co-financing practices, RSSH, pool procurement Mechanism, Wambo etc.)<br>• Support the African Constituencies Bureau mandate<br>• Provide a more prominent best practices exchanges discussion forum of State and non-state PRs in future roundtable discussions |

## Appendix 1: Frequent issues in Progress Update (PU) reports that should be avoided

- Limited analysis and/or explanations in the Comments section explaining the program results and reasons for performance (over/below/on target)
    - No trend analysis
- No supporting documents, or unrelated supporting documents vs. data captured or unreliable documents in the PU report
    - No disaggregated results as required by Performance Framework
- No PR comments in the Management section, and no assessment of performance (PR evaluation section)
- Poor quality assurance resulting in inaccurate data
    - Incorrect period (data from before or beyond reporting period)
    - Incorrect denominators (e.g. use of total population vs. population at risk for malaria, or key population group)
    - Incorrect calculations Per 1,000 result presented as per 100,000 or as a percentage
    - Data transposition errors or incorrect capture e.g. missing digits: 6934 > 693; or 6934 > 6984
    - Missing denominator so results are presented as numbers vs. percentages
- Delayed reporting typically as a result of poor planning and internal coordination within PR, affects the disbursement cycle

# Appendix 2: Roundtable Program

| SESSION AGENDA: DAY 1 Wednesday 14/03/2018<br>(Tea and coffee will be served outside the room) | | |
|---|---|---|
| TIME | SESSION | PRESENTERS AND PANELISTS |
| 08.00 - 09.00 | Registration | Brian Mwangi<br>Michelange Muberuka |
| 09.00 - 09.50 | Workshop opening and introduction of participants | Ida Hakizinka (Aidspan Executive Director)<br>Daniel Ngamije |
| 09.50 - 10.00 | About Aidspan | Djesika Amendah |
| 10.00 - 10.30 | **Presentation -** Contribution of country data to the Global Fund Key performance indicators/ GF Strategic plan result | Daniel Ngamije |
| **TEA/COFFEE BREAK (10.30 – 11.00)** | | |
| 11.00 - 11.30 | **Project presentation and Q&A–** Country findings | Aidspan team - Djesika Amendah |
| 11.30 - 12.30 | **Presentation and Q&A -** Typical data quality challenges in routine reporting and lessons learnt - perspectives of the Local Fund Agent (LFA) | Rita Motlana, Director of DevPart Consult (LFA Monitoring & Evaluation (M&E) support) |
| LUNCH BREAK (12.30-13.45)<br>(tea and coffee will be served outside the room) | | |
| 13:45 - 17.00 | **Presentation and Q&A -** Country experiences: success and challenges on M&E of the Global Fund grants<br>– Kenya (National Treasury)<br>– Rwanda (Single Project Implementation Unit (SPIU))<br>– Zambia (Program Management Unit (PMU)<br>– Cameroon<br>– Malawi (Program Management Unit) | 1. Kenya: Margaret Ndubi (National Treasury)<br>2. Zambia: Boniface Mwanza (PMU)<br>3. Cameroon Delegate<br>4. Rwanda: Dr. Gilbert Biraro (SPIU)<br>5. Malawi: Dr. Doreen Sanje (PMU) |

**Data For Decision Making Roundtable**
**March 14-16, 2018; Nairobi, Kenya**

| SESSION AGENDA: DAY 2 Thursday 15/03/2018<br>( tea and coffee will be served outside the room) | | |
|---|---|---|
| TIME | SESSION | PRESENTERS AND PANELISTS |
| 08.30 - 08.45 | Recap | Rapporteur |
| 08.45 - 09.15 | **Presentation -** Data for responsible--and responsive--decision making – examples from sub-Saharan Africa (SSA) | Africa Population Health Research Center (APHRC) – Danielle Doughman |
| 09:15 - 10:00 | **Presentation -** Systemic issues that affect data quality | Rita Motlana, Director of DevPart Consult (LFA Monitoring & Evaluation (M&E) support) |
| 10.00 - 10.30 | **Presentation -** Importance of accurate data for grant performance according to the Office of the Inspector General (OIG) | Aidspan - Ann Ithibu |
| **TEA/COFFEE BREAK (10.30 – 11.00)** | | |
| 11:00 - 12:15 | **Presentation**: Importance of accurate data for health products and commodities within Global Fund grants<br>- Kenya – KEMSA<br>- Cameroon<br>- Zambia - Churches Health Association of Zambia (CHAZ) | 1. Kenya Medical Supplies Authority (KEMSA) representative - John Kabuchi<br>2. Cameroon Delegate<br>3. Zambia: Catherine Mulikita CHAZ) |
| 12.15 12.45 | Oversight role of the Country Coordinating Mechanisms (CCMs) Obtaining and using accurate data:<br>- Use of the dashboard<br>- Kenya CCM | 1. Kenya: Margaret Mundia |
| LUNCH (13.00-14.00) | | |
| 14.00 - 14.45 | Introductory presentation<br>**Panel Discussion** - Grant absorption capacity- Challenges and lesson learnt (Nigeria, Uganda) | Facilitator - Daniel Ngamije<br>1. Nigeria: Tajudeen Ibrahim<br>2. Uganda: Syson Namaganda |
| 14.45 - 15.30 | Group work per country on strengthening reporting and data quality, and support needed in relation to grant performance (programmatic and budget execution) | Country representatives |
| 15.30- 16.15 | Presentation of results of group work | Group spokesperson |

| SESSION AGENDA: DAY 3 Friday 16/03/2018<br>(tea and coffee will be served outside the room) | | |
|---|---|---|
| 08.30 - 08.45 | Recap | Rapporteur |
| 08.45- 09.45 | **Panel discussion** - Country contribution to the fight against disease: Domestic and counterpart funding - Definition by countries, reporting to GF and related challenges | Country reps<br>4. Nigeria: Tajudeen Ibrahim<br>5. Kenya: Margaret Ndubi (National Treasury)<br>6. Kenya: Stephen Mutuku (NACC)<br>7. Cameroon Delegate<br>8. Aidspan: Djesika Amendah |
| 10:00 - 10:30 | Aidspan's approach to its observer role: giving access to data tools group work | Aidspan - Michelange Muberuka |
| **TEA/COFFEE BREAK (10.30 – 11.00)** | | |
| 11.00 - 11.45 | Workshop recommendations and way forward - Group work | Facilitator |
| 11.45 - 12:15 | Presentation of the group work and recommendations | Facilitator |
| 12.15 - 12.30 | Wrapping up, workshop evaluation and closing remarks | |
| LUNCH (12.30-2.00) | | |

## Appendix 3: Roundtable Participants List

| No | Name | Country | Organisation |
|---|---|---|---|
| 1 | Benoit Bissohong | Cameroon | For Social Impact Cameroon (FIS) |
| 2 | Dr. Antoine de Padoue Etoundi | Cameroon | Programme National de Lutte contre la Tuberculose (PNLT) |
| 3 | Dr. Serge Billong | Cameroon | Comité National de Lutte Contre le SIDA (CNLS) |
| 4 | Duplexine Aimée Nguemne | Cameroon | Cameroon National Association for Family Welfare (CAMNAFAW) |
| 5 | Omengue Kede Noëlle Marlyse | Cameroon | CCM |
| 6 | Thomas Tchetmi | Cameroon | CCM, Oversight |
| 7 | Fred Muwanga | Ethiopia | Africa Constituency Bureau (ACB) |
| 8 | Aiban Rono | Kenya | Ministry of Health - National TB , Leprosy and Lung Disease Program (NLTP) |
| 9 | Ann Ithibu | Kenya | Aidspan |
| 10 | Brian Mwangi | Kenya | Aidspan |
| 11 | Caroline Ngari | Kenya | National AIDS Control Council (NACC) |
| 12 | Djesika Amendah | Kenya | Aidspan |
| 13 | Dr. Rebecca Kiptui | Kenya | Ministry of Health - National Malaria Control Program |
| 14 | Gordon Aomo | Kenya | Kenya Red Cross |
| 15 | Ida Hakizinka | Kenya | Aidspan |
| 16 | John Kabuchi | Kenya | Kenya Medical Supplies Authority (KEMSA) |
| 17 | Joseph Musyimi | Kenya | Aidspan |
| 18 | Margaret Mundia | Kenya | Kenya Coordinating Mechanism (KCM) |
| 19 | Margaret Ndubi | Kenya | National Treasury - Global Fund Unit |
| 20 | Miriam Abong'o | Kenya | Amref Health Africa |
| 21 | Pamela Kibunja | Kenya | Kenya Coordinating Mechanism (KCM) |

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|---|---|---|---|
| **22** | Patrick Igunza Nagide | Kenya | Amref Health Africa |
| **23** | Ruthpearl Wanjiru Ng'ang'a | Kenya | Rapporteur |
| **24** | Stephen Mutuku | Kenya | National AIDS Control Council (NACC) |
| **25** | Titus Kiptai | Kenya | Amref Health Africa |
| **26** | Cuthbert Nyirenda | Malawi | CCM Malawi, Secretariat |
| **27** | Dr. Collins Mitambo | Malawi | Ministry of Health - Department of HIV and AIDS |
| **28** | Dr. Doreen Sanje | Malawi | Ministry of Health - Program Implementation Unit (PIU) |
| **29** | Dr. Kuzani Mbendera | Malawi | Ministry of Health - National TB Program |
| **30** | Dr. Michael Kayange | Malawi | Ministry of Health - National Malaria Control Programme |
| **31** | Maziko Matemba | Malawi | Health N Rights Education Programme(HREP) |
| **32** | Mr. Alexander Chikonga Bofu | Malawi | World Vision |
| **33** | Professor Wilson Mandala | Malawi | CCM, Oversight |
| **34** | Ibrahim Tajudeen Olaitan | Nigeria | CCM |
| **35** | Itete Karagire | Rwanda | CCM |
| **36** | Daniel Ngamije | Rwanda | Facilitator |
| **37** | Dr Gilbert BIRARO | Rwanda | Rwand Biomedical Center (RBC)/Single Project Implementation Unit (SPIU) |
| **38** | Dr. Justin Sangano | Rwanda | Rwanda Biomedical Center (RBC)/Single Project Implementation Unit (SPIU) |
| **39** | Michelange Muberuka | Rwanda | Aidspan |
| **40** | Rita Motlana | South Africa | Director of DevPart Consult (LFA Monitoring & Evaluation (M&E) support) |
| **41** | Yvonne Kahimbura | Tanzania | Eastern Africa National Networks of AIDS Service Organisations (EANNASO) |
| **42** | Phellister Nakamya | Uganda | CCM (M&E) |
| **43** | Syson Namaganda Laing | Uganda | CCM Uganda |
| **44** | Dr Albert Kaonga | Zambia | Ministry of Health |
| **45** | Catherine Mukuka Mulikita | Zambia | Churches Health Association of Zambia (CHAZ-non state PR) |

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|---|---|---|---|
| **46** | Christopher Chikatula | Zambia | CCM, Secretariat/National HIV/AIDS/STI/TB Council (NAC) |
| **47** | Dr. Anthony Yeta | Zambia | Ministry of Health - National Malaria Elimination Centre (NMEC) |
| **48** | Dr. Dean Phiri | Zambia | Ministry of Health - Program Management Unit (PMU) |
| **49** | Dr. Sylvia Simwanza Chila | Zambia | Ministry of Health - TB Program |
| **50** | Martin Chanda | Zambia | Consultant |
| **51** | Mr. Boniface Mwanza | Zambia | Ministry of Health - Program Management Unit (PMU) |
| **52** | Mr. John Mwale | Zambia | CCM/National HIV/AIDS/STI/TB Council (NAC) |