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Prospective Country Evaluation Uganda

2021 EXTENSION REPORT

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



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Acronyms and Abbreviations

AGYW	Adolescent girls and young women
ART	Antiretroviral therapy
C19RM	COVID-19 Response Mechanism
CCM	Country Coordinating Mechanism
CHIS	Community health information systems
CRG	Community, Rights and Gender
CSO	Civil society organization
CSS	Community Systems Strengthening
CT	Country Team
DHIS2	District Health Information Software 2
HMIS	Health Management Information Systems
HRG-Equity	Human rights, gender, and equity
HSDP	Health Sector Development Plan
HSS	Health System Strengthening
iCCM	Integrated community case management
IHME	Institute for Health Metrics and Evaluation
KII	Key informant interviews
KP	Key populations
LFA	Local Fund Agent
M&E	Monitoring and evaluation
MoH	Ministry of Health
NFM2	New Funding Model 2 (Global Fund 2017-2019 allocation cycle)
NFM3	New Funding Model 3 (Global Fund 2020-2022 allocation cycle)
NSP	National Strategic Plan
PAAR	Prioritized Above Allocation Request
PCE	Prospective Country Evaluation
PR	Principal Recipient
PU/DR	Progress Update/Disbursement Request
RMNCH	Reproductive, Maternal, Newborn and Child Health
RSSH	Resilient and Sustainable Systems for Health
SR	Sub-recipient
TASO	The AIDS Support Organization
TERG	Technical Evaluation Reference Group
TRP	Technical Review Panel
WPTMs	Workplan Tracking Measures

Executive Summary

Introduction

The Prospective Country Evaluation (PCE) extension (from April to June 2021) focused on understanding different aspects of Resilient and Sustainable Systems for Health (RSSH), the grant revision processes and lessons learned from the COVID-19 revisions during New Funding Model 2 (NFM2), and New Funding Model 3 (NFM3) grant making. The findings from the extension built on the 2020/2021 findings that explored changes across the different stages of the Global Fund grant cycle and the implications for RSSH, HRG-equity and sustainability.

Methods

The PCE extension phase built on the mixed methods approach used for the 2020/2021 evaluation phase, which included quantitative data from Progress Update/Disbursement Requests (PU/DRs), programmatic reports from sub-recipients (SRs) and performance frameworks. These were used to inform analysis on budget variances with a focus on budget changes for RSSH and Human Rights and Gender (HRG) related activities. Qualitative information from key informant interviews (KIIs), fact checking interviews and documents provided insights on drivers to changes during grant making (with a focus on RSSH and HRG), uptake of RSSH indicators and prioritization and value add of RSSH investments. Qualitative analysis of interview data and document reviews were performed using an analysis matrix where relevant text information from each transcript or document was organized in Microsoft Excel against questions in the KII guide. Key themes were generated according to common responses while divergent issues were identified and further validated during fact checking interviews.

Findings

RSSH Landscape, Complementarity and Comparative Advantage of Global Fund RSSH investments

Overall, 16% (US\$ 4.07 billion of US\$ 25.32 billion) of the 2016-2020 Uganda Health Sector Development Plan (HSDP) overall cost was allocated towards health system strengthening (HSS), with major funders including but not limited to: Government of Uganda, Global Fund, UNICEF, USAID, PEPFAR, WHO and the World Bank. Of the Global Fund's total support (US\$602,541,930) in NFM3, US\$31,986,362 (5.3%) was directly invested in RSSH. Global Fund investments are complementary to government and other donors as reflected in the design of NFM3 grants, where RSSH investments are building on other partner support. For example, to strengthen innovative e-solutions, the Global Fund is complementing other partners' support by rolling out point of care electronic information systems at all regional hospitals. The flexibility of the business model and autonomy given to in-country stakeholders to plan and utilize RSSH funds according to country priorities through existing structures is perceived to have a comparative advantage over other donors. This strengthens leadership and governance, facilitates capacity building, enhances local ownership and promotes sustainability of programs.

Support vs Strengthening investments in RSSH

Investments in RSSH substantially increased from US\$5,517,656 in NFM2 to US\$31,986,362 in NFM3. This contributed to the overall increase in total funding towards system strengthening (US\$2.97 million in NFM2 to US\$13.12 million in NFM3, a 342% increase) according to the 2S analysis. Despite this increase, design of RSSH activities was not based on stakeholder's understanding and application of

the two terminologies (system support and system strengthening) but rather investments are informed by the priorities and needs as indicated in the national health strategic documents.

While the Technical Review Panel's (TRP's) 2017-2019 RSSH review and review of lessons learned from the 2020-2022 funding request applications emphasized RSSH design to shift from systems support toward systems strengthening, TRP review comments on Uganda's funding requests did not indicate the same. Additionally, Global Fund RSSH guidance did not clearly indicate how the two terms should be used during the design and writing of the funding requests. This presented a disconnect between what was recommended at the global level and the operationalization of the guidance at country level.

Performance Monitoring of RSSH investments

In 2019, the Global Fund modular framework was modified and more RSSH indicators were included to be used in monitoring RSSH investments during NFM3. Uganda only selected three RSSH indicators (out of 24 indicators) and introduced four work plan tracking measures (WPTMs) at grant making. Key informants indicated that the choice of indicators to monitor RSSH investments was mainly driven by the ability of the system to generate data and the frequency of reporting. There was low uptake of RSSH indicators in the performance framework in NFM3 mainly because investments in most RSSH modules contribute to the performance of indicators in other modules. This was evident in the TB care and treatment module, malaria case management and vector control modules, where investments in the RSSH-community systems strengthening module contributed to the performance of some coverage indicators in TB and malaria.

Drivers to changes for RSSH and Human Rights, Gender and Equity (HRG-Equity) at Grant making

Changes were made to the RSSH and HRG-Equity modules during grant making, which included increases in their total budget allocations and shifts in budgets within and across modules. While reasons for some changes were context-specific, some common reasons for these changes included: 1) Responding to TRP comments and recommendations; 2) Re-classification of activities under the correct modules and interventions; and 3) Efficiencies realized at grant making, due to a variety of factors like over-budgeting during the funding request development, changing the scale or scope of interventions and reductions in unit costs for some activities.

Inclusiveness and Transparency at Grant making

The NFM3 grant making process was considered more inclusive and had greater participation among stakeholders when compared to NFM2, as more civil society organizations (CSO) networks and advocacy groups, including Country Coordinating Mechanism (CCM) constituency representatives, were engaged. However, changes made were not systematically documented and communicated to other stakeholders that participated in the funding request, thus limiting transparency. Instituting a systematic and detailed tracking mechanism for the changes throughout the grant cycle, including during grant making and grant revisions, will promote transparency and improve grant oversight and monitoring during implementation.

Revisions to mitigate impact of COVID-19

As of December 2020, a total of US\$10,510,356 from NFM2 grant savings and US\$51,935,105 under the COVID-19 Response Mechanism (C19RM) grant had been approved for the COVID-19 response. Depending on the threshold, reallocations towards the COVID-19 response went through different steps of the regular grant revision process, with some adjustments aimed at making the processes faster given the emergency nature of the revisions. Some of the flexibilities that made the process faster were wider stakeholder consultations and participation beyond the usual Global Fund

stakeholders, limiting decision-making processes to a few technical people and the use of digital platforms to conduct meetings and make approvals. However, the replicability of the flexibilities for the COVID-19 response to regular grant revisions remains opaque given the emergency circumstances of the pandemic.

Conclusion and recommendations

Global Fund investments were complementary to domestic and other donor support. The flexibility of the Global Fund business model and the autonomy given to the country to allocate resources according to needs and priorities were perceived by stakeholders to add value. Although the Global Fund guidance encouraged a shift towards systems strengthening, the country's needs and priorities drove the design of RSSH investments as either "supportive" or "strengthening". The investment towards RSSH was low compared to the overall grant portfolio and was fragmented across modules, which limited performance monitoring of the investments. A number of changes happened at grant making; however, transparency remained a challenge despite the continued efforts to improve it through increasing participation in the process. The PCE observed that there was not clear and systematic communication of the changes made to the budget, scope and the decisions that led to the changes, which hindered perceptions of transparency. The COVID-19 revision processes were made faster using digital platforms and other flexibilities due to their emergent nature. However, the extent to which these flexibilities could be replicated in the regular grant revision processes was not clear.

Recommendation 1: To achieve the intended objectives of RSSH investments, there is a need to address gaps in the national strategic design of HSS and in operationalizing the Global Fund's guidance. This will improve RSSH prioritization and the strategic alignment of investments towards health systems strengthening.

- The development of a comprehensive document that clearly articulates HSS needs/priorities and financial gaps will ease prioritization and strengthen alignment of donor HSS investments at the national level. (*Ministry of Health [MoH]*)
- To strengthen the performance of health systems towards sustainable health improvements at scale, there is need to increase investment allocation towards RSSH. This will address the challenge of fragmenting investments across RSSH modules and possibly facilitate the uptake of RSSH indicators to assess the performance of RSSH investments, thus strengthening the value add of Global Fund investments. (*Principal Recipients [PRs] and CCM*)
- During grant design, to promote the prioritization of strategic and catalytic investments in strengthening health systems, technical partners and the Global Fund should provide additional technical assistance for operationalizing the Global Fund's RSSH guidance. (*Global Fund Secretariat and/or Technical Partners, CCM, PRs*)

Recommendation 2: To increase transparency, PRs in consultation with the CCM, should consider developing a systematic and detailed tracking mechanism for significant changes across the grant cycle (including the rationale for shifts during grant making and grant revisions). This could be in the form of a dashboard that progressively monitors changes and performance during implementation, and supports real time understanding and documentation of intervention and budgetary shifts. (*CCM, MoH*)

Recommendation 3: To improve grant revision processes, there is need to invest in e-systems and strengthen the utilization of digital platforms to accelerate the prioritization, decision-making and approval processes of grant revisions. (*CCM, MoH*)

1. Introduction

The Prospective Country Evaluation (PCE) is an independent evaluation of the Global Fund commissioned by the Global Fund's Technical Evaluation Reference Group (TERG). In line with providing timely evidence to inform global, regional, and national stakeholders, an extension phase was commissioned by the TERG from April to June 2021. The PCE extension focused on Resilient and Sustainable Systems for Health (RSSH), the grant revision processes and lessons learned from the COVID-19 revisions during New Funding Model 2 (NFM2), and NFM3 grant making. The Uganda PCE report of 2020-2021 indicated a change in trajectory for investments in RSSH through substantially increased allocation. The PCE, with guidance from the TERG, set out to understand:

- How Global Fund RSSH investments fit within the wider landscape, including their comparative advantage, and added value relative to domestic or other donor support.
- The use/understanding of 'system support' and 'system strengthening' by the CCM and government stakeholders.
- How decisions are made around performance monitoring for Global Fund RSSH grants, specifically the reasons for the limited uptake of RSSH coverage indicators in the NFM3 grant performance frameworks.
- NFM2 grant revision issues and any relevant lessons learned from the Global Fund's response to COVID-19.
- Drivers of RSSH and Human Rights, Gender and Equity (HRG-Equity) shifts during NFM3 grant making.

These findings will complement the PCE findings from the previous years by focusing on different dimensions of the Global Fund business model and how they influence grant design and implementation toward the achievement of strategic objectives in Uganda.

2. Methods

Data collection: The evaluation was undertaken between April and May 2021. A mixed methods approach was utilized in collecting and analyzing data. Quantitative data from performance frameworks, Progress Update/Disbursement Requests (PU/DRs) and grant budgets provided information about budget variance, grant revisions, and indicator selection. Qualitative information from key informant interviews (KIIs) and document review provided insights on how decisions were made, the drivers of shifts during grant making and issues around grant revisions. The PCE reviewed funding requests and budgets, national disease strategic plans, programmatic gap analyses, Technical Review Panel (TRP) comments and responses, final grant award budgets and performance frameworks, Global Fund guidance documents (including the Applicant Handbook, eLearning modules, and guidance regarding COVID-19 flexibilities). Participants for KIIs were purposefully selected based on their knowledge, experience and participation in the planning and implementation of RSSH and HRG, NFM2 grant revisions, and NFM3 grant making. Eighteen KIIs were conducted with representatives from the Ministry of Health (MoH), The AIDS Support Organization (TASO), the Country Coordinating Mechanism (CCM) and RSSH consultants using a semi-structured KII guide. Access to stakeholders during the COVID-19 Response Mechanism (C19RM) application phase was a challenge during April-May 2021, so the PCE team followed up with additional stakeholders for data triangulation and fact checking in June 2021.

Identification of HRG-Equity activities: HRG-Equity-related investments are not identified explicitly by the modular framework. The PCE relied upon the Global Fund gender and human rights disease-specific technical briefs as well as conversations with the TERG Secretariat and the Community, Rights and Gender (CRG) team to identify modules and interventions that contain investments related to HRG-Equity.(1–4) Using the technical briefs, an initial list of modules and interventions related to HRG-Equity was compiled and then shared with the Global Fund CRG team for review and feedback. The PCE had a consultative discussion with the CRG team and reviewed the CRG team’s draft methodology for tracking human rights-related investments to finalize the list of HRG-Equity modules and interventions and categorize them into three sub-categories: human rights-related investments, key and vulnerable populations-related investments, and other equity-related investments (which includes interventions such as “*Gender-based violence prevention and post-violence care*” and “*Community-led advocacy and research*”). This methodology was based on the approach adopted by the Secretariat to measure progress towards key performance indicators.

Data Analysis: Qualitative data from document review alongside data from KIIs (transcribed) was synthesized in an analysis matrix guided by pre-existing sub-themes. Data was triangulated across sources including documents, KIIs and quantitative data sources. Quantitative analysis was conducted to assess budget allocation and budget shifts in RSSH and HRG-Equity during NFM3 grant making. Data from official funding request and grant award budgets was uploaded into Tableau to visualize grant allocation towards specific RSSH modules and to assess budget shifts during grant making.

RSSH “2S” analysis—Support or Strengthening: The PCE analyzed the RSSH activities in NFM2 and NFM3 grant award budgets to ascertain whether they contributed to “systems support” or “system strengthening”, drawing on definitions from Chee et al. (2013).(5) A coding methodology was developed, aligned to Global Fund’s RSSH modules in the modular framework, to designate each RSSH activity in the budget as either predominantly support or strengthening. Three parameters i.e., scope, longevity, and approach were examined for each RSSH intervention/activity pair, adapting upon the methodology previously used by the TRP’s examination of RSSH in the 2017-2019 funding cycle (Table 1).(6) Two coders independently applied a determination of support or strengthening after reviewing each intervention and activity description, the cost input, and any relevant text in the funding request narrative. A third coder reviewed the analysis to identify any discrepancies in code application and the coding team met to reach consensus on the final designation.

Table 1. RSSH system support and strengthening coding parameters.

Parameter	System Support	System Strengthening
Scope	May be focused on a single disease or intervention.	Activities have impact across health services and outcomes; and systems may be integrated into the overall health sector.
Longevity	Effects limited to a period of funding.	Effects will continue after funded activities end.
Approach	Provide inputs to address identified system gaps.	Revise policies and institutional relationships to change behaviors and resource use to address identified constraints in a more sustainable manner.

2.1 Limitations

As mentioned in earlier sections, this phase of the evaluation was building on findings from the 2020/2021 phase, thus affected by similar limitations as highlighted in the 2020/2021 report. These included (but not limited to: - 1) The retrospective data collection on some aspects of the evaluation had the potential for recall bias. This was counteracted by continuous engagement with stakeholders and validation of information from other data sources. 2) The PU/DR data, the primary source for Global Fund expenditure data, does not reflect commitments for ongoing activities and is considered out-of-date by the time of grant reporting, thus failing to present a real-time reflection of grant absorption and program performance. The evaluation examined implementation progress reports from the Principal Recipients (PRs) and SRs to get an updated status of implementation. 3) Limited data on RSSH funding landscape affected the extent to which that study objective was explored. 4) The continued restrictions in response to the COVID-19 pandemic affected movements and this limited PCE access to stakeholders and key Global Fund meetings. Nevertheless, meetings and interviews were conducted virtually. However, the virtual approach had its limitations such as internet interruptions, shortened interview durations and inadequate focus and attention of respondents during interviews. To address this, the team further engaged interviewees by email to get in-depth analysis of the discussion topics. Despite the challenges noted, the evaluation triangulated findings across both qualitative and quantitative data sources.

3. Findings

3.1 RSSH landscape

The RSSH component of the health sector is funded by the Government of Uganda and other donors including but not limited to the Global Fund, UNICEF, USAID, PEPFAR, WHO and the World Bank. The 2016-2020 Health Sector Development Plan (HSDP) prioritized investments in seven health systems areas including: health governance and partnerships, service delivery systems, health information, health financing, health products and technologies, health workforce and health infrastructure.(7) Of the US\$25.32 billion estimated to finance the 2016-2020 HSDP, 27% was expected to come from the government, 36% from bilateral partners, 7% from multilateral contributions including the Global Fund and 30% from private contributions (foreign and local private investors). The HSDP grouped the seven HSS investment areas into four broad categories: Human Resources for Health (US\$ 1.32 billion); health products and technologies (US\$ 18.25 billion); infrastructure development (US\$ 1.47 billion); and service delivery systems (US\$ 1.28 billion).(7) HSS categorization in the national strategic documents generally aligned with the WHO's six health system building blocks and the Global Fund's eight RSSH modules, although with some variability. Uganda relies heavily on donor support to finance the health system, including support from the Global Fund. Of the Global Fund's support during NFM3 (US\$602,541,930) towards malaria, HIV and TB, 5.3% (US\$31,986,362) was invested in RSSH.

Key message 1: Global Fund investments are complementary to government and other donors and are perceived by stakeholders to have a comparative advantage. The latter was attributed to the flexibility of the business model and the autonomy to plan and utilize funds according to country priorities.

Complementarity of Global Fund investments in RSSH

The Global Fund's investments in RSSH are complementary to investments of government and other donors. For example, the strategic priorities for health information systems in the HSDP focused on

building a harmonized and coordinated national health information system that covers the routine Health Management Information Systems (HMIS), surveillance, vital statistics, research and surveys, with innovative e-health solutions. In line with these national priorities, the Global Fund's investments in HMIS for the 2021-2023 implementation period focus on establishing a coordinated system for electronic medical records and improving private sector data collection and reporting in addition to operationalizing and scaling up the community health information systems (CHIS). To strengthen innovative e-solutions, for instance, the Global Fund is complementing other partners' support by rolling out point of care electronic information systems at all regional hospitals while the World Bank is to support 24 general hospitals and PEPFAR is mainly focusing on supporting the antiretroviral therapy (ART) clinics. Additionally, the Global Fund is complementing the Rockefeller-funded UNICEF program for the digitization of community information, through scaling up the digitization of the CHIS from the five Rockefeller/UNICEF-funded districts to 33 additional districts. Furthermore, to strengthen the health product management system, the Global Fund is collaborating with PEPFAR and other partners, to roll out an electronic system to track the commodities and supplies at the regional, district and health facility levels. These investments are aligned with the national health sector focus areas while specifically targeting the fight against HIV, TB and malaria as highlighted in the three diseases' national strategic plans.

Comparative advantage of Global Fund investments in RSSH

The value addition of the Global Fund investments in RSSH was attributed to its flexible business model by stakeholders in several ways. First, the Global Fund business model promoted country autonomy to allocate funds to RSSH during the design and planning phase of the funding request. This enabled prioritization of RSSH activities to address the prevailing challenges and fill the financial gaps, leading to investments in areas with the highest need and areas perceived to generate the highest impact. Second, the Global Fund's business model facilitated the ability to plan and utilize its investments through existing country structures, which adds value as it strengthens leadership and governance, facilitates capacity building, enhances local ownership and promotes sustainability of programs. Additionally, implementing through the existing country structure facilitates timely decision-making in allocating and reallocating funds to respond to emerging bottlenecks during implementation. For example, with the decline in malaria cases in 2018 and the subsequent upsurge in 2019, the malaria program was able to plan and utilize Global Fund investments to mitigate the upsurge. Compared to the Global Fund business model, other partners' decision-making processes for allocating and reallocating funds have to go through their national and international hierarchies and were therefore perceived as less flexible. Third, the Global Fund's RSSH investments, though limited in comparison to other donor investments in health systems, were prioritized across many of the RSSH modules, thus driving impact across the three diseases while benefiting other health areas as explained by a key informant in the quote below:

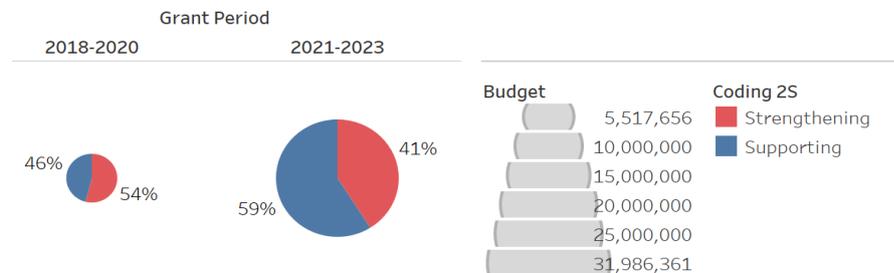
"...Global Fund may be investing little money in specific RSSH modules but the good thing about them is that they tend to invest in various areas....and of course the effects of their investments spill over beyond the three diseases. For example, the [National Medical Stores] NMS warehouse stores health supplies for almost all disease programs." (KII, MoH)

3.2 Support or strengthening investments in RSSH

As previously reported in the 2020-21 Uganda PCE annual country report, there was a substantial increase in RSSH investments in terms of absolute amount and proportion of total investment in NFM3 compared to NFM2: in NFM2, RSSH activities were 1.1% of the total budget (US\$5.5 million out of US\$463.1 million), and, in NFM3, RSSH activities were 5.3% of the total budget (US\$32.0 million out of US\$570.6 million). Through applying the 2S framework, the PCE's findings indicated an overall increase

in the total funding toward systems strengthening (US\$2.97 million in NFM2 to US\$13.12 million in NFM3, a 342% increase), which was attributed to the overall increase in RSSH in NFM3. However, the proportion of the RSSH budget allocated to strengthening is lower in NFM3 when compared to NFM2 (41% in NFM3 vs. 54% in NFM2) (Figure 1 and Annex 2).

Figure 1: RSSH systems support and systems strengthening investments, comparing Uganda’s NFM2 vs. NFM3 grant award budgets.



*Circles are sized according to absolute RSSH budget level (millions) in NFM2 and NFM3 grant award budgets

Key message 2: There was a varied understanding of the concepts of “health system support” and “health system strengthening” among country stakeholders. The two terminologies were not the basis for the design of RSSH interventions but rather investments were informed by the priorities and needs as indicated in the national health strategic documents.

Stakeholders defined and explained their understanding of the two terms differently. Some stakeholders thought that the two terms were interrelated while others defined “support” as short-term input investments such as stationery and vehicles and “strengthening” investments as those directed towards long term effects like infrastructure. The varied understanding of the terminologies seemed to be dependent on the roles stakeholders played in either the design or the implementation of the RSSH activities of the grants.

In addition to the issue that “support” and “strengthening” terminologies were not uniformly understood, the Global Fund RSSH guidance did not clearly indicate how these concepts should be considered during the design and writing of the funding requests. The TRP’s 2017-2019 RSSH review and review of lessons learned from the 2020-2022 funding requests recommended a stronger emphasis and shift from systems support toward systems strengthening.(6,8) However, they did not indicate the same in their comments in response to Uganda’s funding requests. This presented a disconnect between what was recommended at the global level and the operationalization of the guidance at country level. The two terminologies were not emphasized in the writing of the RSSH grants. Key informants indicated that decisions on investments were based on the prevailing needs and priorities of the disease programs irrespective of whether they were “health system support” or “health system strengthening (HSS),” although in many instances they tended to fall under systems support as illustrated in the quotes below:

“So, if you find within the gap analysis there’s more emphasis toward infrastructure then strengthening will dominate....,” (KII, MoH).

“...and people are going to basically focus on what we think are our pressing needs now. It’s unfortunate for Uganda we may not have reached that point where we feel the short term is fully catered for, now we think of big things!” (KII, CCM secretariat).

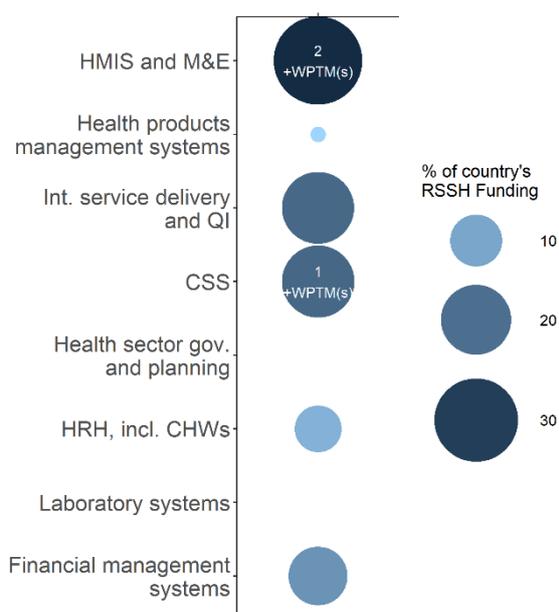
RSSH prioritization process

The RSSH prioritization process was multilayered and guided by the HSDP and the National Strategic Plans (NSPs) for HIV, TB and malaria. Priorities were identified from the evidence generated during the implementation of the HSDP through the MoH annual sector performance reviews, studies and surveys. These were then synthesized and harmonized with priorities from stakeholder constituency consultations by CCM and priorities from the three disease programs, from which a draft gap analysis document was derived. The gap analysis document was discussed with the CCM and senior leadership at MoH, and then the re-prioritization process was undertaken by the HSS writing team to align the refined priorities with the available funds. While these processes generated a detailed HSS gap analysis, this was not attached to the funding request documents like the programmatic gap analysis, although a summary of prioritization was included in the malaria concept note under the RSSH. Despite the fact that a reference was made to national strategic documents for priority-setting during the design of RSSH investments, the absence of a comprehensive HSS funding landscape with detailed priorities and financial gaps remained challenging during the prioritization and alignment of Global Fund’s RSSH investments.

3.3 Performance Monitoring of RSSH investments

The Global Fund revised the Modular Framework in 2019 to make investments more efficient and effective by ensuring consistency in documenting and tracking results, grant budgets and expenditures throughout the grant life cycle.(9) This led to the modification of 12 of the 13 previous RSSH indicators and the introduction of 11 additional RSSH indicators. Despite a 480% increase in RSSH investments in Uganda from US\$5,517,656 in NFM2 to US\$31,986,362 in NFM3, and the availability of more RSSH indicators in the updated Modular Framework, Uganda adopted only one of the new indicators (*CSS-1: Percentage of community-based monitoring reports presented to relevant oversight mechanisms*) bringing the total number of RSSH indicators in the NFM3 performance frameworks to three (Figure 2). During grant making, four additional workplan tracking measures (WPTM) were also added in the grant performance framework to monitor community systems strengthening (CSS) investments and HMIS investments (Annex 1).

Figure 2. Proportion of direct RSSH investment by module, with indicators and WPTMs denoted.



Key message 3: The choice and uptake of indicators to monitor RSSH investments was mainly driven by the ability of the system to generate data, the frequency of reporting and the presence of indicators in other modules whose performance is contributed to by RSSH activities.

The selection of RSSH indicators to be included in the performance framework was dependent on the ability of the health information system to capture and report on the indicators. The current national data tools capture information that is aligned with the HMIS and District Health Information Software 2 (DHIS2) data management systems, which have a limited number of RSSH specific indicators. For example, DHIS2 only captures indicators related to the Global Fund’s HMIS Monitoring and Evaluation (M&E) module under RSSH. To counteract this limitation, WPTMs were included in the performance frameworks for activities with substantial investments that significantly impact the implementation of other activities. The decision on which WPTMs and the number to be included was made at grant making when programs were certain about the investments allocated to each activity of the grant, as was the case for CSS in NFM3. These decisions were made by the PRs in consultation with the Country Team (CT).

Additionally, the transition from a paper-based system to an electronic reporting system is still evolving, limiting the processing of many indicators. Priority was given to standard coverage, outcome and impact indicators that are routinely reported through the national data collection tools. Relatedly, some informants perceived the introduction of more RSSH indicators as increasing the reporting burden that is already constrained by the costly process of transitioning from paper-based to electronic reporting.

“...With a data collection and reporting system that is still paper-based, and the electronic systems underdeveloped, the capacity to effectively manage many new/additional RSSH indicators is limited in terms of the infrastructure to transmit information, personnel and funds to support the overall process...” (KII, MoH)

Furthermore, grant reporting is also dependent on how activities are spread across the grant implementation period. Some activities take place throughout the grant implementation period; however, some RSSH activities are either bi-annual or “one offs” such as training workshops or operational studies, thus limiting the need to use coverage indicators to track performance.

Uganda included few RSSH indicators in the performance framework in NFM3 mainly because investments in most RSSH modules contribute to the performance of indicators in other modules. For example, the TB case notification rate (under the TB care and prevention module) is contributed to by several CSS activities including social mobilization, community-led advocacy and other related RSSH activities that are carried out at the community level. Similarly, the performance of several indicators in the malaria case management and vector control modules (i.e., at community, private and public facility levels) are contributed to by investments in CSS and integrated service delivery modules. Therefore, since adding new indicators would be a duplication in reporting, there was a low uptake of RSSH indicators from the Modular framework.

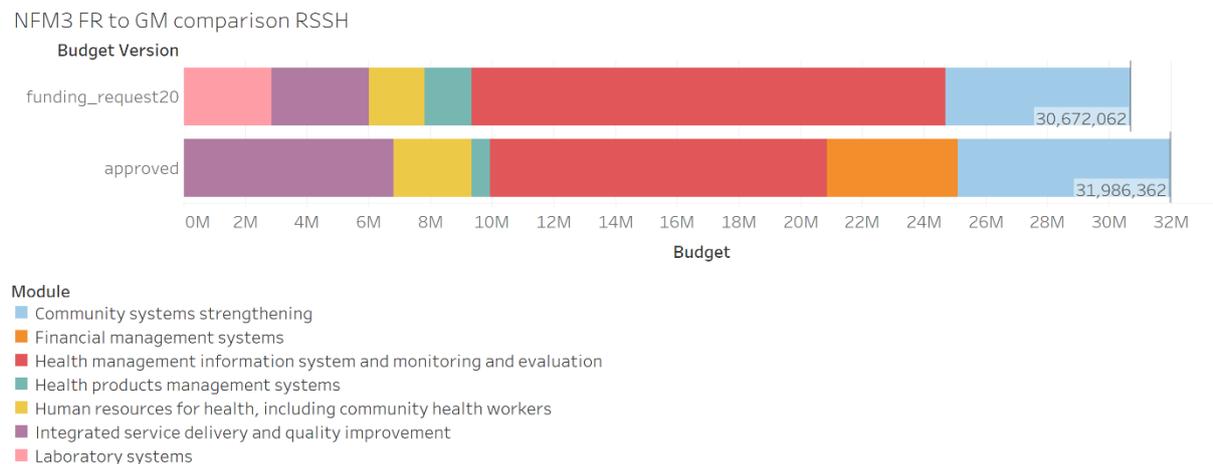
3.4 NFM3 changes at grant making

Changes were made to the RSSH and HRG-Equity modules that led to an increase in their total budget allocations and shifts in budgets within and across modules. The main reasons for these changes were similar to those previously discussed in NFM2 grant making: **1) Responding to TRP comments and recommendations.** TRP recommendations varied and included shifting interventions from the Prioritized Above Allocation Request (PAAR) to the main allocation, introducing interventions and activities not previously planned and budgeted for, rearranging priorities, and making changes to

implementation approaches, among others. **2) Reclassification of activities under the correct modules and interventions.** This was conducted to correct errors that resulted from misclassification due to a rushed budgeting process and minimal coordination between the costing consultants and technical team during the funding request development process. Thus, the shift of activities to the correct interventions at grant making resulted in budget changes. **3) Efficiencies realized at grant making** which were due to a variety of factors like over budgeting during the funding request development, changing the scale or scope of interventions, and reduction in unit costs for some activities. Using examples, these drivers and other RSSH and HRG-Equity specific drivers are discussed in the sections below.

RSSH Changes: The RSSH budget increased by 4.2% (from US\$30.7 million to US\$32 million) with significant shifts across and within modules. Budget changes resulted from the introduction or removal of activities from the budgets, shifting activities across and outside RSSH modules and splitting of activities. This section will focus on exploring specific reasons for changes in four of the modules with the most significant changes (increments, reductions and dropped modules/interventions). Figure 3 illustrates the major shifts by RSSH module during grant making.

Figure 3. RSSH investments by module in NFM3 funding requests and the approved budgets.



Sources: see Annex 5

The *Financial management systems* module was introduced at grant making with an allocation of US\$4.3 million compared to US\$138,857 in NFM2 and reflecting efficiencies identified during grant making. This budget covers routine financial management, which includes supporting internal audits, assurance works and financial management. Key informants noted that the budget is intended to support both external and internal financial audits of the three Global Fund grants to the government PR. The increase in budget was perceived to address the Office of the Inspector General (OIG) recommendation to the country to strengthen overall controls around supply chain distributions, which led to an increase in the frequency of internal audits. This allocation is however ring-fenced for further details to be requested from the PR, in consultation with the CCM, and requires a no-objection from the CT.

The *Laboratory systems* module with a US\$2.8 million budget was dropped from the approved budget; however, one activity under this module, “sample hub transportation”, was shifted to the Treatment, Care and Support module. Two activities worth US\$1.6 million, “procure and conduct the production of 5 proficiency testing panels for External Quality Assessment to cover needs of the Malaria, HIV and

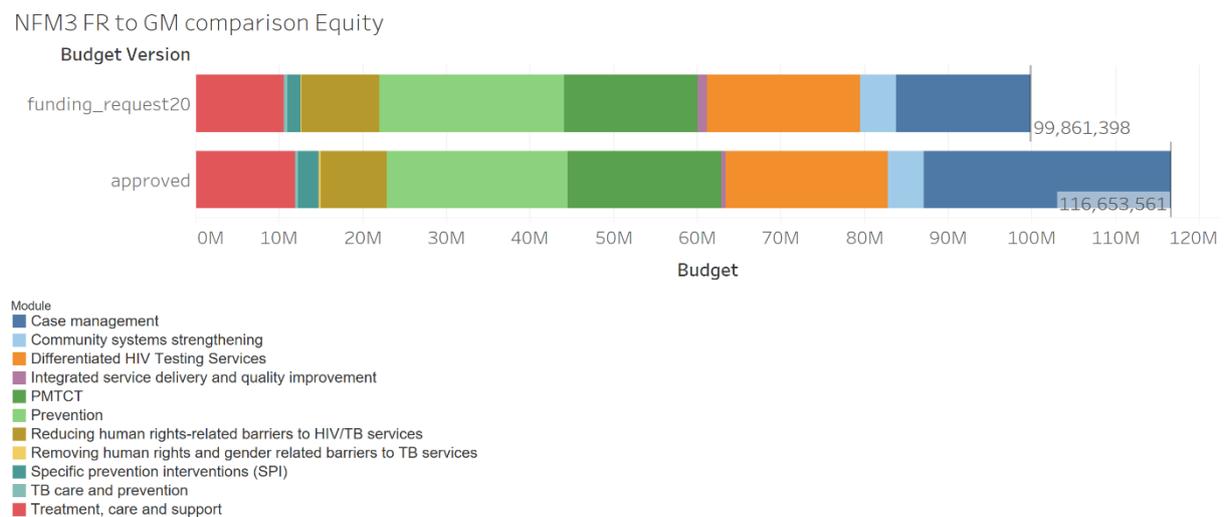
TB programs" and "procure support calibration system equipment," were dropped from the grant. There were no clear reasons for these shifts and specifically why the two activities were dropped.

The allocation for the *integrated service delivery and quality improvement* module increased by 113% (from US\$3.2 million to US\$6.8 million). This was due to re-classification of some activities between modules: Five activities were moved from the *integrated service delivery and quality improvement* module to *Health products management systems* module, while two activities worth US\$4.1 million were moved from *Health products management systems* to *integrated service delivery and quality improvement*.

The *Community systems strengthening* module increased by 15% from US\$6 million to US\$6.9 million at grant making. The increase was in response to a TRP recommendation to increase allocation towards strengthening capacities of communities and CSOs. As a result, the *institutional capacity building, planning and leadership development* intervention that was initially included in the PAAR was shifted to the main allocation.

HRG-Equity Changes: During NFM3 grant making, the overall budget allocated to HRG-Equity increased by 17%, from US\$99.7 million to US\$116.7 million (Figure 4). This was mainly due to the introduction of new modules and shifting of activities from HRG-Equity to non-HRG-Equity modules and vice versa. This section will focus on exploring specific reasons for three modules with >50% change in allocation.

Figure 4. HRG-Equity funds by module in NFM3 funding requests and the approved budgets.



Sources: see Annex 5

The largest budget shift was in the *Case management* module within the *Integrated community case management (iCCM)* intervention where the budget increased by 85% (from US\$16 million at funding request to US\$29.6 million at grant making). This budget increase was due to reclassification of ten activities initially placed under IEC/BCC intervention at funding request to iCCM during grant making. Other changes of at least 50% at the modular level included a 53% decrease (from US\$1.2 million to US\$562k) for *integrated service delivery and quality improvement*. This was mainly due to a shift of one activity "Integrate Private Riders in hub transport system" which was under the *quality of care* intervention to *service delivery infrastructure* intervention a non-HRG-Equity intervention.

The *Specific prevention interventions* module had a 57% increase from US\$1.6 million to US\$2.5 million. The change was in response to TRP comments and recommendations about the need to include interventions that address gender and human rights barriers to accessing Reproductive, Maternal,

Newborn and Child Health (RMNCH) services. The TRP noted a lack of systematic prioritization of RMNCH services for vulnerable groups, as well as human rights and gender actions in the malaria funding request and therefore recommended inclusion of these interventions in case of efficiencies during grant-making. As such, the intervention “*removing human rights and gender related barriers to specific prevention interventions*” was initially included in the PAAR but shifted to the main allocation and allocated US\$99,907. Additionally, four activities were introduced within the intermittent preventive treatment in pregnancy intervention and allocated US\$1.8 million from efficiencies and budget optimization. These activities were “training of regional Malaria in Pregnancy trainers”, “monthly district level Malaria in Pregnancy coordination meetings”, “conducting facility based mentorships” and “conduct Malaria in Pregnancy operational research which is aimed at generating evidence to inform approaches that would increase access to antenatal care services.”

Box 1. New population tab in detailed budget template for grants with an HIV component: For the 2020-2022 allocation cycle, the Global Fund introduced new budget guidelines that for “every grant budget with an HIV component, implementers will be required to break down the investments per key populations at interventions level.”(10) Guidance on filling in the detailed budget includes: “applicants are required to manually breakdown the budget by year, by intervention and by relevant target population.”(11) Furthermore, the new PU/DR templates will include the Population tab for ongoing reporting of expenditure by key population groups. In Uganda, the Population tab was not completed in the funding request budget submitted with the HIV/TB application, nor in the finalized grant award detailed budgets for UGA-H-MoFPED or UGA-C-TASO (the latter of which was missing the Population tab altogether in the detailed budget template and presumed to be an oversight; representatives interviewed from both PRs were unaware of this new tab). However, we were unable to gather additional information regarding the specific barriers to completing this new section of the detailed budget.

3.5 Inclusivity and transparency during grant making.

The 2020-21 Uganda PCE annual country report found that several stakeholders perceived the grant making process as less transparent compared with the funding request development process. It was not clear how changes (and reasons for changes) were documented and communicated to the broader group of stakeholders that participate in the funding request development. The PCE extension sought to assess whether and how the changes at grant making were communicated to other stakeholders and how transparency could be improved.

Key message 4: The NFM3 grant making process was considered more inclusive and participatory compared to NFM2. However, communication challenges remain, particularly in the documentation of the changes and decisions that led to the changes, which hinders transparency.

In NFM3, CSO networks and advocacy groups, including CCM constituency representatives who were engaged from the beginning with priority setting to grant writing, participated in grant making in addition to the mandated participants (PRs, Local Fund Agent [LFA], CT, CCM secretariat). They were included in order to improve transparency and decision-making in the investment priorities.

“Unlike for NFM2, CCM and CSO representatives were invited for grant making, for example adolescent girls and young women (AGYW), key populations (KPs), communities affected and [People living with HIV] PLHIV...but they pick those who are key in each of the constituencies to

be an eye and give feedback to the rest of the constituencies” KII, CCM representative.

Despite the increased stakeholder representation, there was limited feedback to the wider group of stakeholders about changes and the decisions behind those changes. There was no systematic documentation of decisions made and communication was left to the discretion of those involved in the process, which, in most cases, was limited to WhatsApp messages and email exchanges. These channels were perceived to be insufficient as they were limited to a few persons and not detailed in nature. Notably, budget and scope changes are made throughout the grant cycle (from funding requests to grant making through to implementation) but tracking these changes remains challenging, which hinders transparency. As highlighted in the 2020-21 Uganda PCE annual country report, having a systematic and detailed tracking mechanism for the changes throughout the grant cycle will promote transparency and this will improve grant oversight and monitoring during implementation.

3.6 NFM2 grant revisions process

Additional funding through portfolio optimization, non-material program revisions, non-material and material budget revisions were utilized in NFM2 (Annex 4). As of October 2020, there were no program revisions/reprogramming in Uganda, the reasons for which are highlighted in the 2020-21 Uganda PCE annual country report. In the extension phase, the PCE sought to further understand why reprogramming did not take place despite new evidence and data generated during NFM2 implementation that could have been utilized to inform changes to intervention scope and scale.

The PCE observed that most of the information generated during implementation was used to inform budget revisions, but not program revisions. Key informants agreed with this PCE observation and provided insights into the limited usage of new evidence during grant implementation.

1. Depending on the nature of the new evidence generated, it might require additional validation by different partners to be used, which can be a lengthy process that can delay timely usage of the data. In such instances, program implementers are hesitant to use this information to make significant grant changes that require scope and scale modifications during implementation. For example, during the malaria upsurge in 2019, new information acquired could have been used to reprogram the malaria grant, however discussions with partners had to be undertaken, and therefore this information was later used during the design of NFM3 grants.

“...We know from a policy perspective that any information generated goes through validation processes right from the MoH and sometimes up to WHO before it's adopted for use... This is usually a lengthy process that the grant implementation process cannot wait for, instead we use the evidence obtained from one grant cycle to inform the design of the next grant...” (KII, MoH consultant)

2. Additionally, the information generated from grant implementation varies from one context to another. For instance, what worked well in one district may not work in another district. Other factors, such as seasonality, can restrict prompt data usage until further research is done to improve its robustness and usability.
3. Civil Society stakeholders indicated that advocacy of the uptake of new information is important to affect changes but is often limited by the lack of awareness of new information during implementation. In addition, the point at which new evidence is generated during implementation may not be timely to inform changes in scope and scale but can only be used to improve existing interventions.

“...much of this information is not always used because of limited effort to advocate for that change. If there is less advocacy, less discussion, or less engagement to make sure the changes are made, you find that such information is not used. If the affected stakeholders are knowledgeable of the new findings, it is easy to advocate for those changes...” (KII, CSO representative in the CCM)

3.7 Revisions to mitigate impact of COVID-19

As of December 2020, a total of US\$10,510,356 from NFM2 grant savings and US\$51,935,105 under the C19RM grant had been approved for the COVID-19 response. The savings were from several areas, for example, savings within health products, missed opportunities during implementation caused by late sub-recipient (SR) onboarding and un-implemented activities due to COVID-19 restrictions on movements and gatherings. The savings were allocated to procurement of personal protective equipment, laboratory test supplies and reagents (Annex 3) and community response packages to provide prevention and adherence support to people living with HIV, and TB KPs and adolescent girls and young women.

Key message 5. Revisions to respond to the COVID-19 pandemic went through the regular grant revision processes. However, due to the emergency nature of the revisions, there were adjustments with flexibilities aimed at making the processes faster.

Grant revisions towards the COVID-19 response went through the regular processes including identification of savings, ascertaining and quantifying the gaps, engaging key stakeholders on priorities to reallocate savings and eventually seeking approvals from different levels depending on the revision threshold. However, the emergency nature of COVID-19 required flexibilities to these revision processes in order to have a coordinated, collective response to the effects of the pandemic. For instance, there was flexibility in consultation and participation beyond the usual Global Fund stakeholders (SRs, CCM, PRs, LFA, CT) to include representatives from the different government sectors, private sector, technocrats from various agencies and development partners, with the aim of strengthening alignment of program priorities with the national COVID-19 strategic plan.

Despite the wide consultation, decision-making on where to reallocate money was limited to a few technical people, thus shortening the process. For example, during regular revisions, PRs are supposed to present proposed reallocations to the different CCM committees. However, during the COVID-19 revisions, PRs discussed the decisions made with the CCM on where to reallocate the savings without going through the same lengthy process of presentations. Additionally, turnaround time for consultations and decision-making was shortened through use of digital platforms to conduct meetings and make approvals.

“...A number of COVID revisions processes in-country were electronic which made the process faster than usual. So, paperwork was less, meaning that most officers didn't have to make movements to people's offices for approvals and signatures. Once we have strong e-systems, this is something that should be introduced in other aspects of the grants...” (KII, MoH)

While our findings suggest that the COVID-19 operational flexibilities improved the promptness and efficiency of grant revisions, only one aspect (i.e., use of e-systems to quicken decision-making and approvals) seemed to be replicable to the regular grant revision processes. It was unclear the extent to which other COVID-19 revision flexibilities would be replicated to improve grant revisions given that they occurred during an emergency.

4. Conclusion and Recommendations

Global Fund investments were complementary to domestic and other donor support. The flexibility of the Global Fund business model and the autonomy given to the country to allocate resources according to needs and priorities were perceived by stakeholders to add value. Although the Global Fund guidance encouraged a shift towards systems strengthening, the country's needs and priorities drove the design of RSSH investments as either "supportive" or "strengthening". The investment towards RSSH was low compared to the overall grant portfolio and was fragmented across modules, which limited performance monitoring of the investments. Some changes happened at grant making; however, transparency remained a challenge despite the continued efforts to improve it through increasing participation in the process. The PCE observed that there was not clear and systematic communication of the changes made to the budget, scope and the decisions that led to the changes, which hindered perceptions of transparency. The COVID-19 revision processes were made faster through the use of digital platforms and other flexibilities due to their emergent nature. However, the extent to which these flexibilities could be replicated in the regular grant revision processes was not clear.

Recommendations

Recommendation 1: To achieve the intended objectives of RSSH investments, there is a need to address gaps in the national strategic design of HSS and in operationalizing the Global Fund's guidance. This will improve RSSH prioritization and the strategic alignment of investments towards health systems strengthening.

- The development of a comprehensive document that clearly articulates HSS needs/priorities and financial gaps will ease prioritization and strengthen alignment of donor HSS investments at the national level. (*Ministry of Health*)
- To strengthen the performance of health systems towards sustainable health improvements at scale, there is need to increase investment allocation towards RSSH. This will address the challenge of fragmenting investments across RSSH modules and possibly facilitate the uptake of RSSH indicators to assess the performance of RSSH investments, thus strengthening the value add of Global Fund investments. (*PRs and CCM*)
- During grant design, to promote the prioritization of strategic and catalytic investments in strengthening health systems, technical partners and the Global Fund should provide additional technical assistance for operationalizing the Global Fund's RSSH guidance. (*Global Fund Secretariat and/or Technical Partners, CCM, PRs*)

Recommendation 2: To increase transparency, PRs in consultation with the CCM, should consider developing a systematic and detailed tracking mechanism for significant changes across the grant cycle (including the rationale for substantial shifts during grant making and grant revisions). This could be in the form of a dashboard that progressively monitors changes and performance during implementation, and supports real time understanding and documentation of intervention and budgetary shifts. (*CCM, MoH*)

Recommendation 3: To improve grant revision processes, there is need to invest in e-systems and strengthen the utilization of digital platforms to accelerate the prioritization, decision-making and approval processes of grant revisions. (*CCM, MoH*)

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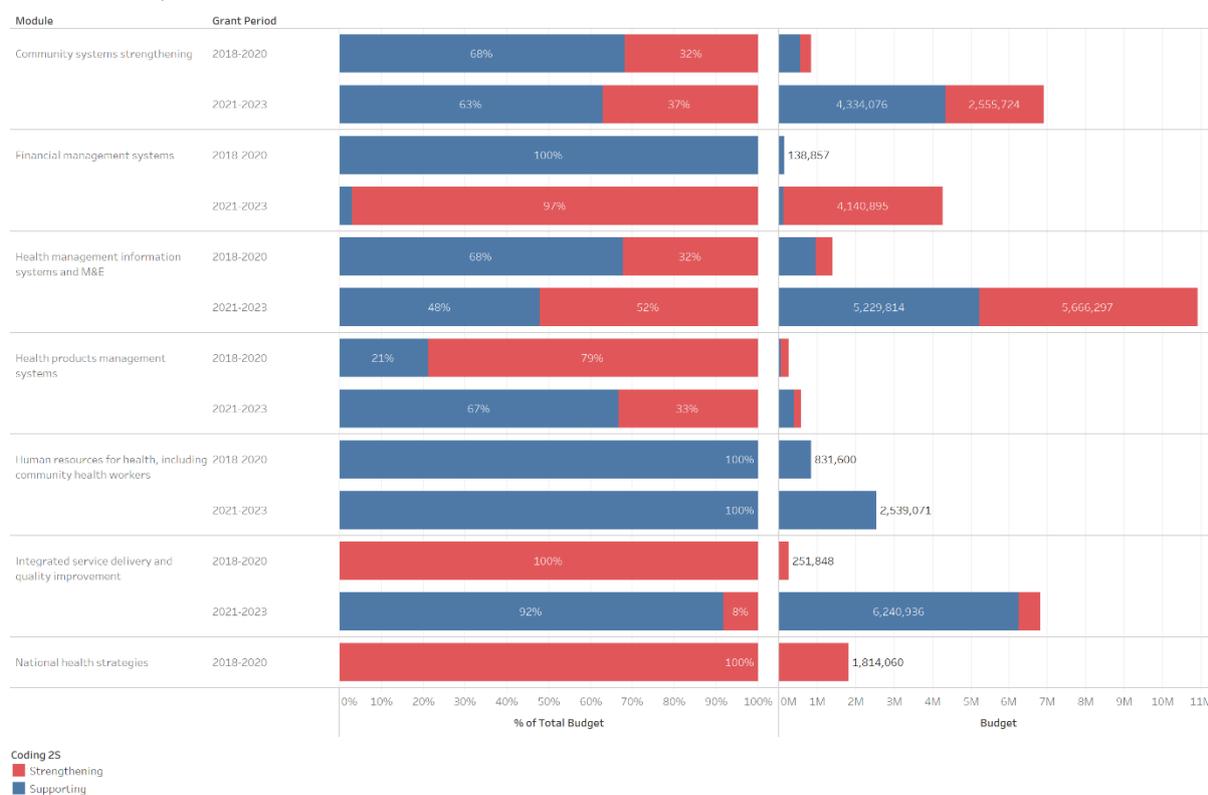
Annexes

Annex 1. RSSH indicators by RSSH module, comparing NFM3 Funding Request to NFM3 grant awards

RSSH Module	RSSH coverage indicators	NFM3 FR	NFM3 GA
HMIS and M&E	M&E-2a: Completeness of facility reporting: Percentage of expected facility monthly reports (for reporting period) that are actually received.	Malaria FR	M-TASO, M-MoFPED
	M&E-2b: Timeliness of facility reporting: Percentage of submitted facility monthly reports (for the reporting period) that are received on time per the national guidelines.	Malaria FR	Not included
	M&E-4: Percentage of service delivery reports from community health workers integrated into HMIS.	Not included	M-TASO
	WPTM(s): Digitization of health facilities (equipped with hardware and software).	Not included	M-MoFPED
Community systems strengthening	CSS-1: Percentage of community-based monitoring reports presented to relevant oversight mechanisms.	Not included	M-MoFPED
	WPTM: Rollout of Community Health Information System (with mid-term review).	Not included	M-MoFPED
	WPTM: Mentor and empower 10 community advocates per district to deepen and sustain social mobilization activities at 14 regional levels.	Malaria FR	M-TASO
	WPTM: Capacity building for Civil society Organizations to support communities for malaria prevention.	Not included	M-TASO
	WPTM: CBO/CSO capacity building (with varied milestones related to training etc.)	Not included	C-TASO

Annex 2. Change in proportion of RSSH investment (left) and overall allocation total (right) by support (blue) and strengthening (red) between NFM2 and NFM3, by RSSH module.

NFM2-NFM3 Comparison Modules



Annex 3. Summary of NFM2 grant savings reallocated to COVID-19 response (as of December 2020).

Grant	Savings (USD)	Covid-19 reallocation
UGA-H-MoFPED	US\$ 3,843,283	Personal Protective Equipment (PPE):
	US\$ 608,922	Laboratory test supply and reagents
UGA-M-TASO	US\$ 773,511	PPE emergency procurement (hand sanitizers; thermometers; and gloves)
UGA-M-MoFPED	US\$2,312,044	Procurement of diagnostics

Annex 4. Number of grant revisions and length of approval process by revision type during NFM2 (as of October 2020).

Type of revision	Number of revisions	Average revision approval duration (days)	Average revision approval date
Additional Funding Revision	5	121	8/14/2019
Budget Revision	10	15	4/26/2020
Program Revision	0	NA	NA
Grand Total	15	63	1/1/2020

Annex 5. Files used for detailed budget data.

Detailed Budget Data Sources

Grant Period	Cycle	Budget Version	File Name
2021-2023	NFM3	funding_request20	FR679-UGA-M_DB_version 2_9th April 2020.xlsx
			UGA_C_NSP_DetailedBudget_20200429_En_2.xlsx
	approved		UGA_C_TASO_DetailedBudget_1.xlsx
			UGA_M_MoFPED_DetailedBudget_1.xlsx
			UGA_M_TASO_DetailedBudget_1.xlsx
			UGA_T_MoFPED_DetailedBudget_1.xlsx
			UGA-H-MoFPED-Detailed Budget-14-Aug-2020 Final.xlsx