



**1st Regional Monitoring and Evaluation
Expert Core Group Meeting Report**



**in collaboration with
Ministry of Health and Child Welfare Zimbabwe,
Tides Foundation, USAID-Africa's Health in 2010 and
Regional Network for Equity in Health in East and Southern Africa
(EQUINET)**

12-16 July 2010, Harare, Zimbabwe



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ACRONYMS

ANC	- Ante Natal Care
CARMMA	- Campaign for the Accelerated Reduction in Maternal Mortality in Africa
DHS/MICS	- Demographic and Health Surveys/ Multiple Indicator Cluster Surveys
DJCC	- Directors Joint Consultative Committee
DOTS	- Direct Observation for Treatment
ECSA-HC	- East, Central and Southern Africa Health Community
EQUINET	- Regional Network for Equity in Health in East and Southern Africa
GDP	- Gross Domestic Product
GFATM	- Global Fund for AIDS, Tuberculosis and Malaria
HCC	- Health Centre Committees
HMC	- Health Ministers Conference
HMIS	- Health Management Information System
HRH	- Human Resources for Health
IMR	- Infant Mortality Rate
IPT	- Intermittent Presumptive Therapy
IRS	- Indoor Residual Spraying
ITN	- Insecticide Treated Bednets
MCH	- Maternal and Child Health
MDGs	- Millennium Development Goals
MMR	- Maternal Mortality Ratio
NCD	- Non Communicable Disease
NMR	- Neonatal Mortality Rate
PHC	- Primary Health Care
PMTCT	- Prevention of Mother to Child Transmission
PNC	- Perinatal Care
PPP	- Purchasing Power Parity
RTA	- Road Traffic Accident
SMART	- Specific, Measurable, Achievable, Relevant and Time-bound
TT2+	- Tetanus Toxoid
U5MR	- Under 5 years Mortality Rate
X/MDR	- Multi Drug Resistance

FOREWORD

The ECSA 50th Health Ministers' conference held in Kampala Uganda in February 2010 directed the Secretariat to finalize the creation of a Regional Monitoring and Evaluation Expert Core Group by August 2010. This was due to the fact that Member States of the region did not have a uniform format of reporting the implementation of the HMC resolutions; and also there was weak mechanism to track and evaluate progress towards meeting the health related MDGs.

In fulfillment of this resolution the ECSA Secretariat organized the 1st Regional Monitoring and Evaluation Expert Core Group meeting in Harare Zimbabwe from 12th to 16th July 2010. The participants came from Member States of Tanzania, Kenya, Lesotho, Zimbabwe, Zambia, Uganda, Malawi, Mozambique and Mauritius and International partners namely EQUINET, UNICEF- ESARO, WHO-IST/ESA and USAID-EA.

The meeting deliberated and agreed on the Terms of Reference for the regional M&E Expert Group. The meeting also updated the HMC Monitoring tool, adopted with amendments the Regional Core set of indicators that will be used to monitor progress towards the MDGs, finalized the M& E Framework, developed indicators to monitor the implementation of the HMC resolutions and included indicators to monitor health equity in order to address inequalities in health in the region. In addition, the meeting resolved that it was necessary to monitor other codes, protocols and conventions such as the WHO Global Code of Practice on the International recruitment of health personnel.

The indicators and the monitoring tools which was agreed upon by the expert core group will not only make it easier to compare member states in progress towards achieving the MDGs, addressing equity issues in health and implementation of the HMC resolutions, but also will be valuable in evaluation of in country changes from the baseline. It will also enable the ECSA Secretariat to develop and create useful health data base for the region.

It is my sincere hope that the Member States will continue to support this M&E regional initiative so that required information is collected in a timely manner and submitted to the Secretariat according to the agreed timelines. Furthermore, I hope that the Secretariat will provide the agreed upon support and guidance to the M&E expert committee so that the region can eventually boast of a robust M&E system. I wish to express my gratitude to all the Member States who sent participants to this meeting, to all the participants for their very useful inputs during the meeting, the ECSA Secretariat for organizing this meeting, the Zimbabwe MOHCW for agreeing to host the meeting, to EQUINET for their dedicated participation and all the development partners; TIDES FOUNDATION, UNICEF, WHO-IST/ESA, USAID-EA, AH2010 for their support and deliberations.

Dr. Isaac Kadowa
Chairman
ECSA-HC M&E Expert Core Group
Ministry of Health, Uganda

1.0 Background and Objectives

During the 50th Health Ministers Conference (HMC) held in Uganda in February 2010 the East, Central and Southern African Health Community (ECSA-HC) Secretariat was directed to facilitate the setting up of a Regional Monitoring and Evaluation Expert Core Group by August 2010 (Resolution ECSA/HMC50/R9- “Tracking progress towards meeting the MDGs”). The aim of this resolution was to ensure that member states are able to track and report on progress of the Resolutions against a standard set of indicators, using a uniform format for all future Health Ministers Conferences.

The decision to set up a Regional M&E Expert Core Group arose out of a growing concern by the Conference of Health Ministers, first expressed at the 2006 HMC, that there was no systematic mechanism for tracking the implementation of its resolutions. Consequently, the overall impact of these resolutions on the health status of the population at national and regional level could not be easily assessed.

Since 2006, there have been efforts to strengthen the M&E functions of the Secretariat, including the development of an ECSA M&E Framework and establishment of an M&E Programme. In addition to monitoring implementation of the resolutions, the Programme was given the responsibility of tracking the implementation of existing and new initiatives as well as the MDGs.

To date, a tool for monitoring the resolutions has been developed and disseminated to member states to guide collection and reporting of relevant information. All member states who attended the recent HMC in Kampala, reported on the implementation of the 2009 Resolutions. However, the conference noted the absence of indicators that would have ensured standardized reporting and enabled the meeting to make comparisons between member states on progress made.

There has also been an initiative (driven by EQUINET, in dialogue with ECSA HC, UNICEF, WHO and institutions in member states) introduced in the region to monitor health equity in an attempt to address inequalities in health. To date, an Equity Watch Guidance has been produced and work is underway to assist Member States to collect and report on health inequalities and means employed to address the challenges, including on health MDGs. At the 50th ECSA Health Ministers Conference, Ministers urged member states to report on evidence on health equity, and directed the secretariat to strengthen capacities and measures to monitor and report on progress in addressing inequalities in health.

The HMC recognizes that all the aforementioned initiatives and processes to strengthen M&E in the region require an all-inclusive, participatory process to foster ownership and sustainability. Thus, the recent Health Ministers Conference in Kampala passed a resolution to set up a Regional Monitoring and Evaluation Expert Core Group. It is with this background that the first meeting of the M & E Core Group was planned.

1.1 Objectives of the meeting

The objectives of this meeting were defined as follows:

1. To finalise and adopt the Terms of Reference, function and procedures of the expert group
2. To revise and update the HMC monitoring tool
3. To adopt a core set of regional indicators for monitoring key programmes /interventions at regional and country level.
4. To finalise the ECSA M&E Framework and harmonize it with other regional frameworks
5. To report on and review the equity watch initiative for analysis of inequalities in health and advise on modalities of its implementation and use at country and regional level.

The meeting was organised by the ECSA-HC Secretariat with support from the Ministry of Health and Child Welfare Zimbabwe (MoHCW), EQUINET, Tides Foundation and USAID (Africa's Health in 2010). A summary report of the deliberations is available through the ECSA-HC Secretariat. The delegate list is shown in Appendix One, and the programme in Appendix Two.

2.0 Opening Session

As chair of the opening session, Dr Davis Dhlakama, Director of Planning, Monitoring and Evaluation, MoHCW, Zimbabwe, welcomed all delegates and thanked ECSA-HC for agreeing to host the first M&E Expert Core Group meeting in Zimbabwe. After delegate introductions, Allie Kibikwa-Muyinda (ECSA-HC), on behalf of ECSA-HC Director General, Dr Josephine Kibaru-Mbae, further welcomed all delegates and emphasized the importance of this meeting in providing a credible framework for monitoring the implementation of ECSA HMC resolutions. He thanked UNICEF, WHO and USAID-EA for the technical support they have provided to date and for their willingness to attend this meeting. He also thanked EQUINET, TIDES FOUNDATION and AH2010 for their continued support.



Dr Rene Loewenson (EQUINET) added her words of welcome on behalf of EQUINET and noted the long-standing collaboration between EQUINET and ECSA- HC. She explained EQUINET's mandate to promote research, dialogue and capacity development in advancing health equity in East and Southern Africa and expressed her support of the ECSA-HC's commitment to include health equity in their monitoring processes.

Principal Secretary of the MoHCW, Zimbabwe, Brigadier General, Dr. Gerald Gwinji, gave the key note address. He expressed gratitude on behalf of the Ministry of Health Zimbabwe for the work of ECSA-HC and the importance of evaluating progress of member states in strengthening the monitoring process. He summarized events since the 42nd and 44th ECSA Health Ministers Conference in February 2006 and March 2007, where Ministers of Health passed resolutions that urged member states and the secretariat to develop a mechanism for monitoring and reporting on implementation of Health Ministers Conference resolutions.



At subsequent Health Ministers Conferences, leading up to the 50th HMC in Uganda in February 2010, Ministers continued to call for the strengthening of a monitoring and evaluation system in ECSA, including the development of a reporting template. The 50th HMC in Uganda in February 2010 passed a resolution to set up a Regional Monitoring and Evaluation Expert Core Group, to develop indicators for measuring change, and to document evidence on health equity and progress in addressing inequalities in health.

Dr. Gwinji noted with pleasure that this meeting is implementing these resolutions in a timely manner and wished all delegates fruitful deliberations.

In terms of the **expectations** of the meeting, participants were unanimous in what they wanted to achieve. They expressed three major expectations – wanting to share experiences and document best practices in monitoring progress; a recognized commitment to strengthening the monitoring process at country and regional level including the need to develop a standardized set of indicators that are comparable across the region and internationally; and, finally, to ensure a more coordinated strategy for implementation of the tool. Participants also noted the increasing inequity between rich and poor in the region and the implications this has on access to health services, meaning that it will be important to monitor these disparities as they impact on policy and programme implementation.

Finally, Sibusiso Sibandze from the ECSA-HC Secretariat outlined the **meeting objectives**, as provided in Section 1.0 of this report. Participants noted that these objectives met their expectations.

3.0 Establishment of the M&E Expert Group – Terms of Reference

After a brief historical overview of the HMC resolutions (see Background section), Sibusiso Sibandze confirmed that representatives from member states attending this meeting constituted the M&E Expert Core Group. He then gave a detailed outline of the proposed terms of reference for the M&E expert group. After discussion, the meeting endorsed the Terms of Reference, with the following modifications:

In relation to **Specific Tasks**, the meeting emphasized that the Group needs to document the process countries engage in (ie. what makes a programme work) in the implementation of the HMC resolutions and that this must be reflected in the database to be developed by the ECSA-HC Secretariat. Recognising that what works in one place may not work in another, the meeting further recommended the Group document good or promising practices from each country in order to identify ‘best’ practices in M&E in the region. The meeting also reworded one of the tasks to read “Identify information gaps on analysis, reporting and use of data, and propose strategies to address these gaps.”

Membership of the Expert Group was expanded to include Senior M&E Planning Officers from various ministries, including Policy and Planning and any other relevant Government Department. It was also agreed that the Group would **meet** bi-annually, adding that the Expert Group could request a member to attend and report back on other M&E activities in the region.

The Expert Group agreed that the **Chair** will be drawn from the member states, based on the annual rotating leadership in the Health Ministers Conference, deputized by the incoming chair. Thus, Uganda represented by Dr. Isaac Kadowa will chair this Expert Group until the next HMC in October 2010, deputized by Zimbabwe represented by Dr. Davies Dhlakama.

A final copy of the Terms of Reference for the Monitoring and Evaluation Expert Group as adopted by the Expert Group is attached in Appendix Three.

Before ending this session, the meeting reflected on the wider role of the Expert Group. They noted that this expert group is the central body of the ECSA-HC in monitoring progress and that it has the responsibility to guide the DJCC and, by extension the HMC, in the development and implementation of the Monitoring Framework.



4.0 M&E Framework and HMC Monitoring Tool

In implementing the 48th HMC Resolution (ECSA/HMC/48/10), the ECSA-HC Secretariat developed an M&E Framework and monitoring tool to assess progress within member states towards meeting the resolutions of the HMC. Allie Kibwika-Muyinda (ECSA-HC Secretariat) presented an outline of this M&E Framework to the meeting. He explained that a monitoring framework is an important tool because it helps to manage and document performance, describe processes and allows for regular and consistent collection of performance data. It also enables the ECSA Secretariat and country teams to actively assess the results and ensure that resolutions are implemented based on measurable performance.

Mr. Kibwika-Muyinda noted that the HMC has adopted 52 resolutions in the last 5 years. This is a large number of resolutions and further points to the importance of developing a framework to monitor progress in their implementation.

Fortunately, these resolutions can be broken down into specific action points but, nevertheless, there is still the problem that almost all the resolutions have no time frame, are not SMART and are therefore difficult to measure.

This Expert Group, therefore, is tasked to make the Framework clear, practical and implementable. In doing so, there are certain key elements in its development. These include:

- Participatory approach, involving the Secretariat, member states and partners
- Development of practical and useful indicators that are direct, objective, practical and which minimize the burden of data collection and reporting.
- Collection and review of performance data – both results level and activity level indicators
- Tracking of progress and results, including the tracking of specific activities across member states and the use of more rigorous evaluations

- Assessing data quality in relation to validity, reliability, timeliness, precision and integrity.
- Review and improvement of the monitoring framework on a regular basis.

Operationalising the Monitoring Framework includes establishing a baseline for each resolution, agreeing on a set of indicators and time frame, identifying responsible actors and adopting a reporting mechanism.

During discussion of the Monitoring Framework, members of the Expert Group recommended that:

- The M&E Framework be harmonized with other regional and international frameworks and member state processes
- The HMC resolutions be broken down into actionable and measurable components
- The HMC Monitoring Tool be divided into two sections –Health Systems and Progress Indicators
- The Progress Indicators function at two levels – process and result
- The Progress Indicators be direct, objective, practical, comparable and minimize the burden of data collection and reporting
- Member countries’ progress be measured against their own individual baseline.

The meeting also reviewed and updated the tool for monitoring the HMC resolutions. The tool will be divided into two sections; Section 1: Health Systems and the Section 2: Progress Indicators. The final version of these tools aimed to be user-friendly, with clear and specific questions in each section. It was further recommended that the monitoring tool be web-based so that guidance on use of the tool could be embedded in the text, and it could be refined more easily, with member states updating their information on a regular basis.

The HMC Monitoring Tool is attached in Appendix Four.

5.0 Indicators for Monitoring Progress

Based on recommendations arising from the 50th HMC Meeting in February 2010 (Resolution ECSA/HMC50/R9), the Expert Group set out to develop indicators to ensure standardized reporting of progress made in implementation of HMC recommendations. Standardized indicators would also enable the HMC to make comparisons between member states. In formulating these indicators, the Expert Group agreed that:

- There would be two sets of indicators
 - core regional indicators that would be used to describe the health system and epidemiological status of each member state, thus also allowing for a regional health analysis to be undertaken by the HMC Secretariat with support from the Expert Group
 - indicators for each of the 10 resolutions made at the last HMC held in Uganda
- All indicators would be predetermined by this Group to allow for better comparison between member states
- In order to operationalise the ECSA HMC resolutions, each resolution would be broken down into a set of measurable actions
- Both the core regional indicators and indicators for the HMC Resolutions would include brief reporting on issues of health equity, drawing on selected parameters from and using the experience of the EQUINET Equity Watch (see Section 6.0 below)
- The indicators should include those that are relevant to reporting on the health MDGs (4, 5 and 6)
- In light of commitments to domesticate all regional and international codes and protocols, including the WHO Global Code of Practice on the International Recruitment of Health Personnel,

the M&E Expert Group will include relevant indicators from these codes to include in the ECSA M&E tool

- A guidance document (and/or web notes) should also be prepared to provide and ensure standardized definitions and calculations of all indicators.

The core regional and resolution-specific indicators are listed below.

5.1 Regional Core Set of Indicators

SOCIO-ECONOMIC AND DEMOGRAPHIC

- GDP (current US\$ and PPP US\$)
- GDP growth rate.
- Population dependency ratio (under 15 and over 65 years)
- Crude birth rate
- Crude death rate
- Life expectancy at birth by gender
- Population growth rate

SOCIAL DETERMINANTS OF HEALTH

- % of children who enroll and complete primary school
- % households within 15 minutes of a safe water supply (*)
- % households with safe sanitation (flush/pit/toilet latrine) (*)

NUTRITION

- Low birth weight (% of infants with low birth weight)
- % children with early initiation of breastfeeding (before 1 hour after birth)
- Infants exclusively breast fed for first 6 months of life
- % Children aged <5 years underweight for age (*)
- Stunting (low height for age among < 5 years)
- Wasting (low weight for age among < 5 years)
- Iodine deficiency (% of households consuming iodine salt)
- Vitamin A supplementation coverage
- Prevalence of iron deficiency anaemia

HEALTH SYSTEMS

Leadership/stewardship/ responsiveness

- Client satisfaction rate

Health financing

- General government expenditure on health as % of GDP
- Total Expenditure on Health as % of GDP
- General government expenditure on health as % of total expenditure on health
- Private expenditure on health as % of total expenditure on health
- Prepaid and pre-pooling funds as % private sector expenditure on Health
- Out of pocket expenditure as a % of private expenditure on health
- External resources on health as % of total expenditure on health
- Total expenditure on health per capita (at PPP international dollar rate)
- Total government expenditure on health per capita (at PPP international dollar rate)
- % of public social health insurance to total health expenditure
- % of private health insurance to total health expenditure

- % expenditure of primary and secondary level health care services over total government health expenditure
- Proportion of population covered by community health financing mechanisms or social health insurance.

Health Services

- % of Health Facilities stock-outs of tracer medicines in last 2 weeks

Human resources for health

- No. of doctors per 10 000 population
- No. of nurses per 10 000 population
- No. of midwives per 100 000 population
- Doctor-patient ratio
- Nurse-patient ratio
- No. of health workers per 10 000 population
- % approved posts that are filled at the level of the Ministry of Health

MATERNAL NEONATAL AND CHILD HEALTH/FAMILY REPRODUCTIVE HEALTH

- Infant mortality rate per 1000 live births (*)
- Maternal mortality rate per 100 000 live births (*)
- Neonatal mortality rate per 1000 live births (*)
- Under five mortality rate per 1000 live births (*)
- Births attended by skilled health personnel (%) (*)
- Contraceptive prevalence (%)
- Full immunization coverage amongst 1 year olds
- Measles immunization coverage amongst 1 year olds (*)
- ANC coverage (%) at least one visit
- ANC coverage (%) at least four visits
- Unmet need for Family Planning
- Adolescent birth rate (below 18 years)
- Total fertility rate
- % coverage TT2+ (pregnant women)
- % Caesarian Section rate
- Couple Years of Protection

MALARIA

- Malaria mortality rate per 100 000 population
- % households in malarious areas protected by IRS
- % of pregnant women sleeping under an ITN
- % of households with at least one ITN
- % of <5 children sleeping under an ITN
- Proportion of children <5 with fever who are treated with appropriate anti-malarial drugs
- Proportion of fever treated with appropriate anti-malaria
- Incidence of malaria per 1 000 population

HIV/AIDS

- Adult (15-49) HIV prevalence percent by country (*)
- Antiretroviral therapy coverage among people with advanced HIV infection (%)
- Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS
- Condom use at last high-risk sex
- Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years

- PMTCT coverage
- HIV/AIDS prevalence among pregnant women 15-24 years

TUBERCULOSIS

- Tuberculosis prevalence per 100 000 population
- Tuberculosis mortality rate per 100 000 population
- Tuberculosis treatment success under DOTS (%)
- TB detection rates
- % HIV+ patients screened for TB
- % TB patients screened for HIV
- TB cure rates
- TB incidence per 100 000 population

NON COMMUNICABLE DISEASES

- Death rate due to heart diseases per 10 000 population
- Prevalence of hypertension (among 25 years and over)
- Prevalence of smoking among adult population (among 25 years and over)
- Prevalence of overweight/obesity among adults (among 25 years and over)
- Prevalence of diabetes (among 25 years and over)
- Prevalence of mental illness
- Incidence of cancer disaggregated by gender
- Death rate due to road traffic accidents per 10 000 population

(*) Provide disaggregations by wealth and urban/ rural residence on asterixed indicators whenever the relevant surveys are done to produce this data (every 4-5 years)

5.2 Indicators for ECSA-HC Resolutions

ECSA/HMC50/R1: Health Insurance and Financing	
Action Point	Reporting Indicators
Adopt pro-poor and equitable health insurance schemes tailored to their unique demographic, economic, and health system circumstances and integrated with their broader health financing policy	<ol style="list-style-type: none"> 1. % of household out-of-pocket health expenditure over total health expenditure 2. % of public social health insurance to total health expenditure 3. % of private health insurance to total health expenditure 4. % expenditure of primary and secondary level health care services over total government health expenditure 5. Proportion of population covered by community health financing mechanisms or social health insurance.
Exercise their stewardship role and develop regulations to govern health insurance schemes that protect against exploitation and promote transparency, equity and financial sustainability	<ol style="list-style-type: none"> 6. Availability of (new) policies or regulations governing health insurance schemes 7. Existence of targeted free health care <ol style="list-style-type: none"> a. % of pregnant women receiving free services (ANC, Delivery, PNC) b. % of under 5 year old children getting free services (vaccinations) 8. Availability of regulatory mechanisms and independent “Equity Watch” structures to monitor pro-poor policies and programmes 9. Mechanisms (e.g. conditional grants, Performance Based Financing, Ring fencing of funds, Direct funding to the operational level etc) to enforce adherence/conformity to established pro-poor policies.

ECSCA/HMC50/R2: Leadership, Stewardship and Governance	
Action Point	Reporting Indicators
Include the leadership, stewardship and governance skills and practices needed by the Ministers and their senior teams in national planning for leadership development	<ol style="list-style-type: none"> 1. Leadership development plans include the leadership, stewardship and governance skills and practices needed by the Ministers and their senior teams 2. No. of training sessions conducted for ministers and their senior teams 3. Availability of functional Parliamentary Committees covering health matters 4. No. of meetings held between Parliamentary Committees and Ministry & National stakeholders on the health budget in the past year
Develop induction programs and coaching for Ministers with a focus on strategic issues as well as public health issues the Ministers will encounter	<ol style="list-style-type: none"> 5. Availability of leadership development plans 6. Availability of a dedicated budget for leadership development plans
Strengthen Ministers and Ministerial Senior Management Team's capacity in Global Health Diplomacy	<ol style="list-style-type: none"> 7. Policy in place regards Global Health Diplomacy 8. Mechanism in place to support Global Health Diplomacy

ECSCA/HMC50/R3: Leadership and Management	
Action Point	Reporting Indicators
Identify gaps and barriers to leadership and management development and design interventions according to set priorities.	<ol style="list-style-type: none"> 1. Availability of report on situational analysis 2. Availability of procedures and guidelines
Institutionalise leadership development programs in the health sector where appointments in the leadership positions require an individual to participate in leadership and management development programmes.	<ol style="list-style-type: none"> 3. Pre- and in-service training leadership development programs in the health sector in place 4. No. of curriculum reviewed/developed 5. No. of managers trained
Strengthening engagement of private sector and leveraging on public private partnership initiative to facilitate the attainment of MDGs	<ol style="list-style-type: none"> 6. Pro-poor health related programmes and projects supported by the private sector 7. Public-private partnership in place 8. Number and type of signed agreements with private sector on primary health care interventions 9. % contribution of the private sector to programmes specific to health 10. Coordination system of private sector partners in place or Framework for public-private partnership collaboration in place 11. Desk or focal point in the Ministry to address public - private sector collaboration in place

	<p>12. % of private financing schemes (insurance, medical aid, employer based) that cover the basic/essential health package</p> <p>13. Provision in law for private insurance to cover the essential/basic health benefit package</p>
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ECSCA/HMC50/R4: Improving the Capacity of HRH Departments	
Action Point	Reporting Indicators
Strengthen capacities of HRH units or departments.	<p>1. Availability of HRH policy and strategy</p> <p>2. Availability of a functional HRH department (vacancy rates and positions filled)</p> <p>3. Availability of appropriately trained human resource management professionals</p>
Establish and strengthen multi-sectoral and stakeholders coordination and collaboration mechanisms for HRH development	<p>4. Availability of national HRH observatory</p> <p>5. Availability of budget for human resources development programmes</p> <p>6. Availability of a functioning HRH management information system</p>
Ensure appropriate skill mix and efficient use of available human resources taking into account task shifting options with appropriate training, support supervision/mentoring and regulations.	<p>7. Availability of staffing norms policy/guidelines</p> <p>8. Availability of multi skilling training programmes</p> <p>9. Number of multi skilled health professionals</p> <p>10. Availability of deployment plan</p> <p>11. Availability of motivation and retention strategy</p> <p>12. % of health facilities meeting minimum staffing norms by level of care</p> <p>13. Health professions by type to population ratio</p> <p>14. % of health professionals working in hard-to-reach areas</p>

ECSCA/HMC50/R5: Improving Maternal and Child Health/Family Planning	
Action Point	Reporting Indicators
Accelerate operationalization of the Maputo Plan of Action and the Campaign for the Accelerated Reduction in Maternal Mortality in Africa (CARMMA).	<p>1. No. of interventions from the Maputo Plan incorporated into the national planning frameworks</p> <p>2. No. of interventions from the CARMMA incorporated into the national planning frameworks</p> <p>3. Maternal mortality ratio</p>

ECSCA/HMC50/R6: Challenges in Funding and Implementing Regional HIV/AIDS, TB and Malaria Programmes	
Action Point	Reporting Indicators
Maximize available opportunities from Global Fund and other partners to obtain additional resources for scaling up interventions to achieve MDGs.	<p>1. % of proposals funded</p> <p>2. GFATM grant rating</p> <p>3. % of GFATM funds accessed for HSS, Malaria, TB, HIV/AIDS, MCH</p> <p>4. % of national Annual Operational Plans funded by domestic and donor financing</p>

	5. Per capita financing
Support the Global Fund Constituency Board Member to effectively represent all Member Countries.	6. No. of GFATM issues from Members States passed on to Executive Board Member 7. No. of issues with feedback from GFATM Board 8. No. of issues satisfactorily passed by GFATM Board 9. No. of consultative meetings with member states by Board member
Develop a proposal for mobilizing resources for an integrated regional HIV/AIDS, TB and Malaria Programme.	10. Regional proposal developed and funded (health system strengthening included in proposal)

ECSA/HMC50/R7: Maternal and Child Nutrition	
Action Point	Reporting Indicators
Raise the profile of nutrition and allocate adequate financial resources for implementation of programmes.	1. Comprehensive nutritional assessment conducted in the last 3 years (including distribution, determinants) 2. Report publicly available through print and broadcast media, internet, webmail etc 3. Functioning multi-sectoral task force 4. No. of high level multisector sensitization meetings conducted in the past year 5. Multi-sectoral strategic plans in place 6. Dedicated budget line on nutrition 7. % of Health Sector budget allocated to nutrition
Accelerate implementation of high impact interventions (e.g Essential Nutrition Actions, fortification of commonly consumed foods, Universal Salt Iodation, vitamin A, iron and folic acid supplementation).	8. Micronutrient supplementation policy on universal salt iodization, vitamin A supplementation, iron and folic acid eg maize, sugar, butter etc supplementation adopted 9. Exclusive breast feeding in first 6 months 10. Complementary feeding after 6 months 11. Breast feeding in first hour
Strengthen public-private partnerships and multi-sectoral collaboration	12. National and Purchasing Power Parity (PPP) policy on nutrition in place

ECSA/HMC50/R8: Prevention of Non- Communicable Diseases (NCDs)	
Action Point	Reporting Indicators
Develop or update an integrated and comprehensive strategy and Action Plan for NCDs.	1. Assessment on the magnitude of NCDs including RTAs conducted 2. Comprehensive country strategy developed 3. Country action plan for NCDs implemented
Promote healthy lifestyles and create awareness on risk factors associated with NCDs including road traffic accidents	4. Availability of screening programmes for early detection of NCDs

ECSA/HMC50/R9: Tracking Progress towards the Millennium Development Goals (MDGs)	
Action Point	Reporting Indicators
Appoint Information Focal Persons within their existing systems to improve channels of communication.	1. Information Focal Persons appointed
Submit annual data-based reports on the status of specific targets and goals.	2. Fully completed annual reports submitted 3. Country annual reports submitted before the stipulated deadlines
Strengthen routine HMIS, analysis and use data for decision making.	4. Assessment of HMIS functionality conducted
Report on evidence on health equity and progress in addressing inequalities in health	5. Health equity technical working groups established 6. Availability of recent empirical research on health equity eg NHA, BIA, DHS, LCMS, integrated health survey, other specific equity studies etc 7. National reports available on health equity and progress in addressing inequalities in health, that disaggregate evidence by wealth, geographical area and other relevant social differentials

ECSA/HMC50/R10: Management of HIV/AIDS and Tuberculosis (TB) in ECSA Region	
Action Point	Reporting Indicators
Review and implement integrated comprehensive National TB and HIV policy guidelines.	1. National integrated TB and HIV policy guidelines reviewed 2. % of HIV positive patients who were screened for TB in HIV care or treatment 3. % of TB patients screened for HIV 4. Percentage of new HIV positive patients starting IPT in the past year
Establish X/MDR Task force to ensure implementation and monitoring of the Global framework and report on the number of X/MDR cases notified and treated	5. X/MDR TB Task force in place 6. No. and percentage of laboratory confirmed X/MDR TB patients enrolled in the preceding year 7. X/MDR-TB Cure Rate
Develop and expand capacity for diagnosis of drug resistant TB, strengthen quality DOTS and allocate adequate resources for management of X/MDR-TB	8. DOTS coverage 9. Percentage of TB funds allocated to X/MDR-TB management

6.0 Monitoring Equity and the Equity Watch

Dr. Rene Loewenson from the Regional Network for Equity in Health in East and Southern Africa (EQUINET) and Dr. Tesfaye Shiferaw from UNICEF East and Southern Africa Regional office (ESARO) presented the need for and ways of monitoring and addressing inequalities in health, including the health MDGs, in line with the Ministers Resolution ECSA/HMC50/R9.

Dr. Shiferaw noted that most countries in the ECSA region (and elsewhere in Africa) will not manage to meet the MDG goals by 2015. For example, there has been little or no progress in terms of under- 5 mortality (MDG4) and especially in reducing new-born deaths, and in reduction of maternal mortality (MDG6). The

common view is that slow growth, insufficient aid and/or poor governance explain why the world will miss the 2015 targets. However, Dr. Shiferaw argued that the main reason is the continued socio-economic inequality within countries, with the bottom quintile not benefiting much, if at all, from social progress and economic growth in most parts of the world. UNICEF's argument, he concluded, is that "Behind every preventable child death, behind each out-of-school child, behind each malnourished child, behind every maternal death lies a story of inequity and discrimination."

Dr. Loewenson reiterated Dr. Shiferaw's argument, noting that aggregate improvements may not reach the lowest income groups, and that rapid scale up of programmes may disproportionately benefit wealthier groups. She showed how periods of improvement in overall child mortality in the early 2000s, for example, were also periods of increasing differentials in mortality. She went on to report on the work EQUINET has implemented at regional and country level on equity in health, now consolidated in the 'Equity Watch', which aims to track, make visible, report on and engage on priority dimensions of health equity. This work is being implemented at regional level in co-operation with the ECSA HC.

As outlined in Appendix Five, the Equity Watch is a means to monitor progress on health equity, through gathering, organising, analysing, reporting and reviewing evidence on equity in health, at national and regional level¹. The report produced consolidates the evidence, analysis and proposals for strengthening health equity. It is implemented through a process that aims to build capacities, awareness, accountability and networking to support and advance health equity. The Equity Watch covers 25 progress markers of equity in health, the social determinants of health and health systems, including the health MDGs, and of equitable health systems.

Five countries (Mozambique, Zambia, Uganda, Zimbabwe, Kenya) represented by Dr. Gertrudes Machitane, Mr. Collins Chansa, Dr. Isaac Kadowa, Dr. Davies Dhlakama/Dr Rene Loewenson and Dr. Ruth Kitetu, respectively, presented the work they are currently doing in the Equity Watch with EQUINET. Each of these countries are at different stages in implementing their Equity Watch work, but all note the importance of undertaking this data analysis and its ability to inform the health policy process at country level, as well as feeding into the regional learning network. In summary:

- The Mozambique Ministry of Health started an Equity Watch in 2009. The report is now under review before publication.
- Zambia's Equity Watch Team is tracking progression towards reducing health inequities, using data gathered since 1992
- Uganda has finalised their Equity Watch and is now focusing on dissemination and advocacy.
- Zimbabwe implemented a pilot equity watch in 2008, and is now updating this and implementing district level disaggregations using the Tanahashi framework in 2010/11.
- Kenya initiated an Equity Watch in 2010 for reporting in early 2011

Finally, Dr. Loewenson, representing the EQUINET Secretariat, outlined the work done on a comprehensive regional equity analysis in 2007, with an updated analysis planned for 2011, building on the country watches. EQUINET has a formal memorandum of understanding with ECSA HC on this and other work on health equity. She outlined further the work WHO is doing at global and regional level to support capacities for analysing equity in health.

The M&E expert group had a wide ranging discussion on the equity watch underway and:

- Endorsed the Equity Watch as a tool for a comprehensive equity analysis in countries using available data, implemented through a national team involving leadership from Ministries of Health, technical institutions and with involvement of other key stakeholders from other government sectors, civil society and parliament; and proposed that it be extended to all countries.

¹ Further work will be done on health equity analysis and progress monitoring at district level, such as that in Zimbabwe using the Tanahashi framework of availability, accessibility, acceptability, contact and effective coverage.

- Proposed to disaggregate MDG reporting by wealth, geographical area and other relevant social differentials, while observing that the current UNDP reporting framework does not currently accommodate this.
- Proposed that evidence from these equity analyses be used to inform national health strategic plans and resource allocation strategies.
- Noted that EQUINET will produce a regional analysis in 2011 to be peer reviewed by the M&E expert group and then presented to the DJCC and HMC
- Confirmed the Equity Watch progress markers presented (see Appendix Five) as relevant and feasible, with the following comments on changes
 - i. On parameter 7: Suggest collecting evidence on the share of formal and informal employment/ unemployment.
 - ii. On parameter 9: suggest adding % stock-outs in tracer drugs at different levels of the health system (primary and secondary level facilities)
 - iii. For parameter 12: include availability of health facilities (population /facility; population within distance/ time to facility and new facilities in areas of low availability)
 - iv. For parameter 15: include the taxes collected on alcohol, tobacco, etc that are allocated to the health sector
 - v. For parameter 18: note PHC spending is difficult to assess so use community, primary and secondary level health facilities
 - vi. For parameter 19: include incentives to support HRH deployment to hard-to-reach areas and primary/ district levels
- Proposed that report on relevant ECSA HC core indicators included in the DHS / MICS surveys be reported with disaggregations by wealth and urban/ rural residence whenever these surveys done, (every 4-5 years), ie on IMR, MMR, U5MR, NMR, Births attended by skilled personnel, ANC coverage, % under 1 year immunised, Children under 5 years underweight; adult HIV prevalence, access to safe water and sanitation and that this evidence be available publicly through the ECSA database. (See core indicators in Section 5.0 where this has been done)
- Proposed that countries strengthen capacities for skills in health information systems and equity analysis through short courses, regional mentoring from EQUINET, the M&E expert group, technical assistance from relevant agencies (eg UN and CDC), and through university level programmes.
- Proposed that reports of the equity analyses be shared in appropriate forms to engage support beyond the health sector with policy makers in relevant ministries (health, education, finance policy and planning, water, agriculture) and with the parliament health and budget committees, civil society and at relevant regional and international forums
- Proposed that the October ECSA HMC be updated with a report prepared by ECSA HC and EQUINET on the work underway on the equity watch/ equity analyses, the recommendations of the M&E expert group and how equity analysis has already fed into country policies and programmes.

7.0 Monitoring of other Codes, Protocols and Conventions

The Expert Group noted that there are a number of codes, protocols and conventions where ECSA needs to draw on for monitoring purposes. These include the MDGs, the Maputo Plan of Action, the Campaign for the Accelerated Reduction in Maternal Mortality in Africa (CARMMA), the WHO Global Code of Practice on the International Recruitment of Health Personnel and others. Key aspects of these codes, protocols and conventions need to be identified as they relate to ECSA to ensure the monitoring process remains relevant to the region, with issues addressed at international level.

As pointed out by Dr Magda Awases from WHO-IST/ESA, this is particularly true in relation to the **WHO Global Code of Practice on the International Recruitment of Health Personnel** (hereafter called The Code), passed at the 63rd World Health Assembly in May 2010 (Resolution WHA63.16). During her presentation, Dr. Awases gave a succinct summary of the code. It was noted that out migration

of health personnel comes at great cost to source countries - weakening health systems, eroding health gains, the loss of intellectual capital, as well as lost investment made in educating and training these health professionals. Africa is the most affected region for this out-migration, which is why the initiative for development of this Code came from this continent.

The adoption of this Code was a major achievement for the WHO. It was unanimously adopted by all member states, being only the second ethical code to be signed by the WHA. The Code secured the right of health workers to migrate, while also acknowledging the right to the highest attainable standard of health. However, as articulated during plenary discussion, there are some key constraints in implementation of the Code:

- The Code is voluntary and not-legally binding, with no sanctions for non-compliance
- The source countries had to make compromises in order for the code to be adopted at global level – including issues of compensation
- There is a lack of adequate and effective data collection and monitoring systems, both from the destination countries and ECSA member states

In light of this analysis, the meeting proposed that the ECSA-HC M&E Expert Group:

- Strengthen the indicators at regional level in regularly tracking health workforce out-migration; this information to be used for lobbying purposes at international fora, including the WHA meeting in 2012
- Monitor multi/bilateral agreements between any member state and recipient country to ensure adherence to Article 5.2 on Health Workforce Development and Health Systems Sustainability. This would include the following indicators:
 - Effective and appropriate technical assistance
 - Support for HRH retention
 - Support for training, including specialist training
 - Twinning of facilities
 - Support for temporary/permanent return migration
- In relation to Article 7.3 on Information Exchange, find out who the authority/focal point is for implementation of the code in-country
- In the short term, indicators should focus on doctor and nurse/midwife migration with the intention of covering other important categories of health workers in the medium-term
- Communicate with WHO to include these points in the global monitoring system being developed for the code

8.0 Annual Data Reporting

Mr. Sibusiso Sibandze from the ECSA-HC Secretariat outlined the objectives for annual reporting as follows:

1. To progressively inform the Best Practice Forum, DJCC & HMC on the implementation of resolutions and their impact on policy and programming at the regional and country level
2. To assist the DJCC to formulate or propose recommendations to the HMC that would be increasingly relevant and beneficial to Member States towards achieving better health outcomes
3. To provide a clear picture of the challenges and needs of Member states so as to gain support for the full implementation of the resolutions
4. To generate information to build on best practice and evidence-based policy-making and sharing this information as widely as possible in the region and beyond.

With this in mind, the meeting endorsed the following schedule for reporting:

- Reporting Timelines
 - Core Indicators - June 30th every year
 - HMC Resolutions - September 30th every year
- Reporting to be accompanied by a qualitative report outlining
 - Significant changes – improvement/lack of improvement in indicator
 - Challenges encountered
 - Lessons learned/promising practices

Deliverables include:

- Annual Report on the Implementation of the HMC Resolutions – Comparative Analysis
- ECSA MDG Factsheet & Report on progress
- Web-based database on Core indicators
- ECSA M&E briefs

This discussion was followed by two presentations **on challenges member states face in data collection and reporting and how they can be overcome**, from Mr. Collins Chansa (Dept of Policy and Planning, Zambia) and Mr. Josibert Joseph Rubona (Monitoring and Evaluation Section, Ministry of Health and Social Welfare, Tanzania).

Both Chansa and Rubona outlined their Health Information System and HMIS structures, and implementation processes. They were clear in articulating their challenges. In summary, these included:

- Structural weaknesses – parallel systems with conflicting information, weak feedback on data analysis from Districts to facilities
- Human Resource Management – turnover of HMIS staff (especially at lower level facilities), Health Workers overburdened with reporting especially in light of the Human Resources crisis, inadequate training in data handling. The important role of Data Information officers not fully appreciated in most countries
- Use and quality of data – varied challenges in terms of data collection, storage, analysis, dissemination and use.

The meeting noted that these challenges are familiar to many other countries, and that it was good to see how both Zambia and Tanzania were actively trying to strengthen their Health Information Systems and HMIS. The meeting felt that it was important to document these and other experiences in the region for discussion at HMC level and to share with member states.

9.0 General Recommendations

The following recommendations for the M&E Expert Group, to the DJCC, and to the ECSA-HC Secretariat were tabled and accepted by the Expert Group:

RECOMMENDATIONS FOR M&E EXPERT GROUP

- Meet at least bi annually
 - June: specific issues identified beforehand
 - October/November: after HMC
- Develop an Action Plan with support from Secretariat, including a set of guidelines and procedures, dates for submission of reports, etc
- Members will submit their first reports on core indicators by Friday 13th August 2010
- It is suggested that each country set up a steering committee to ensure collection of data for the regional M&E process. This is at the discretion of each Expert Group Focal Person.

- At the next M&E Expert Group meeting, and after development of the country baselines, it is suggested the Group discuss the development of regional targets for indicators that are not part of the MDGs (which already exist)
- Provide capacity building for member states as and when needed

RECOMMENDATIONS TO THE DJCC

- Expert Group give input to recommendations to ensure they are measurable (SMART)
- Include in the agenda at the next HMC a report on health equity in the region which will include progress made in implementing the equity watch work and in using the evidence to address health inequities and country experiences

RECOMMENDATIONS TO THE SECRETARIAT

- Secretariat will officially introduce the Expert Group to all member states, providing a list of members and a brief outline of the functions of the Expert Group.
- The Secretariat will provide a template outlining the format of the reports on core indicators
- Set up the web-based info system/database
- Provide support to the Expert Group in collaboration with partners in technical and capacity building eg equity analysis, logistics, M&E techniques
- Document, in collaboration with EQUINET for the October HMC, experiences of member states the equity watch/ equity analyses, the recommendations of the M&E expert group and how equity analysis has already fed into country policies and programmes
- In collaboration with EQUINET, provide support to other member states in undertaking an Equity Watch in their countries. (Lesotho, Malawi, Tanzania and Mauritius have already expressed an interest).

10.0 Next Steps and Closing

10.1 Next Steps

Members of this meeting reviewed the Summary Report and endorsed it as an accurate reflection of deliberations (Zimbabwe proposed, Lesotho seconded). Expert Group members then agreed on the next steps and time frames for the follow-up work as shown below:

STEP	TIMING	RESPONSIBILITY
Report of Meeting and Summary		
Final Draft Report circulated to M&E Group	21 July 2010	Secretariat
Feedback from members	23 July 2010	Member states
Final Report finalized	26 July 2010	Secretariat
Implementation of Recommendations		
Report on core data indicators (baseline)	13 August 2010	Member states
Report on HMC Monitoring Tool	30 Sept 2010	Member states
Compilation of Regional report on Implementation of Resolutions	15 Oct 2010	Secretariat
Post HMC Meeting	29-31 Oct 2010	Expert Group and Sec
Dissemination of M&E Framework to Member states	13 August 2010	Secretariat
Setting up the web-based database	31 August 2010	Secretariat
Expert Group Meeting	June 2011	Expert Group and Sec

The meeting further agreed that the primary form of communication between members will be emails and telephone. The key focal person at ECSA is the M&E Manager (Sibusiso Sibandze). The role of the Expert Group Chairperson will be to convene the group and present reports/briefings to the DJCC and HMC.

Finally, the group proposed the following agenda issues for the June 2011 Expert Group Meeting:

- Review progress on work of the Group
- Report on core indicators
- Improve reporting at HMC and DJCC
- Discuss other M&E needs in the region including capacity building
- Review progress towards meeting the MDGs and other international/regional targets
- Develop an action plan

10.2 Evaluation and Closing

All participants to this meeting concurred that the meeting had been well-organised, both in its preparatory phase and during the 5 days of deliberations. Participants also noted that objectives of the meeting were met. Members of the Expert Group congratulated the Secretariat for sending out the pre-meeting documentation in good time and noted that the meeting had succeeded in fulfilling all its objectives.

In order to improve future meetings, it was suggested that the Secretariat:

- If possible, limit meetings to no longer than 3 days
- Ensure reliable access to the internet
- Include excursions out of the hotel to deepen members' understanding of the host country
- Include sharing of country experiences

The host organizations closed the meeting with thanks to the delegates, partner organizations and secretariat for their contributions and with wishes for a safe travel home.

APPENDIX ONE: LIST OF PARTICIPANTS

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APPENDIX 2: PROGRAMME

DAY ONE (12/07/2010): CHAIR – ZIMBABWE

TIME	ITEM
0830 - 0845	Introductions and Welcome Remarks
0845 - 0915	Official Opening ECSA-HC – <i>Director General, Dr Josephine Kibaru-Mbae</i> EQUINET – <i>Dr. Rene Loewenson</i> MOHCW – <i>Principal Secretary Brigadier General, Dr. Gerald Gwinji</i>
0915 - 0945	Objectives and participant expectations of the meeting
	Session 1: Establishment of the M&E Expert Group
0945-1000	The HMC Resolutions - a brief historical perspective – <i>Allie Kibwika-Muyinda</i> – <i>ECSA-HC</i>
1000-1030	Presentation of the Regional M&E Expert Group TORs - <i>Sibusiso Sibandze</i> – <i>ECSA-HC</i>
1030-1100	Discussions – Adoption of TORs and election of Chairperson
1100-1130	Tea Break
	Session 2: Overview of the issues on the agenda
1130-1200	Presentation of the HMC M&E Framework and DRAFT HMC Monitoring Tool - <i>Allie Kibikwa-Muyinda and Sibusiso Sibandze-ECSA-HC</i>
1200-1300	Discussion of the Framework and monitoring tool- initial responses and issues to address in Days 2 and 3
1300-1400	LUNCH
1400-1430	Equity analysis, and the Equity Watch and core indicators – <i>Rene Loewenson</i> – <i>EQUINET</i>
1430-1500	Discussion - initial responses and issues to address on Day 4
1500-1530	Other areas for monitoring: The Code on International Recruitment of health personnel, other regional codes and protocols – <i>Magda Awases, WHO-IST</i>
1530-1600	Discussion and areas for future expert meetings
1600-1630	TEA BREAK
1630- 1700	Introduction to Group work
	END OF DAY ONE

DAY TWO (13/07/2010): Expert group chair with Malawi co-chairing

TIME	ITEM
	Session 3: HMC Monitoring tool
0830-1030	Group Work – HMC Monitoring Tool (Design/Format)
1030-1100	Tea Break
1100-1200	Feedback and discussions
1200-1300	Group Work – HMC Monitoring Tool – Updating tool with HMC 2010 resolutions
1300-1400	LUNCH
1400-1700	Group Work – HMC Monitoring Tool – Updating tool with HMC 2010 resolutions
	END OF DAY TWO

DAY THREE (14/07/2010): CHAIR – Expert group chair with Kenya co-chairing

0830-0930	Feedback and Discussions
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	Session 4: HMC M&E Framework
0930-1100	Group Work - HMC M&E Framework and Regional Core Set of Indicators
1100-1130	TEA BREAK
1130-1300	Group Work - HMC M&E Framework and Regional Core Set of Indicators
1300-1400	LUNCH
1400-1500	Feedback and Discussions
	Session 5: Monitoring codes, protocols and conventions
1500-1530	Highlights of the Code of Practice on International recruitment of health personnel & Monitoring mechanisms – <i>Magda Awases- WHO-IST</i>
1530-1600	Plenary discussion: Monitoring the Code of Practice – areas for monitoring and follow up work
1600-1630	TEA BREAK
1630-1700	Plenary discussion: Monitoring of and report on other health conventions, codes and protocols in the Region
END OF DAY THREE	

DAY FOUR (15/07/2010): Expert group chair with Uganda co-chairing

	Session 6: Monitoring health/ health systems inequalities
0830-0930	Monitoring Equity in the region – Regional overview Capacity support – WHO Regional MDG analysis - UNICEF Equity Watch – EQUINET
0930-1000	Discussions
1000-1030	Tea Break
1030-1130	Country experiences / proposals on equity analysis/ equity watch (examples from Mozambique, Zambia, Zimbabwe, Kenya)
1130-1230	Working groups: Follow up: analysis and reporting on inequalities in health at national and regional level 1. Capacity support 2. Indicators and analysis 3. Reporting and use of the evidence
1230-1315	Feedback from groups and plenary discussion
1315-1415	LUNCH
	Session 7: Annual data reporting
1415-1500	Annual Data Reporting
1500-1530	Overcoming challenges to data collection and reporting - Country experiences (Zambia and Tanzania)
1530-1600	Plenary Discussion
1600-1615	TEA BREAK
1615-1700	Working Group discussions: future meeting procedures, agenda issues and activities for the M&E expert group Secretariat compilation of the summary report and recommendations of the expert group
END OF DAY FOUR	

DAY FIVE (16/07/2010): Expert group chair

0830-0930	Session 8: Feedback and plenary discussion of working group reports
0930-1030	Presentation, discussion and review of the summary report and recommendations of the expert working group
1030-1100	Discussion of follow up work and roles

1100-1130	TEA BREAK
1130-1200	Formal adoption of the summary report and recommendations
1200-1245	Next Steps
1245-1300	Closing remarks Expert Group Chairperson ECSA-HC EQUINET MOHCW-Zimbabwe Meeting adjournment
1300-1400	LUNCH
END OF DAY FIVE	

APPENDIX 3: TERMS OF REFERENCE - REGIONAL M&E EXPERT GROUP

1.0 Background

In 2006, the Health Ministers Conference after noting the weak M&E systems in the region passed a resolution to strengthen and institutionalize M&E in the ECSA health Community. One of the key motivating factors in passing the resolution was to ensure that the resolutions passed at the annual HMCs are implemented, monitored and evaluated with Member States reporting on progress during the conference.

Since then, there have been efforts to strengthen the M&E function at the Secretariat which has involved the development of an ECSA M&E Framework and establishment of an M&E Programme. In addition to monitoring implementation of the resolutions, the Programme was given the responsibility of tracking the implementation of existing and new initiatives as well as the MDGs. In carrying out this responsibility effectively, there is need to develop a common set of indicators for the member states to report against, on an annual basis.

To date, a tool for monitoring the resolutions has been developed and disseminated to member states to guide collection and reporting of relevant information. All member states who attended the recent HMC in Kampala, reported on the implementation of the 2009 Resolutions. However, the conference noted the absence of indicators that would have ensured standardized reporting and enabled the meeting to make comparisons between as such member states on progress made.

There has also been an initiative (driven by EQUINET, in dialogue with ECSA HC, UNICEF, WHO and institutions in member states) introduced in the region to monitor health equity in an attempt to address inequalities in health. To date, an Equity Watch Guidance has been produced and work is underway to assist Member States to collect and report on health inequalities and means employed to address the challenges, including on health MDGs. At the 50th ECSA Health Ministers Conference, Ministers urged member states to report on evidence on health equity and progress in addressing inequalities in health, and directed the secretariat to strengthen capacities and measures to monitor and report on progress in addressing inequalities in health.

All the aforementioned initiatives and processes to strengthen M&E in the region require an all-inclusive, participatory process to foster ownership and sustainability. Thus, the recent Health Ministers Conference in Kampala passed a resolution to set up a Regional Monitoring and Evaluation Expert Core Group. It is with this background that the first meeting of the M & E Core Group is being planned.

2.0 Overall mandate of the Expert Core Group

The Regional M&E Expert Core Group will guide and advise the ECSA HC through the Secretariat on all issues relating to the monitoring and evaluation of the implementation of the Ministers resolutions and other initiatives or programmes, including the MDGs and inequalities in health at the international, regional and national level. The expert core group will provide guidance and advice on the development and review of frameworks (reporting and implementation), core indicators, data collection methods and M&E tools; and will provide peer review of regional analysis and review of the reported evidence and guidance on dissemination.

2.1 Specific Tasks

- Finalize the ECSA M&E Framework and harmonize it with other regional frameworks
- Advise on appropriate mechanisms for reporting on implementation of activities and flow of information between the Secretariat and Member states

- Guide and review the Secretariat's follow up and periodic reporting on implementation of various regional initiatives at country level
- Develop a standard format of annual data based reports to the HMC and member states
- Develop and define a core set of indicators on implementation of the RHMC resolutions, including on health MDGs, health and health systems, to be monitored and reported on at regional level with input from member states
- Develop evaluation questions and methodologies for key regional programmes
- Advise on and peer review methods and indicators for monitoring and reporting on inequalities in health and health care and progress in addressing inequalities in the region, and for dissemination and use of the evidence
- Support the development and maintenance by the ECSA HC Secretariat of a database of M&E expertise in the region
- Identify information gaps on analysis, reporting and use of data and propose strategies to address these gaps.
- Assist the ECSA HC Secretariat with the documentation of good or promising practices in M&E within the region

2.2 Membership

The Expert Core Group will be composed of Senior M&E Planning Officers from various ministries, including Policy and Planning and any other relevant Government Departments from each of the ten Member States, ECSA-HC, and EQUINET. A total of 15 people are expected to form the Core Group.

The meetings may with agreement of the members co-opt the presence of additional institutional personnel as relevant to the focus of the meeting. Some of the key institutions that will be co-opted from time to time include WHO-AFRO, AH/2010, USAID-EA and UNICEF. Members can also request to attend and report back to the Expert Core Group on other M&E activities in the region.

2.3. Schedule of Meetings

The Expert Core group will meet on a bi-annual basis. The first meeting will be held mid-year to review the HMC monitoring tool and indicators, and to review progress on implementation of various regional initiatives in support of HMC resolutions e.g Equity Watch and TIDES Project) and for tracking progress towards meeting the MDGs. The second meeting would be on revising and updating the HMC Monitoring tool and for reporting and review of relevant regional M&E initiatives to be held immediately after the Conference every year.

2.4 Secretariat and meetings

The ECSA-HC Secretariat through its M&E officer will act as secretariat for the expert group, will take the lead in convening the meetings and ensuring preparation of all background documents and necessary reports and rapporteur and produce the minutes of the meetings.

The Expert group will elect a chair and deputy chair on an annual basis, reflecting the overall chairmanship of the Health Ministers Conference and deputized by the incoming chair.

APPENDIX 4: HMC 2010 MONITORING TOOL

1.1 The HMC 2010 Resolutions

The 50th Health Ministers Conference adopted the following resolutions:

ECSA/HMC50/R1:	Health Insurance and financing
ECSA/HMC50/R2:	Leadership, Stewardship and Governance
ECSA/HMC50/R3:	Leadership and Management
ECSA/HMC50/R4:	Improving the Capacity of HRH Departments
ECSA/HMC50/R5:	Improving Maternal and Child Health/Family Planning
ECSA/HMC50/R6:	Challenges in Funding and Implementing Regional HIV/AIDS, TB and Malaria Programmes
ECSA/HMC50/R7:	Maternal and Child Nutrition
ECSA/HMC50/R8:	Prevention of Non- Communicable Diseases
ECSA/HMC50/R9:	Tracking Progress towards the MDGS
ECSA/HMC50/R10:	Management of HIV/AIDS and Tuberculosis (TB) in ECSA Region
ECSA/HMC50/R11:	Expression of Gratitude to Partners of the ECSA Health community
ECSA/HMC50/R12:	Expression of Gratitude to His Excellency the President of the Republic of Uganda and the people of Uganda

For purposes of reporting on progress achieved to date, focus shall be on Recommendations 1 to 10.

1.2 Organization of the Tool

The tool comprises two sections covering Health System Factors and the Progress Achieved.

Section 1: Health System Factors

A number of resolutions are passed by the HMC. If countries are to address these resolutions, there should be an enabling environment made up of legislations, policy, strategy, action plan and budget. The purpose of this section is to describe the enabling environment that will affect (either positively or negatively) the implementation of the HMC Resolutions. Responses must be concise and be as descriptive as possible

ECSA/HMC50/R1: Health Insurance and financing

Question	Response* for (a) to (e)	Provide details for each response.	Results or Lessons Learnt***	Additional Comments
Is there a (a) Legislation, (b) Policy, (c) Strategy, (d) Action plan (e) Other in place to address health insurance and explore various financing mechanisms?	(a) (b) (c) (d) (e)			
Are there implementation mechanisms** to effectively address issues of Health Insurance and financing within the Planning Processes and ensure subsequent implementation?				
Does the Health Sector have a budget for the implementation of this resolution?				
Is there a monitoring and evaluation system in place for this resolution?				

* Either Yes or No or Not Known/Aware

**Healthy policy advisory committee, Technical working group for health financing, Policy or planning unit, other institutional arrangements, ...etc

***Good practices, achievements,

ECSA/HMC50/R2 &R3 : Leadership and Management, Stewardship and Governance

Question	Response* for (a) to (e)	Provide details for each response.	Results or Lessons Learnt***	Additional Comments
Is there a (a) Legislation, (b) Policy, (c) Strategy, (d) Action plan (e) Other in place to address leadership & Management including stewardship and governance?	(a) (b) (c) (d) (e)			
Are there implementation mechanisms** to effectively address issues of Leadership and Management within the Planning Processes and ensure subsequent implementation?				
Does the Health Sector have a budget for the implementation of this resolution?				
Is there a monitoring and evaluation system in place for this resolution?				

* **Either Yes or No or Not Known/Aware**

**Healthy policy advisory committee, Technical working group for health financing, Policy or planning unit, other institutional arrangements , ...etc

***Good practices, achievements,

Question	Response* for (a) to (e)	Provide details for each response.	Results or Lessons Learnt***	Additional Comments
Is there a (a) Policy, (b) Strategy, (c) Action plan (d) Other in place to improve the capacity of HRH Departments ?	(a) (b) (c) (d)			
Are there implementation mechanisms** to effectively address issues of HRH Capacity within the Planning Processes and ensure subsequent implementation?				
Does the Health Sector have a budget for the implementation of this resolution?				
Is there a monitoring and evaluation system in place for this resolution?				

* Either Yes or No or Not Known/Aware

**Healthy policy advisory committee, Technical working group for health financing, Policy or planning unit, other institutional arrangements , ...etc

***Good practices, achievements,

Question	Response* for (a) to (e)	Provide details for each response.	Results or Lessons Learnt***	Additional Comments
Is there a (a) Legislation (b) Policy, (c) Strategy, (d) Action plan (e) Other in place to improve/strengthen MCH, FP and Nutrition programmes?	(a) (b) (c) (d) (e)			
Are there implementation mechanisms** to effectively address issues of MCH,FP and Nutrition within the Planning Processes and ensure subsequent implementation?				
Does the Health Sector have a budget for the implementation of this resolution?				
Is there a monitoring and evaluation system in place for this resolution?				

* **Either Yes or No or Not Known/Aware**

**Healthy policy advisory committee, Technical working group for health financing, Policy or planning unit, other institutional arrangements , ...etc

***Good practices, achievements,

ECSA/HMC50/R6 & R10: Managing, Funding and Implementing HIV/AIDS, TB and Malaria Programmes

Question	Response* for (a) to (e)	Provide details for each response.	Results or Lessons Learnt***	Additional Comments
Is there a (a) Legislation (b) Policy, (c) Strategy, (d) Action plan (e) Other in place to address financing , management and implementation of regional HIV/AIDS, TB and Malaria programmes?	(a) (b) (c) (d) (e)			
Are there implementation mechanisms** to effectively manage and fund HIV/AIDS, TB and Malaria within the Planning Processes and ensure subsequent implementation?				
Does the Health Sector have a budget for the implementation of this resolution?				
Is there a monitoring and evaluation system in place for this resolution?				

* **Either Yes or No or Not Known/Aware**

**Healthy policy advisory committee, Technical working group for health financing, Policy or planning unit, other institutional arrangements , ...etc

***Good practices, achievements,

Question	Response* for (a) to (e)	Provide details for each response.	Results or Lessons Learnt***	Additional Comments
Is there a (a) Legislation (b) Policy, (c) Strategy, (d) Action plan (e) Other in place for the prevention and control of NCDs ?	(a) (b) (c) (d) (e)			
Are there implementation mechanisms** to effectively prevent and control NCDs within the Planning Processes and ensure subsequent implementation?				
Does the Health Sector have a budget for the implementation of this resolution?				
Is there a monitoring and evaluation system in place for this resolution?				

* **Either Yes or No or Not Known/Aware**

**Healthy policy advisory committee, Technical working group for health financing, Policy or planning unit, other institutional arrangements , ...etc

***Good practices, achievements,

Question	Response* for (a) to (e)	Provide details for each response.	Results or Lessons Learnt***	Additional Comments
Is there a (a) Legislation (b) Policy, (c) Strategy, (d) Action plan (e) Other in place for tracking progress towards the MDGs?	(a) (b) (c) (d) (e)			
Are there implementation mechanisms** to effectively track progress towards the MDGs within the Planning Processes and ensure subsequent implementation?				
Does the Health Sector have a budget for the implementation of this resolution?				
Is there a monitoring and evaluation system in place for this resolution?				

* **Either Yes or No or Not Known/Aware**

**Healthy policy advisory committee, Technical working group for health financing, Policy or planning unit, other institutional arrangements , ...etc

***Good practices, achievements,

Section 2 -Progress on implementation of the HMC Resolutions

In this section, specific progress on each recommendation action point is required. Where possible, baselines must be provided to enable measurement of progress towards meeting set targets. In cases where no action has been taken at all, respondents should make reference to other actions that have a direct impact/relation on the HMC Action Points. Where action has been taken, details must be given corresponding to the reporting indicators.

ECSA/HMC50/R1: Health Insurance and financing					
Action Point	Reporting Indicators	Source of data	Baseline - Status at time of passing the resolution (February 2010)	Achievement - Status at time of reporting (September 2010)	Comments on favorable or/and unfavorable progress made
1. Adopt pro-poor and equitable health insurance schemes tailored to their unique demographic, economic, and health system circumstances and integrated with their broader health financing policy	<p>1.1 Percentage of household out-of-pocket health expenditure over total health expenditure</p> <p>1.2 Percentage of public social health insurance to total health expenditure % of private health insurance to total health expenditure</p> <p>1.3 Percentage expenditure of primary and secondary level health care services over total government health expenditure</p> <p>1.4 Proportion of population covered by community health financing mechanisms or social health insurance.</p>				

ECSA/HMC50/R1: Health Insurance and financing					
Action Point	Reporting Indicators	Source of data	Baseline - Status at time of passing the resolution (February 2010)	Achievement - Status at time of reporting (September 2010)	Comments on favorable or/and unfavorable progress made
2. Exercise their stewardship role and develop regulations to govern health insurance schemes that protect against exploitation and promote transparency, equity and financial sustainability	<p>2.1 Availability of (new) policies or regulations governing health insurance schemes</p> <p>2.2 Existence of targeted free health care</p> <p style="padding-left: 40px;">c. % of pregnant women receiving free services (ANC, Delivery, PNC)</p> <p style="padding-left: 40px;">d. % of under 5 year old children getting free services (vaccinations)</p> <p>2.3 Availability of regulatory mechanisms and independent “Equity Watch” structures to monitor pro-poor policies and programmes Mechanisms (e.g. conditional grants, Performance Based Financing, Ring fencing of funds, Direct funding to the operational level etc) to enforce adherence/conformity to established pro-poor policies.</p>				

ECSA/HMC50/R2: Leadership, Stewardship and Governance

Action Point	Reporting Indicators	Source of data	Baseline - Status at time of passing the resolution (February 2010)	Achievement - Status at time of reporting (September 2010)	Comments on favorable or/and unfavorable progress made
1. Include the leadership, stewardship and governance skills and practices needed by the Ministers and their senior teams in national planning for leadership development	1.1 Leadership development plans include the leadership, stewardship and governance skills and practices needed by the Ministers and their senior teams 1.2 No. of training sessions conducted for ministers and their senior teams 1.3 Availability of functional Parliamentary Committees covering health matters 1.4 No. of meetings held between Parliamentary Committees and Ministry & National stakeholders on the health budget in the past year				
2. Develop induction programs and coaching for Ministers with a focus on strategic issues as well as public health issues the Ministers will encounter	2.1 Availability of leadership development plans 2.2 Availability of a dedicated budget for leadership development plans				
3. Strengthen Ministers and Ministerial Senior Management Team's capacity in Global Health Diplomacy	3.1 Policy in place regards Global Health Diplomacy 3.2 Mechanism in place to support Global Health Diplomacy				

ECSA/HMC50/R3: Leadership and Management					
Action Point	Reporting Indicators	Source of data	Baseline - Status at time of passing the resolution (February 2010)	Achievement - Status at time of reporting (September 2010)	Comments on favorable or/and unfavorable progress made
1. Identify gaps and barriers to leadership and management development and design interventions according to set priorities.	1.1 Availability of report on situational analysis 1.2 Availability of procedures and guidelines				
2. Institutionalise leadership development programs in the health sector where appointments in the leadership positions require an individual to participate in leadership and management development programmes.	2.1 Pre- and in-service training leadership development programs in the health sector in place 2.2 No. of curriculum reviewed/developed 2.3 No. of managers trained				

ECSA/HMC50/R3: Leadership and Management					
Action Point	Reporting Indicators	Source of data	Baseline - Status at time of passing the resolution (February 2010)	Achievement - Status at time of reporting (September 2010)	Comments on favorable or/and unfavorable progress made
1. Strengthening engagement of private sector and leveraging on public private partnership initiative to facilitate the attainment of MDGs	1.1 Pro-poor health related programmes and projects supported by the private sector 1.2 Public-private partnership in place 1.3 Number and type of signed agreements with private sector on primary health care interventions 1.4 % contribution of the private sector to programmes specific to health 1.5 Coordination system of private sector partners in place or Framework for public-private partnership collaboration in place 1.6 Desk or focal point in the Ministry to address public - private sector collaboration in place 1.7 Percentage of private financing schemes (insurance, medical aid, employer based) that cover the basic/essential health package 1.8 Provision in law for private insurance to cover the essential/basic health benefit package				

ECSCA/HMC50/R4: Improving the Capacity of HRH Departments					
Action Point	Reporting Indicators	Source of data	Baseline - Status at time of passing the resolution (February 2010)	Achievement - Status at time of reporting (September 2010)	Comments on favorable or/and unfavorable progress made
1. Strengthen capacities of HRH units or departments.	1.1 Availability of HRH policy and strategy 1.2 Availability of a functional HRH department (vacancy rates and positions filled) 1.3 Availability of appropriately trained human resource management professionals				
2. Establish and strengthen multi-sectoral and stakeholders coordination and collaboration mechanisms for HRH development	2.1 Availability of national HRH observatory 2.2 Availability of budget for human resources development programmes 2.3 Availability of a functioning HRH management information system				

ECSCA/HMC50/R4: Improving the Capacity of HRH Departments					
Action Point	Reporting Indicators	Source of data	Baseline - Status at time of passing the resolution (February 2010)	Achievement - Status at time of reporting (September 2010)	Comments on favorable or/and unfavorable progress made
1. Ensure appropriate skill mix and efficient use of available human resources taking into account task shifting options with appropriate training, support supervision/mentoring and regulations.	1.1 Availability of staffing norms policy/guidelines 1.2 Availability of multi skilling training programmes 1.3 Number of multi skilled health professionals 1.4 Availability of deployment plan 1.5 Availability of motivation and retention strategy 1.6 Percentage of health facilities meeting minimum staffing norms by level of care 1.7 Health professions by type to population ratio of health professionals working in hard-to-reach areas				

ECSCA/HMC50/R5: Improving Maternal and Child Health/Family Planning					
Action Point	Reporting Indicators	Source of data	Baseline - Status at time of passing the resolution (February 2010)	Achievement - Status at time of reporting (September 2010)	Comments on favorable or/and unfavorable progress made
1. Accelerate operationalization of the Maputo Plan of Action and the Campaign for the Accelerated Reduction in Maternal Mortality in Africa (CARMMA).	1.1 No. of interventions from the Maputo Plan incorporated into the national planning frameworks 1.2 No. of interventions from the CARMMA incorporated into the national planning frameworks Maternal mortality ratio				

ECSCA/HMC50/R6: Challenges in Funding and Implementing Regional HIV/AIDS, TB and Malaria Programmes					
Action Point	Reporting Indicators	Source of data	Baseline - Status at time of passing the resolution (February 2010)	Achievement - Status at time of reporting (September 2010)	Comments on favorable or/and unfavorable progress made
1. Maximize available opportunities from Global Fund and other partners to obtain additional resources for scaling up interventions to achieve MDGs.	1.1 Percentage of proposals funded GFATM grant rating 1.2 Percentage of GFATM funds accessed for HSS, Malaria, TB, HIV/AIDS, MCH 1.3 Percentage of national Annual Operational Plans funded by domestic and donor financing 1.4 Per capita financing				
2. Support the Global Fund Constituency Board Member to effectively represent all Member Countries.	2.1 No. of GFATM issues from Members States passed on to Executive Board Member 2.2 No. of issues with feedback from GFATM Board 2.3 No. of issues satisfactorily passed by GFATM Board 2.4 No. of consultative meetings with member states by Board member				
3. Develop a proposal for mobilizing resources for an integrated regional HIV/AIDS, TB and Malaria Programme.	3.1 Regional proposal developed and funded (health system strengthening included in proposal)				

ECSCA/HMC50/R7: Maternal and Child Nutrition					
Action Point	Reporting Indicators	Source of data	Baseline - Status at time of passing the resolution (February 2010)	Achievement - Status at time of reporting (September 2010)	Comments on favorable or/and unfavorable progress made
1. Raise the profile of nutrition and allocate adequate financial resources for implementation of programmes.	1.1 Comprehensive nutritional assessment conducted in the last 3 years (including distribution, determinants) 1.2 Report publicly available through print and broadcast media, internet, web mail etc 1.3 Functioning multi-sectoral task force 1.4 No. of high level multisector sensitization meetings conducted in the past year 1.5 Multi-sectoral strategic plans in place 1.6 Dedicated budget line on nutrition % of Health Sector budget allocated to nutrition				
2. Accelerate implementation of high impact interventions (e.g Essential Nutrition Actions, fortification of commonly consumed foods, Universal Salt Iodation, vitamin A, iron and folic acid supplementation).	2.1 Micronutrient supplementation policy on universal salt iodization, vitamin A supplementation, iron and folic acid eg maize, sugar, butter etc supplementation adopted 2.2 Exclusive breast feeding in first 6 months 2.3 Complementary feeding after 6 months 2.4 Breast feeding in first hour				
3. Strengthen public-private partnerships and multi-sectoral collaboration	3.1 National and Purchasing Power Parity (PPP) policy on nutrition in place				
ECSCA/HMC50/R8: Prevention of Non- Communicable Diseases (NCDs)					
Action Point	Reporting Indicators	Source of data	Baseline - Status at time of passing the resolution (February 2010)	Achievement - Status at time of reporting (September 2010)	Comments on favorable or/and unfavorable progress made
1. Develop or update an integrated and comprehensive strategy and Action Plan for NCDs.	1.1 Assessment on the magnitude of NCDs including RTAs conducted 1.2 Comprehensive country strategy developed 1.3 Country action plan for NCDs implemented				
2. Promote healthy lifestyles and create awareness on risk	2.1 Availability of screening programmes for early				

factors associated with NCDs including road traffic accidents	detection of NCDs				
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ECSA/HMC50/R9: Tracking Progress towards the Millennium Development Goals (MDGs)					
Action Point	Reporting Indicators	Source of data	Baseline - Status at time of passing the resolution (February 2010)	Achievement - Status at time of reporting (September 2010)	Comments on favorable or/and unfavorable progress made
1. Appoint Information Focal Persons within their existing systems to improve channels of communication.	1.1 Information Focal Persons appointed				
2. Submit annual data-based reports on the status of specific targets and goals.	2.1 Fully completed annual reports submitted 2.2 Country annual reports submitted before the stipulated deadlines				
3. Strengthen routine HMIS, analysis and use data for decision making.	3.1 Assessment of HMIS functionality conducted				
4. Report on evidence on health equity and progress in addressing inequalities in health	4.1 Health equity technical working groups established 4.2 Availability of recent empirical research on health equity eg NHA, BIA, DHS, LCMS, integrated health survey, other specific equity studies etc 4.3 National reports available on health equity and progress in addressing inequalities in health, that disaggregate evidence by wealth, geographical area and other relevant social differentials				

ECSCA/HMC50/R10:		Management of HIV/AIDS and Tuberculosis (TB) in ECSCA Region			
Action Point	Reporting Indicators	Source of data	Baseline - Status at time of passing the resolution (February 2010)	Achievement - Status at time of reporting (September 2010)	Comments on favorable or/and unfavorable progress made
1. Review and implement integrated comprehensive National TB and HIV policy guidelines.	1.1 National integrated TB and HIV policy guidelines reviewed 1.2 Percentage of HIV positive patients who were screened for TB in HIV care or treatment 1.3 Percentage of TB patients screened for HIV 1.4 Percentage of new HIV positive patients starting IPT in the past year				
2. Establish X/MDR Task force to ensure implementation and monitoring of the Global framework and report on the number of X/MDR cases notified and treated	2.1 X/MDR TB Task force in place 2.2 No. and percentage of laboratory confirmed X/MDR TB patients enrolled in the preceding year 2.3 X/MDR-TB Cure Rate				
3. Develop and expand capacity for diagnosis of drug resistant TB, strengthen quality DOTS and allocate adequate resources for management of X/MDR-TB	3.1 DOTS coverage 3.2 Percentage of TB funds allocated to X/MDR-TB management				

APPENDIX 5: SUMMARY OF THE EQUINET EQUITY WATCH

(more detailed information can be obtained in the 2010 Guidance document on the Equity Watch. from admin@equinetafrica.org)

An Equity Watch is a means to monitor progress on health equity, through gathering, organising, analysing, reporting and reviewing evidence on equity in health, at national and regional level². The report produced consolidates the evidence, analysis and proposals for strengthening health equity. It is implemented through a process that aims to build capacities, awareness, accountability and networking to support and advance health equity. The Equity Watch thus seeks

- *as a product*, to inform strategic planning and advocacy, and
- *as a process*, to strengthen networking of and exchange between stakeholders to promote knowledge, understanding and action on health equity.

An Equity Watch organises evidence to

- ❑ Track, make visible and support engagement by key national (and regional) institutions (government, parliament, health worker, civil society) on priority dimensions of equity in health and in health systems;
- ❑ Organise and give visibility to evidence on health equity, and to proposals for the measures to improve health equity, as an input to strategic planning and action;
- ❑ Promote dialogue on evidence, experience and perspectives on health equity, and on the priorities and options for action to strengthen health equity to inform and motivate programmes and actions;
- ❑ Monitor progress on actions taken to improve health equity, particularly against commitments made and goals set;
- ❑ Point to areas for deeper research; and
- ❑ Share and compile evidence at regional level, and exchange across countries, including on promising practices.

The Equity Watch aims to analyse and report on standardised clear measures that are comparable across countries and settings, and that are stable and available across points in time in the past two decades, to allow for development of time trends.

The first round of work on the Equity Watch uses available data from available secondary and routine data sources only, including reported household and national surveys. Repeating this analysis after an appropriate period provides a means of reporting on and assessing progress. Follow up to the first round can also involve more detailed further analysis of raw databases, or field research on identified priority questions.

The Equity Watch includes a core set of parameters that map inequalities and that track progress in reaching strategic and policy priorities for advancing health equity. They are not exhaustive and, as a core set, may be added to at country and regional level. They cover socio-economic and other sectoral determinants of health equity, and measures of health and health systems. They meet criteria of being feasible to collect, consistently used including in reporting on international commitments, of having acceptable quality sources, being standardised across countries of the region, with accessible sources of disaggregated data and being meaningful to non technical audiences. The parameters included are termed '*progress markers*' reflecting that the Equity Watch is monitoring and encouraging progress towards health equity, and includes many types of evidence beyond measured, quantified variables or indicators³.

Twenty five progress markers are included in the core set, that is:

- **FIVE** markers of advancing equity in health
- **SEVEN** markers of improving household access to the national resources for health
- **EIGHT** markers of resourcing redistributive health systems
- **FIVE** markers of a more just return from the global economy.

² Further work will be done on health equity analysis and progress monitoring at district level

³ An indicator is commonly referred to in various definitions as a measurable variable or "a number or ratio (a value on a scale of measurement) derived from a series of observed facts". A more rigorous definition is given by the [International Institute for Sustainable Development](#) (IISD):

The overall picture of health equity comes from a composite of the indicators across the four areas, read as a combined set, to provide evidence

- of inequalities in health, access to health care, and care-seeking, knowledge, or opportunities to be healthy;
- against benchmarks – and differentials in their attainment- of affirmative processes, investments and policy decisions that contribute to health equity outcomes; and
- against targets set in policy commitments at global, regional or national levels.

These markers are disaggregated by the key equity stratifiers: wealth, age, sex, educational attainment, urban versus rural residence and region. Stratifying by ethnicity was raised as one dimension, but this was also noted to be very country specific and may be politically divisive or sensitive. The progress markers are disaggregated wherever possible to show:

- The current situation in terms of overall and absolute and relative inequalities
- Trends across time and differentials between areas
- Gaps against benchmarks or targets

The list of progress markers are shown below. The notes in italics are not part of the progress markers but are additional explanatory information on the progress markers.

Advancing equity in health

1. Formal recognition and social expression of equity and universal rights to health
Covering constitution, law, policy, and evidence on application
2. Reducing the Gini coefficient to at least 0.4
0.4 was the lowest Gini coefficient of inequality in ESA in 2007
3. Eliminating differentials in maternal mortality, child (neonatal, infant, <5) mortality, underweight, wasting and stunting
Stratifying by all stratifiers, giving rate ratios, and linking to health coverage differentials, (eg through concentration curves, see Section 3.3)
4. Eliminating differentials in access to immunisation, in treatment for pneumonia, in contraceptive prevalence, in antenatal care and in deliveries by skilled personnel
Stratifying by all stratifiers (see Section 3.2) and giving rate ratios, coverage gaps, and possible co-coverage gaps. Cover as relevant also interventions that relate to priority public health burdens, including treatment for acute respiratory infections, malaria prevention and treatment and oral rehydration for diarrhoea.
5. Achieving universal access to prevention of vertical transmission, condoms and antiretroviral treatment, Noting UN 2010 goal; including HIV prevalence trends and differentials across all indicators. Coverage of ARVs, % coverage of estimated people needing treatment; % coverage PMTCT, ANC and VCT (to identify missed opportunities for PMTCT).

Household access to the national resources for health

6. Achieving the Millennium Development Goal of reducing by half the number of people living on \$1 per day by 2015
A social determinant of health. Checking both \$1 and \$1.25 as targets, disaggregating by stratifiers, and noting the definitions of and evidence on poverty trends from other national poverty assessments.
7. Increasing the ratio of wages to Gross Domestic Product;
A social determinant of health. From national economic data, showing time trends, disaggregated by sector
8. Achieving and closing gender differentials in attainment of universal primary and secondary education
A key social determinant of inequality in health. Capturing enrolment, dropout, transition rates and differentials by all stratifiers
9. Meeting standards of adequate provision of health workers and of vital and essential drugs at primary and district levels of health systems;
A measure of availability coverage. Using WHO and regional health worker norms, density of key health workers per 100 000 people. Using vital and essential drug norms set in essential drug programmes. Noting differentials in availability of health worker types and vital and essential drugs by service level, region, and other stratifiers
10. Abolishing user fees from health systems, backed by measures to resource services
A measure of accessibility coverage. Trends in user fees at primary care level and evidence supported comment on user fee impacts Indicators used in resource allocation formula. Disaggregating by levels of care, providers and other stratifiers, with special focus on primary care level, profiling evidence on formal and informal charges,

exploring implications for referral system, and making links to other indicators of health services coverage (access and effective coverage)

11. Achieving the Millennium Development Goal of halving the proportion of people with no sustainable access to safe drinking water by 2015
A measure of availability and accessibility coverage. Covering evidence on availability, access, functioning, safety of water (ie beyond availability of infrastructure)
12. Overcoming the barriers disadvantaged groups face in accessing and using services.
A measure of accessibility and acceptability coverage. Examining financial and non financial barriers; and demand and supply side barriers; presenting actions taken to address barriers and linking to evidence on health/ health service outcomes

Resourcing redistributive health systems

13. Achieving the Abuja commitment of 15% government spending on health
Noting Abuja refers to government funds, separating donor from government funds
14. Achieving the WHO target of \$60 per capita public sector health sector expenditure;
Separately showing both PPP\$ and local exchange rates, and showing public sector and total health expenditure as a comparison
15. Increasing progressive tax funding to health; reducing the share of out-of-pocket financing in health;
Differentiating progressive and regressive tax funding, examining and making clear unintended negative health equity effects of taxes, including of some progressive taxes, and including analysis of shares to and trends in health insurance, differentiating community, voluntary and mandatory insurance, as well as public and out of pocket funding
16. Harmonising the various health financing schemes into one framework for universal coverage;
Links between different financing schemes public and private; cross subsidies, gaps including external funding and global health initiatives
17. Establishing and ensuring a clear set of comprehensive health care entitlements for the population;
Covering the provisions for comprehensive (not disease specific) services, including essential health packages at different levels, with the term entitlements referring beyond standards to their delivery; and covering through surveys or case studies how far entitlements are known and engaged on by communities.
18. Allocating at least 50% of government spending on health to district health systems (including level 1 hospitals) and 25% of government spending on primary health care;
Share of health expenditure at primary, secondary and tertiary/ quaternary/central level; share at clinic/ hospital level. Disaggregating by service type and the critical commodities for those services. Disaggregating spending on prevention and curative services, and by other stratifiers
19. Implementing a mix of financial and non-financial incentives agreed with health workers organisations
20. Formally recognising in law and policy and earmarking budgets for training, communication and functions of mechanisms for direct public participation in all levels of the health system.
Covering legal, policy measures for public roles in health services at all levels; public budgets and training applied towards supporting people's roles in health

A more just return for ESA countries from the global economy

21. Reducing debt as a burden on health - Debt cancellation negotiated, with debt relief allocated to health and social sectors, and control of debt stress;
Including public, commercial and private debt at national level
22. Allocating at least 10% of budget resources to agriculture, with a majority share used for investments in and subsidies for smallholder and women producers;
Exploring indicator budget lines to smallholder agriculture and gender disaggregations
23. No new health service commitments in GATS and inclusion of all TRIPS flexibilities in national laws;
- 24 Health officials in trade negotiations and clauses for protection of health in agreements;
Actual presence in consultations and / or delegations
25. Bilateral and multilateral agreements to fund health worker training and retention measures, especially involving recipient countries of health worker migration.
Giving priority to approaches that cover the whole sector