

Accountability for women's and children's health in countries Current practices and challenges in Ghana, Rwanda and Tanzania

A case study prepared for the Commission on Information and Accountability for Women's and Children's Health

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Executive summary

1. The accountability framework has to be relevant to countries and allow identification of challenges that need to be addressed to improve information and accountability. A WHO case study was conducted during February March 2011 with three countries - Ghana, Rwanda and Tanzania - represented in the Commission, based on a desk review and discussions with country representatives.
2. All three countries have developed its own system of monitoring, review and action based on many years of experience with Sector Wide Approaches (SWAp) in the health sector. In general, the approach ensures that the health sector strategy is well-linked with the broader development goals and planning processes, notably the national strategies for growth/development and poverty reduction, such as MKUKUTA in Tanzania, Vision 2020 in Rwanda and the Shared Growth and Development Agenda in Ghana. This may imply structural involvement in the health sector accountability processes of for instance the Prime Minister's office as is the case in Tanzania, or local government. There is also a consistent link between reviews and resource allocation through medium term expenditure frameworks and annual operational planning cycles and sub-national processes of review and action.
3. National **monitoring** of progress and performance in the context of the health sector strategic plan focuses on a core set of indicators: 18 in Rwanda, 37 in Ghana and 40 in Tanzania. Maternal, newborn and child health indicators account for at least half of these core indicators; they are also prominent as core indicators in the monitoring component of overall development plans.
4. Data availability and quality have improved during the past decade, mostly because of more frequent health surveys. The monitoring inputs in annual reviews however is largely based on facility and administrative data sources, including government health expenditures, which are affected by persistent problems with the timely availability and quality of data. The completeness, timeliness and quality of the data are an issue and all three countries are looking at ICT to help overcome such obstacles. In Rwanda, the facility and administrative reporting systems are currently improving significantly, driven by the development of an overall architecture, the introduction of ICT, and the use of performance-based funding. Reliable and timely data on births and deaths with a cause of death are lacking in all three countries. Off-budget spending by development partners is not routinely tracked. In general, more systematic investments are needed to improve the performance of the national health information system, ensuring that a reliable and transparent monitoring system is in place.
5. The *institutional mechanisms* to support critical elements of *monitoring*, including data quality assessment, data sharing, analysis and synthesis, and communication of results need considerable strengthening in all three countries. These functions tend to be concentrated in the Ministry of Health with limited capacity, both in terms of numbers of staff and lack of skills. Involvement of key country institutions and independent assessment should be an integral part of the monitoring process. In Ghana, independent consultants from within and outside the country are contracted to prepare the annual review report. In Tanzania, the review is mostly prepared by the Ministry of Health, with inputs of

national institutions. In Rwanda, there is no formal report to synthesize all monitoring data for the reviews, but the performance-based funding and the use of ICT is leading to greater transparency and data access.

6. Health sector *reviews* and planning summits are conducted on at least an annual basis with broad stakeholder involvement. Development partner participation is prominent, but the civil society role is less clear. There are M&E subcommittees of the health sector committee that involve multiple stakeholders. Many but not all development partners have aligned themselves with these country-led monitoring and review platform, which is also promoted as part of the International Health Partnership principles.
7. *Maternal, newborn and child health* appear high on the political agenda in the three countries, as for instance illustrated by the statements of the President of Ghana or leading political party in Tanzania and the prominence of MNCH indicators in national poverty reduction strategies. The three countries have developed roadmaps and plans to accelerate progress towards MDG4 and particularly MDG5. The commitments to the Global Strategy are linked to these national strategies and are perceived as an additional opportunity to strengthen the implementation of these strategies. The MNCH reviews include programme specific reviews but more importantly are embedded in the well-established national system of reviewing progress and performance. Additional high level political events focusing on women's and children's health may be required to gain further support and accelerate progress for MNCH.

Background

The UN Secretary-General's Global Strategy for Women's and Children's Health was launched in September, 2010 (1). Many countries have already responded to the UN Secretary-General's call to action with specific declarations of commitment (2). Delivering on these commitments, and motivating other countries and organizations to make similar pledges, is an urgent priority. The Secretary-General established a Commission on Information & Accountability for Women's and Children's Health which aims to propose ways to make countries and their partners more accountable for women's and children's health.

The Commission's work has been guided by two working groups, one on results and one on resources. At the first meeting of the Commission a general accountability framework was proposed. It defines accountability as a cyclical process of monitoring, review, and action. This is required to assess progress in relation to original commitments and targets, recognize successes and identify problems that need to be rectified. The framework applies at both country and global levels.

At the country level, accountability implies the existence of well-established transparent processes of monitoring, review and action. Monitoring of progress and performance is only possible with a well-functioning health information system to collect, analyze and report health data. Reviews are based on the evidence gathered through monitoring processes and require national institutional mechanisms involving multiple stakeholders. Such reviews need to be systematically linked to actions in-country and provide the basis for mutual accountability between country citizens, country decision-makers and the international community.

At the first meeting of the Commission it became clear that there is a need for more systematic country inputs to ensure that the recommendations would be as relevant as possible to countries and international partners. Therefore, WHO initiated work with three countries - Ghana, Rwanda and Tanzania - represented in the Commission to conduct an assessment of the current practices and identify challenges that need to be addressed to obtain better information and greater accountability.

Approach

The case studies were conducted through desk reviews and interaction with country representatives for all three countries. In addition, country visits to gather information and discuss accountability were conducted in Rwanda and Ghana.

The annexes to this document represent the results of the systematic assessment of current practices in the three countries. For this analysis, we used the draft guidance for country monitoring and review processes, which is based on a WHO common framework and platform for monitoring and review of health progress and performance (3). The assessment focused on the general practices in monitoring and reviewing health sector progress and performance as a whole and then analyse the situation in the field of women's and children's health (which in practice, implied maternal, newborn and child health). The aim was to review current practices in information and accountability, and identify priority areas to strengthen accountability processes for health with special reference to women's and children's health.

The results are presented separately for each of the three countries and synthesized in the last section.

Tanzania

In Tanzania, the current accountability processes are rooted in the Sector Wide Approach (SWAp) which was initiated in the health sector in 1999. The SWAp provides the framework of collaboration among the

stakeholders who have an MOU and have agreed on a code of conduct in the health sector. The stakeholders include Ministry of Health and Social Welfare (MoHSW), the Prime Minister's Office for Regional Administration and Local government (PMO-RALG), the Ministry of Finance and Economic Affairs, civil society, private sector and development partners including UN agencies. The government and health partners have agreed to aim at increasing transparency, improved predictability and allocation of resources, reduced transaction costs, and reduced administrative demands placed upon the government.

The third national Health Sector Strategic Plan 2009-2015 (HSSP III) focuses on the MDGs and is part of the National Strategy for Growth and Reduction of Poverty (*MKUKUTA*). HSSP III prioritizes 11 strategies, including maternal, newborn and child health, AIDS/TB/malaria, health workforce and monitoring and evaluation. Operational plans are generated annually at each council/district for implementation of health sector activities.

Monitoring

The HSSP III includes 40 indicators, with a 2008 baselines and targets for 2015, covering inputs, outputs, outcomes and impact. In addition, a set of indicators is developed annually to monitor for the General Budget Support-Poverty Assessment Framework (GBS-PAF) which takes on the greater picture of poverty reduction and how are the other sectors are linked. The data sources for the health indicators are specified in HSSP III but there is no integrated data collection and analysis plan that specifies all data collection and measurement issues.

The status and use of different data sources can be summarized as follows:

- Health facility and administrative data are the main source for annual monitoring of progress. The facility reporting system, also referred to as the health management information system (HMIS), functions poorly in terms of data quality, in spite of multiple efforts to strengthen the reporting and quality during the past decades.
- There is no functioning civil registration and vital statistics system (e.g. only 7% birth registration coverage by 2005). Tanzania has had several successful local demographic surveillance studies (e.g. TEHIP, AMMP), and steps have been taken to develop a sample registration system.
- The financial monitoring is primarily done through a public expenditure review (PER) which is conducted each year prior to the review, and less regular National Health Accounts (NHA) exercises. Other health input indicators such as health infrastructure, health workforce and medicine availability are of variable quality.
- Health surveys are an important source for monitoring progress. Tanzania has a regular demographic and health survey (DHS) of good quality, allowing it document trends in key indicators, verify health facility statistics, and assess equity. There are also a considerable number of disease specific surveys, e.g. on malaria and HIV/AIDS. There is however no coordinated health survey plan that also includes health data collection in economic surveys.

The Bureau of Statistics leads the work on census and surveys. The Health Information and Research section of the Division of Policy and Planning in the MoHSW is responsible for facility reporting, but there are also separate systems, such as for TB, HIV/AIDS and acute disease surveillance.

There is no publicly accessible central data repository or archive. There is currently no transparent system of assessing data quality and making adjustments as needed. The annual review is preceded by a Joint Review Mission, which aims to carry out a "reality check" on health sector planning and implementation arrangements at regional, district and lower levels. It usually involves 10-20 health facility visits, but no systematic data collection. Information and communication technology (ICT) are beginning to be introduced in the facility and administrative reporting systems of the MoHSW, with data entry at the district level, as part of the DHIS. In addition, programme like HIV and malaria, they have started working on ICT to transmit information, but it is still limited. It will take some time before this will bear fruits.

The main national outputs of the health information system are the health survey reports, such as DHS or malaria indicator survey, and the annual health statistical report, mostly based on facility data. The most recent annual health statistical report available on the web was released in September 2008, with data for mostly 2005/06. More recent reports have been released in 2009 and 2010. The health sector performance profile report synthesizes the information focusing on the core indicators of the HSSP III. It is prepared by the MoHSW, with inputs from partners, PMO-RALG and Ifakara Health Institute. It is largely based on the annual public expenditure review and the routine administrative and facility data. The household survey and NHA data are used when available. Data are usually presented by regions (21).

Review and action

Tanzania has a well-established system of review and planning, based on the SWAp. The annual reviews included a joint annual health sector review, which is preceded by a technical review meeting, and is followed by the main annual health planning meeting, involving a wide range of stakeholders. The review process is led by MoHSW and PMO-RALG in close collaboration with other parts of government and partners. The SWAp technical committee serves as a joint monitoring body of the goals, milestones and activities of the health sector. There are several subcommittees of the technical committee which ideally comprise of arrange of stakeholders including the M&E technical working group.

The agenda of the review includes the progress of implementation of the HSSP, mid term expenditure framework, and the public expenditure review. The health sector performance profile report is a key input into the review. The health sector reviews are summarized in a report and used to develop the new annual plan.

The mid-term and final review or evaluation of the HSSP are less well established processes. The main feature is that there are greater external or international inputs into the synthesis of evidence and review.

Some of the health indicator targets have made it into politics. The ruling party (CCM) election manifesto in 2005 included five indicators with three targets for the year 2010 for infant, child and maternal mortality, coverage of skilled birth attendance. They have also included indicators for physical availability of a health facility at every community (village) which is essentially a dispensary within a radius of 5 km, in line with the primary health care development programme (2007-2017). There is also an indicator for service availability to the most vulnerable groups like the elderly, the <5 children and pregnant women. The special programs like AIDS, TB and EPI are also provided without cost to the users.

Women's and children's health

In most health policy and strategy documents focus on the health MDG. Therefore, women's and children's health is often equated with reproductive, maternal, newborn and child health. The main policy document is the National Roadmap strategic plan to accelerate reduction of maternal, newborn and child deaths in Tanzania, 2008-2015. The plan was developed by MoHSW with contributions of national and international technical experts, including the UN H4 agencies and Tanzania PNMCH technical working group members, and identifies a set of five strategies, guiding principles to achieve the overall goals, each with a set of activities and budget. It is aligned with the major global and national commitments as reflected in Tanzania Vision 2025, the National Strategy for Growth and Reduction of Poverty (*MKUKUTA*) and the primary health services development program (*MMAM*) and HSSP.

The monitoring of the plan implementation appears well integrated with the monitoring of HSSP III and other processes including the Comprehensive Council Health planning processes. For instance, the indicators are linked to *MKUKUTA* and HSSP III goals and include three impact indicators with targets (maternal mortality, neonatal mortality, under-5 mortality), plus 14 operational indicators (mostly access and coverage) with targets for 2015. There is also a set of 67 more process oriented indicators in the monitoring framework. The means of verification are specified for the indicators and generally involve the same data sources as for overall HSSP III monitoring system, using a variety of administrative, facility and population-based data sources.

Tanzania's commitment to the Global Strategy included a number of specific targets (2):

- Health financing: increase health sector spending from 12% to 15% of the national budget by 2015;
- Health workforce: increase the annual enrollment in health training institutions from 5,000 to 10,000, and the graduate output from health training institutions from 3,000 to 7,000; simultaneously improving recruitment, deployment and retention through new and innovative schemes for performance related pay focusing on maternal and child health services
- Service access and quality: reinforce the implementation of the policy for provision of free reproductive health services and expand prepayment schemes; improve referral and communication systems, including radio call communications and mobile technology and introduce new, innovative, low cost ambulances; expand coverage of health facilities; and provide basic and comprehensive Emergency Obstetric and Newborn care; extend PMTCT to all RMNCH services
- Coverage: increase the contraceptive prevalence rate from 28% to 60%; the proportion of Children fully immunized from 86% to 95%; 80% coverage of long lasting insecticide treated nets for children under five and pregnant women; the proportion of children who are exclusively breast fed from 41% to 80%.

No specific review mechanisms have been specified in the M&E chapter of the plan or in conjunction with the Global Strategy related commitments. The Reproductive and Child health Section of MoHSW, has started the process of developing the monitoring framework which will help the programme to track progress based on identified indicators and be able to generate reports on regular basis.

Implications for accountability

Tanzania has a well-established system of monitoring, review, and planning/action, based on more than a decade of SWAp experience. This process is led by the health sector but is well linked with the broader development planning and processes (*MKUKUTA*), including the joint responsibility for leadership with the Prime Minister's office for Regional Administration and Local Government. This forms the linkages to inform the National Vision 2025. This is the ultimate vision of Tanzania. The main goals should be alignment of all partners and strengthening of this platform and system of accountability.

The monitoring of progress and performance has improved during the past decade, mostly because of more frequent household surveys. The annual monitoring is largely based on facility and administrative data sources, which are affected by persistent problems with the availability and quality of data. Reliable and timely data on births and deaths with a cause of death are lacking. ICT provides opportunities to overcome some of the long-standing obstacles, if introduced in the context of a rationalization of the health information system.

The institutional mechanisms to ensure data quality, data sharing, analysis and synthesis, and communicate results need considerable strengthening, as these functions now tend to be concentrated in the Ministry of Health and Social Welfare with limited capacity. A structural involvement of key country institutions such as Bureau of Statistics, National Institute for Medical Research and Ifakara Health Institute and Muhimbili University of Health and Allied Sciences to support the Ministry would be essential to improve monitoring and enhance independent assessment.

Tanzania's commitments to the Global Strategy provide a unique opportunity to strengthen the commitments to and implementation of the national roadmap strategic plan 2008-2015. Embedding the review mechanisms in the HSSP III system of reviewing progress and performance appears to be the best way forward, as the HSSP III itself is focused on the MDG. Additional high level political events focusing on women's and children's health are required at all levels to gain further support and accelerate progress, particularly for MDG5 and sustain the gains for MDG4.

Ghana has a well-established system of monitoring and review of the national health sector strategic plan, based on the systems developed as part of the SWAp which was introduced in the mid nineties. The current health sector medium term development plan 2010-2013 is a continuation of the third five-year programme of work 2007-2011. The plan aims to increase equity in access and financial protection for the poor, improve quality of services and institutional care, increase access to maternal, newborn and child health services, improve prevention and control of communicable and non-communicable diseases. The health sector plan is aligned with the overall development policy framework 2010-2013 (Ghana Shared Growth and Development Agenda).

Monitoring

The national health sector plan 2010-13 includes a chapter on monitoring and evaluation (M&E). It specifies 37 indicators with targets for 2013, including equity, as well as annual targets for 20 of the 37 indicators. All partners are aligned behind the health sector strategy and M&E plan, and have agreed on the reporting framework. Almost all indicators are well-established and include recommended global indicators.

The state of the different data sources is variable and can be summarized as follows:

- Health surveys: Ghana has regular health surveys of good quality, including DHS and MICS, allowing it document trends in key indicators, verify health facility statistics, and assess equity. It however also conducts ad hoc very large and often suboptimal surveys on single topics such as maternal mortality;
- Facility reporting (HMIS): there is a fairly well functioning system but the HMIS has a number of weaknesses regarding data quality;
- Administrative data: financial reviews and National Health Accounts are conducted and human resource and facility databases are operational but private sector data are often incomplete and updating processes not systematized.
- Census: conducted in 2010; provisional census report released
- Birth and death registration: no vital statistics are generated but efforts to improve the system are under way with multiple stakeholder involvement and use of ICT such as mobile phones. Urban areas have considerable potential as coverage of birth and death registration is quite high.

The Medium Term National Development Agenda recognizes the National Statistics Service (NSS) as the lead national agency for official statistics, which includes collating statistics from all sectors. Within the health sector the monitoring responsibilities are divided. The Centre for Health Information Management (CHIM) of the Policy, Planning, Monitoring and Evaluation (PPME) division of the Ghana Health Service is the focal unit responsible for the collection, analysis, reporting and presentation of health service information in the Ghana Health Service. The Ministry of Health has the overall M&E responsibility, including the production of the annual review reports to inform the health sector review. The roles and responsibilities of the Ministry of Health and Ghana Health Service in M&E are partly overlapping and, to some extent, have led to duplication and fragmentation of effort.

Periodic programme reporting and review processes have data quality checks but this is not robust and comprehensive enough. This is further undermined by weak institutional capacity and lack of expertise. Data quality assessment and analyses are recognized as a weakness. The involvement of academic and other institutions is limited. Sharing of data is generally limited to reports, focusing on the national and regional progress. ICT use is not yet common on a large scale, except to some extent by CHIM.

Annual health statistical reports are produced and form the basis or part of the annual health sector performance review. The most recent report available on the web is The Health Sector in Ghana: Facts and Figures 2009, produced by CHIM of Ghana Health Service, with data for 2008.

The health facility data and reports are an important input into the preparation of the annual health sector review report. The PPME unit of the Ministry of Health uses a team of national and international external consultants to conduct an independent assessment of all information and prepare the report for the review.

The Ministry of Health website is easily accessible and well-organized and has several reports in relation to regular monitoring. This includes the annual review reports 2004-2008 and annual health summit reports, as well as the MDG report 2009 and several other data and monitoring reports.

Review and action

Multi-stakeholder annual health sector reviews have been conducted for many years. They involve government, development partners, country institutions and civil society organizations. The review meetings are used to measure progress, address emerging problems, and assign responsibilities. The results are published on the web in an Aide Memoire signed by the Ministry, donors and UN agencies. There are two health summits each year: the first is the annual review (held during Apr-Jun) is dedicated to the assessment of progress and identification of priorities for the coming year. The second summit, held a few months later (Sep-Oct), is the platform for approval of the programme of work for the coming year. The organization of the annual review summits is the responsibility of the Policy, Planning and M&E unit of the Ministry of Health.

In addition, monthly meetings between the ministry of health and development partners meetings are held to monitor progress. Ghana Health Services also conducts half yearly health sector interagency reviews.

A general M&E plan for the health sector is currently being revised and updated. The responsibilities of the different institutions outside of the ministry are not well-specified.

Women's and children's health

The President of the Republic of Ghana has been very explicit about addressing the maternal mortality problem. For instance, at the 2010 African Union Heads of State Conference in Uganda, the president stated that "No woman should die while giving life". In August 2010, the MDG Acceleration Framework (MAF) Ghana action plan was published, recognizing that the progress in reducing maternal mortality ratio by three-quarters by 2015 and MDG5 in general was well off-track. The MAF action plan aims to accelerate efforts to overcome bottlenecks in implementing interventions to improve maternal and newborn health at both community and health care facility levels. The three key priorities interventions areas identified are: improving family planning, skilled delivery and emergency obstetric and newborn care. The MAF action plan was developed by the Ministry of Health and Ghana Health Service in collaboration with development partners, particularly the United Nations country team and other stakeholders in Ghana.

The plan outlines for the indicators for monitoring implementation and progress, as well as responsible institution or structure. There are 32 monitoring indicators covering mostly output and outcome indicators, with 2010 as baseline even though data are not yet available for some indicators. Clearly defined outcome and impact indicators outlined in M&E Framework and resource needs were identified, including capacity building.

It is envisaged to have quarterly review meetings with key partners to monitor progress with implementation of the MAF. Moreover, maternal and newborn health indicators feature prominently in the annual health summits. In addition, programme specific reviews are also undertaken separately by maternal and child health programmes

As with the overall review system, stakeholders participate in sub-national level reviews and routine feedback are also provided to sub-national levels on key programme or service components.

Even though, reducing maternal mortality is a top priority, Ghana's commitment to the Global Strategy only partly focused on this issue. The commitments include a number of specific targets (2):

- Health financing: increase funding for health to at least 15% of the national budget by 2015.
- Maternal health: strengthen the free maternal health care policy, ensure 95% of pregnant women are reached with comprehensive PMTCT service and ensure security for family planning commodities.
- Child health: increase the proportion of fully immunized children to 85% and the proportion of children under-five and pregnant women sleeping under insecticide-treated nets to 85%

Implications for accountability

Ghana has a well-established system of accountability for health. The system is embedded in the broader health and development agenda and receives attention from the political leaders, up to the highest level. The annual review reports are coordinated by the Ministry of Health, but are conducted by independent consultants from within or outside Ghana. The annual review report provides the monitoring data to the annual health summit, which involves a wide range of stakeholders and forms the basis for the new plan.

Monitoring of progress has improved during the past decade, although there are still important information gaps. Regular household surveys and fairly well-functioning facility reporting system, run by Ghana Health Service, provide data for most indicators. On the other hand, there is scope to strengthen the analyses and integration of data from the different sources in the assessment of progress and performance. The civil registration system does not generate vital statistics, including causes of death.

The main responsibility for monitoring lies with the Ministry of Health and Ghana Health Service, each with different responsibilities, although in practice there is overlap. Neither institution has adequate staffing and skills to carry out more thorough analyses. The involvement of academic and other institutions tends to be ad hoc, as there is no systematic engagement in for instance the review report or data verification and quality assessment.

There is particular concern with the lack of progress on maternal mortality, expressed up to the President's level, and efforts have been taken to accelerate implementation of selected interventions to accelerate progress (MAF Ghana Action Plan).

Rwanda

Rwanda is implementing the Health Sector Strategic Plan Development Plan II 2009-2012. HSSP II is a continuation of the HSSP I (2005-2009). It is based on a sound situation analysis, with clearly defined goals, objectives and interventions which are all aligned with Rwanda Vision 2020. HSSP III is linked to the broader development agenda which has been laid out in Rwanda Vision 2020 and the Economic Development and Poverty Reduction Strategy (EDPRS) 2008-2012.

Monitoring

The HSSP II 2009-2012 has a specific chapter on M&E which includes a core set of 18 indicators that cover the strategic objectives. All indicators have baselines for 2005-07 and targets for 2012 and 2015. The indicators are aligned with health-related indicators and targets specifically mentioned in Vision 2020, the MDGs, the EDPRS, and the Common Performance Assessment Framework (CPAF).

The M&E chapter of HSSPII and accompanying M&E strategy and plan, published in 2009, specify the data sources for most of indicators and identify what needs to be strengthened across the ME system.

The health management information system (HMIS), based on facility reports, has generated data of variable quality. Various IT projects have been implemented, and, based on the lessons learned, an overall architecture

has been developed. The new HMIS will be IT based, allowing extensive disaggregation, and is composed of at least four databases able to "talk" to each other: health indicators, human resources, drugs and supplies, and facilities (facility register including geo-codification).

Health expenditures are monitored through the "health resource tracker": web-based software has been developed with the objective of self reporting of both budgets and expenditures by government and development partners. The web-based system aims to communicate with the data warehouse being set-up. Budget and expenditures are mapped at activity level to HSSP II, using NHA codes. In addition, they are tagged by disease (ICD coding), by district, by facility using standard codes in data registries. Standardization of definitions of activities/interventions has been undertaken. It is possible to do tracking for child, maternal and reproductive health. Double tagging is done where appropriate (e.g. child and malaria).

Data quality assessments and audits are implemented in quarterly basis as part of the PBF implementation. The MOH website has several reports in relation to regular monitoring health results. The health statistics are reported in the statistical yearbook of which the 2010 edition is available on the web.

Review and action

The M&E framework is aligned with the overall performance assessment frameworks followed by Rwanda government: the Common Performance Assessment Framework (CPAF) and the Partners Development Partner Assessment Framework (DPAF is an integral part of CPAF). The review processes are defined within M&E framework. The JHSR is held twice a year, co-chaired by government agency and a strategic partner with the participation of both internal and external stakeholders. The UN Group not only functions as knowledge leaders with strong inputs but also supports a balancing act between government, the Development Partners group. Co-ordination mechanisms are being developed for the HSSP II M&E Taskforce.

Reviews take place at all levels of the health and administrative system. Each review results in concrete actions to address gaps and identified challenges. Development partners M&E plans and performance targets are an integral part of HSSP II ME framework.

Performance Based Financing (PBF) is a core mechanism for assessing progress and allocating resources to all levels of health provision. The PBF evaluation by World Bank in 2009 showed that PBF implementation was positively associated with health service utilization. PBF quarterly reviews include qualitative information and recommendations for performance improvement. Quarterly implementation of PBF and other review processes have integrated assessment of performance, identification of gaps and implementation of remedies as part of performance measurement.

Women's and children's health

A strategic plan has been developed to accelerate the reduction of maternal and newborn morbidity mortality 2009-2012 and Road Map to accelerate the reduction of maternal and newborn morbidity and mortality 2015, and Child Health Policy 2009 and Child Survival Strategic plan 2008 -2012.

MNCH progress reviews rely on the overall health sector review. The last JHSR reported modest achievements made in the MNCH areas (October 2010 JHSR Report). Other review mechanisms leading to decisions and actions are built in the routine implementation processes. For example, programme implementation data analysis in 2010 showed that interventions targeting post partum hemorrhage had succeeded in terms of reducing deaths due this cause and that infections were the main cause of maternal deaths. As a result the updated plan for maternal survival highlights infections as a main cause of maternal deaths and related interventions.

At the facility level, the MNCH programme is implementing maternal and child death audits and more recently also at the community level. Audit reports are summarized and analysed at MoH and district levels periodically,

and actions are recommended. The quarterly review of maternal and child deaths at the MoH takes place at the minister and cabinet level, during which recommendations are made and followed up to address causes of death.

The MoH MCH team has established a MCH taskforce, chaired by the MoH and a rotating partner, currently UNICEF. The co-chairs are responsible for the coordination of monthly meetings and timely analysis of technical working group reports. There are four technical MNCH sub-groups

In the Global Strategy Rwanda has committed itself to:

- increase health sector spending from 10.9% to 15% by 2012;
- reduce maternal mortality from 750 per 100,000 live births to 268 per 100,000 live births by 2015
- halve neonatal mortality among women who deliver in a health facility by training five times more midwives (increasing the ratio from 1/100,000 to 1/20,000).
- reduce the proportion of children with chronic malnutrition (stunting) from 45% to 24.5% through promoting good nutrition practices, and
- increase the proportion of health facilities with electricity and water to 100%.

ANNEX A

TANZANIA - SITUATION ANALYSIS

I. Comprehensive national health strategy as foundation for Information & Accountability

Key elements and characteristics	General situation	Maternal, newborn and child health situation	Resource tracking
1. A comprehensive and robust National Health Strategy (NHS) is the basis for sound information and accountability.	Tanzania health sector strategic plan 2009-2015 (HSSP III) Aligned with the National Strategy for Growth and Reduction of Poverty (<i>MKUKUTA</i>)	National Roadmap strategic plan to accelerate reduction of maternal, newborn and child deaths in Tanzania, 2008-2015	Strategy 5 in the HSSP III is on health care financing
1.1 The NHS is based on a sound situation analysis, effective country ownership and policy dialogue with broad participation. 1.2 Goals, objectives and interventions clearly defined and based on an evidence-based assessment of the situation. 1.3 Programme-specific plans are well-integrated with the NHS	<p>The Sector Wide Approach (SWAp) initiated in the health sector in Tanzania in 1999, provides the framework of collaboration among the stakeholders: MoHSW, PMO-RALG, MOFEA, civil society, private sector and development partners including UN agencies.</p> <p>All sector plans are based on extensive processes that involve multiple stakeholders.</p> <p>The Health Sector Strategic Plan 2009-2015 (HSSP III) contains a very brief situation analysis (only using survey data) and focuses on the MDGs and is part of the National Strategy for Growth and Reduction of Poverty (<i>MKUKUTA</i>). HSSP III has two priority "programmes":</p> <ul style="list-style-type: none"> • Primary health services development program (<i>MMAM</i>) • Human resources for health strategic plan. <p>There are 11 strategies in HSSP II including MNCH and M&E itself. All eleven strategic areas have stand alone programs which were in cooperated in the HSSP 111 to avoid repetitions.</p>	<p>Plan is based on a situation analysis that primarily used data from the TDHS 2004/05; developed by MoHSW with contributions of national and international technical experts (Tanzania PNMCH technical working group).</p> <p>Identifies a set of five strategies, guiding principles to achieve the overall goals, each with a set of activities and budget</p> <p>Aligned with the major global and national commitments as reflected in Tanzania Vision 2025, the National Strategy for Growth and Reduction of Poverty (<i>MKUKUTA</i>) and the primary health services development program (<i>MMAM</i>)</p>	<p>The actual plan for health care financing cites limited data on expenditures.</p> <p>The objectives for Strategy 5 on health care financing are specified with expected results, some targets and indicators and sources of data for these indicators. However, the baseline numbers for the indicators is not specified in the document.</p> <p>Strategy 5 on health care financing is a key component of the HSSP III</p>
2 The NHS specifies sound monitoring, review and action mechanisms.	The HSSP III includes a brief chapter on M&E.	The Roadmap includes a chapter on M&E, mostly indicators	The HSSP III does specify the indicators for the objectives of strategy 5 on health

			<p>care financing and source for the data for these objectives. There is no specific mention of public expenditure reviews or national health accounts in the HSSP III, although these are being done.</p>
<p>2.1 The M&E component of the NHS is aligned with the main goals and objectives. 2.2 The M&E plan is country-led and developed with systematic participation of all key stakeholders. 2.3 The M&E plan, based on a situation analysis of the HIS, is costed and funded, with partner alignment.</p>	<p>A brief M&E section in HSSP III specifies the role of the reviews and the link with other major plans. There are three monitoring systems that are used for HSSP III:</p> <ul style="list-style-type: none"> • MKUKUTA monitoring, which is the comprehensive monitoring of development and poverty alleviation • Health information system • Local government monitoring system for PMO-RALG, as part of the local government area technical and financial progress monitoring. <p>HSSP III defines indicators and targets according to the strategic priorities, and the data collection systems are described.</p> <p>An evaluation in 2007 concluded that the M&E system for accountability purposes was acceptable but was much weaker to inform decision-making.</p> <p>The country M&E plan is aligned with the M&E framework of the national development policy framework. All partners are aligned behind the health sector strategy and M&E plans, and have agreed on indicators and reporting framework.</p> <p>Overall M&E and research were budgeted at less than 0.1% of the total budget for HSSP III. A new M/E project funded by the partners and the government is being piloted in two regions Pwani and Mtwara. This will be scaled up when results are obtained. There is also an inbuilt M&E in the National programmes e.g. Global Fund Rounds as an essential part of the program. The</p>		

	next step is harmonization and having an M&E which will serve for the whole sector.		
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II. Sound monitoring

Key elements and characteristics	General situation	Maternal, newborn and child health situation	Resource tracking
3. There is a framework which guides the selection of a core set of indicators	Balanced set of core indicators with targets has been selected	Core indicators selected and in line with global standards	
3.1 Balanced and parsimonious set of core indicators with well-defined measurement, baselines, and targets 3.2 Use of global standards for indicators and metadata.	<p>There are 40 indicators, with a 2008 baselines and targets for 2015, and data sources. There are no annual targets. The indicator set covers inputs, outputs, outcomes and impact, but not equity.</p> <p>Almost all indicators are well-established and include recommended global indicators, as well as the health-related MDGs.</p> <p>The LGA reporting aims to make use of 20 CCHP indicators, but technical progress reporting is not used well</p> <p>The indicators have been revised in line with the new NSGRP 2010-2015; the Comprehensive Council Health Planning Guidelines forthcoming (the draft has been approved)</p>	<p>The indicators are linked to <i>MKUKUTA</i> and HSSP III goals. Includes 3 impact indicators with targets, plus 14 operational indicators with targets for 2015.</p> <p>The 3 impact indicators are maternal mortality ratio, neonatal mortality rate and under-5 mortality rate.</p> <p>The 14 operational indicators include 7 coverage indicators, 5 access indicators, and 2 risk factor indicators (breastfeeding and child anthropometry)</p> <p>There is also a set of 67 more process oriented indicators in the monitoring framework.</p>	
4 Data sources are specified in an integrated manner, data gaps identified and addressed.	There is no integrated data collection and analysis plan that specifies measurement issues and how the different data sources should contribute		
4.1 Critical data gaps identified and addressed in the plan and subsequent actions. 4.2 Responsibilities for data collection and management are specified for different levels.	<p>Health surveys - Tanzania has regular health surveys of good quality, allowing it document trends in key indicators, verify health facility statistics, and assess equity. There are also disease specific surveys (e.g. up to 6 surveys on malaria in 2008).</p> <p>Facility reporting (HMIS) - the system functions poorly and has a number of weaknesses regarding data quality. Continuous efforts</p>	The means of verification are specified for the indicators and involve a variety of administrative, facility and population-based data sources.	The following systems for collection of data need to be strengthened: health expenditure data from the districts; off budget expenditures from development partners and expenditures from business and private insurance.

	<p>are made to improve the reporting and quality.</p> <p>Administrative data - public expenditure reviews are major input into annual reviews; NHA every 2 years and PERs every year; NHA study is ongoing to feed into the resource allocation and is geared towards equity in resource allocation and targeting the most vulnerable groups e.g. MNCH components (MDGs 4,5&6) health workforce and facility databases operational but private sector data are often incomplete</p> <p>Census - latest conducted in 2002, projections available by district</p> <p>Birth and death registration - coverage is below 10% (2005); local demographic surveillance systems have produced data on mortality and causes of death; ongoing efforts to establish a sample registration system based on one district in each region</p> <p>Responsibilities - The Bureau of Statistics lead role in census and surveys is clear; the Health Information and Research section of the Division of Policy and Planning is responsible for facility reporting, and there are separate systems for TB, HIV/AIDS and acute disease surveillance.</p> <p>Data are also gathered by local councils for a separate reporting system to PMO-RALG</p> <p>There is no publicly accessible central data repository or archive.</p>		
5 Data analysis work is specified and data quality issues are anticipated and addressed.	No specifics ; the analytical capacity in the health sector is weak		
5.1 Specific processes for data quality assessment and adjustment in place and transparent.	There is no system of assessing data quality and making transparent adjustments. No data on completeness, timeliness and accuracy of reporting. No integrated analysis of survey and facility data.	No specifics	
5.2 Data analysis and synthesis work specified			

and funded 5.3 Prospective evaluation planned and linked to M&E of NHS.	ICT use only beginning to emerge in the facility reporting system, with data entry at the district level, as part of the DHIS, which is now introduced in two regions. Both HSSP III and MMAM calls for end of programme evaluation. There are no specific activities during plan implementation that would allow this to happen.		
6 Data dissemination and communication is effective and regular.			
6.1 Analytical outputs as basis for national and global reporting. 6.2 Appropriate decision support tools and approaches are used. 6.3 Data and reports are publicly available.	The joint annual health sector review is informed by a monitoring report: health sector performance profile report. This report is prepared under the coordination of the Directorate of Policy and Planning of the MoHSW (HIR) with the support from a technical review group. The most recent publicly available report is for the 2008/09 review and 2020 September Major data inputs for the performance profile report are the public expenditure review and administrative and facility data. The household surveys are used when available, although they are no synchronized with the health sector strategic planning cycle. Data are usually presented by regions (21). Annual health statistical reports are produced by MoHSW, mostly based on facility data. The most recent report was produced for 2008, the one before that for 2006. The Ministry of Health website provides access to selected planning, monitoring and review documents, as well as statistics. the Tanzania Development partners group website has a more comprehensive set of reports in relation to regular monitoring.	No specifics	

III. Country mechanisms for review and action

Key elements and	General situation	Maternal, newborn	Resource tracking
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characteristics		and child health situation	
7. There is a system of joint periodic progress and performance reviews			
<p>7.1 Regular and transparent system of reviews with broad involvement of key stakeholders</p> <p>7.2 Systematic linkages between disease programme M&E, global reporting and the overall health sector reviews.</p> <p>7.3 M&E system is regularly assessed for how well it monitors progress and generates needed information.</p>	<p>Annual health sector reviews have been conducted for many years. A technical review precedes the main review. MoHSW, Prime Minister's Office for Regional Administration and Local Government, Ministry of Finance, civil society, private sector and development partners including UN agencies participate. The process is led by MOSW and PMORALG in close collaboration with other parts of government and partners.</p> <p>The PMO-RALG has the task to monitor and supervise and coordinate the activities. The Local Government system of monitoring is not completely aligned with the MoHSW monitoring system of NHSS III.</p> <p>Assessments of the HMIS which forms the basis of the review system, and deficiencies have repeatedly been pointed out. There are plans to address these shortcomings.</p>	No specifics	
8. Regular assessments of progress and performance as basis for policy dialogue and review.			
<p>8.1 Synthesis of M&E findings focusing on key goals.</p> <p>8.2 Systematic analysis of contextual and qualitative information.</p>	<p>The SWAp committee is the agreed overall body for dialogue among all stakeholders in health. There is one annual health planning meeting and one joint annual health sector review (JAHSR). The agenda included the MTEF, progress of implementation of the HSSP; and the PER.</p> <p>There is no systematic assessment of contextual information that may influence the progress and performance, but they are taken into account on an ad hoc basis.</p> <p>The annual review is preceded by a Joint Review Mission, which aims to carry out a "reality check"</p>		

	on health sector planning and implementation arrangements at regional, district and lower levels. It usually involves 10-20 health facility visits.		
9. There are processes by which related corrective measures can be taken and translated into action			
9.1 Results from reviews are incorporated into decision-making, including resource allocation. 9.2 Multi-stakeholder mechanisms to provide routine feedback to sub-national and key stakeholders are specified.	Review meetings are used to address emerging problems, measure progress, set priorities and assign responsibilities. The review's timing is aligned with the budget cycle and aims to provide input to the annual MKUKUTA and general budget support reviews.		

IV. Institutional capacity

Key elements and characteristics	General situation	Maternal, newborn and child health situation	Resource tracking
10 Roles and responsibilities of country institutions are clearly defined and capacity is strengthened.			
10.1 Well-established coordination mechanisms for M&E of the NHS. 10.2 Key institutions and stakeholders have clear roles and responsibilities. 10.3 Capacity strengthening in monitoring and evaluation is addressed.	<p>The National Institute for Medical Research (NIMR) is identified in the HSSP III as responsible for carrying out, controlling, coordinating, registration and monitoring, evaluation and promoting of health research.</p> <p>Ifakara Health Institute has supported annual health sector performance profiles, but there is normal arrangement.</p> <p>The collaboration between the Bureau of Statistics and MoHSW focuses on surveys and data collection.</p> <p>Capacity issues within the MoHSW have been flagged in HSSP III.</p>	<p>The PER estimated that the share of the health sector budget that goes to reproductive health is about 7%. This is considered inadequate by the development partners (Statement JAHSR Oct 7 2009) (Note that the costs for human resource, the infrastructure and the operational costs for the cold chain are not captured in the 7% figure - this is addressed through the MMAM which will increase substantially the expenditures on MNCH)</p>	<p>The appropriate unit in the Department of planning is identified as being in charge of expenditure tracking.</p> <p>There is need for capacity building for expenditure tracking. New persons have been hired to assist in the work but need to be trained.</p>

ANNEX B

GHANA - SITUATION ANALYSIS

I. Comprehensive national health strategy as foundation for Information & Accountability

Key elements and characteristics	General situation	Maternal, newborn and child health situation	Resource tracking
1. A comprehensive and robust National Health Strategy (NHS) is the basis for sound information and accountability.	Ghana health sector medium term development plan 2010-2013, which is a continuation of the 3rd five-year programme of work 2007-2011; Aligned with the Medium Term National Development Policy Framework: Ghana Shared Growth and Development Agenda (GSGDA) 2010-2013	MDG Acceleration Framework (MAF) country action plan published in Aug 2010, aiming to accelerate efforts to overcome bottlenecks in implementing evidence-based interventions to improve maternal and newborn health at both community and health care facility levels. The three key priorities interventions areas identified are: improving Family Planning, Skilled Delivery and Emergency Obstetric and Newborn care. Under 5 Child Health Policy 2007-2015 and Under 5 Child Health Strategy 2007-2015	
1.1 The NHS is based on a sound situation analysis, effective country ownership and policy dialogue with broad participation. 1.2 Goals, objectives and interventions clearly defined and based on an evidence-based assessment of the situation. 1.3 Programme-specific plans are well-integrated with the NHS	The new health sector plan is based on a very brief situation analysis. It however built upon the regular performance assessments that are conducted at least annually and involve relevant stakeholders. There are 5 strategic objectives: (1) equity in access and financial protection for the poor (2) better health service delivery (3) increased access to MNCH services (4) improve prevention and control of communicable and NCDs (5) strengthen institutional care; the plan specifies interventions for each objective	MAF resulted from a thorough multi-sector stakeholders' review of strategies, interventions and progress on MDG 5 as of 2010; The Under-5 Child Health is focused on MDG 4 through 12 strategic objectives, 4 of which deal with the continuum of pregnancy, perinatal, neonatal, infant and child care services. Other 8 strategies are on programme support to deliver services.	Ghana Health Sector Medium Term Development Plan objective 4 on "sustainable financing arrangements that protect the poor" was aligned on the third POW 2007-2011, though this latter has not yet been reviewed since it is still in process. The POW 2007-2011 has the same objective of "Good governance and sustainable financing". It was developed upon an evaluation of preceding POWs and is called a living document, that continues to be refined through consultative

			<p>processes.</p> <p>The Health Sector Programme of Work 2007-2011 lists the challenges around the financing of the health sector, activities to implement, expected results to monitor and performance indicators to be measured for each key result.</p>
2 The NHS specifies sound monitoring, review and action mechanisms.	The health sector plan 2010-13 includes a chapter on M&E.	The MAF includes a monitoring plan	
<p>2.1 The M&E component of the NHS is aligned with the main goals and objectives.</p> <p>2.2 The M&E plan is country-led and developed with systematic participation of all key stakeholders.</p> <p>2.3 The M&E plan, based on a situation analysis of the HIS, is costed and funded, with partner alignment.</p>	<p>The M&E plan specifies the frequency of monitoring implementation, the role of the annual review, and specifies indicators and targets, as well as milestones for each strategic objective. The M&E components are aligned with the main goals and objectives of the health sector plans, with responsibilities clearly defined.</p> <p>The country M&E plan is aligned with the M&E framework of the national development policy framework. All partners are aligned behind the health sector strategy and M&E plans, and have agreed on indicators and reporting framework.</p> <p>There is no specification of data sources and costs to collect, compile, analyse and disseminate the data. A Health Information Management strategic plan 2007-2011 was developed with support from HMN, but it was not costed. Recently, a costed HIS plan has been developed .</p>	<p>The monitoring plan – as an integral part of the MAF Country Action Plan – outlines for each defined priority activity under each thematic area, the indicators for measurement, implementation timelines, indicator for monitoring, and responsible institution or structure for undertaking the activity.</p>	<p>NHA are neither integrated in the M&E, nor aligned with strategic objectives. Only one NHA report was produced for year 2002, before the implementation of the NHIS.</p> <p>The MoH developed an institutionalization plan to improve the regularity and timeliness of NHA reports.</p> <p>This plan was to be disseminated to all stakeholders</p>

II. Sound monitoring

Key elements and characteristics	General situation	Maternal, newborn and child health situation	Resource tracking
3. There is a framework which guides the selection of a core set of indicators	Balanced set of core indicators with targets has been selected	Core indicators selected and in line with global standards	
3.1 Balanced and parsimonious set of core	There are guidelines for national health sector stakeholders	There are about 32 monitoring indicators	In addition to the indicators proposed in

<p>indicators with well-defined measurement, baselines, and targets</p> <p>3.2 Use of global standards for indicators and metadata.</p>	<p>planning and indicator selection, monitoring and periodic sector performance review.</p> <p>There are 37 indicators, with a 2008 baselines for all but 2 indicators, for a total of 7 thematic areas. All have targets for 2013, and 20/37 have annual targets. The indicator set covers inputs, outputs, outcomes and impact, as well as equity.</p> <p>The core sector wide indicators cover the following major programmes: maternal health, child health and nutrition, malaria, HIV/AIDS, TB, NTD, and health financing, human resources for health and access to health services.</p> <p>Almost all indicators are well-established and include recommended global indicators.</p>	<p>covering mostly output and outcome indicators, with 2010 as baseline even though data are not yet available for some indicators.</p> <p>Clearly defined outcome and impact indicators outlined in M&E Framework and resource needs identified, including capacity building. Documented in the MAF and Under 5 Health Strategy document these. Inputs, outputs, and targets for monitoring for progress monitoring</p> <p>Impact indicators selected are consistent with global standard impact indicators for maternal and child health.</p>	<p>the POW, the NHA institutionalization project engaged health stakeholders to validate what information is necessary for decision makers</p> <p>The 2002 NHA report used international accounting guidelines.</p>
<p>4 Data sources are specified in an integrated manner, data gaps identified and addressed.</p>	<p>There is no integrated data collection and analysis plan that specifies measurement issues and how the different data sources should contribute</p>	<p>Data sources are identified but no active and consistent action to address data gaps in data sources and data management</p>	
<p>4.1 Critical data gaps identified and addressed in the plan and subsequent actions.</p> <p>4.2 Responsibilities for data collection and management are specified for different levels.</p>	<p>Health surveys - Ghana has regular health surveys of good quality, allowing it document trends in key indicators, verify health facility data, and assess equity</p> <p>Facility reporting (HMIS) - functioning system but has a number of weaknesses regarding data quality.</p> <p>HMIS strategic plans provides guidance, although the roles of Ministry of Health and Ghana Health Services are sometimes confusing and conflicting</p> <p>Administrative data - NHA, human resource and facility database operational but private sector data are generally missing; a monitoring system related to the Medium Term Expenditure Framework has been developed.</p> <p>Census - latest conducted in 2010;</p>	<p>Data sources are often not specified but a combination of routine data collection, annual reviews and surveys are envisaged to be used</p> <p>Critical data gaps are not reflected in these programme specific areas (of maternal, newborn, and child health). This responsibility is deferred to the PPME (Policy Planning Monitoring and Evaluation) Division of the Ghana Health Service.</p> <p>Private sector data is not reported into the national system - this represents a significant draw back for maternal, newborn and child health care delivery monitoring and evidence collection for decision making and intervention actions.</p>	<p>NHA institutionalization plan identifies the gaps and suggests ways to remedy (particularly information from the private sector through regulatory procedure; formatting of donors information; households information and insertion of expenditure questions in routine DHS).</p> <p>There are no responsibilities assigned for sub/national level of data collection and management.</p>

	<p>provisional census report released.</p> <p>Birth and death registration - no vital statistics are generated but efforts to improve the system are under way</p> <p>Bureau of Statistics role in census and surveys is clear; the Medium Term National Development Agenda recognizes the National Statistics Service (NSS) as the lead national agency for official statistics and institutional arrangements and capacity building efforts are underway to have the NSS provide guidance and collate official statistics from all sectors</p>		
5 Data analysis work is specified and data quality issues are anticipated and addressed.	No specifics ; the analytical capacity in the health sector is weak	There is no data analysis plan -	
<p>5.1 Specific processes for data quality assessment and adjustment in place and transparent.</p> <p>5.2 Data analysis and synthesis work specified and funded</p> <p>5.3 Prospective evaluation planned and linked to M&E of NHS.</p>	<p>Periodic programme and service reporting and review processes have built-in data quality check but this is not robust and comprehensive enough and further undermined by weak institutional capacity and lack of expertise.</p> <p>ICT use is very limited except to a limited extent at the national CHIM (Center for Health Information Management).</p>	<p>Same situation as for general monitoring</p> <p>There are major weaknesses in capacity both at institutional and individual levels for proper data analysis and data management for proper monitoring and progress tracking.</p>	<p>For 2002 NHA data Quality of data reporting</p> <p>The quality varies across NHA data points, with more reliable public information from records, and estimates for private sector expenditures on health (based on surveys).</p> <p>Comprehensiveness: Aims to covers all current health expenditures</p> <p>Timeliness: needs to be improved (3 year delay)</p>
6 Data dissemination and communication is effective and regular.			
<p>6.1 Analytical outputs as basis for national and global reporting.</p> <p>6.2 Appropriate decision support tools and approaches are used.</p> <p>6.3 Data and reports are publicly available.</p>	<p>Annual health statistical reports are produced and form the basis or part of the annual health sector performance review. However there are some gap years when the report is not produced; need to institutionalize practice for consistent annual reporting.</p> <p>The Health Sector in Ghana: Facts</p>	<p>Quarterly reports are submitted from lower levels to higher levels, semi-annual and annual reports are compiled and shared.</p> <p>Need for analytical output as basis for national reporting recognized but poorly resourced</p>	<p>Quote:"There is a lack of information on health financing indicators for policy makers within the Ministries of Finance and Health. Raw accounting data is submitted to the Controller and</p>

	<p>and Figures - produced by CHIM of Ghana Health Service, most recent document 2009 (data for 2008)</p> <p>MOH website is easily accessible and well-organized and has several reports in relation to regular monitoring:</p> <p>Annual review reports 2004-2008 and annual health summit reports</p> <p>MDG report 2009, several other data and monitoring reports</p>		<p>Accountant General's Department (a department of MoFEP) and lacks the analysis that is needed by policy makers."</p> <p>2002 NHA report is not available on MoH website.</p>
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III. Country mechanisms for review and action

Key elements and characteristics	General situation	Maternal, newborn and child health situation	Resource tracking
7. There is a system of joint periodic progress and performance reviews			
<p>7.1 Regular and transparent system of reviews with broad involvement of key stakeholders</p> <p>7.2 Systematic linkages between disease programme M&E, global reporting and the overall health sector reviews.</p> <p>7.3 M&E system is regularly assessed for how well it monitors progress and generates needed information.</p>	<p>Annual health sector reviews have been conducted for many years. The results are published on the web in an Aide Memoire signed by the Ministry, donors and UN agencies. There are two health summits each year: the first is the annual review (held during Apr-Jun) is dedicated to the assessment of progress and identification of priorities for the coming year. The second summit, held a few months later (Sep-Oct), is the platform for approval of the programme of work for the coming year</p> <p>Monthly MoH-partners meetings are held to monitor progress Ghana Health services conducts half yearly health sector interagency reviews Civil society is involved in regular reviews</p> <p>There is a system of district and regional reviews which promotes monitoring of local progress and performance, as well as use of data for local decision-making. These processes feed into the annual reviews.</p>	<p>It is envisaged to have quarterly review meetings with key partners to monitor progress with implementation of the MAF Maternal , newborn and child health issues and indicators feature prominently in these reviews and programme managers are held to account for findings in these reviews at all levels.</p> <p>Additionally, programme specific reviews are also undertaken separately by maternal and child health programmes</p>	<p>Government expenditure data are usually included in the annual reviews</p>
8. Regular assessments of progress and performance			

as basis for policy dialogue and review.			
8.1 Synthesis of M&E findings focusing on key goals. 8.2 Systematic analysis of contextual and qualitative information.	Independent reviews, often with external consultants from either within or outside Ghana, are conducted on an annual basis and bring together all data, on behalf of the Policy Planning and M&E unit of MoH	It is envisaged to have quarterly review meetings with key partners to monitor progress with implementation.	
9. There are processes by which related corrective measures can be taken and translated into action			
9.1 Results from reviews are incorporated into decision-making, including resource allocation. 9.2 Multi-stakeholder mechanisms to provide routine feedback to sub-national and key stakeholders are specified.	Review meetings are used to address emerging problems, measure progress and assign responsibilities An "Aide Memoire" is produced and signed by government and selected development partners.	Content of annual work plans and to a large extent funding decisions and levels are informed by the results of the reviews Stakeholders participate in sub-national level reviews and routine feedback are also provided to sub-national levels on key programme or service components.	

IV. Institutional capacity

Key elements and characteristics	General situation	Maternal, newborn and child health situation	Resource tracking
10 Roles and responsibilities of country institutions are clearly defined and capacity is strengthened.		Responsible partners are outlined in MAF	
10.1 Well-established coordination mechanisms for M&E of the NHS. 10.2 Key institutions and stakeholders have clear roles and responsibilities. 10.3 Capacity strengthening in monitoring and evaluation is addressed.	A general M&E plan for the health sector is currently being revised and updated. The responsibilities of the different institutions and how they work together still needs to be specified. The Centre for Health Information Management of the Policy, Planning, Monitoring and Evaluation division of the Ghana Health Service is the focal unit responsible for the collection, analysis, reporting and presentation of health service information in the Ghana Health Service	The M&E plan has defined for each activity the partner responsible. Further details are not provided	NHA institutional capacity should be put into place in the near future, following the institutionalization report.

ANNEX C RWANDA

I. Comprehensive national health strategy as foundation for Information & Accountability

Key elements and characteristics	General situation	Maternal, newborn and child health results tracking	Resource tracking
<p>1. A comprehensive and robust National Health Strategy (NHS) is the basis for sound information and accountability.</p>	<p>Rwanda is implementing the Health Sector Strategic Plan Development Plan II 2009-2012. HSSP II is a continuation of the HSSP I (2005-2009). It is based on a sound situation analysis, with clearly defined goals, objectives and interventions which are all aligned with Rwanda Vision 2020.</p>	<p>Strategic plan to accelerate the reduction of maternal and newborn morbidity mortality 2009-2012 and Road Map to accelerate the reduction of maternal and newborn morbidity mortality 2015</p> <p>Child Health Policy 2009 and Child Survival Strategic plan 2008-2012.</p>	<p>Rwanda's HSSP II has a strategic programme area of health financing. Health financing strategy review and policy have been completed. Health financing strategy still to be developed.</p>
<p>1.1 The NHS is based on a sound situation analysis, effective country ownership and policy dialogue with broad participation.</p> <p>1.2 Goals, objectives and interventions clearly defined and based on an evidence-based assessment of the situation.</p> <p>1.3 Programme-specific plans are well-integrated with the NHS</p>	<p>HSSP II development process involved all major stakeholders in the health sector. HSSP II is built based on the evaluation of HSSP I recommendations. The result is a comprehensive, high-quality plan owned by MoH and all stakeholders responsible for its implementation and evaluation.</p> <p>HSSP II has three main programmes: 1. Maternal and child health, family planning, reproductive health and nutrition. 2. Prevention of diseases and promotion of health. 3. Treatment and control of diseases.</p> <p>HSSP II has three strategic objectives: 1. To improve accessibility to, quality of and demand for MCH/FP/RH/Nutrition services. 2. To consolidate, expand and improve services for the prevention of disease and promotion of health 3. To consolidate, expand and improve services for the treatment and control of disease. HSSP II In addition, HSSP II highlights the following strategic programme areas: Institutional capacity, Human resources for health, Health sector financing, Geographic accessibility, Drugs, vaccines and consumables ,</p>	<p>MNCH related objectives and targets are part of the Rwanda Vision 2020, as well as objectives of the HSSP. During HSSP II development, MNCH issues attracted wide and inclusive consultations. These were carried out in Group work as part of two 3-day HSSP II planning workshop. A further review was conducted at a later date in another venue before finalization.</p> <p>Important areas that were emphasized in HSSP II because of wide intervention gap noted in HSSP I were nutrition and maternal health. The HSSP II was the basis of the improvements made in programme co-ordination including the MCH Technical Working consisting of Family Planning, MCH, Nutrition and Community Health subcommittees.</p> <p>All programme specific plans are integrated in HSSP II. The Strategic plan to accelerate the reduction of maternal and newborn morbidity mortality 2009-2012 has 7 priority areas: (1)ensuring universal access to RH services by all Women of</p>	<p>NHSSP II does not include health expenditure indicators in the health sector performance review nor does it link expenditures to results. In the description of the strategic programme area for health financing, it includes expenditure data in the description.</p>

	<p>Quality assurance, Specialised services, National Referral Hospitals and research capacity.</p> <p>The HSSPII is the driving strategic document for all activities related health and implemented by all stakeholders. All programme specific objectives and activities are integrated in the plan. All stakeholders are following this plan, implementing parts of it and are accountable for related results.</p>	<p>reproductive age , (2) increasing access to and availability of Skilled Delivery and Emergency Obstetric and Newborn care services including commodities and supplies; (3) empowering women, families and community for timely and appropriate decisions for MNH; (4) gender mainstreaming; (5) treatment of Obstetric fistula, rehabilitation and integration of women with fistula into their community; (6) Community participation and involvement (7) Strengthening health information system for monitoring services and Maternal and perinatal death reporting and audits. All priority areas work is co-chaired by MoH and a development partner.</p>	
2 The NHS specifies sound monitoring, review and action mechanisms.	The HSSP II 2009-2012 has a specific chapter on M&E. The mid year and the annual reviews are co-chaired by government agency and a strategic partner. Reviews take place at all levels of the system. Each review results in concrete actions to address gaps and identified challenges	Both plans: the strategic plan to accelerate the reduction of maternal and newborn morbidity mortality 2009-2012 and the Child Survival Strategic plan 2008 -2012 include a monitoring plan chapter.	M and E does not specifically mention monitoring of health expenditures although HSSP II in its strategic programme area mentions one indicator associated with health expenditures; % of government expenditure on health, aside from other health financing indicators relevant to CBHI and PBF.
<p>2.1 The M&E component of the NHS is aligned with the main goals and objectives.</p> <p>2.2 The M&E plan is country-led and developed with systematic participation of all key stakeholders.</p> <p>2.3 The M&E plan, based on a situation analysis of the HIS, is costed and funded, with partner alignment.</p>	<p>The detailed M&E framework specifies output, outcome and impact indicators that measure progress towards the attainment of the HSSPII objectives. Most of indicators have baseline, targets, frequency and source of information.</p> <p>The M&E framework is aligned with the overall performance assessment frameworks followed by Rwanda government: the Common Performance Assessment Framework (CPAF) and the Partners Development Partner Assessment Framework (DPAF) is an integral part of CPAF). The output indicators measuring the attainment of desired objectives and outputs are linked and feed into the National EDPRS and subsequently support the attainment of the Vision 2020.</p>	<p>The M&E log frame of the MCH strategic plans is linked and fed into the National EDPRS and subsequently support the attainment of the Vision 2020 and MDGs. The indicators and respective reporting timelines for monitoring activities are defined. The data sources and cost for measuring MNCH indicators as part of the MNCH strategies are not well specified.</p> <p>The M&E planned interventions are discussed during the development of the Joint action plan(JAP). The JHSR is led by government with the participation of both internal and external stakeholders. The last JHSR reported modest achievements made in the MNCH areas (October 2010 JHSR Report). IMNCI review is</p>	

	<p>The review processes are defined within ME framework. Sector Performance is a key mandate of the government and a best practice. The JHSR is held twice a year, led by government with the participation of both internal and external stakeholders. The UN Group not only functions as knowledge leaders with strong inputs but also supports a balancing act between government, the Development Partners group amongst which are the more vocal donors. The well documented event highlights sector achievements and key points on way forward. During the last JHSR of October 2010, two main priorities for 2011 were highlighted-Health System strengthening and Human resource capacity development. Next JHSR is planned for 12 April 2011.</p> <p>Development partners ME plans and performance targets are an integral part of HSSPII ME framework.</p> <p>Costing of the HSSP II was done using the MBB methodology in 2009. Competing priorities led to the deferment of the 2010 planned HSSPII Midterm review to first quarter of 2011. An important feature of the approach to the review was government openness to invite external stakeholders including IHP+ Team to participate during the review. The UN in partnership with the Development partners Group have put this as an important line item agenda in the Health Sector Working Group.</p> <p>A specific Health Sector M&E strategy and plan 2009-2012 was developed to address capacity issues and streamline reporting mechanisms. The costing of M&E is done as part of the costing of the HSSPII. In all scenarios costs related to M&E varies between 4%-5% of the total budget requirement for health.</p>	<p>annually carried out by the Ministry of Health with all relevant partners including the community.</p> <p>Other review mechanisms leading to decisions and actions are built in the routine implementation processes. For example, Programme implementation data analysis in 2010 showed that interventions targeting post partum hemorrhage had succeeded in terms of reducing deaths due to PPH and that infections were the main cause of maternal deaths. As a result the updated Plan for Maternal Survival highlights infections as a main cause of maternal deaths and related interventions.</p> <p>Another example of accountability and remedy actions is the quarterly review of maternal and child deaths at the MoH. The review takes place at the minister and cabinet level, during which recommendations are made and followed up to address causes of death.</p>	
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II. Sound monitoring and evaluation (M&E)

Key elements and characteristics	General situation	Maternal, newborn and child health results tracking	Resource tracking
<p>3. The M&E plan is comprehensive and guides the selection of a core set of indicators.</p>	<p>HSSPII has a core set of indicators that cover the strategic objectives in terms of health indicators (the ME framework) and the strategic programmatic objectives (inputs and processes).</p>	<p>The ME framework of the MCH strategies have a set of indicators which feed into HSSPII and follow the internationally agreed MNCH indicators.</p>	<p>The choice of indicators is mostly aligned with the strategic interventions</p>
<p>3.1 Balanced and parsimonious set of core indicators with well-defined measurement, baselines, and targets</p> <p>3.2 Use of global standards for indicators and metadata.</p>	<p>The M&E framework has 18 indicators, with 2005/6/7 baselines for all. All have targets for 2012 and 2015. The indicator set covers inputs, outcomes and impact. They follow the strategic objectives of HSSPII. They are aligned with health-related indicators and targets specifically mentioned in Vision 2020, the MDGs, the EDPRS, the CPAF and the SBS agreement. Baseline data are taken from the latest information available: the intermediary DHS2008 and DHS 2005, specific studies, data compiled by disease programmes or the HMIS system. Indicators are well-established and follow recommended global indicators.</p>	<p>The MNCH core indicators are defined and have targets for 2012. Some outcome and impact indicators outlined in M&E chapters are missing baselines, source of data, resource needs as well as capacity building needs are not well elaborated. However, partial information related to these aspects could be found in other documents such as HSSP.</p> <p>Selected indicator sets have been helpful in tracking progress. Few 2012 targets were achieved in 2010 (e.g. 2012 target of IMR 62/1000 live birth in 2008 was attained in 2010).</p> <p>Some issues are surfacing in terms of defining targets. For example, in light of increased FP utilization and decreased fertility, population projections have changed. This implies changes in denominators for some of the MCH indicators. Currently MCH indicators use population projections based on data from 2002 census and DHS 2005/2008 and will not be able to change before the results of the DHS 2011 and Census 2012. This creates problems in terms of establishing targets for indicators such as "number of children fully</p>	<p>The indicators are:</p> <ul style="list-style-type: none"> - public expenditure (including domestic, GBS and SBS) as % of GoR total expenditure - % population covered by health insurance - % of eligible hospital bills reimbursed by District Risk Pool - % health facilities covered by whole package of PBF - % CHW cooperatives covered by complete PBF package <p>Note: It is not clear which is the indicator that directly addresses this strategic intervention: Allocate Health Sector Budget according to priority areas (need)</p> <p>Note other internationally recommended indicators for health system financing are not included: e.g. out of pocket expenditures as a share of THE although % of population covered by health insurance could be considered as a proxy indicator for financial risk protection.</p>

		immunized in a year", etc. Shortcomings of the indicator sets will be reviewed during the 2011 planned MTR.	
4 Data sources are specified in an integrated manner, data gaps identified and addressed.	The M&E chapter of HSSPII and the ME strategy and plan (2009) indicate the data sources for most of indicators. The M&E strategy and plan 2009 indicates what needs to be strengthened across the ME system.	The strategies for MNH Survival and Child Survival often indicate data sources.	
4.1 Critical data gaps identified and addressed in the plan and subsequent actions. 4.2 Responsibilities for data collection and management are specified for different levels.	<p>The HSSPII chapter on M&E identifies and plans for implementation of improvements of information system (eg. revision of HMIS) and surveys (DHS, census). The ME strategy and plan (2009) identifies the main areas for development. However it is not clear how this plan is linked to HSSPII.</p> <p>HMIS is functioning as paper based in community and PHC levels, tends to computerize from hospital to district level and up. A recent facility assessment found that over 95% of PHC and facility based analysed, summarized and reported records correctly and timely to the next level (JHPIEGO 2011).</p> <p>HMIS architecture is being revised and developed. List of core indicators simplified from 900+ to 160. All indicators could be disaggregated by gender, region, age group, diseases code, etc. New HMIS will be IT based and composed of at least four databases able to "talk" to each other: Health indicators, Human Resources, Drugs and Supplies and Facilities (facility register including geo-codification.)</p> <p>MoH is responsible for overall governance of HMIS.</p>	<p>Same as general situation, in addition:</p> <p>The ME parts of specific strategies are not as well developed as the ME framework of the HSSPII (see point 3). The data gaps in the MNCH strategies are not well highlighted.</p> <p>Roles and responsibilities in ME for MCH are clearly defined and documented in both MCH strategic documents.</p> <p>Facility reporting (HMIS) is functioning at all levels, disaggregated data not always available.</p> <p>MoH MCH team has a dedicated M&E team that follows up on data collection and reporting.</p>	<p>Two types of resource tracking: one financial and the other is non-financial. There are also two methods of resource tracking: as part of a routine monitoring and as special studies.</p> <p>For financial reporting, it is important to look at all sources of financing: general government, development partners, private sector including health insurance, firms and households (particularly out of pocket expenditures). Special studies: Framework for collection and reporting of expenditures is the national health account. Latest national health account was in 2006; there is a concrete plan to do a 2009-2010 NHA. General government and development partner budget and expenditures can be expected to be obtained routinely (see HRT below). Private sector including private insurance firms and businesses are still to be obtained through primary data collection/surveys. Household spending is obtained through household surveys. The latest household survey is the DHS with an expenditure module for 2010. Routine reporting: Health resource tracker (HRT): web-based software has been developed with the objective of self reporting of both budgets and expenditures by government and development partners. The web-based system can communicate with the data warehouse being set-up. Budget and expenditures are mapped at activity level to HSSP</p>

	<p>Each level within the health sector has specific roles and responsibilities.</p> <p>Bureau of Statistics under MINICOFIN is responsible for vital registration (births and deaths) and for implementing large scale population surveys such as census and DHS. Efforts are needed to register birth and death that are from the community level.</p>		<p>II , NHA codes; in addition, they are tagged by disease (ICD coding), by district, by facility using standard codes in data registries.</p> <p>Standardization of definitions of activities/interventions has been undertaken. It is possible to do tracking for child, maternal and reproductive health. Double tagging is done where appropriate (e.g. child and malaria)</p> <p>Note: a concept note is being prepared to prepare the national health accounts yearly, considering that a large part of the health expenditures coming from the government and development partners will be updated yearly through the health resource tracker. All other (private) expenditures can be updated using accepted accounting techniques, particularly for household expenditures. Private firms and insurance constitute a small part of total health expenditures (<5%).</p>
5 Data analysis work is specified and data quality issues are anticipated and addressed.	Data collection and analysis is specified for both routine and surveys. DQA is an integral part of the system and closely related to resource allocation (Performance Based Financing). PBF functions as a mechanism to assess gaps and inform corrective actions.	The same apply also for the MNCH plans	
<p>5.1 Specific processes for data quality assessment and adjustment in place and transparent.</p> <p>5.2 Data analysis and synthesis work specified and funded</p> <p>5.3 Prospective evaluation planned and linked to M&E of NHS.</p>	Data quality assessments and audits are implemented in quarterly basis as part of the PBF implementation: Primary health care checks upon community data reported, hospitals check on PHC, hospitals peer review each other, district teams review the hospitals. PBF uses the information produced by HMIS to check on indicator status. Completeness and thoroughness of reported data is one of the indices rewarded in PBF. The cross-checking between HMIS reports, the PBF reports and the DQA is used routinely.	<p>Same as per general situation. In addition:</p> <p>MNCH programme is implementing maternal and child death audits in facility level and more recently at the community level. There is no formal evaluation yet to indicate the impact of this intervention. However, audit reports are summarized and analysed at MoH and district levels periodically, and actions are recommended.</p> <p>Special surveys: EMOC assessment was implemented in 2008. A facility based assessment</p>	<p>Quality of data reporting: First round of data collection started FY2009-2010.</p> <p>Comprehensiveness: in terms of response rates, 100% by government and development partners. Incentive offered to development partners to fill in the form is to condition issuance of employment visas on its completion. In terms of detail of reporting, most would have accomplished second level of disaggregation; others would have provided more detail (third or 4th level of disaggregation). Use of garbage code (e.g. not classified) is minimized by providing very general (two classes only) first level codes.</p>

	<p>Population and facility based surveys: Past population based surveys: Census 2002, DHS 2005, mini DHS 2008. Facility based surveys: EMOC 2008, facility survey JHPAGO 2011). Relevant evaluations: Evaluation of PBF.</p> <p>On-going and planned surveys: DHS 2010 (results due by June 2011), census 2012. External evaluation of HSSPII, evaluation of Community Health Workers PBF, etc.</p> <p>Analytical capacity needs further strengthen and development especially at the district level.</p>	<p>was implemented in selected districts by JHPIGO in Feb 2011, targeting their areas/zones of intervention.</p> <p>Population based surveys: DHS was implemented last year and results are due by June 2011.</p> <p>Birth and death registration - vital statistics from HF are generated but efforts are needed to register birth and death that occur at the community level</p> <p>MCH team in MoH has a team dedicated to ME which undertakes data analysis and ensures communication.</p>	<p>Accuracy: first round is a learning curve; some amount of double counting coming from donors and their implementers. Considerable time spent in cleaning the data by third party. It is anticipated that the second round will provide more accurate data as data providers are more familiar with the system and a large part of what will be entered in the second year will be updating versus new data entry especially with regard to continuing projects and commitments.</p> <p>Timeliness: It is anticipated that twice yearly updates will be done; most recent expenditures reported theoretically will be at least within the current fiscal year.</p>
6 Data dissemination and communication is effective and regular.	Data dissemination is assured by MoH and districts.	MNCH data dissemination and communication is effective and regularly done through MNCH task force meeting	
<p>6.1 Analytical outputs as basis for national and global reporting.</p> <p>6.2 Appropriate decision support tools and approaches are used.</p> <p>6.3 Data and reports are publicly available.</p>	<p>MoH publishes its annual report in regular basis. Reports are accessible in MoH website (the most recent is the 2009 annual report). MOH website has several reports in relation to regular monitoring health results.</p> <p>Statistical yearbook 2009 edition available.</p> <p>The website of the MoH has links to websites that contain databases such as PBF website. Currently MoH website has no database on line on health indicators available.</p> <p>PBF website has a detailed data set of all facilities. The website has information regarding performance agreements templates for each level, indicators, etc.</p>	<p>Same as general situation. In addition:</p> <p>MCH summary bulletins are regularly released .</p> <p>Color coding is used during the reviews</p> <p>MDG report annually produced</p> <p>Daily reports are available on the MOH website Other , dissemination and communication means include weekly media reports, quarterly town hall meetings, etc.</p>	<p>Usefulness: still to be proven; system will go live in next few months. Reporting formats potentially very flexible and responsive to common policy concerns. Potentially, tables and graphs and maps can be generated using any combination of tags and codes, at whatever level of disaggregation. For accountability: it is anticipated that it will be possible in the near future to compare budget with expenditures.</p> <p>Public availability of data: It is not anticipated that the completed web based system will be available to the general public. It is panned that a yearly report will be provided to the general public.</p>

III. Strengthened country mechanisms for review and action

Key elements and characteristics	General situation	Maternal, newborn and child health results tracking	Resource tracking
7. There is a system of joint periodic progress and performance reviews	Rwanda has a regular strong public review processes in place across all levels of the system to assess and reports on achievement of agreed targets.		
<p>7.1 Regular and transparent system of reviews with broad involvement of key stakeholders</p> <p>7.2 Systematic linkages between disease programme M&E, global reporting and the overall health sector reviews.</p> <p>7.3 M&E system is regularly assessed for how well it monitors progress and generates needed information.</p>	<p>The joint sector review cycle runs twice a year, in April (mid year review) and October (annual review). Fiscal year and planning cycle runs July-June.</p> <p>During Joint Sector Reviews all stakeholders, including MoH and partners, who are responsible for implementing the plan and accountable for its results analyze the agreed indicators and targets and propose remedy actions for poor achievement.</p> <p>Programmes are part of the Joint Sector Review. In addition to it, programmes, districts, health facilities communities undertake their own reviews, which contribute to the JSR.</p> <p>Review reports are shared with all stakeholders. All reviews are co-chaired by a government institution, e.g. MoH and a development partner.</p> <p>Under the "Localizing MDGs" initiative, each district local government produces its quarterly MDG related report. Each village is collecting MDG related indicators and send them at the local government level.</p> <p>The ME strategy and plan 2009 developed by MoH and external consultants, was based on a review of the ME system.</p>	<p>The adherence to Paris Declaration Principles and Aid Effectiveness has support consistent sector wide approaches in strengthening government systems and more specifically in MNCH. The Subcommittees and parent MCH TWG are effective in conducting MNCH reviews for action.</p> <p>Independent Review was conducted on Community Health Initiative in 2010. Findings have been used to fine tune programme process.</p> <p>MNCH services reviews are conducted yearly with relevant partners though this is not clearly stated in the two strategic plans.</p>	<p>It is anticipated that the budget and expenditure data will be used during the quarterly swap meetings and during the health sector reviews. Budget information can also be matched to areas of priority, both in terms of disease programme as specified in the hssp2 (codes) and geography.</p>
8. Regular assessments of progress and performance as basis for policy dialogue and review.			
8.1 Synthesis of M&E findings focusing on key	Programme and sector reviews analyse achievement of goals and objectives as per the agreed	Same as general situation	See above

goals. 8.2 Systematic analysis of contextual and qualitative information.	performance frameworks. PBF quarterly reviews in addition to quantitative information analyse qualitative information and recommendations for performance improvement. Synthesis of findings and progress towards goal achievement are presented in the review meetings and through other media such as special reports, radio transmissions.		
9. There are processes by which related corrective measures can be taken and translated into action	Periodic implementation of PBF and other review processes have integrated assessment of performance, identification of gaps and implementation of remedies as part of performance measurement.	Same as general situation. In addition: MNCH task force review meetings with key partners to monitor progress with implementation though this is not clearly stated in the two strategic plans	
9.1 Results from reviews are incorporated into decision-making, including resource allocation. 9.2 Multi-stakeholder mechanisms to provide routine feedback to sub-national and key stakeholders are specified.	Performance Based Financing (PBF) is a core mechanism for assessing progress and allocating resources to all levels of health provision. The PBF evaluation by World Bank (2009) showed that PBF implementation was directly linked to the increase of health service utilization and improved health outcomes. In quarterly basis teams will assess the results reported by providers in different levels and recommend additional funding. In addition to quantitative indicators, PBF assessment framework includes qualitative and contextual information which explain performance. All this information is used to decide on allocating or not additional funding to the provider. This is also used to channel support to the provider to improve performance. All review mechanisms, including PBF implementation, are done in partnership with all concerned stakeholders.	Same as general situation	See above

IV. Institutional capacity

Key elements and characteristics	General situation	Maternal, newborn and child health results tracking	Resource tracking
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10 Roles and responsibilities of country institutions are clearly defined and capacity is strengthened.	HSSP II M&E Taskforce	MCH M&E taskforce	
<p>10.1 Well-established coordination mechanisms for M&E of the NHS.</p> <p>10.2 Key institutions and stakeholders have clear roles and responsibilities.</p> <p>10.3 Capacity strengthening in monitoring and evaluation is addressed.</p>	<p>Co-ordination mechanisms are still developing for HSSP II M&E Taskforce. Modest efforts have been seen but more needs to be done in strengthening government in-house capacity to conduct M&E. The Government M&E housing infrastructure was developed in 2010-2011. There is now a recruited government staff and focal officer for HMIS. The effect of technology has also boosted M&E activities including the planned development of the Integrated Web based MCH National Database that will be part of the National e-HMIS. This first Quarter also saw the meeting of stakeholders for the selection of Key HMIS indicators in MNCH. The Cross-cutting One UN M&E Taskforce has also played an important role in development and review of indicators for MNCH.</p> <p>Routine HMIS is the responsibility of MoH, Bureau of Statistics is responsible for vital registration, surveys and census. All stakeholders use the information resulting from HMIS and contribute to its development.</p> <p>Analytical capacity may be limited to the levels where information is produced.</p>	<p>Same as general situation, in addition:</p> <p>The MoH MCH team has a specific MCH taskforce chaired by the MoH and a rotating partner, currently UNICEF. The co-chairs are responsible for the coordination of monthly meetings and timely analysis of technical working group reports. There are four technical MNCH sub-groups co-chaired between the MoH and a partner: FP co-chaired by UNFPA , Community MNCH co chaired by UNICEF, Safe Motherhood co chaired by DFID and Nutrition co chaired by USAID.</p> <p>In each of the technical sub-groups there is a M&E focal person.</p>	<p>The health financing unit is newly established with one national and one expatriate seconded by a development partner. They are expected to be the unit that will take-charge of this software. There is need to expand and deepen the capacity and experience of the unit.</p> <p>The national health accounts are currently being prepared by the University of Rwanda School of public health.</p>
<p>ICT: Information technology and innovation used for ME purposes</p>	<p>Rwanda is aiming at becoming a high-tech country. Use of broadband for development purposes is a government priority.</p> <p>Health sector is in the forefront of the developments. The new HMIS architecture and data warehouse is an example.</p> <p>Rwanda is trying to use mobile</p>	<p>MCH is using ICT based applications for MCH. With UNICEF support, the MoH has developed a rapid SMS system is established for MCH. Community Health Workers use mobile phones to report different MCH related activities, interventions, as well as risk factors (eg pregnant woman bleeding)leading to quick referral.</p>	<p>The resource tracking tool is a web based application.</p>

	<p>tech for data and information reporting and feedback, as well as for strengthening referral.</p>	<p>Whenever a risk is announced, the sms is received by the health centre staff that addresses the referral. SMS are collected at a central database in the MoH and used to develop real time reports and have a real time monitoring system in place for selected priority interventions and indicators</p> <p>Daily reports are available on the MOH website</p>	
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