Summary of CHAT-TAG second meeting  
6-7 June 2019  
Danny Kaye room, UNICEF House in New York, NY USA

This report summarizes the Second Child Health Accountability Tracking and Technical Advisory Group Meeting (CHAT-TAG) which was organized by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). USAID supports the TAG with a grant provided to WHO.

The primary focus of the June meeting was to review the first iteration and decide on next steps for a comprehensive mapping of child health and well-being indicators, and to define a set of criteria for prioritizing indicators from this mapping exercise for global monitoring purposes. Indicators presented in global monitoring frameworks need to be harmonized to reduce confusion over what countries should measure and report on, and to enable assessments of trends over time and comparisons across countries and regions. Standard, harmonized indicators will help global efforts towards the ultimate aim of holding us all to account for progress towards fostering children who are alive, healthy, functional, and happy by the time they become pre-teenagers.

The draft mapping of indicators included in relevant global monitoring initiatives discussed at the meeting was prepared by a consultant, Holly Newby, who completed a similar exercise for the MoNITOR Technical Advisory group. The mapping of indicators produced the following results:

- A total of 180 indicators related directly to children ages 1 month to 9 years of age and focused on child survival, growth and development; 135 of these were unique, the remainder were similar enough to be considered duplications.
- Of the 135 unique indicators, 12 are input indicators, 4 are outputs, 61 are outcome and 58 are impact related indicators; all are linked to health service delivery.
- Many of the 135 indicators cannot currently be disaggregated into smaller age groups; 57 indicators relate only to children under 5 years and 76 indicators measure only children under 10 years; and
- Two indicators were specific to capturing health impact in children aged 5 to 9 years.

The map is meant to be a living document to be added to, worked on, and refined by the CHAT-TAG. The following challenges with its completion were identified:
• Defining the scope (i.e., should the mapping focus on global initiatives for now, should the emphasis be on outcome and impact measures and less on the upper stream indicators like inputs, outputs and process indicators for which there is greater variability across countries, should the focus be limited to survive and thrive indicators with transform indicators considered at a later stage?);
  • Handling a diverse set of indicators with varying metadata, especially related to age categories;
  • Dealing with overlapping indicators;
  • Developing sufficient filters for organizing and categorizing indicators; and
  • Deciding on the level of detail to include in the map and associated documentation.

In the plenary session, it was agreed that the mapping exercise should be based on the common evaluation framework (e.g., inputs, process, outputs, outcomes, impact, with clear definitions for the types of indicators that are included in each of these categories) and that the “process” category needs to be added in. It was also agreed that the mapping should be limited to indicators in global accountability frameworks for this first phase of CHAT work. The child health and well-being indicators recommended for collection through routine administrative systems (e.g., in the disease specific and RMNCAH Health Data Collaborative modules) will be kept in a separate worksheet in the mapping file and will be reviewed as a second phase of work when the CHAT group focuses on subnational monitoring.

The CHAT-TAG divided itself into three working groups to discuss the indicators in the map, each one led by a co-chair. These groups collectively cover the domains of survive and thrive (as described in the Global Strategy for Women’s, Children’s and Adolescents’ Health) and included: “Acute conditions and prevention,” “Promotion and development,” and “Chronic conditions and disability”. The groups each focused on defining a core set of indicators within their domain areas that could be recommended for global monitoring. They were asked to make recommendations for how to harmonize indicators capturing information on similar interventions but using different definitions, and to define a set of criteria for prioritizing indicators. They were also asked to prioritize indicators that need further measurement work as part of a research agenda. The report back of each group is summarized below:

1. **Acute conditions and prevention** (led by Joanna Schellenberg):
The group first defined key criteria for prioritizing indicators and these were: 1) An evidence-based intervention effective against major causes of mortality and morbidity; 2) Evidence of effectiveness across countries; and 3) Evidence of validity and data quality. They reached consensus that the core set of indicators should capture information on interventions proven effective against leading killers of children: immunization, nutrition, pneumonia, diarrhoea and malaria with data disaggregated at minimum by the age groups of under-5 years and 5 to 9 years. Given that immunization and nutrition are the focus of other measurement groups, the group agreed to focus on malaria, diarrhoea and pneumonia, with a view to covering additional areas after the NYC meeting. The following recommendations were made for indicators related to these three diseases:

- The diarrhoea indicator should be defined as children with diarrhoea in the previous 2 weeks who received treatment with ORS and zinc, following WHO recommendations for treatment,
- At the population level, the pneumonia indicator for children under-5 years should be “care-seeking for children with rapid or difficult breathing, not due to a blocked nose, in the last two weeks”;
- Treatment should not be measured at the population level because there is evidence that it is not feasible to collect information that would discriminate between children with pneumonia and children with a non-pneumonia acute respiratory infection who do not need antibiotics through a household survey questionnaire;
- Health facilities should capture “percentage of children correctly diagnosed with pneumonia who received treatment with an antibiotic”;
- The MERG (Malaria Expert Reference Group) will be asked for their recommendations for indicators for children on malaria prevention and treatment;
- Measuring equity gaps using prioritized indicators should be a guiding principle; and
- Noted gaps included IMCI policy indicators, Paediatric human resources (staff and training) indicators, equipment and supplies indicators, accessibility of health services indicators; children’s rights indicators (and the Convention on the Rights of the Child could be a starting point for developing/identifying these); and indicators on overtreatment.
The group agreed that guidance needs to be developed on quality assurance for routine indicators (that could build off of the DHIS2 module on this topic) and indicators of data quality.

2. *Promotion and development* (led by Ambrose Agweyu):

The group agreed that the core set of indicators for promotion and development would include subdomains for child development, nutrition, and child abuse and neglect. The group discussed approaches for assigning the mapped indicators to the three subdomains including possible criteria for prioritization and harmonization where redundancy was observed. The following example illustrates how the process was applied for identification and review of one indicator:

- The group reviewed the indicator for exclusive breastfeeding for the first six months of life under the nutrition sub-domain. This indicator was selected as a priority indicator based on the application of the following proposed criteria: evidence base for intervention as proven effective (both efficacious and effective when implemented in diverse settings), validity, alignment to “thrive” theme, potential for promoting accountability (e.g., clarity on what the responding action should be), and “child-centredness”. Four unique definitions were identified among the indicators mapped. The group, through consensus, selected the following preferred definition for this indicator: **Exclusive breastfeeding (<6 months, %): Percentage of children aged 0–5 months who are fed exclusively with breast milk in the 24 hours prior to the survey**

- The group agreed to further refine this process/set of steps with input from other CHAT members and to aim towards mapping other indicators that fall under the promotion and development theme into the three sub-domains.

- Among the observations and recommendations made by the group were: (1) Consider including indicators from the Nurturing Care framework/Early Childhood Development profiles from Countdown 2030 in the mapping exercise (2) Review the approach for handling indicators that extend to the neonatal period (covered by MoNITOR) and other unclear age disaggregations (3) Indicators for children aged 5 to 9 years were an acknowledged gap with limited available data for this group.
3. **Chronic conditions and disability** (led by Neil McKerrow):

The group agreed that this domain falls primarily within the “thrive” dimension of child health and well-being, and identified four sub-domains of chronic diseases, disability, accidents/injuries and violence. The steps they followed to complete the tasks assigned involved using the map to: identify all indicators relevant to the four sub-domains noted above, identify gaps where no indicators are available, and prioritize sentinel indicators. The group noted that there are 56 indicators out of the 180 that are relevant to the chronic disability and disability domain. Of these 56, 12 are input indicators, 4 are output indicators, 24 are outcome indicators, and 14 are impact indicators. After further review, the group selected 13 of the 56 indicators as possible sentinel indicators, noting that these 13 are predominantly HIV and TB indicators. They listed 3 additional indicators for further exploration as possible sentinel indicators: Prophylaxis for neglected tropical diseases, incidence of cancer, and road traffic accidents. Regarding gaps, the group noted these exist in the areas of injury and violence, disability, mental health and non-communicable diseases. The group concluded that indicators currently recommended in global accountability initiatives related to chronic conditions and disability have a very narrow focus, reflecting historical emphasis on life-threatening and communicable diseases of HIV and TB.

The three groups reconvened on the second day to develop an example of an effective coverage “cascade” for one indicator relating to their domain areas (1) Acute conditions and prevention, 2) Promotion and development, and 3) Chronic disease and disability). The sample cascades developed by each group is available in the powerpoints in the dropbox folder.

In addition to group work, updates were provided on the MONITOR and GAMA groups, and presentations were given on progress with the recommendations on a set of pediatric quality of care indicators, and on ways to measure effective coverage of child health interventions based on the outcomes of the WHO-UNICEF led Effective Coverage Think Tank Series. The CHAT-TAG agreed on the importance of monitoring progress with pediatric quality of care and effective coverage to better understand how well health systems are delivering for children. The discussion of the pediatric quality of care draft document raised concerns around determining what it means for the CHAT to provide its endorsement to activities of other initiatives and products. The Secretariat agreed to develop a governance document with a draft set of principles for the CHAT TAG to review. The CHAT TAG also
agreed to pursue developing a second paper on effective coverage once the indicator mapping paper is completed or at least well-underway.

**Next steps**

The meeting generated some action points for the CHAT-TAG to complete prior to the third meeting of the group (December 11-12, location TBD).

1. The Secretariat will develop a commentary on CHAT-TAG describing the aims and objectives of the group and highlighting its work. The commentary will be circulated to the group by the end of June 2019 and will be submitted for publication in a peer-reviewed journal.

2. The CHAT-TAG will also have the opportunity to complete a survey on recommended indicators to include in a module being developed under the Health Data Collaborative umbrella for community health information systems.

3. The CHAT-TAG will aim to submit a publication for a peer-reviewed journal based on the mapping work that will present recommendations for a core set of indicators for global monitoring of children aged 1 month to 9 years. The recommendations will consider the 3 domains described above that formed the basis for the meeting’s working groups. Recommendations for a research agenda will also be proposed in this paper.

4. To finalize the indicator mapping work and to generate the recommendations, the CHAT co-Chairs will re-convene the three working groups formed during this meeting with the tasks of defining a set of criteria for prioritization (which may differ for survive compared to thrive indicators, and the co-chairs will need to work with their respective groups on laying out the criteria for these two types of indicators), identifying and reaching consensus on a core set of indicators for their domain area, harmonize duplicative indicators, and define a research agenda for new indicators or to improve the measurement of existing indicators.

5. The Secretariat will produce a governance document to provide guidance on what CHAT-TAG “endorsement” means.

6. Once this governance document is agreed upon, the CHAT TAG can apply these principles when generating its feedback on the pediatric quality of care work, including review of:
   - the methodological document;
   - initial set of proposed indicators;
   - revised set of proposed indicators.
The CHAT-TAG will play additional roles on improving the measurement of effective coverage of child health interventions, child health related indicators for humanitarian situations, and eventually on making recommendations for indicators to be used for sub-national monitoring. For the effective coverage work, CHAT TAG will work together on a paper after the mapping paper is underway that will help to:

- identify proxy indicators for effective coverage of the child;
- make recommendations on measurement approaches, especially on where there are gaps along the coverage cascades for specific interventions.
Appendix A. List of participants

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