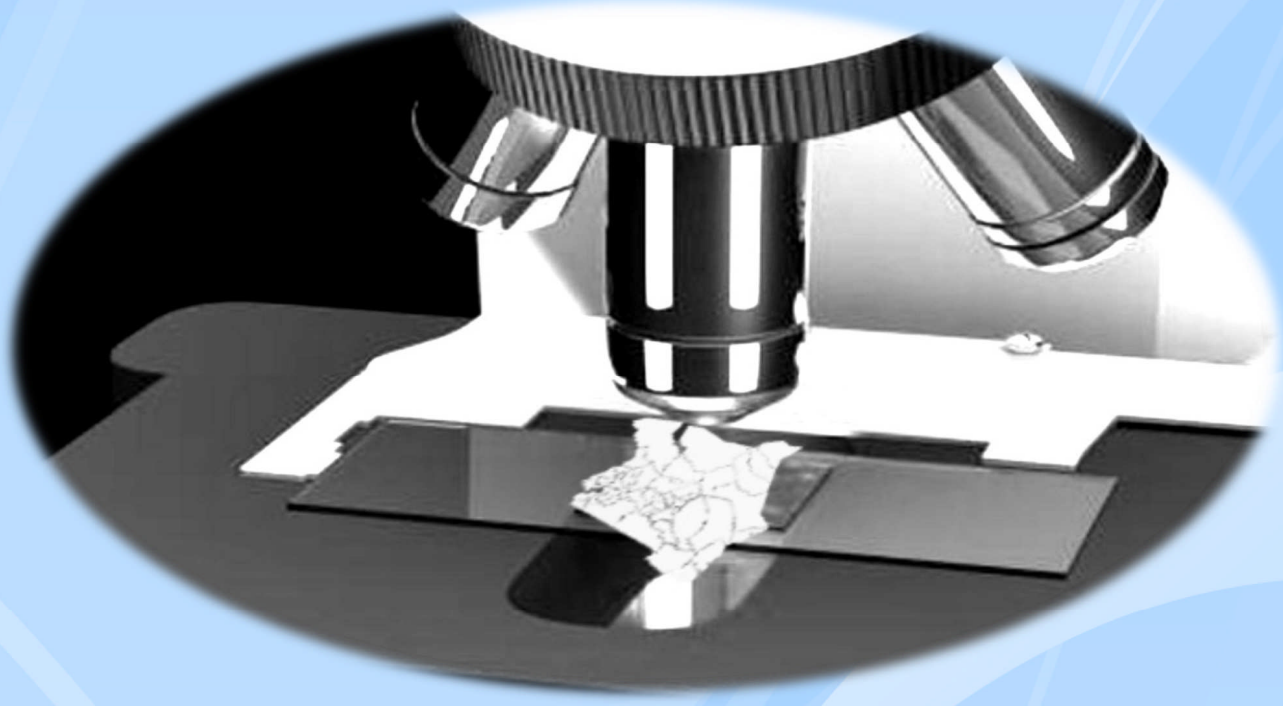
REPUBLIC OF KENYA

MINISTRY OF HEALTH

Accelerating attainment of Universal Health Coverage



HEALTH SECTOR MONITORING & EVALUATION FRAMEWORK

July 2014 - June 2018

Published by: Health Sector Monitoring and Evaluation Unit
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ACRONYMS

AHSPR	Annual Health Sector Performance Report
ARV	Anti-retrovirals
AWP	Annual Work Plans
BEOC	Basic Emergency Obstetric Care
BMI	Body Mass Index
CEOC	Comprehensive Emergency Obstetric Care
CHMT	County Health Management Team
CPD	Continuous Professional Development
CRD	Civil Registration Department
DDSR	Division of Disease Surveillance and Response
DHIS2	District Health Information System 2
DPHK	Development Partners for Health in Kenya
DQA	Data Quality Audit
ECSA HC	Eastern, Central and Southern Africa Health Community
HIS	Health Information Systems
HMIS	Health Management Information System
HRI	Human Resource Information System
HSCC	Health Sector Coordinating Committee
IDSR	Disease Surveillance and Reporting
JAR	Joint Annual Reviews
JRM	Joint Review Mission
KDHS	Kenya Demographic and Health Survey
KEMSA	Kenya Medical Supplies Authority
KEPH	Kenya Essential Package for Health
KHSSP	Kenya Health Sector Strategic and Investment Plan
KNBS	Kenya National Bureau of Statistics
LLITNs	Long-Lasting Insecticide-Treated Nets
LMIS	Logistics Management Information System
M&E	Monitoring And Evaluation
MDA	Multi- Drug Administration
MDG	Millennium Development Goal
MoH	Ministry of Health
NHSSP	National Health Sector Strategic Plan

SAGA	Semi-Autonomous Government Agencies
SCHMT	Sub County Health Management Team
SOP	Standard Operating Procedures
ST	Sector Technical Committees
SWAP	Kenya Health Sectorwide Approach
WHO	World Health Organization

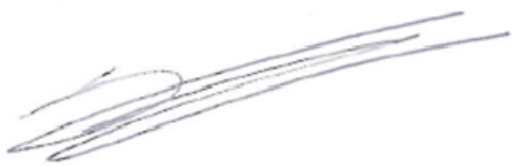
FOREWORD

This document is geared towards providing a harmonized health sector Monitoring and Evaluation system that aims at improving efficiency, enhancing transparency and increasing accountability. An M&E framework and guidelines document is an important **management and governance tool** that will assist the entire health sector to maintain a clear focus on the goals of the Kenya Health Policy and Kenya Health Sector Strategic Plan (KHSSP), and aim to focus the attention of stakeholders and guide efforts towards the ultimate goal of the sector: *to attain the highest possible standard of health in a manner responsive to the needs of the population.*

The presence of a unified approach to monitoring programmatic and sector performance will ensure that the sector is working towards the aforementioned goal in a synchronized manner. This will result in reduction of in duplication of efforts, enhance efficiencies, enhance capacity in the analysis of health sector performance and in implementing comprehensive M&E, and improve the culture of data demand and use of information for decision-making.

By articulating how the health sector will manage the sector Monitoring and Evaluation , this document aims to illustrate how the various health sector stakeholders can ensure the provision of strategic health sector information to decision-makers, who will combine this information with other strategic information to make evidence-based decisions. Enhanced M&E will inform decisions at the national , sub-national (county, sub-county) and institutional/facility levels.

I urge all the health sector stakeholders, both at the National and the County level, to adopt this M&E Framework and Guidelines and ensure that it is implemented so that the health sector goals and objectives as spelt out in the Kenya Health Policy and the Kenya Health Sector Strategic plan are successfully attained.



James W Macharia
CABINET SECRETARY

ACKNOWLEDGEMENTS

This document was developed through a consultative process with inputs from various stakeholders in Health. The Ministry of Health wishes to acknowledge the contribution of all those who participated in the development of this report in one way or the other. We acknowledge the Cabinet Secretary Mr James W. Macharia for providing the overall leadership and guidance. In addition,Special thanks go to the Director of Medical Services Dr. Nicholas Muraguri for his able leadership and technical guidance during the development of this framework.

Our appreciation goes to the technical working group whose membership was drawn from the health sector monitoring and evaluation unit, planning unit, Health information system unit, and partners for their dedication and tireless effort in the development and completion of this Monitoring and Evaluation framework. The team comprised of the following officers: Dr. Isabel Maina, Pepela Wanjala, Dr Hellen Kiarie, Dr Ruth Kitetu, Dr Grace Ikahu, Dr David Soti, Dr Humphrey Karamagi, Dr Martin Osumba, Hillary Kipruto, Rose Nzyoka, Dr Salome Ngata, Maria Kamau, and Tom Mirasi. The work done by this team is especially commended.

We also offer thank to the Heads of Directorates, Divisions and programs, parastatals, NGOs, development partners that provided input that was vital to the completion of this framework. In particular the Ministry is indebted to World Health Organization, USAID-AfyaInfo for offering technical and financial support in development of this framework

The Ministry would like to thank all those whose names may have been inadvertently left out but who were either consulted during the development of the health sector monitoring and evaluation framework and who in one way or another contributed to this process. We wish to state that without their contributions this work would not have been possible. We are greatly indebted to them.

Dr Khadijah Kassachoon

PRINCIPALSECRETARY

EXECUTIVE SUMMARY

The constitution of Kenya 2010, establishes monitoring and evaluation as an important component in operationalizing activities to ensure transparency, integrity, access to information, and accountability principles embraced at all levels of service delivery to the citizens. Strategic and operational information is critical for effective collaboration of the two tiers of government. This framework therefore aims at providing the common platform for the health sector performance monitoring and evaluation by guiding all actors at both national and county levels. A robust monitoring and evaluation system will ensure efficient and effective implementation of planned activities outlined in the Kenya Health Sector Strategic and Investment plan. To ensure that the health sector commitments towards attainment of vision 2030 goals, establishment of a robust health information system with the ability to support performance monitoring of health programmes and to track progressive improvement in health is critical.

The prevailing absence of a unified approach to monitoring programmatic and sector performance has created duplication of effort, inefficiencies, loss of information, weak capacity in the analysis of health sector performance and implementation of a comprehensive M&E plan. This has also aggravated to a weak culture of data demand and use of information for decision-making. This M&E framework therefore provides for a harmonized and robust monitoring and performance measurement to ensure adequate good information is readily available for decision-making to improve the health outcomes in the health sector and provides for counties to domesticate it at operational level.

The framework promotes a one functional sector wide monitoring and evaluation system for improved decision making, transparency and accountability. Alignment of the fragmented programmatic M&E approaches to a single health sector M&E system; align all state and non-state and external actors towards one M&E system; build capacity of stakeholders monitor and report progress in KHSSP implementation; align M&E within the health sector with the overall government M&E, the regional and international monitoring and reporting requirements, and other non-sector-specific information needs and Promote integration of health information systems. This Monitoring and Evaluation (M&E) strategic document provides a framework for the health sector to fully realize one M&E system to improve efficiency, transparency and accountability of the health interventions. The framework has outlined the importance of documentation and reporting performance of the health system; to keep institutional memory; improve transparency and ownership; guide implementation; strengthen coordination and collaboration among the different stakeholders and standardization of information shared within and outside borders of Kenya.

The framework and guidelines tends to ensure provision of strategic health sector information to all for evidence-based decision making. It also provides a framework for enhanced M&E at the national and subnational (i.e. county, subcounty) and institutional/facility levels and community levels. The framework has clearly outlined the various legal provisions and requirements in particular, the constitution of Kenya 2010, the Public finance management Act 2012, the County Government Act 2012, Kenya Health Bill 2012, the Kenya Health Policy 2014- 2030, Intergovernmental Relations Act 2012, KHSSP 2013- 2017 and Health Information Policy documents that have described the health information systems, management of health information in the health sector and reporting requirements.

The Health Sector M&E Framework and guidelines presented in this document enables the sector to track and report on progress toward the MDGs, health sector coverage outcomes and investment areas using impact indicators, Outcome indicators, process indicators and input indicators. The document has also outlined the various outcome and output targets for instance reduce, by at least half, the infant, neonatal and maternal deaths; reduce, by at least 25%, the time persons spend in ill health; improve, by at least 50%, the levels of client satisfaction with services; and reduce, by 30%, the catastrophic health expenditures as the primary health sector targets to be achieved through the health sector medium plan 2013- 2017.

To facilitate knowledge translation and use of appropriate evidence, the framework has also outlined the measures to be taken to achieve this by having a regular performance monitoring; use of appropriate indicators as define in health sector indictor and standard operational manual; a strong institutional anchorage, with clearly defined roles and responsibilities of all actors; use of the Key performance indicators (KPIs) and balance score card as an accountability measure to the commitments made to attain the highest standards of healthcare accessible by all; sufficient financial resources to support implementation and monitoring; and a strong workforce with adequate technical competencies in M &E and information management at various levels of the health system.

The document has provided for a conceptual framework and outlines what to be reported and measured across the six objectives and eight investment areas. The framework also states the various performance targets and source of the information to be collected. The result framework and how to generate the indices has been highlighted with guidelines on how this is to be achieved. The framework has also outlined the key responsibilities of the various units under which the M&E functions fall at National and County levels. An elaborate data collection, tools

and techniques to be used in the data management, sources of the various data and information with reporting responsibilities have been stated. A clear road-map of how and when the various evaluations will be carried the key health actors and M&E functions across all levels of health care.

Finally this framework has provided for a partnership and coordination structure as expressed in the Kenya health policy 2014 -2030 and the KHSSP. The total guestmet budget cost for implementation of this M&E framework/plan is Kenya Shillings (Kshs) KHS1,615 302,690 at national level and all the 47 counties are expected to develop domesticated M&E plans well costed to support their implementation of the County Health strategic and investment plans 2013-2017. Various Annexes have been provided for in this document for detailed informationon all core set of KHSSP indicators and assigned to reporting commitments. Moreover, the key step by step standard operating procedures (SOPs) on data management and knowledge translation are highlighted.

In summary Chapter 1: gives basically the introduction; Chapter 2: Outlines the goals and objectives of this health sector framework; Chapter 3: elaborates on how operationalization of the health sector M&E stewardship goals are to be achieved and measured; Chapter 4: specifically introduces the KHSSP monitoring and evaluation implementation framework and finally Chapter 5: overally shows the organizational requirements for a robust M&E framework and the annexes in details.

1 INTRODUCTION

1.1 Background

This document should accompany the Ministry of Health's Transforming Health: Accelerating Attainment of Universal Health Coverage: Kenya Health Sector Strategic and Investment Plan (KHSSP), July 2014 – June 2018. The health sector has taken a deliberate step to formulate a monitoring and evaluation (M&E) framework for the KHSSP, as explained in Chapter 8 of the KHSSP. The development of a robust M&E framework was informed by the recommendations from mid-term and end-term evaluation of the National Health Sector Strategic Plan II (NHSSP II), which stated that the lack of a clear framework for performance monitoring of the sector strategic plan contributed to the plan's mixed implementation results. This document provides the details and guidelines required to operationalize the monitoring and evaluation framework for the health sector.

Several other important policy documents provide the foundation for a comprehensive M&E framework for Kenya's health system. In relation to Kenya's development more broadly, still other documents note the need for improved performance monitoring. For example, the Constitution of Kenya 2010 provides for fundamental rights to health and a devolved arrangement of governance. Separation of functions between the National and County Government for various sectors, including health, has been defined. In addition, the constitution establishes monitoring and evaluation as important in operationalizing activities to ensure that transparency, integrity, access to information, and accountability principles are embraced at all levels of government. Strategic and operational information will be critical for effective collaboration of the two tiers of government. This framework and these guidelines are aimed at providing the common platform for health sector performance monitoring and evaluation that will guide all actors at both the national and county level.

Further, within the context of Kenya Vision 20301, the country's economic blueprint, the health sector is identified as key. This blueprint identifies several flagship projects, including the establishment of a robust health information system with the ability to support performance

[1] Kenya Vision 2030: Government of the Republic of Kenya, Ministry of Planning and National Development and the National Economic and Social Council (NESC), Office of the President, 2007

monitoring of health programmes and to track progressive improvement in the health of the Kenya citizenry. In addition, the Second Medium-Term Plan (MTPII)2 of the Kenya Vision 2030 lays emphasis on a robust monitoring and evaluation system to ensure efficient and effective implementation of planned activities, as outlined in strategic plans.

1.2 Rationale: Why Are an M&E Framework and Guidelines Necessary?

The conceptual framework that informs the KHSSP strives to ensure that investments/inputs in health, accompanied with effective and efficient management, to translate to better health outcomes, equity in health, and financial risk protection for Kenyans. The KHSSP strategic plan also defines clear objectives, whose successful achievements will translate to the desired impact on the Kenyan population.

This M&E strategic document provides a framework for the health sector to fully realize one M&E system to improve efficiency, transparency and accountability. An M&E framework and guidelines are an important **management and governance tool** for the health sector for the following reasons:

- They document the performance of the health system, and so preserve institutional memory.
- They document consensus on what will be monitored and the process of doing so, thus improving transparency and ownership.
- They guide M&E implementation, strengthening coordination and standardization.
- They state how various levels of the health system measure achievements through the M&E system; this increases accountability in the sector.

The M&E framework and guidelines maintain a clear focus on the goals of the Kenya Health Policy and KHSSP, and aim to focus the attention of stakeholders and guide efforts towards the ultimate goal of the sector: *to attain the highest possible standard of health in a manner responsive to the needs of the population.*

By articulating how the health sector will manage M&E, the framework and guidelines aim to ensure the provision of strategic health sector information to make evidence-based decisions. Enhanced M&E will inform decisions at the national and subnational (county, subcounty) and institutional/facility levels. At the national level, the management and partnership structures that the KHSSP describes will use strategic information to improve management and service delivery.

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[2] [2] The Second Medium-Term Plan, 2013-2017 (MTPII)

Information generated and managed through M&E approaches will inform stakeholders in both the health sector and other health related sectors, including government, nongovernmental and external stakeholders. This important framework provides information in line with government procedures and partnership commitments. Such information will be required for resource allocation and funding distribution decisions within the health sector and to fulfill reporting obligations towards international commitments with entities such as the World Health Organization (WHO), the Eastern, Central and Southern Africa Health Community (ECSA-HC), Global fund and others.

1.3 Current Status of M&E in the Health Sector

Over the last decade, the health sector has made a concerted effort to improve its approach to monitoring and evaluation. The National Sector Strategic Plan II laid emphasis on a common monitoring and evaluation system for all players in the sector. Indeed, the sector saw some tremendous growth in M&E through the streamlining of data collection; and through defining data flow conduits, and generating sector reports and information-sharing among the different stakeholders.

However, the M&E system within the health sector still faces challenges: its activities are disjointed, with no coordination structures or framework. Numerous programme specific/disease-based M&E systems operate separately, not sharing data and information with each other. Most of these M&E systems satisfy the reporting needs of funding agencies and implementing partners, but seldom meet the information needs of the government and the health sector as a whole. Many large-scale data collection efforts (such as household or facility surveys) are conducted within the health sector to bridge the gap that should typically be filled by a robust routine health information systems.

The prevailing absence of a unified approach to monitoring programmatic and sector performance has created duplication of effort, inefficiencies, lagging capacity in the analysis of health sector performance and in implementing comprehensive M&E, and a weak culture of data demand and use of information for decision-making.
Here are some examples of steps that stakeholders have taken to improve the situation significantly:

- The Ministry of Health (MoH) developed a compendium of health sector indicators so that data collection will be done using common metrics across all levels of government, all programmes, and among different stakeholders in health.

- A number of technological advancements have been made:
  - Deployment of a Master Facility List, which is an active inventory of all health facilities with unique code and geographic coordinates
  - Deployment of District Health Information System 2 (DHIS2®), a web-based application for facility-based routine reporting of standard metrics
  - Strengthening of key information systems such as the Kenya Medical Supplies Authority (KEMSA) Enterprise Resource Planning System, the Human Resource Information System (HRIS), the Logistics Management Information System (LMIS), and Electronic Medical Records Systems.

1.4 Alignment of M&E Framework to Existing Laws and Policies

The Health Sector M&E Framework aligns with a number of existing laws and policies, as outlined below.

Constitution of Kenya 2010 – Article 43 subsection (a) states that every person has a right to the highest attainable standard of health, which includes the right to health care services including reproductive health. The Health Sector M&E Framework identifies this right as one of the key reasons why health services delivery needs to be monitored. In addition, the Constitution of Kenya 2010, Articles 10 and 201 emphasize the need for transparency, accountability, and public participation.

Health Bill (2012) – The Health Bill (2012) is an Act of Parliament to consolidate the law relating to health, regulate health care service provision and providers, establish national regulatory institutions, coordinate the interrelationship between the national and county health institutions, establish a coordinating agency of professionals within the health industry, and provide for attainment of the basic right to health. Article 16 (1) stipulates a national health system and M&E-related roles. These M&E-related roles include providing technical support on M&E for health services standards and delivery, formulating health performance indicators to measure and enhance equitable access to health services, undertaking medical audits on maternal and neonatal deaths to inform improvement of obstetric and neonatal care, and monitoring the national health system for efficiency and standard performance.

The implementation plan of this framework also addresses and incorporates the following processes.

Article 28 (1) requires the Director General of Health to prepare quarterly and annual reports, which are submitted to the Cabinet Secretary, who in turn submits them to the National Assembly.

County Government Act (2012) – Article 47 of the Act requires the County Executive Committee to develop a performance management plan and a five-year county integrated plan. Progress on implementation of these plans would be documented in the annual county performance report, which the Governor is required to submit to the County Assembly. The County Health Management Team (CHMT) is expected to participate and give input in the development of the performance plan. Additionally, the CHMT will submit the county-level health sector performance to the County Executive Committee for incorporation in the annual county performance report, which is in turn submitted to the County Assembly for consideration. In addition, the Article emphasizes the need for public sharing of performance progress.

Intergovernmental Relations Act (2012) – Article 7 of this Act underscores the need for a national and a County Government Summit. The summit is intended to: evaluate the performance of the national or county governments and recommend actions; receive progress reports and provide advice as appropriate; and monitor the implementation of national and county development plans, recommending appropriate action. Article 9 spells out the frequency of meetings for the summit twice a year for the national and county governments. The CHMTs will submit the progress reports to the County Executive Committee twice a year as required.

The Public Finance Management Act, Article 166, points out that the accounting officer will prepare quarterly reports for the county government entity. In preparing a quarterly report for a county government entity, the accounting officer shall ensure that the report contains information on the financial and non-financial performance of the entity.

Additional Health Sector Policies – The Health Sector M&E Framework has been aligned to other existing health sector policies. These include:

i. *Kenya HSSP (2014/2018)* – The M&E framework is built around the structures of the M&E stewardship goals as specified in the KHSSP. Mechanisms for developing a common data architecture, enhancing data-sharing and use of information, and performance monitoring review are provided in this M&E Framework.

ii. *Kenya Health Policy (2014-2030)* – The M&E Framework is aligned to the impact indicators at the Health Policy's goal and objective levels. The M&E Framework shows the way existing data sources shall provide data for performance measurement at the impact level, and also illustrates how the implementation of the KHSSP will progressively achieve annual targets contributing to the ultimate Health Policy 2030 targets.

iii. *Health Information System Policy (2010-2030)* – The M&E Framework has adopted the existing Health Information System (HIS) tools and database (DHIS2), which are the MoH's routine aggregated reporting systems, to enhance harmonized data collection and analysis as stipulated in the policy.

International commitments – In addition, Kenya is committed to achieving international commitments such as the Millennium Development Goals (MDGs) by 2015. The MDGs directly relevant to the health sector are MDG 4: Child health; MDG 5: Maternal health; and MDG 6: HIV and AIDS. The health sector also bears indirect responsibility in the achievement of MDG 1: End poverty and hunger, MDG 3: Gender equality, and MDG 7: Environmental sustainability.

Annex A provides a detailed overview of the reporting linkages across these and other international obligations.

The Health Sector M&E Framework and guidelines presented in this document will enable the sector to track and report on progress toward the MDGs, measured by the impact of the sector's activities.

1.5 The KHSSP Conceptual Framework and Implications for M&E

1.5.1 KHSSP Conceptual Framework

The KHSSP Framework shows how various investment inputs and processes are expected to result in better access to services and improved quality in service delivery. These outputs should contribute to improved health outcomes in the areas of communicable and non-communicable diseases, violence and injuries, essential health care and exposure to common risk factors. These outcomes, and strengthened inter-sectoral collaboration, are expected to translate to better overall health for Kenyans.

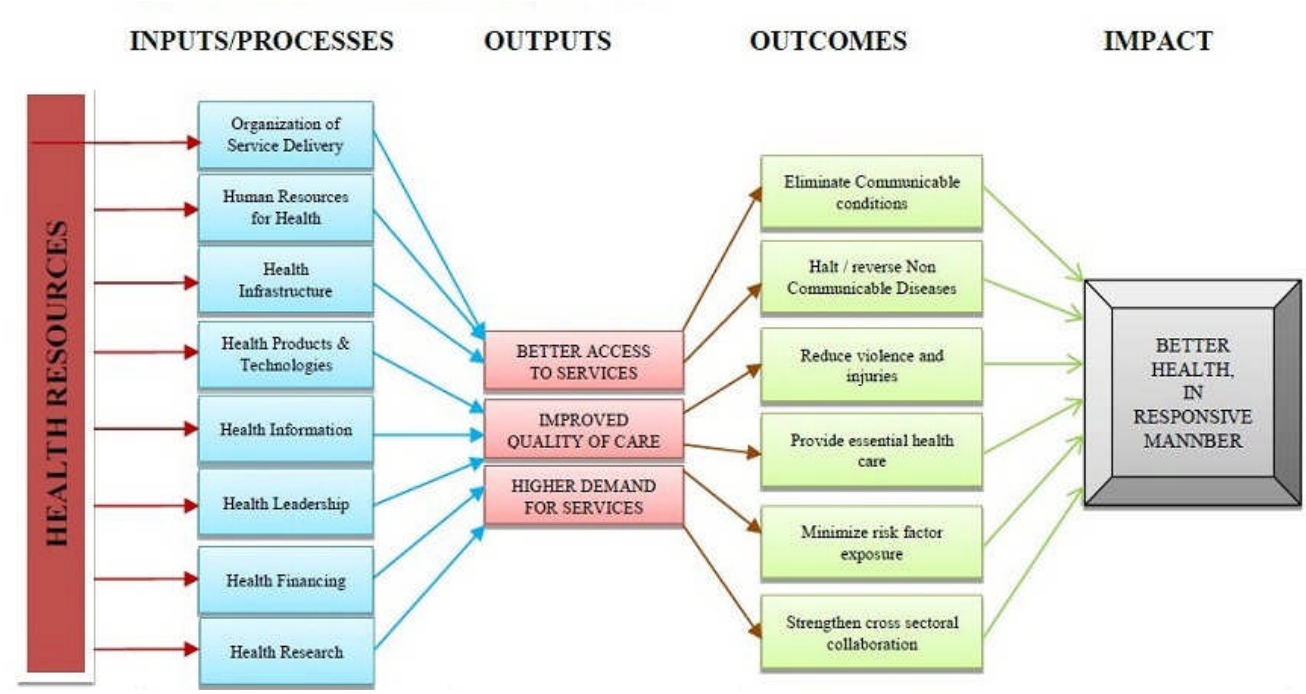


Figure 1: Planning Framework for Health

1.5.2 KHSSP Priority Targets, Outputs and Outcomes

The sector will focus on the following **impact priority targets** in an equitable and effective manner, to attain the sector goal.

1. Reduce, by at least half, the infant, neonatal and maternal deaths.
2. Reduce, by at least 25%, the time persons spend in ill health.
3. Improve, by at least 50%, the levels of client satisfaction with services.
4. Reduce, by 30%, the catastrophic health expenditures.

To attain these impact targets, the following service delivery outcomes will be prioritized:

- Eradication of polio, Guinea worm, and emerging/re-emerging health threats occurring during the KHSSP period. such as hemorrhagic fevers
- Elimination of malaria, mother-to-child HIV transmission, and neglected tropical conditions

- Containment of conditions causing major disease burden, with efforts focusing on the top 10 causes of morbidity/mortality
- Containment of the main risk factors to health, focusing on the top 10
- These service delivery outcomes will be attained through focusing on the following service outputs:
- Ensure 100% of Kenya Essential Package for Health (KEPH) services are being provided in special settings. These special settings in KHSSP are:
    - Congregate settings – prisons, internally displaced person camps, schools, refugee camps, army barracks
    - At-risk populations – health workers, carers, commercial sex workers
    - Hard-to-reach areas – northern Kenya, and informal settlements
- Improve access to KEPH to at least 90% by focusing on
    - Upgrading 40% of dispensaries to full primary care units
    - Operationalizing 100% of model health centres to make them fully functional primary care facilities
    - Putting in place a fully functional referral system in at least 80% of counties
    - Further reduction of the burden of pre-payment for health services
- Improve by 50% the quality of service delivery at all levels of the system, through innovative mechanisms such as performance-based financing and improved availability of health investments

1.5.3 KHSSP Implementation Priorities

These outputs will be attained through investing in the following priorities:

- Implement County Health System in all counties.
- Recruit additional 50,000 health workers, to ensure all functional facilities have minimum human resources according to defined staffing norms.
- Procure infrastructure and equipment for 2,000 dispensaries, 500 health centres, and 200 hospitals to build them up to required minimum norms.
- Establish demand-driven procurement system in all counties.
- Automate holistic Health Information System.
- Initiate and implement process of Universal Coverage attainment through Social Health Insurance.
- Establish mechanisms for collaboration with all health-related sectors.

1.5.4 KHSSP Implications for M&E

KHSSP is a strategic plan that is strongly focused on clearly defined results at the level of impact, outcomes and outputs, with clear linkages to priority investments. In order to achieve these results, managers and policy-makers will continuously be required to take the right decisions. This is only possible by creating a comprehensive knowledge management system, which ensures that information needs are clearly defined for the entire result chain, and information is regularly and competently analysed, used and disseminated. This requires:

- Regular performance monitoring
- The use of appropriate indicators
- A strong institutional anchorage, with clearly defined roles and responsibilities of all actors
- Sufficient financial resources; and
- A workforce with adequate technical competencies in M&E at various levels of the health system.

2 Overview of the Health Sector M&E Framework and Guidelines

This Health Sector M&E Framework aims to achieve the following:

2.1 Goals and Objectives of the Health Sector M&E Framework

2.1.1 Goal

One functional, sector-wide Monitoring and Evaluation system for improved decision-making, transparency and accountability in health

2.1.2 Objectives

Within the health sector, to:

- Align fragmented programmatic M&E approaches to a single health sector M&E system.
- Align all state and non-state and external actors towards one M&E system.
- Build capacity of stakeholders within the MoH, semi-autonomous government agencies (SAGA), CHMTs, and sub county health teams, and of non-state actors, to monitor and report progress in KHSSP implementation.
- Align M&E within the health sector with the overall government M&E, the regional and international monitoring and reporting requirements, and other non-sector-specific information needs.
- Promote integration of health information systems.
- Standardize M&E procedures at all levels of the health system.
- Increase ownership and partnership through collaboration and consensus- building.
- Enhance institutional memory through improved documentation.

2.1.3 Key Outputs

- An integrated health sector-wide M&E system that can provide timely information to all stakeholders.
    - Improved relations between M&E and research through integration of data sources.
    - Improved birth and death registration in the entire country.
    - A functional surveillance and response system.
    - Regular key health surveys whose findings would be used to make evidence-based decisions.
- Available standardized performance reports from various levels of the health system.

2.2 The Process of Developing the M&E Framework

The purpose of the Health Sector M&E Framework is to provide a foundation through which health sector actors can monitor the implementation of the health sector strategic plans at the national and county levels. The framework operationalizes the M&E elements of the KHSSP, and aligns with various other health sector policies (as outlined above). The M&E Framework was developed through a consultative process spearheaded by the Health Sector Monitoring and Evaluation Unit, and involved a wide range of stakeholders, including Ministry of Health staff at both national and county levels, implementing partners, development partners, technical experts and others.

2.3 Components of the Framework

The Health Sector M&E Framework describes in detail the methodology or processes for collecting and using data, including purpose/uses of the data collected, type of data to be collected (both qualitative and quantitative), and frequency of data collection. The M&E Framework aims to operationalize the M&E requirements of the KHSSP, including the processes and mechanisms through which the core KHSSP indicators will be monitored and reported. It also specifies, for the monitoring requirements of the KHSSP, additional details and specificity, such as:

- Data collection methods and approaches
- What tools will be used to collect data
- Key M&E roles and responsibilities; and
- The types of reports that will be prepared, including for whom, why and how often.

2.4 M&E Conceptual Framework

The M&E framework and guideline is grounded on the conceptual framework illustrated in Figure 2 below.

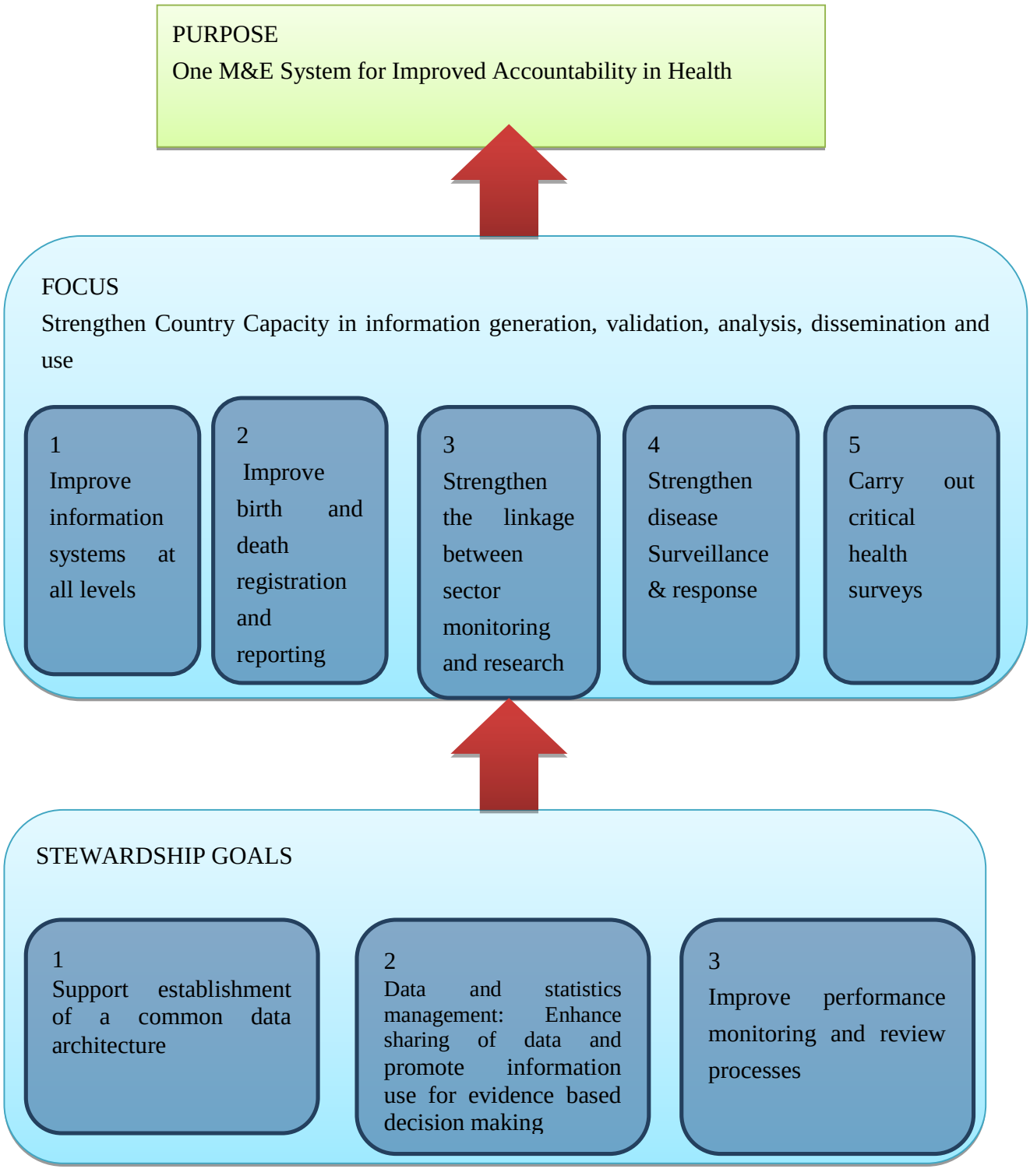


Figure 2: Scope of the Monitoring and Evaluation Framework

2.5 Purpose of an M&E Framework

The overall goal for documenting a health sector M&E framework and guideline is to steward the sector towards establishing one M&E system to be used at all levels by all actors. The aim is to improve transparency and accountability in health at all levels.

Achieving transparency will allow citizen participation in the organization and management of health service delivery. Investments in health at all levels should be applied and communicated in a language and format that common citizens can follow and understand so they appreciate the importance of these investments.

Achieving accountability means that the stewards of health remain faithful to the intent of the KHSSP carry out their duties efficiently and effectively, and document and communicate their decisions and activities in a language and format that the common citizens can follow.

2.6 The Focus of the M&E Framework

The focus in adoption and implementation of this M&E Framework by actors at all levels of the health sector is to strengthen the country's capacity in information generation, validation, analysis, dissemination and use.

Improve information systems at all levels: the health sector should strengthen all the key input information systems to be able to routinely capture coherent facility-level data. These systems include those for information about logistics and supplies management, human resources, financial management, and service delivery. Common data architecture should be used effectively across the systems to ensure and enhance data and information sharing.

*Improve birth and death registration and reporting: C*omprehensive documentation of the vital events of birth and death is needed to accurately determine population size (a key data element in a number of health indicators), disease burden, and the impact of interventions/programing in health. To acknowledge the dignity of human life, all births should be counted and registered and all deaths notified and recorded.

Strengthen linkage between sector monitoring and research: The relationship between health sector performance M&E and research should be cyclical, with one feeding the other routinely. Health sector M&E should continuously generate research questions (on

operations and policy), and research should continuously identify possible solutions and/or interventions to problems identified through M&E.

Under this M&E Framework the health sector will define the research agenda to inform the priority operational, strategic and policy questions that need to be answered with respect to efficiency, effectiveness, equity, quality improvement, financial risk protection, etc. A collaborative relationship with research institutions will be essential.

Strengthen surveillance and response: Not all phenomena in health system performance should be measured by routine data collection or surveys. The health sector should strengthen its capacity to exploit other surveillance methods, in both disease surveillance and demographic surveillance.

Carry out critical health surveys: The health sector should build its capacity to carry out critical health surveys that answer predetermined questions, for use at both the strategic and operational levels.

2.7 Stewardship Goals Defined through the M&E Framework

Monitoring and evaluation is a management function. Success in establishing an M&E system hinges on the stewardship role that health managers play at all levels of the health sector. The M&E Framework defines the key stewardship goals that health managers should strive towards, as outlined below.

2.7.1 Support Establishment of a Common Data Architecture.

Common data architecture is a prerequisite for achieving a single M&E framework for the health sector. Data architecture in this text refers to use of standard nomenclature for services, medicines and medical supplies, cadres of staff, etc. It also refers to use of standard coding systems shared across all databases. It includes use of defined standards for exchange of patient- and aggregate-level data across information systems. The framework appreciates the fact that adoption and consistent application of standards is a management function. It calls for strong leadership at all the management levels and thus is flagged in this conceptual framework as a key domain of the stewardship goals.

2.7.2 Enhance Data and Statistics Management, Sharing of Data, and Use of Information for Evidence-Based Decision-Making

It is recognized that lack of sharing, and inaccessibility, of health and health-related data and statistical information is a driver of emerging parallel information systems, leading to duplication and the inefficiencies witnessed in the monitoring and evaluation of the sector's performance.
This conceptual framework identifies data- and information-sharing as a key domain of the stewardship goals. It is aimed at sensitizing health managers, at all levels, about the oversight responsibility they have for data management, the ultimate objective being to ensure high-quality data, managed in a manner that informs both operational and strategic directions. The M&E framework articulates the reporting obligations at all levels, across departments and agencies, and across the two tiers of government. Information is important only if it is made available to the entities that need it to make decisions.

Data sources, data collection tools, and responsibilities for collection need to be identified and documented. Data validation procedures and data quality assurance need to be enhanced to ensure that data is not just timely but also accurate, complete and reliable. Data use increases with increased data quality, and vice versa.

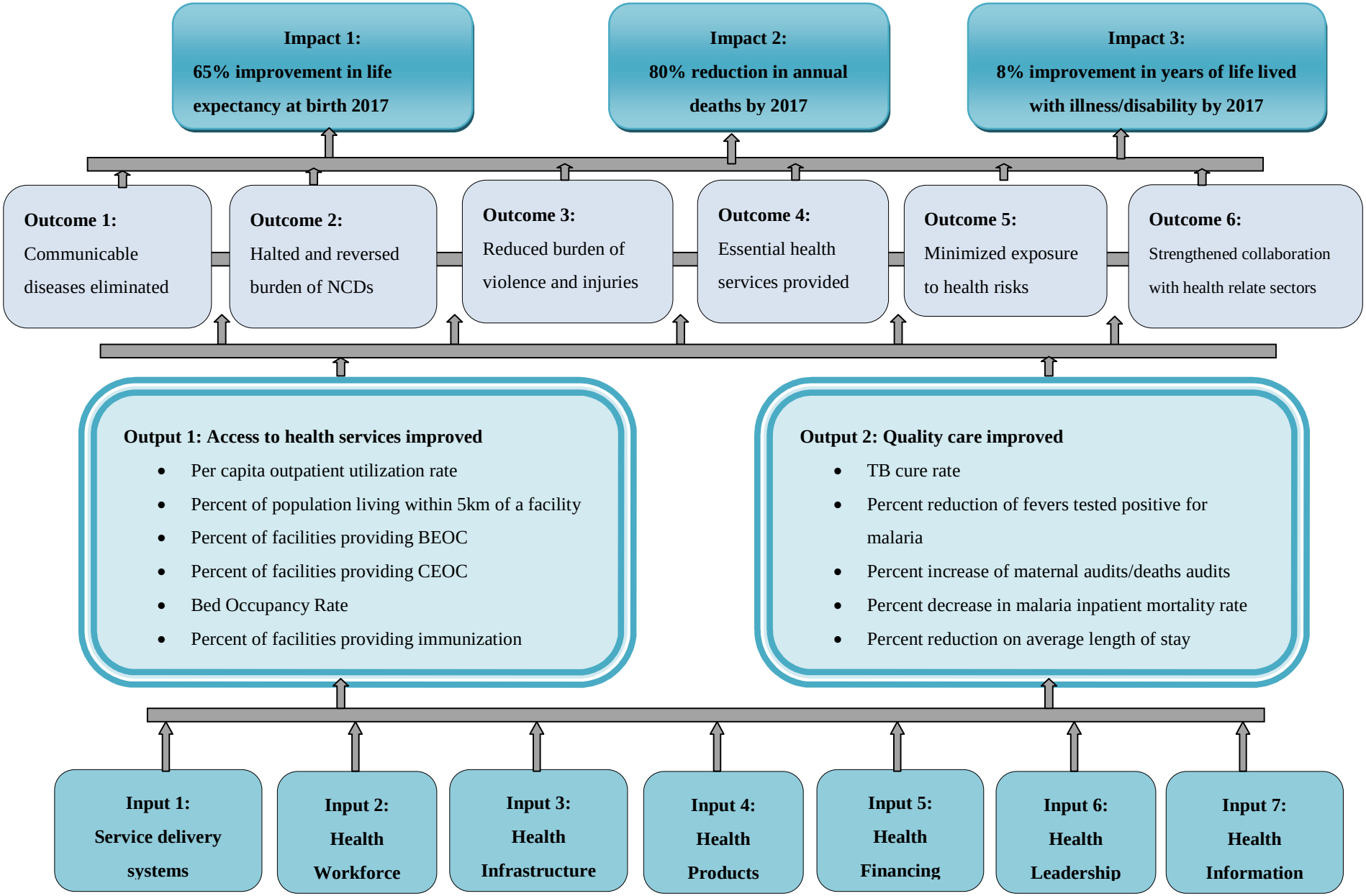
2.7.3 Improve Performance Monitoring and Review Process

Data management is not an end to itself. This framework emphasizes the use of data and information for local action.

2.8 What Is Measured through the Health Sector M&E Framework?

As indicated above, the Health Sector M&E Framework aligns with existing health policies and sector plans. The underlying architecture of the M&E Framework is driven by the KHSSP Results Framework (see Figure 3 below). This results framework provides the basic structure of the health sector M&E approach, and all metrics included in the health sector M&E Framework are intended to feed into this structure.

Figure 3: KHSSP Performance Results Framework



KHSSP has structured its objectives along a rational pathway, from inputs to processes, outputs, outcome and impact as indicated in Figure 4 below, the World Health Organization (WHO) joint framework for health system strengthening.

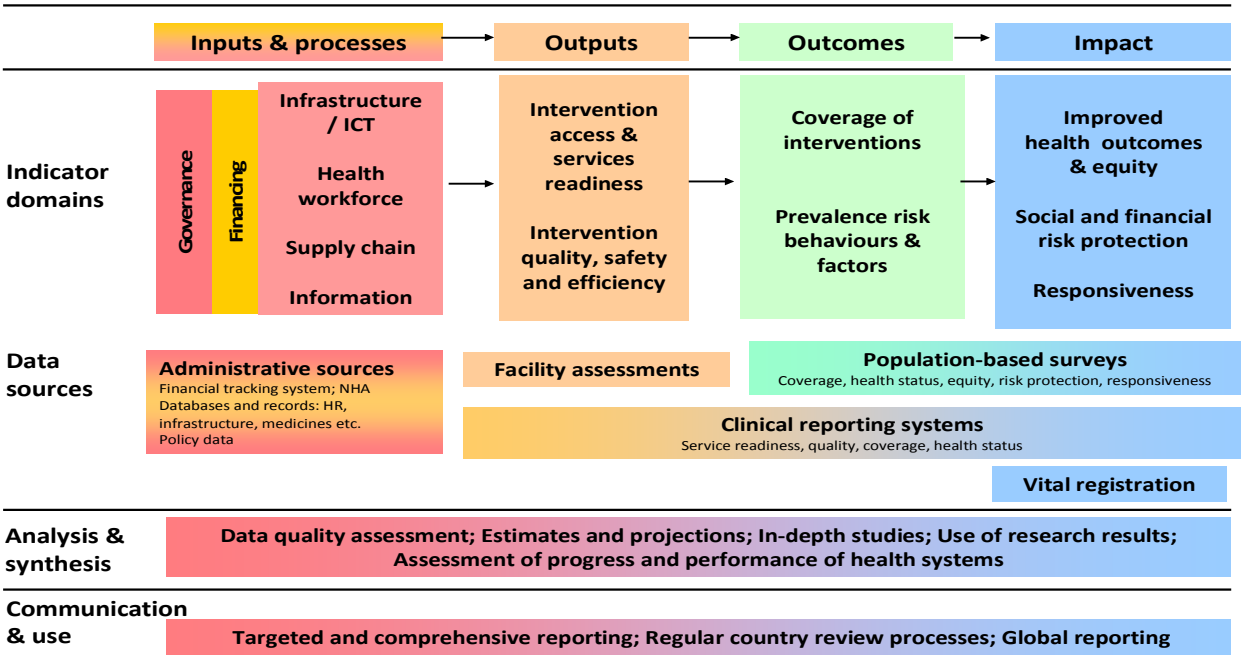


Figure 4: Monitoring and Evaluation of Health Systems Reform/Strengthening[3]

2.9 Health Sector Indicators

The KHSSP results framework has been populated with selected performance indicators and targets that the sector will monitor on a regular basis to assess progress. (See Table 1 below)

2.9.1 Core Sector Indicators and Indices

The selected core health sector indicators meet the following characteristics:

- Each indicator contributes to measuring an element of the results chain (input, process, output, outcome and impact); together, all results levels are covered, across health system

[3] Monitoring and evaluation of health systems strengthening; an operational framework, WHO, Geneva, November 2009

domains (e.g., the domains of health finance, workforce, health infrastructure, health products and technology).

- The indicator list reflects all lifecycle cohorts.
- The indicators align to existing health sector monitoring commitments.

The core indicators, collectively, provide information on overall health sector progress. In order to emphasize this point, the sector will use these indicators to calculate indices that reflect progress on specific strategic objectives, as well as an overall Health Sector Service Index.

The Core Sector Indicators will be used to report and communicate sector results to higher management, government, and partnership structures, including for inter-ministerial performance assessments. They will always act as an entry point for further discussions to inform decisions.

Table 1 lists the Health Sector Core Indicators (KHSSP), as well as the indicators currently required for Kenya to meet its international reporting requirements.

Table 1: Health Sector Core Indicators (KHSSP)

Policy Objective	Indicator	Targeted trends			Source
		Baseline (2012)	Mid-Term (2015)	Target (2017)	
IMPACT					
Improve health outcomes	Life expectancy at birth	52	56	65	KNBS
	Total annual number of deaths (per 100,000 population)	106	95	80	
	Maternal deaths per 100,000 live births	400	300	150	KNBS
	Neonatal deaths per 1,000 live births	31	25	15	KNBS
	Under-five deaths per 1,000	74	50	35	KNBS
	Youth and adolescent deaths per 1,000	45	30	20	CRD
	Adult deaths per 1,000	30	20	10	CRD
	Elderly deaths per 1,000	80	80	80	CRD
	Years of life lived with illness/disability	12	10	8	WHO
Distribution of health	% range of Health Services Outcome Index	45	30	20	HIS
Services responsiveness	Client satisfaction index	65	78	85	Policy and planning
HEALTH & RELATED SERVICE OUTCOME TARGETS					
Eliminate communicable conditions	% Fully immunized children	79	90	90	HIS
	% of target population receiving Multi-Drug Administration (MDA) for schistosomiasis	50	95	95	HIS
	% of TB patients completing treatment	85	90	90	HIS

Policy Objective	Indicator	Targeted trends			Source
		Baseline (2012)	Mid-Term (2015)	Target (2017)	
	% HIV+ pregnant mothers receiving preventive antiretrovirals (ARVs)	63	90	90	HIS
	% of eligible HIV clients on ARVs	60	90	90	HIS
	% of targeted children under one year old provided with long-lasting insecticide-treated nets (LLITNs)	44	85	85	HIS
	% of targeted pregnant women provided with LLITNs	30	70	85	HIS
	% of children under five treated for diarrhoea	40	10	5	HIS
	% school age children dewormed	49	85	90	HIS
Halt and reverse the rising burden of non-communicable conditions	% of adult population with Body Mass Index (BMI) over 25	50	40	35	KNBS/HIS
	% women of reproductive age screened for cervical cancers	50	70	75	HIS
	% of new outpatients with mental health conditions	<1	2	1	HIS
	% of new outpatients cases with high blood pressure	1	5	3	KNBS/HIS
	% of patients admitted with cancer	1	2	2	HIS
Reduce the burden of violence and injuries	% new outpatient cases attributed to gender-based violence	<1	3	2	HIS
	% new outpatient cases attributed to road traffic Injuries	4	2	2	HIS
	% new outpatient cases attributed to other injuries	<1	0.5	0.5	HIS
	% of deaths due to injuries	10	5	3	HIS

Policy Objective	Indicator	Targeted trends			Source
		Baseline (2012)	Mid-Term (2015)	Target (2017)	
Provide essential health services	% deliveries conducted with skilled attendant	44	60	65	HIS/KNBS
	% of women of reproductive age receiving family planning	45	80	80	HIS
	% of facility based maternal deaths	400	100	100	HIS
	% of facility-based under-five deaths	60	20	15	HIS
	% of newborns with low birth weight	10	6	5	HIS
	% of facility-based fresh stillbirths	30	10	5	HIS
	Surgical rate for cold cases	0.40	0.85	0.90	HIS
	% of pregnant women attending four antenatal care visits	36	80	80	HIS
Minimize exposure to health risk factors	% population who smoke	18			KNBS
	% population consuming alcohol regularly	35			KNBS
	% infants under six months on exclusive breastfeeding	32			KNBS
	% of population aware of risk factors to health	30			KNBS
	% of salt brands adequately iodized	85			KEBS
Strengthen collaboration with health-related sectors	% population with access to safe water	60		85	KNBS
	% children under five stunted	35		15	KNBS/HIS
	% children under five underweight	17		5	KNBS/HIS
	School enrolment rate	60	80	80	MoE
	% of households with latrines	34		70	KNBS
	% of houses with adequate ventilation	65		80	KNBS

Policy Objective	Indicator	Targeted trends			Source
		Baseline (2012)	Mid-Term (2015)	Target (2017)	
	% of classified road network in good condition	30		50	MoT
	% schools providing complete school health package	15		50	MoE/HIS
HEALTH INVESTMENT OUTPUT					
Improving access to services	Per capita outpatient utilization rate	2	3	4	HIS
	% of population living within 5km of a facility	80	90	90	KNBS
	% of facilities providing Basic Emergency Obstetric Care (BEOC)	65	80	90	HIS/NCPD
	% of facilities providing Comprehensive Emergency Obstetric Care(CEOC)				HIS/NCPD
	Bed Occupancy Rate	85	95	95	HIS
	% of facilities providing immunization	80	100	100	HIS
Improving quality of care	TB cure rate	83	88	90	HIS
	% of fevers tested positive for malaria	45		20	HIS
	% maternal audits/deaths audits	10	70	85	HIS
	Malaria inpatient case fatality	15	8	5	HIS
	Average length of stay	5.6	4.5	4	HIS
HEALTH INPUT AND PROCESS INVESTMENT					
Service delivery systems	% of functional community units	20	30	45	HIS
	% outbreaks investigated within 48 hours	90	100	100	IDSR
	% of hospitals offering emergency trauma services	35	65	80	HIS
	% hospitals offering Caesarean services	45	85	95	HIS

Policy Objective	Indicator	Targeted trends			Source
		Baseline (2012)	Mid-Term (2015)	Target (2017)	
	% of referred clients reaching referral unit		70	85	HIS
Health workforce	# of nurses per 10,000 population	5	7	7	HIS
	% staff who have undergone continuous professional development (CPD)	40	65	70	HIS
	Staff attrition rate	10	5	2	HIS
	% public health expenditure (government and donor) on human resources	55	45	40	HIS
	% of facilities equipped as per norms	25	60	70	HIS
	# of hospital beds per 10,000 population	50	150	150	HIS
	% public health expenditures (government and donor) spent on Infrastructure	30	25	25	HIS
Health products	% of time out of stock for Essential Medicines and Medical Supplies – days per month	8	2	2	HIS
	% public health expenditures (government and donor) spent on health products	10	15	15	HIS/NHA
Health financing	General government expenditure on health as % of the total government expenditure	4.5	8	12	NHA/PETS
	Total health expenditure as a percentage of GDP	1.5	2	2.5	NHA/PETS
	Off-budget resources for health as % of total public sector resources	60	25	5	NHA/PETS
	% of health expenditure reaching the end users	65	80	80	NHA/PETS

Policy Objective	Indicator	Targeted trends			Source
		Baseline (2012)	Mid-Term (2015)	Target (2017)	
	% of total health expenditure from out of pocket	33	25	15	NHA/PETS
Health leadership	% of health facilities inspected annually	15	80	85	All regulatory bodies and councils
	% of health facilities with functional committees	70	100	100	HIS
	% of counties with functional County Health Management Teams	0	100	100	HIS
	% of health sector steering committee meetings held at national level	50	100	100	HIS
	% of county interagency forum meetings held at county level	0	100	100	HIS
	% of facilities supervised	40	100	100	HIS
	% of facilities with functional anti-corruption committees	0	80	100	
	% of policies/documents using evidence as per guidelines	30	100	100	Unit R&D
	% of planning units submitting complete plans	65	95	95	Unit P&SP
	# of health research publications shared with decision-makers	3	20	20	Unit R&D
	% of planning units with performance contracts	70	100	100	HIS
	% of county planning units with performance contracts				

Policy Objective	Indicator	Targeted trends			Source
		Baseline (2012)	Mid-Term (2015)	Target (2017)	
Health information	# of sector quarterly reports produced and disseminated.	50	100	100	HIS
	% of planning units submitting timely, complete and accurate information	25	70	85	HIS
	% of facilities submitting timely, complete and accurate information	25	70	85	HIS
	% public health expenditures (gov't. and donor) spent on health information	3	5	5	HIS
	% public health expenditures (gov't. and donor) spent on health information	3	5	5	HIS

The ***2nd Edition Health Sector Indicator Manual*** has been prepared for all core sector indicators. This manual includes

(1) A description of how each indicator maps to a specific KHSSP objective;

(2) HIS, WHO and MDG codes;

(3) The usefulness of the indicator for management purposes;

(4) A description of the indicator, including a precise definition and (type of) facilities included/excluded;

(5) The method of calculation (e.g., numerator and denominator); variables and levels for disaggregation;

(6) The data collection method (sources, timing, frequency and responsible organization/individual);

(7) Annual targets, as appropriate.

The manual fully describes the core health sector indicators and the health service index indicators, including details of their method of collection and aggregation. The indicator manual complements the health sector M&E framework and guidelines.

2.9.2 Programme and Other Indicators

In addition to the KHSSP core indicators and indicators required to meet international reporting requirements, the health sector will continue to support and use Programme Indicators that specific programmes require to track and report progress, for both internal and external use. These indicators will be used for monitoring and evaluation of specific subsector strategic plans, but not for overall sector-wide quarterly and annual performance monitoring, nor as part of the KHSSP mid- and end-term reviews.

All programme-specific indicator sets (HIV/AIDS, malaria, tuberculosis, Sexual and Reproductive Health Rights (SRHR), child health, etc.) will be developed in alignment with the health sector M&E framework and guidelines, which will remain the guiding structure for all health sector M&E, as an important step in moving towards a standardized national M&E framework.

The health sector programmes and subnational units can collect additional indicators, as they deem necessary, in addition to the required core indicators. They will be used in addition to the core indicators for overall performance monitoring within the health sector, quarterly and annually as part of the Annual Health Sector Performance Report AHSPR, and as part of the KHSSP mid- and end-term reviews.

All programme-specific indicator frameworks (HIV/AIDS, malaria, tuberculosis, SRHR, child health, etc.) will be adapted in line with this health sector M&E framework and guidelines as an important step in moving towards a standardized national M&E framework.

2.9.3 Indices for Sector-wide Performance

The KHSSP includes the use of an overall Health Index and a number of indices, each summarizing the indicators selected to measure progress in achieving one of the six strategic objectives. The trends in these indices over the years will serve as a proxy for overall achievement of the strategic objectives. The Health Index includes all core indicators.

The average achievement in terms of coverage for health services indicators chosen is captured in a **Health Services Coverage Index**. This provides, in a broad manner, information on whether the health service coverages are improving for the priority interventions of the KHSSP. The trends in this Index over the years will serve as a proxy for overall coverage trends in health services. In line with the need to attain universal coverage with health services, the sector will work towards attaining 80% achievement, by 2017, for the index and for all the health service coverage indicators selected.

As the aim is to assess coverage for the services with the greatest health impact, the index is composed of all core health service coverage indicators.

The method of calculating the indices is outlined below.

2.9.3.1 Method to Calculate Indices

The health service index is expected to measure the performance of the health sector as demonstrated by the indicator values for the health policy and strategic plan objectives for the reporting period. The index is expected to be 100%. Each policy objective will contribute equally to the index, and hence each will carry equal weight. The idea is to ensure that each indicator under each policy objective is treated as important, rather than concentrating on performing on selected indicators. Hence, with the index, the sector lays emphasis on all indicators, and all policy objectives hence become equally important. The baselines used will be the baselines for KHSSP III, unless a county has more-recent baselines, perhaps based on an assessment or survey. This index can be calculated at both the county and national level.

The Table below (Table 2) is for illustration of how to calculate the health service index. To calculate column C (relative weight): divide the value in column B by the value in column A.

Multiply the result by 100. Subtract 100 from the resulting value to get the relative weight, then sum all the values in column C to form the health service index:
C= (B/A*100)-100.

Table 2: Health Service Index

Policy Objective	Indicator	Baseline (Year) (A)	Achievement (B)	Relative weight (%) (C)	Comment
HEALTH & RELATED SERVICE OUTCOME TARGETS					
Eliminate communicable conditions	% fully immunized children	79			
	% of target population receiving MDA for schistosomiasis	50			
	% of TB patients completing treatment	85			
	% HIV+ pregnant women receiving preventive ARVs	63			
	% of eligible HIV clients on ARVs	60			
	% of targeted children under one year old provided with LLITNs	44			
	% of targeted pregnant women provided with LLITNs	30			
	% of children under five treated for diarrhoea	40			
	% school-age children dewormed	49			
Cluster weight					
Halt, and reverse, the rising burden	% of adult population with BMI over 25	50			

Policy Objective	Indicator	Baseline (Year) (A)	Achievement (B)	Relative weight (%) (C)	Comment
of non-communicable conditions	% women of reproductive age screened for cervical cancers	50			
	% of new outpatients with mental health conditions	<1			
	% of new outpatients with high blood pressure	1			
	% of patients admitted with cancer	1			
Reduce the burden of violence and injuries	% new outpatient cases attributed to gender-based violence	<1			
	% new outpatient cases attributed to road traffic injuries	4			
	% new outpatient cases attributed to other injuries	<1			
	% of deaths due to injuries	10			
Provide essential health services	% deliveries conducted by skilled attendant	44			
	% of women of reproductive age receiving family planning	45			
	% of facility-based maternal deaths	400			
	% of facility-based	60			

Policy Objective	Indicator	Baseline (Year) (A)	Achievement (B)	Relative weight (%) (C)	Comment
	under-five deaths				
	% of newborns with low birth weight	10			
	% of facility-based fresh stillbirths	30			
	Surgical rate for cold cases	0.40			
	% of pregnant women attending four antenatal care visits	36			
Minimize exposure to health risk factors	% population who smoke	18			
	% population consuming alcohol regularly	35			
	% infants under six months on exclusive breastfeeding	32			
	% of population aware of risk factors to health	30			
	% of salt brands adequately iodized	85			
	Couple year protection due to condom use				
Strengthen collaboration with health-related sectors	% population with access to safe water	60			
	% children under five stunted	35			
	% children under five underweight	17			
	School enrollment rate	60			

Policy Objective	Indicator	Baseline (Year) (A)	Achievement (B)	Relative weight (%) (C)	Comment
	% of households with latrines	34			
	% of houses with adequate ventilation	65			
	% of classified road networks in good condition	30			
	% schools providing complete school health package	15			
Health service coverage Index					

The same formula that is described above is used to calculate the other two coverage indices below.

2.9.3.2 Interpretation of Health Service Coverage Indices

The health service index for the county will be compared with national median values. If the county health index is positive, i.e., higher than the national average health index value, the county's performance will be interpreted as positive (green). If the county's health index is negative, i.e., less than the national average health service index, it will be interpreted as a negative performance (red). If the value is the same as (or close to) the national average health index, this will be interpreted as neutral (amber). This comparison can also be done for the sub county units for subsequent years, by comparing the average county health coverage index with the average achievements of the various sub county units, in this way introducing comparability among, for example, Tier 2, 3 or 4 facilities; SAGAs; etc. This approach will identify sub county units that are contributing to a decline in the health service index for close follow-up/support, as well as those contributing to an increase in the index for recognition/reward.

Table 3: Other Health Determinants Coverage Index

Indicator	Baseline(Year)	Indicator value	Relative weight (%)	Comment
% people within 1.5 km (rural) or 0.2 km (urban) of an improved water source				
% of households with a functional latrine				
% households with handwashing facilities with soap				
Indicator reflecting food security at household level				
Health determinants coverage index				

Table 4: Risk Factor Coverage Index

Indicator	Baseline	Indicator value	Relative weight (%)	Comment
% of infants exclusively breastfed by the age of six months				
Contraceptive Prevalence Rate				
% adults aged 15-49 years who did not have sex with a non-marital, non-cohabiting partner in the last 12 months (m/f)				
% children under five who slept under an ITN the previous night				
% of new outpatients (over 15) with Body Mass Index under 26				
% adults (over 15) not using tobacco products (m/f)				
% of caretakers (m/f) who				

Indicator	Baseline	Indicator value	Relative weight (%)	Comment
know how to manage acute diarrhoea at home				
% of population (m/f) aged 15-24 years with comprehensive correct knowledge of HIV/AIDS (m/f)				
Risk factors coverage Index				

The health service index will be interpreted at both the county and national level. The National Health Service index will collate all the available information from all reporting units and from surveys.

Sub analyses of the indicator information shall be carried out, to provide information on the impact of multi-dimensional poverty on actual coverage and on impact achievements. This shall enable better targeting of strategies to address the multi-dimensional poverty issues influencing the results being sought.

The different aspects of poverty and analysis to be carried out are shown in the table below.

Table 5: Poverty Dimensions

Poverty Dimension	Data disaggregation to be made
Income Poverty	Disaggregation of data by poverty index
Illiteracy	Disaggregation of data by literacy levels
Gender	Disaggregation of data by gender index
Poverty of Security	Regional analysis of data, to compare secure regions with less secure regions

The analysis can be carried out at both the county and national levels. For income poverty, coverage levels will be disaggregated by the poverty index. For the illiteracy dimension, the Kenya Demographic and Health Survey (KDHS) literacy index for the county will be used. In the absence of a reliable gender index, the literacy index will be used as a proxy for the disaggregation of achievements by gender.

Mortality and disease-specific morbidity data, client satisfaction, data on households with catastrophic payments, risk factors, and other health determinant indicators are collected every five years through surveys. Information on the variables income, literacy, gender and level of security (based on place of residence) can also be readily obtained during the surveys.
Survey data is not available for the health service coverage and output indicators, which are mainly obtained from the Health Management Information System (HMIS). For these indicators, it is not possible to link each indicator to the contextual factors. As a proxy, therefore, the sector will use county rankings for the different poverty dimensions to separate counties with high and low attainment of the respective index/level (see Table 6). The indicator achievements for the top quintile of counties will be compared with the achievements of the bottom quintile of counties to illustrate any differences. The impact, risk factors and health determinants indicators can, of course, also be disaggregated by counties with different income, literacy and gender indices/levels, but this information is less informative, as income, literacy and gender indices may vary widely within counties.

The counties in the top and bottom quintiles will be determined at the beginning of the KHSSP for income poverty, literacy, and gender index categories. This information will, as soon as available, be presented as shown in the following table.

Table 6: Sub counties for Which Service Coverages Will Be Compared for Poverty Impact

Income Poverty		Literacy Levels		Gender Index	
Top quintile sub counties	Bottom quintile sub county	Top quintile sub county	Bottom quintile sub counties	Top quintile sub counties	Bottom quintile sub counties

Equity Analysis

Equity considerations cover all indicator domains, from investments to impact, and are in the first place addressed by disaggregating data by sub county. However, the disaggregation of data by certain poverty dimensions (income, security) provides additional information for equity analyses.

3 Operationalization of the Health Sector M&E Stewardship Goals

3.1 Support Establishment of a Common Data Architecture

3.1.1 Developing a Unified HIS

The national M&E Unit will carry the mandate of establishing and overseeing the common data architecture to ensure coordinated information generation, sharing and management. The health sector has identified sector indicators for monitoring and evaluating the implementation of the KHSSP. The common data architecture will provide the data sources for these indicators, which have been defined in the 2nd edition of the health sector indicator manual. Table 1 above provides the baseline data, the mid- and end-term targets, and data sources for core indicators.
The two levels of government and all the stakeholders in health need to work together in order to achieve the stipulated targets. The M&E framework defines the responsibilities of each actor and stakeholder.

Information from different sources shall be brought together to inform the sector on overall performance trends. A composite of indicators shall be used to calculate the health service index. This index shall be used to compute and interpret trends, to show sector progress (or lack of it). It will summarize performance of the different priority areas of intervention, thus allowing an overall and fair judgment of progress of implementation of this strategic plan. The index is designed in line with the sector service package, the KEPH. The number of indicators in the index represents a balance between ensuring that no single indicator on its own has a significant impact on the overall index, and having a manageable number of service coverage indicators for monitoring progress.

The total number of indicators per policy objective is fixed. Where no data is available for an indicator, its value/achievement shall be reflected as zero.

3.1.2 Enhanced Data Sharing

There is need to put in place standards related to data collection, transmission, analysis, presentation, reporting, and utilization, and policy formulation. Data from various sources should be brought together to enable the MoH to assess trends in diseases, injuries, disabilities, health service access, and deaths. The figure below illustrates the proposed data architecture.

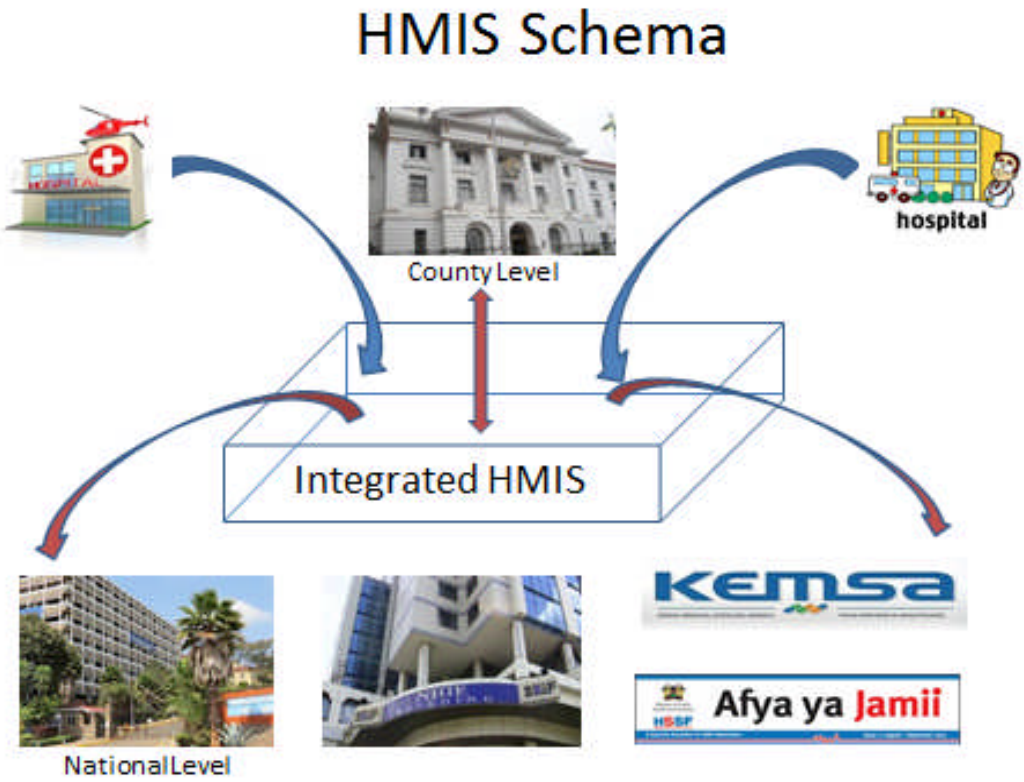


Figure 5: HMIS Schema

Establishment, maintenance and management of one functional, unified sector-wide M&E system, supporting both national and county governments, will:

- Use a single body of data to generate information products required by different constituencies.
- Promote standardization of procedures and practices and thereby ensure comparability between counties.
- Provide the national government with mechanisms for reporting on health national sector development, including addressing Kenya's obligations for international health reporting.
- Implementation will be guided by the 2010 Intergovernmental Relations Act.

HIS infrastructure in Kenya has to evolve from paper-based generation, transmission and storage to the new web-based system. The sector envisages use of a clouding platform to support its huge databases. Under centralized government, the sector invested, developed and deployed a common Sub county Health Information Software (the DHIS) to facilitate the flow and interaction of information from the sub counties and the central level for operational and policy decisions. Harmonization and alignment of HIS is ongoing, with a view to strengthening a single, efficient, unified system.

3.1.3 Technical HIS Responsibilities at National and County Levels

In order to make optimum use of the integrated HMIS, both the national and the county levels have to work together.

The following are the roles assigned to the national and county levels of government on HIS. Cooperation and collaboration, a key message in the devolution agenda, will be key in ensuring that the two levels of government are able to carry out their concurrent roles.

Table 7: HIS Responsibilities at National and County Levels

Role	National level	County level
Development of guidelines	• Determine categories or key health indicators for collection and submission. • Determine type and content of data for submission at various levels. • Identify those responsible for data management at all levels. • Develop the schedules and formats for data collection. • Develop national guidelines on data management tools. • Develop national guidance on population-based surveys and other health-related research. • Streamline reporting health information in the country.	• Comply with national government requirements on health information sharing by the two levels of government. • Adopt national reporting mechanisms and tools for county health information systems. • Apply national guidelines and tools on data management. • Legislate on establishment and maintenance of county health information systems. • Enforce mandatory reporting by county health care providers. • Apply relevant measures on confidentiality of data.
Development of legislation	• Establishment and maintenance of national health information system. • Mandatory reporting by all health care providers (private and Government). • Obligations of service providers to provide service-related information to	• Establishment and maintenance of county health information system. • Enforce reporting by all health care providers (private and public). • Obligations of service providers to provide service-related information to

Role	National level	County level
Development of guidelines	• Determine categories or key health indicators for collection and submission. • Determine type and content of data for submission at various levels. • Identify those responsible for data management at all levels. • Develop the schedules and formats for data collection. • Develop national guidelines on data management tools. • Develop national guidance on population-based surveys and other health-related research. • Streamline reporting health information in the country.	• Comply with national government requirements on health information sharing by the two levels of government. • Adopt national reporting mechanisms and tools for county health information systems. • Apply national guidelines and tools on data management. • Legislate on establishment and maintenance of county health information systems. • Enforce mandatory reporting by county health care providers. • Apply relevant measures on confidentiality of data.
	communities. • Patient's right to information and confidentiality of the same. • Health research.	communities. • Patient's right to information and confidentiality of the same.
Data management	• Develop and maintain a countrywide unified integrated Health Information System. • Analyze national health data for decision-making. • Publish and publicize annual reports on national health statistics pertaining to the health status of the nation, health services coverage, and use of services. • Establish a data validation mechanism (data quality audit).	• Establish and maintain county health information system as part of the integrated health information system. • Provide the Governor with all information required for the Governor to meet his or her reporting duties to the county assembly. • Analyze county data for decision-making. • Prepare quarterly county health report for discussion and ratification by the CG.

Role	National level	County level
Development of guidelines	• Determine categories or key health indicators for collection and submission. • Determine type and content of data for submission at various levels. • Identify those responsible for data management at all levels. • Develop the schedules and formats for data collection. • Develop national guidelines on data management tools. • Develop national guidance on population-based surveys and other health-related research. • Streamline reporting health information in the country.	• Comply with national government requirements on health information sharing by the two levels of government. • Adopt national reporting mechanisms and tools for county health information systems. • Apply national guidelines and tools on data management. • Legislate on establishment and maintenance of county health information systems. • Enforce mandatory reporting by county health care providers. • Apply relevant measures on confidentiality of data.
		• Apply data validation mechanisms for county health information.
Evidence generation for health	• Undertake national population-based surveys in collaboration with other institutions. • Promote all forms of research that can advance the interest of public health. • Set national research agenda and issue standards and guidelines. • Undertake health research. • Support the generation of data for vital statistics. • Establish and maintain a national disease surveillance system. • Institutionalize national system	• Facilitate the generation of data for vital statistics within the county. • Contribute county data to the national health observatory. • Implement and maintain a county disease surveillance system as part of the national disease surveillance system.

Role	National level	County level
Development of guidelines	• Determine categories or key health indicators for collection and submission. • Determine type and content of data for submission at various levels. • Identify those responsible for data management at all levels. • Develop the schedules and formats for data collection. • Develop national guidelines on data management tools. • Develop national guidance on population-based surveys and other health-related research. • Streamline reporting health information in the country.	• Comply with national government requirements on health information sharing by the two levels of government. • Adopt national reporting mechanisms and tools for county health information systems. • Apply national guidelines and tools on data management. • Legislate on establishment and maintenance of county health information systems. • Enforce mandatory reporting by county health care providers. • Apply relevant measures on confidentiality of data.
	of health accounts. • Prepare annual state of health report on progress made in fulfilling international obligations. • Conduct surveillance and report on disease outbreaks and public health events, and share this information with defined global surveillance systems. • Contribute county data to the national health observatory.	

3.2 Performance Monitoring and Review Processes

The sector recognizes that different actors use different data in their decision-making processes and investment decisions. For this reason, data need to be translated into information that is

relevant for different audiences at different levels for decision-making. Data will be packaged and disseminated in formats that are determined by the needs of these stakeholders.

In line with the Kenya 2010 Constitution's recognition of the need for transparency, an electronic web platform for learning and knowledge management will be established to support information sharing for both government and non-government actors, including the public. Public display of relevant information at the health facility, county and national level will also be used as a means of dissemination. The inter-agency joint stakeholder forums will be critical in information sharing. M&E units at the national and county level will coordinate the production and sharing of information products such as bulletins, pamphlets, policy briefs, newsletters and reports, among all relevant stakeholders at the two levels.

3.2.1 Scope of the Monitoring and Review Process

During KHSSP implementation, performance and progress will be monitored quarterly, annually, at mid- and end-term. Progress and performance monitoring will include *both quantitative and qualitative assessments*, and will include analyses on (1) progress towards achieving the KHSSP goals; (2) equity; (3) efficiency; (4) contextual factors (these will be qualitative analyses); and (5) benchmarks.

- Progress will be measured on the extent to which the KHSSP goals and objectives have been attained, using the KHSSP indicators, complemented with a brief analysis of what policies/strategies/programmes have been successful and what can explain the results seen in the area of inputs, processes and various result levels.
- Equity analyses will include analysis of differences in results between counties, based on the level of urbanization, arid/non-arid, secure/less secure, income level/human poverty index, secondary school enrolment rate and gender development index.
- Efficiency: this relates the level of attainment of the objectives to the inputs used to achieve them.
- Context: qualitative information on the leadership, policy environment and regulations is crucial to understand how well and by whom Government of Kenya policies are translated into practice and implemented.
- Benchmarking: this refers to comparisons in performance between and within various levels of service providers, based on a standard set of criteria. The results are often presented as league tables; the sector will, annually, prepare league tables for:
  - Counties—service delivery; CHMTs
  - Hospitals
  - Operational units within the MoH

Specific questions will need to be answered during the specific review processes.

3.2.2 Progress Review

The **Progress Reviews** will consist of two components: quarterly reports and annual reports.

3.2.2.1 Quarterly Reports

At all levels, performance review reports will be produced, outlining the performance against the strategic objectives. The reports will be discussed by the health management teams, including all the stakeholders, at the quarterly performance review meetings. The discussion will focus on a review of the findings and the agreed action points, and on progress against the improvement-tracking plan that will have been agreed on during the previous quarterly review meeting.

3.2.2.2 Annual Reports

a) County Annual Health Sector Performance Report

This is the annual report documenting progress against the implementation of the County Annual Work Plans (AWPs) for all planning units in the county, as well as against sector performance (indicators and targets) set in this strategic plan, and any additional county-specific indicators. It will include challenges encountered during the period under review, and key priorities for the coming year. The report will be developed by the county health stakeholders' forum through a consultative process, and will be presented at a County Annual Health Review forum and the county assembly.

b) National Annual Health Sector Performance Report

This is the annual report for the state department of health, documenting progress against the implementation of the AWP for all planning units at the national level and county level, as well as against sector performance targets set in the KHSSP. The report will be presented to national-level senior management for endorsement. It will also be disseminated to all stakeholders in health, including county health management teams, for feedback and buy-in. It will contribute to the annual report on the state of health in Kenya, and will be discussed at the national health congress.

c) Annual State of Health in Kenya Report

The health sector shall publish annually a state of health report produced by the M&E unit at the national level. This will be a comprehensive analytical report giving a snapshot of performance, covering the different strategic objectives articulated in this strategic plan and the overall state of health in Kenya. It will be informed by the county annual health sector reports, the national annual health sector report and other health-related

reports such as the KDHS, economic surveys, KHSP, etc. The report will also present efficiency and equity analysis considering various dimensions such as gender, poverty, literacy, regions, and residence. This report will be shared at an annual health congress before submission to the Ministry of Devolution and Planning for eventual presentation at summit.

A popular version of the health report will be developed in the form of a fact sheet including the key components of the annual state of health in Kenya report. The target audience for the popular version includes all health actors and members of the public.

NB: The sector shall use various communication channels such as radio, television, websites, e-bulletins, and newsletters, among other media, to disseminate the reports and information to the public and other stakeholders.

3.2.3 Performance Monitoring as a Decision-Making and Learning Tool

The performance review process will be one of the learning mechanisms in the sector. For proper follow-up and learning:

- All performance reviews and evaluations will contain specific, targeted and actionable recommendations.
- All target institutions will provide a response to the recommendation(s) within a stipulated timeframe, and outlining a) agreement or disagreement with said recommendation(s), b) proposed action(s) to address said recommendation(s), and c) a timeframe for implementation of said recommendation(s).
- All the planning units and institutions will be required to maintain a recommendation implementation-tracking plan, which will keep track of review and evaluation recommendations, agreed follow-up actions, and status of these actions.
- The implementation of the agreed actions will be monitored by the M&E unit at all levels. The CHMT and SCHMTs will provide coordination and oversight of performance review at the subnational levels, while the M&E unit at the national level will oversee the county units' implementation-tracking plan. During the quarterly performance review meetings, the subnational management teams, together with all the implementing partners and other stakeholders in their regions, will discuss the quarterly performance review report, review the implementation-tracking plan for the quarter, and identify performance gaps that will be mitigated and action points to be minuted and followed up.

3.2.4 Mechanisms for Review and Action

The health sector – whose service delivery is organized around several levels, from national to county, facility and community – has several mechanisms for performance review. This section outlines how performance review will be carried out at each of these levels.

3.2.4.1 The National Mechanism for Review and Action

Table 8: Overview of the KHSSP Monitoring and Review Process

Methodology	Frequency	Output	Focus	Level of Monitoring and Review
Integrated supervision of both public and private primary care facilities by DHMTs; SCHMTs and county hospitals by CHMTs; CHMTs by national level.	Quarterly	Quarterly progress report; copy transmitted to next higher level of supervision	A review of progress against targets and planned activities	Inputs, process, output and outcomes
Joint Annual Review/Annual health congress	Annual	Annual progress reports; copy transmitted to next higher level of supervision Subcounty, county and hospital performance league tables	A review of progress against KHSSP objectives/targets and planned activities' progress against resolutions; equity; benchmarking; analysis of context	Inputs, process, output and outcomes
Mid-Term Review	2015	Mid-Term Review Report	Review progress against planned impact	Inputs, process, output, outcomes and impact
End-term review by independent team	At end of KHSSP	End-Term Evaluation Report	Review progress against planned impact; efficiency analysis	Inputs, process, output, outcomes and impact

3.2.5 Performance Monitoring at National Level

a) Health Sector Coordinating Committee (HSCC)

The Health Sector Coordinating Committee formally coordinates all operational and strategic actions in the Health Sector, i.e., it provides oversight and steering in planning and monitoring. The committee:

- Serves as the main oversight and steering body for monitoring compliance with the Code of Conduct. Specifically, [4] it will:
  - Review and approve the results of the annual (1) self-assessments of the Government of Kenya, external actors and non-state actors and (2) assessments of each constituent actor by the other constituent actors, covering commitments and common working arrangements.
  - Review and approve Quarterly Progress Reports on procurement, based on the annual procurement plan. [5]
  - Review and approve Quarterly Progress Reports on the implementation of Joint Review Mission (JRM) resolutions/Aide-Memoire. [6]
  - Review and approve Quarterly Progress Reports on the implementation of the sector priorities as outlined in the AWPs[7] (including a quarterly Joint Financing Agreement (JFA) progress report[8]); this includes a review of the financial allocations and expenditures to ascertain performance and make recommendations to accelerate implementation where necessary.
  - Review and approve the Annual AWP/Sector Progress Review Reports.
  - Take note of the annual performance report of the JFA.[9]
  - Take note of the final annual financial statements of the MoH, together with the corresponding Kenya National Audit Office (KENAO) Audit Certificates.
  - Takes note of the audit reports of the Implementing Partners (IPs).

[4] The specific elements of the assessment will be updated when the new Code of Conduct is agreed upon.

[5] Code of Conduct, article 6.6.2. The progress report will be prepared and presented by the Procurement Dept.

[6] Code of Conduct, article 6.3.2.

[7] Code of Conduct, article 6.3.2.

[8] Joint Financing Agreement, September 2010, article 10.2.

[9] Joint Financing Agreement, September 2010, Annex 3. The annex does *not* state that the HSCC JAF/KHSSP needs to approve the work plan.

- Review and approve a quarterly progress report on the activities of the partnership coordination structures:
  - Sector Technical Committees (STCs) and Interagency Coordinating Committees; and
  - Kenya Health Sector wide Approach (SWAp) Secretariat.
- Review and approve a quarterly report on the implementation of the quarterly programme of technical and management supervisions carried out by the national level.
- Monitor the implementation of a roadmap for advancing the Kenya Health SWAp.

b) M&E Interagency Coordinating Committee

The M&E Interagency Coordinating Committee will also play an active role in M&E. They will:

- Facilitate and participate in a quarterly review of departmental/divisional work plans in their respective investment areas, so as to ensure that activities planned for in the AWPs are on course.
- Facilitate and participate in undertaking joint annual reviews (JARs) and preparing joint annual performance reports for relevant investment areas, to feed into Annual Sector Performance Reports and Joint Annual Reviews.
- Follow up on identified gaps/recommendations of the JAR in the specific investment areas, to ensure they are implemented and avoid repetitive recommendations.
- Participate in KHSSP mid-term reviews and end evaluation.

c) Health Sector M&E Unit

The M&E Unit will be the overall coordinator of M&E activities in the health sector; and of the quarterly and annual performance reviews at national level, as well as the sector mid-term and end evaluation. More specifically, it will:

- Develop and review from time to time all performance review formats for all national-level planning units (departments, SAGAs and professional councils) as well as County Health Management Teams (CHMTs).
- Ensure that all reports that these planning units need for their presentations at the national quarterly performance review meetings are prepared on time and in line with the agreed format, and disseminated to all participants of the quarterly review meetings.
- Organize the quarterly performance review meetings.
- Prepare and present at the quarterly review meetings:
  - A summary report of the reports from national-level teams who have participated in county stakeholders forums

- A summary report of the supervisions of counties conducted by national-level teams

- After the quarterly performance review meetings, compile all reports into one National-Level Quarterly Performance Report and submit the report to the HSCC for review and approval.

3.2.5.1 Quarterly Performance Review at the National Level

Table 9: Responsibilities for Preparation and Presentation of Reports at Health Sector Quarterly Performance Monitoring Meetings

Report	To be Prepared By	To be Presented By
Overview of national achievements in terms of Core KHSSP input, process, output and outcome indicators	HIS unit	Head M&E unit
Assessment of achievements against the KHSSP Investment Area Indicators	STCs	STC Secretaries
Assessment of the implementation of planned activities against set targets	Departments, SAGAs, professional councils	Heads
Assessment of progress made against action points of the previous quarterly review	Departments, SAGAs, professional councils	Heads
Assessment of the implementation of JRM decisions	SWAp Secretariat	Head SWAp Secretariat
Budget performance: expenditure against allocations	Accounts unit	Public Accounts Committee
Challenges and strategies to address challenges in subsequent quarters	Departments, SAGAs, professional councils	Heads
Summary report of the reports from national-level teams who have participated in county stakeholders forums	M&E Unit	Head M&E Unit
Summary report of the supervisions of counties conducted by national-level teams	M&E Unit	Head M&E Unit

A standard agenda for these meetings will be prepared. After the meeting, the M&E unit of the MoH will compile all reports into one national-level Quarterly Performance Report and submit the report to the HSCC for review and approval. The Quarterly Reports will also feed into the AWP Report.

The M&E Unit is responsible for organizing the quarterly review meetings, and for dissemination of the approved national-level Quarterly Progress Report, including publication on the MoH website.

3.2.5.2 Joint Assessment of Progress

The principle of joint assessment shall be used at all levels of the health sector during performance reviews. This will involve all stakeholders, both government and non-government actors, in review of performance. The county management teams will prepare the quarterly reports, and, in collaboration with county stakeholders, organize county quarterly performance review forums.

3.2.5.3 Performance Monitoring at Community Level

A community health services stakeholder forum will be responsible for the joint assessment at the community level.

3.2.5.4 Quarterly Performance Review at Subnational Level

The county M&E units in all CHMTs will take the lead in the joint assessments at the subnational level. The national M&E unit will organize for the annual health congress, which will bring together all stakeholders in health to jointly review the performance of the health sector for the year under review. The purpose of the joint assessments is to review performance, and to determine priorities, action plans and spending for the subsequent period. As with the work at the national level, sub counties and counties will conduct quarterly progress reviews on progress made during the implementation of the AWPs by facilities in their area of responsibility, both state and non-state, non-facility-based interventions, management teams and local divisions of SAGAs (e.g., KMTC, KEMSA).

The reviews will include:

- An overview of sub county and county achievements in terms of service provision: this is a selection of KHSSP outcome, output and input indicators
- An assessment of the implementation of planned activities against set targets
- An assessment of progress made against recommendations of the previous quarterly review
- An assessment of the implementation of Joint Annual Review Mission (JARM) decisions
- Budget performance: expenditure against allocations
- Strategies to address challenges in subsequent quarters

The reviews will be carried out using standardized reporting formats during quarterly performance review meetings (stakeholder fora), attended by state, non-state and external actors with operations in the sub county or county. As information from each sub county is required for

the county stakeholder meeting, the sub county meetings will need to be organized before the county-level meeting.

The assessments of progress made in activity implementation will be based on observations made during supervision and the actions agreed with the supervised staff. The supervisions will be integrated, i.e., they will be conducted by state, non-state and external actors, and be both management and technical, the latter ones being conducted by the national referral hospitals. The facilities covered in the assessment will include state and non-state facilities.

Table 10: Performance Review at Sub county Level

Report	To be Prepared By	To be Presented By
An overview of achievements in service provision in the Sub county: a selection of HSSP III outcome, output and input indicators	Sub county HRIO	County Health Records and Information Officer
An assessment of the implementation of planned activities of facilities, SCHMT and partners against set targets	Sub county Health Management Teams	SCHMT
An assessment of progress made by facilities, SCHMT and partners against action points arising from the previous quarterly review	SCHMT	SCHMT
An assessment of the implementation of JRM decisions	SCHMT	SCHMT
Budget performance in the Sub county: expenditure against allocations	SCHMT	SCHMT
Strategies to address challenges in subsequent quarters	SCHMT	SCHMT

Table 11: Performance Review at County Level

Report	To be Prepared By	To be Presented By
An overview of achievements in service provision in the county, by Sub county: a selection of KHSSP outcome, output and input indicators	CHRIO	CHRIO
An assessment of the implementation of planned activities of facilities, SCHMTs, CHMT and partners against set targets	CHMT	CDOH
An assessment of progress made by facilities, SCHMTs and CHMT against action points arising from the previous quarterly review	CHMT	CDOH
An assessment of the implementation of JRM decisions	CHMT	CDOH
Budget performance in the county: expenditure against allocations	CHMT	CDOH
Strategies to address challenges in subsequent quarters	CHMT	CDOH

3.2.5.5 The Joint Annual Review Meeting/Annual Health Congress

The national M&E unit will organize for the Annual Health Congress, which will bring together all stakeholders in health to jointly review the performance of the health sector for the year under review. The purpose of the joint assessments is to review performance, and to determine priorities, action plans and spending for the subsequent period.

The joint annual review meeting will be carried out as part of the annual health sector congress (first three days). The objective of the meeting will be to review the performance of the health sector against the targets set out in the sector strategic plan as well as the annual work plans. The first three days of the congress will be attended by technical teams representing a wide range of stakeholders, from all the actors in the health system – state, non-state and external actors. The principal secretary of health will chair the meeting. Two reports will be discussed: the health sector annual performance review report, which will represent the performance of all counties, and the annual health performance analytical report, which will consist of analysis of the annual health performance review report, highlighting trends identified, major issues and gaps identified, and priorities that the sector needs to focus on in the next planning cycle. The last two days of the congress will be attended by senior leaders, and will be chaired by the cabinet secretary for health. Alongside the meeting, best practices and innovations in health care delivery will be showcased.

3.2.6 Monitoring Compliance with Code of Conduct

Each year, the sector will monitor adherence by all signatories to the Code of Conduct, developed for the KHSSP period. The annual results will be presented to the HSCC, for further action.

3.2.7 Linkage between Programmatic and Sector Monitoring

There is need for a clear linkage between the monitoring and evaluation framework and programmatic and other sector monitoring. The key issues to be put in place to ensure that this occurs include:

- Programme reviews should inform the sector review. Indicators used by the programmes should therefore include sector review indicators as appropriate; the reviews should be held before the sector review and the reports should be sent to the health sector monitoring and evaluation unit in the MoH before the sector review meeting.

- Programme reviews should be led by the Programme M&E officer, but should involve non-programme staff for the sake of objectivity.
- Reporting obligations to the Global Alliance for Vaccines and Immunization, Global Fund for AIDS TB and Malaria, U.S. President's Emergency Plan for AIDS Relief, and others should be an extension of the above processes.
- After validation, reporting and use by the MoH, information will be forwarded to the respective global grantors, as appropriate.

3.2.8 Reporting Requirements on International Commitments and Resolutions

The M&E framework for the health sector appreciates the international commitments for which Kenya a signatory. This framework ensures that the indicators set are in tandem with those being monitored by the international commitments. The commitments include the MDGs, The Paris Declaration, UN Convention on the Rights of the Child, the WHO member states (The World Health Statistical Report), UN General Assembly Special Sessions (UNGASS), the Abuja Declaration, and The East, Central and Southern African Health Community ECSA- HC, among others. See Annex A for a depiction of how the core indicators relate to various international commitments and reporting requirements.

3.2.9 KHSSP Evaluation

3.2.9.1 Mid-Term KHSSP Review

The mid-term review will be conducted after two to three years of implementation. The analysis will focus on progress of the entire sector against planned impact, but will also include an assessment of inputs, processes, outputs and outcomes, using the KHSSP indicators. The main result will be a list of recommendations for the remaining KHSSP years. This will be an internal, joint exercise involving all stakeholders.

3.2.9.2 End-Term KHSSP Review (Evaluation)

The end-term review will be conducted in the second half of 2016 in order to enable the sector to review the findings on sector performance to generate recommendations for the formulation of the next strategic plan. Like the mid-term review, the analysis will focus on progress of the entire sector against planned impact, but it will also include an assessment of inputs, processes, outputs and outcomes, using the KHSSP indicators (core and others). The review will be conducted by a team of independent consultants.

Table 12: Health Sector M&E Framework Priority Activities

	Priority Areas for Investment	Measure of Success	Baseline	Mid-Term	Target
Monitoring and Evaluation	Establishment of a common data architecture	Review of the health sector Indicator manual			
		Review of integrated data capture tools and registers			
		Establishment of a learning and knowledge management platform/website			
	Performance monitoring and review	Joint assessments at county level			
		Joint assessments at national level			
		Quarterly performance review reports at county level		8	8
		National-level quarterly performance review reports		8	8
		County annual heath sector report		2	2
		National-level annual health sector report		2	2
		Annual state of health In Kenya report		2	2
		Mid-term evaluation report		1	
		End term evaluation report			1
	Enhanced sharing of data and use of information	Quarterly county health sector performance review forums			
		Annual county health performance review			
		Information products being produced and shared with relevant stakeholders (national and county level)			
		Health congress held		2	2

The national and county M&E committees will be responsible for overall oversight of M&E activities at the respective levels. Functional linkage of the health sector to the overall national intersectoral government M&E will be through the M&E directorate in the Ministry of Devolution & Planning. M&E units at the national and county level will be responsible for the day-to-day implementation and coordination of the M&E activities to monitor this strategic plan.

3.3 Enhance Ssharing of Data and Promoting Use of Information

3.3.1 Rationale

In evidence-based-decision-making, decisions are made about a programme, practice or policy using the best available research, experiential evidence from the field and contextual evidence. Practitioners and researchers need to provide comprehensive and accurate evidence that is appropriate for decision-making. The M&E Framework therefore should put in place or identify creditable data sources; develop flexible data collection subsystems; and develop clear analysis guidelines so as to guarantee generation of quality data. In addition, there should be reporting guidelines to enhance preparation of easy-to-use reports with actionable recommendations, which would be then be used by decision-makers.

3.3.2 Challenges and Existing Gaps

Health workers at the facility and community level are frustrated by burdensome demands for data, health managers and local planners are frustrated by competing demands and lack of capacity to respond, national-level planners are frustrated by lack of information relevant to policy- and decision-making, and funders (both internal and external) are frustrated because they cannot effectively assess the impact of interventions. A collection of data-collection systems exists alongside continuing unmet needs for information. There is therefore a growing receptiveness towards the development of strategies to produce more-coherent and more-efficient systems. There has been little standardization of the indicators, targets or tools to be used. Too much information is collected, and it is poorly analyzed, not easily comparable, and often not used. There is data overload, especially at peripheral levels, and major problems with the quality and use of information for decision-making. Those tasked with collecting and reporting data often cite a lack of relevance of the multitude of data collected, the limited capacity of facility and Sub county staff in data collection and analysis, and the often limited decision-making power at the county and Sub county level. There are too many forms to fill in at the facility or Sub county level, with the same person often reporting similar information to several recipients but in slightly different formats. Ironically, joined with this information overload is an almost total absence of information from some key players in health, notably the

private sector. The huge volumes of data collected also impinge upon data quality and reliability. It is a common complaint that data are inaccurate because of poor diagnostic tools, inaccurate classification and coding of diseases, and inadequate validation procedures.

This M&E framework seeks to work towards addressing these challenges by proposing the standardization of data collection tools, adoption of a minimum set of indicators to demonstrate progress, adoption of common data architecture, and a unified HMIS to increase access to data and the quality of data available to stakeholders as well as reduce the burden of data collection.

3.3.3 Data Sources for Health Sector Monitoring

The primary data sources for health sector M&E include the following:

Routine Service Data: This includes data collection based on patient service records and reporting from community health workers and various health facilities. Routine health data collection is conducted through a network of community units, in addition to the approximately 8,000 health facilities (government, faith-based, non-governmental organization, and private) that are distributed throughout the country. The service delivery points complete the applicable paper summary form(s) and submit them to the Sub county level on a monthly basis. Data is entered into the DHIS2. According to the Division of HIS, the overall rate of reporting from facilities to the sub counties is just over 80%.

Census and Vital Statistics: Two key components of the population-based data are census and vital registration. The last census was organized and carried out by the KNBS in 2009, and official results, which were made public, were questioned because the data for North Eastern County was seen as questionable. The vital registration system is weak. According to the HMIS Strategy document, the system captures only about half of the births and deaths within the country. Vital Registration actually had not compiled a report in the last 10 years. Currently, the HMIS is not receiving any data from VR. The linkages between the HIS Division and the KNBS and the Department of Civil Registration are weak.

Surveys: Another component of the population-based data is various recurring surveys. The most recent KDHS was carried out by the KNBS in 2008-2009, with results released in May 2010. Three large-scale surveys were conducted in 2007 – the Malaria Indicator Survey, the Kenya AIDS Indicators Survey, and the Kenya Household Health Expenditure and Utilization Survey. The results of the first two were published in March

and September 2009, respectively. All the surveys in Kenya in general are heavily funded by external donors.

Surveillance: There are primarily three types of surveillance taking place: (1) Integrated Disease Surveillance and Response, which is managed by the Division of Disease Surveillance and Response (DDSR) of the Department of Disease Control; (2) the Kenya Demographic Surveillance System, consisting of five sites, one each in Kibera, Kilifi, Kisumu, Nairobi, and Rusinga, and heavily supported by USAID/K; and (3) various programme-specific surveillance sites such as National AIDS/STI Coordinating Programme's (NASCOP)'s HIV/AIDS surveillance system, with approximately 44 sites across the country and supported by PEPFAR and the Division of Malaria Control's surveillance system in epidemic-prone areas. IDSR has some level of integration with DHIS, however minimal, while Demographic Surveillance System sites collectively produce very high-quality data, which unfortunately does not make it to the mainstream aggregate reporting system, the DHIS.

Programme-Specific M&E: Several programme-specific monitoring efforts are taking place in Kenya. Key examples include: (1) the Malaria Information and Acquisition System, maintained by the Division of Malaria Control; (2) Community-Based Programme Activity Reporting, maintained by the NACC; (3) the Kenya HIV/AIDS Programme Monitoring System, maintained by PEPFAR; and (4) various programmes by the Department of Family Health.

Administrative Records: This is a key component of the management information, and consists of finance/budget, physical assets information, human resources, and logistics and supply system information. Currently, there is no interoperability between the HMIS and these systems. Moreover, there is very little communication between them, which means that many decisions are being made in silos without key information from the other systems, resulting in significant waste of resources.

Facility-generated data will be collected by all public and private health service delivery facilities and community units. In addition, different programmes and projects managed at the MoH/national level shall provide reports on programme-specific activities, e.g., immunization campaigns. Health projects managed by implementing partners (IPs and civil society organizations) at Sub county or community level shall provide reports through the Sub county health system. This data will be collected

routinely using established data collection methods and tools and aggregated at the health facility, Sub county, county and national level.

Overall, the sources of M&E information will be guided by different information needs, particularly the Government, Parliament, development partners, private sector and the community. The MoH ministerial M&E unit will house the central database for reporting on progress of the KHSSP and serve as a repository for all service delivery data and information at national level.

3.3.4 Data Management

3.3.4.1 Data Collection

Data collection and processing is carried out at all health levels for different purposes; however, the following activities are necessary for all:

- Performance data collection (i.e., data on inputs-activities-outputs)
- Processing (aggregation) of the performance data from various service delivery points
- Ensuring quality of reports

3.3.4.2 Coordination of Data Collection

The HIS Unit will work closely with various stakeholders at both the national and county levels to coordinate collection of data that will be used to generate information products. The data collection strategy for the routine national service statistics (indicators and dataset) at the facility and county level has already been developed and rolled out through the DHIS2. This enables collection of data from the community, health facility (public and private), Sub county, and county up to the national levels.

The process of data collection for service delivery data will occur at various levels.

- At the household level, data will be collected by the CHWs, guided by the household register, which lists all the households in the community unit. The CHW will fill in the service delivery data on a community log/diary. This log will be presented to a CHEW at the facility to which the community unit is attached. The CHEW will aggregate all the community logs received into the CHEW summary, which will be further aggregated at the Sub county level into a Sub county CHEW summary and posted on DHIS. For those facilities that have DHIS access, the CHEW summary for the facility can be posted at the facility.
- At the facility level, all public and private facilities and all implementing partners will collect routine service delivery data using standard tools and registers. These will then be collated into

standardized reporting forms and submitted monthly into the DHIS, or from the Sub county level for those facilities that do not have DHIS access.

The different levels of the M&E System shall use the data for management decisions and ensure feedback is relayed to the respective levels.

3.3.4.3 Data Collection Methods and Tools

Data collection will combine quantitative and qualitative methods, and will use standardized data collection tools and techniques. Data for many indicators will be collected annually. The survey-based indicators will be collected at baseline, mid-term where possible, and in the last year of implementation. The main data collection tools and techniques will include the DHIS, LMIS, HRIS, commodity supply systems and financial systems, among others.

Table 13: Data Management and Reporting Responsibilities

Sno	Available Reporting Forms	County responsible(Action) Person	Overall responsibility at county	Sub county Reporting Channel	Hospitals	Primary Health Facility/ Community Unit	Overall Responsibility at Health Facility	HF Reporting Channel (Where Applicable)
1	CHEW Summary	Community Unit Focal person	County director of health	DHIS	CHEW	CHEW	Med Sup/ In-Charge	Hardcopy/DHIS
2	MoH 711 Integrated	Reproductive Coordinator/ District Public Health Nurse (DPHN)	County director of health	DHIS	Sectional in-charge/HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
3	MoH 731-1 HIV CT	CHMT Member responsible for HIV	County director of health	DHIS	Sectional in-charge/HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
	MoH 731-2 PMTCT	CHMT Member responsible for HIV	County director of health	DHIS	Sectional in-charge/HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
	MoH 731-3 C&T	CHMT Member responsible for HIV	County director of health	DHIS	Sectional in-charge/HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
	MoH 731-4 VMC	CHMT Member responsible for HIV	County director of health	DHIS	Sectional in-charge/HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
	MoH 731-5 PEP	CHMT Member responsible for HIV	County director of health	DHIS	Sectional in-charge/HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
	MoH 731-6 Blood Safety	CHMT Member responsible for HIV	County director of health	DHIS	Sectional in-charge/HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
4	HCBC	CHMT Member responsible for HIV	County director of health	DHIS	Sectional in-charge/HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS

Sno	Available Reporting Forms	County responsible(Action) Person	Overall responsibility at county	Sub county Reporting Channel	Hospitals	Primary Health Facility/ Community Unit	Overall Responsibility at Health Facility	HF Reporting Channel (Where Applicable)
5	IDSR Weekly	District Disease Surveillance Coordinator(DDSC)	County director of health	DHIS	Facility surveillance focal person	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
6	Hospital Administrative Statistics (HAA)	County HRIO	County director of health	DHIS	HRIO			Hardcopy/DHIS
7	MoH 75 A OPD <5 years	County HRIO	County director of health	DHIS	HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
8	MoH 75 B OPD >5 years	County HRIO	County director of health	DHIS	HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
9	MoH 717 Service Workload	County HRIO	County director of health	DHIS	HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
10	MoH 718 Inpatient M and M	County HRIO	County director of health	DHIS	HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
11	MoH 710 Immunisation	CHMT member responsible for immunisation	County director of health	DHIS	HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
12	MoH 706	CHMT member	County director of	DHIS	Lab In-Charge	Facility Lab	Med Sup/	Hardcopy/DHIS

Sno	Available Reporting Forms	County responsible(Action) Person	Overall responsibility at county	Sub county Reporting Channel	Hospitals	Primary Health Facility/ Community Unit	Overall Responsibility at Health Facility	HF Reporting Channel (Where Applicable)
	Laboratory Report	responsible for lab services	health			In-Charge	In-Charge	
13	Support Supervision	Chair CHMT	County director of health	DHIS	Sectional In-Charge/HRIO			Hardcopy/DHIS
14	IMAM	CHMT member responsible for nutrition	County director of health	DHIS	Nutritionist	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
15	MoH 713 Nutrition Monthly Reporting	CHMT member responsible for nutrition	County director of health	DHIS	Nutritionist	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
16	MoH 78 Environmental Health	CHMT member responsible for environmental health	County director of health	DHIS	PHT	Public Health Officer/Public Health Technician	Med Sup/ In-Charge	Hardcopy/DHIS
17	Quarterly report on Tuberculosis and Multiple Drug Resistant TB case-finding	CHMT member responsible for TB	County director of health	DHIS	CO Tuberculosis and Lung	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
18	Cohort Report for TB	CHMT member responsible for TB	County director of health	DHIS	CO Tuberculosis and Lung	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS

Sno	Available Reporting Forms	County responsible(Action) Person	Overall responsibility at county	Sub county Reporting Channel	Hospitals	Primary Health Facility/ Community Unit	Overall Responsibility at Health Facility	HF Reporting Channel (Where Applicable)
19	HSSF Monthly Expenditure	County Accountant	County director of health	DHIS	Facility accountant	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
20	HSSF summary	County Accountant	County director of health	DHIS	Facility accountant	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
21	Malaria Commodities Form	CHMT member responsible for malaria	County director of health	DHIS	Pharmacist	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
22	Non-Pharmaceutical	CHMT member responsible for Non-Pharmaceuticals	County director of health	DHIS	Matron	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
23	Division of Occupational	County Occupational Therapist	County director of health	DHIS	Occupational Therapist	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
24	Logistic Management Information	Reproductive Health Coordinator/Sub county PHN	County director of health	DHIS	Pharmacist	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
25	FP Contraceptives	CHMT Member responsible for Reproductive Health	County director of health	DHIS	MCH In-Charge	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
26	Maternal Death Review Form	County HRIO	County director of health	DHIS	Maternity In-Charge – Maternal Death	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS

Sno	Available Reporting Forms	County responsible(Action) Person	Overall responsibility at county	Sub county Reporting Channel	Hospitals	Primary Health Facility/ Community Unit	Overall Responsibility at Health Facility	HF Reporting Channel (Where Applicable)
					Review team			
27	Ophthalmology Services	County Ophthalmologist	County director of health	DHIS	Ophthalmologist	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
28	Orthopaedic Plaster	County Plaster technologist	County director of health	DHIS	Plaster technologies	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS

3.3.5 Data Quality Assurance

The need for strengthened systems and capacity for effective integrated supportive supervision and quality assurance programmes at all levels is recognized (for example, it was a key recommendation of the NHSSP II midterm evaluation). The quality of data collected through the national HIS depends on proper data input and the quality of the subsequent processes in the recording and reporting system, which are defined in the data management standard operating procedures (SOPs).To assure that data collected are of the highest possible quality, data quality assessment and data quality assurance will be conducted. National data quality audits (DQAs) should be conducted once in two years, while counties and facilities can conduct routine DQAs as needed. The health sector data quality assurance protocol outlines procedures for data quality assurance.

The DQA protocol outlines data quality assurance procedures and practices including:

- Establish external data checks involving supervisory visits to the different levels.
- Agree to record completeness targets, particularly for core data items such as age, sex, geographical location and type of case (for example, “these variables are complete for at least 95% of in a particular recording/reporting”), and monitor the system to ensure such completeness targets are met.
- Define a process for regular sample checks against original paper documents, if relevant.
- Train staff so that all are aware of their roles and responsibilities.
- Develop clear SOPs for the various data quality processes to ensure uniformity of data quality mechanisms across all facilities using the system; complement these SOPs with clear, up-to-date definitions of all terms and expressions used within the system.
- Avoid the use of double data entry, since it adds a considerable burden, is intended only to prevent transcription errors, and is not necessary if procedures are clearly stated and made available in a standard data management manual or SOPs. While double-data entry may be appropriate for specific research, it is not an ideal approach for routine monitoring.
- Ensure adequate resources are available to carry out these and other activities to ensure data quality: some activities are specialized and time-consuming, so planning and budgeting for these is important.

Data validation should be carried out at all levels, including variation checks against figures reported in previous reporting periods, and identification of outliers and unusual data trends. All reports need to be checked for accuracy by the responsible persons, including programme managers, before submission to stakeholders. DQA will be carried out at points of data

collection, collation and analysis by the technical staff. Standardized Rapid Data Quality Assessment, data review, and performance review tools are available from the division of health informatics and M&E.

In addition to the above data checks and validation, the M&E unit at the county level and at the national level shall carry out periodic Rapid Data Quality Assessment, in which selected health facilities will be drawn from the master facility list for this assessment. The Rapid Data Quality Assessment will be carried out as a quality assessment of the entire process of data collection, analysis and synthesis.

At KHSSP mid-term and end-term, DQA will be carried out with the aim of identifying and accounting for biases due to incomplete reporting; inaccuracies; and non-representativeness of data received at the county and national levels. The DQA will focus on:

- The completeness of reporting by community units, facilities and sub counties and counties
- Accuracy of county population denominators (calculation of the denominators should be done following the formula/procedure highlighted in the DHIS)
- Accuracy of coverage estimates from reported data
- Systematic analysis of facility-based and household survey-based indicator values

The DQA report could lead to adjustments of the indicator values, using transparent and well-documented methods. To ensure transparency and overcome bias, the MoH shall collaborate with independent institutions such as the health observatory in the DQA process and consequent adjustment of the county and national figures.

3.3.6 Data Analysis and Synthesis

Data analysis and synthesis will be done at various levels (national, county, Sub county and health facility) to enhance evidence-based decision-making. The focus of analysis will be on comparing planned results (targets) with actual results, determining a better understanding of the reasons for divergences, and comparing the performance at different levels as well as across different interventions as much as possible. This data analysis and synthesis will be presented and shared through the various reporting mechanisms already described, such as Quarterly and Annual Progress Reports, mid- and end-term evaluations, thematic studies and surveys.
The MoH and its partners will strengthen the capacity of data analysis and synthesis in the CHMTs, MoH, Departments, SAGAs, and health facilities and civil society organizations, to enhance bottom-up planning and decision-making.

3.3.7 Reporting, Data Dissemination and Data Sharing

Data need to be translated into information that is relevant for decision-making. Data will be packaged and disseminated in formats that are determined by management at the various levels to the Congress and the Constitutional Summit. For example, service delivery data shall be packaged and displayed at the various health facilities using formats such as the DHIS dashboard reports, service charter boards, etc. The timing of information dissemination should fit in with the planning cycles and needs of the users. Knowledge management is the systematic management of an organization's knowledge assets for creating value and meeting tactical and strategic requirements[10]. The KHSSP identifies knowledge management as a key approach that will be promoted and used during the implementation of the strategic plan to ensure availability and use of quality information to aid in decision-making. The health sector will apply a knowledge management approach in the production and management of its knowledge base. Data and information generated at all levels of the sector and from different sources will be shared, translated and applied for decision-making during routine monitoring, periodic sector performance review, planning, resource mobilization and allocation, accountability, designing disease-specific interventions, policy dialogue, review and development.

Effective knowledge management will be based on the following assumptions:

- First, all relevant data will be collated, validated and analyzed for use at various levels of the sector from the community to the national level.
- Second, all reports produced through M&E activities, once approved by the appropriate actors, will be made easily accessible in a timely manner to all stakeholders.
- Third, the users of M&E should have the capacity to translate and use the data/information for decision-making, policy dialogue, review and development.
- The following information products related to monitoring of the strategic plan will be produced and disseminated during the life of the KHSSP:
- Annual Health Statistical Report

This report, which is usually produced by the division of HIS, is compiled from the periodic statistical reports, and submitted through the DHIS2. The annual health statistical report provides attention to data quality issues, including timeliness, completeness and accuracy of reporting, and adjustments and their rationale. The Division of Health Informatics and M&E will be responsible for compiling and disseminating this report. The use of this report in aiding decision-

[10] www.knowledge-management-tools.net

making will be promoted by ensuring that it meets the needs of the target audience. An electronic version of the report will be availed on the MoH website.

Quarterly Performance Review Reports

Quarterly performance review reports will be prepared by the various levels of health delivery. The health facilities will produce the reports, which will be aggregated at the Sub county level through the SCHMT and at the county level through the county HMT, then at the national level by the M&E unit. At the subnational level (county and Sub county), quarterly performance review reports will be presented and discussed at the quarterly review meetings, which will be attended by all the key implementers. The discussion will focus on identifying performance gaps and agreeing on a plan of action for mitigating these in the subsequent quarter. At the national level, the M&E unit will aggregate the performance review reports from the various planning units into a sector quarterly performance review report, which will be disseminated to the stakeholders through the MoH website as well as a stakeholders forum.

Annual Operating Plan Review Report

The reports will assess progress on the health sector annual work plans, and assess overall sector performance against the sector priorities and targets set in the NHSSP III. The different levels of health care delivery are expected to compile their service delivery reports and post them electronically using the AWP tools available in DHIS2, and use them for performance review. The AWP tools, which the different planning units in the health sector use, will also enable planning units to report on sector investments by health system domain (such as health financing, HR, infrastructure, medical products and commodities, and health information systems).The M&E Unit at the national level will then aggregate the reports from all the planning units and compile the health sector AWP performance report for that year.

The Annual Work Plan performance report will bring together all data from different sources, including the facility reporting system, household surveys, administrative data (minutes, supervision reports, financial reports, HRIS reports, etc.) and research studies, to answer the key questions on progress and performance using the KHSSP core indicators and health goals. The AWP should also be able to reflect attribution of outputs and inputs to the public and private sectors. This report will present a detailed account of annual performance against the core and programmatic indicators of the sector strategic plan, comparing current results with results of previous years, and formulate challenges and recommendations. It will be sent to all the planning units, and an electronic version will be posted publicly on the MoH website. The report will also be presented and discussed at an annual stakeholder's forum and the Health Summit, which

draws attendance from the county and Sub county health management teams, DPs, county and Sub county implementers, etc.

The M&E unit will translate data and information according to the target audience, and use various communication channels pass the information to all the stakeholders, e.g., radio, TV, MoH websites, e-bulletins, newsletters, booklets.

3.3.8 Data Use

Each health system level will develop maps to promote the use of information to make decisions. The information use map will identify barriers/constraints to use of information and identify stakeholders within that level, outlining the resources they will bring on board, the role they will play in promoting use of information, and a work plan with activities for promoting use of information.

Data review and data use forums will be strengthened at all levels. All the stakeholders will meet routinely to review their data, identify and address data quality issues, and discuss ways in which data had been used in the period preceding the meeting to aid in decision-making.

4 KHSSP Monitoring and Evaluation Implementation Framework

The M&E Framework for KHSSP will be implemented using the guiding structure of the stewardship goals.

4.1 Key Activities

To operationalize the M&E framework, the following are the activities proposed and tasks therein:

4.1.1 Support Establishment of a Common Data Architecture

Tasks:

- Develop data exchange standards.
- Develop new generation integrated tools.
- Orient health care workers to the integrated revised tools.
- Train users on the 2nd edition indicator manual.
- Develop standard operations procedures to guide M&E.

4.1.2 Improve performance monitoring and review process

Tasks:

- Develop a joint integrated supervision checklist.
- Revitalize the Joint Annual Review meeting.
- Strengthen periodic performance review forums at all levels.
- Establish and operationalize Kenya National Health Observatory.
- Develop SOPs and guidelines on data management, data quality assurance, and performance reviews.

4.1.3 Enhance Sharing of Data and Use of Information for Evidence-based Decision-making

Tasks:

- Revitalize data review forums.
- Develop and disseminate appropriate information products.
- Establish a Kenya National Health Observatory

Per the Kenya Health Partnership Framework (November 2013), there are three key interrelated stakeholder/health actor groups within the health sector, including,

- State actors (national and county governments)
- Non-state actors (civil society organisations, NGOs, for-profit and not-for-profit organisations)
- External actors (bilateral and multilateral development partners)

The above activities will be spearheaded by the state actors, primarily the health sector Monitoring and Evaluation unit at the national level, in collaboration with the external actors, with input from non-state actors, and public participation to be cascaded to all stakeholders. The stakeholder buy-in, especially from non-state actors, in uptake and use of the M&E framework established is crucial in ensuring uniform implementation and reporting.

4.2 Standard Operating Procedures to be Developed to Guide M&E Implementation

The following SOPs and templates have been developed to further operationalize this M&E Framework

- Data management SOPs
- Data quality protocol
- Data review templates and procedures
- Joint supervision checklists
- Issues tracking log
- National and county annual performance review templates and guidelines (annual performance review guidelines)
- Incorporation of research into policy SOPs
- An issue tracking log is yet to be developed to track the implementation of action items raised during performance review meetings

4.3 M &E Tools

During KHSSP, the Sector will use the following tools for M&E purposes:

- The Code of Conduct for partners supporting the implementation of KHSSP
- The KHSSP Core Sector Indicators and targets
- The KHSSP Investment Indicators
- Specific Programme, Project and Memorandum of Understanding indicators
- 2nd Edition indicator Manual
- Programme and Project-Specific M&E Frameworks or Plans
- SOPs (Data Management, Data Quality, etc.)

4.4 M&E Framework Implementation Plan and Budget

A detailed set of priority activities and tasks, is outlined in Table 13 below to ensure full implementation of the M&E Framework.

Table 14: Monitoring and Evaluation Framework Implementation Plan and Budget 2012/13-2016/17

Activity	Responsible Person/Department	2014/15	2015/16	2016/17	2017/18	Technical Assistance	Worrkshops//training	Transport	Printing	Total
1. Institutionalising Monitoring and Evaluation										
1.1 Printing of KHSSP 2013-2017 M&E Framework	National and County M&E Units	x							1200000	1,200,000
1.2 Launching and dissemination of KHSSP 2013-2017 M&E Framework at national level	National and County M&E Units	x					280,000			280,000
1.3 Setting up of M&E units at the national and county level	National and County M&E Units	x					4,850,400			4,850,400
1.4 Carry out an Institutional assessment of MoH to identify the capacity gaps for implementing the health sector M&E framework	National and County M&E Units	x				1000000				1,000,000
1.5 Development of training materials for the health sector M&E framework	National M&E Units	x					727,500	40000		767,500
1.6 Training on implementation of the M&E framework across all levels	National and County M&E Units	x					34,192,500	2820000	9000	37,021,500
1.7 Dissemination at county level	County M&E Units	x							300000	300,000
1.8 Dissemination at Sub county level	County M&E Units	x							1200000	1,200,000
1.9 Continued development and expansion of national HMIS countrywide (Health Bill 2013)	National M&E Unit	x	x	x	x	6 000 000	30 000 000	2800000	1200000	40 000,000

Activity	Responsible Person/Department	2014/15	2015/16	2016/17	2017/18	Technical Assistance	Worrkshops//training	Transport	Printing	Total
2. Enhancing data sharing and promoting use of information										
2.1 Define standards for data sharing between aggregate and patient-level data	National M&E Unit	x					436,500			436,500
2.2 Develop data use information maps	National M&E Unit	x				1000000	291,000			1,291,000
2.3 Development and operationalization of a health sector DQA protocol	National M&E Unit						34,192,500	2820000	21375	37,033,875
2.4 Development and operationalization of data management SOPs	National M&E Unit	x					727,500	40000		767,500
2.5 Production & sharing of Information products with relevant stakeholders (national and county level)	National and County M&E Units	x	x	x	x		6,075,000		1645000	7,720,000
3. Compilation and submission of performance reports										
3.1 National Annual Health sector performance report submitted to the Cabinet Sectary (Health Bill, 2013)	Director of Medical Services	x	x	x	x				17000	17,000
3.2 Annual state of Health Report in Kenya submitted to the National Assembly (Health Bill, 2013)	Cabinet Secretary	x	x	x	x				17000	17,000
3.3 County Quarterly, Semi-annual and Annual Performance Reports submitted to the County Assembly (Health Bill 2013 , Intergovernmental Relations Act 2012)	County Director of Health	x	x	x	x				799000	799,000
3.4 Quarterly performance reports (county & national)	County & National M&E Units	x	x	x	x		34,192,500	2820000	9000	37,021,500
3.5 County Annual Health Sector Report	County M&E	x	x	x	x				300000	300,000

Activity	Responsible Person/Department	2014/15	2015/16	2016/17	2017/18	Technical Assistance	Worrkshops//training	Transport	Printing	Total
	Units									
3.6 National Annual Health Sector Report	National M&E Unit	x	x	x	x				1200000	1,200,000
3.7 Annual State of Health in Kenya Report	National M&E Unit	x	x	x	x				1200000	1,200,000
3.8 Mid-term evaluation report	County & national M&E Units		x		x	1000000	51,365,000	1600000	1200000	55,165,000
3.0 End-term evaluation report	County & national M&E Units		x		x	2000000	51,365,000	2000000	1200000	56,565,000
3.10 Summary report of the reports from national-level teams who have participated in county stakeholders forums	M&E Unit	x	x	x	x	1000000	727,500		1200000	2,927,500
3.11 Summary report of the supervisions of counties conducted by national-level teams	M&E Unit	x	x	x	x		11,397,500		475875	11,873,375
3.12 Performance Contract report	M&E Unit	x	x	x	x		727,500		475875	1,203,375
3.12 International Obligations reports (ECSA-HC, MDG report)	M&E Unit	x	x	x	x	3000000	1,455,000			4,455,000
4. Data quality assurance										
4.1 Monthly Health Facility Data Quality Audit	Facility I/C,	x	x	x	x		0		1062500	1,062,500
4.2 Quarterly Sub county Data Quality Audit	District Health Records and Information Officer DHRIO	x	x	x	x		48,600,000			48,600,000

Activity	Responsible Person/Department	2014/15	2015/16	2016/17	2017/18	Technical Assistance	Worrkshops//training	Transport	Printing	Total
4.3 Semi-Annual County Data Quality Audit	CHMT	x	x	x	x	1000000	8,460,000			9,460,000
4.4 Rapid Annual Data Quality Audit	Health Information System Unit	x	x	x	x		11,397,500		475875	11,873,375
4.5 Dissemination of data quality assurance reports	Health Facility, Sub county, CHMT, National M&E Unit	x	x	x	x		700,000		117000	817,000
4.6 Data quality adjustments	Health Facility, Sub county, CHMT, Health Information System Unit	x	x	x	x	3000000	1,455,000			4,455,000
5. Performance Reviews										
5.1 Monthly Community Progress review meetings	CHEW									47,000,000
5.2 Quarterly Sub county progress review meetings	Sub county M&E Unit/DHRIO	x	x	x	x	3000000	13,500,000		2,430,000	18,930,000
5.3 Quarterly County progress review meetings	CHMT	x	x	x	x		18,800,000		423,000	19,223,000
5.4 Annual County Progress Review meetings	CHMT	x	x	x	x		4,700,000		423,000	5,123,000
5.5 Annual National Progress Review	National M&E	x	x	x	x		12,889,750	1410000		15,568,750

Activity	Responsible Person/Department	2014/15	2015/16	2016/17	2017/18	Technical Assistance	Worrkshops//training	Transport	Printing	Total
meetings	Unit								1,269,000	
5.6 Annual Health Congress	National M&E Unit	x	x	x	x	3000000	14489750	3760000	1,797,750	217725000
5.6 Health Sector Coordinating Committee review meetings	National M&E Unit	x	x	x	x		300,000			300,000
5.7 Sector Technical Committees	National M&E Unit	x	x	x	x		180,000			180,000
5.8 Joint Annual Review meeting	National M&E Unit	x	x	x	x		240,000			240,000
5.9 Overview of national achievements in terms of Core KHSSP input, process, output and outcome indicators	National M&E Unit	x	x	x	x	3000000	450,000			3,450,000
5.10 Assessment of achievements against the KHSSP Investment Area Indicators	Sector Technical Committees	x	x	x	x	3000000	180,000			3,180,000
5.11 Assessment of the implementation of planned activities against set targets	Directorates, SAGAs, professional councils	x	x	x	x	3000000	180,000			3,180,000
5.12 Assessment of progress made against action points of the previous quarterly review	Directorates, SAGAs, professional councils	x	x	x	x		180,000			180,000
5.13 Assessment of the implementation of JRM decisions	M&E Unit	x	x	x	x		540,000			540,000

Activity	Responsible Person/Department	2014/15	2015/16	2016/17	2017/18	Technical Assistance	Worrkshops//training	Transport	Printing	Total
5.14 Budget performance: expenditure against allocations	Accounts unit	x	x	x	x	1000000	8,249,440			9,249,440
5.15 Challenges and strategies to address in subsequent quarters	Directorates, SAGAs, professional councils	x	x	x	x		1,600,000			1,600,000
6. Surveys										0
6.1 HIV/AIDS Indicator survey	National M&E Unit	x								45,000,000
6.2 Malaria Indicator Survey	National M&E Unit									25,000,000
6.3 Service Availability Readiness Assessment	Health Information System Unit	x								90,000,000
6.4 Kenya Demographic Health Surveys	KNBS	x								500,000,000
6.5 Kenya Service Provision Assessment	National M&E Unit	x								60,000,000
6.6 Kenya National Household Survey	KNBS	x								20 000 000
6.7 Kenya National Census	KNBS									0
6.8 Client Satisfaction Survey	Planning & Policy Division	x	x	x	x					90,000,000
6.9 National Health Accounts	Planning & Policy Division	x	x	x	x					5,000,000
6.10 Specific Programme Evaluations	Programme Directorates/N	x	x	x	x					45,000,000

Activity	Responsible Person/Department	2014/15	2015/16	2016/17	2017/18	Technical Assistance	Worrkshops//training	Transport	Printing	Total
	ational M&E Unit									
7. Dissemination										
7.1 Sub county Quarterly performance reports	Sub county M&E Unit	x	x	x	x				3,645,000	3,645,000
7.2 County Quarterly performance reports	County M&E Unit								634,500	634,500
7.3 Annual health Sector performance report	National M&E Unit	x	x	x	x				634,500	634,500
7.4 Mid-term review report	National M&E Unit			x					2,326,500	2,326,500
7.5 End -term review report	National M&E Unit				x				2,326,500	2,326,500
7.6 Survey reports	Programmes/Research Institutions	x	x	x	x				1,269,000	1,269,000
8. Health Research and Evidence Generations										
8.1 Research on health financing models (Health Bill, 2013)		x	x	x	x				2,326,500	2,326,500
9. Monitoring and Evaluation for the M&E framework										
9.1 M&E Technical Working Group meetings	National M&E Unit	x	x	x	x				2,326,500	2,326,500

Activity	Responsible Person/Department	2014/15	2015/16	2016/17	2017/18	Technical Assistance	Worrkshops//training	Transport	Printing	Total
9.2 Compile quarterly KHSSP M&E framework implementation reports	National M&E Unit	x	x	x	x	2000000	450,000			2,450,000
9.3 Compile annual KHSSP M&E framework implementation reports	National M&E Unit	x	x	x	x	1000000	2,910,000			3,910,000
9.4 Facilitate implementation of mid-term and end-term evaluations	National M&E Unit		x	x	x	750000	450,000			1,200,000
										KHS. 1,615 302,690

5 Organisational Requirements for a Robust M&E Framework

5.1 Key Responsibilities for Health Sector M&E

To be fully successful, M&E functions need to be carried out at all the levels of health care delivery, from the national to the community level. The following section outlines the key responsibilities of various units under which M&E functions fall at the national and county level.

Table 15: Scope and Responsibilities of M&E Functions at the National Level

National Level: Health Sector M&E Unit	
Stewardship Goal	National-Level Functions at the Health Sector M&E Unit
Establishment of a common data architecture	• Define standards for data sharing between aggregate and patient-level data. • Coordinate development of minimum data sets and data requirements of the health sector. • Create and maintain a data repository of health and health related information. • Carry out oversight functions to manage all health and health-related data from service providers at all levels to inform policy formulation.
Improve performance and review processes	• Aggregate, analyse, disseminate and use health and health-related data on the performance of the health sector priorities outlined in the KHSSP from all MoH departments, SAGAs, national hospitals, CHMTs and others, and provide feedback to all. • Compile all reports at the national level on performance tracking of the strategic plan. • Analyse the quality of all reports received and ensure follow-up in case of incompleteness, problems with validity, and delays. • Provide technical support to all national-level operational units, SAGAs, and national referral hospitals in monitoring and evaluation.
Enhancing sharing of data and promoting use of information for decision-making	• Develop M&E-related guidelines and policies. • Prepare and disseminate national annual and quarterly performance review reports. • Ensure proper information flow from various levels in accordance with national and international data and reporting obligations. (This includes, specifically, forwarding Country Health information as required to the Director for Health for forwarding to international actors.) • Provide capacity-building in M&E. • Prepare and share the Annual State of Health reports during the Health Congress.

National Level: Partners (DPs, IPs, NGOs, FBOs)	
Stewardship Goal	Partner Functions at the National Level
Establishment of a common data architecture	• In the spirit of the Kenya Health Sectorwide Approach, partners are encouraged to: – Provide technical, material and financial support to strengthen monitoring and evaluation at SAGAs and National Referral Hospitals. – Promote one national integrated health information system. • Work collaboratively with the MoH M&E unit to provide data, as appropriate, on population- based statistics and on vital events (births and deaths), and provide health-related research data for comparative analysis and warehousing.
National Level: Partners (DPs, IPs, NGOs, FBOs)	
Stewardship Goal	Partner Functions at the National Level
Improve performance and review processes	• Work within the existing M&E framework and meet the reporting requirements as defined by minimum datasets. • Participate in generation of the reports.
Enhancing sharing of data and promoting use of information for decision-making	• Provide support to strengthen the national-level M&E Unit in its areas of operation (e.g., through provision of technical support and capacity building). • Participate in dissemination of data, research and performance reports.

Table 16: Scope and Responsibilities of M&E Functions at the County Level

County Level: County Health Management Team	
Stewardship Goal	CHMT Functions at the County Level
Establishment of a common data architecture	• Establish M&E Technical Working Groups. • Conduct oversight to manage all health and health-related data from all service providers within their area of jurisdiction. • Create and maintain a data repository. • Collaborate and work in partnership with other statistical constituencies at the county level to build one county-wide M&E system based on the principles outlined in this document. • Compile all reports from the Sub county health facilities into a single County Health report.
Improve performance and review processes	• Produce a health sector performance report that includes service delivery metrics. • Analyse the quality of all reports received and ensure appropriate follow-up in

County Level: County Health Management Team	
Stewardship Goal	CHMT Functions at the County Level
	case of incompleteness or problems with validity, as well as delays from the Sub county levels. • Provide technical, material and financial support for M&E to all subcounties. • Collate, analyse, disseminate and use health and health-related data from all Sub county offices and give feedback.
Enhancing sharing of data and promoting use of information for decision-making	• Ensure proper information flow from various levels to inform policy formulation, guidelines, and development of protocols, and to address country's international obligations. (This specifically includes forwarding the County Health report to the National MoH.) • Prepare data analyses for discussion during the CEC and directorate meetings and forum for decision-making. • Develop County Health report and share with the CEC. • Develop quarterly feedback to the CEC and County Director for Health and share with them. • Disseminate quarterly reports to Sub county health teams and Health Committee.
County Level: Partners	
Stewardship Goal	Partner Functions at the County Level
Establishment of a common data architecture	• Support the counties in establishing data collection structures. • Work collaboratively with the MoH M&E Unit to provide data, as appropriate, on population-based statistics, and vital events (births and deaths), and health-related research data for comparative analysis and warehousing.
Improve performance and review processes	• Work within the health sector M&E framework and guidelines, and meet the reporting requirements as defined by minimum datasets.
Enhancing sharing of data and promoting use of information for decision-making	• Provide support to strengthen the MoH M&E Unit in their areas of operation (e.g., through provision of technical support and capacity building).

Table 17: Scope and Responsibilities of M&E Functions at the Facility Level

Facility Level: Facility Management Team	
Stewardship Goal	Facility Management Team Functions
Establishment of a common data	• Maintain and update the Health Information System, including records, filing system(s) and registry for primary data collection tools (such as registers, cards, file folders), and summary forms (such as reporting forms, CDs,

Facility Level: Facility Management Team	
Stewardship Goal	Facility Management Team Functions
architecture	electronic backups). • Safeguard data and information system from any risks, e.g., fire, floods, access by unauthorized persons. • Compile all reports from the Technical Officers into a single health facility report.
Improve performance and review processes	• Ensure compilation and processing of minutes, inventory, supervision and other activity reports. • Analyse the quality of all reports received from various health facility units and ensure follow-up in case of incompleteness, problems with validity, or delays.
Enhancing sharing of data and promoting use of information for decision-making	• Ensure that every health facility summarises health and health-related data from the community and health facility; analyses it; disseminates it and uses the information for decision-making; provides feedback; and transmits summaries to the next level. • Prepare an analysis of the data for discussion during staff and board meetings for decision-making. • Forward health and health-related reports to the Sub county level. • Provide quarterly feedback to the health providers and the community unit committee. • Disseminate quarterly reports to the health facility committee. • Disseminate annual report to the health facility committee and Sub county forum.

Table 18: Scope and Responsibilities of M&E Functions at the Community Level

Community Level: Community Health Management Team	
Stewardship Goal	Community Health Management Team Functions
Establishment of a common data architecture	• Community Units: Maintain and update its M&E, which shall be shared regularly with household members in a forum as stated in the relevant community strategy. • Community health workers: Maintain registers to document daily activities and report regularly to supervising health facility. Compile all reports from the CHW.
Improve performance and review processes	• Develop quarterly and annual community health reports for integration into facility reports.
Enhancing sharing of data and promoting	• Prepare an analysis of the data for discussion during the staff and committee meetings for decision-making.

Community Level: Community Health Management Team	
use of information for decision-making	• Forward the committee report to the facility In-Charge. • Provide quarterly feedback to the community unit. • Disseminate quarterly reports to the community unit. • Disseminate annual report to the community unit.

5.2 Health Actors and M&E Functions Across All Levels

Table 19: Overview of Key Health Actors by M&E Function and Task

	Data Collection	Data Validation	Data Analysis	Information Dissemination	Information Use
Routine Information	Division of health informatics and M&E MoH Service delivery units IPs Disease programmes	Division of health informatics and M&E MoH Service delivery units	Division of health informatics and M&E MoH Service delivery units	Division of health informatics and M&E Dept. of technical planning	Division of health informatics and M&E Service delivery units (HMTs) National health observatory Development Partners for Health in Kenya (DPHK) IPS
Vital Statistics	CBS SAGAs	SAGAs	SAGAs	National health observatory	National health observatory DPHK IPS Service delivery units MED-NIMES
Health Research	Kenya Medical Research Institution	Kenya Medical Research Institution	National health observatory	National planning authority M&E unit	National health observatory Service delivery units DPHK

	Data Collection	Data Validation	Data Analysis	Information Dissemination	Information Use
					IPS MED-NIMES
Surveys			National health observatory	KNBS National AIDS Control Council Disease programmes M&E unit	National health observatory Service delivery units DPHK IPS MED-NIMES
Surveillance	DDSR	DDSR	DDSR	DDSR M&E unit	National health observatory DPHK IPS

5.3 Partnership and Coordination Framework

The health sector partnership in Kenya is guided by the Kenya Health Sector-wide Approach, introduced in 2005. The SWAp provides a framework through which all sector actors can engage to improve effectiveness of health actions. The SWAp principles reflect those set out in the Paris Declaration on Aid Effectiveness, built around country ownership, alignment, harmonization, managing for results, and mutual accountability. It is based on having the sector working around:

- One planning framework
- One budgeting framework
- One monitoring framework

The Health Sector M&E Framework shall be implemented in line with these same SWAp principles. In addition, the implementation of the M&E Framework will take into account the Constitution of Kenya 2010, which brought a major shift from central government to a devolved system of government. The partnership and coordination framework during the implementation of this M&E Framework therefore has the component of the national level partnership framework and county level framework, as well as the framework for coordination between the two levels of Government. (Note, the KHSSP and the Kenya Health Sector Partnership

Framework documents provide a detailed description of the partnership and coordination framework, which shall guide the health sector during the implementation of KHSSP, and the M&E Framework for the KHSSP.) Also see Figure 6 below.

5.4 National and County Government Coordination Structures

5.4.1 Development Partnership Forum

The Development Partnership Forum seeks to strengthen mutual accountability between the Government and its Development Partners to accelerate the development of Kenya. It is a multi-sectoral biannual high-level forum to reflect on ongoing cooperation, discuss political and policy developments as they relate to Kenya's economic and social development programme in Vision 2030, and identify joint goals and targets.

5.4.2 GOK Coordination Group

The GOK Coordination Group provides a high-level monthly forum for government to discuss economic, development, and humanitarian issues with a focus on aid effectiveness across ministries, and to increase the effectiveness and efficiency of external assistance to Kenya by exchanging information and experiences on key issues and ensuring that clear guidance is communicated to development partners in a coordinated manner and aligned with shared objectives.

5.4.3 Donor Coordination Group

The Donor Coordination Group provides a monthly forum for donors to discuss economic and development issues and to increase the effectiveness and efficiency of external assistance to Kenya by exchanging information and experiences on key issues, ensuring that support is provided in a predictable and coordinated manner and aligned with shared objectives.

5.4.4 Aid Effectiveness Group

The Aid Effectiveness Group brings GOK and donors together on a monthly basis with an aim to increase the effectiveness and efficiency of development assistance in Kenya by reducing transactions costs to the government, streamlining systems for delivering aid, standardizing procedures, eliminating duplication, managing for development results, and upholding mutual accountability

5.4.5 Health Sector Intergovernmental Consultative Forum

This is a consultative forum established to facilitate active engagement, consultation, cooperation and mutual accountability between the national-level MoH and the county departments of health. It was established Pursuant to Article 6(2) of the Constitution 2010, on devolution and access to services, and Article 13(2) of Intergovernmental Relations Act, 2012, on intergovernmental sectoral working groups and committees. This forum shall provide a forum for active engagement in implementation of priorities as spelt out in the M/E framework between the national level and the county level.

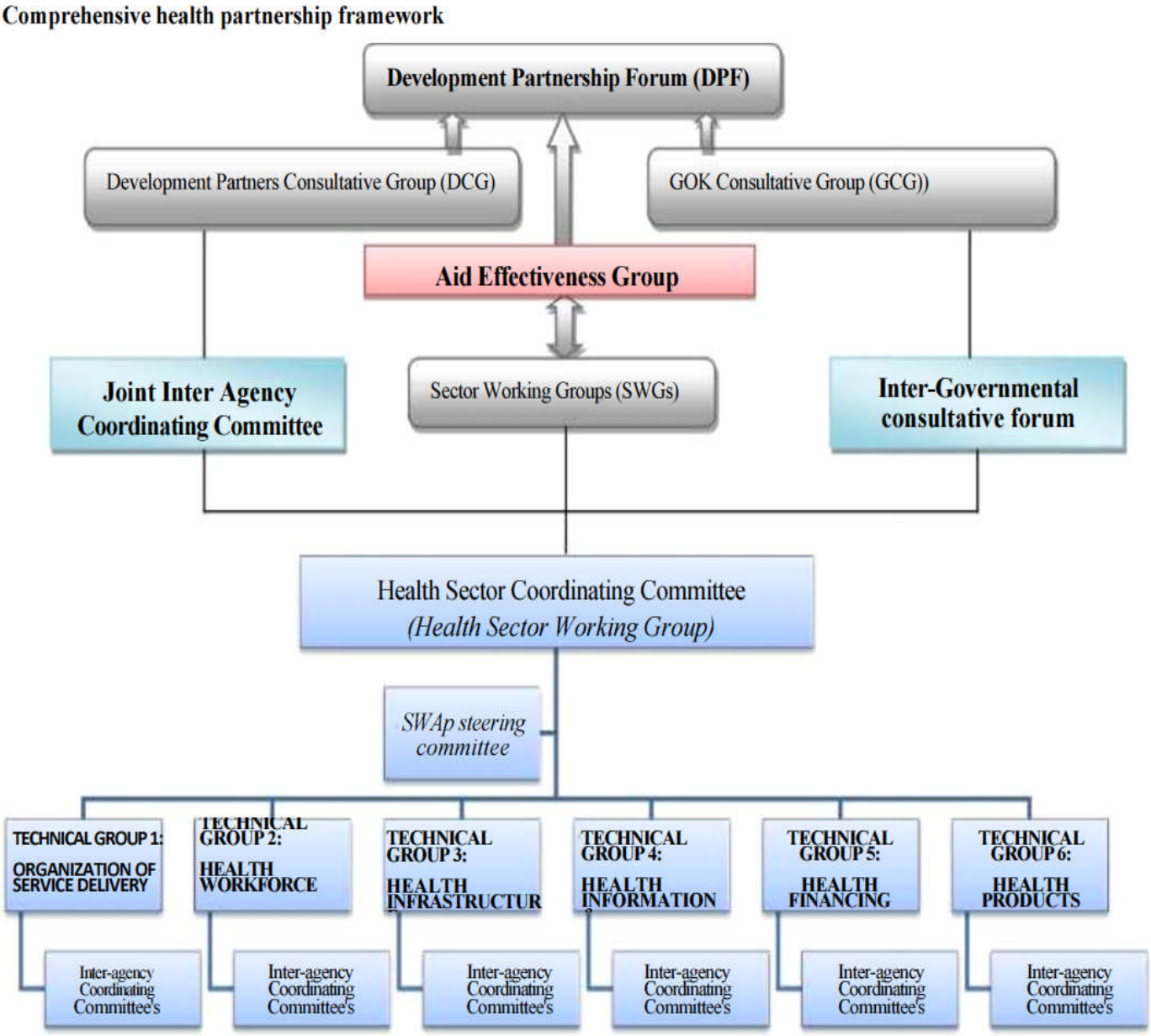
5.4.6 Health Sector Coordinating Committee (HSCC) Technical Working Groups

Both national and county levels will establish HSCC technical working groups.

The HSCC Technical Groups provide a forum for joint monitoring of specific investments/priorities within the sector. Their purpose in terms of M&E is to:

- Enable partners to become jointly responsible for monitoring, reviews and reporting.
- Hold all sector partners jointly accountable for achieving results.
- Provide easy access to coordinated TA and support for priority actions.

Figure 6: Comprehensive National Level Coordination Framework



6 ANNEX A. Alignment of KHSSPCore Indicators to Reporting Commitments

Policy Objective	Indicator	KHSSP	ECSA-HC	UNGASS	PEPFAR/PMI	MDGs	JFA	GAVI	GFTAM	MoU KEMSA
Level of Health	Life Expectancy at birth	√	√			√				
	Total annual number of deaths (per 100,000 population)	√	√							
	Maternal deaths per 100,000 live births	√	√			√				
	Neonatal deaths per 1,000 live births	√	√			√				
	Under five deaths per 1000	√	√			√				
	Youth and adolescent deaths per 1000	√								
	Adult deaths per 1000	√								
	Elderly deaths per 1000	√								
	Years of life lived with illness /disability	√	√							
	Due to communicable conditions	√				√		√	√	
	Due to non-communicable conditions	√								
	Due to violence /injuries	√								
Distribution of health	% range of Health Services Outcome Index	√								
Services Responsiveness	Client satisfaction index	√	√							
HEALTH & RELATED SERVICE OUTCOME TARGETS										
Eliminate Communicable	% fully immunised children	√	√					√		
	% of target population receiving MDA for schistosomiasis	√	√							

Policy Objective	Indicator	KHSSP	ECSA-HC	UNGASS	PEPFAR/PMI	MDGs	JFA	GAVI	GFTAM	MoU KEMSA
Conditions	% of TB patients completing treatment	√	√			√			√	
	% HIV+ pregnant women receiving preventive ARVs	√	√			√			√	
	% of eligible HIV clients on ARVs	√	√			√			√	
	% of targeted children under five provided with LLITNs	√	√			√			√	
	% of targeted pregnant women provided with LLITNs	√	√			√			√	
	% of children under five treated for diarrhoea	√	√			√		√		
	% school age children dewormed	√	√							
Halt, and reverse the rising burden of non-communicable conditions	% of adult population with BMI over 25	√	√							
	% women of reproductive age screened for Cervical cancers	√	√					√		
	% of new outpatients with mental health conditions	√								
	% of new outpatients cases with high blood pressure	√	√							
	% of patients admitted with cancer	√	√							
Reduce the burden of violence and injuries	% new outpatient cases attributed to gender based violence	√								
	% new outpatient cases attributed to road traffic Injuries	√	√							
	% new outpatient cases attributed to other injuries	√								
	% of deaths due to injuries	√								
Provide essential health services	% deliveries conducted by skilled attendant	√	√			√				
	% of women of reproductive age receiving family planning	√	√			√				
	% of facility based maternal deaths	√	√			√				
	% of facility based under five deaths	√	√			√				
	% of newborns with low birth weight	√				√				

Policy Objective	Indicator	KHSSP	ECSA-HC	UNGASS	PEPFAR/PMI	MDGs	JFA	GAVI	GFTAM	MoU KEMSA
	% of facility based fresh stillbirths	√				√				
	Surgical rate for cold cases	√								
	% of pregnant women attending four antenatal care visits	√	√			√				
Minimise exposure to health risk factors	% population who smoke	√	√							
	% population consuming alcohol regularly	√								
	% infants under six months on exclusive breastfeeding	√				√				
	% of population aware of risk factors to health	√								
	% of salt brands adequately iodised	√	√							
	Couple year protection due to condom use	√				√				
Strengthen collaboration with health-related sectors	% population with access to safe water	√				√				
	% children under five stunted	√	√			√				
	% children under five underweight	√				√				
	School enrolment rate	√				√				
	% of households with latrines	√				√				
	% of houses with adequate ventilation	√				√				
	% of classified road network in good condition	√								
	% schools providing complete school health package	√				√				
HEALTH INVESTMENT OUTPUT TARGETS										
Improving access to services	Per capita outpatient utilisation rate (M/F)	√	√							
	% of population living within 5km of a facility	√	√							
	% of facilities providing BEOC	√								
	Bed Occupancy Rate	√								

Policy Objective	Indicator	KHSSP	ECSA-HC	UNGASS	PEPFAR/PMI	MDGs	JFA	GAVI	GFTAM	MoU KEMSA
	% of facilities providing immunisation	√					√			
Improving quality of care	TB cure rate	√	√			√		√		
	% of fevers tested positive for malaria	√	√		√	√		√		
	% maternal audits/deaths audits	√	√			√				
	Malaria inpatient case fatality	√	√		√	√		√		
	Average length of stay	√								
HEALTH INPUT AND PROCESS INVESTMENT TARGETS										
Service delivery systems	% of functional community units	√								
	% outbreaks investigated within 48 hours	√				√				
	% of hospitals offering emergency trauma services	√								
	% hospitals offering Caesarean services	√								
	% of referred clients reaching referral unit	√								
Health Workforce	# of medical health workers per 10,000 population	√	√							
	% staff who have undergone CPD	√	√							
	Staff attrition rate	√	√							
	% Public Health Expenditures (gov't. and donor) on Human Resources	√								
Health Infrastructure	# of facilities per 10,000 population	√								√
	% of facilities equipped as per norms	√								√
	# of hospital beds per 10,000 population	√	√							√
	% Public Health Expenditures (gov't. and donor) on Infrastructure	√								√

Policy Objective	Indicator	KHSSP	ECSA-HC	UNGASS	PEPFAR/PMI	MDGs	JFA	GAVI	GFTAM	MoU KEMSA
Health Products	% of time out of stock for Essential Medicines and Medical Supplies – days per month	√	√							√
	% Public Health Expenditures (gov't. and donor) on Health Products	√								√
Health Financing	General Government Expenditure on health as % of the total government expenditure	√								√
	Total Health Expenditure as a percentage of GDP	√	√							
	Off budget resources for health as % of total public sector resources	√	√							
	% of health expenditure reaching the end users	√	√							
	% of Total Health Expenditure from out of pocket	√	√							
Health Leadership	% of health facilities inspected annually	√								
	% of health facilities with functional committees	√								
	% of counties with functional County Health Management Teams	√								
	% of Health Sector Steering Committee meetings held at national level	√								
	% of Health Sector Steering Committees meeting held at county level	√								
	% of facilities supervised	√								
	Number of counties with functional anti-corruption committees	√								
	% of facilities with functional anti-corruption committees	√								
	% of policies/document using evidence as per guidelines	√							√	
	% of planning units submitting complete plans	√								

Policy Objective	Indicator	KHSSP	ECSA-HC	UNGASS	PEPFAR/PMI	MDGs	JFA	GAVI	GFTAM	MoU KEMSA
	# of health research publications shared with decision- makers	√							√	
	% of planning units with Performance Contracts	√								
Health Information	% of quarters for which analysed health information is shared with the sector	√								
	% of planning units submitting timely, complete and accurate information	√	√							
	% of facilities submitting timely, complete and accurate information	√	√							
	% of health facilities with data quality assurance	√								
	% Public Health Expenditures (gov't. and donor) spent on Health Information	√								

ANNEX B: Standard Operating Procedures (SOPs)

Data Management

Data collation

This should be a daily activity in all Service Delivery Points.

- Enable partners to become jointly responsible for monitoring, reviews and reporting.
- Use standard tally sheet or registers
- Under each event/disease, count the number of events. Do this by drawing tally marks to keep an accurate account of the data being collated using the five bar gate system, e.g.,
- Sum up the tallies daily and at the end of every week.
- Sum up the weekly summaries at the end of the month.
- Collate data from the first to the last day of the month (e.g., 1st to 31st of Jan). Data collated for a particular month should not overlap into the next month.
- Recheck totals of every event/disease.
- Add the outreach, emergency and other services rendered in various parts of the facility.
- Keep tally sheets/registers filed for audit purposes.
- Transfer totals unto appropriate standard reporting forms at the end of the month.
- Complete ALL fields that require data in the standard reporting forms.
- Facility In-Charge or a designated person should cross- check and sign all reporting forms.
- Hospitals and other health facilities with the capacities to do so should enter data from the reporting forms into the DHIS.
- Complete ALL data fields in DHIS

Data cleaning and validation

Data cleaning and data validation are steps in the process of collecting data either from routine surveillance systems or periodically from surveys. These processes should ensure that the highest possible quality of data is collected and processed in the routine surveillance system. The collection of high-quality data starts at the source of information, where direct contact with the patient, diagnosis and/or treatment as well as data registration takes place and is conducted. All staff members involved in the data collection are responsible for the quality of data in the health information system. The roles in cleaning and validation of data are related to the roles defined in the later chapters. The Data Management Unit within the MoH M&E unit is responsible for the final cleaning and validation of the data set.

The M&E unit conducts the following procedures stepwise to clean and validate the data set:

STEP 1

Data checking for empty records

Records that have no information (system missing) on all of the following variables: County, Sub county health facility and registration number are invalid and need to be corrected. The data management will trace the source of these invalid records, collect the correct information and report on this immediately to the responsible officer as well as document this in the Data Management Register.

Data checking for system missing variables

Run frequencies for all variables and check system missing variables. Correct system missing variables if needed and possible. To correct the system missing variables, direct contact with the source of information is needed. The frequencies of system missing variables and the corrections are documented in the Data Management Register.

Data checking for duplicates

Duplicates can be traced by using the variables that identify a unique record. These variables are also called the 'key' variables for identification. In case of the present data set, the key variables to identify duplicates are SUB-COUNTY-SEX-AGE. If any of the records of these key variables contain one or more variables than are system, missing the duplicates cannot be traced and the data file cannot be validated on duplicates, it should be recorded in the report. Tracing for duplicates systematically is made possible by using an application like EpiData or SPSS/Stata/SAS. Use this application to trace duplicates and remove the duplicates from your data file. Save these duplicates in a different data file and report on the findings. For data management reasons it is important to report duplicates to the source of information.

Data checking for completeness of reported number of records

County, Subcounty and Health Care Facility could compare the number of reported records with those of the previous reports. By comparing trends over the year(s) outliers can be identified. These outliers should be reported to the county and subcounty. The sub county should confirm the number of reported records before the county can be included in the reports and the further action taken

STEP 2

Data checking for inconsistencies

The following checks should be done for tracing inconsistencies:

- Single variables
    - Frequency tables

    - Histograms

- Date variables
    - Logical order single date variables
    - Logical difference between date variables (example: Date of start treatment is before or equal to the date of end treatment)
- Two or more variables in relation to each other
    - Cross-tables for discrete variables
    - Scatter plots for longitudinal variables

Distribution

Frequency tables of all variables separately

- Check lowest and highest values
    - Out of normal range?
    - Within inclusion criteria?
- Check for unlikely values
    - Value too small or large to be likely
    - Negative values
    - Character instead of numeric values
    - o instead of 0
    - Comma instead of point in a number, or the other way around
    - Incorrect dates
    - Small vs. capital letters
- Check missing values
    - All coded in the same way?
    - Blank, 9, 99, or 999
- Check the distribution of all values
    - Likely? Outliers? Peaks?

Histograms of longitudinal variables

- Check the distribution of all values
    - Likely? Outliers? Peaks?
- Check lowest and highest values
    - Out of normal range?
    - Within inclusion criteria?
- Check for unlikely values
    - ‘Heaping’ of certain values (e.g., due to rounding)?

Cross-tabulation and scatter plots of two variables

- Some (possible) errors will appear only when looking at two variables at the same time
    - Check for unlikely associations in discrete variables in cross-tabulations
        - For example a two-year-old who is pregnant
    - Check for outliers in a scatter plot of two longitudinal variables
        - For example a height of 1.80 meters and a weight of 40 kilos

The above described steps should be registered and all inconsistencies should be reported. As soon as this report has been finished it is advisable to consult the data management coordinator on how these inconsistencies should be dealt with and the way the inconsistencies should be corrected. These steps need to be registered and reported as well.

STEP 3

Preparing the data file for analyses

National surveillance data files consist of identification variables, which preferably will not be forwarded for analyses. These identification variables will mostly be excluded from the data file, which will be used for analyses outside the Data Management Unit. For example the age can be calculated based on the date of birth and the date of diagnosis. Following this procedure a new variable, Age (at time of diagnosis) will be included in the data file.

- If you make a new variable out of one or more existing variables, first make sure the existing variables have no errors in them anymore.
- Then compare all values of the existing and the new variable to make sure all values of your new variable are correct.
- List the existing and new variables next to each other, for example, age calculated from date of birth and date of diagnosis.
    - Check some calculations at random
    - No negative values?
    - How have missing values (for either date of birth or diagnosis) been converted?
- Always check:
    - Number of observations is the same
    - Number of missing values is in general at least the number of missing values of the old variable(s)
    - Consistency of old and new variables
- Look at the new variables as you did with the existing variables

- Frequency tables, histograms of the new variables
- Cross-tabulation and scatter-plots with other variables.

Real-time validation checks

- To improve the data entry quality, during data entry, real-time data validation checks at the point of data entry should be defined, such as:
- Enforcing data types (for example, numeric fields cannot accept text)
- Defining mandatory fields (such as a patient's name and sex) without which a record cannot be saved
- Defining plausible ranges for numeric variables
- Enforcing valid options for categories by using drop-down lists or tick boxes instead of entering free text
- Checking valid formats for some fields, such as identifiers
- Defining hierarchies such as districts within a region
- Defining "skip" or conditional fields (for example, do not ask about drug regimens if a patient has not started treatment yet)
- Checking for implausible or illogical combinations (for example, a male patient cannot be pregnant; date of diagnosis cannot be before date of symptoms onset)

Deriving or calculating fields rather than requiring data entry (for example, if date of birth is known there is no need to enter the age of a patient).

Data quality assurance

Data quality assurance procedures will be adhered to. Details of the procedures and processes are outlined in the data quality assurance protocol that is to be read alongside this document.

Data validation

All the levels of health service delivery should constitute a Data Validation/review team. The chairperson of the health management team at that level should be the chairperson of this team.

- Data validation routine:
- Meet monthly to validate data before transmission.
- Data validation meetings should be held between the 1st and the 5th of the following month.
- Cross-check total figures on the reporting forms.
- Check for accuracy and completeness of reports.
- Cross check data consistency across reports.
- Look for unusually low or high values for events/diseases.
- Compare with previous months and same period the year before.

- Do necessary corrections before transmission.
- Chairperson of the validation team should sign off the reports as having been validated.

All errors detected after the submission of the reports can be changed upon submission of a completed Data Change Request Form/Data Change Form to the chair of the data validation. The data should be changed in all the associated data sets, both hard copy and electronic, and the higher level of reporting informed about the changes made.

Data analysis and synthesis

The procedure for data analysis at the different levels will be as follows:

- Always indicate the level of completeness of data being used for the analysis (all expected reports have been received and all forms have been filled completely without gaps).
- Run simple frequencies for events and cases, sector monitoring indicators and any other variables of interest.
- Cross-tabulate events/cases by months, age, sex, location, etc.
- Compare performance with KHSSP III targets for the level, and/or with historical data.
- Draw graphs to demonstrate performance and trends.
- Interpret findings and discuss results.
- Perform data review and feedback.

As per the guide, performance monitoring of the health sector at the subnational level will involve preparation of an integrated report based on the three-tier health facility reports and containing the following sections:

- Introduction
- Service delivery achievements
- CHMT/SCHMT achievements
- Partner achievements
- County/Sub county performance

The performance reports will be compiled by representatives from state and non-state actors under the leadership of county health heads, and dissemination of the reports is to all stakeholders.

Assess and rank the performance of stakeholders against stated indicators, communicate findings and provide structures for (feedback/exchange of ideas and knowledge)

Facilitate evidence-based decision-making

Establish and use the Kenya Research Agenda and Kenya National Health Observatory[11] to

- Conduct performance assessments addressing concerns on equity, efficiency, and effectiveness, and develop progress reports
- Incorporate research into findings for evidence-based decision-making. Develop an integrated health information system.

[11] Kenya National Health Observatory Concept notes.

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