REPUBLIC OF KENYA

BUSIA COUNTY

COUNTY GOVERNMENT OF BUSIA

DEPARTMENT OF HEALTH AND SANITATION

MONITORING AND EVALUATION PLAN 2018–2023

MARCH 2019

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Monitoring and Evaluation Plan 2018–2023

CONTENTS

LIST OF FIGURES

LIST OF TABLES

List of Acronyms

ALOS	Average Length of Stay
ALs	Artemether Lumefantrine
ANC	Antenatal Care
APR	Annual Performance Review
ARVs	Antiretroviral
AWP	Annual Work Plan
BCRH	Busia County Referral Hospital
BEmONC	Basic Emergence Obstetric Care
BMI	Body Mass Index
CASCO	County AIDS and STIs Coordinator
CCO	County Clinical Officer
CDH	County Director of Health
CECM	County Executive Committee Member
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHA	Community Health Assistant
CHAO	County Health Administration Officer
CHC	Community Health Committee
CHEW	Community Health Extension Worker
CHMT	County Health Management Team
CHRIO	County Health Records and Information Officer
CHSSIP	County Health Sector Strategic and Investment Plan
CHVs	Community Health Volunteers
CHWs	Community Health Workers
CLTS	Community-Led Total Sanitation
CMCC	County Malaria Control Coordinator
CMLT	County Medical Laboratory Technologists
CNO	County Nursing Officer
CPD	Continous Professional Development
CPHO	County Public Health Officer
CRD	Civil Registration Department
CSO	Civil Society Organization
CTLC	County TB and Leprosy Coordinator
CU	Community Unit
DDSR	Division of Disease Surveillance and Response
DDU	Data Demand and Use
DHIS2	District Health Information System 2
DQA	Data Quality Assurance
EMMS	Essential Medicine and Medical Supplies
EMR	Electronic Medical Record
EPI	Expanded Program on Immunization
FANC	Focused Antenatal Care
FBO	Faith Based Organization
FP	Family Planning
GIS	Geographical Information System
HCWs	Healthcare Workers
HEI	HIV Exposed Infant
HF	Health Facility
HIS	Health Information System
HMIS	Health Management and Information System
HRIO	Health Records and Information Officer
HSSP	Health Sector Support Programme
HTS	HIV Testing Service
ICT	Information and Communication Technology

ICU	Intensive Care Unit
IDSR	Integrated Disease Surveillance and Response
IEC	Information, Education and Communication
IFAS	Iron Folic Acid Supplement
iHRIS	Integrated Human Resources Information System
IMCI	Integrated Management of Childhood Illness
IPV	Inactivated Polio Vaccine
KDHS	Kenya Demographic and Health Survey
KEMSA	Kenya Medical Supplies Authority
KEPH	Kenya Essential Package of Health
KEPI	Kenya Expanded Programme on Immunization
KHSSIP	Kenya Health Sector Strategic and Investment Plan
KNBS	Kenya National Bureau of Statistics
KPI	Key Performance Indicators
LLINs	Long Lasting Insecticidal Nets
LMIS	Logistic Management Information System
M&E	Monitoring and Evaluation
MCH	Maternal Child Health
MDA	Multi-Drug Administration
MOH	Ministry of Health
MRI	Magnetic Resonance Imaging
NBU	New Born Unit
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organization
NHIF	National Health Insurance Fund
NHP Plus	Nutrition and Health Program Plus
ODF	Open Defecation Free
OPD	Out-Patient Department
RDQA	Routine Data Quality Assessment
RDT	Rapid Diagnostic Testing
SCHMT	Sub-County Health Management Team
SCHRIO	Sub-County Health Records and Information Officer
SDGs	Sustainable Development Goals
SETH	System Enhancing for Transforming Health
SGBV	Sexual and Gender-Based Violence
SMOH	Sub- County Medical Officer of Health
SOPs	Standard Operating Procedures
SWOT	Strength, Weakness, Opportunity and Threats
TB	Tuberculosis
TWG	Technical Working Group
UHC	Universal Health Coverage
WHO	World Health Organization

Foreword

This Monitoring and Evaluation (M&E) Plan is based on and carries forward an inclusive partnership between the County Department of Health and Sanitation and the stakeholders. It establishes a common platform to monitor CHSSIP 2018 - 2023 for the attainment of the sector vision of '*a healthy, productive and internationally competitive County*.'

Specifically, the M&E Plan articulates the CHSSIP results then delineate performance indicators and targets for the required coverage of services and interventions in the medium-term period. Plus, the data sources and analyses required to generate information for programmatic questions across the intervention areas. Further still, it details critical M&E processes including data documentation and information generation, data quality assurance, performance monitoring and review, and information sharing and learning. Without a doubt, the M&E Plan will impact positively on the County's capacity in performance management and the data use culture. It will also enhance management and governance across the Department for effective implementation of the CHSSIP. More importantly, it will align and guide efforts of stakeholders towards the sector goal of '*better health in a responsive manner.*'

I am confident that this M&E Plan provides the necessary framework for harnessing health information for planning, decision making, policy development, responding to inequities, and accountability for results during the CHSSIP period. I urge all stakeholders to concentrate their effort in its implementation to arch our beloved County towards Universal Health Coverage (UHC) and Sustainable Develop (SDG) 3.

Hon. Moses Mulomi
Deputy Governor and
Acting County Executive Committee Member for Health and Sanitation
BUSIA COUNTY

Preface

For the County to achieve the goal and objectives that are set out in the CHSSIP 2018 - 2023, a robust and efficient HIS/ M&E system is crucial. An M&E system that ensures information needs are clearly defined for the entire result chain and the information is regularly and competently analyzed, used and disseminated. The purpose of this M&E Plan is to steward the sector towards establishing one M&E system for improved accountability in health at all levels.

The focus in adoption and implementation of this M&E Plan by actors at all levels of the health sector being to strengthen the Busia County's capacity in information generation, validation, analysis, dissemination, and use. The M&E Plan outlines the processes, methods, and tools that the sector will use for collection, compilation, reporting, and use of data, and to provide feedback. It is an important performance management tool that will guide the County Department of Health and Sanitation and all other stakeholders towards achieving the CHSSIP goal and objectives.

I urge all health stakeholders to sincerely adopt and execute this M&E Plan in line with their scopes and in collaboration with the Department.

Dr. Isaac Omeri
Chief Officer for Health and Sanitation
BUSIA COUNTY

Acknowledgement

The County Department of Health and Sanitation wishes to acknowledge the contribution of all those who participated in the development of this M&E Plan in one way or the other. We acknowledge his Excellency the Governor for stewardship of the County. We acknowledge both the Acting County Executive Committee Member (CECM) and the Chief Officer of the Department of Health and Sanitation for providing leadership and resources.

We acknowledge all County Health Management Team (CHMT) and Sub-County Health Management Teams (SHMTs) for their contribution to the M&E Plan development process. Special acknowledgment goes to CHMT and SHMT members who participated directly through the M&E Plan Development Team—your dedication and tireless efforts have borne fruit. Further special acknowledgment goes to the M&E Unit for steering the M&E Plan development.

Last but not least, we acknowledge the partners—Tupime Kaunti, NHP Plus, AMPATH Plus, and SETH Project—who walked with us on this journey and offered technical and financial support.

Dr. Melsa Lutomia
County Director of Health,
Preventive and Promotive Services
BUSIA COUNTY

Dr. Janerose Ambuchi
County Director of Health,
Curative and Rehabilitative Services
BUSIA COUNTY

Executive Summary

For the County to achieve the goal and objectives set out in County Health Sector Strategic Plan (CHSSIP) 2018 - 2023, a robust and efficient HIS/ M&E system is crucial. It is with this backdrop that the sector through the stewardship of the County Department of Health and Sanitation sought to bring all stakeholders in health together to forge a common course for M&E. The purpose of the M&E Plan is to steward the sector towards establishing one M&E system for improved accountability in health at all levels.

The sector has made notable investments in strengthening the routine reporting system to make it more responsive and useful for sector performance monitoring. The Department has shown increased commitment to a single unified HIS by developing or adopting key HIS/ M&E policies. New technologies, realigning to UHC, measurement priorities, and national commitments to strengthening HIS present a major opportunity. HIS subsystems including TIBU (Program Management System for Tuberculosis), Community AIDS Program Reporting (CAPR), Logistics Management Information System (LMIS), Community Health Information System (CHIS), and Integrated Disease Surveillance and Response (IDSR) are now integrated into DHIS2 making it the default routine reporting system. This has greatly improved health data quality and use. Though the sector still has patient management systems that do not share data with DHIS2 leading to data gaps and parallel reporting systems. Other challenges are an insufficient investment toward building sustainable and comprehensive information systems, inefficient investments in data collection and analysis, inadequate capacity to produce quality health data and statistics, and limited access to and usability of data.

The focus in adoption and implementation of this M&E Plan by actors at all levels of the health sector is to strengthen the County's capacity in information generation, validation, analysis, dissemination, and use. Success in establishing a strong unified M&E system to improve the accountability of the health sector hinges on the stewardship role that health managers play at all levels of the County health sector. The M&E Plan defines the key stewardship goals that health managers in Busia County should strive towards as: supporting the establishment of common data architecture, improving the performance monitoring and review processes, and enhancing the sharing of data and promoting information use. The M&E Plan identifies key activities necessary for the attainment of the stewardship goals. Further still, it outlines the processes, methods, and tools that the sector will use for collection, compilation, reporting and use of data, and to provide feedback. The M&E Plan then translates these processes into annualized and costed activities with assigned responsibilities at relevant levels of the County health system.

1 INTRODUCTION

1.1 Background

The Constitution of Kenya 2010 under Article 43 guarantees citizens the right to the highest attainable standard of health, including reproductive health. Counties carry a much bigger burden and overall responsibilities for planning, financing, coordinating, delivery and monitoring of health services toward the fulfilment of this right to 'the highest attainable standard of health'. In Busia County, the health sector strives to achieve this aspiration by implementing effective and efficient strategies guided by Vision 2030 Third Medium-Term Plan 2018 - 2022, Kenya Health Policy 2014-2030, Kenya Health Sector Strategic and Investment Plan (KHSSIP) 2018-2023, County Integrated Development Plan (CIDP) 2018-2023 and County Health Sector Strategic and Investment Plan (CHSSIP) 2018-2023.

The CHSSIP is aligned to the CIDP and guides refocusing of the County health system towards Universal Health Coverage (UHC) and attainment of Sustainable Development Goal (SDG) 3. Accelerating UHC—all people have access to quality health services without suffering financial hardship—is one of the country's Big Four Agenda. The CHSSIP therefore brings together all the actions needed for health systems strengthening to impact UHC into a common consolidated logic. It elaborates the inputs or processes (health systems strengthening initiatives) needed to produce a comprehensive set of outputs (health systems performance) that will facilitate the attainment of the required coverages of services and interventions important for the people of Busia County to achieve the impact (level and distribution of health) that they desire.

SDG 3 Goal
'Healthy lives and wellbeing for all ages'

Kenya Health Policy Goal
'Attaining the highest possible standard of health in a responsive manner'

1.1.1 County Vision

A healthy, productive and internationally competitive County.

1.1.2 County Mission

A progressive, sustainable, technologically driven, evidence-based and client-centered health system with the highest attainable standards of health at all levels of care.

1.2 Rationale for M&E Plan 2018-2023

For the County to achieve the goals and objectives that are set out in the policy, strategic and operational documents, a robust and efficient HIS/M&E system is crucial. It is against this backdrop that the sector; through the stewardship of the County Department of Health and Sanitation, sought to bring all stakeholders in health together to forge a common course for M&E. The M&E Plan outlines the processes, methods, and tools that the sector will use for collection, compilation, reporting, use of data, and to provide feedback. The M&E Plan further translates these processes into annualized and costed activities with assigned responsibilities at relevant levels (County, Sub-County, facility and community) of the health system. The M&E Plan shall be the basis for:

- Guiding implementation of the CHSSIP by providing information on progress and results.
- Providing a unified approach to monitoring progress by all sector stakeholders.
- Guiding decision making in the sector by characterizing the implications of progress (or lack of it) being made by the sector.
- Guiding information dissemination and use by the sector stakeholders and the public.

1.3 Current Status of M&E in the Health Sector

The sector has made notable investments in strengthening the routine reporting system to make it more responsive and useful for sector performance monitoring. New technologies, measurement priorities, and national commitments to strengthening HIS present a major opportunity. HIS subsystems including TIBU (Program Management System for Tuberculosis), Community AIDS Program Reporting (CAPR), Logistics Management Information System (LMIS), Community Health Information System (CHIS), and Integrated Disease Surveillance and Response (IDSR) are now integrated into DHIS2 making it the default routine reporting system. This has greatly improved health data quality and use. However, the sector still has patient management systems that do not share data with DHIS2 leading to data gaps and parallel reporting systems. Other M&E/HIS challenges are insufficient investment toward building sustainable and comprehensive information systems, inefficient investments in data collection and analysis, insufficient capacity to produce quality health data and statistics, and limited access to and usability of data.

The County Department of Health and Sanitation has shown increased commitment to a single unified HIS by developing or adopting key HIS/M&E policies including Health Sector M&E Framework 2018-2023, Kenya Health Sector Data Quality Assurance (DQA) Protocol 2014, HIS Policy 2014-2030, HIS Strategic Plan 2014-2018, Kenya National e-Health Strategy 2011 - 2017, Kenya Standards and Guidelines for mHealth Systems 2017, and 3rd Edition Health Sector Indicator Manual and Standard Operating Procedures (SOP). However, there is still ground to be covered more so, in the institutionalization of the policies.

1.3.1 SWOT Analysis

SWOT analysis of the current status of M&E in the Health sector for Busia County is summarized in Table 1.1.

Table 1.1: SWOT Analysis of M&E in the Health Sector for Busia County

STRENGTHS

- Availability of policy guidelines and strategic documents (CIDP and CHSSIP).
- Existence of the M&E Unit—established in 2018.
- Existence of strong, unified and integrated HIS system—DHIS2 and EMR.
- Increased EMR coverage through scale-up.
- Availability of HIS/ M&E technical capacity.
- Continuous HIS/ M&E skills building.
- Active health stakeholder forum.
- Top leadership support for M&E.

WEAKNESSES

- Data quality issues—integrity, timeliness, accuracy, completeness.
- Inadequate HIS/ M&E budget.
- Inadequate human resources for HIS/ M&E.
- Over-reliance on partner support.
- Data collection and reporting tools shortages.
- Inadequate HIS ICT infrastructure—inadequate digitization of health records.
- Policies and guidelines not fully disseminated.
- HIS/ M&E skill gaps.

OPPORTUNITIES

- A willingness by the County and partners to carry out operational research.
- Multi-sectoral collaboration to improve health indicators.
- Availability of sector HIS/ M&E policies.
- Existence of County M&E Unit at the Department of Planning/ Governor's Office.
- Good working arrangement with the national government especially capacity strengthening.
- Existence of Kenya M&E curriculum for County level.
- Functional County online portal/ website.
- National and inter-County learning forums for and sharing best practices and success stories.
- DHIS2 enhancements that have improved data availability, quality, and sharing.
- Implementation at scale of tested mHealth innovations.
- Technical and financial support from health partners.

THREATS

- The diminishing donor funding stream.
- Partner-led health agenda.

1.4 Alignment of the M&E Plan to Existing Laws and Policies

The M&E Plan is aligned to a number of existing laws and policies as follows:

Constitution of Kenya (2010) — Article 43 talks about the right of the citizens to the highest attainable health care. In addition, Articles 10 and 201 emphasize the need for transparency, accountability, and public participation. The M&E Plan identifies these clauses as the key reasons why health services delivery needs to be monitored.

Health Act (2017) — Section 16 (1) stipulates Kenya health system and M&E-related roles. These 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 the improvement of obstetric and neonatal care, and monitoring the health system for efficiency and standard performance.

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 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 for submission to County Executive Committee for incorporation into the County 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 underscores the need for a national and a County government summit 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. The CHMTs will submit the progress reports to the County Executive Committee twice a year as required.

The Public Finance Management Act (2012) — 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 M&E Plan 2018-2023 has been aligned to other existing health sector policies including:

i. **Kenya Health Policy (2014-2030)** - The M&E Plan 2018-2023 is aligned to the Kenya Health Policy 2014-2023. The M&E Plan 2018-2023 uses existing data sources to measure achievement of CHSSIP 2018 - 2023 targets that are aligned to Kenya Health Policy 2014- 2023 goal.

ii. **KHSSIP (2018-2023)** - The M&E Plan 2018-2023 is organized around the three M&E stewardship goals as specified in the KHSSIP 2018 - 2023. The M&E stewardship goals are: establish a common data architecture, enhance sharing of data and promote information use, and improve performance monitoring and review processes.

iii. **HIS Policy (2010-2030)**—The M&E Plan 2018-2023 implements the existing unified and integrated HIS. The main HMIS data system is DHIS2—which is the MOH's routine institutional-based HIS for harmonized data collection, reporting and data analysis as stipulated in the policy.

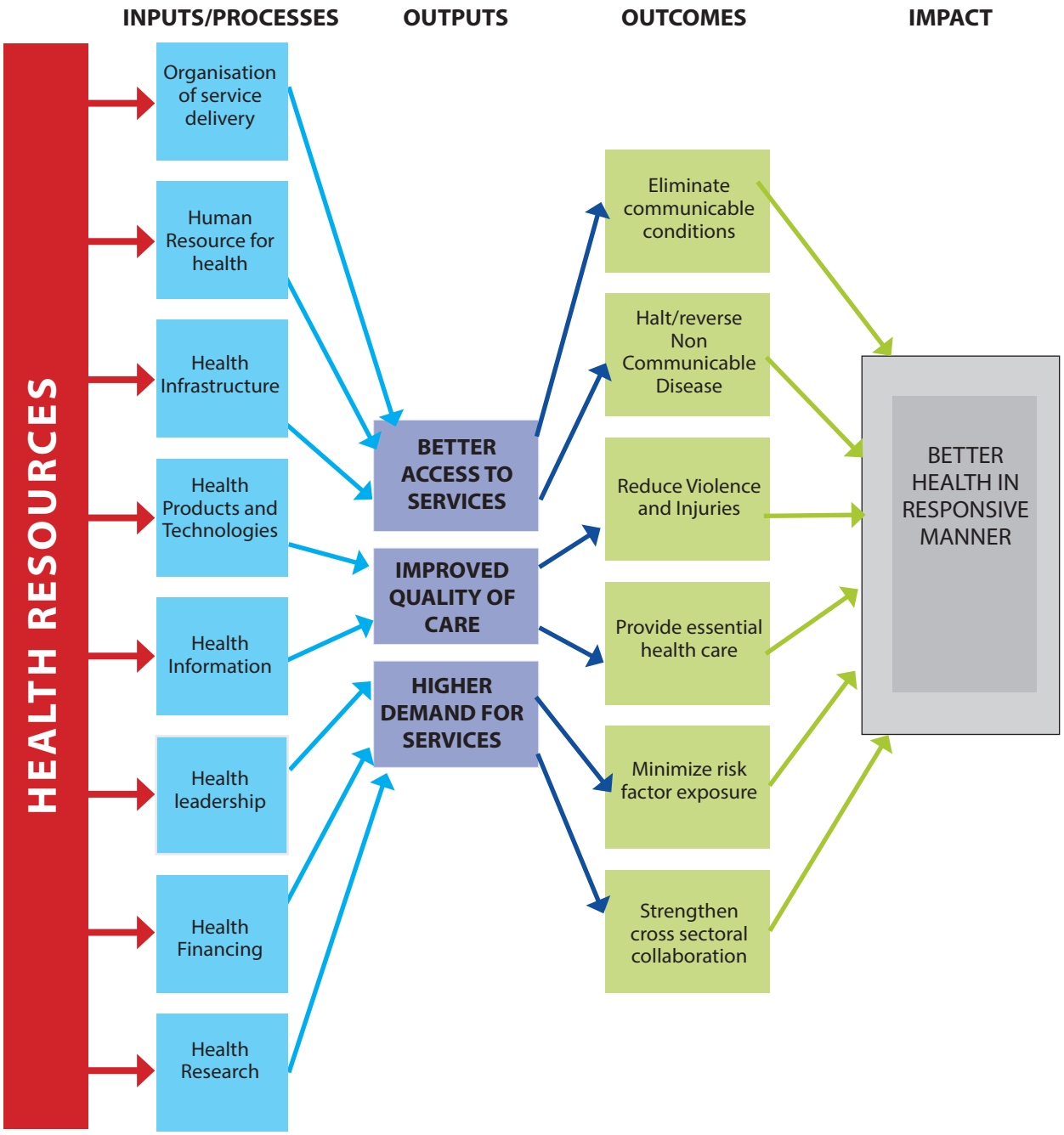
iv. **Health Sector M&E Framework (2018-2023)**—M&E of KHSSIP 2018-2023 is guided by the Health Sector M&E Framework 2014-2018. The M&E Framework 2014-2018 advocates for one M&E system for improved accountability in health.

v. **CIDP (2018-2023) and CHSSIP (2018-2023)**—The M&E Plan 2018-2023 maintains a clear focus on the goals of the CHSSIP 2018-2023. The operationalization of the Health sector priorities in the CIDP 2018-2023 will be through the CHSSIP 2018-2023.

1.5 The Kenya Health Systems Framework and Implications for M&E

The CHSSIP is strongly focused on clearly defined results at the level of impact, outcomes and outputs with clear linkages to priority investments—See Figure 1.1. To achieve the required coverages of services and interventions important for the people of Busia County to attain the impact that they desire, County health managers and policy-makers will continuously be required to take the right decisions. This is only possible by creating a comprehensive M&E system, which ensures that information needs are clearly defined for the entire result chain, and the information is regularly and competently analyzed, used and disseminated.

Figure 1.1: Kenya Health Systems Framework



Source: KHSSIP 2018 - 2023

2 OVERVIEW OF THE HEALTH SECTOR M&E PLAN

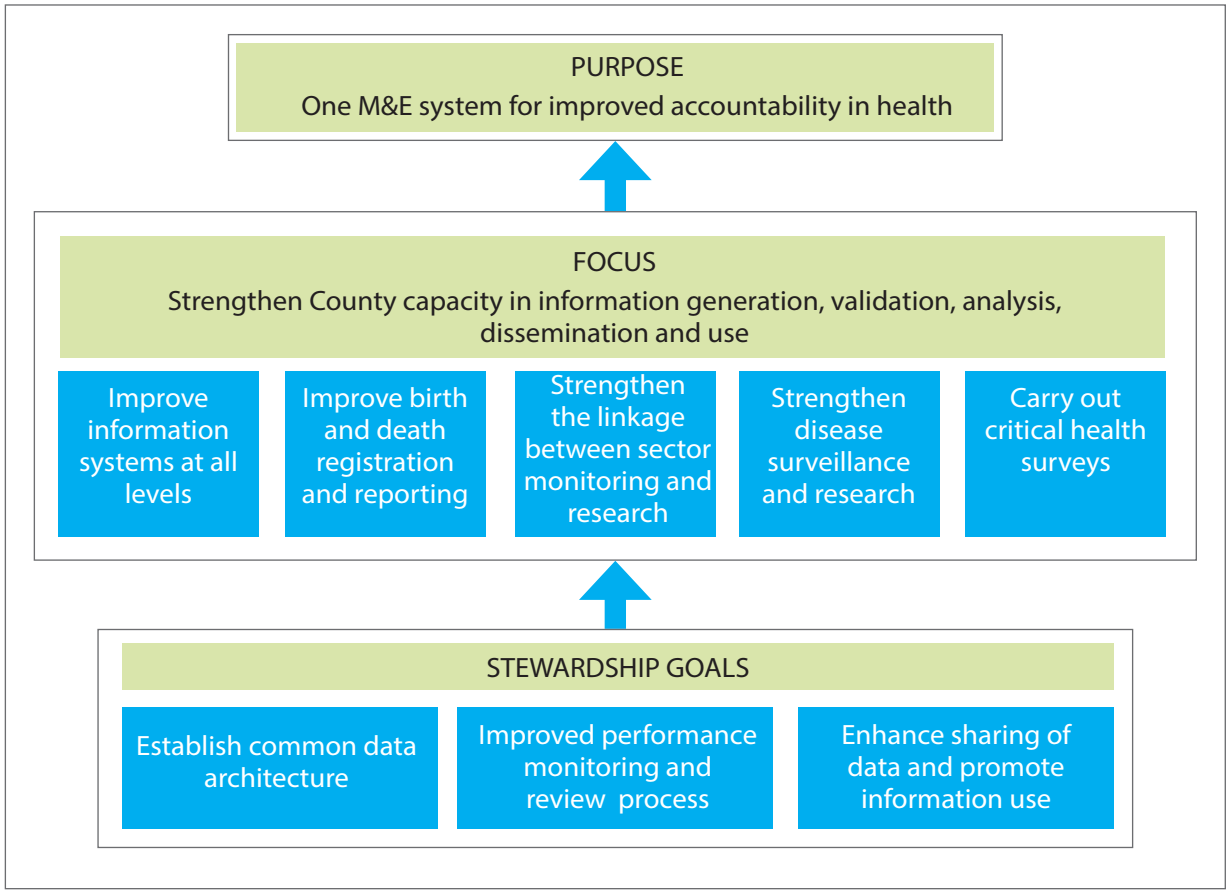
2.1 M&E Conceptual Framework

Strategic M&E direction of Kenya's health sector is informed by the Health Sector M&E Framework 2018 - 2023. The Framework also proposes an M&E conceptual framework—and the same has been adopted by the M&E plan—See Figure 2.1.

2.2 Purpose of the M&E Plan

The purpose of the M&E Plan is to steward the sector towards establishing one M&E system for improved accountability in health at all levels.

Figure 2.1: Scope of the M&E Framework



Source: KHSSIP 2018 - 2023

2.3 Objectives of the M&E Plan

- Align fragmented programmatic M&E approaches to a single unified County health sector M&E system.
- Build capacity of sector stakeholders to monitor and report the progress of the CHSSIP.
- Standardize M&E procedures at all levels of the health system.
- Enhance data demand and use at all levels of the health system.
- Promote social accountability in health service delivery.
- Identify lessons for organizational learning and knowledge sharing.
- Enhance institutional memory through improved documentation.

2.4 Focus of the M&E Plan

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

a) **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 Logistics Management Information System (LMIS), Integrated Human Resources Information System (iHRIS), financial management information system, and Health Management Information System (HMIS). Common data architecture should be used effectively across the systems to ensure and enhance data and information sharing.

b) **Improve birth and death registration and reporting:** Comprehensive 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/ programming in health. To acknowledge the dignity of human life, all births should be counted and registered and all deaths notified and recorded.

c) **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 Plan, 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 and financial risk protection amongst others. The M&E Plan outlines strategies for a collaborative relationship with research institutions.

d) **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.

e) **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.

2.5 Stewardship Goals Defined by the M&E Plan

Success in establishing a strong unified M&E system to improve the accountability of the health sector hinges on the stewardship role that health managers play at all levels of the health sector. The M&E Plan defines the key stewardship goals that health managers in Busia County should strive towards as follows:

a) **Supporting the establishment of a common data architecture:** Data architecture in the context of the M&E Plan refers to the use of standard nomenclature for services, medicines, medical supplies, and cadres of staff amongst others. Also, it refers to the use of standard coding systems across all databases. A common data architecture ensures coordinated information generation and sharing—and maximizes efficiencies in data and information management. The health sector has identified sector indicators for tracking progress and results of the CHSSIP. The prevailing common data architecture provides the data sources for these indicators—the indicators are defined in the 3rd Edition Health Sector Indicator Manual and SOPs. The Manual complements the M&E Plan—it fully describes the core health sector indicators including details of their method of collection and aggregation.

b) **Improving the performance monitoring and review processes:** Performance monitoring and review process are useful for documenting lessons learned during implementation of the CHSSIP. All performance reviews and evaluations will contain specific, targeted and actionable recommendations—as per the process outlined in the M&E Plan. All target institutions or responsible persons will provide a response to the recommendations within a stipulated timeframe, outlining proposed actions and a timeframe for implementation. All health managers will be required to properly document and closely track the agreed follow-up actions and status of these actions.

c) **Enhancing the sharing of data and promoting information use:** The M&E Plan recognizes the fact that different data is used by different actors for their decision-making processes. Thus, data should be translated into information that is relevant for different audiences at different levels for decision-making. Then packaged for dissemination in formats determined by the needs of these audiences. For the M&E Plan, the information will be disseminated using: electronic web platforms, public display of relevant information at the different levels, quarterly and annual performance review forums, and joint stakeholder forums.

Box 2.1: The 12 Components of a Functional M&E System

1. **Organizational Structures with M&E Functions**: An entity entrusted with the role and responsibility of managing all the M&E tasks is critical for optimal functioning of an M&E system.
2. **Human Capacity for M&E**: Rolling out M&E activities requires sufficient number of staffs and correct skills mix together with a strategy for continuously updating their knowledge and skills.
3. **Partnerships for Planning, Coordinating and Managing the M&E System**: Involvement of stakeholders contributes to effective M&E system.
4. **M&E Frameworks/ Logical Framework**: M&E framework is essential as it links the objectives with the processes and enables the M&E expert know what to measure and how to measure it.
5. **M&E Work Plan and Costs**: M&E work plan illustrates how personnel, time, materials and money will be used to achieve the set M&E functions. It also outlines how the resources that have been allocated for the M&E functions will be used to achieve the goals of M&E.
6. **Communication, Advocacy and Culture for M&E**: Refers to presence of relevant policies and strategies within the organization to support M&E functions.
7. **Routine Programme Monitoring**: Data needs to be collected and reported on a continuous basis to show whether the organization is on course to meeting the set objectives.
8. **Surveys and Surveillance**: Surveillance provides regular and timely information on status of indicators for notifiable conditions.
9. **National and Sub-National Databases**: Service delivery data is collected routinely using recommended data tools, then summarised and transmitted to national and sub-national (i.e. County) databases
10. **Supportive Supervision and Data Auditing**: Data auditing implies that the data is subjected to verification to ensure its reliability and validity. Supportive supervision is important since it ensures the M&E process is run efficiently.
11. **Evaluation and Research**: Evaluation establishes whether the organization has achieved intended results. It informs design of new programs, and enables program improvement and sharing of lessons with stakeholders.
12. **Data Dissemination and Use**: M&E outputs should be shared with relevant stakeholders for program improvement and accountability purposes.

2.6 Components of the M&E System

Functional M&E system provides essential data for monitoring agreed sector priorities as stipulated in the CHSSIP. UNAIDS describes components that should be present and working to an acceptable standard for the M&E system to function well (UNAIDS, 2009)—See Box 2.1. Busia County will focus on a few of the components at the outset and phase-in M&E investments over time to get all of the system components operational. The County will build on systems and capacity that already exist and address the issues of human resources and functioning partnerships to support the collection of good quality data. Most importantly, the County appreciates the ultimate purpose of M&E: using data for decision-making. It is a waste of valuable resources to collect data that are not used.

Busia County will focus on a few of the components at the outset and phase-in M&E investments over time to get all of the system components operational. The County will build on systems and capacities that already exist and address the issues of human resources and functioning partnerships to support the collection of good quality data. Most importantly, the County appreciates the ultimate purpose of M&E: using data for decision-making. It is a waste of valuable resources to collect data that are not used.

2.7 How does M&E relate to the HIS?

HIS provides the underpinnings for decision-making and have four key functions: data generation, compilation, analysis and synthesis, and communication and use. M&E is a process that helps improve performance and achieve results. The HIS is essential for M&E but also serves broader objectives, such as providing an alert and early warning capability, supporting patient and health facility management, enabling planning, underpinning and stimulating research, permitting health situation and trends analyses, orienting national and County reporting, and reinforcing the communication of health challenges to diverse users. M&E needs to draw on existing data from the HIS. As such, M&E performance is directly linked to the capacity of the HIS. Efforts to coordinate M&E with the overall HIS are therefore essential and strengthening M&E should contribute to the overall performance of the HIS and vice versa. To accomplish this, the M&E Plan will promote building the M&E capacity of health managers and healthcare workers (HCWs) across all levels. Equally important, M&E requirements will be designed in such a way that they do not overwhelm the capacity of the health staff.

2.8 The M&E Unit

In Busia County, the M&E Unit is mandated with overall oversight of M&E activities in the Department. Established in 2018, the M&E Unit is responsible for the day-to-day implementation and coordination of the M&E activities to monitor the CHSSIP. Functional linkage of the health sector to the County-wide and multi-sectoral M&E Unit in the County Department of Planning or the Governor's Office will be through the CECM for Health and Sanitation.

2.9 The Process of Developing the M&E Plan

The Department spearheaded the M&E Plan development in a process that was guided by roadmap from M&E Technical Working Group (TWG). The inaugural step was a consolidation of Draft 0 by a M&E Plan Development Team constituted by the M&E Unit and comprising select CHMT and SCHMT members, and some partners—See Annex VII. The Draft 0 underwent stages of reviews during which CHMT and stakeholders' inputs were sought and incorporated. The consultative process culminated in a stakeholder validation meeting. Final Draft with stakeholder inputs was submitted to top leadership for endorsement and signing. The approved Draft was then readied for publishing and joint launch with the CHSSIP 2018-2023.

2.10 Health Sector Indicators

The CHSSIP results framework has been populated with selected performance indicators and targets that the sector will monitor on a regular basis to assess progress. These are core indicators that collectively provide information on overall health sector progress—See Table 2.1. The core indicators meet the following characteristics:

- Each indicator contributes to measuring an element of the results chain: input, process, output, outcome, and impact. All CHSSIP result levels are tracked.
- The indicator list reflects all lifecycle cohorts: pregnancy and new-born, childhood, adolescence, adulthood and elderly.
- The indicators align with existing health sector monitoring commitments.

Table 2.1: Health Outputs and Outcomes Indicators and Targets

Objective	Indicator	Baseline (%) 2016/17	Targets (Where Applicable)					Source
			2018/19	2019/20	2020/21	2021/22	2022/23	
HEALTH & RELATED SERVICE OUTCOMES								
Eliminate Comm-unicable Conditions	% fully immunized children	(66%) 20,584	70%	75%	80%	90%	95%	HIS
	% of TB patients completing treatment	(83.3%) 959	90%	100%	100%	100%	100%	HIS
	% of HIV + pregnant mothers receiving preventive ARV's	(95%) 1532	100%	100%	100%	100%	100%	HIS
	% of pregnant mothers getting IPT2	(64%) 19973	90%	100%	100%	100%	100%	HIS
	% of targeted under 1's provided with LLITN's	(63%) 19,510	90%	100%	100%	100%	100%	HIS
	% of targeted pregnant women provided with LLITN's	(70%) 22,564	90%	100%	100%	100%	100%	HIS
	Proportion (%) of under-5s treated for diarrhoea	19%	17%	15%	13%	11%	9%	HIS
Reduce the burden of violence and Injuries	# of new outpatient cases attributed to gender-based violence	3,776	3,588	3,409	3,239	3,077	2,924	HIS
	# of new outpatient cases attributed to road traffic injuries	4,030	3,829	3,638	3,456	3,284	3,120	HIS
	# of new outpatient cases attributed to other injuries	11,261	10,698	10,164	9,656	9,174	8,716	HIS
Halt, and reverse the rising burden of non-comm-unicable conditions	% Women of Reproductive Age screened for cervical cancers	(4.6%) 5,503	8%	12%	16%	20%	24%	HIS
	Proportion (%) of adult population with body mass index (BMI) over 25	84%	81%	77%	73%	70%	67%	HIS

Objective	Indicator	Baseline (%) 2016/17	Targets (Where Applicable)					Source
			2018/19	2019/20	2020/21	2021/22	2022/23	
	% of new outpatients with mental health conditions	480	458	438	412	390	373	HIS
	# of new outpatients with high blood pressure	16,778	15,981	15,184	14,386	13,386	12,984	HIS
Provide essential health services	% deliveries conducted by skilled attendant	(51.9%) 16,865	58%	64%	70%	76%	80%	HIS
	% of women of Reproductive Age receiving Family Planning	(47%) 91,568	53%	59%	67%	73%	77%	HIS
	# of facility based maternal deaths	17	14	11	8	6	5	HIS
	# of facility based under-5 deaths	177	168	156	144	138	133	HIS
	# of new born with low birth weight	657	617	577	537	497	460	HIS
	# of facility based fresh still births	299	269	239	209	179	150	HIS
	% of pregnant women attending 4 ANC visits	(41%) 13,336	49%	57%	65%	72%	80%	HIS
	% of adolescent pregnancies among new ANC mothers	(42%) 6,790	37%	32%	27%	22%	17%	HIS
	% of infants under-6 months on exclusive breastfeeding	(61%) 19,025	63%	67%	72%	75%	78%	HIS
	# of clients screened for eye related conditions	15,125	15,830	16,650	17,420	18,200	21,150	HIS
	# of patients who have undergone eye surgery	2,170	2,200	2,340	2,670	2,930	3,200	HIS
	Couple Year Protection due to condom use	4,954	5,449	5,944	6,439	6,934	7,431	HIS
Strengthen collabo--ration with health-related sectors	% of children under-5 whose growth is being monitored	23.10%	26%	29%	35%	42%	50%	HIS
	Proportion (%) of stunted under-5 children	9.60%	8.20%	6.80%	5.40%	4%	2.50%	HIS

Objective	Indicator	Baseline (%) 2016/17	Targets (Where Applicable)					Source
			2018/19	2019/20	2020/21	2021/22	2022/23	
	% of underweight under-5 children	25.20%	22.70%	20.20%	17.70%	15.20%	12.50%	HIS
	Proportion (%) of households with latrines	59.70%	65.80%	71.90%	78%	84%	90%	HIS
	Proportion (%) of households with adequate ventilation	70%	75%	80%	85%	90%	95%	HIS
	Proportion (%) of schools providing complete school health package	6%	17%	28%	39%	40%	60%	HIS
	% of children 12 - 59 months dewormed at the health facility	(50.36%) 77,204	58%	65%	70%	75%	80%	HIS
	% of children 6 - 59 months receiving 2 doses of vitamin	47.2%	54%	62%	68%	75%	80%	HIS
	% of children 6 - 23 months receiving adequate and diverse comple-mentary foods	20%	30%	40%	50%	60%	70%	HIS
	% of pregnant women receiving combined IFAS	(59.8%) 79161	62%	65%	69%	74%	80%	HIS
	% of children below-5 years wasted	2%	1.9%	1.8%	1.7%	1.6%	1.5%	HIS
Improving access to services	Proportion (%) of population living within 5km of a health Facility	701,769 (82%)	83%	85%	86%	88%	90%	HIS
	Proportion (%) of facilities providing BEOC (80 GoK facilities)	40%	53%	67.50%	81.20%	95%	100%	HIS
								HIS
	Proportion (%) of facilities providing CEOC (8 facilities GoK)	4 (50%)	6 (75%)	7 (87.5%)	8 (100%)	8 (100%)	8 (100%)	HIS
	Bed Occupancy Rate	117%	100%	100%	100%	100%	100%	HIS
	Proportion (%) of facilities providing immunization services	83%	100%	100%	100%	100%	100%	HIS

Objective	Indicator	Baseline (%) 2016/17	Targets (Where Applicable)					Source
			2018/19	2019/20	2020/21	2021/22	2022/23	
Improving the quality of care	TB Cure Rate	50%	58%	66%	74%	82%	92%	HIS
	Proportion (%) confirmed malaria cases treated with ACT	85%	100%	100%	100%	100%	100%	HIS
HEALTH INPUT AND PROCESS INVESTMENT								
Service Delivery	Proportion (%) of maternal audits/death audits	18%	100%	100%	100%	100%	100%	HIS
	Malaria inpatient case fatality rate	5%	4%	4%	3.50%	3%	2.50%	HIS
	Proportion (%) of functional community units	184 (94%)	184 (94%)	190 (97%)	195 (100%)	195 100%)	195 100%)	HIS
	Proportion (%) of existing laboratories accredited	0%	17%	23%	29%	35%	50%	HIS
	Proportion (%) of referred clients reaching referral unit	25%	40%	55%	70%	80%	85%	HIS
	Proportion (%) of health facilities inspected annually	15%	34%	49%	72%	87%	100%	HIS
Human Resources for Health	# of staffs recruited	441	134	150	150	150	100	HR Reports
	# of health workers per 10,000 population	9	12	14	15	16	18	HR Reports
	Staff Attrition Rate	2.50%	2.50%	2.50%	2.50%	2.50%	4.25%	HR Reports
	Proportion (%) of staff with job description	0%	100%	100%	100%	100%	100%	HR Reports
	# of staffs trained in leadership management	0	25	25	25	25	25	HR Reports
	# of staffs on professional training	22	25	25	25	25	25	HR Reports
	# of best performing staff awarded	14	14	14	14	14	14	HR Reports
Health Products and tech-nologies	Proportion (%) of days per month when essential medicines and medical supplies (EMMS) are out of stock	13/30 days	0%	0%	0%	0%	0%	HIS

Objective	Indicator	Baseline (%) 2016/17	Targets (Where Applicable)					Source
			2018/19	2019/20	2020/21	2021/22	2022/23	
	Proportion (%) of public health funds (government and donor) spent on health products	18%	8.50%	10%	12%	14%	16%	HIS
	% of health facilities with essential medicines (order-fill rate)	100%	100%	100%	100%	100%	100%	HIS
	# of supply plans developed by the County	1	1	1	1	1	1	HIS
	Amount of funds allocated to the department of health and sanitation for essential medicines and commodities	107,728,918	169,000,000	200,000,000	280,000,000	340,000,000	400,00,000	Budget Documents
Health Financing	County government expenditure on health as proportion (%) of total expenditure	24.60%	27.1%	29.5%	32%	33%	34%	Budget Documents
	% of total health expenditure contributed by partners/ donor projects/ programs	52.20%	48.70%	45.20%	41.70%	38.2	34.70%	Budget Documents
	% of indigent population covered by insurance/ NHIF/ Mandatory Prepayment Schemes	13%	13%	15%	15%	16%	16%	Budget Documents
	Proportion (%) of funds allocated and utilized for maintenance of health facilities	3%	4%	4%	6%	7%	7%	Budget Documents
	County government expenditure on health as proportion (In millions)	1,501,220,941	1,979,519,340	1,850,092,649	2,080,119,573	2,288,131,531	2,496,143,489	Budget Documents
Leadership & Governance	Proportion (%) of health facilities with functional committees	100%	100%	100%	100%	100%	100%	MOH Documents

Objective	Indicator	Baseline (%) 2016/17	Targets (Where Applicable)					Source
			2018/19	2019/20	2020/21	2021/22	2022/23	
	Proportion (%) of Sub-Counties with functional Sub-County health management teams	7%	7%	7%	7%	7%	7%	MOH Documents
	Proportion (%) of health facilities supervised	50%	60%	70%	80%	90%	100%	MOH Documents
	AWP developed and approved in time	1	1	1	1	1	1	MOH Documents
Health Infra-structure	# of facilities constructed	1	0	0	1	0	3	MOH Documents
	# of incinerators constructed	5	5	5	5	0	0	MOH Documents
	# of warehouses constructed	1	0	0	1	1	2	MOH Documents
	# of GBV centers constructed	1	0	0	1	0	1	MOH Documents
	# of Orthopedic workshops constructed (Port Victoria)	0	0	0	0	0	0	MOH Documents
	# of health centers upgrade to Sub-County hospitals (Amukura, Nambale, Matayos)	0	0	1	1	1	0	MOH Documents
	3 of hospitals upgraded to level 5 (Busia County Referral Hospital)	0	0	0	0	0	0	MOH Documents
	# of SCH upgraded to level 4 (Port Victoria SCH)	0	0	0	0	0	0	MOH Documents
	# of dispensaries upgraded to health centers	0	20	5	5	5	5	MOH Documents
	# of facilities under construction completed (Buyosi, Muyafwa, Luliba, Benga, Kapina, Aloyet, Omayembe, Totokakile),	8	0	2	2	2	2	MOH Documents

Objective	Indicator	Baseline (%) 2016/17	Targets (Where Applicable)					Source
			2018/19	2019/20	2020/21	2021/22	2022/23	
	# of level 4 hospitals equipped with assorted medical equipment	1	0	0	1	0	1	MOH Documents
	# of disability-friendly delivery bed purchased	0	7	7	7	7	7	MOH Documents
	# of physiotherapy equipment purchased	0	0	4	2	3	9	MOH Documents
	# of EPI cold-chain equipment purchased	70	12	12	15	20	22	MOH Documents
	# of operationalized new dispensaries	12	2	2	3	3	3	MOH Documents
	# of orthopedic equipment and tools purchased	0	1	1	1	1	1	MOH Documents
	# of assorted equipment for a satellite eye clinic purchased	0	0	2	1	1	0	MOH Documents
	# of existing equipment maintained all facilities	80	80	82	85	88	91	MOH Documents
	# of laundry machines procured for every hospital in each Sub-County	0	3	3	0	0	1	MOH Documents
	# of anesthetic machines for every hospital in each Sub-County (Matayos, Nambale, Khunyangu, and Sio Port)	0	0	1	2	1	0	MOH Documents
	# of baby resuscitative procured for every Sub-County and County Referral Hospital	1	2	2	1		6	MOH documents
	# of short-wave diathermies procured	0	0	2	2	2	1	MOH documents
	# of oxygen concentrators per facility purchased	1	5	5	5	5	5	MOH documents

Objective	Indicator	Baseline (%) 2016/17	Targets (Where Applicable)					Source
			2018/19	2019/20	2020/21	2021/22	2022/23	
	# of therapeutic ultra sound machine purchased	0	2	2	2	1	0	MOH documents
	# of refrigeration equipment for mortuaries procured	3	1		1	1	0	MOH documents
	# of pressure equipment for embalming for the hospitals procured	3	1		1	1	0	MOH documents
	# of EPI refrigerators purchased	0	16	0	0	0	0	MOH documents
	# of purchased EPI deep freezers	0	1	1	1	1	2	MOH documents
	#r of purchased cold chain gas cylinders for 12 new facilities, and 10 for the regional warehouse	0	12	10	0	0	0	MOH documents
	# of assorted medical equipment purchased for all primary health care facilities	75	75	75	75	75	75	MOH documents
	# of radiology equipment (x-ray) machines purchased for the new hospitals (Matayos, Alupe, Sio Port, Port Victoria, Khunyangu)	0	1	1	1	1	2	MOH documents
	# of imaging equipment (MRI, CT scan) machines purchased for BCRH	0	1	1	0	0	0	MOH documents
	# of water testing kits (3 per Sub-County) purchased	0	0	6	6	9	0	MOH documents
	# of microscopes procured	10	9	9	9	0	0	MOH Documents
	# of oxygen plants purchased for the County hospital	0	1	0	0	0	0	MOH Documents

Objective	Indicator	Baseline (%) 2016/17	Targets (Where Applicable)					Source
			2018/19	2019/20	2020/21	2021/22	2022/23	
	# of ambulances purchased (1 per Sub-County and 2 for County Referral Hospital)	7	2	2	2	3	0	MOH Documents
	# of utility vehicles purchased	3	2	2	2		0	MOH Documents
	# of trucks purchased for delivery of drugs	0	0	1	0	0	0	MOH Documents
	# of ICT equipment procured and installed	7	2	2	2	2	0	MOH Documents
	# of ICT equipment routinely maintained at County and Sub-County	67	89	84	100	104	0	MOH Documents
Health Information systems and Monitoring and Evaluation	# of research framework developed	0	0	1	0	1	0	MOH Documents
	# of research repository developed	0	0	1	0	0	0	MOH Documents
	# of health research publications shared with decision makers	0	0	4	4	4	4	MOH Documents
	# of researches approved and conducted	0	0	20	30	30	30	MOH Documents
	# of research findings disseminated	0	0	20	30	30	30	MOH Documents
	# of functional research committee	0	0	1	0	1	0	MOH Documents
	Proportion (%) of planning units submitting timely, complete and accurate information (AWP reports)	72% (372 - CUs, HFs, SCHMT, CHMT)	100%	100%	100%	100%	100%	MOH Documents
	Proportion (%) of facilities submitting timely and accurate information	68%	62%	100%	100%	100%	100%	MOH Documents

Objective	Indicator	Baseline (%) 2016/17	Targets (Where Applicable)					Source
			2018/19	2019/20	2020/21	2021/22	2022/23	
	# of annual County review meetings held (RMNCAH, WASH, Malaria, HIV, TB, M&E, Nutrition, Commodity security, CHMT service delivery)	0	36	36	36	36	36	MOH Documents
	Proportion (%) of hospital deaths having reliably been determined and certified cause of death (Event capture)	0	90%	100%	100%	100%	100%	MOH Documents
	# of DQAs conducted and findings implemented	4	4	4	4	4	4	MOH Documents
	% of facilities with reporting tools, policies and standards	56%	71%	100%	100%	100%	100%	MOH Documents
	# of County repository in place and functional	0	0	1	0	0	0	MOH Documents
	# of data review meetings conducted and findings utilized	4	4	4	4	4	4	MOH Documents
	# of information products developed	4	9	9	9	9	9	MOH Documents
	# of M&E Plan in place	0	1	0	0	1	0	MOH Documents
	# of performance review reports developed	1	1	4	4	4	4	MOH Documents

3 OPERATIONALIZATION OF THE HEALTH SECTOR M&E STEWARDSHIP GOALS

3.1 Support Establishment of a Common Data Architecture

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

3.1.1 Developing a Unified HIS

The demand for timely and accurate data and statistics in the Constitution of Kenya (2010) era is a great opportunity to build stronger HIS. Indeed, Kenya has made tremendous progress in the area of HIS/ M&E—the HIS infrastructure has evolved from paper-based generation, transmission and storage to the new web-based system. DHIS2 is now well accepted as the default routine reporting system leading to improved quality of health data. A concerted effort is necessary to safeguard the gains while tackling the challenges. This M&E Plan advocates for investments to strengthen information governance, eHealth architecture, and data standards—to allow interoperability.

3.1.2 Technical HIS Responsibilities at County Level

For optimal utilization of the unified HIS, national and County levels must work together—technical HIS responsibilities at County level are as follows:

Development of guidelines

- Comply with national government requirements on health information sharing by the two levels of government.
- Adopt national reporting mechanisms and tools for County HIS.
- Apply national guidelines and tools on data management.

- Legislate on establishment and maintenance of County HIS.
- Enforce mandatory reporting by County health care providers.
- Apply relevant measures on the confidentiality of data.

Data management

- Establish and maintain County HIS as part of the integrated HIS.
- Provide the County top leadership including the Governor with all information required to fulfill duties such as reporting to County Assembly.
- Analyze County data for decision-making.
- Prepare quarterly County health report for discussion and ratification by stakeholders.

Evidence generation for health

- 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.

3.1.3 Data Management

The data collection strategy for the routine service statistics (indicators and dataset) at the community and facility levels has already been developed and rolled out through the DHIS2—See Annex III. The HIS Unit coordinates data management including the collection of data.

- At the household level, data will be collected by the Community Health Volunteers (CHVs)—guided by the household register, which lists all the households in the community unit. The CHV fills in the service delivery data on a community log/diary. This log is presented to a Community Health Extension Workers (CHEW) at the facility to which the Community Unit is attached. The CHEW aggregates all the community logs received into the CHEW summary. For those facilities that have DHIS2 access, the CHEW summary for the facility can be posted at the facility. While for those without, the CHEW summary is posted on DHIS2 at the Sub-County.
- At the facility level, all public and private facilities and all partners collect routine service delivery data using standard tools and registers. These are then collated into standardized reporting forms and submitted monthly in DHIS2—or from the Sub-County level for those facilities that do not have access to DHIS2.
- Data flow and dissemination for Busia County including data management hierarchy and feedback is illustrated in Table 3.1.

Table 3.1: Data Flow and Feedback for Busia County

Data Management Hierachy

Data Flow

Feedback

LEVEL	DATA COLLECTION	COMPILATION	STORAGE	ANALYSIS	REPORTING	USE
National Responsible Person(s)	Indicator Development & Tools Development	Data Aggregation	Data Warehousing	National Level	National Reports & Donor Reports	Policy Formulation & Resource Management
	M&E TWG	HMIS Department & Divisional Heads	HMIS Department & Divisional Heads	HMIS Department & Divisional Heads/ National TWGs	HMIS & Divisional Heads	Policy Makers
County Responsible Person(s)	Indicator Development/ Customization & Tools Development	Data Aggregation	Data Storage & Archiving	County Level	County Level	Policy Formulation & Resource Allocation
	CHMT & TWGs	CHRIO	CHRIO	CHRIO	CHRIO	County Government
Sub-County Responsible Person(s)	Data Verification & Audit	Data Entry & Tabulation	Data Storage & Archiving	Sub-County and Facility Levels	Sub-County Level	Indicator Monitoring
	SCHRIO & SCHMT	SCHRIO & SCHMT	SCHRIO	SCHRIO	SCHRIO	SCHMT
Facility Responsible Person(s)	Data Capture	Collation & Transmission	Data Storage & Archiving	Facility	Depart-mental & Facility Data	Resource Manage-ment, Health Talks
	HRIO & Facility Managers	HRIO & Facility Managers	HRIO & Facility Managers	HRIO & Facility Managers	HRIO & Facility Managers	HRIO & Facility Managers
Community Responsible Person(s)	Data Capture	Collation & Transmission	Data Storage & Archiving	CU	CHA	Community Mobilization & Planning
	CHA	CHA	CHA	CHA	CHA	CHA

3.1.4 Data Quality Assurance

For consistent data use to occur, data need to be of high quality so that data users are confident that the data they are consulting are accurate, complete, and timely. Without quality data, data-informed decision making will not occur and program efficiency and effectiveness will suffer. In addition, when data quality is poor the demand for data drops, thus crippling the cycle of data-informed decision making even further. Assessment and improvement of data quality in the sector will be guided by the Health Sector Data Quality Assurance Protocol – See Table 3.2.

Table 3.2: Data Quality Assurance Roles and Responsibilities

Stakeholder	Functions	Interest in High-Quality Data	Role in Identifying Quality Issue	Role in Addressing Data Quality Issues
CHMT/ SCHMT	Coordinate health affairs in the County/ Sub-County	Demand quality health information for decision making	Monitor and analyze data received from the health facility and provide feedback on data quality	Oversee the development of data improvement strategies and action plans for the County/ Sub-County
				Coordinate and supervise implementation of action plan to improve data quality
				Support implementation of the DQA Protocol and supportive supervision with Sub-County, health facilities and community units
Facility Management Teams	Coordinate service provision within the facility	Demand quality data to be used in decision making	Provide feedback on the quality of data available for planning and program monitoring Validate data with facility staff	Allocate resources
				Ensure that data quality forums are held
				Provide routine support supervision and convene regular data review meetings, to ensure data quality assurance
Facility HCWs	To provide health services to the community	Report quality data, utilize data to make decisions	Monitor data collected and provide immediate feedback to staff responsible for generating, recording and entering data.	Implement the DQA Protocol
				Ensure quality collection of data and sharing of information to the management/ decision makers/ stakeholders
CHWs/ CHEWs	To provide health services to the community	Report quality data, utilize data to make decision	Monitor data collected and provide immediate feedback to staff responsible for generating, recording and entering data	Implement the DQA Protocol
			Validate data with the community through stakeholder's forum	Ensure quality collection of data and sharing of information to the community

Source: The DQA Protocol

3.2 Performance Monitoring and Review Processes

Performance monitoring is a systematic and continuous assessment of whether set objectives are being met in a timely manner. It allows for feedback on the achievements and is undertaken by all actors. Performance monitoring and review of the CHSSIP implementation will be monitored weekly, monthly, quarterly, biannually, and annually—See Table 3.3. Assessing progress towards the CHSSIP results will entail quantitative and qualitative analyses using outcome measures. This will be complemented with brief analyses policies, strategies or programs. Performance monitoring will also assess equity, efficiency, contextual factors, and benchmarks. Equity pertains to differences in results between Sub-Counties based on urbanization, security, income, school enrolment, physical access, and gender. Efficiency relates the level of attainment of the objectives to the inputs used to achieve them. Contextual factors refer to qualitative information on the leadership, policy environment and regulations crucial to understanding how well and by whom the policies of Busia County are translated into practice and implemented. Benchmarks are comparisons in performance between and within various levels of service providers, based on a standard set of criteria will guide the performance review process.

Table 3.3: Performance Monitoring in Busia County

Process/Report	Frequency	Responsible	Timeline
Annual Work Plans	Annually	All Levels and Planning Units	End of June
Surveillance Reports	Weekly	SDSC and Health Facility in Charges	COB Friday
Health Data Reviews	Quarterly	All Levels and Planning Unit	End of Each Quarter
Monthly Reports Submissions	Monthly	Facilities, CUs	5th of Every Month
Quarterly Reports	Quarterly	All Levels and Planning Units	After 21st of Preceding Month
Bi-Annual Performance Reviews	Every Six Months	All Levels	End of January and End of July
Annual Performance Reports and Reviews	Annually	County, MOH National Government	Begins July and Ends November
Monthly Expenditure Returns	Monthly	All Levels	5th of Every Month
Annual Expenditure Reports	Annually	All Levels and Planning Units	Begins July and Ends November
Health Assessment Reports	As per Need	MOH/ DIVMERDHI	Periodic Surveys
County Health Forums	Annually	Clustered Block Counties	By the End of October
Kenya Health Forum	Annually	National MOH, Partners and Counties	By the End of November

3.2.1 Quarterly and Annual Performance Reviews

Quarterly performance review reports documenting progress against the implementation of the Annual Work Plans (AWPs) will be produced at all levels. The quarterly reports will be discussed by respective health management teams and key stakeholders in quarterly progress or performance review meetings. The discussions will focus on: the quarterly progress or performance review findings, the agreed upon action points, and progress in the implementation of the action plan from the previous quarterly review meeting.

Annual performance review reports outlining the performance against the CHSSIP goal and objectives will be produced by all planning units in the County. The annual reports will include achievements against the CHSSIP targets, challenges encountered during the period under review, and key priorities for the coming year. It will be developed through a consultative process that is Department–led and will be shared at the annual performance review meeting and with the County Assembly.

3.2.2 Mechanisms for Review and Action

The Department has mechanisms for performance review across the service delivery levels—Table 5 outlines how performance review will be carried out at each of these levels.

Table 3.4: Mechanisms for Review and Action

Planning Unit	Forum	Information Product	Frequency	Probable Participants
Community Unit	Community Dialogue Days	Chalkboards MoH 516	Monthly	CHVs CHEWs Community Health Committee Members Community Members
	Barazas	Reports and Others	Monthly	CHVs CHEWs Community Health Committee Members Community Members
Health Facilities	Data Reviews	Reports and Others	Monthly	Facility In-Charge Facility Staff, SCHMT (Appointed Member) Facility Committee Member CHEWs
	Facility Management Committee Meetings	Reports and Others	Quarterly	Facility Committee Member SCHMT (Appointed Member)
	Quality Improvement Teams (QIT)	Reports and Others	Quarterly	Facility QIT Teams
	AWP Meetings/ Development	Reports and Others	Annual	Facility Staff
Sub-County	Facility In-Charges Meeting	Reports and Others	Monthly	Facility In-Charges SCHMT
	Stakeholders Meetings	Reports and Others	Quarterly	Facility In-Charges SCHMT Hospital Management Committee Members Facility Management Committee Members Community Health Committee Members Sub-County Administrator Religious Leaders Youth Representatives Women Leader Partners MCAs Other Ministries e.g. Ministry of Education

Planning Unit	Forum	Information Product	Frequency	Probable Participants
	Data Quality Improvement Teams (DQIT)	Reports and Others	Quarterly	DQIT Members
	Data review Meetings	Reports and Others	Quarterly	SCHMT Facility In-Charges Partners CHMT (Appointed Member)
	International and National Health Commemoration Days and Weeks	Reports and Others	Annual	Community Members Health Workers SCHMT CHMT Community Leaders Sub-County Administration Partners
	Technical Working Groups	Reports and Others	Quarterly	TWG Members (Multi-Disciplinary Team)
	Sub-County Health Management Teams (SCHMT)	Reports and Others	Monthly	SCHMT Members
	Annual Performance Reviews	Reports and Others	Annually	SCHMT Members Partners CHMT Repesenrtative
	Annual Work Planning Meetings	Reports and Others	Annually	SCHMT Members Partners CHMT Representative
County	Stakeholder Bi-Annual Meetings	Reports and Others	Biannually	CHMT and SCHMTS Facility In-Charges Hospital Management Committee Members Facility Management Committee Members Community Health Committee Members Sub-County Administrator Religious Leaders Youth Representatives Women Leader Partners MCAs Other Ministries e.g. Ministry of Education
	CHMT Meetings	Reports and Others	Monthly	CHMT Members
	TWG Meetings	Reports and Others	Quarterly	TWG Members
	County Assembly Health Meetings	Reports and Others	Quarterly	MCAs CECM for Health Chief Officer for Health Director of Health
	County Health Advisory Meetings	Reports and Others	Quarterly	CHMT CECM for Health Chief Officer for Health

3.2.3 Data Sources for Health Sector Monitoring

The M&E Plan will rely on common data sources in HIS including data from population-based surveys and civil registers and from the operations of institutions that deliver health services—the health facilities. These data sources also capture data generated through the administrative, management, and logistical process of those institutions that support the delivery of health services (for example human resources, finances, and commodities). The M&E Plan will also utilize data sources from sectors that also affect health (for example education and agriculture); and those organizations that report select health outcomes (for example, police)—as they are rich sources that can inform decision making. Different data sources will have different levels of importance to each health system building block. For example, iHRIS will be important to health workforce decision making, while LMIS will be important in making decisions about logistics, and DHIS2 will be important for service delivery decision making.

3.2.4 CHSSIP Evaluation

The CHSSIP implementation framework anticipates a mid-term review and end-term evaluation at the midpoint and at the end of the planning period respectively. It stipulates that the mid-term review will guide the re-adjustment of strategic choices for remaining years. While the final evaluation will inform the design of future CHSSIP. The mid-term review and end-term evaluation will be County-led with broad stakeholder participation. Mixed methods will be applied to show progress and results. The assessment will explore strengths, weaknesses and emerging opportunities in the sector and beyond and propose strategies for improving quality of service delivery at identified levels. The assessment approach will mainly be as follows:

- Systematic analysis of health data for various outputs and outcomes.
- Analysis of the implementation of the CHSSIP activities, budgets and finances.
- Analysis of strengths, weaknesses, and opportunities of the health system. components in view of existing programme policies and strategies.

3.3 Enhance Sharing of Data and Promoting Use of Information

Data-informed decision making refers to the proactive and interactive processes that consider data during performance monitoring, planning, resource allocation, program improvement, advocacy, and policy development. Positive experiences using data contribute to a demand for additional data and a continued commitment to improving the quality of data and continued data use. The relationship of improved information, demand for data, and continued data use creates a cycle that leads to improved health programs and policies.

3.3.1 Data Analysis and Synthesis

Data users have different information needs in terms of levels of details and complexity intensities of interest, and roles in the decision-making process. Ensuring that data are understood by potential users requires that data be synthesized and disseminated in formats that are targeted to the individual and organizational contexts in which they are intended to be used. During the CHSSIP period, all of these factors will be taken into account when data are synthesized and communicated into information products for stakeholders at the different levels of the health system. The M&E plan will ensure data are made available through the development of targeted information products that respond to specific data users' information needs. To improve demand for and use of data in decision making, individual capacity in core competencies of data demand and use will be strengthened at all levels of the health system. The competencies include skills in data analysis, interpretation, synthesis, and presentation, and the development of data-informed programmatic recommendations.

3.3.2 Enhanced Data Sharing

The M&E Plan proposes putting in place standards related to data collection, transmission, analysis, presentation, reporting, utilization, and policy formulation. This will enable data from various sources to be brought together to enable the Department of Health to assess trends in health service access, morbidity, injuries, disabilities, and mortality.

3.3.3 Data Demand and Use Framework

The logic of the M&E Plan is based on the recognition that increasing use of data leads to improving its quality, which in turn leads to increased use. This applies at all levels—whether using data in communities to improve outreach, in facilities to improve quality of services, or at the County level to resolve health system constraints in the workforce and in financing. As more use is made of data from County systems, the quality of data will improve, building stakeholders' confidence and removing the need for separate, duplicating systems. For Busia County, recent years have witnessed significant commitments to and investments in the strengthening of HIS that has improved quality, relevance, and comprehensiveness of data—and this should translate to increased data use. The M&E Plan adopts a conceptual framework and logic model by MEASURE Evaluation on the specific interventions that can improve the demand for and use of data from all health information data sources (MEASURE Evaluation, 2010). The conceptual framework demonstrates how information systems improve other health system building blocks. It provides interventions that most directly affect the demand for and use of data. These interventions include:

- Assessing and improving the data use context.
- Engaging data users and data producers.
- Improving data quality; improving data availability.
- Identifying information needs.
- Building capacity in data use core competencies.

- Strengthening the organization's data demand and use infrastructure.
- M&E.
- Communicating data demand and use successes.

The MEASURE Evaluation logic model identifies three interrelated components that are necessary to improve routine information systems and the use of the data they generate. The three components include technical, behavioural, and organizational elements. The technical component refers to systems such as data collection processes, systems, and methods. The behavioural component refers to the behaviours of data users and how data are used for problem-solving and program improvement. The organizational component refers to the structure and processes of the organizations that use the resulting information. The M&E plan proposes specific technical, behavioural, and organizational activities that need to be implemented to improve demand for, analysis, review, and use of health data in decision making.

4 M&E PLAN ACTIVITIES AND BUDGET

4.1 Key Activities

The M&E Plan identifies key activities necessary for the attainment of the stewardship goals and improving capacity in information generation, validation, analysis, dissemination, and use—See Annex I.

4.2 Guiding Documents of the M&E Plan

Guidelines necessary for effective implementation of the M&E Plan will be developed—or adopted when they already exist. These guidelines and SOPs will be required during the M&E Plan implementation period.

- Health Sector Data Quality Assurance Protocol.
- 3rd Edition Health Sector Indicator Manual and SOP.
- Programmatic (HIV, malaria, RMNCAH, and others) M&E plans.
- Data management SOPs—Annex VI.
- Annual work plan templates and guidelines.
- Annual performance review templates and guidelines.
- Data analysis and use plan—Annex II.
- Stakeholder coordination framework.
- Stakeholder inventory.

4.3 M&E Tools

Existing and new M&E tools will be required for effective implementation of the M&E Plan. The M&E tools crucial for the M&E Plan implementation are as follows:

- Code of Conduct for partners supporting the implementation of the CHSSIP.
- Joint supervision checklists and issues tracking log.
- Data change tracking tool.
- Annual work plan implementation monitoring template—See Annex III.

5 M&E SYSTEM ORGANIZATIONAL STRUCTURE AND FUNCTIONS

5.1 Key Responsibilities for Health Sector M&E

To be fully successful, M&E functions need to be carried out at all levels of healthcare delivery from the County to the community level.

County Level Responsibilities

- Domestication and dissemination of policies, guidelines, and reports.
- Resource mobilization.
- Development of County health report and sharing with the CECM.
- Conduct quarterly health stakeholders' forum.
- Form and operationalize M&E TWG.
- Define, implement and monitor key project performance indicators.
- Develop frameworks and procedures for M&E activities.
- Provide technical and material support for M&E activities.
- Hold quarterly and annual performance reviews.
- Conduct integrated support supervision.
- Facilitate the development and consolidation of the County annual work plan.
- Conduct oversight on data collection and reporting.
- Promote data demand and information use.
- Conduct routine data quality assessment (quarterly).
- Acquisition and distribution of HMIS tools.
- Coordination of training, mentorships, and OJTs.
- Coordinate research and survey activities.
- Development of quarterly and annual County health bulletin.
- Monitor and report on disease trends.
- Operationalize the DQA Protocol.
- Monitoring facilities to ensure adherence to the standard guidelines and SOPs.

Sub-County Level Responsibilities

- Dissemination of policies, guidelines, and reports.
- Mobilization of resources for Sub-County level planned activities.
- Establish and operationalize M&E TWG at the Sub-County.
- Monitor key project performance indicators.
- Operationalize frameworks and procedures for M&E activities.
- Provide technical and material support for M&E activities.
- Hold quarterly and annual performance reviews.
- Conduct Sub-County integrated support supervision.
- Facilitate the development and consolidation of the Sub-County annual work plan.
- Data compilation, analysis, and reporting.
- Promote data demand and information us
- Conduct routine data quality assessment (quarterly).
- Conduct a quarterly data revie
- Conduct monthly data validatio
- Distribution and redistribution of HMIS tools.
- Coordination of training, mentorships, and OJT.
- Coordinate research and survey activities.
- Monitor and report on disease trends.
- Operationalize the DQA Protocol.
- Hold quarterly stakeholders' forum.
- Monitoring facilities to ensure adherence to the standard M&E guidelines and SOPs.
- Providing feedback to SCHMT and Facilities.

Facility Level Responsibilities

- Report collection, compilation, and submission to the next level.
- Institutionalization of the DQA Protocol.
- Maintain and update health information system.
- Conduct a monthly facility data review.
- Give feedback to FHMT, CHC, and staff.
- Implementation of policies and guidelines.
- Conduct mentorships and OJTs.
- Conduct client satisfaction survey.

Community Level Responsibilities

- Update and maintain CHIS.
- Compile and submit monthly reports.
- Conduct dialogue and action days.
- Implementation of policies and guidelines.
- Conduct community level training, mentorships, and OJTs.
- Give feedback to CHC, CHVs and the community.

Table 5.1 outlines the key responsibilities of the CHIS Department and partners for M&E functions at the County, Sub-County, facility and community levels.

Table 5.1: Scope and Responsibilities for Health Sector M&E in Busia County

Stewardship Goal	Entity	Function
County/ Sub-County		
Establishment of a common data architecture	CHMT/ SCHMT	• Establish M&E TWGs • 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.
	Partners	• 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	CHMT/ SCHMT	• Produce a health sector performance report that includes service delivery metrics. • Analyze the quality of all reports received and ensure appropriate follow-up in case of incompleteness or problems with validity, as well as delays from the Sub-County levels.
	Partners	• Work within the health department M&E plan and guidelines, and meet the reporting requirements as defined by minimum datasets.
Enhancing the sharing of data and promoting the use of information for decision-making	CHMT/ SCHMT	• Provide technical, material and financial support for M&E to all Sub-Counties. • Collate, analyze, disseminate and use health and health-related data from all Sub-County offices and give feedback. • Ensure proper information flow from various levels to inform policy formulation, guidelines, and development of protocols, and to address the County's 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 a County Health Report and share with the CEC. • Disseminate quarterly reports to Sub- County health teams and Health Committee, through the CDH.
	Partners	• Provide support to strengthen the County Health Department M&E Unit in their areas of operation (e.g., through the provision of technical support and capacity building).

Stewardship Goal	Entity	Function
Facility Level		
Establishment of a common data architecture	Facility health Management Team and Partners	• 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, 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	Facility Management Team and Partners	• Ensure compilation and processing of minutes, inventory, supervision, and other activity reports. • Analyze the quality of all reports received from various health service delivery points and ensure follow-up in case of incompleteness, problems with validity, or delays.
Enhancing the sharing of data and promoting the use of information for decision-making	Facility Management Team and Partners	• Ensure that every health facility summarizes 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. • 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.
Community Level		
Establishment of a common data architecture	SHMT and Partners	• 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 Volunteers: Maintain registers to document daily activities and report regularly to link health facility. Compile all reports from the CHW.
Improve performance and review processes	SHMT and Partners	• Develop quarterly and annual community health reports for integration into facility reports.
Enhancing the sharing of data and promoting the use of information for decision-making	SHMT and Partners	• Prepare an analysis of the data for discussion during the staff and committee meetings 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 Partnership and Coordination Framework

The full implementation of the CHSSIP will require multi-sectoral effort and approach with various health stakeholders playing different roles at the various levels—more often than not, the roles will be complementary and synergistic. Stakeholder Coordination Framework developed by the Department will guide stakeholder coordination during the CHSSIP period.

6 ANNEXES

Annex I
Costed M&E Work Plan for 2018 – 2023

Key Activities	Key Performance Indicators/ Deliverables	5 Year Budgets (Kshs)				
		2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
SERVICE DELIVERY						
Community Dialogue Days	No. of monthly and quarterly reports compiled	1,104,000	1,137,120	1205347	1277668	1354328
Facility: Data collection, validation, analysis, dissemination	No. of monthly reports compiled, analyzed and disseminated	1,740,000	1,792,200	1899732	2013715	2134538
Sub-County data review meeting	No of data review meetings held and action plans developed	336,000	346,080	366844	388855	412186
County data review meeting	No of data review meetings held and action plans developed	200,000	206,000	218360	231461	245349
Emergency preparedness planning report	No. of reports on emergencies	110,000	113,300	120098	127303	134942
Therapeutic committee meetings & follow up	No. of therapeutic meetings held and action plans developed	536,000	552080	585204	620317	657536
Clinical audits (Maternal & Perinatal Deaths, Guidelines, SOPs) Maternal Audits (general deaths, maternal and perinatal)	No. of maternal and perinatal deaths audited and clinical audits	1,208,000	1244240	1318894	1398028	1481909
Quality of service delivery	Exit survey, client satisfaction surveys	845,256	856,317	878,455	895,231	903,235
Referral monitoring activities	No of referral assessments reports developed	98000	98000	98000	98000	98000
SUB TOTAL		6,177,256	6,345,337	6,690,934	7,050,578	7,422,023

Key Activities	Key Performance Indicators/ Deliverables	5 Year Budgets (Kshs)				
		2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
HEALTH INFRASTRUCTURE AND HIS						
Equip one repository center at the County level/	Functioning repository center	1,000,000	100,000	100,000	100,000	100,000
Host a functional health webpage on the County website/	Functional health webpage	1,000,000	110,000	105,000	100,000	95,000
Undertake biannual inventory update of infrastructure	No of inventory reports developed	226,000	239560	253934	269170	285320
Generation of infrastructure project monthly reports (County & Sub-County team visits)	No of project reports developed	280,000	296800	314608	333484	353494
Monthly asset procurement & maintenance report	No of asset maintenance reports developed	50,000	53000	56180	59551	63124
Monthly motor vehicle inspection and maintenance supervision	No. of inspection reports and maintenance reports	58,000	58,000	62,000	65,000	65,000
Monthly equipment maintenance and annual equipment service follow ups	No. of equipment service reports and maintenance reports.	67,500	69,473	72,413	73,500	76000
SUB TOTAL		2,681,500	926,833	964,135	1,000,705	1,037,938
HEALTH PRODUCTS						
Inventory audit of health products	No of developed inventory audit reports	864,000	915840	970790	1029038	1090780
SUB TOTAL		864,000	915,840	970,790	1,029,038	1,090,780
HEALTH INFRASTRUCTURE						
Undertake health expenditure reviews	No of health expenditure reports developed	8,664,000	9,183,840	9,734,870	10,318,963	10,938,100
	Quarterly and annual financial status reports submitted					
SUBTOTAL		8,664,000	9,183,840	9,734,870	10,318,963	10,938,100
LEADERSHIP AND GOVERNANCE						
Community: hold quarterly stakeholder meetings and forums	No of quarterly stakeholder forums held with action plans	504,000	534240	566294	600272	636288
Provide quarterly feedbacks to the link facilities on activities using provided formats	No of feedback	54,000	57240	60674	64315	68174
Facility: Hold health facility committee meetings	No. of facility committee meetings held	147,000	155820	165169	175079	185584
Compile facility quarterly performance appraisal reports	No of quarterly performance reports disseminated	5,600	5936	6292	6670	7070

Key Activities	Key Performance Indicators/ Deliverables	5 Year Budgets (Kshs)				
		2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
Carry out monthly Sub-County HMTs	No of Sub-County HMTs held	567,000	601020	637081	675306	715824
Development of AWP/ APR at County and Sub-County level	Developed, validated and published AWP	900,000	954000	1011240	1071914	1136229
Carry out quarterly CHMT meetings	No of CHMT meetings held with action plans	480,000	508800	539328	571688	605989
Annual County Health Congress	No of participants in the annual Health Congress	2,000,000	2,400,000	2,500,000	2,600,000	2,700,000
SUBTOTAL		4,657,600	5,217,056	5,486,078	5,765,244	6,055,158
HEALTH WORKFORCE						
Improve skills of staff at all levels on data management (all pillars)	The proportion of staff trained in data management (all staff)	2,920,000	3095200	3280912	3477767	3686433
Encourage exchange programs and benchmarking	No of exchange programme sessions held	834,000	884040	937082	993307	1052906
Annual human resource audits	No. of human resource audits held with reports	320,000	320,000	320,000	320,000	320,000
SUBTOTAL		4,074,000	4,299,240	4,537,994	4,791,074	5,059,339
HEALTH INFORMATION						
Quarterly M&E TWG meeting	No of quarterly TWG meetings Held	240,000	254,400	269664	285844	302994
Printing and distribution of revised data collection and reporting tools.	Proportion of facilities with updated reporting tools	519,000	550140	583148	618137	655226
Improved data demand and use at the Sub-County and County	The proportion of facilities with accurate reporting rates	2,976,000	3154560	3343834	3544464	3757131
data quality audits and verification	No of data quality audits held	1,840,000	1950400	2067424	2191469	2322958
Conduct mid and end term M&E of the strategic plan	No of SP review sessions held	3,121,000	3308260	3506756	3717161	3940191
Conduct mid and end term M&E of the CIDP	No of CIDP review sessions held	1,321,000	1400260	1484276	1573332	1667732
SUBTOTAL		10,017,000	10,618,020	11,255,102	11,930,407	12,646,232
HEALTH RESEARCH AND INNOVATION						
Conduct evidence-based research and surveys	No of relevant surveys held	1,920,000	2035200	2157312	2286751	2423956
Operational research	No of operations research	2,000,000	2120000	2247200	2382032	2524954
SUBTOTAL		3,920,000	4,155,200	4,404,512	4,668,783	4,948,910
GRAND TOTAL		41,055,356	41,661,366	44,044,415	46,554,792	49,198,480
						222,514,409

Annex II

Data Analysis and Use Plan

Programmatic Questions	Indicator	Data Source	Method of Analysis	Data Disaggregation	Data Visualization	Frequency	Proposed Actions/ Decisions	Decision maker	Communication Channel
How does the County increase case identification?	% of PLHIV identified	Data Source MOH 362/ MOH 731/ DHIS2	Trends/ Mapping	Gender/ Age/ Population Type	Graphs/ Tables/ Maps	Quarterly/ Monthly/ Annually	• Strengthen/ scale up • Targeted testing e.g. PNS	CDH / CASCO	• Feedback meetings • Support supervision • Periodic data review meetings involving all stakeholders
How does the County retain clients PLHIV on care?	% of PLHIV retained on care	MOH 731/ DHIS2	Trends/ Mapping	Gender/ Age	Graphs/ Tables/ Maps	Annually	• Improve ART uptake and adherence • Establish Adolescent Friendly Services • Capacity building HCWs on Pediatric HIV	CASCO	• Stakeholders' meeting • Sensitization • Training/ OJTs and mentorship
How does the County ensure PLHIV are virally suppressed?	% of PLHIIV ART with suppressed viral load	MOH 731/ DHIS2/ NASCOP DB	Trends	Gender/ Age/ Population Type	Graphs/ Tables/ Charts	Annually	• Form MDT to review patients failing the first-line regimen • Improve ART uptake and adherence • RRI to identify clients with no viral load and order • Monitor clients' progress	CASCO	• Viral load report • Interpretation • Dissemination meeting • Stakeholders' meeting
How does the County improve the uptake of cervical cancer screening among WRA?	% of WRA screened for cervical cancer	Cancer Register/ MOH 262	Trends	Age	Graphs/ Tables/ Charts	Monthly/ Quarterly	• Increase the number of facilities offering cervical cancer screening • Training HCWs on cervical cancer screening • Sensitization of CHVs on cervical cancer screening to enhance referrals and linkages	CDH/ County RH Coordinator	• Feedback meetings at all relevant levels • Support supervision (specific to RH) • Data review meetings involving all the stakeholders

Programmatic Questions	Indicator	Data Source	Method of Analysis	Data Disaggregation	Data Visualization	Frequency	Proposed Actions/ Decisions	Decision maker	Communication Channel
How does the County improve SGBV survivors' access to PEP within 72 hours?	% of SGBV survivors accessing PEP within 72 hours	MOH 364	Trends	Gender/ Age	Tables/ Charts	Monthly/ Quarterly	• Training the HCWs on care and management of SGBV survivors • Increase the number of SGBV centers within facilities • Sensitization of community health volunteers to enhance timely referrals	CDH/ County RH Coordinator	• Feedback meetings • Quarterly SGBV data review meetings • Support supervision (specific SGBV) • Stakeholders meeting
How does the County increase number of deliveries by skilled attendant?	% of pregnant women delivering at health facilities	MOH 405 ANC Register/ MOH 333 Maternity Register/ MOH 406 PNC register/ DHIS2	Mapping	Age	Graphs/ Charts	Monthly/ Quarterly/ Annually	• Community mobilization and sensitization • Resource mobilization • Capacity building in customer care • Structural improvement of labor	County RH Coordinator	• Monthly reports • Quarterly RH reports • Quarterly RH bulletin • Quarterly AWP implementation Plan • RH budget report
How does the County improve the uptake of FP services?	% of WRA receiving FP commodities	MOH 512 FP Register/LMIS/ DHIS2/Survey reports (KDHS)	Trend/ Mapping	Age	Graphs/ Charts/ Tables	Monthly/ Quarterly/ Annually	• Community mobilization and sensitization • Resource mobilization • Capacity building on Long-Acting FP Methods • Male involvement	County RH Coordinator	• Monthly reports • Quarterly RH reports • Quarterly RH bulletin • Quarterly AWP implementation Plan • RH budget report
How does the County increase the proportion of infants below the age of 6 months who are exclusively breastfed?	% of infants below the age of 6 months who are exclusively breastfed	MOH 407A & B Nutrition Register/ DHIS2/ LMIS/ KDHS/ MOH 406 PNC Register/ Mother Child Booklet/ CHAINS	Mapping	Age/ Gender	Graphs/ Charts	Monthly/ Quarterly/ Biannual/ Annual	• Community mobilization and sensitization • Resource mobilization • Capacity building in exclusive breastfeeding • Breastfeeding corners	County Nutrition Coordinator	• Monthly reports • Quarterly RH reports • Quarterly RH bulletin • Quarterly AWP implementation Plan • Nutrition budget report

Programmatic Questions	Indicator	Data Source	Method of Analysis	Data Disaggregation	Data Visualization	Frequency	Proposed Actions/ Decisions	Decision maker	Communication Channel
How does the County reduce the proportion of stunted under-five children?	% of stunted under-five children	MOH 512 CWC Register/ MOH 407 A&B Nutrition Register/ MOH 204A OPD Register Under 5/ KDHS/ MOH 301 Inpatient Register/ Mother Child Booklet/ CHANIS	Mapping/ Trends	Age/ Gender	Graphs/ Charts	Monthly/ Quarterly/ Biannual/ Annual	• Community mobilization and sensitization • Resource mobilization • Capacity building of HCWs in growth monitoring and breastfeeding • Breastfeeding corners • Kitchen gardening	County Nutrition Coordinator	• Monthly reports • Quarterly nutrition reports • Quarterly nutrition bulletin • Quarterly AWP • implementation Plan • Nutrition budget report
How does the County improve immunization coverage?	% of fully immunized children (FIC)	Immunization Tally Sheet/ Permanent Register MOH 510/ MOH 710 (Immunization Summary)/ DHIS2	Trends	Age/ Gender	Graphs/ Charts	Monthly/ Quarterly	• Social mobilization • Outreaches • Identify the gap • Resource mobilization and allocation	County Nursing Officer	• Performance review meetings • AWP • Budget submission and Presentation
How does the County improve latrine coverage?	% of households with functional latrines	Environmental Health Reports/ CBHIS/ MOH 204 A&B OPD Register for Under & Over Five Years/ Surveys (KDHS	Mapping	Sub-County/ Ward	Charts	Biannual	• Community mobilization and sensitization • Resource mobilization • Capacity building in latrine use	County Public Health Officer	• Quarterly environmental health reports • Quarterly environmental health bulletin • Quarterly AWP implementation Plan • Environmental health budget report • Latrine coverage report
How does the County reduce malaria prevalence among under-fives?	% of confirmed cases of malaria among under- fives	MOH 505 Weekly Surveillance Report/ MOH 240 Laboratory Register/ Under Fives OPD Register/ Tally Sheet MOH 705 A	Trends/ Mapping	Gender/ Age	Charts/ Graphs	Weekly/ Monthly/ Quarterly	• Change of control strategy • Mass treatment • Training and mentorship on IMCI • Provision of LLINs • Conduct survey	County Malaria Coordinator	• Feedback • Review meetings • Budget submission and presentation • Support supervision

Programmatic Questions	Indicator	Data Source	Method of Analysis	Data Disaggregation	Data Visualization	Frequency	Proposed Actions/ Decisions	Decision maker	Communication Channel
What does the County improve emergency preparedness?	Number of facilities with functional emergency preparedness plans in place	Reports (IDSSR etc.) /Minutes/ Policies/ Response guidelines/ Plan Supervision reports	Mapping	Sub-County/ Ward	Charts/ Graphs	Monthly/ Quarterly	• Quick response • Monitoring • Projections for supplies • Planning for campaign • Procurement and distribution of • Emergency equipment and supplies • Decision making on the intervention needed	CDH/ County Disease Surveillance Coordinator	• Feedback • Review meetings
What does the County increase coverage of youth Friendly services?	Number of facilities with Youth Friendly Services	Supervision Reports/ Minutes of the Youth Meetings/ KDHS	Mapping	Age/ Gender	Charts	Quarterly	• Roll out more youth friendly services • Training HCWs on Youth Friendly Service • Mobilization of youths • Engage the youths on self-reliance activities	County RH Coordinator/ CASCO	• Supervision report • Feedbacks in all directions • Meetings
How does the County reduce malnutrition?	% of malnourished under-fives	DHIS/ MOH 711/ Under-fives OPD register/ tally sheet MOH 705A/ MOH 407B/ MOH 511/ CHANIS	Mapping	Age/ Gender	Charts	Monthly/ Quarterly	• Procurement and distribution of supplies • Nutrition commodity distribution • Case management • Advocacy on kitchen gardening • Community outreaches/ sensitization	County nutrition officer	• Feedback • Review meetings • Stakeholders' meetings • County bulletins
How does the County improve utilization of safe water?	Number of households with access to safe water	CHEW Summary/ CHW Reports/ CMLTs/ DHIS/ AWP/ MOH 708/ Water Services Providers (KIWASCO)	Mapping	Sub-County/ Ward	Charts	Monthly/ Quarterly	• Community sensitization on the importance of safe water use • Improve unprotected springs	Health Promotion Officer/ County Public Health Officer	• Feedback • Review meetings with • Stakeholders

Annex III

Data Management and Reporting Responsibilities

Serial Number	Available Reporting Forms	County responsible (Action) Person	Overall responsibility at County	Sub-County Reporting Channel	Hospitals	Primary Health Facility/CU	Overall responsibility at Health Facility	HF Reporting Channel (Where Applicable)
1	CHA Summary (MOH 515)	County Community Strategy Focal Person	CDH	DHIS2	CHA	CHA	Med Sup/ In-charge	Hardcopy/ DHIS2
2	MOH 711 Integrated	County RH Coordinator/ DPHN	CDH	DHIS2	Sectional In-charge/ HRIO	Facility In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2
3	MOH 731-1 HIV CT	CASCO	CDH	DHIS2	Sectional In-charge/ HRIO	Facility In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2
	MOH 731-2 PMTCT	CASCO	CDH	DHIS2	Sectional In-charge/ HRIO	Facility In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2
	MOH 731-3 C&T	CASCO	CDH	DHIS2	Sectional In-charge/ HRIO	Facility In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2
	MOH 731-4 VMC	CASCO	CDH	DHIS2	Sectional In-charge/ HRIO	Facility In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2
	MOH 731-5 PEP	CASCO	CDH	DHIS2	Sectional In-charge/ HRIO	Facility In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2
	MOH 731-6 Blood Safety	CASCO	CDH	DHIS2	Sectional In-charge/ HRIO	Facility In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2
4	HCBC	CASCO	CDH	DHIS2	Sectional In-charge/ HRIO	Facility In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2
5	IDSR Weekly	CDSC	CDH	DHIS2	Facility surveillance focal person	Facility In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2
6	Hospital Administrative Statistics (HAA)	CHRIO	CDH	DHIS2	HRIO			Hardcopy/ DHIS2
7	MOH 705A OPD <5 years	CHRIO	CDH	DHIS2	HRIO	Facility In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2
8	MOH 705B OPD >5 years	CHRIO	CDH	DHIS2	HRIO	Facility In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2
9	MOH 717 Service Workload	CHRIO	CDH	DHIS2	HRIO	Facility In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2
10	MOH 718 Inpatient M&M	CHRIO	CDH	DHIS2	HRIO	Facility In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2
11	MOH 710 Immunization	CNO/ County Lab Coordinator	CDH	DHIS2	HRIO	Facility In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2
12	MOH 706 Laboratory Report	County Lab Coordinator	CDH	DHIS2	Lab In-charge	Facility Lab In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2

Serial Number	Available Reporting Forms	County responsible (Action) Person	Overall responsibility at County	Sub-County Reporting Channel	Hospitals	Primary Health Facility/CU	Overall responsibility at Health Facility	HF Reporting Channel (Where Applicable)
13	Support Supervision	CDH	CDH	DHIS2	Sectional In-charge/ HRIO			Hardcopy/ DHIS2
14	IMAM	County Nutritionist	CDH	DHIS2	Nutritionist	Facility In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2
15	MOH 713 Nutrition Monthly Reporting	County Nutritionist	CDH	DHIS2	Nutritionist	Facility In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2
16	MOH 78 Environmental Health	CPHO	CDH	DHIS2	PHT	PHO/ PHT	Med Sup/ In-charge	Hardcopy/ DHIS2
17	Quarterly report on Tuberculosis and MDR-TB case-finding	CTLC	CDH	DHIS2	SCTLC	Facility In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2
18	Cohort Report for TB	CTLC	CDH	DHIS2	SCTLC	Facility In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2
19	HSSF Monthly Expenditure	County Accountant	CDH	DHIS2	Facility Accountant	Facility In charge	Med Sup/ In-charge	Hardcopy/ DHIS2
20	HSSF summary	County Accountant	CDH	DHIS2	Facility Accountant	Facility In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2
21	Malaria Commodities Form	CMCC	CDH	DHIS2	Pharmacist	Facility In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2
22	Non-Pharmaceutical	CNO	CDH	DHIS2	Nursing Officer In-charge	Facility In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2
23	Division of Occupational Therapy	County Occupational Therapist	CDH	DHIS2	Occupational Therapist	Facility In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2
24	Logistic Management Information	CNO	CDH	DHIS2	Pharmacist	Facility In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2
25	FP Contraceptives	County RH Coordinator/ County Pharmacist	CDH	DHIS2	MCH In-charge	Facility In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2
26	Maternal Death Review Form	County RH Coordinator/ CHRIO	CDH	DHIS2	Maternity In-charge/ MPDSR Team	Facility In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2
27	Ophthalmology Services	County Ophthalmologist	CDH	DHIS2	Ophthalmologist	Facility In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2
28	Orthopedic Plaster	County Rehabilitative Services Coordinator	CDH	DHIS2	Plaster Technologies	Facility In-charge	Med Sup/ In-charge	Hardcopy/ DHIS2

Annex IV

AWP Implementation Monitoring Template

_____Sub-Program: AWP FY XXXX/XXXX																
Activities	**Total Amount**	**Target Quarter for Delivery**				**Implementation Status (In progress, Cancelled, Completed, On-Going, Delayed, On-Schedule)**										
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Comments on status**	**Action (for delayed/ not done)**	**Person responsible**

Annex V
Summary of Core Health Indicators in the M&E Plan

Indicator	Numerator	Denominator	Data Source	Frequency	Responsible Entity
Percentage of full immunized children	No.of children under 1 year who received all antigens	Estimated no.of children younger than one year for a given period	MOH 710, MOH 510, MOH 702, Surveys KNBS 2019	Monthly, Annually	CHRIO
Percentage of target population receiving MDA for schistosomiasis	No.of people receiving MDA.	No.of people at risk for NTD in endemic counties	MOH 705 A&B	Monthly	CHRIO
Percentage of TB patients completing treatment	No.of patients completed TB treatment	All TB cases recorded in the TB Registers (within the assessed cohort period)	TB Treatment Register, MOH 711	Monthly	CTLC
Percentage of HIV positive pregnant mothers receiving preventive ARV drugs	No.of HIV/AIDS positive pregnant women who received antiretroviral medicines.	No.of HIV/AIDS pregnant mothers	MOH 405, MOH 333, MOH 406, MOH711, MOH 731	Monthly	CASCO
Percentage of eligible HIV clients on ARV drugs	No.of HIV +ve adults and children currently receiving ARV therapy at the end of the reporting period.	Estimated No.of HIV +ve adults and children eligible for ARVs	MOH 361B, MOH 731, MOH 711, KAIS 2014	Monthly	CASCO
Percentage of children under 1 year provided with LLTNs	Total No.of <1year children who have received LLINs per year	Estimated No.of infants in the catchment area	MOH 511, MOH 105, malaria netpack record, KNBS 2019, Surveys: DHIS, MICS, MIS	Monthly	CMCC
Percentage of pregnant women attending at least 1 ANC visit and provided with LLTN	Total No.of pregnant women who have received LLINs per year	Estimated No.of pregnant women in the catchment area	MOH 511, MOH 105, malaria net pack record, KNBS Surveys, DHS, MICS, MIS	Annual	CMCC
Percentage of children under 5years treated for diarrhea	Number of children under 5years treated for diarrhea	Number of children under 5years with diarrhea	MOH 204A, MOH 705A	Monthly	CHRIO
Percentage of school-age children dewormed	Number of school-age children de-wormed				
	Total number of children 2-14years	MOH 105, surveys, reports	Biannual	CHRIO	
Percentage of children 12-59 months dewormed	Number of children 12-59 months de-wormed	Total number of children 12-59 months in the catchment area	MOH 713	Monthly	CHRIO
Percentage of adult population with body mass index over 25	Number of adults with BMI over25	Total adult population in the area	Survey	Biennial	CHRIO
Percentage of women of reproductive age screened for cervical cancer	Number of women of reproductive age screened for cervical cancer	Estimated total number of women of reproductive age	MOH 204 B, MOH 405, MOH 406; FP and cervical cancer service registers	Monthly	RH coordinator

Indicator	Numerator	Denominator	Data Source	Frequency	Responsible Entity
Percentage of new out-patients with mental health conditions	Number of new outpatient cases with mental health conditions	Total number of all cases with the newly diagnosed mental condition	Out-patient registers, MOH 204 A and 204B; MOH 705A, MOH 705B	Monthly	CHRIO
Percentage of new out-patient cases with high blood pressure	Number of cases diagnosed with hypertension in a month	Total number of all newly diagnosed cases for all diseases in a month	MOH 204 B; MOH 705B	Monthly	CHRIO
Percentage of patients with cancer admitted	Number of patients with cancer admitted	Total number of cases admitted in a month	Hospice records, MOH 301, in-patient morbidity, and mortality report	Monthly	CHRIO
Percentage of new out-patient cases attributed to gender-based violence	Number of new outpatient cases treated for gender-based violence	Total number of outpatient attendance	MOH 363, post-rape care register, MOH 364 sexual gender-based summary form	Monthly	CHRIO
Percentage of new out-patient cases attributed to road traffic injuries	Number of new outpatient cases attributed to a road traffic accident	Total number of outpatient attendance	OPD register MOH 204A, MOH 204B, MOH 705A, MOH 705B	Monthly	CHRIO
Percentage of new out-patient cases attributed to the injuries	Number of out-patient cases with new injuries other than those caused by a road traffic accident	Total number of outpatient attendance	Out-patient register; MOH 204B, MOH 204A, MOH 301, and MOH 268; MOH 705A & B	Monthly	CHRIO
Percentage of facility deaths due to injuries	Number of deaths in a facility due to reported injuries	Total number of institutional deaths	Out-patient death register; MOH 204B, MOH 204A, MOH 301, and MOH 268; MOH 705B & A	Monthly	CHRIO
Per capita outpatient utilization rate (male to female)	Number of out-patient facility visits for ambulant care per year	Total population in the area	Out-patient registers; MO 204A, MOH 204B; MOH 717	Annually	CHRIO
Percentage of population living within 5km of a facility	Total population living within a 5km radius of a facility	Total population in the area	Survey	Every Five Years	CHRIO
Percentage of facilities providing BEmONC	Total number of facilities at levels 2-6 providing BEmONC	Total number of facilities at levels 2-6 in the area	Rapid facility surveys, updated MFL.	Annually	CHRIO
Percentage of facilities providing CEmONC	Number of health facilities at levels 4-6 providing CEmONC	Total number of health facilities at levels4-6	Rapid facility surveys, updated MFL	Annually	CHRIO
Bed occupancy rate	Number of patient bed daysX100	Number of beds in institution times the number of days in the time period under review	MOH-301, Daily bed returns, MOH 717	Daily, monthly, Annually	CHRIO
Percentage of facilities providing Immunizations	Number of level 2–5 health facilities providing immunization services	Total number of level 2–5 health facilities in the area	Rapid facility surveys, updated Master Facility List (MFL)	Annually	CHRIO

Indicator	Numerator	Denominator	Data Source	Frequency	Responsible Entity
Percentage of deliveries conducted by a skilled attendant	Number of deliveries conducted by skilled personnel	Total number of expected deliveries	MOH 333, MOH 711, MOH 717, KNBS projections 2019	Monthly	CHRIO
Percentage of women of reproductive age receiving family planning	Number of women receiving family planning services	Total number of women of reproductive age	MOH 512, MOH 711, MOH 717, KNBS projection 2019	Monthly	CHRIO
Percentage of facility-based maternal deaths	Number of maternal deaths occurring at the facility	Total number of live births	MOH 333, MOH 711, KNBS projection 2019	Monthly	CHRIO
Percentage of facility-based under-five deaths	Number of deaths of children under 5years occurring at the facility	Total number of children under 5years	MOH 511, MOH 301, MOH 204A DHIS	Monthly	CHRIO
Percentage of newborns with low birth weight	Number of newborns with less than 2.5kg body weight	Number of live births whose birth weights were measured	MOH 333, MOH 105	Monthly	CHRIO
Percentage of facility-based fresh stillbirths	Number of fresh stillbirths	Total number of deliveries conducted	MOH 333, MOH 717	Monthly	CHRIO
Surgical rate for cold cases	Cold surgical cases	Total catchment population	Theatre register, MOH 105, KNBS projection 2019	Monthly	CHRIO
Percentage of pregnant women attending four ANC visits	Number of women attending fourth ANC	Total number of pregnant women	MOH 406, MOH 105, MOH 711, KNBS projections 2019	Monthly	CHRIO
Percentage of infants under 6 months on exclusive breastfeeding	Number of children under 6 months on exclusive breastfeeding	Number of infants less than 6 months attending child welfare clinic (CWC) in the month	MOH 704, MOH 713, MOH 511, MOH 216	Monthly	CHRIO
Couple year protection due to condom use (family planning)	Number of couples sampled using a condom	Total number of couples surveyed	KDHS	Annually	CHRIO
Percentage of population with access to safe water	Total population who have treated a safe drinking water source	Estimated population in the area, urban, rural	Household survey, administrative reporting system	Biennial	CHRIO
Percentage of children under 5years who are stunted	Number of children under 5years attending CWCwho fall below minus 2 standard deviations from the median height for age according to WHO child growth standards	Total number of children under 5 years measure	MOH 511, MOH 216, MOH 704 MOH 713, KNBS projection 2019	Monthly	CHRIO
Percentage of children under 5years who are underweight	Number of children under 5 years attending CWC during them on than surveyed, with weight for age below 2 standard deviations	Total number of children under 5 years weighed in CWC during the month	MOH 511, MOH 206, MOH 704 MOH 713, MOH 105	Monthly	Nutrition Coordinator

Indicator	Numerator	Denominator	Data Source	Frequency	Responsible Entity
School enrollment rate	Number of children enrolled in primary schools, secondary schools	Estimated population of school children to been rolled in every level	Primary school, secondary school enrollment register and monthly report to MOE	Biannual	Public Health Officer
Percentage of households with latrines	Number of households that use an improved sanitation facility, urban and rural	Estimated number of households in the area, urban and rural	MOH 514, MOH 515 household survey, administrative reporting system	Biannual	Public Health Officer
Percentage of houses with adequate ventilation	Number of houses with adequate ventilation, urban and rural	Estimated houses in the area, urban and rural	Household survey, administrative reporting system	Biannual	Public Health Officer;
Percentage of schools providing complete school health package	Number of primary and secondary schools providing complete school health package	Total number of schools	MOH 708	Monthly	Public Health Officer
Tuberculosis cure rate	Number of TB patients with smear-positive results at treatment initiation	Number of TB patients with smear-negative results at the end of 6 months	TB register	Monthly	TB Coordinator
Percentage of fever tested positive for malaria	Number of malaria RDT positive slide results at treatment initiation	Number of patients tested for malaria	MOH 240 laboratory register	Monthly	Lab Coordinator
Percentage of maternal death audits	Number of maternal death records reviewed	Total number of maternal deaths reported	MOH 105, maternal death review form	Monthly	Reproductive Health Coordinator
Number of malaria in-patient case fatalities	Number of patient deaths in malaria cases (per1,000)	Total number of patient deaths plus discharges due to malaria	MOH 301, MOH 268; DHIS in-patient morbidity and mortality report	Monthly	Facility
Average length of stay (ALOS)	Number of in-patient days plus half-day patients	Number of in-patient discharge plus deaths	MOH 717, MOH 268, MOH 718; DHIS in-patient morbidity and mortality report	Monthly	Facility in-charge
Percentage of children registered for birth notification (B1)	Number of children issued birth notification	Total number of births	B1, MOH 333	Monthly	Facility in-charge

Annex VI
Data Management SOPs

COUNTY GOVERNMENT OF BUSIA

DEPARTMENT OF HEALTH AND SANITATION

Document: Procedure for Data Collection	
Document Number:	1
Point of Use:	Health Facility and Community Unit
Frequency:	Daily

Objective: To ensure the use of standardized data collection tools, complete and timely data collection.

Context: Standard data collection tools (registers) are used to ensure consistency of the data collected in health facilities and community units. The SOP will be used by health workers and Health Management Team (HMT) of County, Sub-County, and Facility.

CHECKLIST FOR DATA COLLECTION

- Use standard MOH-coded data collection tools e.g. MOH 204A, MOH 405, etc.
- All data collection tools must be vetted and authorized by the MOH.
- Parallel partners' or donors' data collection tools should not be used.
- Refer to the guidelines provided in the data collection tools (cover page of registers).
- Fill in the data collection tools/ registers as the patients are being seen—do not fill the tools later or after service delivery.
- When starting a new day, start a new page in the register or write the total for the day then put a divider line in red color.
- When starting a new month, start on a new page.
- Fill all rows and columns completely and appropriately.

COUNTY GOVERNMENT OF BUSIA

DEPARTMENT OF HEALTH AND SANITATION

Document: Procedure for Data Collation and Validation	
Document Number:	2
Point of Use:	Health Facility and Community Unit
Frequency:	Daily, Weekly, and Monthly

Objective: To ensure accurate, complete and timely collation and validation of data.

Context: Data collation and validation should be done at facility and community levels where data is collected on manual/ paper registers by the health workers responsible for data collation. For electronic data, generate the report summaries. The health workers should verify the collected data and summarize for their own reporting before entering into the DHIS2. All summary tools/ reports MUST have the supervisor's name, facility name, and stamp. Failure to which they should not be accepted as official records.

CHECKLIST FOR DATA COLLATION AND VALIDATION BY DATA COLLECTOR

- Make a page summary based on the guide provided at the bottom of the page.
- Use the page summaries to populate the monthly summary tool.
- When aggregating the data variables, use the summary totals at the bottom of each page of the register.
- Add the in- and outreach services data to the daily tallies.
- Add CHEWs summaries to the relevant facility reporting tools e.g. MOH 204A, MOH 405, etc.
- Recount the variables and verify the data and totals.
- Document data changes made during collation.
- Use the confirmed totals to fill the relevant summary tools.

CHECKLIST FOR DATA VALIDATION BY SUPERVISOR

- The summarized form/ report **MUST** be counter checked by a second party and signed by the supervisor (facility-in-charge).
- During counterchecking, check the totals in the summary sheet (add all totals for each variable to ensure the calculation is correct).
- A minimum sample (5 days in a month) of the daily registers should be counterchecked and accuracy of data and totals confirmed.
- If inconsistencies are found in this sample, increase the sample days and refer to the data collector to make corrections.
- Notify the data collector of inconsistencies and corrections made and documented.
- Vetted data summary reports should be duly signed, dated and stamped by the facility-in-charge (nursing officer-in-charge or clinical officer-in-charge or medical superintendent).

COUNTY GOVERNMENT OF BUSIA

DEPARTMENT OF HEALTH AND SANITATION

Document: Procedure for Reporting in DHIS2	
Document Number:	3
Point of Use:	County, Sub-County and Health Facility
Frequency:	Weekly, Monthly and Quarterly

Objective: To ensure accurate, complete and timely reporting of data in DHIS2.

Context: Data entry is done by the facility and/ or Sub-County Health Records and Information Officer (SCHRIO) for all facility data collected on electronic/ manual/ paper registers. All data should be entered into the DHIS2 system and in the relevant data sets (tables) The Sub-County Medical Officer of Health (SCMOH) is expected to review the previous month's report by the 16th day of each month and forward them to the next level. Any issues raised should be discussed and the errors identified corrected by the relevant person within the specified timeline. Consider the formation of health data review team that looks at the data prior to entry into DHIS2.

CHECKLIST FOR REPORTING IN DHIS2

- Use a standard checklist to confirm the facilities whose reports have been submitted and entered into DHIS2.
- The checklist used to confirm facilities data entry should have the date that the report was received at the Sub-County office.
- Health data team review team to discuss the data prior to submission.
- Enter **ALL** data into the relevant data set in DHIS2.
- Run validation to identify any errors that could have been missed during the manual/ paper registers data collation and validation stage.
- For all the errors detected, recheck the summary tool or refer to the relevant facility for correction and resubmission.
- Document all corrections made.
- Run the completeness report to ensure completeness by confirming that all facilities have submitted the relevant reports.
- Communicate to facilities that have not submitted reports.
- The SCHRIO to provide feedback to facilities based on issues raised and data entry errors identified.
- The SCMOH should review the reports by the 16th day of each month.

COUNTY GOVERNMENT OF BUSIA

DEPARTMENT OF HEALTH AND SANITATION

Document: Procedure for Data Analysis	
Document Number:	4
Point of Use:	County, Sub-County, Health Facility and Community Unit
Frequency:	Weekly, Monthly, Quarterly, and Yearly

Objective: To ensure accurate, valid, reliable and consistent analysis of data

Context: Data analysis should be done at all levels to enable data use by all at all stages. The analysis should be done on verified 'clean' data that has been approved and shared to all. This includes basic summaries and at M&E level, bivariate/ relational analysis. The correct interpretation, presentation and use of the analysis outputs should be emphasized. The M&E/ HIS units will be tasked with providing health information products to various stakeholders—community, Health Management Board, HMTs (County, Sub-County, and Facility), policy makers, planners, and health managers—at specified periods.

CHECKLIST FOR DATA ANALYSIS

- Final approved data should be made available for data analysis.
- Analyze data for priority indicators i.e. aligned to Annual Work Plans, programmatic strategic plans, CHSSIP, the CIDP, UHC and SDG.
- Standard indicators should be used and the information verified and availed using information products e.g. dashboard, chalkboards, bulletins, County profiles amongst others.
- Health information products should be developed, verified and circulated to relevant stakeholders including HMTs (County, Sub-County, and Facility) for discussions on data quality and performance improvement during data use meetings/ forums.
- Document statistical methods used to ensure that the process can be replicated in future.

COUNTY GOVERNMENT OF BUSIA

DEPARTMENT OF HEALTH AND SANITATION

Document: Procedure for Sharing and Use	
Document Number:	5
Point of Use:	County, Sub-County, Health Facility and Community Unit
Frequency:	Monthly, Quarterly and Yearly

Objective: To ensure accurate, consistent and reliable data is provided for use

Context: This involves a review of the information products at different levels. The structure of this process is meetings hence this SOP provides/ outlines the functions of the teams involved and their importance in data quality assurance and performance improvement.

CHECKLIST FOR DATA SHARING AND USE

- All levels should hold regular data use meetings/ forums (minimum once per month) to review the data, reports or information products.
- Data quality will form part of the agenda in these data review meetings and will provide an opportunity for documentation of data quality concerns by users.
- Actions from the data review meetings will be shared and used as a reference for data quality and performance improvement.
- Data quality concerns requiring verification and correction either at community or facility level will be documented and shared.
- HMTs (County, Sub-County and Facility) should participate in data review meetings and provide feedback to all relevant parties at lower levels.
- Advocate for continuous sensitization on data quality through staff training with an emphasis on process documentation.

Annex VII
The M&E Plan Development Team

	NAME	Designation/ Organization
1.	Dr. Melsa Lutomia	County Department of Health and Sanitation
2.	Dr. Janerose Ambuchi	County Department of Health and Sanitation
3.	Ali Oyuyo Atemba	County Department of Health and Sanitation
4.	Eric Reuben Wamalwa	County Department of Health and Sanitation
5.	Faiza Barasa	County Department of Health and Sanitation
6.	Rosemary Okuku	County Department of Health and Sanitation
7.	James Kuya	County Department of Health and Sanitation
8.	Tito Kwena	County Department of Health and Sanitation
9.	John Mukoma	County Department of Health and Sanitation
10.	Joseph Oprong	County Department of Health and Sanitation
11.	Jude Oduor	County Department of Health and Sanitation
12.	Moses Magero	County Department of Health and Sanitation
13.	Dr. Onyango Oluoch	County Department of Health and Sanitation
14.	Dr. Oscar Opiyo	County Department of Health and Sanitation
15.	Dr. Patroba Lukale	County Department of Health and Sanitation
16.	Nick Oyugi	Tupime Kaunti
17.	George Ayoma	Tupime Kaunti
18.	Dr. Sam Wangila	Tupime Kaunti
19.	Bernard Otieno	Tupime Kaunti
20.	Valentine Okumu	AMPATH Plus
21.	Caroline Chebet Kirui	SETH
22.	Hellen Okochil	NHP Plus

COUNTY GOVERNMENT OF BUSIA
MONITORING AND EVALUATION PLAN
2018-2023