SAMBURU COUNTY GOVERNMENT

COUNTY HEALTH SECTOR MONITORING AND EVALUATION PLAN

(2018- 2022)

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Acronyms and Abbreviations

ANC	Antenatal Care
APRP	Annual Performance Review and Plan
ARVs	Antiretroviral
BCC	Behaviour Change Communication
BCG	Bacilli Calmette-Guerin
BEmONC	Basic Emergency Obstetric and Newborn Care
BMI	Body Mass Index
CASCO	County AIDs and STI Coordinator
CDH	County Director Health
CDSC	County Disease Surveillance Coordinator
CECM	County Executive Committee Member
CEmONC	Comprehensive Emergency Obstetric and New- born Care
CHC	Community Health Committee
CHA	Community Health Assistance
CHMT	County Health Management Team
CHRI-	County Health Record and Information OfficerCounty
OCHSIP	Health Strategic Investment Plan
CHW	Community Health Volunteer
CIMES-	County Integrated Monitoring and Evaluation System Com-
CLTS	munity-led Total Sanitation
CNC	County Nutrition Coordinator
COH	Chief Officer Health
CPD	Continuing Professional Development
CP	County Pharmacist
CPHO	County Public Health Officer
CRHC	County Reproductive Health Coordinator
CSFP	Community Strategy Focal Person
CU	Community Unit
CWC	Child Welfare Clinic
CMLAP II	County Measurement Learning and Accountability
DDIU	Data Demand and Information Use
DDSC	Division of Disease Surveillance and Control
DHIS2	District Health Information Software-2
DMR	Data Management Register
DPT	Diphtheria, Pertussis and Tetanus
DQA	Data Quality Audit
EHR	Electronic Health Records
EMMS	Essential Medicines and Medical Supplies
ESHE	Enabling Sustained Health Equity
FIC	Fully Immunized Child
FP	Family Planning

GDP	Gross Domestic Product
GOK	Government of Kenya
HAO	Health Administration Officer
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRIO	Health Records and Information Officer
iHRIS	Integrated Human Resources Information System
HSP	Health Service Provider
HSSF	Health Sector Service Fund
HCW	Health Care Worker
ICD	International Classification of Diseases and health-related-problems
ICT	Information and Communication Technology
IDSR	Integrated Disease Surveillance & Response
IEC	Information, Education and Communication
IMAM	Integrated Management of Acute Malnutrition
KABP	Knowledge Attitude Beliefs & Practice
KDHS	Kenya Demographic and Health Survey
KEBS	Kenya Bureau of Standards
KHSSP	Kenya Health Sector Strategic Plan
LLITN	Long-Lasting Insecticide-treated Net
M&E	Monitoring and Evaluation
MDA	Mass Drug Administration
MDG	Millennium Development Goal
MOH	Ministry of Health
NCDs	Non-communicable Diseases
NHIF	National Hospital Insurance Fund
NIMES	National Integrated Monitoring and Evaluation System
NGO	Non-Governmental Organization
NTDs	Neglected Tropical Diseases
OPD	Outpatient Department
OPV	Oral Polio Vaccine
PMTCT	Prevention of Mother-to-Child Transmission
PO	Project Officer
PRB	Population Reference Bureau
RDT	Rapid Diagnostic Test
RMNCAH	Reproductive Maternal New-born Child & Adolescent Health
SCHMT	Sub-County Health Management Team
SCHRIO	Sub-County Health Records Information Officer
SCHSSP	Samburu Health Sector Strategic Plan

SCMLT	Sub-County Medical Laboratory Technologist
SCMOH	Sub-County Medical Officer for Health
SD	Standard Deviation
SMARTA	Specific, Measurable, Attainable, Realistic, Timely Agreeable-
SMART	Standardized, Monitoring, Assessment, Relief, Transition
SOP	Standard Operating ProcedureTransforming Health Sys-
THS - UC	tems- Universal Care
TB	Tuberculosis
TOR	Terms of Reference
TWG	Technical Working Group
USAID	United States Agency for International Development
WVK	World Vision Kenya

Foreword

The County Government of Samburu is committed to the establishment of a harmonized health sector Monitoring and Evaluation system that truly promotes transparency and accountability. Towards this end, the county health sector has developed a strategic plan for the five-year period 2018 to 2022, and a Monitoring and Evaluation plan to provide guidance on focused tracking of the specific goals and objectives of the sector. This approach is informed by the national health sector policy orientations and the county's overall agenda of integrating monitoring and evaluation agenda.
Implementing the County Health M&E Plan will be a major step in pursuit of County's vision statement of A county free from preventable diseases and ill health. This vision is attainable if there is commitment by all stakeholders, substantial investments in the county health system, and a robust monitoring strategy characterised by clearly defined indicators that support periodic evaluation of the health care delivery system.

The M&E Plan provides the roadmap for measuring achievements of the County Health Sector Strategic Plan and the County Health System as a whole. It defines data collection, management, and dissemination mechanism. Further, it elaborates how the county health sector will be monitored, reviewed and evaluated. A comprehensive list of indicators at various levels – input, process, output, and outcome are embedded. With the full implementation of this plan, gaps in the health delivery system will be identified, improvement in data collection and management will be addressed and prompt interventions will be affected for the benefit of stakeholders and citizens of Samburu County.

I wish to express my gratitude to all those who committed their efforts, time and resources in the preparation of this M&E Plan. I remain confident that the implementation of this plan is critical and achievable. I appeal to all stakeholders to offer their support in the implementation of this plan as we seek to transform the delivery of health services in Samburu County.

Hon. Stephen Lekupe
County Executive Committee Member for Medical Services, Public Health and Sanitation,
Samburu County

Acknowledgement

The Samburu County Health Monitoring and Evaluation Plan 2018-2022 was developed with the support of numerous individuals and organisations. The County Government is appreciative of the leadership offered by H.E Julius Leseeto, the Deputy Governor and the County Executive Committee Member for Health; the overall coordination by Dr. Martin Thuranira, County Director for Health. Contributions by the members of CHMT and SCHMT and representatives of partners during the various stages of development of this document were crucial in enriching the content of this final draft.

We are grateful to the County Health M&E Unit Coordinator, Geoffrey Mukuria for provided coordination in ensuring that required information was availed on time and coordinating logistics. We applaud USAID funded partners representatives from CMLAP II, Afya Timiza, NHP Plus and Population Reference Bureau, as well as Uzazi Salama, and World Vision programs for their insights and contributions.

USAID funded CMLAP II and Afya Timiza provided financial and technical support that was fundamental towards completion of this plan. Once more, I am pleased to recognize and appreciate the dedicated sacrifices and commitments of partners and individuals who have contributed immensely to the development of this plan. It is my hope that this document will be implemented in full and that the Department of Health's M&E Unit continues to work with these individuals, programs and partner organizations as we deliver on the promises in our CHSSP.

Samuel Nakope,
Chief Officer of Medical Services, Public Health and Sanitation

Executive Summary

The County Health Monitoring and Evaluation Plan is a significant step in a series of interventions aimed at strengthening the M&E capacity of the Samburu County Health Sector. The County Government of Samburu underscores the crucial role of a robust M&E system in generating useful information for decision making, measuring performance and fostering learning. The M&E plan will facilitate the application of a harmonized approach in tracking performance across all the health programs within the county health sector and ensure that the programs contribute to the overall desired results articulated in the strategic plan and the County Integrated Development Plan (CIDP). The County Government envisages that M&E will be integrated into the daily work of the county staff as well as other stakeholders. In this way, M&E systems will enable generation and sharing of data and information, thus promoting greater accountability and continuous learning.

The development of this M&E Plan for the County Health Sector Strategic Plan is premised on the need to establish a robust monitoring and evaluation platform that provides information to all stakeholders for planning and evidence-based decision making. This is also in line with the requirements of the Constitution of Kenya 2010 in terms of advancing rights to health and information, and accountability in service delivery. Legislations including the County Government Act, 2012 and Public Financial Management Act, 2012, the Health Act, 2017, Inter-Governmental Relations Act, 2012 do also affirm the requirements for monitoring and evaluation in entrenching accountability through establishment of appropriate systems for data collection, reporting, information sharing, and feedback. Similarly, health sector policies including the Kenya Health Policy (2014 -2030), the Health Information System Policy do also lay specific requirements and provide guidance on strengthening accountability mechanisms.

This plan is informed by a situational assessment of the M&E situation in Samburu County Health Sector. A review of the County Health Sector M&E plan for the period 2013 to 2018 was undertaken with a view to establishing the level of implementation and identifying key strategic issues for monitoring and evaluating the recently developed County Health Sector Strategic Plan (2018-2022). The analysis indicates that the County Health Department has formulated the necessary strategic direction for supporting M&E activities and commenced the setting up of the necessary institutional arrangements. Challenges were identified with regards to the capacity at the various levels to collect, process and disseminate information at the various levels of the county health system. Further, the need was identified for increasing resources allocated to M&E and improving the coordination of the various stakeholders in the county health system.

This M&E plan is therefore designed to provide a common platform for the health sector performance monitoring and evaluation by guiding all actors at the county, sub-county, facility, and community levels. It envisages that the County will build the capacity of the existing workforce in data management and information use at all levels for better planning and decision making. Further, it will enhance the health sector of coverage outcomes and investments at all levels applying impact indicators, outcome indicators, process indicators, and input indicators.

The plan lays out specific measures for data collection, analysis, and reporting. In addition, it provides guidance on how the county health sector will carry out regular performance monitoring at the facility level, sub-county level and county level. The M&E plan provides a detailed analysis of the M&E audience information requirements to facilitate effective and responsive data collection and reporting procedures. These are anchored on a countywide health strategic M&E logical framework that illustrates the causal chain of inputs/processes, outputs and outcomes that ultimately lead to the achievement of the overall goal of the County Health Sector Strategic Plan. The indicators selected are elaborated in terms of definitions, data sources, frequency of collection and responsible persons for collection, in line with the guidance provided in the national health sector indicators and standards operating procedures manual. Further, a schedule of reporting considerations and requirements has been included to facilitate timely and accurate reporting. The M&E plan has an elaborate evaluation plan that provides for various evaluations to be undertaken during the implementation of the CHSSP.

To facilitate effective implementation of this M&E plan, institutional arrangements that support accountability at all levels of the county health system and embed alignment to the national M&E system and countywide M&E system will be enabled. Specifically, appropriate stakeholder coordination structures including a stakeholder coordination steering committee and M&E Technical Working Group will be established. Further, the existing M&E unit at the health department will be strengthened with a budget and human resources to support the effective delivery of M&E activities.

Chapter 1: Introduction

1.1 County Health Sector

Samburu County, which covers an area of approximately 21,022 Sq. Km. is the tenth largest county amongst Kenya's 47 counties. The county has an estimated population of 331,376 people and 66,275 households (2009 KNBS). The population is distributed across three administrative sub-counties of Samburu Central, Samburu East and Samburu North as 153,668, 90,267, and 87,442 respectively.

Over the past five years the county has registered progressive improvement in the health sector. Despite life expectancy is below national average, the mortality indicators estimates are below the national ones. The main causes of mortality in the county are HIV and AIDS, Tuberculosis, Malaria, Ppneumonia, and Diarrheal diseases. The burden of non-communicable diseases remains a challenge in the county in terms of financial risk exposure to households and as a cause of mortality. Furthermore, prevailing health risk factors such as malnutrition, poor housing, pollution, unsafe water poor hygiene and unsafe sex expose the population to the top morbidity and mortality conditions. Table 1 summarise the key health indicators and comparison against national estimates.

Table 1: Key Health Impact Indicators

Impact level Indicators	National KDHS (status as at 2017)	County estimates
Life Expectancy at birth (years)		52
Male Life Expectancy at birth (years)	63	53
Female Life Expectancy at birth (years)	65	56
Annual deaths (per 1,000 persons) – Crude mortality	8.9	2*/1000,6/100,000
Neonatal Mortality Rate (per 1,000 births)	15	11*/1000
Infant Mortality Rate (per 1,000 births)	39	34*/1000
Under 5 Mortality Rate (per 1,000 births)	52	50*/1000
Maternal Mortality Rate (per 100,000 births)	443/100,000	362*/100,000
Adult Mortality Rate (per 1000 population)		183*/1000
Children under five years stunted		35/100

Source: *KDHS 2014. National Estimates.

Samburu County has not performed well in some health indicators especially Reproductive Maternal Newborn Child and Adolescent Heath (RMNCAH). In response, interventions have been introduced to improve these indicators including free health services in all tier 2 facilities and free maternity services in all facilities. This includes the results-based programs such as Beyond Zero, THS-UC and Performance Based Financing (PBF) with specific targets for RMNCAH. Some improvement varying across sub-counties, has been noted at the output and outcome indicators level with deliveries by skilled attendants at the facility increasing from 19.2% to 37%, Fully Immunized Children (FIC) from 58.8% to 68.9%, ANC fourth visit from 28.3% to 30.8%, WRA receiving Family Planning (FP) commodities from 17.8% to 26.7%.

Other interventions were also introduced to specifically address the high burden of diseases such as HIV/AIDS, TB, and Respiratory Tract Infections. Notably, HIV/AIDS control programming showed progress, with HIV prevalence rate in Samburu County reducing from 4.8% (KAIS, 2012) to 1.8% (Kenya HIV/AIDS Estimates Report 2018). TB control was challenged by HIV co-infection, it also showed improvements in cure rate rising to 86%.

Non-communicable conditions represent an increasingly significant burden of ill health and deaths due to; cardiovascular diseases, cancers, respiratory diseases, digestive diseases and psychiatric conditions. Finally, injuries are relatively high (at 4.8% of new outpatient cases) in the county though anecdotally believed to be under reported.

The risk factors that threaten health in Samburu County include unsafe sex, sub optimal breastfeeding, alcohol and tobacco use, poor sanitation and hygiene practices, poverty, illiteracy, among others (retrogressive cultural practices). Breastfeeding practices stands at 99.5% with exclusive breastfeeding for six months at 77.6% (KABP Survey February 2018). Tobacco and alcohol use are also high and stands at 14.3% and 27% respectively.

Availability of safe water sources and sanitation facilities has also improved, particularly with support from partners. However, coverage is still low at 17%. Housing conditions remain poor with majority of the population living in manyattas.

The County has over the years experienced significantly high levels of acute and chronic malnutrition. This has been exacerbated by suboptimal infant and young child feeding practices, unfavourable cultural practices, and perennial food shortages among others. The rates of malnutrition have remained persistently above the national average. In 2018 Acute Malnutrition decreased from 18.3% to 15.7%, stunting increased from 34.0% to 35.8; severe Acute malnutrition increased from 3.8% to 4.1 % and underweight decreased from 34.3% to 31.6% (SMART Survey June 2018). With such an unstable nutrition status, children are at risk of reduced cognitive ability and unproductive adult life.

In terms of health systems strengthening, the county government has progressively made investments and registered improvements in health investments output at the various levels of the county health system. The county has a total of 95 health facilities including 3 hospitals 15 health centres and 60 dispensaries. These facilities are supported by 615 staff, who include 7 medical specialists, 12 medical officers, 233 nurses, 4 Pharmacists, 9 Pharmaceutical technologist, 38 Public Health Officers, 14 Nutritionists and 30 Community Health Assistants. Situational analysis reveals that the investments are still below the norms and standards envisaged under the Kenya Essential Package for Health (KEPH, 2016).

The county acknowledges the contribution made by partners and stakeholders in supporting health service delivery and has been improving the coordination structures to see to it that the contribution is optimised. The main areas of supportive collaboration are in reproductive maternal, new-born child health, adolescent health, water sanitation hygiene promotion, nutrition promotion, and HIV/AIDS. Notably, the county government continues to rely mainly on the shareable revenue for the financing of most health activities.

1.2 County Monitoring and Evaluation for Health

Monitoring and Evaluation (M&E) together with operational research, measures the overall performance of a programme or project and continuously evaluates achievements in targeted results. Monitoring is defined as the routine tracking of key elements selected to determine programme performance through record keeping, regular reporting, supportive supervision, surveillance systems and periodic surveys. In addition, monitoring involves assessing whether the implementation of the planned activities is consistent with the programme design through generating data on inputs, processes and outputs of an on-going programme over time.

Evaluation, on the other hand, is defined as the periodic assessment of the change in targeted results that can be attributed to an intervention. It links outcome or impact directly to an intervention over time. Evaluation involves systematic use of quantitative and qualitative research methods to investigate the programme's effectiveness, efficiency, relevance, sustainability and impact to determine the extent to which the investment has yielded the expected results (Guidelines for the Institutionalisation of Monitoring and Evaluation in the Health Sector, 2014).

The need to have systems that support accountability to the citizens is entrenched in the Constitution of Kenya, 2010 and various legislations such as the County Government Act, 2012; the Public Financial Management Act, 2012, Intergovernmental Relations Act, 2012 and sector-specific legislation like the Health Act, 2017. As such the establishment of robust M&E system to support the county health sector is a critical ingredient for achievement of the desired level of accountability.

County governments are required to have elaborate plans laying out their agenda for the medium term and sectoral plans that articulate the sectoral agenda. The County Government of Samburu has put in place a County Integrated Development Plan for the period 2018-2022 and has a draft County Health Strategic Plan (SCHSSP) 2018 – 2022. To ensure close monitoring of the progress of implementation of health sector strategic plan, and thus drive the path to the attainment of overall health goal, the county government has put in place this M&E plan. The M&E plan outlines data needs, indicators, sources of data, data collection methods and data flow, analysis, use and reporting, feedback as well as the responsibilities of the various health stakeholders. This is in response to critical gaps identified in the County Health M&E systems that include: ineffective coordination, sub-optimal utilisation of data in decision making, inadequate physical infrastructure; inadequate personnel, inadequate supply of data collection and reporting tools and equipment, knowledge gaps in data management, research and evaluation; insufficient funding and limited use of ICT.

1.3 Purpose of the M&E Plan

The overall purpose of this M&E plan is to facilitate the tracking of the progress of implementation of the County Health Sector Strategic Plan for the period 2018-2022. This plan will also facilitate the institutionalisation of the M&E principles and practices in support of decision making and adaptive learning, planning, and management across all the programs implemented by the County Health Sector. It is expected to serve as a vital tool for timely and systematic data collection, analysis and reporting with the overall goal of improving performance and accountability to stakeholders.

Specifically, the M&E plan will:

1. Build coherence in the approach to systematically track performance across county health programs and ensuring that they contribute to the overall goal reflected in the County Health Sector Strategic Plan 2018-2022.
2. Define the data requirements (collection, sources, tools, collation, analysis) and assign responsibilities for effective tracking of interventions implemented at all levels.
3. Provide reporting requirements including reporting formats needed to promote timely reporting both within the county and externally to national government, partners and donors.
4. Define data feedback mechanisms and utilisation for decision making internally and among stakeholders.
5. Document progress and enhance performance through continuous learning, sharing and improvement.

1.4 Process of Development

This M&E plan was developed through a participatory and consultative process that involved county health department as well as partners. Specifically, the approach applied included the following:

a) Review of national and county documents to understand the M&E planning requirements and environment
b) Consultative meetings with senior management of the County Department of Medical Services, Public Health and Sanitation, program managers and M&E focal persons.
c) Consultations with the County Health M&E Technical Working Group and partners.
d) Technical workshop to review the prior period's M&E plan and formulate this plan.
e) Final draft review and validation with stakeholders to build consensus on and obtain further feedback.

Chapter 2: Monitoring and Evaluation Mechanisms

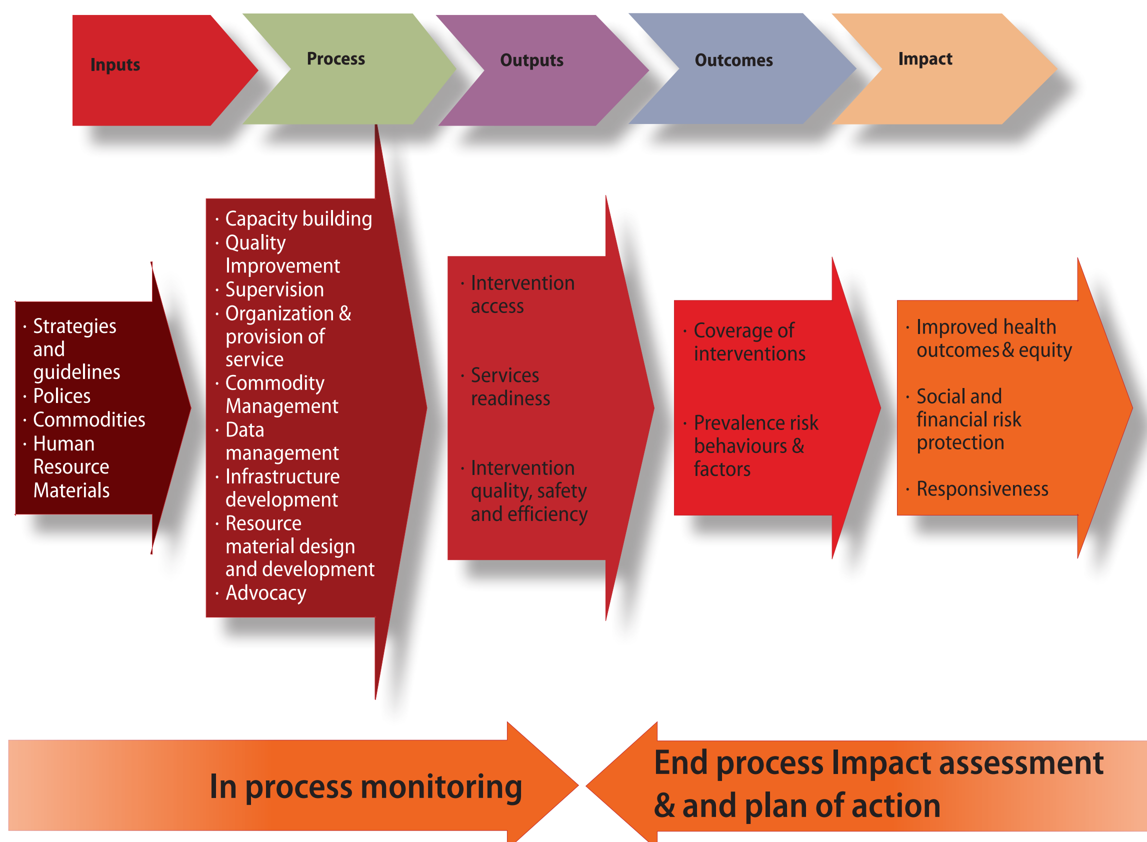
This section outlines the mechanisms for monitoring and evaluation including the general monitoring framework and the county-led M&E matrix.

2.1 Health Sector M&E Logical Framework

The logical M&E framework applicable to this plan is premised on the fact monitoring and evaluation will be carried out guided by performance indicators tracked at inputs, processes, outputs, outcomes, and impact level. Investments through inputs and process will result in immediate outputs, outcomes and ultimately create an impact in the health sector. At the input level, indicators related to various health systems investments such as human resources for health, health financing, policies and others, will be utilized to measure performance. The processes (training, commodities, and advocacy) will directly translate to various outputs which, in turn, and if effectively designed to reach the target populations, will result in short-term effects or outcomes such as increased coverage and service quality.

Additionally, these outcomes could result in a longer-term impact of the programme on the population in terms of a reduction in disease burden, reduction in mortality, increase in life expectancy and improved well-being. These specific indicators are mapped alongside associated health policy and strategic objectives guided by the health sector strategic plan are shown in Figure 1. To enhance the M&E framework the plan will design strategies to enrich in process and end process impact evaluation thus formulating action plans based on generated data evidence, therefore informing health programs interventions.

Figure 1 Basic Monitoring and Evaluation Framework



2.2 Monitoring and Evaluation Matrix

The Samburu County Health Sector Strategic Plan will be monitored and evaluated as illustrated in Table 4 below.

Table 4: Monitoring and Evaluation Matrix

Indicator	Inputs	Processes	Outputs	Outcome	Impact	Data Source
Objective 1: To Reduce Non-Communicable Diseases						
% Fully immunized children	• Vaccine doses acquired • Immunization equipment • cold chain • Immunization information, education and communication (IEC) materials • Training and capacity building for health care providers plans • Outreach services.	• Updating/training of health care workers on immunization policies and guidelines • Availing vaccines to buffer stock • Conducting outreaches on immunization • Sensitization of community units on immunization policies and guidelines • Conducting stakeholders' forums on immunization • Conducting quarterly data review meetings on immunization	• Number of children fully immunized • Number of facilities providing immunization • Number of community units sensitized • Number of health workers updated on immunization guidelines • Number of immunization defaulters traced	Increased proportion of children below the age of one year who are fully immunized	Reduction in mortality, increase in life expectancy	DHIS (MOH 510,702,710), HIS SURVEYS (EPI, KDHS, KSPA) KNBS
% of target population receiving Multi-Drug Administration (MDA) for schistosomiasis Trachoma, Snake bites	• Human resources • Training • available funds, • Equipment and supplies.	• Creation of awareness, • Conduct supervision • Procure supplies.	• Number of outreaches conducted, • Number of supplies procured and distributed • Number of supervisions conducted	Reduced schistosomiasis	Reduction of mortality	MDA registers and tally sheets, demographic estimation

Indicator	Inputs	Processes	Outputs	Outcome	Impact	Data Source
% of TB patients completing treatment	• Partners supporting the TB program • Updates on TB policies and guidelines.	• Updating/training of health care workers and community health volunteers on current TB policies and guidelines • Sensitization of community units on TB policies and guidelines • Conducting quarterly data review meetings • Conducting TB stakeholders' forum • Updating/training of health care workers on TB and nutrition	• Number of health care workers and community health volunteers trained / updated on TB policies and guidelines • Number of dialogue/action days conducted • Number of TB-related commodities procured • Number of TB-related commodities distributed • Number of health care workers trained on TB and nutrition	Increased proportion of bacteriologically confirmed TB clients completing treatment	Reduction of mortality	TB Treatment Register, MOH 711, TIBU Demographic Estimation (HIS)
% HIV+ pregnant mothers receiving preventive antiretroviral (ARVs)	• Human resources • available funds	• Conduct awareness on PMTCT • Conduct supervision, procure supplies and conduct training.	• Number of outreaches conducted • Number of supplies procured and distributed • Number of supervisions conducted	Reduced MTCT of HIV	Reduction in mortality	MOH 405,333, 406,731(HIS)
% of HIV+ clients on ARVs	• Partners supporting the HIV/ AIDS program • Supplies and equipment • IEC materials on HIV/AIDS	• Updating/training of HIV testing and counseling (HTC) providers on treatment guidelines • Sensitization of community units on HIV/AIDS policies and guidelines • Conducting quarterly HIV/AIDS meetings • Conducting HIV/AIDS stakeholder forum	• Number of HTC providers trained / updated on HIV management guidelines • Number of community units sensitized on HIV/AIDS policies and guidelines • Number of HIV-related commodities procured • Number of HIV-related commodities distributed	90% of people living with HIV/AIDS accessing care and treatment	Reduction in Mortality	ART registers (HIS)

Indicator	Inputs	Processes	Outputs	Outcome	Impact	Data Source
Under-5s treated for diarrhea	Skilled human resources, transport, structure, available funds, equipment, supplies.	Conduct outreaches, conduct training, procure supplies, community sensitization, and conduct supervision.	Number of outreaches conducted Number of supplies procured and distributed Number of supervisions conducted Number of health care workers (HCWs) trained	Reduced cases of under-five diarrhea cases or increased child survival	Reduction in under 5 mortality	MOH 204 A, MOH 705 A (HIS)
School age children de-wormed (6-14 yrs.)	Human resources, transport, structure, available funds, equipment, supplies.	Human resources, school health outreaches, supplies, reporting, training.	Number of outreaches conducted Number of supplies procured and distributed Number of supervisions conducted Number of health care workers (HCWs) trained	Increased child survival rate	Reduction in morbidity	SURVEYS, REPORTS (HIS), School health program MOH 708
12-59 months Children de-wormed	Human resources, transport, structure, available funds, equipment, supplies.	Conduct outreaches, conduct training, procure supplies, community sensitization, conduct supervision, and conduct training.	Number of outreaches conducted Number of supplies procured and distributed Number of supervisions conducted Number of health care workers (HCWs) trained	Increased child survival rate		MOH 713 (HIS), ECDE Vit A and Dewormers
Objective 2: To Halt, and Reverse Burden of Non-Communicable Conditions						

Indicator	Inputs	Processes	Outputs	Outcome	Impact	Data Source
% of adult population with Body Mass Index (BMI) over 25	Human resources, equipment, documentation tools, logistics.	Develop health promotion package on healthy lifestyle, conduct mass screening, regulate/ enact/enforce laws that govern food markets, establish recreation centers.	Number of sensitization meetings on lifestyle held Number of recreation centers initiated Number of mass screenings conducted Number of laws enacted/ enforced	Reduced /halted non-communicable conditions	Reduction in mortality	Survey HIS
% women of reproductive age screened for cervical Cancers	• Number of partners supporting the cervical cancer screening program • Updates on cervical cancer screening, management and referral policies and guidelines.	• Updating/training of health care workers on cervical cancer screening, management and referral • Updating community health volunteers on cervical cancer advocacy and referral • Procurement and distribution of cervical cancer equipment and commodities • Conducting cervical cancer stakeholders' forum • Conducting quarterly cervical cancer data review meetings	• Number of health care workers (HCWs) • trained / updated on cervical cancer screening, management and referral • Number of community health volunteers • updated on cervical cancer advocacy and referral • Amount of cervical cancer equipment and related commodities procured	Increased proportion of women of reproductive age screened for cervical cancer	Reduction in mortality	ANC register, Post-natal register, Family planning, cervical cancer service register, OPD register (HIS)
New outpatients with mental health conditions	Skilled human resources, documentation tools, logistics.	Establish mental health units in high volume sub-county hospitals.	Number of mental health centers providing outpatient services	Reduced /halted non-communicable conditions	Reduction in mortality	Outpatient registers (HIS)

Indicator	Inputs	Processes	Outputs	Outcome	Impact	Data Source
New outpatients' cases with high blood pressure	Skilled human resources, documentation tools, logistics.	Create awareness of the risk of hypertension and the importance of regular checkups; conduct mass screening, establish rehabilitation centers.	• Number of health education sessions conducted monthly • Number of public awareness sessions on importance of regular checkups conducted monthly	Number of new outpatients with high blood pressure seen. Reduced/halted burden of non-communicable conditions	Improvement of well being	OPD REGISTER MOH 204 B, OPD summary sheet (FORM 705B), HIS
Patients admitted with cancer	Skilled human resources, documentation tools, logistics	Procure the medical equipment for screening, supply of drugs.	Number of screening equipment procured Number of stock-out of drugs reported	Reduced /halted non-communicable conditions Improved treatment outcome of case load, reduced new cancer cases	Improvement of wellbeing and life expectancy Reduction in mortality	OPD REGISTER MOH 204 B and OPD summary sheet (FORM 705B (HIS)
Objective 3: To Reduce the Burden of Violence and Injuries						
New outpatient cases attributed to gender-based violence	• Partners supporting services dealing with sexual and gender-based violence • Updates on sexual and gender-based violence management and referral policies and guidelines	• Updating/training of health care workers on the sexual and gender-based violence program • Updating community health volunteers on SGBV advocacy and referrals • Upgrading health facilities so that they can offer services dealing with SGBV • Procurement and distribution of equipment and commodities that can assist SGBV survivors • Conducting SGBV stakeholders' forum • Conducting quarterly SGBV data review meetings	• Number of health care workers trained / updated on SGBV management and referrals • Number of community health volunteers updated on SGBV advocacy and referrals • SGBV-related equipment and commodities procured • Number of health facilities offering services dealing with SGBV	Increased proportion of SGBV survivors accessing health care services	Minimize effects of GBV	GBV register (HIS), Survey

Indicator	Inputs	Processes	Outputs	Outcome	Impact	Data Source
New outpatient cases attributed to road traffic injuries	Skilled human resources, available funds, medical equipment, drugs, advocacy and enforcement of traffic rules, infrastructure and medical supplies.	Training of staff on how to handle emergencies.	Number of staff trained to handle emergencies.	Reduction in the number of deaths and disabilities due to road traffic accidents.	Reduce mortality and morbidity related to RTA	Outpatient registers (HIS)
New outpatient cases attributed to other injuries	Skilled human resources, available funds, medical equipment, drugs, advocacy and enforcement of traffic rules, infrastructure and medical supplies.	Community sensitization and respecting the rule of law.	Number of community sensitization meetings held	Reduced number of other injuries	Reduce mortality and morbidity related to other injuries	Outpatient registers (HIS)
Deaths due to injuries	Ambulance services.	Upgrade county referral hospital to have ICU facilities, equip ambulances.	County referral hospital with capacity to handle emergencies. Availability of well-coordinated ambulance services Number of equipped ambulances	Coordinated emergency servicesZdue to injuries	Reduce mortality and morbidity related to other injuries	Death registers (HIS), KDHS, Census
Objective 4: To Provide Essential Health Service to Samburu County By 2022						
% deliveries conducted with skilled attendant	• Guidelines and standard operating procedures (SOPs) • Emergency obstetric and new-born care (EmONC) checklist • Comprehensive emergency obstetric and new-born care (CEmONC) checklist • IEC materials	• Training of health workers • Assessment of health facilities' EmONC readiness • Supportive supervision • Community mobilization • Distribution of IEC materials	• Number of health care workers trained on EmONC • Number of facilities that are EmONC compliant • Number of facilities that are CEmONC compliant • Number of community units that are sensitized 1.	Increased proportion of deliveries conducted by skilled attendants	Reduce infant and maternal mortalities related to deliveries	HIS

Indicator	Inputs	Processes	Outputs	Outcome	Impact	Data Source
% of pregnant women attending four antenatal care visits	Human resource, equipment and IEC Materials	• Capacity building of health workers in focused antenatal care (FANC) • Community advocacy and mobilization on FANC • Procurement of health commodities • Strengthen referral system • Distribution of IEC materials	• Number of HCWs whose capacity in FANC has been built • Number of community units mobilized and sensitized on FANC • Number of health facilities supplied with commodities	Increased proportion of pregnant women attending 4 ANC visits	Reduce maternal &child mortality,	HIS
% of women of reproductive age receiving family planning	• Training curriculum • Family planning commodities • and equipment • Guidelines and SOPs • IEC materials	• Training of health workers on current FP methods • Supportive supervision • Community awareness • Distribution of IEC materials	• Number of health care workers (HCWs) trained in current FP methods • Number of community units that are sensitized	Increased proportion of women of reproductive age receiving FP commodities	Reduce Maternal mortality,	HIS
% of facility based maternal deaths	Human resource, equipment and IEC Materials	• Capacity building of health workers • Maternal death audits at all levels • Community mobilization • Strengthen referral system • Distribution of IEC materials	• Number of HCWs whose capacity has been built • Number of maternal death audits conducted • Number of verbal autopsies conducted at the community level • Number of community units sensitized	Reduced number of maternal deaths reported and audited	Reduce Maternal Mortality	HIS
% of facility-based under-five deaths	Human resource, equipment and IEC Materials	• Building the capacity of health care workers (HCWs) in child health • Community advocacy and mobilization on child health • Procurement of health commodities • Strengthen referral system • Distribution of IEC materials	• Number of HCWs whose capacity in child health has been built • Number of community units mobilized • and sensitized on child health Number of health facilities supplied with commodities	Reduced proportion of facility-based under-five deaths reported	Reduce infant mortality	HIS

Indicator	Inputs	Processes	Outputs	Outcome	Impact	Data Source
% of new-born with low birth weight	Human resource, equipment and IEC Materials	• Capacity building of health care workers in newborn health • Community advocacy and mobilization on newborn health • Procurement of health commodities • Strengthen referral system • Distribution of IEC materials	• Number of HCWs whose capacity in new-born health has been built • Number of community units mobilized and sensitized on new-born health • Number of health facilities supplied with commodities	Increased number of newborns with normal birth weight	Reduce infant mortality	HIS
% of facility-based fresh still births	Human resource, equipment and IEC Materials	• Capacity building of health workers in management of labor and delivery • Community advocacy and mobilization on at least 4 antenatal care (ANC) visits • Procurement of health commodities • Strengthen referral system • Distribution of IEC materials	• Number of HCWs whose capacity in management of labor and delivery has been built • Number of community units mobilized and sensitized on 4 ANC visits • Number of health facilities supplied with commodities	Reduced number of fresh still births reported		HIS
Objective 5: To Minimize Exposure to Health Risk Factors						
% population who smoke	Regulatory laws (NACADA), guidelines, by-laws on smoking and miraa consumption	• Community sensitization on NACADA laws and by- laws,	• Number of community sensitizations carried out on NACADA laws,	Reduced / halted non-communicable conditions due to smoking	Reduce cases / deaths related to smoking	Surveys, (NACADA), KDHS, Census
% of salt brands adequately iodized	Funds available	• sensitization on use of iodized salt	• use of iodized salt,	Reduce the cases related to intake of un iodized salts.		SURVEYS KNBS (KDHS), Sample surveys
Objective 6: To Strengthen Collaboration with Health-Related Sectors						

Indicator	Inputs	Processes	Outputs	Outcome	Impact	Data Source
% infants under six months on exclusive breastfeeding	IEC materials	• Training health care workers to promote exclusive breastfeeding • Community advocacy and mobilization on exclusive breastfeeding • Distribution of IEC materials	• Number of HCWs who have been trained to promote exclusive breastfeeding • Number of community units mobilized and sensitized on exclusive breastfeeding. • Number of health facilities supplied with commodities	Increased proportion of infants under the age of 6 months who are exclusively breastfed	Reduce infant mortality	KNBS/HIS
% children under five stunted	IEC materials	• Capacity building of health workers in nutritional requirements of under-fives • Community advocacy and mobilization on nutrition in under-fives • Distribution of IEC materials	• Number of HCWs whose capacity in nutrition for under-fives has been built • Number of community units mobilized and sensitized on nutrition for under-fives. • Number of health facilities supplied with nutrition commodities	Reduced proportion of children under the age of 5 years who have stunted growth	Reduce malnutrition in under-fives, Reduced under five mortality	KNBS/HIS
% children under five underweight	Human resource, equipment and IEC Materials	• Capacity building of health workers in nutritional requirements of under-fives • Community advocacy and mobilization on nutrition in under-fives • Distribution of IEC materials	• Number of HCWs whose capacity in nutrition for under-fives has been built • Number of community units mobilized and sensitized on nutrition for under-fives • Number of health facilities supplied with nutrition commodities	Reduced proportion of children under the age of 5 years who are underweight	Reduce under-fives mortality	KNBS/HIS
% population with access to safe water	Human resource, equipment and IEC Materials	• Training of HCWs and CHVs. • Community sensitization	• Number of HCWs and CHVs trained. • Number of community sensitizations conducted	Increased proportion of households with access to safe water	Reduce the burden of diarrheal diseases	SURVEYS, REPORTS; KDHS MOH 708)HIS
% of households with latrines	Human resource, and IEC Materials	• Community advocacy and mobilization on latrine use • Capacity building of community health volunteers on community led total sanitation (CLTS) • Distribution of IEC materials	• Number of community units whose capacity in CTLS has been built • Number of open defecation free (ODF) villages. • Number of CLTS sessions conducted.	Increased proportion of households with latrines	Improved sanitation and waste management	SURVEYS, REPORTS KDHS MOH 708) HIS

Chapter 3: Operationalization of M & E Plan through Stewardship Goals

3.1 Support Establishment of a Common Data Architecture

Common data architecture is a prerequisite for achieving the One M&E framework desired for the health sector. Data architecture in this context refers to the use of standard nomenclature for services, medicines and medical supplies, cadres of staff amongst others. It also refers to the use of standard coding systems shared across all databases, as well as the use of defined standards for the exchange of patient and aggregate level data across information systems. The county health department will adopt a consistent application of standards as a data management function. This will require strong leadership at all management levels and thus it is a prerequisite in the logic framework as a key domain of the stewardship goals.

3.2 Enhancing sharing of data and promoting use of information for decision-making

Data and statistics management will be enhanced through sharing and information use to allow evidence-based decision making. Data management will be coordinated at the county level. The County Department of Health will undertake the procurement and distribution of HMIS data collection and reporting tools to meet the data requirements of the county. The County Health Management Team (CHMT), through the Monitoring and Evaluation unit and the M&E TWG (TWG), will provide oversight and will coordinate initiatives in Samburu County aimed at supporting efficiency and effectiveness of electronic data management for assuring data quality, timeliness and accuracy.

The CHMT, through the county health records and information officer (CHRIO), will coordinate data collection and reporting of service data through the routine health management information (HMIS) system at the community, health facility, sub-county, and county levels through the laid down structures, as illustrated in the flow chart below. The CHMT will ensure availability and adherence to standard operating procedures (SOPs) for data management. Some SOPs are included in Annex 5.

DATA MANAGEMENT HIERARCHY

UPWARD DATA FLOW

FEEDBACK FLOW

	Data Collection	Compilation	Storage	Analysis	Reporting	Use
National	Indicator definition; Tools development	Data aggregation	Data warehousing	National level	National reports; Donor reports	Policy formulation; Resource management
Person(s) responsible	M&E TWG	HMIS department; Divisional heads	HMIS department; Divisional heads	HMIS department; Divisional heads; National TWGs	HMIS department; Divisional heads	Policy makers
County	Indicator definition; Customization; Tools development	Data aggregation	Data archiving	County level	County level	Policy formulation; Resource allocation
Person(s) responsible	CHMT, TWGs	CHRIO and M&E Coordinator	CHRIO and M&E Coordinator	CHRIO and M&E Coordinator	CHRIO and M&E Coordinator	County government
Sub County	Data verification and audit	Data entry and tabulation	Data archiving	Sub county and facility level	Sub county level	Indicator monitoring
Person(s) responsible	SCHRIO, SCHMT	SCHRIO, SCHMT	SCHRIO	SCHRIO	SCHRIO	SCHMT
Facility	Data Capture	Collation and transmission	Data archiving	Facility + Community	Departmental and facility data	Resource Management; Health talks
Person(s) responsible	HRIO, facility managers	HRIO, facility managers	HRIO, facility managers	HRIO, facility managers	HRIO, facility managers	HRIO, facility managers
Community	Data Capture	Collation and transmission	Data archiving	Community Unit	CHEW	Community mobilization, planning
Person(s) responsible	CHEW	CHEW	CHEW	CHEW	CHEW	CHEW

Regular data quality audits and data and performance review forums will be conducted to track indicator performance at all levels, including community dialogue days. CHMT and SCHMT will carry out supportive supervision and provide mentorship.

The county department of health will support capacity building on data management and use at all levels as well as support development and sharing of health information products.

3.2 Data Management

In line with the Health Information policies and guidelines the county will manage data through setting up appropriate structures and adopting approaches to deliver packaged information that is reliable, accessible and timely to satisfy the needs of the various stakeholders. The county government will seek to provide quality data by minimizing errors and gathering maximum data for analysis, dissemination and information use. To ensure this is achieved and uniformity maintained, various standard operating procedures (SOPs) and guidelines for data management will be developed/adopted/adapted/updated and utilized.

3.2.1 Coordination of Data Collection

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

- At the household level, data will be collected by the CHVs, guided by the household register, which lists all the households in the community unit. The CHV will fill in the service delivery data on a community log/diary. This log will be presented to a CHEW at the facility to which the community unit is attached. The CHEW will aggregate all the community logs received into the CHEW summary, which will be further aggregated at the sub county level into a Sub county CHEW summary and posted on DHIS. For those facilities that have DHIS access, the CHEW summary for the facility can be posted at the facility.
- At the facility level, all public and private facilities and all implementing partners will collect routine service delivery data using standard tools and registers. These will then be collated into standardized reporting forms and submitted monthly into the DHIS, or from the sub county level for those facilities that do not have DHIS access.

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

3.2.2 Data Collection Methods and Tools

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

3.2.3 Data Quality

Data quality ensures effectiveness and efficiency of evidence-based decision making at all levels. The officers in charge of data and information management will conduct data validation, interpretation and analysis by adhering to the 6 principles of data, namely, precision, reliability, validity, integrity, completeness and timeliness. The M&E unit will ensure that data is always available and accessible. Data quality will thus be maintained through supportive supervision, routine data quality assessment, data reviews, and capacity building of staff. The county will ensure that all programmes and levels of service delivery will generate and disseminate quality data to support informed decision making.

3.3 Improving Performance Monitoring and Review Processes

The County Health Department's M&E unit, in collaboration with stakeholders, will coordinate performance monitoring through periodic assessment of M&E activities and incorporating feedback as appropriate. Performance monitoring and review will be carried out at all levels on a regular basis, the frequency being driven by the sector's need for information, as follows:

- At the community level, performance monitoring and review will be done on a monthly, quarterly and annual basis.
- At the facility level, it will be done on a daily, weekly, monthly, quarterly, biannual, annual and need-by-need basis.
- At the sub county level, it will be done on a weekly, monthly, quarterly, biannual, annual and need-by-need basis.
- At the county level, monitoring and review will be done on a weekly, monthly, quarterly, biannual, annual, midterm, end term and need-by-need basis.

The M&E Unit will ensure performance reports generated are distributed to the data generating points and are also reviewed, amended and if need be, new priorities for implementation for the subsequent years identified. In addition, to the periodic performance report, there will be special surveys, such as patient exit surveys and data quality audits, that shall be undertaken by the M&E Unit.

After the M&E plan is adopted, it forms the basis of performance contracting and staff performance appraisal. A mid-term review will be conducted in the third year of the strategic plan's implementation, as well as at the end term to ascertain the county's performance in achieving health objectives. All health stakeholders will be involved at every level. As far as possible, the M&E framework will provide critical information to inform decision making and planning among various users at the community, facility, sub-county and county levels.

3.3.1 Scope of the Monitoring and Review

The M&E unit will ensure Monitoring and review will be done at all levels. The CHMT will ensure that the M&E Unit will have adequate staff and other resources to serve the county's M&E needs and to coordinate M&E activities in the health sector. The unit's officers will be responsible for tracking the performance of indicators in the county and producing timely and accurate monthly, quarterly and annual reports on indicators highlighting progress and challenges in implementing the various activities outlined in this M&E plan.

Progress and performance monitoring will include both quantitative and qualitative assessments and will include analyses on: (1) progress towards achieving the county's goals; (2) equity; (3) efficiency; (4) qualitative analyses of the contextual factors, and (5) benchmarks.

3.3.2 Performance Monitoring as a Decision Making and Learning Tool

The performance review process will be utilized as one of the learning mechanisms in the sector. For optimal use, follow-up and learning, all performance reviews and evaluations will contain specific, targeted and actionable recommendations.

The technique of performance monitoring and review is aimed at promoting accountability, supporting timely decision making and providing a basis for evaluation and learning at the community, facility, sub-county and county levels. It also helps to ensure that:

- Work progresses according to schedule,
- Resources are used rationally and as planned,
- The required information is available and utilized,
- Problems are detected in time during the implementation period to allow for corrective measures,
- Plans are verified to ascertain that they are being implemented in the manner planned, and
- Standards such as storage and administration of vaccines are maintained.

3.3.3 Performance Review

Continuous quality improvement requires strong and regular performance review mechanisms at all implementation levels of the health sector. It is an essential component of technical accountability and guides in the establishment of priority activities. It provides a mechanism by which health care managers and service providers are held accountable for the stewardship of the resources under their care. Therefore, the county will actively participate in different forums for reviewing performance by focusing on a set of indicators selected through consensus. The results of the review processes will be packaged and disseminated widely to provide feedback throughout the sector and allowing for corrective action and mid-course adjustments resulting in the improvement of performance. Mid-term reviews will offer comparisons between planned and achieved targets to date.

Table 6: Highlights the required mechanisms needed for performance review

Methodology	Output	Frequency	Prepared by	Responsible person
Monthly progress report	Monthly progress reports; transmitted	Monthly	CHEWs, Facility In charges, SCHMT	SCHRIO
Quarterly bulletin	Quarterly bulletin reports; transmitted	Quarterly	County M&E Unit	Head of M&E unit
Quarterly report	Quarterly reports; transmit-ted	Quarterly	County M&E Unit/SCHRIO	Head of M & E unit, SCHRIO
Quarterly performance review	Quarterly performance review reports; transmitted	Quarterly	County M&E Unit/SCHRIO	Head of M&E unit, SCHRIO
Bi-annual DQA reports	Bi-annual DQA reports; transmitted	Bi-annual	County M&E Unit/SCHRIO	Head of M&E unit
Annual performance report	Annual performance reports; transmitted	Annual	County M&E Unit/SCHRIO	Head of M & E unit, SCHRIO
Annual health statistical report	Annual health reports; transmitted	Annual	County M&E Unit/SCHMT	Head of M&E unit, SCHRIO

3.3.4 Data Demand and Use Framework

Data demand and use will be accelerated to guide decision making and planning while taking into consideration the information needs of all stakeholders. This will further allow for advocacy, communication and social mobilization, budgeting, and operational research. It will be achieved through the data use plan, as outlined in the table 7.

Table 7: Data demand and use plan for selected programmatic questions

Programmatic Questions	Indicator	Data Source	Timeline for analysis	Proposed Decisions	Decision maker	Communication Channel
How can the county improve the uptake of clients seeking HIV and AIDS services?	Proportion (%) of clients accessing HIV and AIDS Services	MOH 362/ MOH 731/ DHIS	• Quarterly • Monthly	• Establishment of youth friendly sites • Procurement of adequate HIV/AIDS supplies and equipment • Training HCWs on HTC skills • Strengthening community units for referrals and linkages	CDH/ county AIDS and STD coordinator	• Feedback meetings at all levels • Support supervision (specific to HIV/AIDS) • Quarterly data review meetings involving all stakeholders
What is the uptake of ARVs?	Proportion (%) of people living with HIV on ART with suppressed viral load	MOH 731/ DHIS/ NASCOP website	• Monthly • Quarterly	• Form MDT to review patients failing first line regimen • Improve ART uptake and adherence • Rapid results initiative (RRI) to identify clients with no viral load and order • Monitor clients' progress	CASCO	• Viral load report • Interpretation • Dissemination meeting • Stakeholders' meeting
How can the county improve the uptake of Cervical cancer screening among women of reproductive age?	Proportion (%) of women of reproductive age screened for cervical cancer	Cancer register MOH 262	• 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 reproductive health (RH) coordinator	• Feedback meetings at all relevant levels • Support supervision (specific RH) • Data review meetings involving all the stakeholders
How can the county improve SGBV survivors' access to (post-exposure prophylaxis (PEP) within 72 hours?	Proportion of SGBV survivors accessing PEP within 72 hours	MOH 364	• 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 can the county increase number of deliveries by skilled attendant?	Proportion (%) of pregnant women delivering at health facilities	MOH 405, ANC register/ MOH 333 Maternity register/ MOH 406, Post-natal, register/ DHIS	• Monthly • Quarterly Biannual • Annual	• Community mobilization and sensitization • Resource mobilization • Capacity building in customer care • Structural improvement of labor wards	County RH Coordinator	• Monthly reports • Quarterly RH reports • Quarterly RH bulletin • Annual work plan • Quarterly implementation plan • RH Budget report

Programmatic Questions	Indicator	Data Source	Timeline for analysis	Proposed Decisions	Decision maker	Communication Channel
How can the county reduce stunting rates among children under five years?	Proportion (%) of children under five years who are stunted	MOH 711, MOH 511 CWC register/	• Monthly • Quarterly Biannual • Annual	• Capacity building HCWs on nutrition screening • Complementary and supplementary feedings for children under two years using BFCI interventions. • Conduct SMART and KAPB surveys	County Nutrition Coordinator	• Monthly reports • Quarterly Nutrition reports • Quarterly nutrition bulletin • Annual work plan • Quarterly implementation plan • SMART survey reports • KAPB survey reports
How can the county improve utilization of immunization services as per EPI immunization schedule?	Proportion (%) of children under one year who are fully immunized	MOH 710, MOH 702, MOH 510 Immunization register	• Monthly • Quarterly • Biannual • Annual	• Increase the number of children reached through consistent outreaches and in-reaches • Ensure proper EPI commodity management to reduce stock outs • Strengthen defaulter tracing by CHVs	County EPI Logistician	• Monthly reports • Quarterly EPI reports • Quarterly EPI bulletin • Annual work plan • Quarterly implementation plan • Facility REC categorization
How can the County improve disease surveillance, reporting and response?	Proportion (%) of health facilities with timely weekly IDSR reports. Proportion (%) of outbreaks responded to within 48 hours	MOH 502, MOH 503, MOH 504, MOH 505	• Weekly • Monthly • Quarterly • Biannual • Annual	• Capacity build HCWs on disease surveillance. • Ensure availability of collecting and reporting tools	County Disease Surveillance Coordinator	• Weekly reports • Monthly reports • Quarterly IDSR reports • Quarterly IDSR bulletin • Annual work plan • Quarterly implementation plan • Maternal death audit reports
How can the County improve delivery of level 1 (community) KEPH services?	Proportion (%) of population covered by community units.	MOH 513, MOH 514, MOH 515, MOH 516, MOH 100	• Monthly • Quarterly • Biannual • Annual	• Capacity build CHVs on CBHMIS • Improve household visits • Capacity build CHVs on technical modules • Improve referrals and linkages from and to community level. • Improve data capture, analysis and use • Conduct quarterly planning and performance review • Functionality assessments and supervisions	County Community Health Development Coordinator	• Monthly reports • Quarterly CHS reports • Quarterly CHS bulletin • Annual work plan • Quarterly implementation plan • Bi-annual HH registration

Programmatic Questions	Indicator	Data Source	Timeline for analysis	Proposed Decisions	Decision maker	Communication Channel
How can the County improve TB prevention and cure rate?	Proportion (%) of TB cases cured	MOH 711, TIBU demographic estimation, MOH 731, TB register	• Monthly • Quarterly • Biannual • Annual	• Improve on active case finding and referrals • Procurement of TB diagnostic kits • Ensure adherence and completion of TB treatment • Ensure accurate and timely diagnosis of TB cases • Ensure proper data capture, reporting and utilization.	County TB and Leprosy Coordinator	• Monthly reports • Quarterly TB&L reports • Quarterly TBL bulletin • Annual work plan • Quarterly implementation plan
How can the county improve on Malaria prevention, diagnosis, treatment and management?	Proportion (%) of confirmed malaria cases	MOH	• Weekly • Monthly • Quarterly • Biannual • Annual	• Capacity build HCWs on proper diagnosis • Put preventive strategies in place • Proper malaria commodity and supplies management • Procurement of diagnostic equipment • Strengthen surveillance and reporting	County Malaria Coordinator	• Weekly reports • Monthly reports • Quarterly Malaria reports • Quarterly malaria bulletin • Annual work plan • Quarterly implementation plan
How can the county improve quality of health services?	Proportion (%) of facilities achieving QOS score of 80%	KQMH tools	• Monthly • Quarterly • Biannual • Annual	• Capacity build HCWs on KQMH • Establish and strengthen existing QITs and WITs • Conduct regular quality improvement assessment.	County Quality Improvement Coordinator	• Monthly reports • Quarterly QI reports • Quarterly QI bulletin • Annual work plan • Quarterly implementation plan

Chapter 4: Implementation of the M&E Plan

Under the County Health Sector Strategic Plan for 2018-2022, streamlining the organisation of collection and utilisation of data for evidence-based decision making at all levels of the county health care system is identified as a priority. The strategy appreciates that addressing the capacity issues across the health strengthening systems is critical to improving the county health M&E system. Various initiatives, including those supported by development and implementation partners, are currently under implementation towards this end.

This plan seeks to ensure that county M&E system for the health sector is linked to the County Integrated Monitoring and Evaluation (CIMES) spearheaded by the Department of Planning; as well as the national government's health monitoring and evaluation system coordinated by the Monitoring and Evaluation unit of the national Ministry of Health and the National Integrated Monitoring and Evaluation Systems (NIMES) under the national ministry responsible for planning. In the sections that follow, the proposed coordination structures for monitoring and evaluation; proposed key activities and the attendant cost estimates are outlined.

4.1 Implementation Arrangements

The coordination arrangements proposed in this plan are geared towards ensuring that the key M&E functions that focus on information generation, validation, analysis, dissemination and use towards delivery of the sector priorities identified in the strategic plan and the CIDP, are effectively and efficiently delivered. This will be achieved through collaboration with state, non-state and external actors present in Samburu County.

4.1.1 Coordination of County Health Monitoring and Evaluation

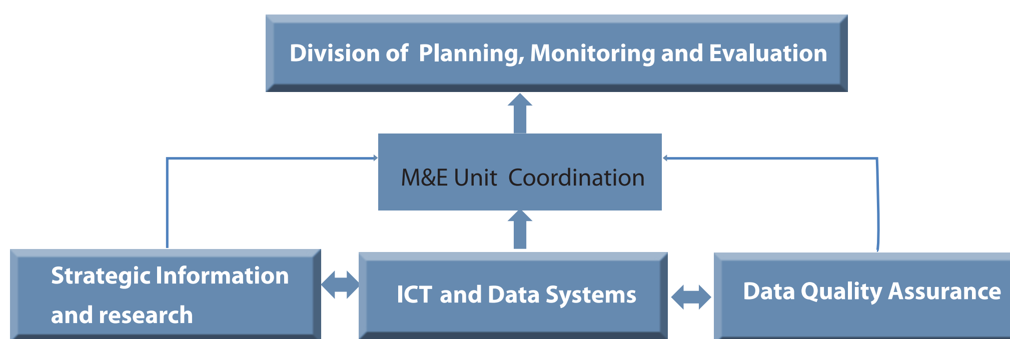
The county department of health together with partners have agreed to work together in the spirit of the UNAIDS three-ones key principles (one implementation plan, one coordination mechanism, and one M&E framework). The contribution of the partners to county health M&E will be effected by ensuring partners' efforts are in line with and coordinated by the county department of Health and, where appropriate, sharing and developing the capacity for county health M&E. Data collected by partners has to be coordinated in order for the county health department to be able to monitor, evaluate and report holistically on the progress of health interventions in Samburu County. This will enable the county department of health to provide comprehensive reports on national and international commitments too.

To enable the county government to effectively co-ordinate M&E activities, the department of health has identified and sensitised staff and stakeholders on the institutional and individual capacities required to support the M&E functions. At the institutional level, the CHSSP proposes the creation of a division that is responsible for planning, monitoring, and evaluation, under which the unit responsible for coordinating M&E functions for the health department will fall. The division is expected to accord the necessary linkages with the key programs for health services (curative and preventive and rehabilitative) as well as the planning unit for the county government. The roles and responsibilities for the M&E unit are summarised in Table 4.1

Roles and Responsibilities of Health Department's M&E Unit
• Coordinating the setting up the monitoring and evaluation system for health with focus on developing work plan and budget for monitoring and evaluation activities • Collect, compile relevant M&E information • Establish and maintain a database of health outcome measures • Establish and maintain functional linkages with other relevant partners involved in county health M&E, including the national Ministry of Health, other County departments and sectors • Analyze and interpret programmatic as well as outcome and impact data • Prepare and regularly update the county health profile • Provide feedback; prepare quarterly monitoring reports and annual health reports and reviews • Develop capacity at the sub county level in M&E • Serve as the Secretariat of the M&E Technical Working Group (TWG) that coordinates M&E within the County Health Sector. • reviewing and providing feedback to programmes on the quality of methodologies established to collect monitoring data • preparing consolidated progress reports for the County Health Stakeholders Forum

The County Department for Health Services will strengthen the current M&E unit within the department to enable it to support coordination of the county health M&E functions. In proposing a suitable structure for the M&E unit, the county government has considered the need to ensure close linkages with the highest decision making organs, need to build a blend of skills necessary for delivery of the functions and build-up of a functional M&E system as well as providing opportunities for career development; and close collaboration with the County planning unit with a bid to feed appropriately into the County Integrated Monitoring and Evaluation System (CIMES).

The proposed structure is presented below:



4.1.2 Linkage with stakeholders

To accord effective participating of stakeholders and partners in the delivery of health M&E functions, the county health sector will strengthen and utilise the Monitoring and Evaluation TWG. The M&E TWG will be reconstituted and its capacity needs identified, and support sought to fill in gaps from the partners closely working with the county health department. The M&E TWG shall share its reports with the County Health Stakeholder Forum through its Steering/Coordination Committee.

Table 4.2 outlines the functions of the county M&E TWG for health services.

Key functions of M&E TWG

- Supporting coordination/harmonization of M&E activities (data collection, analysis, dissemination) among the MOH and the partners.
- Identifying and prioritizing critical action steps for county, Sub-County and Facility M&E work to assure that action is taken by the relevant group(s) to achieve quality M&E in a timely fashion.
- Promote operational research to support evidence-based, efficient programme implementation and the use of M&E tools.
- Identifying and recommending strategies for addressing the needs for capacity building in M&E at all levels.
- Developing and maintaining consensus around M&E strategies across county department of health and partners.
- Developing and providing technical guidance on selection and definition of indicators for county health reporting.
- Providing technical guidance on appropriate data collection methods, analytic strategies, and dissemination of recommendations.
- Monitoring changing needs in health M&E arena.

4.2 Operational Guidelines and Tools for County Health M&E

Implementation of this M&E Plan requires the county department of health to put in place various guidelines, standard operating procedures and protocols for data management, data quality assurance, data analysis and synthesis, and data dissemination. During the implementation of the CHSSP 2018-2022, the county government will formulate guidelines (or adopt the national ones where they are in existence) and follow up on implementation. This plan acknowledges the role of the national government in setting policies, standards and regulation; and therefore, the existence of various standards. The county government will disseminate the standards and guidelines to the decentralized structures and support their implementation. These guidelines include amongst others: National M&E Framework, Monitoring and Evaluation Institutionalization Guidelines, Health Information System Policy, Indicators Manual and SOP, Data Quality Assurance Protocol, and the Kenya Health Enterprise Architecture.

This plan envisages that the county health department will need to develop SOPs for data collection, data collation and reporting; data cleaning and validation, evaluations, survey and research, performance review, data review, and data dissemination. With regards to the tools supporting the implementation of the above SOPs, the county will continue support the application of both manual and electronic tools at the appropriate levels of the healthcare system.

4.3 Dissemination of Information and Information Products

Data need to be translated into information that is relevant for decision-making. Data will be packaged and disseminated in formats that are determined by management at the various levels. Service delivery data shall be packaged and displayed at various health facilities using the HMIS formats and designed non-HMIS formats. The timing of information dissemination will be scheduled to fit in the planning cycles and needs of the users.

County health information will be disseminated through reports (electronic and print) to stakeholders, presentations and workshops, annual health review meetings, media briefs international health days, publications, websites and other documentation.

- Quarterly and Annual Health Statistical Reports and Bulletins
- Quarterly Performance Review meetings and Reports
- Annual Performance Review
- Dissemination of Survey Findings: Feedback on survey findings will be in form of workshops and dissemination of reports which will be circulated to relevant stakeholders in hard copy as well as on the county website

4.4 Key Responsibilities for Samburu Health Sector M&E

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

Table 8: Key Responsibilities and functions of the M&E unit

Stewardship Goal	National level	County Level: CHMT	Sub-County Level: SCHMT	County Level: Partners	Facility level	Community level
Establishment of a common data architecture	• Define standards for data sharing between aggregate and patient-level data. • Coordinate development of minimum data sets and data requirements of the health sector. • Create and maintain a data repository of health and health related information. • Carry out oversight functions to manage all health and health-related data from service providers at all levels to inform policy formulation.	• Conduct oversight to manage all monitoring, evaluation and research data from all programmes within their area of jurisdiction. • Create and maintain a monitoring system and 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 counties into a single County Health report.	• Conduct oversight to manage all monitoring, evaluation and research data from all programmes within their area of jurisdiction. • Compile all reports from the Sub county health facilities into a single sub-County Health report.	• 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.	• 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.	• Community Units: Maintain and update its M&E, which shall be shared regularly with household members in a forum as stated in the relevant community strategy. • Community health workers: Maintain registers to document daily activities and report regularly to supervising health facility. Compile all reports from the CHW

Stewardship Goal	National level	County Level: CHMT	Sub-County Level: SCHMT	County Level: Partners	Facility level	Community level
Improve performance and review processes	• Aggregate, analyse, disseminate and use health and health-related data on the performance of the health sector priorities outlined in the KHSSP from all • MoH departments, SAGAs, national hospitals, CHMTs and others, and provide feedback to all. • Compile all reports at the national level on performance tracking of the strategic plan. • Analyse the quality of all reports received and ensure follow-up in case of incompleteness, problems with validity, and delays. • Provide technical support to all national-level operational units, SAGAs, and national referral hospitals in monitoring and evaluation.	• Produce a health sector performance report that includes service delivery metrics. • Analyse 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. • Provide technical, material and financial support for M&E to all sub counties. • Collate, analyse, disseminate and use health and health-related data from all Sub county offices and give feedback	• Produce a health sector performance report that includes service delivery metrics. • Analyse 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 facilities • Collate, analyse, disseminate and use health and health-related data from all Sub county facilities and give feedback	• Work within the health sector M&E framework and guidelines and meet the reporting requirements as defined by minimum datasets.	• Ensure compilation and processing of minutes, inventory, supervision and other activity reports. • Analyse the quality of all reports received from various health facility units and ensure follow-up in case of incompleteness, problems with validity, or delays	• Develop quarterly and annual community health reports for integration into facility reports.

Stewardship Goal	National level	County Level: CHMT	Sub-County Level: SCHMT	County Level: Partners	Facility level	Community level
Enhancing sharing of data and promoting use of information for decision-making	• Develop M&E-related guidelines and policies. • Prepare and disseminate national annual and quarterly performance review reports. • Ensure proper information flow from various levels in accordance with national and international data and reporting obligations. (This includes, specifically, forwarding Country Health information as required to the Director for Health for forwarding to international actors.) • Provide capacity-building in M&E. • Prepare and share the Annual State of Health reports during the Health Congress.	• Ensure proper information flow from various levels to inform policy formulation, guidelines, and development of protocols, and to address country's international obligations. (This specifically includes forwarding the County Health report to the National MoH.) • Prepare data analyses for discussion during the CECM and directorate meetings and forum for decision-making. • Develop County Health report and share with the CECM • Develop quarterly feedback to the CECM and County Director for Health and share with them. • Disseminate quarterly reports to Sub county health teams and Health Committee.	• Ensure proper information flow from health facilities and community health units to inform policy formulation, guidelines, and development of protocols in the sub counties. • Prepare data analyses for discussion during the directorate meetings, the County M&E congress and other forum for decision making forwarding the Sub-County Health report to the County Director for Health.	• Provide support to strengthen the MoH M&E Unit in their areas of operation (e.g., through provision of technical support and capacity building).	• Ensure that every health facility summarises health and health-related data from the community and health facility; analyses it; disseminates it and uses the information for decision-making; provides feedback; and transmits summaries to the next level. • Prepare an analysis of the data for discussion during staff and board meetings for decision-making. • Forward health and health-related reports to the Sub county level. • Provide quarterly feedback to the health providers and the community unit committee. • Disseminate quarterly reports to the health facility committee. • Disseminate annual report to the health facility committee and Sub county forum	• 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.

4.5 Monitoring & Evaluation Implementation Framework

The key M&E interventions during the period 2018-2022 is tabulated below with the associated budget estimates

Table 10: Monitoring & Evaluation Budget

			Total		**Yr 1**	**Yr 2**	**Yr3**	**Yr4**	**Yr 5**	
Domain/ Category	**Key interventions**	**Activity Indicator**	**Target**	**Budget**						**Responsible Person(s)**
M&E Unit	Define the mandate and structure of the County Health M&E unit	M&E Unit structure defined	1		X					COH
	Create a strategy concept document for the establishment of the County Health M&E Unit	Number of strategy concept document created.	1		X					CDH
	Develop a resource mobilization plan for a fully functional M&E unit	Number of resource mobilization plan developed	1	500,000	X					CDH
	Establish of a fully functional M&E unit	Fully functional M&E Unit	1	2,000,000	X	X				COH
Policy and Planning	Review and update the staffing plan to include the M&E unit	Number of staffing plan reviewed, and M&E included.		650,000		X				Head M&E
	Undertake a training needs assessment for MLA	Number of assessments done	1	300,000		X				Head M&E
M&E Unit Staffing	Develop Job Descriptions for the staff dedicated to M&E	Number of M&E job description developed	1	200,000		X				CDH
	Develop a capacity building plan for the existing staff to take up M&E roles	Number of existing staff capacity build on M&E	1			X				Head M&E
	Recruit additional (at least 3)staff with the relevant M&E qualifications.	Number of M&E staffs recruited	3	4,000,000		X	X			COH
Data Standards	Review and adopt the National DQA protocol	DQA Protocols	1	300,000		X				Head M&E
	Disseminate and sensitize the staff on the DQA protocol	Number of staff sensitized on DQA protocols	300	800,000		X	X			CDH
	Develop SOPs for Data Management aligned to the DQA protocol	Aligned Data management SOPs.	1	500,000		X	X			CDH

			Total		Yr 1	Yr 2	Yr3	Yr4	Yr 5	
Domain/ Category	**Key interventions**	**Activity Indicator**	**Target**	**Budget**						**Responsible Person(s)**
County Databases	Conduct a mapping, assessment and costing of the current status of the ICT infrastructure in the health department. (Loop in the county ICT officer) .	Assessment report	1	200,000	X					CDH
	Develop a county repository (website) for information products access	County M&E repository website.	1	100,000		X				CDH
	Develop dashboard that can easily be accessed by the relevant stakeholders as an information product for sharing health data	Information products Dashboard	1	200,000		X				Head M&E
Routine Monitoring	Develop and adopt guidelines for best practices in data management.	Best practice guidelines developed and adopted	1	500,000		X				Head M&E
	Sensitize the staff on the guidelines for data management	Number of staffs sensitized on data management guidelines	500	1,200,000			X			CHRIO/Head M&E
	Advocate for budget for printing of the missing MOH tools from the county and implementing partners	% of MOH tools printed.	100	10,000,000	X	X	X	X	X	CHRIO
	Sensitize and train staff on the Samburu County health department performance contract reviews.	Number of staffs sensitized on performance contracts	50	1,500,000		X				COH
	Review, update, disseminate the staff appraisal forms	% of staff sensitized on revised appraisal forms	100%	2,100,000		X	X			HRH Coordinator

			Total		Yr 1	Yr 2	Yr3	Yr4	Yr 5	
Domain/ Category	**Key interventions**	**Activity Indicator**	**Target**	**Budget**						**Responsible Person(s)**
Routine Data Quality Assurance	Conduct monthly facility and quarterly subcounty data review meetings	Number of review meetings conducted	20	2,000,000	X	X	X	X	X	Head M&E
	Conduct quarterly RDQAs with action plans for follow-up	Number of RDQAs with action plan developed	50	3,500,000	X	X	X	X	X	Head M&E
	Conduct follow-up support supervision for facilities	Quarterly supervision conducted	60	6,000,000	X	X	X	X	X	CHRIO
Data Analysis and Dissemination	Capacity build the county leadership, CHMT, SCHMT and High-volume facility in charges on data analytics and visualization	Number of staffs trained on data analytics	45	3,600,000		X	X	X	X	CDH
Evaluation	Perform periodic evaluations on program outcomes	Number of Evaluations undertaken	8	3,200,000		X	X	X	X	M&E Coordinator
Support	Scale up implementation of the EMR to all high-volume facilities	Number of EMRs installed in high volume facilities	5	2,000,000		X	X			CDH
	Sensitization of the CHMT and SCHMT and facility in charges on DHIS2	Number of CHMT/ SCHMT and facility in charges trained on DHIS2	32	1,600,000		X	X			CHRIO
	Support HRIOs with data bundles	Number of HRIOs supported with data bundles	8	3,000,000	X	X	X	X	X	COH
County Coordination Body	Conduct regular(quarterly) M&E TWG meetings.	Number of M& E TWG Meetings Conducted	20	2,000,000	X	X	X	X	X	M&E Coordinator
	Develop ToR for all thematic TWGs	Number of TWGs with ToR developed	5	250,000		X	X			CDH
	Create a schedule of activities (Annual Plan) for the TWGs.	Number of TWGs with activities schedules approved	5			X	X			CDH

			Total		Yr 1	Yr 2	Yr3	Yr4	Yr 5	
Domain/ Category	**Key interventions**	**Activity Indicator**	**Target**	**Budget**						**Responsible Person(s)**
	Establish a county editorial team including health staff and partners	Number of editorial team established	1			X				COH
	Capacity build the editorial team and program officers on development of information products	Number of editorial team and program officer's capacity build	1	300,000		X				COH
M&E Technical Working Group	Develop information products (county fact sheet, county health factsheet) and publish on quarterly basis	Number of information products developed	4	3,000,000	X	X	X	X	X	CDH
Internal Coordination	Conduct quarterly performance reviews of the M&E system and communicate the findings to health staff at sub county and facilities.	Number of quarterly performance review conducted	20	4,000,000	X	X	X	X	X	CDH
				59,410,000						

Chapter 5: Evaluation Plan

5.1 Introduction

The evaluation plan describes what will be evaluated, how and when. The evaluation endeavors to look at the overall project/ interventions in terms of the operations, governance, deliverables, and hence assist the County Health Management Team and partners to learn and make improvements. The information obtained helps in planning, designing/redesigning and developing health sector interventions that are relevant, effective, efficient, sustainable and impactful.

5.2 What will be evaluated?

i) Relevance (measure use of resources and the process used to obtain the results): The extent to which the interventions are suited to the priorities of the target group.

ii) Effectiveness (measures results – health outcomes): A measure of the extent to which the health department will attain its six priority objectives. These objectives include:

- Eliminate Communicable Conditions
- Halt, and or reverse the rising burden of non-communicable conditions
- Reduce the burden of violence and injuries
- Minimize exposure to health risk factors
- Provide essential health services
- Strengthen collaboration with health-related sectors

In answering questions to measure effectiveness (Table 11), the evaluation will track indicators for each of the objectives listed in Annexes 3 and 4.

iii) Efficiency: Efficiency measures the outputs in relation to the inputs. This signifies that the county health sector uses the least costly resources possible in order to achieve the desired results.

iv) Impact: The positive and negative changes produced by health interventions, directly or indirectly, intended or unintended. This involves the main impacts and effects resulting from the implementation of interventions on health indicators (refer to Annexes 3 and 4).

v) Sustainability: Sustainability is concerned with measuring whether the benefits of the health programme interventions are likely to continue after external funding has been withdrawn or ceased. Interventions or projects need to be environmentally and financially sustainable.

vi) Innovations: Monitoring innovations aims to assess the functioning and effectiveness of innovation platforms to improve policy and practice, develop capacity and improve links among actors. The information it gathers will be used to improve the management of the platform and its activities, change policies, and promote larger scale changes. The three aspects of innovation platforms to be monitored will be:

- Activities that aim to resolve a problem or take advantage of an opportunity. They may include technologies, methods and approaches, policies, empirical evidences or other tangible products. Monitoring activities will make it possible to track progress, provide feedback and improve performance.
- Process outputs include changes in knowledge, attitudes and practices of the platform members and the organizations or groups they represent, and the relationships amongst them. Monitoring process outcomes gives an understanding of how the innovation platform changes the knowledge, attitudes and practices of individuals and the links between them.
- Results of the impacts on target beneficiaries. Monitoring results provides quantitative and qualitative evidence of the platform's work and allows it to be compared with other approaches.

Table 11: Evaluation Plan

What to Measure	Evaluation Questions	Method to answer the Questions	Frequency	Responsible Person
Relevance	• How well was the health programme designed, planned, and how well was that plan implemented? • To what extent are the objectives of the health programme still valid? • Are the activities and outputs of the health programme consistent with the overall goal and the attainment of its objectives? • Are the activities and outputs of the programme consistent with the intended impacts and effects?	• Monitoring system that tracks actions and accomplishments related to bringing about the mission of the initiative (activity) • Survey on satisfaction with goals (Client satisfaction survey) • Survey on satisfaction with outcomes (Provider satisfaction survey)	• Baseline (2017) • Annual • Midterm (2021) • End term (2023)	County M&E Coordinator
Effectiveness	• To what extent were the objectives achieved / are likely to be achieved? • What were the major factors influencing the achievement or non-achievement of the objectives?	• Monitoring system that tracks actions and accomplishments related to bringing about the mission of the interventions (activities) • Behavioural surveys (primary and secondary data sources) • Interviews with key informants	• Baseline (2017) • Annual • Midterm (2021) • End term (2023)	County M&E Coordinator
Efficiency	• Were activities cost-efficient? • Were objectives achieved on time? • Was the health programme implemented in the most efficient way compared to alternatives?	• Cost-effectiveness analysis	• Baseline (2017) • Annual • Midterm (2021) • End term (2023)	County M&E Coordinator

What to Measure	Evaluation Questions	Method to answer the Questions	Frequency	Responsible Person
Impact	• What resulted from the health programme? • How has behaviour changed as a result of participation in the program? • Are participants satisfied with the experience? • Were there any negative results from participation in the program? • Were there any negative results from the program? • How many people have been affected? • Do the benefits of the program outweigh the costs?	• Behavioural surveys (primary and secondary data sources) • Interviews with key informants	• Baseline (2017) • End term (2023)	County M&E Coordinator
Sustainability	• To what extent did the benefits of the programme or project continue after donor funding ceased? • What were the major factors which influenced the achievement or non-achievement of sustainability of the programme or project?	• Monitoring system that tracks actions and accomplishments related to bringing about the mission of the initiative (activity) • Behavioural surveys (primary and secondary data sources) • Interviews with key informants	• Baseline (2017) • Midterm (2021) • End term (2023)	County M&E Coordinator

Annex 1: Indicator Definition Manual

Indicator	Numerator (N), Denominator (D)	Data source	Frequency	Responsible person(s)
Life expectancy at birth	Life expectancy at birth is defined as the average number of years that a new-born could expect to live if he or she were to pass through life subject to the age-specific mortality rates of a given period.	Vital registration; Census and surveys: Age -specific mortality rates required to compute life expectancy at birth.	Five years	Head, M&E unit
Total annual number of deaths (per 100,000 population)	The number of deaths in general population	Scaled to the size of that population, per unit of time. Mortality rate is typically expressed in units of deaths per 100,000 individuals per year	Five years	Head, M&E unit
Maternal deaths per 100,000 live births	Number of maternal deaths per 100 000 live births during a specified time period, usually one year.	Vital registration; KDHS; census; health service records	Five years	Head, M&E unit
Neonatal deaths per 1,000 live births	Number of deaths during the first 28 completed days of life per 1 000 live births in a given year or period.	Vital registration; KDHS	Five years	Head, M&E unit
Under five deaths per 1,000	Under-five mortality rate is the probability of a child born in a specific year or period dying before reaching the age of five, if subject to age - specific mortality rates of that period	Civil registration; Census; KDHS	Five years	Head, M&E unit
Youth and Adolescent deaths per 1,000	Deaths among young people aged 10–24 years	Vital registration; KDHS; Census; health service records	Five years	Head, M&E unit
Adult deaths per 1,000	Deaths among adults aged above 25 years	Vital registration; KDHS; Census; health service records	Five years	Head, M&E unit
Elderly deaths per 1,000	Deaths among adults aged above 60 years	Vital registration; KDHS; Census; health service records	Five years	Head, M&E unit
Years of life lived with illness / disability	The sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability	Vital registration; KDHS; Census		Head, M&E unit
Proportion (%) of fully immunized Children	N: Number of children under the age of 1 who received 3 doses of Oral Polio Vaccine (OPV), 3 doses of pentavalent, and 1 dose each of Bacilli Chalmette-Guerin (BCG) and measles vaccine (static and outreach), 3 doses pneumococcal vaccine and 3 doses of rotavirus before the age of 12 months D: Estimated number of children younger than one year in a given period	DHIS-MOH 710; MOH 510; MOH 702; Surveys; KNBS	Monthly/ Quarterly/ Annually	Head, Family Health
Proportion (%) of target population receiving mass drug administration (MDA) for Trachoma	N: Number of people receiving MDA D: Number of people at risk of Trachoma in the county.	MOH 517; DHIS; Surveys; Reports	Monthly/ Quarterly/ Annually	Head, Preventive/Promotive
Proportion (%) of TB patients completing treatment	N: Number of patients who completed TB treatment D: All TB cases recorded in the TB registers (within the assessed cohort period)	TB treatment register; DHIS - MOH 711	Monthly	Head, Preventive/Promotive

Indicator	Numerator (N), Denominator (D)	Data source	Frequency	Responsible person(s)
Proportion (%) of HIV+ pregnant women receiving (PMTCT) preventive ARVs	N: Number of pregnant women living with HIV/AIDS who received antiretroviral medicines D: Number of pregnant women living with HIV/AIDS	MOH 405,333,406; DHIS – MOH 711,731	Monthly	Head, Preventive/Promotive
Proportion (%) of eligible HIV clients on ARVs	N: Number of HIV+ adults and children who are eligible for ARVs and are currently receiving ARVs therapy at the end of the reporting period D: Estimated number of HIV+ adults and children eligible for ARVs	MOH 361B; DHIS- MOH 731, 711; KAIS	Monthly	Head, Preventive/Promotive
Proportion (%) of under-5s treated for diarrheal	N: Number of under-5s treated for diarrheal D: Number of under-5ss with diarrheal	MOH 204 A; DHIS - MOH 705 A	Monthly	Head, Family Health
% of school age children de-wormed	N: Number of de-wormed school-age children D: Total number of children aged 2-14 years	DHIS – MOH 517; Surveys; Reports	Biannual	Head, Family Health
% of children aged 12-59 months de-wormed	N: Number of de-wormed children aged 12-59 months D: Total number of children aged 12-59 months in the catchment area	DHIS - MOH 517	Monthly	Head, Family Health
Proportion (%) of adult population with BMI over 25	N: Total number of adults with BMI over 25 D: Total adult population in the area	Survey	After every 2 Yrs.	Head Preventive & Promotion
Proportion (%) of women of reproductive age screened for cervical cancer	N: Number of women of reproductive age screened for cervical cancer D: Estimated number of women of reproductive age	MOH 405, MOH 406; Family planning, Cervical cancer service register; MOH 204B	Monthly	Head, Family Health
Proportion (%) of new outpatients with mental health conditions	N: Number of new outpatients with mental health conditions D: Total number of all newly diagnosed cases	Outpatient Registers MOH 204A & 204B; DHIS – MOH 705A, MOH 705B	Monthly	Head, Curative
Proportion (%) of new outpatient cases with high blood pressure	N: Number of cases diagnosed with hypertension in a month D: Total number of all newly diagnosed cases (for all diseases) in a month	MOH 204B; DHIS – MOH 705B	Monthly	Head, Curative
% of patients admitted with cancer	N: Number of cancer patients admitted D: Total number of cases admitted in a month	Hospice records; MOH 301 DHIS – Inpatient Morbidity and Mortality Report	Monthly	Head, Curative
Proportion (%) of new outpatient cases attributed to gender-based violence	N: Number of new gender-based violence cases treated in outpatient D: Total number of outpatients in a month	MOH 363- Post Rape Care Register; DHIS- 364 Sexual Gender Based Summary Form	Monthly	Reproductive health focal person

Indicator	Numerator (N), Denominator (D)	Data source	Frequency	Responsible person(s)
Proportion (%) of new outpatient cases attributed to road traffic accident Injuries	N: Number of new outpatient cases attributed to road traffic accidents D: Total number of outpatients in a month	OPD register MOH 204A, MOH 204B; DHIS -705A, MOH 705B	Monthly	Outpatient Department (OPD) in-charge
Proportion (%) of new outpatient cases attributed to other injuries	N: Number of new injuries other than those caused by road traffic accidents seen in outpatient D: Total number of outpatients in a month	OPD register MOH 204B, 204A; MOH 301, MOH 268; DHIS -705A,705B	Monthly	Outpatient Department in-charge
Proportion (%) of facility deaths due to injuries	N: Number of deaths due to injuries reported in a facility D: Total number of institutional deaths in a month	OPD register MOH 204B, 204A; MOH 301, MOH 268; DHIS -705B,705A and Inpatient Morbidity and Mortality; Report Mortuary Records	Monthly	Hospital/Facility in-charge
*Per capita outpatient utilization rate (m/f)	N: Number of visits to outpatient facility for ambulant care per year D: Total population in the area	Outpatient registers MOH 204A, MOH 204B; DHIS - MOH 717	Yearly	Facility in-charge
Proportion (%) of population living within 5 km of a health facility	N: Total population living within 5 km radius of a health facility D: Total population in the health facility's catchment area	Survey	Every five years	Head, Planning and Policy
Proportion (%) of facilities providing BEmONC	N: Total number of level 2-6 facilities providing BEmONC D: Total number of level 2-6 facilities in the area	Rapid health facility surveys; Updated Master Facility List (MFL)	Annually	Head, Planning and Policy
Proportion (%) of facilities providing CEmONC	N: Number of level 4-6 health facilities providing CEmONC D: Total number of level 4-6 health facilities in the catchment area surveyed	Rapid health facility surveys; Updated Master Facility List (MFL)	Annually	Head, Planning and Policy
Bed occupancy rate	N: Number of patient bed days (X 100) D: Number of beds in institution X Number of days in time period under review	MOH 301; Daily bed returns; DHIS – MOH 717	Daily/ Monthly/ Annually	Head, Planning and Policy
Proportion (%) of facilities providing immunization services	N: Number of level 2-5 health facilities providing immunization services D: Total level 2-5 health facilities level in the area	Rapid health facility surveys; Updated Master Facility List (MFL)	Annually	Head, Planning and Policy
Proportion (%) of deliveries conducted by skilled attendant	N: Number of deliveries conducted by skilled personnel D: Total number of expected deliveries	MOH 333; DHIS – MOH 711, MOH 717, KNBS projection	Monthly	Facility in-charge, M&E Unit
Proportion (%) of women of reproductive age receiving family planning services	N: Number of women receiving family planning services D: Total number of women of reproductive age	MOH 512; DHIS – MOH 711, MOH 717; KNBS projection	Monthly	Facility in-charge, M&E Unit
Proportion (%) of facility- based maternal deaths	N: Number of maternal deaths occurring at the facility D: Total number of expected deliveries	MOH 333; DHIS – MOH 711; KNBS projection	Monthly	Facility in-charge, M&E Unit

Indicator	Numerator (N), Denominator (D)	Data source	Frequency	Responsible person(s)
Proportion (%) of facility- based under-five deaths	N: Number of under-five deaths occurring at the facility D: Total number of children under the age of 5	MOH 511, MOH 301, MOH 204A; DHIS – Inpatient Morbidity and Mortality Report; KNBS projection	Monthly	Facility in-charge, M&E Unit
Proportion (%) of new-borns with low birth weight	N: Number of new-borns with less than 2.5kg body weight D: Actual number of live births whose birth weights were measured	MOH 333; DHIS – MOH 105	Monthly	Facility in-charge, M&E Unit
Proportion (%) of facility- based fresh still births	N: Number of fresh still births D: Total number of deliveries conducted	MOH 333; DHIS – MOH 717	Monthly Monthly	Facility in-charge, M&E Unit
Surgical rate for cold cases	N: Cold surgical cases D: Total catchment population	Theatre register; MOH 105; KNBS projection		Facility in Charge, M&E Unit
Proportion (%) of pregnant women making 4 ANC visits	N: Number of women making 4th ANC visit D: Total number of pregnant women	MOH 406; MOH 105; DHIS – MOH 711; KNBS projection	Monthly	Facility in-charge, M&E Unit
Proportion (%) of population who smoke	N: Number of people who report that they smoke regularly and who report that they had smoked in the preceding 24 hours of the interview (KDHS) D: Total number of persons interviewed in the survey	KDHS or other survey	Annually	CDH
Proportion (%) of population consuming alcohol regularly	N: Number of people who report that they consume alcohol regularly D: Total number of people sampled in KDHS or other surveys	KDHS or other survey	Annually	CDH
Proportion (%) of infants under the age of 6 months who are exclusively breastfed	N: Number of infants who are exclusively breastfed up to the age of 6 months D: Number of infants aged less than 6 months attending a child welfare clinic in a month	MOH 704; MOH 713; MOH 511; MOH 216	Monthly	Facility in-charge, M&E Unit
Proportion (%) of population aware of health risk factors to health	N: Number of people in the survey who are aware of health risk factors D: Total number of people sampled in KDHS or other surveys	KDHS or other survey	Annually	CDH
Proportion (%) of salt brands that are adequately iodized	N: Number of salt brands that are adequately iodized D: All salt brands available in the market	KEBS, nutrition and public health	Yearly	M&E Unit
Couple year protection	N: Number of sampled couples using condoms D: Total number of couples in the survey	MOH 711	Monthly	Reproductive health focal person
% population with access to safe water	N: Total population with treated safe drinking water source D: Estimated population in the area/ urban/rural	MOH515	Annually	County Public Health Officer

Indicator	Numerator (N), Denominator (D)	Data source	Frequency	Responsible person(s)
% under-5s stunted	N: Number of children under 5 years attending CWC who fall below minus 2 SD from the median height for age of WHO child growth standards D: Total number of children under 5 years measured	MOH 713	Monthly	County Nutrition Officer
% under-5s underweight	N: Number of children under 5 years attending CWC during the month/survey with weight for age below 2SD D: Total number of children under 5 years weighed in CWC during the month	MOH 713	Monthly	County Public Health Officer
School enrolment rate	N: Number of children enrolled in primary and secondary schools D: Estimated population of school children to be enrolled in every level	School register	Annually	County Public Health Officer, County Department of Education
% of households with latrines	N: Number of households that use an improved sanitation facility, urban/rural D: Estimated households in urban and rural areas	MOH 515	Annually	County Public Health Officer
Proportion (%) of households with adequate ventilation	N: Number of urban/rural households with adequate ventilation D: Estimated total number of households in the urban/rural area	Household survey; administrative reporting system	Biannually	County Public Health Officer
Proportion (%) of schools providing complete school health package	N: Number of primary and secondary schools providing complete school health package D: Total number of primary and secondary schools	MOH 708	Monthly	County Public Health Officer, County Department of Education
TB cure rate	D: Number of TB patients with negative smear results at the end of 6 months of treatment N: Total number of TB patients with positive smear results at the start of treatment	TB register	Monthly	TB Coordinator
Proportion (%) of patients with fever who tested positive for malaria	N: Number of positive malaria slide/RDT results at treatment's initiation D: Number of patients tested for malaria	MOH 240- Laboratory register	Monthly	Laboratory Coordinator
Proportion (%) of maternal audits/ death audits	N: Number of maternal death records review D: Total number of maternal deaths reported	DHIS – MOH 105; Maternal Death Review Form	Monthly	RH Coordinator
Malaria inpatient case fatality	N: Number of inpatients who died from malaria (per 1,000) D: Total number of patient deaths plus discharges due to malaria	MOH 301, MOH 268; DHIS- Inpatient Morbidity and Mortality Report	Monthly	Facility in charges

Indicator	Numerator (N), Denominator (D)	Data source	Frequency	Responsible person(s)
Average length of stay (ALOS)	N: Inpatient days plus half-day patients D: Inpatient discharge plus deaths	MOH 717, MOH 268, 718; DHIS- Inpatient Morbidity and Mortality Report	Monthly	Facility in-charge
Proportion (%) of children registered for birth notification (B1)	N: Number of children issued with birth notification D: Total number of births	B1, MOH 333	Monthly	Facility in-charge
Number of Community Units established	N: Number of Community Units established D: Total number of Community Units established	MOH 515	Monthly	County Public Health Officer
Number of Community Units reporting to DHIS	N: Number of Community Units reporting to DHIS D: Total number of Community Units established	DHIS 2	Monthly	County Public Health Officer
Number of facilities reporting IDSR	N: Number of facilities reporting IDSR D: Total number of facilities	DHIS	Monthly	County Disease Surveillance Coordinator
% of referrals initiation	N: Number of referrals D: Total number of clients seen	MOH 100	Monthly	County Public Health Officer
% of referrals received	N: Number of referrals received D: Total number of referrals initiated	MOH 100	Monthly	County Public Health Officer
% of referrals completion	N: Number of referrals complete D: Total number of referrals initiated	MOH 100	Monthly	County Public Health Officer
% of referrals counter referred	N: Number of referrals counter-referred D: Total number of referrals	MOH 100	Monthly	County Public Health Officer
Number of health facilities reporting stock-outs of essential medicines	N: Number of facilities reporting stock-outs D: Total number of health facilities	LMIS	Monthly	County Pharmacist
% of health facilities reporting improved quality of care services (QoC survey)	N: Number of facilities reporting improved QoC D: Total number of health facilities	Health Facility Assessment	Bi-annually	County Public Health Officer
Number of health facilities with citizen service charter	N: Number of facilities with citizen service charter D: Total number of health facilities	Health Facility Assessment	Bi-annually	County Public Health Officer
% of intra-facility referral initiation	N: Number of intra-referrals initiated D: Total number of referrals	Health Facility Assessment	Bi-annually	County Public Health Officer
% of intra-facility referral completion	N: Number of intr- referrals completed D: Total number of intra referrals initiated	Health Facility Assessment	Bi-annually	County Public Health Officer
% of inter-facility counter referrals	N: Number of inter-facility counter-referrals D: Total number of inter-facility referrals	Health Facility Assessment	Bi-annually	County Public Health Officer
Number of stakeholders actively participating in the stakeholder forums	N: Number of stakeholders actively participating D: Total number of stakeholders	Program Report	Quarterly	County Director for Health
% of resources allocated to the health sector	N: Amount allocated to the health sector D: Annual county budget	Budget	Annually	County Director for Health

Annex 2: Data Management and Reporting Responsibilities

Sno	Available Reporting Forms	County responsible(Action) Person	Overall responsibility at county	Sub county Reporting Channel	Overall responsibility at Sub-county	Hospitals	Primary Health Facility/ Community Unit.	Overall Responsibility at Health Facility	HF Reporting Channel (Where Applicable)
1	CHEW Summary	Community Unit Focal person	County director of health.	DHIS	SCHRIO/ SCMOH	CHEW	CHEW	Med Sup/In-Charge	Hardcopy/DHIS
2	MoH 711 Integrated	Reproductive Coordinator/ District Public Health Nurse (DPHN)	County director of health.	DHIS	SCHRIO/ SCMOH	Sectional in charge/ HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
3	MoH 731-1 HIV CT	County AID and STI Coordinator	County director of health.	DHIS	SCHRIO/ SCMOH	Sectional in charge/ HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
	MoH 731-2 PMTCT	County AID and STI Coordinator	County director of health.	DHIS	SCHRIO/ SCMOH	Sectional in charge/ HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
	MoH 731-3 C&T	County AID and STI Coordinator	County director of health.	DHIS	SCHRIO/ SCMOH	Sectional in charge/ HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
	MoH 731-4 VMC	County AID and STI Coordinator	County director of health.	DHIS	SCHRIO/ SCMOH	Sectional in charge/ HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
	MoH 731-5 PEP	County AID and STI Coordinator	County director of health.	DHIS	SCHRIO/ SCMOH	Sectional in charge/ HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
	MoH 731-6 Blood Safety	County AID and STI Coordinator	County director of health.	DHIS	SCHRIO/ SCMOH	Sectional in charge/ HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
4	HCBC	County AID and STI Coordinator	County director of health.	DHIS	SCHRIO/ SCMOH	Sectional in charge/ HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
5	IDSR Weekly	District Disease Surveillance Coordinator(DDSC)	County director of health.	DHIS	SCHRIO/ SCMOH	Facility surveillance focal person	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
6	Hospital Administrative Statistics (HAA).	County HRIO	County director of health.	DHIS	SCHRIO/ SCMOH	HRIO		Med Sup/ In-Charge	Hardcopy/DHIS

Sno	Available Reporting Forms	County responsible(Action) Person	Overall responsibility at county	Sub county Reporting Channel	Overall responsibility at Sub-county	Hospitals	Primary Health Facility/ Community Unit.	Overall Responsibility at Health Facility	HF Reporting Channel (Where Applicable)
7	MoH 75 A OPD <5 years	County HRIO	County director of health.	DHIS	SCHRIO/ SCMOH	HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
8	MoH 75 B OPD >5 years	County HRIO	County director of health	DHIS	SCHRIO/ SCMOH	HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
9	MoH 717 Service Workload	County HRIO	County director of health.	DHIS	SCHRIO/ SCMOH	HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
10	MoH 718 Inpatient M and M	County HRIO	County director of health	DHIS	SCHRIO/ SCMOH	HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
11	MoH 710 Immunization	County Public Health Nurse.	County director of health.	DHIS	SCHRIO/ SCMOH	HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
12	MoH 706 Laboratory Report	County Lab Coordinator	County director of health.	DHIS	SCHRIO/ SCMOH	Lab In-Charge	Lab In-Charge.	Med Sup/ In-Charge	Hardcopy/DHIS
13	Support Supervision	Chair CHMT	County director of health.	DHIS	SCHRIO/ SCMOH	Sectional In- Charge/HRIO			Hardcopy/DHIS
14	IMAM	County Nutritionist	County director of health.	DHIS	SCHRIO/ SCMOH	Nutritionist	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
15	MoH 713 Nutrition Monthly Reporting.	County Nutritionist	County director of health.	DHIS	SCHRIO/ SCMOH	Nutritionist	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS

Sno	Available Reporting Forms	County responsible(Action) Person	Overall responsibility at county	Sub county Reporting Channel	Overall responsibility at Sub-county	Hospitals	Primary Health Facility/ Community Unit.	Overall Responsibility at Health Facility	HF Reporting Channel (Where Applicable)
16	MoH 708 Environmental Health	County Public Health Officer.	County director of health.	DHIS	SCHRIO/ SCMOH	PHT	Public Health Officer/Public Health Technician	Med Sup/ In-Charge	Hardcopy/DHIS
17	Quarterly report on Tuberculosis and Multiple Drug Resistant TB case-finding	County TB and Leprosy Coordinator.	County director of health.	DHIS	SCHRIO/ SCMOH	CO Tuberculosis and Lung	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
18	Cohort Report for TB	County TB and Leprosy Coordinator.	County director of health	DHIS	SCHRIO/ SCMOH	CO Tuberculosis and Lung	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
19	HSSF Monthly Expenditure	County Accountant	County director of health.	DHIS	SCHRIO/ SCMOH	Facility accountant	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
20	HSSF summary	County Accountant	County director of health.	DHIS	SCHRIO/ SCMOH	Facility accountant	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
21	Malaria Commodities Form	County Malaria Coordinator.	County director of health.	DHIS	SCHRIO/ SCMOH	Pharmacist	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
22	Non-Pharmaceutical	County Pharmacist.	County director of health.	DHIS	SCHRIO/ SCMOH	Nursing Officer In charge	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
23	Division of Occupational	County Occupational Therapist	County director of health.	DHIS	SCHRIO/ SCMOH	Occupational Therapist	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS

Sno	Available Reporting Forms	County responsible(Action) Person	Overall responsibility at county	Sub county Reporting Channel	Overall responsibility at Sub-county	Hospitals	Primary Health Facility/ Community Unit.	Overall Responsibility at Health Facility	HF Reporting Channel (Where Applicable)
24	Logistic Management Information	Reproductive Health Coordinator/Sub county PHN	County director of health	DHIS	SCHRIO/ SCMOH	Pharmacist	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
25	FP Contraceptives	County Reproductive Health.	County director of health.	DHIS	SCHRIO/ SCMOH	MCH In-Charge	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
26	Maternal Death Review Form	County HRIO	County director of health.	DHIS	SCHRIO/ SCMOH	Maternity In-Charge – Maternal Death review team.	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
27	Ophthalmology Services	County Ophthalmologist	County director of health.	DHIS	SCHRIO/ SCMOH	Ophthalmologist.	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
28	Orthopedic Plaster	County Plaster technologist	County director of health	DHIS	SCHRIO/ SCMOH	Plaster Technologies.	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS

Annex 3: County Key Indicators Targets

Policy Objective	Indicator	Targeted trends		
		Baseline (2017/2018)	Mid Term (2020/2021	Target (2022/2023)
IMPACT				
Improve health outcomes	Life expectancy at birth	52		
	Total annual number of deaths (per 100,000 population)	2*/1000 6/100,000		
	Maternal deaths per 100,000 live births	362*/100,000		
	Infant mortality rate per 1000 livebirths	34*/1000		
	Neonatal deaths per 1,000 live births	11/1000		
	Children under five years stunted	35/100		
	Under five deaths per 1,000	50/1000 5/100,000		
	Youth and Adolescent deaths per 1,000	TBD		
	Adult deaths per 1,000	183*/1000		
	Elderly deaths per 1,000	TBD		
	Years of life lived with illness / disability	TBD		
Distribution of health	% range of health services outcome index	TBD		
Services responsiveness	Client satisfaction index	TBD		
HEALTH & RELATED SERVICE OUTCOME TARGETS				
Eliminate communicable conditions	% of fully immunized children	67%	88%	96%
	% of target population receiving MDA for Trachoma	81%(yr. 2015(		100%
	% of TB patients completing treatment	86%	100%	100%
	% HIV+ pregnant mothers receiving preventive ARVs	84%	100%	100%
	% of HIV clients on ARVs	80%	87.5%	97%
	% of HIV+ clients virally suppressed	75%	85%	90%
	% of under-5s treated for diarrhoea	41%	26%	16%
	% children aged (12-59 months) dewormed	24.6%	39.6%	49.6%
	% of school age children de-wormed(6-14yrs)	24.6%	39.6%	49.6%
Halt, and reverse the rising burden of non-communicable conditions	% of adult population with BMI over 25	5%	2%	1%
	% of women of reproductive age screened for cervical cancers	0.05%	45%	75%
	% of new outpatients with mental health conditions	0.2%	0.2%	0.2%
	% of new outpatient's cases with high blood pressure	0.8%	0.5%	0.3%
	% of patients admitted with cancer	5%	2%	1%
	% of under-five attending CWC for growth monitoring (new cases)	53.4%	1%	1%
	% of newly diagnosed diabetic patients	1.3%	0.875%	0.375%
	% of severely and moderately malnourished children admitted	50%	37.5%	27.5%
Reduce the burden of violence and injuries	% new outpatient cases attributed to gender-based violence	0.2%	0.15%	0.05%
	% new outpatient cases attributed to road traffic Injuries	0.3%	0.15%	0.05%
	% new outpatient cases attributed to other injuries	4.8%	1.8%	0.5%
	% of deaths due to injuries	0.004%	0.003%	0.002%

Policy Objective	Indicator	Targeted trends		
		Baseline (2017/2018)	Mid Term (2020/2021)	Target (2022/2023)
Provide essential health services	% deliveries conducted by skilled attendants	37%	60%	70%
	% of women of reproductive age receiving family planning services	33%	60%	70%
	% of facility-based maternal deaths	0.02%	0.00%	0.00%
	% of facility-based under-five deaths	0.05%	0.00%	0.00%
	% of new-borns with low birth weight	27.5%	12.5%	2.5%
	% of facility-based fresh still births	5.25%	0.0%	0.00%
	% of pregnant women attending 4 ANC sessions	27.4%	57.4%	77.4%
Minimize exposure to health risk factors	% of population who smoke	14.3%	5.3%	1.3%
	Couple year protection due to condom use	41.9%	71.9%	91.9%
	% of population consuming alcohol regularly	27%	21%	17%
	% of infants aged under 6 months on exclusive breastfeeding	85%	91%	95%
	% of population aware of health risk factors	80%	80.3%	80.3%
	% of children (6-11 months) supplemented with Vit A	93%	95%	97.5%
	% of children (12-59 months) supplemented with Vit A	50%	65%	85%
	% of lactating mothers supplemented with Vit A	75%	82.5%	92.5%
	% of pregnant women receiving IFAS	65%	69%	77.5%
	% of children (6-23months) supplemented with MNP	0%	65%	85%
	% of salt brands adequately iodized	100%	100%	100%
Strengthen collaboration with health-related sectors	% population with access to safe water	17%	48%	68%
	% under-5s stunted	35.8%	1.6%	1%
	% of under-5s underweight	21.5%	18.25%	12.5%
	School enrolment rate	60%	75%	85%
	% of households with latrines	33.4%	48.4%	58.4%
	% of houses with adequate ventilation	50.9%	65.9%	75.9%
	% of classified road networks in good condition	3%	6%	11.5%
	% of schools providing complete school health package	2%	12.5%	27.5%
HEALTH INVESTMENT OUTPUT				
Improving access to services	Per capita outpatient utilization rate	F=4.8 M=3.9 1.2/0.98	2	2
	% of population living within 5km of a facility	21.5%	51.5%	71.5%
	% of facilities providing BEmONC	35.8%	68.8%	88.8%
	% of facilities providing CEmONC	33%	83%	100%
	Bed occupancy rate	60%	75%	80%
	% of facilities providing immunization	65%	80%	90%
Improving quality of care	TB cure rate	85%	91%	95%
	% of fevers tested positive for malaria	31%	16%	10%
	% of maternal audits/death audits	50%	100%	100%
	Malaria inpatient case fatality	2%	1%	1%
	Average length of stay (ALOS)	4 days	3days	3days
Health Input and Process Investment				

Policy Objective	Indicator	Targeted trends		
		Baseline (2017/2018)	Mid Term (2020/2021	Target (2022/2023)
Service delivery systems	% of functional community units	100	100	100
	% of outbreaks investigated within 48 hours	100	100	100
	% of hospitals offering emergency trauma services			100
	% hospitals offering Caesarean sections	100	100	100
	% of referred clients reaching referral unit	100	100	100
Health workforce	# of nurses per 10,000 population	TBD		
	% of eligible staff who have undergone CPD		100	
	Staff attrition rate		1%	0.5%
	% of public health expenditure (government and donor) spent on human resources	TBD		
Health Infrastructure	% of facilities equipped as per norms		100%	100%
	# of hospital beds per 10,000 population	TBD		
	% of public health expenditure (government and donor) spent on infrastructure	TBD		
Health products	% of time out of stock for essential medicines and medical supplies (EMMS) – days per month	0%	0%	0%
	% of public health expenditure (government and donor) spent on health products	TBD		
Health financing	General government expenditure on health as % of the total government expenditure		40%	40%
	Total health expenditure as a percentage of GDP	TBD		
	Off-budget resources for health as % of total public sector resources	TBD		
	% of health expenditure reaching the end users	TBD		
	% of total health expenditure from out of pocket	TBD		
Health leadership	% of health facilities inspected annually	65	80	100
	% of health facilities with functional boards / committees	75	85	100
	% of county stakeholder forums held	100	100	100
	% of facilities supervised	90	100	100
	# of health research publications shared with decision-makers	0	2	4
Health Information	# of sector quarterly reports produced and disseminated	4	4	4
	% of facilities submitting timely, complete and accurate information	89	95	100
	% of health facilities with DQA	89	100	100
	% of public health expenditure (government and donor) spent on health information	TBD	-	-

Source: DHIS 2 Ministry of Heath

** Baseline data will be obtained where it does not exist, and the targets identified within the first year of the plan. These are indicated as TBD.

Annex 4: Service Outcome and Output Targets for the Achievement of County Objectives

Objective	Indicator	Targets (where applicable)					
		Baseline 2016/17	Yr. 1 2018/2019	Yr. 2 2019/2020	Yr. 3 2020/2021	Yr. 4 2021/2022	Yr. 5 2022/2023
Eliminate Communicable Conditions	% Fully immunized children	67	80	84	88	92	96
	% of target population receiving MDA for trachoma	81(Year 2015)	84	84	90	95	100
	% of TB patients completing treatment	86	100	100	100	100	100
	% HIV + pregnant mothers receiving preventive ARV's(HAART)	84	100	100	100	100	100
	% of eligible HIV clients on ARV's	100	100	100	100	100	100
	% tested for HIV	12	90	90	90	90	90
	% viral suppression	55.8	90	90	90	90	90
	% of under 5's treated for diarrheal	41	36	31	26	21	16
	% School age children dewormed	24.6	29.6	34.6	39.6	44.6	49.6
Halt, and reverse the rising burden of non-communicable conditions	% of adult population with BMI over 25	5	4	3	2	1	0
	% Women of Reproductive age screened for Cervical cancers	0.05	15	30	45	60	75
	% of new outpatients with mental health conditions	0.2	0.2	0.2	0.2	0.2	0.2
	% of new outpatient's cases with high blood pressure	0.8	0.7	0.6	0.5	0.4	0.3
	% of new outpatients admitted with cancer	5	0	0	0	0	0
Reduce the burden of violence and injuries	% new outpatient cases attributed to gender-based violence	0.2	0.19	0.18	0.15	0.10	0.05
	% new outpatient cases attributed to Road traffic Injuries	0.3	0.25	0.2	0.15	0.1	0.05
	% new outpatient cases attributed to other injuries	4.8	3.8	2.8	1.8	0.8	0
	% of deaths due to injuries		-	-	-	-	-
Provide essential health services	% deliveries conducted by skilled attendant	37	50	55	60	65	70
	% of women of Reproductive age receiving family planning	143/4 36	50	55	60	65	70
	% of facility based maternal deaths	0.02	0	0	0	0	0
	% of facility based under five deaths		-	-	-	-	-
	% of new-borns with low birth weight	27.5	22.5	17.5	12.5	7.5	2.5
	% of facility based fresh still births	5.25	4.25	3.25	2.25	2.25	1.25
	% of pregnant women attending 4 ANC visits	27.4	37.4	47.4	57.4	67.4	77.4

Minimize exposure to health risk factors	% population who smoke	14.3[1]	11.3	8.3	5.3	2.3	1.3
	% population consuming alcohol regularly	27	25	23	21	19	17
	% infants under 6 months on exclusive breastfeeding	85	87	89	91	93	95
	% of Population aware of risk factors to health	80.3	80.3	80.3	80.3	80.3	80.3
	% of salt brands adequately iodized	100 (SURVEY)	100	100	100	100	100
	Couple year protection due to condom use	41.9	51.9	61.9	71.9	81.9	91.9
Strengthen collaboration with health-related sectors	% population with access to safe water	17	28	38	48	58	68
	% under 5's stunted	35.8	2.2	1.9	1..6	1.3	1.0
	% under 5 underweight	10.2	8.2	6.2	4.2	2.2	0.2
	School enrolment rate	60.1	65.1	70.1	75.1	80.1	85.1
	% of households with latrines	33.4	38.4	43.4	48.4	53.4	58.4
	% of houses with adequate ventilation	50.9	55.9	60.9	65.9	70.9	75.9
	% Schools providing complete school health package	32.4	37.4	42.4	47.4	52.4	57.7
INVESTMENT OUTPUTS							
Improving access to services	Per capita Outpatient utilization rate (M/F)	F=4.8 M=3.9 1.2/0.98	2	2	2	2	2
	% of population living within 5km of a facility	21.5	31.5	41.5	51.5	61.5	71.5
	% of facilities providing BEmONC	34/95 35.8	45.8	55.8	68.8	78.8	88.8
	% of facilities providing CEmONC	2/6 33	50	67	83	100	100
	Bed Occupancy Rate	60	65	70	75	80	80
	% of facilities providing Immunization	62/95 65	70	75	80	85	90
Improving quality of care	TB Cure rate	85	87	89	91	93	95
	% of fevers tested positive for malaria	31	26	21	16	13	10
	% maternal audits	3/6 50	100	100	100	100	100
	Malaria inpatient case fatality	-					
	Average length of stay (ALOS)	4	2	2	2	2	2

Annex 5: Standard Operating Procedures (SOPs)

Data Collection

Introduction

Data collection is a process of gathering information (raw facts) from patients/clients, human resources, commodities, finance and/or equipment into manual/electronic registers at the health facility by health workers or any other assigned person(s). It is a process that establishes a record of reporting and for future reference. The data is collected at the health facility on a daily and monthly basis.

Materials

- MOH registers
- Computer (DHIS2/EHR)
- Tally sheets
- Hospital request forms
- Patient file
- Patient cards
- Questionnaires

Procedure

1. The health worker interacts with the patient/client and completes the relevant registers on a daily basis.
2. The health worker completes patient bio data, diagnosis, investigation and treatment
3. The health worker completes tally sheets after offering treatment.
4. Facility managers collect information related to finance, commodity, human resources and equipment on a monthly basis.
5. The health worker secures information collected and upholds confidentiality.

Data Collation and Reporting

Introduction

Data collation is the process through which a health worker brings together data from different sources into daily/ weekly/monthly summary sheets and tally sheets.

Reporting is the process of transferring information from the summary sheets in the DHIS-2/ IDSR on a daily/weekly/monthly.

Materials

- MOH registers
- Computer.(DHIS2)
- Summary sheets
- Tally sheets
- Patient file
- Questionnaires

Procedure

COLLATING

1. This is done at all service delivery points.
2. Use standard tally sheet /summary sheet registers.
3. Do this by drawing tally marks to keep an accurate account of the data being collated.
4. Sum up the tallies daily.
5. Sum up the daily summaries on a weekly basis.
6. Collate data from the first to the last day of the month.
7. Data collated for a particular month should not overlap into the next month.
8. Add the outreach, emergency and other services rendered in various parts of the facility.
9. Under each event/disease count the number of events
10. Re-check totals of every event/disease.
11. Transfer totals into respective standard reporting forms at the end of the month.
12. Complete ALL fields that require data in the standard reporting forms.
13. Facility in-charge or a designated person to cross- check and sign all reporting forms.

REPORTING

14. Facilities to submit report by 5th of every month.
15. Hospitals and other health facilities with the capacities to enter data from the reporting forms into the DHIS by 5th of every month.
16. Complete ALL data fields in DHIS by 10th of every month.
17. Sub-county to submit report to the DHIS by 15th of every month
18. Keep tally sheets/registers for audit purposes.

Data Cleaning and Validation

Introduction

Data cleaning and validation is the process that takes place to ensure the highest possible quality of data is collected and processed in the routine system. The collection of high-quality data starts at the source of information where direct contact with the patient, diagnosis and/or treatment, as well as data registration, takes place. All health workers involved in the data collection are responsible for the quality of data in the health information system.

Materials

- Computer
- Data to be cleaned
- DHIS-2
- Printed outputs

Procedure

The M&E unit conducts the following procedures step b -step to clean and validate the data set.

Checking Data for Empty Records

Records that have no information (system missing) on

Facility, sub-county, county and registration number variables are invalid and need to be corrected. The data management will trace the source of these invalid records, collect the correct information and report on this immediately to the responsible officer, as well as document this in the data management register (DMR).

Checking Data for Missing Variables in the System

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

Checking Data for Duplicates

Duplicates can be traced by using the variables that identify a unique record. These variables are also called the 'key' variables for identification. In case of the present dataset the key variables to identify duplicates are SUB-COUNTY-SEX-AGE. If any of the records of these key variables contain one or more variables which are missing in the system the duplicates cannot be traced and the data file cannot be validated on duplicates.

Checking Data for Completeness of Reported Number of Records

The county, sub-county and health facility should compare the number of reported records that can be compared with previous reports. By comparing trends over the year(s) outliers can be identified. These outliers should be reported to the county and sub-county.

Surveys/ Research

County / sub- county survey and research files consist of identifiable variables that preferably will not be forwarded for analyses. These identifiable variables will mostly be excluded from the data file which will be used for analyses.

Data Quality Assurance

Introduction

Data quality assurance is the process of profiling the data to discover inconsistencies and other anomalies in the data as well performing data cleaning activities to improve the quality of data.

The sub- County should constitute a data validation/review team. The chairperson of the health management team at that level should be the chairperson of this team.

Materials

- MOH Registers
- Computer (DHIS2)
- Summary registers
- Tally sheets
- Data quality assurance tool

Procedure

1. Meet on monthly /quarterly basis to validate data before transmission.
2. Data quality assurance meetings should be weekly/monthly/quarterly.
3. Cross-check total figures on the reporting forms.
4. Check for accuracy and completeness of reports.
5. Cross-check data consistency across reports.

6. Look for unusually low or high values for events/diseases.
7. Compare with previous months and same period the year before.
8. Do necessary corrections before transmission.
9. The chairperson of the data quality assurance team should sign off the reports as having been validated.

All errors detected after the submission of the reports can be changed upon submission of a completed data change request form/ data change form to the chair of the data validation. The data should be changed in all the associated data sets, both in hard copy and electronically and a higher level in charge of reporting should be informed about the changes made.

Data Analysis and Synthesis

Introduction

Data analysis is the process of inspecting, cleaning, transforming, and modeling data with the goal of discovering useful information, suggesting conclusions and supporting decision-making. Data analysis and synthesis will be done at the county, sub-county and health facility levels to enhance evidence-based decision-making. The results obtained will be summarized into a consistent assessment of the health situation and trends, using core indicators and targets to assess progress and performance. The focus of analysis will be on comparing planned results with actual results, understanding the reasons for divergences and comparing the performance at different levels, as well as across different interventions (quarterly and annual progress reports, mid- and end-term evaluations, operation research and surveys). Data analysis and synthesis capacity will be strengthened within the CHMTs, SCHMTs and health facilities to enhance bottom-up reporting.

Materials

- Processed data
- Statistical software
- Computer
- Printed out-put

Procedures

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

Performance Review and Feedback

Introduction

Performance review and feedback of the health sector at the county and sub-county levels will involve preparation of an integrated report based on 3 tier health facility reports and containing the following sections:

- Introduction
- Service delivery achievements (indicators)
- CHMT/SCHMT activity achievements
- Partner activity achievements
- County/sub-county performance
- Lessons learnt
- Recommendations

The performance reports will be compiled by representatives of county, sub-county and health stakeholders under the leadership of the county health director and the reports will be disseminated to all stakeholders on a monthly/ quarterly/bi-annual and annual basis.

Material

- Computer (DHIS2)
- Stakeholders' reports
- County/sub-county reports

Procedure

1. Assess and rank health priority indicators against targets.
2. Asses and rank the performance of county and sub-county planned activities.
3. Asses and rank the performance of stakeholders' planned activities.
4. Incorporate research findings for evidence-based decision-making.
5. Communicate findings and provide structures for feedback/exchange of ideas and knowledge to all health stakeholders

Data Dissemination

Introduction

Data dissemination is the release to users of information obtained. It consists of distributing or transmitting statistical data to users through various media e.g. internet, paper publication, press release, etc. Data is packaged and disseminated in formats that are determined by CHMT/SCHMT to all stakeholders. Information generated at all levels of the sector and from different sources is shared, interpreted and applied for decision-making during periodic sector performance reviews, planning, resource mobilization and allocation, accountability, designing disease specific interventions and policy dialogue. The timing of information dissemination should coincide with county planning cycles and the needs of the data users at the county /sub -county levels and of all stakeholders.

Materials

- Computers
- Internet/intranet
- Printed information product
- Projector
- Printer

Procedure

1. Service delivery data is packaged in different formats and presented in information products.
2. Information products are printed and shared (uploaded to the website) among all stakeholders.
3. All reports produced through M&E activities are made accessible to all stakeholders.
4. M&E results users translate and use the data/information for decision-making, policy dialogue and planning.
5. Information products related to monitoring of the strategic plan is produced and disseminated during the period of the strategic plan.

Performance Review and Feedback

Performance review and feedback of the health sector at the county and sub-county levels will involve preparation of an integrated report based on 3 tier health facility reports and containing the following sections:

- Introduction
- Service delivery achievements (indicators)
- CHMT/SCHMT activity achievements
- Partner activity achievements

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Material

- Computer (DHIS2)
- Stakeholders reports
- County/sub-county reports

Procedure

- Assess and rank health priority indicators against targets.
- Asses and rank the performance of county and sub-county planned activities.
- Asses and rank the performance of stakeholders' planned activities.
- Incorporate research findings for evidence-based decision-making.
- Communicate findings and provide structures for feedback/exchange of ideas and knowledge to all health stakeholders.

Support Supervision

Supportive supervision is a process of helping staff to improve their own work continuously.

It is carried out in a respectful and non-authoritarian way with a focus on using supervisory visits as an opportunity to improve the knowledge and skills of health staff.

Supportive supervision encourages open, two-way communication and team building approaches that facilitate problem solving. It focuses in monitoring performance towards goals and using data for decision-making. It depends upon regular follow-up with staff to ensure new tasks are being implemented correctly.

Materials

- Supervision checklist
- Human resources
- Finance
- Means of transport
- Supportive supervision guidelines and tools
- Stationary

Procedure

- Set up supervision system
- Train supervisors on supportive supervision core competencies
- Generate a supportive supervision plan with timelines
- Decide on priority supervision sites
- Visit facilities to be supervised
- Review the previous action points and implementation status
- Use check list and recording forms to gather information
- Listen to problems and challenges

- Address and follow up on problem areas
- Analyze data obtained
- Provide immediate feedback to all staff
- Identify training needs and skills that need updating
- Give OJT on techniques and approaches, if required
- Update facility supervisees on new guidelines and updates, if any
- Follow up on agreed actions by supervisor and staff
- Share the information on identified gaps with stakeholders
- Support Supervision Checklist Format

Supportive supervision checklist for use by CHMT/SCHMT Samburu County.

1. Each health facility to be visited at least once quarterly
2. Checklist to be completed in duplicate - original left at the facility and duplicate stored by the SCHMT.

For each section rate performance in any of the following: 1=Excellent, 2=Good, 3=Fair, 4=Poor

Date of visit:	
Date last visited:	
Facility Supervised	☐ Yes ☐ No (tick where applicable)
Facility Name	

PART I: Observations

SECTION A. Adequacy of staffing

Category	Number
Clinical officer	
Nurses	
Laboratory staff	
Clerk	
Support staff	
Security staff	
Others	

Remarks by supervisor (consider staffing norms, workload and competencies):

Facility meets staffing norms	☐ Yes ☐ No
Number staff members attended training during last quarter (specify training and number staff trained)	
Number of health personnel trained HSSF	
All service areas have staff allocated	☐ Yes ☐ No
Overall remark on adequacy of staff: Please indicate 1=Excellent, 2=Good, 3=Fair, 4=Poor	

B. Governance and financial management

Component	Response
1.Facility Management Committee (HFMC) in place	Yes No
2.HFMC held meeting for previous quarter	Yes No
3.Facility has one bank account for all incomes	Yes No
4.Bank account signatories are as per guidelines	Yes No
5.Facility has an APRP for the current year	Yes No
6.Facility has a QIP for the current quarter	Yes No
7.Facility has an HSSF for the current quarter	Yes No
8.Financial management guidelines (FM Operations Guide, Guidelines on FM) available	Yes No
9.Basic FM tools (Receipt books, Cash book & payment vouchers) in use	Yes No
10.Latest financial report submitted	Yes No

Remarks by supervisor:

Component	Response
HFMC holding regular quarterly meetings (record of minutes available):	Yes No
Facility meets core financial management requirements (HFMC functional, bank account, QIP available, basic tools – receipt books, cash book and payment vouchers – in use, dedicated staff for accounts):	Yes No
Financial information shared among stakeholders (chalkboard, meetings, etc.):	Yes No
Overall remark on financial management: Please indicate 1=Excellent, 2=Good, 3=Fair, 4=Poor	

C. Delivery of Kenya Essential Package for Health (KEPH)

Service	Number
OPD - all visits	
OPD female - all visits	
Immunization (fully immunized)	
ANC clients completed 4 visits	
Deliveries	
New FP clients	Long term- Short term-
No malaria parasites slides done	

TB patients started on treatment	
Patients on ART	

Remarks by supervisor, including quality:

Service delivery appropriate for the level (KEPH package for level):	☐ Yes ☐ No
Overall remark on service delivery: Please indicate 1=Excellent, 2=Good, 3=Fair, 4=Poor	

D. Health and management information

Report	**Response**
1.Latest activity reports submitted to SCHRIO	☐ Yes ☐ No
2.Latest financial report submitted to accountant	☐ Yes ☐ No
3.Reports discussed in facility staff meeting (availability of minutes)	☐ Yes ☐ No
4.Finanacial and activity data "displayed" for stakeholders	☐ Yes ☐ No
4.Written feed-back from latest reports received from SCHMT / Accountant	☐ Yes ☐ No

Remarks by supervisor:

Activity information shared among stakeholders (chalkboard, meetings, graph display etc.):	☐ Yes ☐ No
Preparation and submission of reports timely: (by 5th of every month).	☐ Yes ☐ No
Facility data used for decision making: (evidence)	☐ Yes ☐ No
Overall remark on HMIS: Please indicate 1=Excellent, 2=Good, 3=Fair, 4=Poor	

E. Essential Medicines and Medical Supplies (EMMS)

Component	**Response**
1. EMMS received as ordered during last quarter.	☐ Yes ☐ No
2. Delivery verified and signed off by HFMC (evidence).	☐ Yes ☐ No
3. Community and users (staff) informed of delivery	☐ Yes ☐ No
4. Stock-outs during last quarter (ACT, vaccines, cotrimoxazole, FP, paracetamol)	☐ Yes ☐ No
5. Are there local purchases of EMMS	☐ Yes ☐ No
6. Were there expiries during last quarter	☐ Yes ☐ No

7. Stock control cards present and updated for latest delivery	☐ Yes ☐ No
8. Facility displaying quarterly information on availability of drugs	☐ Yes ☐ No

Remarks by supervisor:

Mechanisms of informing users and community on deliveries in place:	☐ Yes ☐ No
Overall remark on availability of EMMS:Please indicate 1=Excellent, 2=Good, 3=Fair, 4=Poor	

F. Utilities, equipment, infrastructure and environment

Component	**Response(tick appropriately)**
Utilities	
1. Availability of water	☐ Yes ☐ No
2. Availability of power source / fuel	☐ Yes ☐ No
3. Disposal of waste	☐ Yes ☐ No
Basic equipment at service areas	
1. MCH / FP (weighing scale, fridge, BP machine)	☐ Yes ☐ No
2. Laboratory (microscope) and others.	☐ Yes ☐ No
3. Consultation room (diagnostic set, BP machine)	☐ Yes ☐ No
4. Maternity (delivery sets, resuscitation equipment, delivery bed)	☐ Yes ☐ No
Infrastructure	
1. Good maintenance state for buildings	☐ Yes ☐ No
2. Compound well maintained	☐ Yes ☐ No
Overall remark on utilities, equipment, infrastructure and environment: 1=Excellent, 2=Good, 3=Fair, 4=Poor	

PART II: At most three identified gaps and actions needed

1			
2			
3			

Supervised by:

Name	Designation/ Organization	Signature

Facility Stamp

Annex 6: References

1. National Health Sector Monitoring and Evaluation Framework (July 2014- June 2014)
2. Kenya Health Sector Strategic Plan (KHSSP) III (2012-2017)
3. Ministry of Health, Kenya Health Policy 2014-2013
4. Kenya Malaria Monitoring and Evaluation Plan (2009-2017)
5. Samburu County Health Sector Strategic and Investment Plan 2013-14/2017-18.
6. Kenya Demographic Health Survey (KDHS) 2014.

Annex 7: List of Contributors

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