MINISTRY OF HEALTH
DIVISION OF DISEASES SURVILLANCE AND RESPONSE

Report on the Baseline Assessment of Capacity for Monitoring and Evaluation

September 2013

ACKNOWLEDGEMENTS

ACRONYMS AND ABBREVIATIONS

AFP   Acute Flaccid Paralysis
AWP   Annual Workplan
CDC   Centers for Disease Control
DCHS   Division of Community Health Services
DDSR   Division of Disease Surveillance and Response
DHIS   District Health Information System
DQA   Data Quality Audit
HIS   Health Information System
HMIS   Health Management Information System
IDSR   Integrated Disease Surveillance and Response
M&E   Monitoring and Evaluation
MECAT   Monitoring and Evaluation Capacity Assessment Tool
MoH   Ministry of Health
MOPHS   Ministry of Public Health and Sanitation
MTEF   Medium Term Expenditure Framework
NHIS   National Health Information System
TB   Tuberculosis
TWG   Technical Working Group
UNAIDS   Joint United Nations Programme on HIV/AIDS
USAID   United States Agency for International Development
VPD   Vaccine Preventable Diseases
WHO   World Health Organization
ZDU   Zoonotic Disease Unit

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BACKGROUND

The Division of Disease Surveillance and Response (DDSR) is established under the Department of Disease Prevention and Control. DDSR comprises seven technical units and one administrative unit: Epidemic Preparedness and Response, Vaccine Preventable Disease (VPD), Influenza, Integrated Diseases Surveillance, Zoonotic Diseases, Laboratory Surveillance, Monitoring and Evaluation (M&E), and Program Management. To establish DDSR's capacity to perform its M&E functions, MEASURE Evaluation conducted a baseline assessment in collaboration with DDSR.

ASSESSMENT OBJECTIVES

The overall objective of the assessment was to understand DDSR's current capacity to perform its M&E objectives and determine a baseline for comparison as DDSR takes steps to strengthen its capacity. The assessment also will help guide decisions on the most appropriate interventions to address gaps. The specific objectives of the assessment were to (1) understand, document, and clarify DDSR's performance on its M&E objectives; (2) determine the current status of performance in key M&E functional areas, including data collection, analysis, and reporting; and (3) identify gaps in DDSR's capacity to meet performance objectives.

METHODOLOGY

The assessment used a cross-sectional observational study design with a mixed-methods approach. Quantitative data were collected using an Excel-based questionnaire, while and a range of qualitative data collection techniques, including key informant interviews and document reviews were used for the qualitative data. Tools for the group assessment and qualitative interviews were designed to collect data along the twelve capacity areas of interest to monitoring and evaluation.

KEY FINDINGS

Overall, most of the elements of the 12 capacity areas for M&E are in place, albeit with varying degrees. Some capacity areas, such as the costed work plans, routine monitoring, surveys and surveillance, and supervision and auditing have stronger capacities, and therefore, represent opportunities to strengthen the overall capacity for M&E. The weakest capacity areas are in evaluation and research, human capacity for M&E, and partnerships and governance. Following is a summary list of assessment findings.

- DDSR's draft strategic plan includes a mission statement; however, not all DDSR staff can state it, although they apply the spirit of the mission statement.
- DDSR's capacity for M&E is generally low; some key personnel responsible for M&E have varying capacities in key competencies and skills required to perform their functions.
- Governance structures, such as technical working groups at the national level and local leadership to coordinate stakeholders, are missing in DDSR, and a specific policy to support and coordinate M&E activities is lacking.
- The M&E Unit has the capacity to coordinate the generation of information on the trends of 36 priority diseases from all health facilities in Kenya and trigger response in a disease outbreak.

- The M&E activities under the annual workplan are costed, with set implementation timelines and identified sources of funding.
- Several champions support M&E at DDSR, including the program head, focal and various unit heads, and data managers.
- DDSR has the essential tools and equipment to facilitate data collection, management, transfer, analysis, and reporting, although occasional shortages of some of them such as the MOH 505 undermine DDSR's ability to undertake routine monitoring.
- DDSR has a fairly functional surveillance system, with activities and procedures that conform to World Health Organization guidelines for international best practices. Protocols for surveys and surveillance activities are always approved by the relevant bodies.
- DDSR has a database that serves current needs, but it does not capture all data elements required for monitoring and evaluating various components of interest.
- DDSR lacks dedicated resources for supportive supervision, which makes the activity infrequent. Supportive supervision guidelines are incomplete and require updating to incorporate a component on the feedback and action plan.
- DDSR's capacity to undertake research and evaluation is low and lacks focus on undertaking evaluation and research activities.
- DDSR has no data use plan, although it does produce various information products, such as bulletins and policy briefs that contribute to influencing policy and practice.

RECOMMENDATIONS

- Strengthen leadership, advocacy for resources, and partnership building to address DDSR's limited capacity for technical and financial independence and promote sustainability of the strengthened capacity.
- Strengthen skills and capacity to carry out advanced data analysis, including analysis of qualitative data and presentation skills.
- Develop an M&E plan, an activity that has been identified as an urgent area for capacity building for DDSR.
- Develop a coherent communication strategy that is cross-cutting and addresses all issues of interest on disease surveillance and response.
- Carry out a systems gap analysis for DDSR to guide discussions with the Division of Health Information System and inform interventions to strengthen routine monitoring functions.
- Promote stakeholder engagement on technical discussions with stakeholders in disease surveillance to avoid duplication.
- Update or develop a policy on data quality audits that stipulates the procedures for undertaking audits across all diseases of interest to DDSR.
- Develop an evaluation and research agenda that corresponds to DDSR's stated mandate and aligns to the national agenda, where appropriate.
- Develop data use plans following a detailed analysis of program data needs and mapping of data users.

CHAPTER 1: INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

This report presents results of a baseline assessment of the Division of Disease Surveillance and Response (DDSR) to determine existing capacity to perform its monitoring and evaluation (M&E) functions. The assessment was conducted by MEASURE Evaluation's PIMA Project, in collaboration with DDSR, as part of a broader U.S. Agency for International Development (USAID)-funded project with a mandate to support the Government of Kenya in its efforts to build sustainable M&E capacity in using evidence-based decision making to improve the effectiveness of the Kenya Health System. The project focuses on the development and institutionalization of approaches and tools to identify information needs, plan for data collection, and use data for decision making. This is especially important as the National Health Information System (NHIS) continues to be improved and rolled out nationally and as program-level M&E staff continues to take on the role of systematically collecting and using information to manage programs and guide strategies and policies. To successfully take on this role, program M&E teams need strengthened capacity to generate, manage, disseminate, and use information. At the same time, improvements are developing in a unified national Health Information System (HIS), with organizational strengthening and improved approaches.

1.2 BACKGROUND

1.2.1 Division of Disease Surveillance and Response

DDSR was established under the Department of Disease Prevention and Control. Its vision is to build an effective, efficient public health surveillance and response system that results in the reduction of morbidity, mortality, and disability from disease outbreaks. DDSR's mission is to provide leadership and participate in public health surveillance, preparedness, and response to outbreaks and other public health events. The Division's goal is to establish a functional partnership with stakeholders to strengthen preparedness, early warning systems, diseases surveillance, and response to epidemics. DDSR comprises seven technical units and one administrative unit (DDSR, Draft Strategic Plan, 2013), as shown in Table 1: Epidemic Preparedness and Response, Vaccine Preventable Disease (VPD), Influenza, Integrated Diseases Surveillance, Zoonotic Diseases, Laboratory Surveillance, Monitoring and Evaluation, and Program Management (DDSR, Quarterly Progress Report, April-June 2012).

DDSR's goal is to detect changes in disease trends early enough to initiate effective and timely public health actions. Kenya is implementing the World Health Organization (WHO) Integrated Disease Surveillance and Response (IDSR) strategy for improving priority communicable disease surveillance. Under this strategy, the sub county (formerly district) level is the focus for integrating surveillance functions; it is the first level in the health system with full-time staff dedicated to all aspects of public health, such as monitoring health events in the community, mobilizing community action, and advocating for support to protect the community's health. In addition, all surveillance activities are coordinated and streamlined into one integrated activity and take advantage of similar surveillance functions, skills, resources, and target populations. For example, surveillance activities for acute flaccid paralysis (AFP) can address surveillance needs for neonatal tetanus, measles, and other diseases; and thus, health workers who routinely monitor AFP cases can also review district and health facility records for information about other priority diseases. Surveillance focal points at the regional and national levels collaborate with epidemic response committees at each level to plan relevant public health response actions and actively seek

opportunities to combine resources. The integration also involves the harmonization of different methods, software, data collection forms, and standards in case definition to prevent inconsistencies in information and maximize efforts. Implementation of the IDSR strategy is based on the following four pillars:

- Epidemic preparedness and response
- Data management
- Strengthening laboratory capacity
- Coordination

Table 1: DDSR's Units and Their Functions[1]

Unit	Key Functions
Epidemic Preparedness and Response	• Coordinate preparedness for public health emergencies • Coordinate response to public health emergencies or threats of public health emergencies • Review and prepare proposals for procurement of emergency preparedness supplies in consultation with the procurement officer and accountant • Review proposals for support from the district during emergencies and prepare revised requests to the Ministry of Health (MoH) for support • Coordinate the operations of the emergency operation center (EOC) in the division • Prepare monthly reports on the status of epidemic-prone diseases in Kenya • Organize health and nutrition sector committee meetings during and outside emergencies • Organize monthly epidemic technical working groups
Vaccine Preventable Disease	• Coordinate surveillance of vaccine preventable diseases • Coordinate response to vaccine preventable disease threats and outbreaks where vaccination is indicated • Organize meetings for polio eradication committees, • Coordinate measles control activities • Coordinate rotavirus, and IBD surveillance • Prepare weekly updates on AFP surveillance and measles trends • Organize the measles, rotavirus, and other VPD surveillance technical working group meetings • Coordinate polio eradication activities in the country • Prepare regular updates on HIB, MNT, and IBD surveillance • Conduct regular risk analysis of VPDs, especially polio and measles

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[1] DDSR Draft Strategic Plan 2013–2017.

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Unit	Key Functions
Influenza	• Coordinate expansion and implementation of Influenza surveillance activities in the country • Coordinate country influenza preparedness and response • Organize influenza task force meetings • Prepare weekly reports on trends in influenza and other respiratory viruses circulating in the country • Coordinate the organization of annual surveillance and response conferences • Represent DDSR in influenza-related surveillance activities at partners meetings • Coordinate implementation of nosocomial infections surveillance • Coordinate development or revision of the Influenza National Plan of Action • Coordinate the subnational-level emergency response multisectoral capacity development activities • Represent DDSR in the national disaster operation and the crisis response center activities
Integrated Disease Surveillance	• Coordinate implementation of the IDSR strategy • Organize monthly surveillance technical meetings • Coordinate cross-border surveillance with the East African Community and other regional health bodies • Coordinate implementation of community surveillance • Liaise with the Health Management Information System (HMIS) and monthly analyze data on priority diseases reported through the HMIS • Monitor the weekly disease trends, taking into account outbreak thresholds, and advise DDSR appropriately • Coordinate implementation of the International Health Regulations 2005 • Coordinate and manage roll out of electronic reporting system • Coordinate review of IDSR strategy • Finalize revision of surveillance teams terms of references
Zoonotic Disease	• Operationalize preparedness and management of zoonotic disease epidemics • Strengthen zoonotic disease surveillance • Enhance efforts to prevent and control zoonotic infection • Operationalize Zoonotic Disease unit through internal M&E, develop a One Health Communication Strategy, and review curricula of biomedical training institutions • Facilitate a regional information exchange with the scientific community and stakeholders on zoonotic diseases • Identify and develop research activities related to zoonosis
Monitoring and Evaluation	• Coordinate all DDSR M&E activities • Prepare and implement an integrated DDSR-wide M&E framework • Coordinate integrated supervisory activities • Organize quarterly surveillance technical review meetings • Organize and coordinate annual and biannual comprehensive data quality audit exercises
Laboratory Surveillance	• Coordinate laboratory surveillance in Kenya

Unit	Key Functions
Program Management	• Coordinate DDSR administrative functions • Manage and coordinate transport, including during emergencies, and ensure DDSR vehicles are used and maintained appropriately • Prepare annual procurement plans in consultation with all units • Develop and maintain an electronic record management and filing system • Coordinate transformation of existing records into electronic format • Coordinate follow-up activity requisitions to MoH • Prepare annual leave schedules in consultation with staff and heads of units • Manage DDSR resources, including an integrated inventory on equipment status • Spearhead expansion of existing DDSR office space and storage facilities • Manage DDSR finances and ensure that staff adhere to financial procedures • Ensure funds and resources are accounted for immediately after an activity is completed and returns are safely kept according to government requirements

While disease surveillance has contributed significantly to improvements in the public health situation and advancement of health systems in Kenya since the roll out of IDSR in 2006, DDSR continues to experience several challenges (DDSR, Draft Strategic Plan, 2012). Following is a summary list of some key challenges:

- *Limited human resources.* Kenya's entire health system is inadequately staffed. The pre-service training does not adequately prepare health workers to provide IDSR services. This challenge requires continuous capacity development among the in-service health workforce. In addition, health facility surveillance focal persons are not full-time or dedicated surveillance practitioners. They often conduct surveillance activities as an add-on to their core responsibilities at lower health facilities and in hospitals.
- *Inadequate funding for surveillance activities* from the government and limited support and interest from partners in surveillance.
- *Limited capacity for the national public health laboratories* at Levels 2, 3, and 4, which often lack basic equipment and reagents, which compromises the capability of the laboratory surveillance system to complement the data from the clinical-based surveillance system.
- *Limited response to outbreaks and other public health events.* Response often is contingent on the ability of the Ministry of Public Health and Sanitation (MOPHS) to identify and mobilize funds in time, which has resulted in slow response to outbreaks because protected surveillance funds are inadequate.

Table 2: Kenya's IDSR Priority Diseases, Conditions, and Events

Epidemic-prone Diseases	Diseases Targeted for Eradication or Elimination	Other Major Diseases, Events, or Conditions of Public Health Importance
• Anthrax • Brucellosis • Cholera • Diarrhea with blood (*Shigella*) • Dengue Fever • Measles • Meningococcal meningitis • Plague • Rift Valley Fever • Severe Acute Respiratory Infections[1] • Typhoid Fever • Viral Hemorrhagic Fever Syndrome[2] • Yellow Fever [1]Ebola, Marburg, Lassa, Crimean Congo, West Nile Fever [2]National programs may want to add Influenza-like illnesses to their priority disease list	• Acute Flaccid Paralysis (poliomyelitis)[3] • Guinea Worm Disease (Dracunculiasis) • Leprosy • Leishmaniasis • Neonatal tetanus [3]Disease specified by international health regulations (2005) for immediate notification	• Acute jaundice • Adverse events following immunization • Cancers (breast, cervix, esophagus, and prostate) • Diabetes mellitus • Diarrhea with dehydration in children under 5 years of age • HIV/AIDS (newly diagnosed cases) • Hypertension • Malaria • Malnutrition in children under 5 years of age • Maternal deaths • Neonatal deaths • Rabies (animal bites) • Road traffic Injuries and fatalities • Schistosomiasis • Severe pneumonia in children under 5 years of age • Sexually transmitted infections • Trachoma • Tuberculosis (including MDR, XDR TB)

Diseases or Events of International Concern
• Human influenza from a new subtype* • Severe Acute Respiratory Syndrome* • Smallpox* • Any public health event of international or national concern (infectious, zoonotic, foodborne, chemical, radio, nuclear, or from unknown condition)
*Disease specified by international health regulations (2005) for immediate notification

1.2 PURPOSE OF THE BASELINE ASSESSMENT

A preliminary review of DDSR documents to determine its capacity to undertake its M&E functions indicated a general weakness across major organizational, technical, and behavioral aspects. The overall assessment had the following specific objectives:

- Understand, document, and clarify DDSR's performance on M&E objectives.
- Determine DDSR's performance status in key M&E functional areas, including data collection, analysis, and reporting.
- Identify gaps in DDSR's capacity to meet performance objectives.

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CHAPTER 2: APPROACH AND METHODOLOGY

2.1 DESIGN AND METHODS

The assessments utilized a cross sectional observational study design using a mixed methods approach. Quantitative data were collected using an excel-based questionnaires and a range of qualitative data collection techniques including key informant interviews and document reviews.

2.2 PARTICIPANTS

Participants were mainly drawn from DDSR senior management, including the Division Head, unit heads, data managers, M&E personnel, and other thematic focal point personnel. Individuals were identified using a purposive sampling strategy, which made it possible to interview only those people who are knowledgeable of DDSR M&E responsibilities and specific individuals tasked with implementing M&E functions in DDSR.

2.3 PROCEDURES AND APPROACH

The assessment used several approaches, including stakeholder engagement and consensus building discussions on the objectives and intended outcomes of the exercise. This was followed by a detailed review of relevant documents to develop an initial understanding of DDSR's existing capacity for M&E and to help sharpen the focus of issues to be assessed. The document review examined DDSR's historical background and status of the M&E units for staffing levels, key functions, and the challenges that prevent them from performing their responsibilities.

Three data collection tools were developed and used to collect primary data from participants: These included; 1) a group assessment tool, (2) an individual assessment tool, and (3) key informant guides. The group assessment tool, Monitoring and Evaluation Capacity Assessment Tool (MECAT) was developed to align with the 12 Components approach used by the Joint United Nations Programme on HIV/AIDS (UNAIDS) for M&E systems strengthening (UNAIDS, 2008). The tool was used to capture data on the different dimensions of each of the 12 capacity areas (see the text box below). Specific questions targeted the status and quality of each component's implementation. In addition, questions were asked to determine the financial and technical autonomy of various DDSR M&E activities. The MECAT tool comprises a series of statements and questions that were scored using three different scales (3-point, 4-point, and 5-point), depending on the specific attributes of a given performance area. The tool, administered to participants in a workshop format, was facilitated by an experienced moderator. Scoring for each question was based on group consensus and use of deliberative democracy to vote where consensus was difficult to achieve.

The individual capacity assessment tool was adapted from the UNAIDS guidelines (MERG, 2010) to assess the knowledge, skills, and competencies of people tasked with M&E responsibilities at an individual level. The tool helped participants focus on the required knowledge, skills, and competencies needed to support the implementation of professional development plans to strengthen DDSR's M&E capacity. The text box below shows the key competencies and skills that were assessed with the individual assessment tool. The tool was sent to participants electronically, and returned to the facilitator after it was completed. A total of nine participants took part in the M&E competencies and skills assessment.

M&E Competencies and Skills Assessed
• M&E leadership • Data collection and management • Evaluation competencies • Data analysis, dissemination, and use • General management competencies

The key informant interview guides, which were developed on the basis of document reviews, focused on the 12 capacity areas that were assessed in the group assessment tool. Key informant interviews aimed at collecting in-depth understanding of the issues that affect M&E performance based on the views and opinions of personnel with a better understanding of DDSR. A total of six interviews were conducted among participants from DDSR and stakeholders who have worked closely with DDSR.

2.4 OVERVIEW OF CAPACITY AREAS ASSESSED

Table 3: Capacity Areas Assessed

Capacity Area	Main Focus of Questions
Organizational	• Leadership: effective leadership for M&E in the organization • Human resources: job descriptions for M&E staff, adequate number of skilled M&E staff, defined career path in M&E • Organizational culture: national commitment to ensure M&E system performance • Organizational roles and functions: well-defined organizational structure, including a national M&E unit; M&E units, or M&E focal points in other public, private, and civil society organizations; written mandates for planning, coordinating, and managing the M&E system; well-defined M&E roles and responsibilities for key individuals and organizations at all levels • Organizational mechanisms: routine mechanisms for M&E planning and management, for stakeholder coordination and consensus building, and for monitoring the performance of the M&E system; incentives for M&E system performance • Organizational performance: organization achieves its annual workplan objectives for M&E
Human Capacity for M&E	• Defined skill set for individuals at the national, subnational, and service-delivery levels • Workforce development plan, including career paths for M&E • Costed human capacity building plan • Standard curricula for organizational and technical capacity building • Local or regional training capacity, including links to training institutions • Supervision, in-service training, and mentoring
Partnership and Governance	• National M&E Technical Working Group established • Mechanism to coordinate all stakeholders • Local leadership and capacity for stakeholder coordination • Routine communication channel to facilitate exchange of information among stakeholders
National M&E Plan	• Broad-based participation in developing the national M&E plan • M&E plan explicitly linked to the National Strategic Plan • M&E plan adheres to international and national technical standards • M&E system assessments and recommendations for system strengthening addressed in the M&E plan

Capacity Area	Main Focus of Questions
Annual M&E Costed Workplan	• M&E workplan contains activities, responsible implementers, timeframe, activity costs, and identified funding • M&E workplan explicitly links to workplans and government Medium-Term Expenditure Framework (MTEF) budgets • Resources (human, physical, financial) committed to implement the M&E workplan • National M&E workplan endorsed by relevant stakeholders • M&E workplan updated annually based on performance monitoring
Advocacy, Communication, Culture, and Behavior	• Communication strategy includes a specific M&E communication and advocacy plan • M&E explicitly referenced in national policies and the National Strategic Plan • M&E champions, identified among high-level officials, actively endorse M&E actions • M&E advocacy activities implemented according to the M&E advocacy plan • M&E materials that target different audiences and support data sharing and use available
Routine Monitoring	• Data collection strategy explicitly linked to data use • Clearly defined data collection, transfer, and reporting mechanisms, including collaboration and coordination among the different stakeholders • Essential tools and equipment for data management (e.g., collection, transfer, storage, analysis) available • Routine procedures for data transfer from subnational to national levels
Surveys and Surveillance	• Protocols for all surveys and surveillance based on international standards • Specified schedule for data collection linked to stakeholders' needs, including identification of resources for implementation • Inventory of surveys conducted • Well-functioning surveillance system
National and Subnational Databases	• Databases designed to respond to the decision making and reporting needs of different stakeholders • Linkages between different relevant databases to ensure data consistency and avoid duplication of effort • Well-defined and managed national database to capture, verify, analyze, and present program monitoring data from all levels and sectors
Supervision and Auditing	• Guidelines for supervising routine data collection at facility- and community-based levels • Routine supervision visits, including data assessments and feedback to local staff • Periodic data quality audits • Supervision reports and audit reports
Evaluation and Research	• Inventory of completed and ongoing country-specific evaluation and research studies • Inventory of local evaluation and research capacity, including major research institutions and their focus of work • National evaluation and research agenda • Guidance on evaluation and research standards and appropriate methods • National conference or forum for dissemination and discussion of research and evaluation findings
Data Demand and Use	• National Strategic Plan and national M&E plan include a data use plan • Analysis of program data needs and data users • Data use calendar to guide the timetable for major data collection efforts and reporting requirements • Evidence of information use (e.g., data referenced in funding proposals and planning documents)

2.5 DATA MANAGEMENT

2.5.1   Data Storage

An MS Excel database to enter and store quantitative data from the group and individual assessments. The database was made accessible only to authorized study investigators and trained data management personnel. Forms for data collection were stored in a secure cabinet with access limited to authorized personnel in the study.

2.5.2   Data Analysis

Quantitative data were analyzed using simple descriptive statistics (simple scoring) and presented the information with dashboards with a score range of 0–10 points, where 10 represents the highest achievement in capacity.

Qualitative data were transcribed and analyzed using a thematic approach. The themes were predefined on the basis of literature and closely followed the 12 capacity areas of interest to the assessment. Both the audio-recorded interviews and interview notes were transcribed and analyzed with thematic analysis charts that presented the key themes and issues that emerged from the interviews. These themes later were corroborated with data from other sources to guide the description of DDSR's M&E capacity.

2.6 ETHICAL CONSIDERATIONS

Ethical approval for this assessment was granted by the Kenya Medical Research Institute Ethical Review Committee. Before beginning the data collection for the assessment, MEASURE Evaluation explained the voluntary nature of the exercise to participants. All participants were assured of the confidentiality of their responses and information generated. Before each interview, MEASURE Evaluation explained the objectives of the assessment approach to participants and clarified any issues and concerns.

CHAPTER 3: ASSESSMENT RESULTS

This chapter presents the assessment results. Section 3.1 gives a general overview of the dimensions under each of the 12 capacity areas assessed. The overview provides a snapshot of the capacity that exists at DDSR and identifies if specific elements that constitute capacity exist (status); quantifies how robust these elements for established norms (quality); and evaluates the extent to which DDSR can develop, fund, and execute these elements without depending on external support (technical and financial autonomy). The overview is presented in a 10-point scale, where 0 is the least or no capacity, and 10 points illustrates a high level of capacity. For this assessment, any score below 5 points suggests weak capacity and represents an area that needs focus for capacity strengthening intervention. Section 3.2 presents data on specific components in each capacity area.

3.1 GENERAL OVERVIEW OF DDSR CAPACITY FOR M&E

Overall, most of the elements of the 12 capacity areas for M&E are in place in DDSR, albeit with varying degrees. Figure 1 shows key elements under the various capacity areas. Some capacity areas, such as the costed workplans, routine monitoring, surveys and surveillance, and supervision and auditing, have stronger capacities, and therefore, represent opportunities that can be used to strengthen overall capacity. The weakest capacity areas are those that relate to evaluation and research, human capacity for M&E, and partnerships and governance. Out of the 12 capacity areas, seven attained scores between 0 and 5 which suggests that capacity in these areas is limited.
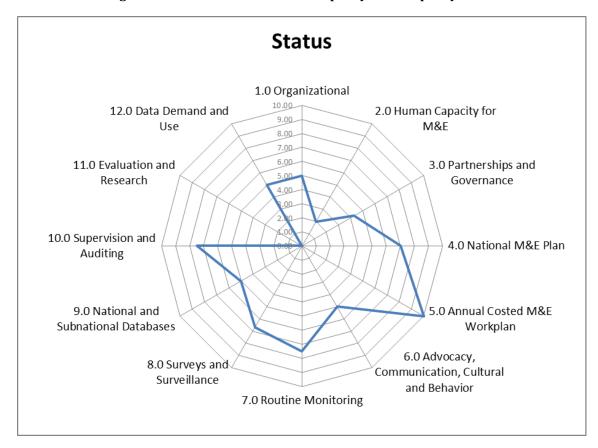
Figure 1: Status of DDSR's Overall Capacity in All Capacity Areas

The overall quality of DDSR's current capacity is above average, although it is not robust enough to functionally carry out M&E tasks. The areas where the quality of various dimensions of capacity were limited include evaluation and research, human capacity for M&E, national M&E plan, and surveys and surveillance. All the capacity areas had scores of less than 7 for the quality dimension (see Figure 2).

Figure 2: Quality of DDSR's Overall Capacity in All Capacity Areas

Figures 3 and 4 show that DDSR's overall technical and financial autonomy is limited in most capacity areas, except organizational structure, national and subnational databases, and supervision and auditing.

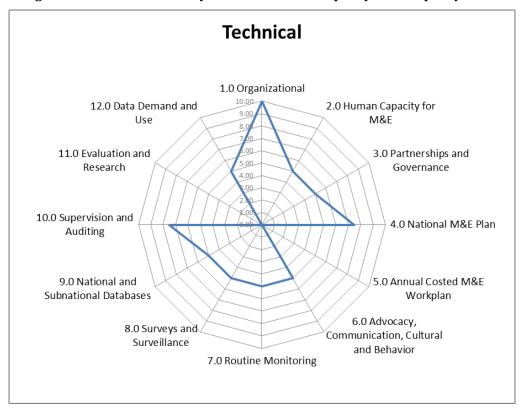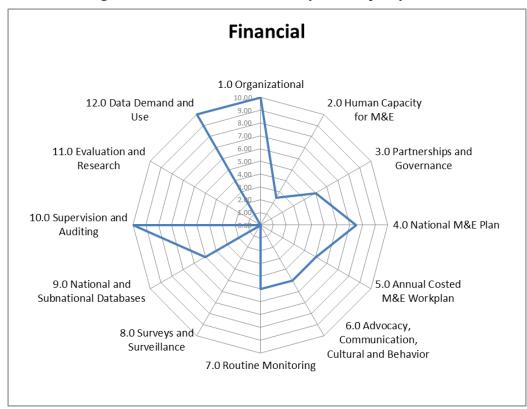**Figure 3: Technical Autonomy of DDSR's Overall Capacity in All Capacity Areas**

Figure 4: DDSR's Financial Autonomy in All Capacity Areas

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3.2 EXISTING CAPACITY IN THE 12 CAPACITY AREAS

The description of DDSR's existing capacity is based on data collected in the group and individual assessment tools and the key informant guide. (See Chapter 2 for a description of the tools.)

3.2.1 Organizational Capacity

The assessment examined the organizational structure through group consensus using MECAT, which examined the existence of a DDSR-specific mission statement and stated objectives. DDSRS's mission is stated in a draft strategic plan that was being finalized at the time of the assessment and in annual plans of action. The mission statement, while in its draft form, has shaped and influenced DDSR M&E activities; however, the group's perception was that not all DDSR staff can quote the mission statement, although they likely can apply the spirit of the mission.

DDSR's values and ethics statements exist in draft form and are awaiting approval. Again, not all staff can quote the ethics and values statements; however, participants noted that DDSR staff apply the values in their day-to-day work because the values are extracted from the civil service charter that enjoins all civil servants. The participants noted that national-level staff should be able to state the values, ethics, and objectives, especially when performing supervision. Study participants commented on the importance of ethics and values statements in guiding DDSR to achieve its objectives. The mission statement and ethics and values statements were developed internally without external support.

According to the participants, DDSR has a comprehensive system that guides and directs overall workplan activities, including those related to M&E. In addition, DDSR has mechanisms, such as the quarterly reporting of activities for all units that summarize quarterly activities. Despite this, DDSR scored low in status because several elements, such as a mission statement and values and ethics statements, were in draft form, awaiting completion of the strategic plan. In addition, M&E meetings are held quarterly, rather than monthly, and meeting minutes are rarely taken. Figure 5 summarizes DDSR's capacity for organizational structure.
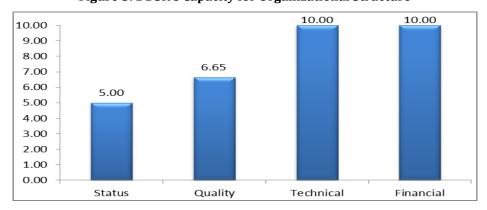
Figure 5: DDSR's Capacity for Organizational Structure

In summary, some of the identified capacity gaps in the organizational structure include weak internal communication, demonstrated by staff members' lack of comprehension of the values and ethics statements, absence of an M&E plan to guide DDRS M&E activities, and a lack of clarity on roles and responsibilities of M&E staff.

3.2.2   Human Capacity for Monitoring and Evaluation

DDSR develops capacity mainly through training at different levels of the health care system. It has a multisectoral surveillance and response coordination framework facilitated through various governance structures, such as a taskforce, the IDSR secretariat, technical working groups (TWG), and focal point officers at the national and formerly provincial and district levels (Nzioka, 2009).

Assessment group participants said the low scores in the status and quality dimensions result from a lack of capacity-building plans in key areas, such as organizational development, M&E, and data demand and information use, and a systematic analysis of gaps in these areas has not been undertaken. During an interview, a key informant summarized areas that need M&E capacity strengthening:

> *"… we need more capacity in M&E. There is need to restructure the M&E of the entire division. We need to diagnose and see where we are; we need proper coordination. We are very weak in coordination because when one is given work there is no job description…"* (KI 002, DDSR).

Figure 6 summarizes the overall DDRS scores for M&E capacity.
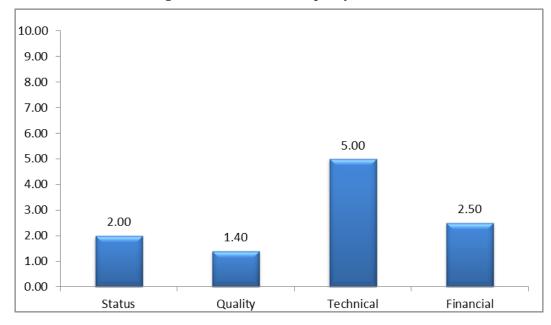
Figure 6: Current DDSR Capacity for M&E

Findings from the individual assessment tool agreed with those from the group assessment tool: DDSR M&E capacity is low. Some key personnel responsible for M&E at various units reported that they have varying capacities in key competencies and skills, such as data analysis, and can undertake data quality assessment tasks and offer recommendations for decision making based on health data. Figures 7 and 8 show scores in specific competencies and skills among M&E staff. The scores for data management were higher than other areas because staff responsible for M&E at DDSR are data managers. Despite these competencies, the need to strengthen M&E skills at DDSR was captured by a key informant who commented:

> *"… The M&E unit requires additional skills: We need data analysis manipulation and presenting skills. We are not able to do annual reports so we need report writing skills.*

We need additional staff like analytical staff with a biased towards statistics…"
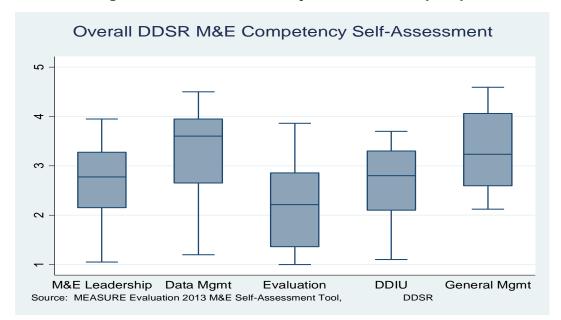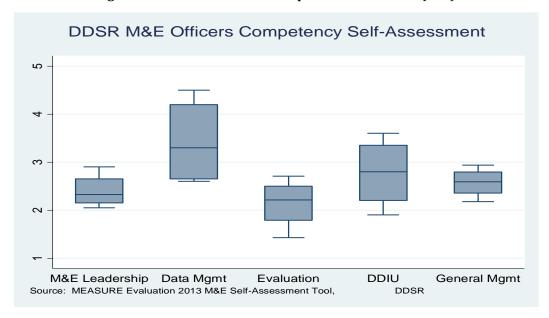(KI, 003 DDSR).

Figure 7: Overall DDSR M&E Competencies and Skills (n=12)

Figure 8: Overall DDSR M&E Competencies and Skills (n=5)

3.2.3 Capacity for Partnerships and Governance

Harnessing the synergies and resources from partners and stakeholders is critical for the implementation of M&E functions in DDSR. To achieve this, governance structures are required, such as TWGs at the national level, local leadership that coordinates stakeholders, and routine communication channels to facilitate exchange of information. According to the assessment group, DDSR's current capacity to coordinate partners involved in M&E is limited. This capacity is

compromised by the lack of a specific policy to support and coordinate M&E activities, a lack of clearly defined roles and responsibilities relating to M&E functions, and the absence of an M&E-specific TWG to bring partners together. In addition, clear terms of reference for the key governance structures do not exist.

Despite the limited capacity for partnership and governance, DDSR has several governance mechanisms. For example, it holds quarterly meetings that involve stakeholders from priority disease and program areas, such as polio, measles, and surveillance. In addition, DDSR shares communication products with stakeholders, such as a weekly epidemiological bulletin for sharing programmatic decisions; however, these mechanisms require some targeted strengthening, such as holding regular meetings and extending the range of information products and stakeholders. Figure 9 shows DDSR's capacity for partnership and governance.
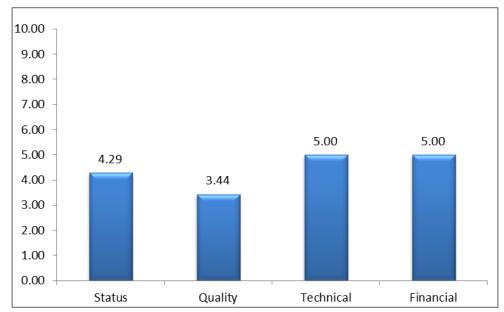
Figure 9: DDSR's Capacity for Partnership and Governance

3.2.4   Capacity in Relation to the National M&E Plan

DDSR has an M&E unit that coordinates the generation of information on trends in the 36 priority diseases from all health facilities in Kenya and triggers response in a disease outbreak. Discussions with key informants showed that the DDSR M&E unit was established in 2010, out of a need to monitor and evaluate division activities. The unit has three staff who work with five data managers in other units. The M&E unit provides support to other units in key areas, such as the development of data collection tools and limited data analysis. The M&E unit has the following key performance objectives:

- Assess the effectiveness of surveillance and response systems for timeliness, quality of information, preparedness, thresholds, case management, and overall performance and take action to correct problems and make improvements.
- Coordinate surveillance technical advisory meetings.
- Report and disseminate a weekly surveillance data bulletin by improving the data flow of surveillance information between and within levels of the health system.
- Collect quality data to guide epidemic preparedness for priority diseases.

- Provide standardized case definitions for all priority diseases and indicators.
- Improve the use of information to detect changes on time; conduct rapid response for suspect epidemics and outbreaks; evaluate the effect of interventions, such as declining incidence, spread, and case fatality; facilitate evidence-based response to public-health events; and improve health policy design, planning, and management.

The participants in the group assessment explained that the M&E unit is organized into smaller disease-specific structures that undertake M&E functions. Most established posts are filled, with defined roles and responsibilities that are specified in the roles and responsibilities section of the IDSR technical guidelines. The M&E unit is expected to hold meetings twice in a quarter, although this has not been achieved due to a busy schedule. Minutes are not taken regularly at the meetings and if they are, minutes are not regularly circulated to M&E unit members. Interviews with key informants indicated that the unit lacks clear M&E leadership, summarized by this informant:

> *"… since its inception in 2010 the M&E Unit runs on a trial and error basis. From inception to now, it has not changed much because 3 years is long enough to have a functional M&E unit at the division…" (KI 004, DDSR).*

Participants also said that although DDSR has over the years developed annual workplans (AWPs) that are aligned to the draft strategic plan, the current workplan does not have a monitoring plan complete with goals and objectives. Some M&E functions are, therefore, performed ad hoc, depending on what the M&E Unit perceives to be its responsibility, such as data quality audits (DQAs). The assessment group noted that no mechanisms exist at the DDSR level to track budgets, although it was clarified that such mechanisms exist at the MOH level but not at the division level following Government of Kenya procedures. DDSR appreciates the need to develop a system for tracking budgets (budgets, received, and actuals) and acknowledges this is an area that needs improvements to facilitate planning, budgets, and financial status of activities. Funding for M&E is inadequate; in the last financial year, for example, only 50% of the anticipated funds for M&E were received to support planned activities. Despite this, DDSR has clear guidelines that specify when information or reports need to be received and distributed. The self-assessment findings show that M&E staff members have the skills needed to carry out tasks to compile and process DDSR's information needs. M&E staff also are familiar with the reporting guidelines, but do not always adhere to them, especially the guidelines that specify timelines for receipt and transmission of information.

Data from the group assessment indicate that although DDSR lacks an M&E plan, M&E activities are linked to the multisectoral plans, including the MOH NHSP and the broader Vision 2030 Monitoring and Evaluation Framework. The current AWP identifies required M&E activities, responsible implementers, timelines, costs, and funding sources and links to the Government of Kenya MTEF. It usually is updated based on performance. Figure 10 shows DDSR scores on its capacity for the national M&E plan.

Figure 10: DDSR's Capacity for the national M&E plan

3.2.5 Capacity in Relation to the Costed M&E Annual Workplan

M&E-related activities under the current workplan have been costed, which indicates that the responsible parties have set implementation timeframes and identified funding sources. Staff have attempted to link the M&E workplan with the government MTEF by ensuring that activities are allocated and have specific timeframes for implementation and ensuring that periodic updates are made based on performance monitoring.

DDSR's inadequacies in this component are demonstrated by the finding that the division lacks dedicated resources to implement M&E activities. Several partners, including the World Bank, Japan International Cooperation, Centers for Disease Control and Prevention (CDC), Deutsche Gesellschaft für Internationale Zusammenarbeit, Strathmore University, and the African Medical and Research Foundation, among others, can provide resources if well mobilized. Figure 6 shows DDSR's the scores for capacity in costed annual workplans. Figure 11 shows DDSR's scores for a costed M&E annual workplan.
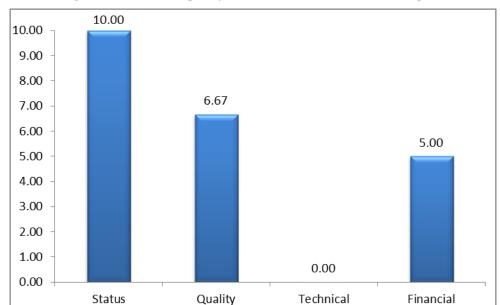
Figure 11: DDSR's Capacity for a Costed M&E Annual Workplan

3.2.6   Capacity for Advocacy, Communication, and Cultural Behavior

The assessment for this particular capacity area focused on the existence of champions who support M&E activities, a communication strategy that includes a specific M&E communication and advocacy plan, and specific references to M&E in the national strategic plan.

According to the group assessment, several champions support M&E at DDSR, including the program head, focal personnel and various unit heads, and data managers. These champions have expressed a need for specific M&E-related activities, including the introduction of and advocacy for novel technologies, including an electronic supervision tool, among others. DDSR has a functional communication center provided by support from the United Nations Children's Fund. The center focuses primarily on developing messages for health promotion. A focal person has responsibility for spearheading communication for DDSR; however, the division lacks a communication strategy. Instead, it has a risk communication manual that is also used by the Department of Health Promotion. In summary, although piecemeal strategies address communication needs for a specific situation, DDSR lacks a comprehensive communication strategy that can address division communication and advocacy for public health actions. Figure 12 shows DDSR's scores for advocacy, communication, and cultural behavior.

Figure 12: Current Capacity in Advocacy, Communication, and Cultural Behavior

3.2.7   Capacity for Routine Monitoring

Assessment questions for this particular area focused on the existence of tools and equipment for data management, existence of standard operating and reporting procedures at the facility level, and if tools capture essential indicators. Questions also explored if a system gap analysis has been undertaken and if findings are incorporated in the NHIS.

Document reviews indicated that DDSR uses an electronic reporting system to transmit data from health facilities to a central national database using various approval methods.[2] The data are collected using standard forms that are downloadable on a computer and smart phone, a process that takes approximately five minutes. Data from health facilities are transmitted through an unstructured mobile-based (short message system (SMS)to the districts. The data are collated by the district surveillance coordinator and transmitted to the national level through a web-based data capture system (Ope, 2010).

Figure 13 illustrates the data flow in the e-IDSR tool.

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[2] East Africa Public health Laboratories Networking Project. Status of e-reporting of surveillance data in the East African Community Assessment report. 2012.

Figure 13: Data Flow Through the e-idsr

This process of data transmission faces several challenges, especially on data quality. Group assessment participants expressed the need to develop a data collection strategy that stipulates routine procedures for data transfer from peripheral health facilities to the national level, and espouse the linkages to data use plans. A key informant noted similar challenges:

> *"...The facilities send data using phones or hard copy. But the challenge in this is there are many data entry errors. We need structured SMS as the current one is non-structured, people just key in what they feel is their priority..." (KI 003, DDSR)*

Participants in the group assessment reported that DDSR has the essential tools and equipment to facilitate data collection, management, transfer, analysis, and reporting (see Table 3). The IDSR technical guidelines describe the procedures for data collection, recording, collating, and reporting (MOPHS, 2012).

Table 3: IDSR Data Collection Tools

Form	Title
MoH 502	Integrated case-based surveillance form
MoH 503	IDSR health facility line listing form
MoH 504	IDSR monthly summary form
MoH 505	IDSR weekly epidemic monitoring form

DDSR's capacity for routine monitoring is hampered by several circumstances, particularly the occasional shortages experienced. For example, during the group assessment, informants commented that the Division experiences shortages in MOH Form 505. These shortages undermine the ability to undertake routine monitoring using standardized tools. In most cases, health facilities are forced to improvise, which could compromise the quality of data collected. Data from key informant interviews identified other challenges, such as some technological problems, especially when the web-based system is inaccessible when the division internet is unavailable. In addition, most personnel who collect data (health workers) are not computer literate (KI 002, DDSR).

Participants in the group assessment revealed that DDSR also faces challenges in training health workers on new or updated tools. DDSR plans to train health workers on how to use the revised tools. Other areas that require strengthening include development of tools for laboratory monitoring on new technical guidelines and updating the system to provide monthly summaries from weekly reports.

Ideally, DHIS is charged with the responsibility to collect, collate, analyze, publish, and disseminate health and management data and information to all stakeholders (public and private) for evidence-based decision making.[3] DDSR should create synergies with HMIS to facilitate capture of the necessary information from HIS and avoid duplication of effort. Although the vision of MoH is to develop a unified NHIS, participants in the group assessment revealed that DDSR remains reluctant to surrender its databases until certain conditions are met, including the availability of DHIS personnel to identify and troubleshoot when required and to ensure that the system is robust and capable of capturing weekly data. In the meantime, a link will be created to automatically pull data from DDSR. Based on the findings of this assessment, it is apparent that DDSR has capacity for routine monitoring. The IDSR technical guidelines have been instrumental in strengthening DDSR's

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[3] GoK, Health Information Systems Policy, Ministry of Health, 2011

capacity to undertake routine monitoring functions. These guidelines were developed with technical and financial support from partners, including WHO and CDC.

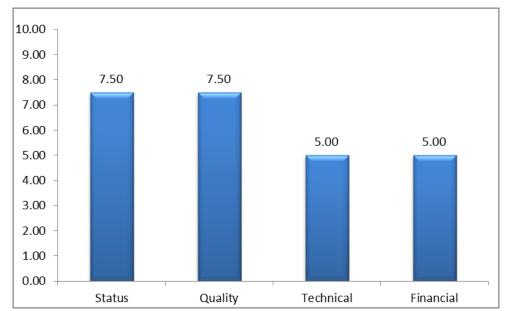Figure 14 shows DDSR's scores for routine monitoring.

Figure 14: DDSR's Capacity for Routine Monitoring

3.2.8   *Capacity for Surveys and Surveillance*

As part of its mandate to carry out active surveillance, DDSR is expected to undertake surveys and surveillance. The division has a fairly functional surveillance system, with activities and procedures that conform to international best practices according to WHO guidelines. Protocols for surveys and surveillance activities are always approved by the relevant bodies, and the relevant M&E stakeholders are involved in associated activities. Although participants in the group assessment reported that DDSR did not have an inventory of surveys and surveillance activities undertaken in the past, the division indicated that protocols for surveys and surveillance activities undertaken in the last year are available. A division-specific inventory that documents DDSR activities before populating it with partners is also required. The integrated disease surveillance system was adopted from WHO in 2006, and participants expressed a need for a systems gap analysis to identify gaps and areas for improvement.

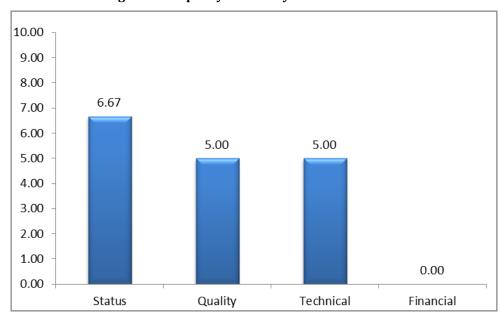Figure 15 shows scores for DDSR's capacity for surveys and surveillance.

Figure 15: Capacity for Surveys and Surveillance

3.2.9 Capacity of National and Subnational Databases

In this , the group assessment explored the existence of national databases to capture and store data, whether these databases capture all data elements, and if the necessary equipment and supplies to link data to the national and subnational databases are available.

Discussions with participants in the group assessment reported that while the databases maintained by DDSR can serve current needs, they do not capture all data elements required to monitor and evaluate various components of interest to the Division. For example, budget data are not captured in current databases, and they do not capture data on early warning systems or meteorological data, despite that being necessary for epidemic preparedness and response to various diseases of interest to DDSR.

Discussions with participants in the group assessment further showed that the databases at the subnational level lack hardware and the software to make them fully functional. In particular, the subnational level lacks adequate computers and personnel with IT skills to link the database and make them interoperable. The existing structures, mechanisms, and procedures for data capture, transmission, and merging present a unique opportunity that can be used to further strengthen the databases to support M&E functions.

As noted in Section 3.2.8, linkages between databases held by DDSR and those held by DHIS face several bottlenecks that range from poor quality to late transmission. For example, it was reported that although DDSR depends on weekly epidemiological data, DHIS can report these data only monthly. Despite the challenge of operating unlinked databases, DDSR can regularly generate reports on routine monitoring.

Figure 16 shows scores for DDSR's capacity for national and subnational databases.
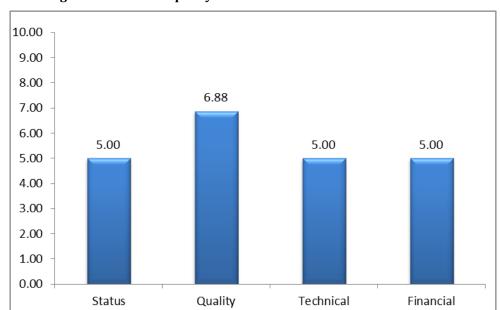
Figure 16: DDSR's Capacity for National and Subnational Databases

3.2.10   Capacity for Supervision and Auditing

The assessment explored the existence of DDSR guidelines and tools for supportive supervision and if they are used. The results show that DDSR has tools that were developed with support from WHO, but that these tools focused only on the Vaccine Preventable Diseases unit. Over the years DDSR has implemented several aspects of supportive supervision and data quality audits; for example, the Division can perform DQAs with minimal external support and marshal financial resources from the government for these audits. Ideally, DQAs are conducted quarterly, and reports are disseminated through the quarterly surveillance meeting that includes stakeholders at different levels (national and former provincial and district levels). Despite the high scores from the group assessment on financial autonomy, a key DDSR informant reported that the DQA for the last quarter did not take place last year due to the lack of resources.

DDSR relies on the IDS technical guidelines to direct its supportive supervision and feedback activities; however DDSR faces some challenges in supportive supervision. First, the guidelines are incomplete and require updating to incorporate a component on feedback and action plan. Second, most of the supportive supervision activities focus on a few aspects, such as data quality, despite the fact that the tool is integrated. Third, a policy that merges all different aspects of the audit and supportive supervision is needed.

The quality dimension scored slightly low compared with the rest of the dimensions because the supportive supervision guidelines did not include all the relevant aspects and components, such as a feedback and action plan. In addition, the score was affected by the fact that, in most cases, supportive supervision focused only on certain aspects, such as data quality, and not all other components. Figure 17 shows scores for DDSR's capacity for supervision and auditing.
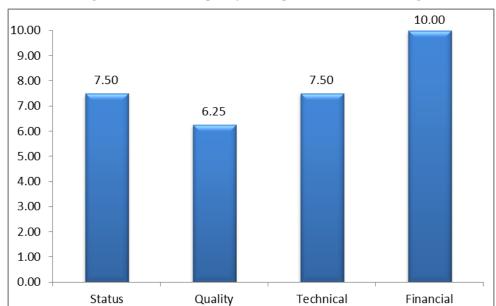
Figure 17: DDSR's Capacity for Supervision and Auditing

3.2.11   Capacity for Evaluation and Research

According to participants in the group assessment, DDSR's capacity to undertake research and evaluation is very low, and the division scored a zero in all the elements. This finding is supported by the low scores that were reported under the competence for research and evaluation in the individual assessment. Although the DDSR M&E unit has been functioning, the focus has not been on evaluation and research activities. That said, the M&E unit has a research responsibility that requires staff to work with partners to achieve this purpose. Key informant interviews reported that some units, such as VPD, have undertaken several studies in collaboration with partners, such as CDC and WHO, mainly focusing on topics of interest to DDSR.

Research responsibilities often are articulated in the annual workplan, but they are not documented clearly in a specific research agenda. Group assessment participants noted that for DDSR to harness the benefits associated with research and evaluation, the division must develop an evaluation and research agenda that corresponds to its stated mandate and aligns to the national agenda where appropriate. Part of the process for building this capacity will involve stakeholder mapping to develop an inventory of major institutions that carry out research and evaluation locally, and subsequently compile a database of completed country-specific studies relevant to DDSR, and develop a mechanism, such as a TWG, to coordinate stakeholders and develop a national forum for dissemination and discussion of research and evaluation findings relevant to the work of the division.

3.2.12   Capacity for Data Demand and Use

The assessment of this component explored DDSR's capacity for data use and demand. It examined the existence of a national data use plan, whether DDSR disseminated its information products to stakeholders, and the availability of data and presentation guidelines. It also examined quality aspects of a data use plan, dissemination of information products, and data analysis and presentation guidelines.

The group assessment findings showed that DDSR lacked a data demand and use plan, and that guidelines for data analysis and presentation mainly were adapted from the technical guidelines and are not comprehensive enough. Despite the lack of a data demand and use plan, participants reported that DDSR produces a variety of information products, such as bulletins and policy briefs, that are shared with stakeholders. One key informant said several dissemination strategies are used:

> *"…We have a website, which is our means of dissemination. We also have been using emails to disseminate to partners etc. On the website you will find the bulletins also. Our website is www.ddsr.or.ke. The web is still under development though it is functional…" (KI 002, DDSR)*

These information products have contributed to influencing policy and practice in various ways, and DDSR often disseminates these information products without relying on external financial support. Figure 18 shows DDSR's capacity for data demand and use.
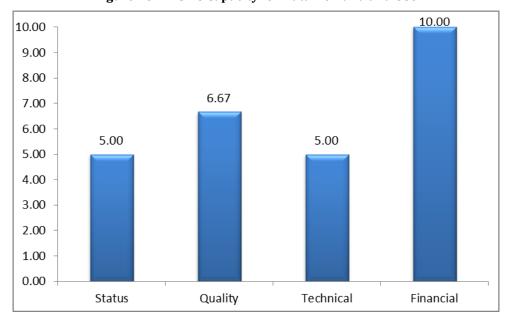
Figure 18: DDSR's Capacity for Data Demand and Use

3.3 SUMMARY OF IDENTIFIED CAPACITY GAPS AND SUGGESTED ACTION PLANS

Table 4 lists gaps identified in the baseline assessment gaps and suggested action plans.

Table 3: Summary of Identified DDSR Capacity Gaps and Suggested Action Plans

Capacity Area	Identified Weaknesses or Gaps	Action to be Taken
Organization	Values and Ethics statement, internal communication not robust, irregular M&E meetings, terms of reference and terms and responsibilities unclear or not well defined	Induct staff to the values and ethics statements, especially new staff Define TORS and roles and responsibilities Develop program management skills and competencies Finalize and disseminate the strategic plan
Human capacity for M&E	Lack of human capacity building plan for Organizational Development, DDU, and validated M&E curriculum; no mechanism to coordinate M&E CB plan; inadequate staff numbers, skills, and competencies for M&E; human capacity for M&E not fully developed	Develop CB plans around OD, DDU, and M&E and an overall human-capacity building plan
Partnership and Governance	Strategic plan to support M&E performance is in draft form; no SOPs to define M&E roles and responsibilities, although some might be subsumed in the DDSR technical guidelines; no national M&E TWG; M&E not discussed as standing agenda in other program areas; no updated inventory of stakeholders for M&E	Develop SOPs Start an M&E TWG Undertake stakeholder mapping of DDSR M&E and develop inventory
National M&E Plan	Budgetary constraints for M&E activities; no M&E plan for DDSR; incomplete M&E system assessment	Advocacy for M&E budget Develop M&E plan Undertake a system gap analysis (e.g., data, data flow)
Annual Costed M&E Workplan	Inadequate budget for M&E	Mobilize and commit resources
ACCB	Few M&E champions; communication strategy still in draft; not all M&E issues strategies and products in the national strategic plan	Identify more M&E champions Update or finalize communication strategy Update strategic plan with M&E as a central area that needs to be better addressed and articulated
Routine Monitoring	Unavailability of tools, such as MOH 505, especially at lower facilities; capacity building lacking around new MOH 505; tools are not updated (e.g., electronic tool captures only 11 of 22 diseases; lack of ICT equipment; lack of integration of DDSR system with NHIS and DHIS-2	Print additional Form MOH 505 Build capacity required for new or revised Form MOH 505 Work with partners to link IDSR with NHIS and DHS-2 through a stakeholders meeting

Capacity Area	Identified Weaknesses or Gaps	Action to be Taken
Surveys and Surveillance	No survey and surveillance inventory; routine surveillance system has challenges, such as resources, data quality, and timeliness	Develop surveys and surveillance inventory Mobilize resources for the surveillance system Work on data quality and timeliness issues
National and Subnational Databases	National database does not capture all data and information required for full program monitoring and evaluation; lack of skills and ICT infrastructure; lack of system linkages with other national databases, such as NHIS 502 and line-listing (503); databases don't capture these, just Form MOH 505	Develop a comprehensive list of indicators and data elements required for program M&E
Supervision and Auditing	Guidelines for supportive supervision captured in DDSR technical guidelines, but not everything (e.g., feedback and action plan); DQA sections of the technical guidelines not comprehensive and staff add ad hoc tools to capture DQ issues; lack of adequate resources for SS	Review and update TWGs and develop guidelines for SS, including missing elements, Mobilize resources for SS and DQA
Evaluation & Research	No inventory of research and evaluation; no division-specific research agenda; no national forum	Develop evaluation and research inventory Develop DDSR research agenda and hold first national forum
DDU	No DDSR data use plan; data analysis and presentation part of the technical guidelines not comprehensive; limited capacity in data and information packaging	Review and update TWGs and develop guidelines for data use, analysis, and presentation Train M&E staff on data analysis and presentation skills Build skills in data and information packaging

CHAPTER 4: DISCUSSION AND RECOMMENDATIONS

4.1 DISCUSSION

Results from the baseline assessment of DDSR's capacity to perform its M&E functions shows that several opportunities are available to strengthen the division's overall ability to collect and use data for decision making. Most performance areas that are critical for establishing organizational, technical, and behavioral capacity need to be strengthened to achieve DDSR's M&E objectives. The ongoing finalization of the strategic plan and the commitment by the senior management presents key opportunities to address the gaps discussed in Chapter 3.

DDSR's ability to undertake its M&E responsibilities is hampered by several challenges, such as lack of an M&E plan and governance mechanisms that call on support from partnerships, policies to support human resources development, and other organizational development aspects. In addition, linkages of databases, below optimal supervision and auditing, limited capacity for research, evaluation, and data hamper the program.

These weakness and challenges affect DDSR's technical, organizational, and behavioral capacity, but the underlying complexity of its disease-focused program requires a larger systems approach to strengthen its capacity. The following paragraphs summarize actions needed to address the capacity gaps from a systems perspective.

Strengthen organizational capacity to support M&E. Policies and rules guide DDSR short- and long-term plans and strategies that, in turn, direct division activities. Of paramount importance is finalization of the division's strategic plan, the entry point to establish DDSR's vision, mission, and values that should govern DDSR activities and provide the impetus for establishing staff, building partnerships, and creating governance mechanisms, such as technical working groups, to spearhead M&E, operations-research, and data use strategies. Human resources M&E capacity requires strengthening policies that define preferred staffing needs to fulfill DDSR's mission and objectives. Weaknesses in planning human capacity for Organizational Development and DDU and the lack of mechanisms to coordinate M&E capacity building are symptoms of a weak organizational capacity.

Develop governance structures and mechanisms for M&E. Establishing the rules, principles, norms, and governance structures is essential to shape the overall system design and determine system behavior. A basic starting point is to establish structures, such as TWGs, to coordinate the division and bring in stakeholders to embed M&E principles in monitoring, evaluation and operations research.

Provide leadership and mentorship for M&E. Leadership skills are needed for advocacy and resource mobilization for M&E activities to galvanize internal and external support for M&E and champion the use of M&E data for programmatic decision making. Limited budgetary support is an underlying cause that affects various capacity areas.

Develop skills to undertake M&E functions. Knowledge and skills are vital for DDSR staff to carry out M&E functions. Support is needed for increased knowledge and skills development in data analysis, presentations, data dissemination, database management at county levels, and development of information products. Several staff members tasked with M&E responsibilities have skills in some of these areas: M&E staff and data managers undertake preliminary data analyses and

produce various information products, such as a weekly epidemiological bulletin, and they monitor district data reports every Wednesday; however, these competencies need to be strengthened.

4.2 RECOMMENDATIONS FOR INTERVENTION

Based on the findings from this baseline assessment, the following recommendations address DDSR's identified capacity gaps:

Strengthen organizational capacity to support M&E:
- Finalize and launch the DDSR strategic plan.
- Develop an M&E plan.
- Develop a coherent, cross-cutting communication strategy that addresses all issues of disease surveillance and response.

Develop M&E governance structures and mechanisms:
- Establish and institutionalize national TWGs to coordinate M&E activities and operations research.
- Undertake high-level advocacy and resource mobilization to address the limited capacity for technical and financial independence and promote sustainability of the strengthened capacity.

Provide leadership and mentorship for M&E capacity:
- Promote stakeholder engagement on technical aspects of disease surveillance to avoid duplication and facilitate DDSR's ability to capture data on a range of diseases.
- Undertake stakeholder discussions on DHIS to develop synergies that strengthen routine monitoring functions.
- Develop an evaluation and research agenda that correspond to DDSR's stated mandate and align it to the national agenda where appropriate.
- Develop a surveys and surveillance inventory to strengthen partnerships and stakeholder engagement.
- Support regular quarterly review meetings to assess progress and provide opportunities for program improvements.
- Hold regular M&E review meetings to discuss accomplishments, oversights, and activities that need to be undertaken.

Develop M&E skills:
- Strengthen skills and capacity for advanced data analysis, including qualitative data and presentation skills among M&E officers.
- Update or develop a policy on data quality audits that stipulates procedures for undertaking audits across all diseases of interest to DDSR; broaden DDSR's focus beyond vaccine preventable diseases.
- Conduct a detailed analysis of program data needs and map data users to strengthen data demand and use capabilities; develop data use plans.
- Undertake an IDSR systems gap analysis to facilitate linkages between databases and development of a comprehensive list of indicators and data elements required to monitor and evaluation DDSR activities.

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