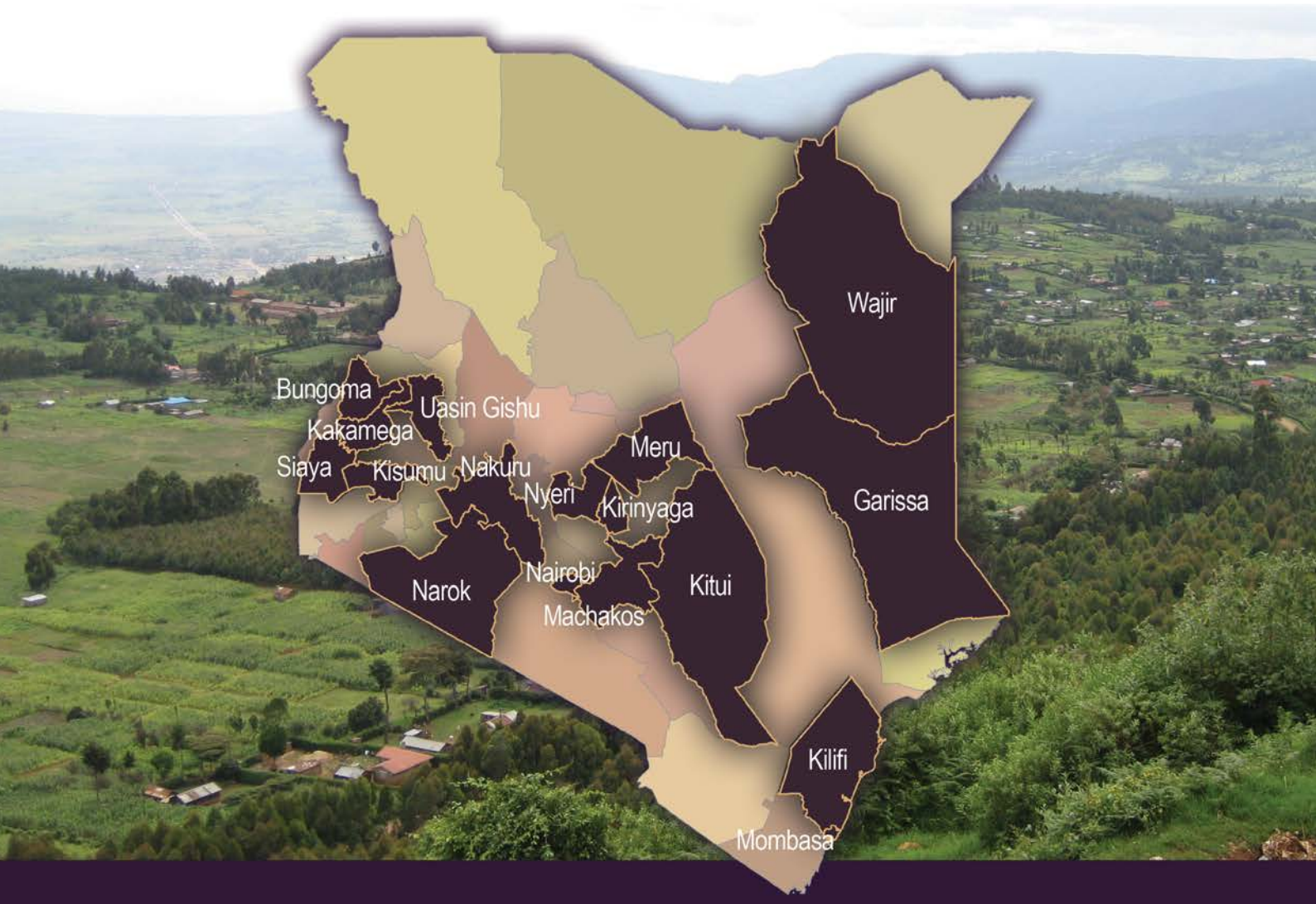

Baseline Assessment of Monitoring and Evaluation Capacities in 17 Counties in Kenya

April 2015

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MEASURE Evaluation PIMA

Baseline Assessment of **Monitoring** and **Evaluation Capacities** in **17 Counties** in **Kenya**

April 2015

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ABBREVIATIONS

AWP	annual work plan
CHMT	county health management team
CIDP	county integrated development plan
CSO	civil society organisation
DDU	data demand and use
DQA	data quality assurance
HIS	health information system
HMIS	health management information system
HRIOs	health records information officers
ICT	information and communication technology
IDSR	integrated disease surveillance and response
KHP	Kenya Health Policy
KII	key informant interview
M&E	monitoring and evaluation
MEASURE	Monitoring and Evaluation to Assess and Use Results
MOH	Ministry of Health
NHSSP	national health sector strategic plan
OCI	organisational capacity index
SOP	standard operating procedure
SP	strategic plan
TB	tuberculosis
TWG	technical working group
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development

CONTENTS

TABLES 8
FIGURES 8
EXECUTIVE SUMMARY 9
CHAPTER 1. INTRODUCTION 14
1.1 Background and Context 14
1.2 Policy Context of the Assessment 14
1.3 Health Governance Structures 15
1.4 Rationale for the Assessment 17
CHAPTER 2. METHODS 18
2.1 Study Population and Sampling 18
2.2 Study Procedures 18
2.3 Data Management 23
2.3.1 Data Storage 23
2.3.2 Data Analysis 23
2.4 Ethical Considerations 24
CHAPTER 3. RESULTS 25
3.1 Overall Organisational Capacity Index 25
3.2 Key Findings from Each Capacity Area 25
3.2.1 Capacity Area 1: Organisational Structure 26
3.2.2 Capacity Area 2: Human Capacity for M&E 27
3.2.3 Capacity Area 3: Partnerships and Governance 28
3.2.4 Capacity Area 4: County M&E Plan 28
3.2.5 Capacity Area 5: Annual Costed M&E Work Plan 29
3.2.6 Capacity Area 6: Advocacy, Communication, Culture, and Behaviour 29
3.2.7 Capacity Area 7: Routine Monitoring 30
3.2.8 Capacity Area 8: Surveys and Surveillance 30
3.2.9 Capacity Area 9: County and Subcounty Databases 31
3.2.10 Capacity Area 10: Supervision and Auditing 31
3.2.11 Capacity Area 11: Evaluation and Research 31
3.2.12 Capacity Area 12: Data Demand and Use 31
3.3 Mainstreaming Gender in M&E at the County Level 32
3.4 Summary of Key Findings 34
CHAPTER 4. DISCUSSION, CONCLUSION, AND RECOMMENDATIONS 35
4.1 Discussion 35
4.2. Conclusion 36
4.3 Recommendations 37
REFERENCES 38
SUMMARY OF COUNTY-SPECIFIC M&E CAPACITY STATUS 39

TABLES

Table 1. Roles and responsibilities of county-level units 16
Table 2. Capacity areas assessed by the group assessment tool 20
Table 3. Period of assessment across all counties 22
Table 4. Summary of methods, targets, and data collection tools used to meet assessment objectives 23
Table 5. Summary of gender issues in the group assessment 33

FIGURES

Figure 1. Overarching planning and review framework 15
Figure 2. Summary of overall capacity scores in 17 counties 25
Figure 3. Human capacity scores from individual assessment 27

EXECUTIVE SUMMARY

Background

The Kenya Health Policy Framework of 2012–2030 provides direction and outlines long-term goals towards the fulfilment of the 2010 Kenyan Constitution and Vision 2030, the country's long-term development agenda. Effective implementation of the health policy strategies requires a robust monitoring and evaluation (M&E) framework to provide evidence for the achievement of the policy objectives. Currently, national and county governments are responsible for performance monitoring of the health sector. The role of counties in service delivery requires them to have adequate and effective M&E systems to assess progress towards achieving the sector's objectives and targets.

This report is a summary of assessments that were conducted with the goal of understanding and documenting the capacities of county health management teams (CHMTs). Specifically, they assessed the CHMTs' capacities to perform M&E functions, identify capacity gaps, and determine the most effective ways to build the county's capacity for M&E of health interventions.

The assessment was conducted in 17 counties: Kakamega, Bungoma, Garissa, Nakuru, Machakos, Kirinyaga, Kilifi, Kisumu, Nyeri, Siaya, Wajir, Uasin Gishu, Narok, Nairobi, Meru, Mombasa and Kitui. The MEASURE Evaluation PIMA (MEval-PIMA) project, funded by the U.S. Agency for International Development (USAID), conducted the assessment between March and June 2014.

Methods

The assessment focused on the CHMT as an organisational unit. Data were collected by the MEval-PIMA team using a mixed-methods approach. Primary data were collected from key programme managers, M&E personnel, thematic focal persons, and selected stakeholders that provide technical assistance to the counties. Primary data collection involved key informant interviews (KIIs) and group and individual assessment tools. Secondary data collection was conducted through desk reviews of existing policies, to discover current gaps in capacity.

MEASURE Evaluation PIMA developed a generic data collection tool that captures three dimensions of capacity: organisational, technical, and behavioural. The team developed group and individual assessment tools in Excel to manage quantitative data. Quantitative data from the group and individual assessment tools were analysed using simple scores from each question and overall scores for each competency or component, displayed in easy-to-interpret dashboards. Scoring was based on group consensus for the group tool and perceived score for the individual tool. Overall competency scores were displayed using simple descriptive statistics. An organisational capacity index (OCI) was computed to illustrate the existing capacity for M&E, including organisational, technical, and behavioural aspects. The final scores on the OCI were calculated by adding actual scores under each capacity area, divided by the maximum score. Qualitative data were categorised using a thematic framework and analysed using NVivo 10.

Key Findings

Across all counties, the OCI scores were generally low, with only seven out of the seventeen counties scoring about a third. The largest OCIs were recorded in Kilifi (47.2), Garissa (40.7), Kirinyaga (39.8), Siaya (38.3), and Kakamega (37.7). The lowest OCI scores were recorded in Kitui (12.7) and Wajir (14.8). The relatively high OCI scores in Kilifi, Garissa, Kirinyaga, Siaya, and Kakamega counties were largely due to stronger organisational dimensions that support M&E, such as an overarching health sector strategic plan (SP), dedicated M&E units, and work plans to implement the sector strategy. Overall, a higher OCI score was explained by the existence of structures, guidelines, and a supportive policy environment in key capacity areas that encourage M&E.

Key findings in each capacity area are outlined below:

1. *Organisational structure*: Nearly all counties did not have completed SPs; most of these were in draft format, and others were finalised and awaiting launch. Out of the 17 counties, only five had set up explicit units or structures to address functions relating to M&E. The individual-based assessment among county-level health workers tasked with carrying out M&E functions showed that they were not well prepared to handle M&E functions in most counties. In most cases, respondents were found to have basic knowledge and skills in data management but required additional technical expertise in specific areas to effectively manage the units. Overall, CHMT members noted that M&E responsibilities are not clearly defined in job descriptions. A key factor was that the revised Scheme of Service for Community Health Services Personnel does not identify M&E as a distinct cadre with separate job requirements.
2. *Human capacity*: No county reported a clearly defined skills set for personnel tasked with leading the execution of M&E functions, nor did any report the availability of workforce development plans, perhaps due to limited planning at the policy level. As a result, most counties did not have either plans for capacity building in place or budgetary allocations for it. For staff supporting M&E activities, individual competency assessments found higher scores for general management and M&E leadership; their lowest scores were in evaluation and data analysis and use.
3. *Partnership and governance*: Group assessments across the counties indicated that the capacity to coordinate among partners and stakeholders at the county level is limited. The biggest challenges are 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-coordination mechanism to bring partners together. In addition, clear terms of reference for these key governance structures did not exist. Most counties did not have a separate M&E policy and often relied on the health management information system (HMIS) policy instead, which has implications for M&E. Even in the few counties that had M&E technical working groups (TWGs), they were largely in their formative stages. An additional weakness related to partnership and governance was the absence of stakeholder inventories that detail the actors or stakeholders working at the county level.
4. *County M&E plans*: Although most counties did not have M&E plans, many of them had completed the development of the county integrated development plan (CIDP) in order to comply with a legal requirement that makes it a prerequisite to access funding from national government. Some of the CIDPs included an M&E component.
5. *Annual costed M&E work plan*: Since counties did not have M&E plans, due to delays in the completion of health strategic plans, an in-depth examination of the activities and budget allocations was not possible. Despite the lack of dedicated plans, counties had more general annual work plans that outlined M&E-related activities.

6. *Advocacy, communication, culture, and behaviour*: Advocacy for M&E appears to be largely absent from all the counties covered by this report for a number of reasons. First, the systems are not yet fully developed. Second, the institutional memory has not embraced the concept of advocacy for data and its use in decision making. Although there were reports that senior health department leadership supported M&E at the county level, these were not backed by policy documents.

7. *Routine monitoring*: Most counties reported having access to clearly defined mechanisms to guide data collection, transfer, and reporting, as well as the necessary tools for data collection. In most cases, the strategy and tools referenced had been developed at the national level, then adopted and implemented at the county level. However, the mechanism for guiding data collection, management, and transfer was not necessarily county-driven but rather was often dependent on support from nongovernmental stakeholders. Counties had challenges related to reporting in a timely manner or adhering to nationally prescribed performance reviews and planning cycles.

8. *Surveys and surveillance*: Most of the sites scored relatively high in dimensions related to quality. These results were based on an existing infrastructure for and culture of surveillance, the legacy of a disease-specific focus on the part of the government and its partners. Most counties have an up-to-date database for ongoing surveillance activities in the county but none for surveys conducted. Nor is there any functional repository of all protocols that are implemented at the county level. Existing surveillance data is used, at times, but it largely focuses on communicable diseases, and local use is limited by a lack of coordination with the county.

9. *County and subcounty databases*: All the counties reported having databases that were linked to national-level databases for data aggregation. The databases are not largely designed to respond to the decision making and reporting needs of county actors. This is partly because there is a disconnect between different databases, which makes it difficult to easily utilise data from various data sets, or even move between data sets, to allow comprehensive syntheses. In addition, there are challenges in terms of timing when information is updated for each database. Facilities and lower-level management often submitted data late because health information officers lacked support to upload data and had inadequate equipment. Inaccurate or incomplete data entries were associated with heavy workloads, and individuals were responsible for too many tools with different demands for various data needs.

10. *Supervision and auditing*: All counties reported the existence of supervision guidelines to support routine data collection at the facility level. However**,** these guidelines are developed by the national government, although supervision is the responsibility of the county government. One weak area uncovered by this assessment was that CHMTs lacked policy and guidance on conducting data quality audits. Even where such guidance was available, members of the CHMT reported lack of financial resources to undertake data quality audits as expected.

11. *Evaluation and research*: This capacity area received the lowest score, and there were no county-specific research agendas. In one county, where a draft research agenda was being developed, discussions were in the consultation stage for designing research tools, and every programme was required to come up with areas of interest. In some counties there is a budget line for research, but since there is no research agenda, use of these funds is likely to be limited. In counties where research partners are active, these partners hosted forums and otherwise disseminated research findings. Even then, there was no follow-up by the county to find out if the results of the research had an effect on policy.

12. *Data demand and use*: Across all counties, there were no data-use strategies in place, with some counties a data-use approach guided only by the SP or draft M&E work plans. Participants suggested an assessment to find out the users' needs before developing a data-use plan. Some observed that data generated from supportive supervision processes and data quality assessments did not lead to effective programmes, because data demand and use lag behind; this is partly due to the lack of a culture of evidence-informed decision making and partly to a systematic feedback

process that involves both data users and data producers. In some instances, no supportive supervision has been conducted since devolution, and in cases where it has been tried, participants report that it was not conducted correctly. In general, dissemination of information products is not clearly defined. This means that the products are unlikely to be used for strategic decisions. However, partners do push for dissemination of their project-specific information. At the community level, dissemination occurs during dialogue days, which only take place if a partner supports them.

Key Recommendations

There are several specific capacity-building areas that can be implemented in the short term:

- Update and train core M&E staff—and train those who are recruited for M&E roles on how to align M&E activities to the existing SPs.
- Support counties that have not developed costed M&E work plans, and various guidelines relevant to M&E, and build their capacity to develop comprehensive work plans that are attuned to annual work plans and the overall SP.
- Help counties to adequately adapt M&E policies to the local context (e.g., on how the current health information system (HIS) policies align with local realities).
- Provide support for counties to develop their own research agendas and incorporate this in the SP and work plans. This will go hand in hand with supporting the use of routine surveillance and research data.
- Encourage counties to develop an advocacy agenda for M&E that will help provide visibility. This can help counties develop a culture of data demand and use. Focus advocacy agendas on measurable and achievable outcomes.
- Key areas of advocacy could be the following:
    i. Budget allocation for M&E
    ii. Identifying and building the capacity of M&E champions to advocate for M&E activities
    iii. Adequacy of M&E staff
    iv. Use of data and creation of data demand and use at the county level by all actors
    v. Gender mainstreaming in M&E to increase the capacity of staff to understand the importance of gender and how it applies to M&E (e.g., through M&E plans, sex-disaggregated data analysis and use, and capacity building)

There may be a need to provide support for counties to review M&E structures currently being created, focusing on how they will promote data demand and use. Immediate core activities may include the following:

- Review potential harmonisation of existing databases, and examine how the architecture can interact, including timing of data entry, submissions, and utility of data
- Review and include indicators that are sex-disaggregated and gender-sensitive, when appropriate
- Advocate for a county-specific TWG, where necessary, to support advocacy and provide avenues for partnership and governance

Conclusion

This assessment indicates that counties have made progress in several areas important to the establishment of structures that support M&E activities in the health sector. However, there are several gaps in the development of effective infrastructures for data demand and use. To be relevant, capacity building will need be done with an awareness of the different baseline capacities in different counties. Further analyses need to be completed before support can be provided for gender mainstreaming activities in M&E. Although they are ongoing, capacity-building activities bear fruit over time and patience will be required for the culture of data demand and use and evidence-informed decision making to take root.

Chapter 1

INTRODUCTION

1.1 Background and Context

This report synthesises individual assessments undertaken to understand and document the capacity of the CHMTs to perform M&E functions in 17 counties: Kakamega, Bungoma, Garissa, Nakuru, Machakos, Kirinyaga, Kilifi, Kisumu, Nyeri, Siaya, Wajir, Uasin Gishu, Narok, Nairobi, Meru, Mombasa, and Kitui. This larger assessment was part of efforts to improve M&E systems across the 17 counties. It was implemented by the MEASURE Evaluation PIMA project between March and June 2014.

1.2 Policy Context of the Assessment

In the last decade, Kenya's health policy was guided by the Kenya Health Policy (KHP) of 1994–2010, which aimed to promote and improve the health of all Kenyans through restructuring the health sector to make health services more effective, accessible, and affordable [1]. The policy was implemented through two National Health Sector Strategic Plans (NHSSPs): NHSSP I: 1999–2004 and NHSSP II 2005–2010 and the current KHSSP III [2]. Currently, three key documents guide the Kenya health sector policy:

i. *Vision 2030* provides the overall strategic long-term national development agenda aimed to transform Kenya into a globally competitive and prosperous industrialised middle-income country by 2030. Health is one of Vision 2030's social pillars that supports a healthy and skilled workforce necessary to drive the economy.

ii. *The Constitution of Kenya 2010* provides the overarching legal framework for ensuring a comprehensive and people-driven health service delivery. It seeks to ensure a rights-based approach to the delivery of health services and introduces a devolved system of governance to enhance access to services by all Kenyans.

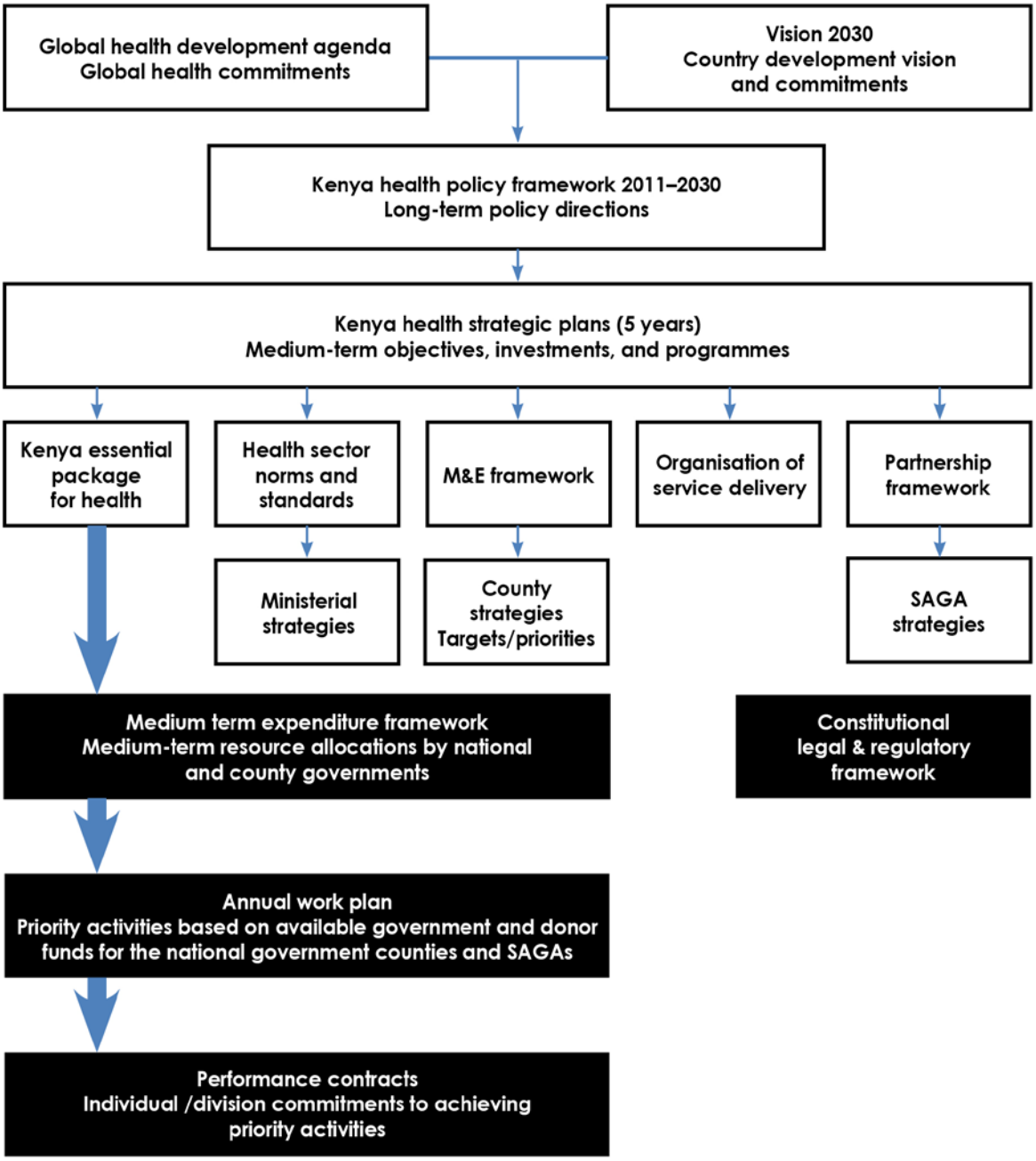
iii. *Kenya Health Policy (2014–2030)* provides policy direction and the long-term health sector goals that the country intends to achieve towards the fulfilment of the Constitution. It aims to improve the overall health status in Kenya, in line with Vision 2030.

The KHP 2014–2030 recognises the organisation of the healthcare system into the two tiers of governance—the national and county governments—as envisaged in the 2010 Constitution. It outlines seven orientations[1] organised around the health system building blocks, namely: health financing, leadership, health products and technologies, health information, workforce, service delivery system, and infrastructure. The purpose of the orientations is to influence policy objectives and provide an overarching goal. Figure 1 provides a schematic illustration of the relationship between the broad country development strategies, the health sector policy framework, and the planning cycles at all levels of care.

Effective implementation of the KHP 2014–2030 requires a robust M&E framework to provide evidence for the achievement of the policy objectives. However, the current health sector M&E system is characterised by disjointed activities, with no structures or framework for coordination. It consists of numerous programme-specific or disease-based M&E systems that operate separately and do not share information with each other, and systems that rarely satisfy the information needs of the government and the health sector as a whole [7]. The recent development of an M&E framework is a response to the need to have a unified approach to monitoring programmatic and sector performance. The framework will act as a management and governance tool to improve efficiency, transparency, and accountability at all levels, including service delivery at the county level.

[1] This refers to how the health sector will organise itself to facilitate achievement of policy objectives.

Figure 1. Overarching planning and review framework



Source: Government of Kenya. 2014. Kenya Health Policy 2014–2030: Towards Attaining the Highest Standard of Health. Nairobi: Government of Kenya, Ministry of Health.

1.3 Health Governance Structures

The Constitution of Kenya 2010 establishes three classifications for government functions that involve one or both of the two levels of government. The first classification includes functions exclusive to one level of government according to Schedule 4 of the Constitution.[2] The second is concurrent functions that are assigned to both levels of government, in which case those functions are performed

[2] The constitution of Kenya comprises a preamble, 18 chapters, and six schedules. The fourth schedule describes the functions of national and county governments.

collaboratively by both governments. The final classification covers the residual functions not expressly mentioned in Schedule 4 that are assigned to the national government [8]. M&E functions are examples of concurrent functions that are implemented by both levels of government.

The senior management at the national level comprises five directorates of health that oversee strategic policy and set priorities. The Curative and Rehabilitative Services Directorate is tasked with policy formulation and the implementation of curative and rehabilitative services, and the Preventive and Promotive Services Directorate focuses on preventive strategic issues as well as policy formulation. The Standards and Quality Assurance Directorate develops policies and oversees implementation of standards and quality in the health sector. The Policy, Strategy, and International Health Directorate coordinates policy and strategic development for the Ministry of Health (MOH), while the Directorate of Administration and Finance oversees support services to complement health-related technical activities. M&E and the HMIS are the functions under the directorate of Policy, Strategy, and International Health. Currently, the HIS houses the M&E functions at the national level. This organisational approach is mirrored at the county level.

The CHMT manages healthcare at the county level. Its key roles include the following: providing leadership and stewardship for overall health management; providing strategic and operational planning; M&E of health services; providing linkages with the national MOH; collaborating with state and non-state stakeholders at the county level and between counties on health services; mobilising resources for county health services; establishing mechanisms for the referral function within and between the counties, as well as between the different levels of the health system in line with the sector referral strategy; coordinating and collaborating through county health stakeholder forums composed of county health management boards, faith-based organisations, nongovernmental organisations, civil society organisations (CSOs), and development partners; and supervising county health services.

Table 1. Roles and responsibilities of county-level units

Units	Policy implementation responsibiities	Constitutional functions	Constituent subunits
Disease prevention and health promotion	• Eliminate communicable conditions •Minimize exposure to health risk factors	•Promotion of primary health care •License and control undertakings that sell food to the public •Refuse removal; refuse dumps and solid waste disposal	•Child health •HIV, tuberculosis (TB), and malaria •Health promotion •Neglected disease management •Hygiene control -Community services
Curative services and rehabilitation	•Halt and reverse the rising burden of non-communicable conditions •Provision of essential health services •Reducing the burden of violence and injuries	•Ambulance services •Management of health facilities and pharmacies •Cemeteries; funeral parlors and crematoria	•Maternal health •Blood safety •Laboratory services - Pharmaceutical services •Nursing services
Planning and monitoring	•Organization and management of health service delivery •Strengthening collaboration with health-related sectors		•Health planning •Sector coordination •Health information

M&E is supposed to be the responsibility of planning and monitoring units at the county level (see Table 1), but these units lack clear structures and roles. This absence can be traced to the county health strategic plans. The KHP 2014–2030 recognises that an HIS can do more than collect health service

data and convey it to higher levels of the healthcare system. The core focus of HIS is facilitating evidence-informed decision making at all levels, especially at the point of collection [9]. However, Kenya's HIS is largely equated with an M&E system, a misconception that is likely to discourage investments in a comprehensive M&E system.

1.4 Rationale for the Assessment

Performance monitoring of the health sector is the responsibility of the national and county health sectors. The latter's role in service delivery requires that counties have adequate and effective M&E systems to assess progress made towards achieving the sector's objectives and targets. The overall aim of the baseline assessment was, therefore, to assess current capacity in M&E performance, to identify capacity gaps, and to determine the most appropriate interventions that can build the county's M&E capacity to monitor and evaluate implementation of health interventions. Specifically, the aims of the assessment were to:

- Understand, document, and clarify performance objectives for programme-level M&E
- Determine the current status of performance in the county's M&E functional areas
- Identify gaps in the county's capacity to meet performance objectives
- Develop action plans for counties to address the identified gaps and areas for strengthening

Chapter 2

Methods

This assessment focused on the CHMT, as an organisational unit, and its stakeholders. Data were collected by the MEval-PIMA assessment team using a mixed-methods approach. The team used qualitative methods (document reviews and key informant interviews) as well as quantitative methods (group and individual assessment tools).

2.1 Study Population and Sampling

Primary data were collected from key county management staff, such as heads of programmes, key programme managers, M&E personnel, thematic focal points, and selected stakeholders that provide technical assistance to the county. MEval-PIMA identified participants through a purposive sampling strategy. The approach made it possible to interview knowledgeable people with M&E responsibilities and specific individuals tasked with implementing M&E functions. Additional insights were gathered from non-M&E respondents.

2.2 Study Procedures

Two main approaches were used for data collection. First, secondary data was collected through a desk review of existing policies. The review was conducted to expose gaps in existing capacity. Review of relevant documents focused on: history and structure of the M&E institution and its activities; current status of the institution and M&E activities; existing documentation on M&E capacity; and the existing gaps.

The second set of primary data collection methods were KIIs and group and individual assessments. MEval-PIMA developed a generic data collection tool that captures various dimensions of capacity—organisational, technical, and behavioural. This tool was originally used to assess national-level capacity in M&E and was adapted to align with that specific context. The tool was adapted from several other capacity assessment tools, including the following:

- Global Fund's Monitoring and Evaluation System Strengthening Tool[3]
- Joint United Nations Programme on HIV/AIDS (UNAIDS) 12 components tool[4]
- MEASURE Evaluation's PRISM tools[5]
- MEASURE Evaluation's individual competency assessment tool[6]
- Organisational capacity assessment tool by FANIKISHA[7]
- Management and organisational sustainability tool (MOST)[8]
- Institutional development framework[9]

[3] Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). 2006. Monitoring, and Evaluation System Strengthening Tool. Chapel Hill, NC: MEASURE Evaluation, University of North Carolina
[4] Joint United Nations Programme on HIV/AIDS (UNAIDS), 2009a. 12 Components Monitoring & Evaluation System Assessment: Guidelines to support preparation, implementation and follow-up activities. Geneva: Monitoring and Evaluation Reference Group (MERG), UNAIDS
[5] MEASURE Evaluation. 2011. Performance of Routine Information Systems Management (PRISM) Tools. Chapel Hill: MEASURE Evaluation, University of North Carolina
[6] MEASURE Evaluation, Improvement Plan for Individual Capacity Development in Monitoring and Evaluation (M&E) as Based on Self-Assessment Using "SCORE ME." Retrieved from https://www.measureevaluation.org/our-work/capacity-building/score-me-documents/score-me-individual-m-e-capacity-self-improvement-plan/view
[7] Management Sciences for Health (MSH). 2012. Organisational Capacity Assessment Tool: CSO Self-Assessment Tool
[8] MSH. 2004. Management and Organisational Sustainability Tool, 3rd Edition.
[9] Management Systems International (MSI). 1996. Institutional Development Framework. Washington, DC: MSI

The MEval-PIMA tool was customised into an Excel-based group assessment tool with customised dashboards. Table 2 shows the main components of capacities evaluated and the core areas covered.

Although there were 12 areas of assessment, gender issues were integrated across different areas of assessment. The issues examined are in indicted in Table 2. For each capacity area, a number of capacity elements were evaluated through a series of questions using the following dimensions:

- *Status*: if a given element exists, such as a county M&E plan
- *Quality*: if the element conforms to established quality norms
- *Technical autonomy*: the extent to which a programme can develop and execute the element on its own
- *Financial autonomy*: the extent to which a programme can develop and execute the element using its own resources

Table 2. Capacity areas assessed by the group assessment tool

	Capacity Area	Main Focus of Questions
1	**Organisational**	• **Leadership**: Effective leadership for M&E in the county • **Human Resources**: Job descriptions for M&E staff; adequate number of skilled M&E staff; defined career path in M&E • **Organisational Culture**: Commitment to ensure M&E system performance • **Organisational Roles and Functions**: Well-defined organisational structure, including an M&E unit or M&E focal points in other public, private, and civil society organisations; written mandates for planning, coordinating, and managing the M&E system; well-defined M&E roles and responsibilities for key individuals in the county • **Organisational 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
2	**Human Capacity for M&E**	• Defined skills set for individuals at service-delivery levels • Work force development plan, including career paths for M&E • Costed human capacity building plan • Standard curricula for organisational and technical capacity building • Training capacity, including links to training institutions • Supervision, in-service training, and mentoring
3	**Partnership and Governance**	• M&E Technical Working Group • Mechanism to coordinate all stakeholders • Leadership and capacity for stakeholder coordination • Routine communication channel to facilitate exchange of information among stakeholders
4	**M&E Plan**	• Broad-based participation in developing the M&E plan • Explicit linkages to the national strategic plan • M&E plan adheres to international and national technical standards • M&E system assessments and recommendations for system strengthening are addressed in the M&E plan
5	**Annual M&E Costed Work Plan**	• M&E work plan contains activities, responsible implementers, time frame, activity costs, and identified funding • M&E work plan explicitly links to the work plans and medium-term expenditure framework budgets • Resources (human, physical, financial) are committed to implement the M&E work plan • All relevant stakeholders endorsed the M&E work plan • M&E work plan is updated annually based on performance monitoring
6	**Advocacy, Communication, Culture and Behaviour**	• Communication strategy includes a specific M&E communication and advocacy plan • M&E is explicitly referenced in policies and the strategic plan. • High-level M&E champions have been identified; these champions are actively endorsing M&E actions • M&E advocacy activities are implemented according to the M&E advocacy plan • M&E materials that target different audiences and support data sharing and use are available

	Capacity Area	Main Focus of Questions
7	**Routine Monitoring**	• Data collection strategy is 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, and analysis) are available • Routine procedures for data transfer to national level
8	**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
9	**County and Subcounty 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 to avoid duplication of effort • Well-defined and managed database to capture, verify, analyse, and present programme monitoring data from all levels and sectors
10	**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
11	**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 • Evaluation and research agenda • Guidance on evaluation and research standards and appropriate methods • Conference or forum for dissemination and discussion of research and evaluation findings
12	**Data Demand and Use**	• The programme's strategic plan and the national M&E plan include a data use plan • Analysis of programme 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)
13	**Gender**	• Staff are able to collect, process, and analyse sex-disaggregated and gender-sensitive data • The health sector M&E plan includes activities for gender-based analysis • Gender analysis and reporting is included as an element of the data analysis and presentation guidelines

An individual self-assessment tool was also developed using the UNAIDS guidelines for M&E competencies for M&E personnel. These competencies include M&E leadership, data collection and management, evaluation competencies, data analysis dissemination and use, and general management competencies. The questions under each key competency were programmed into an Excel-based self-assessment tool. Both the group and individual assessment tools were administered during workshops held between March and July 2014 (Table 3).

Table 3. Period of assessment across all counties

	Period of Assessment 2014	
County	**Month**	**Workshop Dates**
Kakamega	April/May	2 –4 April
Bungoma	April/May	2–4 April
Garissa	April/May	14–5 April
Kilifi	April/May	15–17 April
Kirinyaga	April/May	14–25 April
Kisumu	April /May	15–17 April
Kitui	April /May	5–7 May
Machakos	March/April	8–10 April
Nakuru	April /May	7–9 May
Narok	Abril/May	14–16 April
Nyeri	April/May	16–18 April
Siaya	April /May	12–14 June
Uasin Gishu	April /May	9–11 May
Wajir	March/April	25–26 April
Nairobi	May/June	22–25 June
Mombasa	March/April	23–25 April
Meru	March/April	22–25 April

The group assessment tools were facilitated by officers from the MEval-PIMA project through a consensus-building method. The facilitator read the question and asked participants to discuss and arrive at an answer. Only the final answer derived through this consultative process was recorded as the final score. The individual assessment tool was explained to all participants in the workshop through an introductory session. Thereafter, the tool was emailed to M&E staff at the subcounty level only to fill out. A facilitator carefully went through the participants' answers and archived a final version for data analysis and presentation.

The MEval-PIMA team also developed two interview guides for key informants with staff and stakeholders. These interviews were administered by project staff after the workshop to provide context for the observations arising from the group and individual assessments. Each interview took approximately one hour to complete. Table 4 summarises the methods, targets, and data collection tools used to assess the capacity assessment objectives across all counties.

Table 4. Summary of methods, targets, and data collection tools used to meet assessment objectives

Objective	Method	Position of Interest	
Understand and confirm the performance objectives of the M&E unit	Desk review	NA	Desk review guide
	In-depth interviews	Senior programme	KII guide
		M&E unit staff	
		Stakeholders n=15	
Determine the current status of performance in key M&E functional areas	Desk review	NA	Desk review guide
	Group assessment	M&E (n=18) and	Group assessment tool
	In-depth interviews	Senior programme	KII guide
		Stakeholders (n=18)	KII guide for stakeholders
Identify gaps in capacity to meet performance expectations	In-depth interviews	Senior programme	KII guide
	Individual self-assessment	Staff	Individual assessment tool

2.3 Data Management

2.3.1 Data Storage

MEval-PIMA developed group and individual assessment tools in Excel to manage quantitative data. Data sets were made accessible to only authorised study investigators and trained data management personnel. Completed KIIs and other data collection matrices, such as desk review guides, were stored in a secure cabinet with access limited to authorised personnel in the assessment. Only summaries of the quantitative data were shared with the CHMT during the workshop. Data from the KIIs were also shared with the analytical team.

2.3.2 Data Analysis

MEval-PIMA analysed quantitative data in the group and individual assessment tools using simple scoring for each question and overall scores for each competency or component, displayed in easy-to-interpret dashboards. Scoring was based on group consensus for the group tool and perceived score for the individual tool.

Questions in the group assessment tool had a variety of possible responses, from simple Yes/No to a five-point scale—e.g., weekly, monthly, quarterly, biannually, and annually. Because of this variation in response categories, scores were scaled up to a range from 0 to 10 for easy display in the dashboards and spider plots. Further, because the number of individuals doing the individual assessment was relatively small, overall competency scores were displayed as box-and-whisker plots, with the median as a measure of central tendency. Simple, descriptive statistics (e.g., means, frequencies) were used where appropriate.

Qualitative data were analysed using a thematic framework. The themes were predefined on the basis of literature and closely followed the 12 capacity areas of interest for the assessment. Both the audio recorded interviews and the notes from the interviews were transcribed in MS Word 2007 and analysed using NVivo 10. The text was coded into the themes and analysis charts developed around issues emerging from the data. These data were corroborated with other data sources to guide the description of M&E capacity of the CHMT. Each transcript received a unique identifier with the date and participant identifier to provide confidentiality and anonymity.

2.4 Ethical Consideration

Ethical approval for this assessment was granted by the Kenya Medical Research Institute's Ethical Review Committee. The voluntary nature of the assessment was clearly explained to all participants and they were told that there was no obligation to respond to any of the questions during assessments and administration of the various tools. Before each interview and the administration of other tools, participants had an opportunity to query the aim, objectives, and benefits of the assessment. They were asked to sign an informed consent sheet, when appropriate.

To ensure the safety of the documents used in this study, all original documentation was kept in a secured location at ICF International offices. The documentation was available only to the assessment study team. To protect research participants' confidentiality, data were kept anonymous by using participant codes instead of participant names, which were not recorded. All participants were told that they could voluntarily withdraw from the assessment at any time without any consequences or implications for their careers.

CHAPTER 3

RESULTS

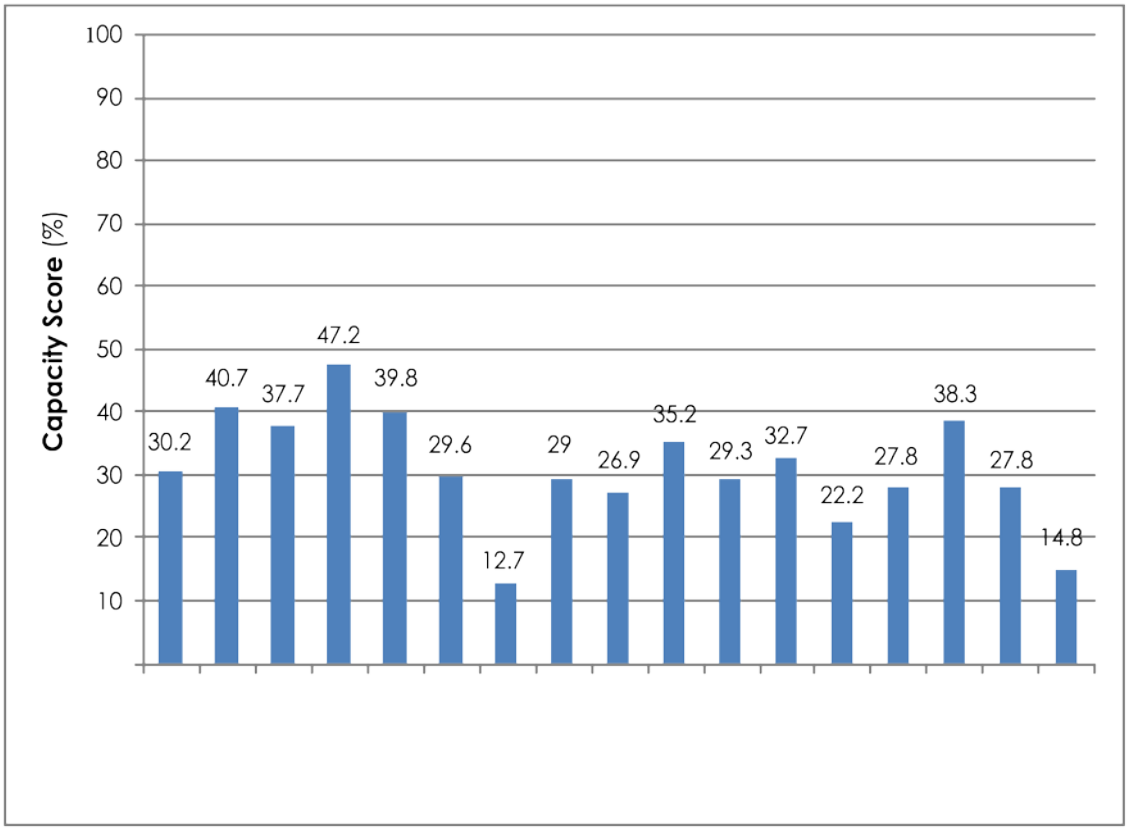
This section describes results from both the group and individual assessment tools and the KIIs. The results of group and individual assessments are presented as a summary of OCI indices from the 12 capacity areas. This presentation enables comparisons across counties and delineates the areas that contribute to the overall score. The results from the KIIs highlight issues with each capacity area. This provides an additional qualitative dimension for each area, allowing for a more in-depth analysis.

3.1 Overall Organisational Capacity Index

An OCI score was computed to illustrate the existing capacity for M&E, including organisational, technical, and behavioural aspects. The OCI score was calculated by adding actual scores under each capacity area divided by the maximum score on the OCI.

Across all counties, the OCI score is largely low, with only seven out of the 17 counties scoring about a third. The largest OCI scores were recorded in Kilifi (47.2), Garissa (40.7), Kirinyaga (39.8), Siaya (38.3), and Kakamega (37.7). The lowest OCI scores were recorded in Kitui (12.7) and Wajir (14.8) (Figure 2). The fairly high OCI scores in Kilifi, Garissa, Kirinyaga, Siaya, and Kakamega counties are largely due to better or stronger organisational structures that support M&E, such as a strategic plan, M&E units, and existing work plans. Overall, a higher OCI score was mainly explained by the existence of structures, guidelines, and supportive policy environments in key capacity areas that support effective M&E. Figure 3 shows the current capacity for M&E across the 17 counties.

Figure 2. Summary of overall capacity scores in 17 counties



3.2 Key Findings from Each Capacity Area

3.2.1 Capacity Area 1: Organisational Structure

Strong leadership and enabling structures are critical for proper implementation of any policy; and dedication to M&E at the county level depended on the presence of relevant policies articulating its importance. At the time of the survey, all of the counties examined had developed SPs, most of which were in draft format, while others were finalised and awaiting launch. The county SPs had been developed in line with constitutional requirements for the health sector. The M&E activities described in the SPs were geared towards addressing each county's mission, and the SPs of some counties outlined key M&E activities, such as generating basic reports, data collection, and surveillance. Despite the inclusion of broad mission and vision statements in these strategic documents, the institutional values required to implement them ethically are still in their infancy. In most cases, the people interviewed did not articulate a connection between the ethics statements and their professional responsibilities, but they referred instead to the Public Service Act [10], as reflected in the statement below:

> *I think there is the Public Officers Ethics Act and the Civil Service Code of Regulation. Of course there are values that are specific to health workers which are not captured in the Public Officer Ethics Act or the Code of Regulation, for example the issue of confidentiality where a health worker will have to keep the health records of a patient confidential because that is a value that a health worker should have. There are issues to do with punctuality, professionalism in handling cases that one comes across. Let me just be honest and say that these values have not been isolated and put forward for the health sector staff. . . . I'm probably very sure there is a set of core values out there that health workers should observe around their workplaces issues to do with accountability, transparency.*
> —Respondent from Bungoma County

Out of the total number of counties that participated in the assessment, only five had set up explicit units or structures to address functions related to M&E. In other cases, the M&E units were in the process of being created. Interestingly, however, M&E was often conflated with HIS, and, in one case, former staff working as health records information officers (HRIOs) had been designated as M&E officers. The competency-based assessment among county-level health workers tasked with carrying out M&E functions, however, showed that this cadre was not well prepared to handle M&E functions. In most cases, respondents were found to have only basic data management knowledge and skills, and thus required greater technical expertise to effectively manage the units. In some cases, the units had written mandates, but there was a huge gap between those mandates and the way the units actually operated.

> *. . . Looking at what I know for sure there is a skeletal staff, and when you look at capacity in terms of being able to fulfill their mandate, then they need to have more human resource coming on board. And in terms of skills, I might not be in a position to share what each one has in terms of qualification, knowledge, experience, and skills but all I know is that . . . like the HRIO, we have been working together with him, and I find that he is someone who is knowledgeable—he knows his work; he can articulate data very well; he can do analysis by the use of special programmes like SPSS and make sense out of that data.*—CHMT member, Garissa

Overall, the CHMT members noted that M&E responsibilities are not clearly defined in the job descriptions, with the main setback being the fact that the revised Scheme of Service[10] does not have an M&E job description. The CHMT members are also aware of the fundamentals of M&E (collection, verification, analysis, and dissemination) but their juniors do not have a proper and adequate grasp of what to do with the information once it is generated.

[10] Defines the roles for various cadres of staff within the public service.

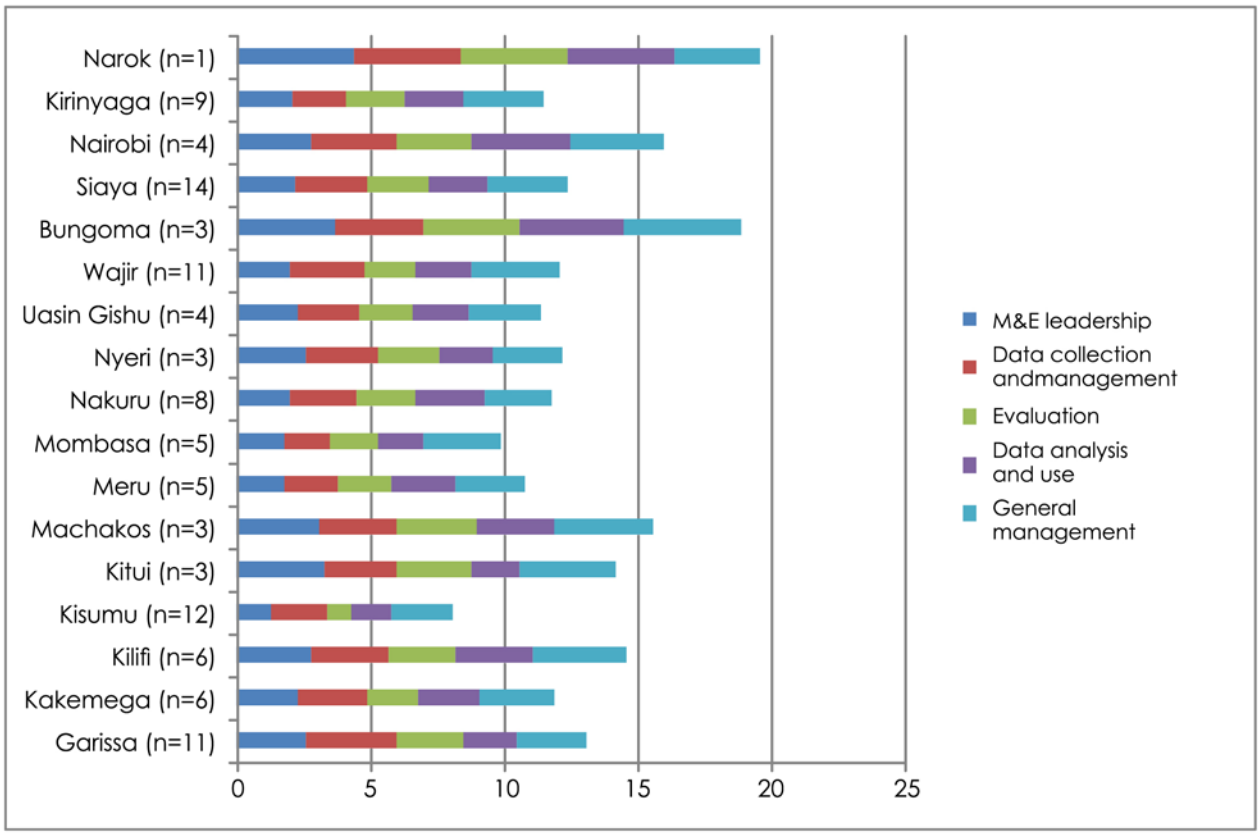
3.2.2 Capacity Area 2: Human Capacity for M&E

In this assessment, human capacity for M&E was assessed by examining the existence of policy documents or guidelines that seek to develop the skills, competencies, and career paths for staff undertaking M&E-related functions.

No county reported a clearly defined skillset for personnel tasked with leading M&E functions nor did any county have workforce development plans, perhaps due to limited planning at the policy level. As noted in the previous section, though some counties had included M&E as an important strategic objective, they did not recognise the need for structures and human resources. As a result, most counties did not have capacity-building plans or budgetary allocations for them. A lack of human capacity-development plans, an absence of links between the CHMTs and local training institutions to build M&E capacity, and limited opportunities for in-service training and mentorship were further indications of this general weakness.

The assessment also examined individual capacities of staff that were deployed to support M&E issues in the counties. Figure 3 shows average individual assessment scores by the staff in five areas: M&E leadership, data collection and management, evaluation, data analysis and use, and general management. Staff supporting M&E activities reported varied scores in each element, across the counties. Higher scores were reported on general management and M&E leadership, and the lowest scores were recorded in evaluation and data analysis and use.

Figure 3. Human capacity scores from individual assessment



3.2.3 Capacity Area 3: Partnerships and Governance

A functional M&E system requires governance structures, such as TWGs; local leadership that coordinates stakeholders; and routine communication channels to facilitate exchange of information. These mechanisms are particularly important for creating synergies and harnessing resources from partners and stakeholders to support the implementation of M&E functions. Group assessments across the counties indicated that counties had limited capacity to coordinate partners and stakeholders. The biggest challenges were a 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 such key governance structures do not exist.

Most counties did not have a separate M&E policy and often relied on the HIS policy (which has a bearing on M&E). Even in the few counties where M&E TWGs were in existence, they were largely in their formative stages; participants in the group assessment reported that there were plans to establish TWGs.

The absence of stakeholder inventories that detail the actors or stakeholders working at the county level was an additional weakness related to partnership and governance. Such inventories are a good starting point towards better coordination and sharing of technical and financial resources. Counties did not report the existence of standard operating procedures detailing roles and responsibilities for M&E. Instead, study members mentioned partners who have traditionally provided support to the counties.

Reporting mechanisms vary across counties; however, they seem to operate within the previously existing framework involving subcounties, formerly called districts. In some cases, the reporting is programme-specific, especially where it is partner-driven. Some counties were in the process of putting together an inventory of stakeholders, but lacked vital information, such as physical address or contact information:

> *. . . I think we have been trying to set up a stakeholders' forum this has not materialised yet, but I think we have identified the stakeholders; they have been profiled. What needs to happen is to have a meeting with them and operationalise the county health stakeholders' forum. . . . I think enough partners from Bungoma County are out there. So probably what needs to happen is probably as a county could avail the funds to do the initial mobilisation of these partners and then henceforth, I think it can be smoother. I don't know why we wouldn't just avail funds because we need to meet them and know what they can do for us and move forward.*—CHMT member, Bungoma County

Across most of the counties, respondents reported limited capacity to share M&E communication products (newsletters, bulletins, etc.) and decisions with relevant stakeholders in a timely manner.

3.2.4 Capacity Area 4: County M&E Plan

An M&E plan provides direction and focus in terms of efforts to track performance against set targets. The development of such a plan should be undertaken in a participatory manner by bringing together broad-based partnerships for technical and financial resource leveraging.

At the time of the assessment, most counties were in the process of developing their health sector strategic plans, and therefore, their M&E plans were unavailable. Only Garissa and Siaya counties reported having a strategic plan, but the development of an M&E plan had not commenced. Interestingly, most counties had completed the development of the CIDP, and a few included an M&E component. Nonetheless, several counties had draft annual working plans (AWPs) that were guiding programme implementation.

3.2.5 Capacity Area 5: Annual Costed M&E Work plan

As noted in section 3.1.4, counties that participated in the assessment did not have M&E plans, due to delays in the completion of the health strategic plans. Thus, an in-depth examination of their activities and budget allocations was not possible. Despite this, counties had AWPs that outlined M&E-related activities. A bigger challenge, however, was the near absence of proper structures to carry out M&E activities. None of the counties that were surveyed had M&E units or directorates in place to implement M&E. The newly formed units are struggling with implementation of M&E largely due to capacity issues associated with understaffing and the mix of available skills.

In counties where the AWPs were used to guide the implementation of M&E activities, there was no budgetary monitoring process to track resource commitments to M&E. For example, there was no system that could show the date for which funding was requested, responses, and the percentage of funding received specifically for M&E. Budgets exist, but there is no monitoring process unless one is inquiring about a specific budget activity. The budgets have only funds allocation and expenditure columns, which makes it difficult to provide evidence for the total budget cost for any planned M&E activities.

Resources were generally reported as being inadequate to meet all the counties' M&E activities. This lack of resources affects the reporting of data and the overall implementation of effective M&E activities. In most cases, information and data are received as stipulated in guidelines. However, though the M&E unit staff have skills to compile and process the information, some counties were unable to report on time due to a lack of resources to upload the data into the system.

3.2.6 Capacity Area 6: Advocacy, Communication, Culture, and Behaviour

Advocacy for M&E is likely absent in the counties for two reasons. First, the systems are not yet fully developed. Second, the institutional memory has not embraced the concept of advocacy for data needs and use of data for decision making. In many districts, respondents reported the existence of key champions of M&E among the M&E focal people, CHMT members, or departmental directors.

The presence of strong partners supporting M&E provides some counties with an opportunity to develop and enhance a strong advocacy strategy. A well-functioning TWG may have good avenues to lobby politicians who have the power to direct resources and determine the health priorities for the county. An informed county health leadership is critical for the success of health programmes. These leaders often act as champions to galvanise support for M&E-related activities at the county level.

Although there were reports that the senior health department leadership supported M&E at the county level, these reports were not backed by policy documents. In the few counties that had draft strategic plans, the M&E section was poorly developed and not well thought out. The interview excerpt below indicates a common perception and attitude towards M&E among the county teams:

> *For me, I'm new in the county—I wouldn't say definitely for the general staff, but I can say about my colleagues in the CHMT, generally, they think M&E is somebody else's task . . . but when you talk in details about M&E with them, they start to own up that M&E is their task; they have been doing it, but they didn't know that they were doing M&E.*—CHMT member, Bungoma

Although participants in the group assessment mostly reported that the senior leadership at the CHMT supported M&E, it is clear that counties often lacked a written strategy to comprehensively guide advocacy for M&E. In addition, many counties lacked a health sector-specific communication strategy, meaning these activities are carried out on an ad hoc basis. This was reflected, for example, in the key products for M&E reported, which include annual reports, monitoring framework, performance review reports, stakeholder coordination reports, bulletins, presentations, and conferences.

3.2.7 Capacity Area 7: Routine Monitoring

Most counties reported the availability of clearly defined mechanisms for guiding data collection, transfer, and reporting, as well as the necessary tools for data collection. In most cases, the strategy and tools referred to were those developed at the national level, adapted for the county level. However, the mechanisms for guiding data collection, management, and transfer were not necessarily county-driven, but often depended on support from nongovernmental stakeholders. The Kenyan Constitution, which established the county government as the second tier of governance, accords the development of tools and guidelines to drive the M&E agenda at the county level as the function of the Division of Health Informatics and Monitoring and Evaluation at the national level. The Division, together with that of policy and planning, develops and disseminates templates to support the development of county health strategic plans and county-level M&E plans. It also provides guidance on performance reporting, reviews, and planning to the health sector.

Despite the inherent capacity of the national government in this area, there were challenges relating to the ability of the counties to report in a timely manner or adhere to nationally prescribed performance reviews and planning cycles. There were further challenges to reporting, especially due to staff shortages described in capacity area 2. In addition, some counties were able to identify key gaps in terms of the missing indicators that need to be addressed. The specific gaps are outlined in the respective county summaries. The missing the indicators include post-rape care, nutritional indices, cervical cancer screening, deworming, classification of Integrated Management of Childhood Illnesses, gender-related disaggregation in some indicators, obesity, latrine coverage, and distribution of condoms as a family planning method, among others. These gaps will need to be addressed at the national level as part of indicator harmonisation.

It is important to note that at the national level, it may not be possible to have indicators that reflect different settings, and therefore counties might need to be empowered to capture relevant context-specific data for measuring progress in particular areas. This particular finding should be interpreted in the context of a constitutional demand for a common data architecture.

3.2.8 Capacity Area 8: Surveys and Surveillance

This capacity area scored relatively high across sites, especially in terms of quality dimensions, indicating an existing infrastructure and potential culture of surveillance based on the previous disease-specific focus that has been supported by the government and partners. Most counties have an updated database for ongoing surveillance activities in the county but none for surveys conducted. The latter is reflected by the lack of a functional repository of all protocols implemented at county level. Surveillance data is used at times but largely focuses on communicable diseases, whose local use was limited, given the weak feedback loop to the county.

The second aspect that was weakest was a database for all surveys conducted in the county. A number of things contribute to this. The county does not keep a copy of the protocols of all surveys conducted to confirm that the proper authorities have authorised the research carried out. Second, researchers rarely provide feedback to the counties to help in decision making. Third, the county team may lack expertise and avenues to quickly utilise the findings in decision making.

3.2.9 Capacity Area 9: County and Subcounty Databases

All the counties reported having databases that were linked to the national databases for data aggregation. The databases are not largely designed to respond to the decision making and reporting needs of county actors. This is partly because there is a disconnect between different databases. This makes it difficult to easily use data from various data sets or move between data sets that could allow comprehensive syntheses. In addition, there are challenges in terms of timing, such as when the information is updated for each database. For example, data for the Integrated Disease Surveillance and Response (IDSR) system is keyed in weekly, while the district HIS is updated monthly. This means that the reporting timelines are different and the data summaries generated are also different.

Despite the capacity at the county level described above, we noted several challenges relating to reporting and completeness of most data. Late submission of data from the facilities and lower-level management systems was associated with lack of support to health information officers to upload data and with inadequate equipment. Inaccurate data entries or completeness were associated with heavy work loads and the use of many tools with different demands for various data needs, a situation which makes it difficult for one officer to execute.

3.2.10 Capacity Area 10: Supervision and Auditing

All counties reported the existence of supportive supervision guidelines to support routine data collection at the facility level. As noted earlier, these guidelines are developed by the national government, although the implementation of the supervision is the function of the county government. Some of the weak areas that were noted in some counties relate to absence of policy or guidance on undertaking data quality audits. Even where such guidance was available, members of the CHMT reported a lack of financial resources to undertake data quality audits as expected.

3.2.11 Capacity Area 11: Evaluation and Research

This capacity area scored lowest, with all the four dimensions scoring zero in most counties. The counties did not have an inventory, register, or database of institutions undertaking research and evaluation. Additionally, there was no county-specific research agenda, and some counties had no research agenda in their county SPs. In one county, where a draft research agenda was in development, discussions were in the consultation stage for designing research tools and every programme was required to come up with areas of interest. In some counties, there is a budget line for research but since there is no research agenda, use of these funds is likely to be limited.

County forums for dissemination and discussion of research findings were said to be dependent on the institution that wanted to disseminate the results (i.e., they were driven by the research organisation). This was more likely to happen in counties where research partners are active. In addition, there is no follow-up by the county to find out if the results of the research conducted have an effect on policy.

3.2.12 Capacity Area 12: Data Demand and Use

Across all counties, there were no data use plans in place. Some counties had only a data use approach captured in the SP or in the draft M&E work plans, where these were being developed. The participants, however, recommended conducting an assessment to find out user needs before developing the data use plan.

An additional observation is that use of the data generated from supportive supervision processes is not often effective. Data demand and use lag behind partly due to lack of a culture of evidence-informed decision making. In some instances, no supportive supervision has been conducted since devolution; in cases where it has been tried, it was reported that such supervision doesn't follow all the procedures.

Data analysis and presentation exist in various guidelines, although they are scattered in various documents, such as health information strategic plans and health sector indicator manuals. There is a need to consolidate the guidelines into one document.

In general, dissemination of information products is not clearly defined, with some counties stating that it does not happen regularly or in a strategic manner. This means that the products are unlikely to be used for strategic decisions. Partners generally push for dissemination of their project-specific information, and at the community level, dissemination occurs during dialogue days, which are only conducted if a partner supports them.

3.3 Mainstreaming Gender in M&E at the County Level

The synthesis of the current assessment indicates a gap in the respondents' understanding of the role and importance of gender in M&E. This was reflected in the county SPs, which included limited mention of gender issues; the only explicit mention of gender was the constitutional requirement for recruitment of female staff. There was mention of respect for human dignity and values related to gender, such as the need to have equal access to health care, but this was not explicitly mentioned and its implementation remains to be seen. In short, gender-based issues have not been incorporated in the draft SPs or in the national HIS guidelines adopted by counties.

Initial efforts to incorporate gender considerations were evident in the two areas of: (1) training attendance and (2) data disaggregation. Staff record the number of male and female attendees at M&E trainings. In the future such information could be used to encourage training of more women if large gaps between men and women persist. Second, in most counties data are compiled and disaggregated by sex. However, those data are often not analysed by sex or used.

Table 5 provides a summary of gender issues from the group assessment. In order to integrate gender in M&E, gender must be deliberately included in strategic documents and accompanied by a guided implementation approach. For example, M&E plans should include attention to gender by disaggregating indicators by sex, as well as specifying data analysis and reporting by sex. There are, therefore, opportunities to include gender in M&E plans, as these were largely at their infancy at the county level. And it will be important to increase staff capacity to understand the importance of gender by including gender in M&E trainings.

Table 5. Summary of gender issues in the group assessment

Domain	Elements	Gender-related M&E questions	Key findings
Organisational	Values and ethics statements	Do the county's health sector values include attention to gender equity?	There is no evidence that gender is a consideration when making appointments. Some efforts have been made, but most counties have not complied with the constitution requirement to ensure 30 percent representation by women. In some counties respect for human dignity and cultural values are stated in the values that capture gender equity.
Human Capacity M&E	Staff M&E skills and competencies	Are staff are able to collect, process and analyse sex-disaggregated data and gender-sensitive data to analyse potential gender differences in health access/use/quality?	Results showed a range of staff capacity to collect and analyse data by sex to investigate potential gender differences in health access/use/ quality. Additionally, not all staff interviewed appreciated the need for sex-disaggregated data analysis and use.
	Validated M&E training curriculum	Does the M&E training curriculum include a session or subsession on gender M&E?	Although there was mention of attention to gender in some M&E training, there is a need to ensure that gender dimensions are well articulated in M&E curriculum and cascaded to tools for data collection and to approaches for analysis.
Advocacy, Communication, and Cultural Behaviour	M&E champions	Is there is an M&E champion that can advocate for attention to gender in analysis, reporting, and use of sex-disaggregated and gender-sensitive data?	There are limited M& E champions but they do not focus on or advocate gender issues. In some counties a gender liaison officer might be a useful starting point.
Routine Monitoring	M&E guidelines to Document procedures for collecting, recording, collating, and reporting routine programme data	Does the health sector M&E plan include activities for gender-based analysis?	Sex-disaggregated indicators dealing with gender mainstreaming exist though there is need for improvement
Data Demand and Use	Data analysis and presentation guidelines	Are gender analysis and reporting included as elements of the data analysis and presentation guidelines?	As mentioned in section 3.2.12, there were limited data use strategies in place, which indicates an opportunity to include gender in the data use strategies, and data analysis and presentation guidelines when they are developed.

3.4 Summary of Key Findings

i. Overall, counties had very low scores in the OCI, with only 7 out of the 17 counties scoring about a third. The highest score was observed in Kilifi, with an OCI score of 47.2 and the lowest was observed in Kitui, with an OCI score of 12.7. The main contributors to low OCI scores are lack of or inadequate structures for operationalising a functional M&E system—such as strategic policies and guidelines that have explicit guidance on M&E, costed M&E workplans, human capacity, and a supportive environment, including champions for M&E.

ii. Despite these observations, counties have begun setting up the necessary infrastructure for the implementation of M&E activities in line with relevant guidelines developed by the national government. This was indicated by the presence of:

- Ongoing work to develop county health strategic plans with sufficient attention to M&E
- Establishment of M&E units with core staff and seconded ones from the HIS unit
- Recruitment of M&E staff in some counties
- Description of M&E activities, where possible, in line with the strategic plan documents

iii. Supporting structures of governance and partnerships were generally weak, with many counties having no standard operating procedures (SOPs), TWGs, or inventories of stakeholders that could further guide collaboration, accountability, and feedback.

iv. There were overarching shortages in terms of staff to carry out M&E functions.

v. There is a general weakness in terms of core competencies for M&E. Key areas with low scores include M&E leadership, data collection, analysis, and data use for decision making

vi. The weakest capacity areas in terms of status and quality dimensions were human capacity for M&E, partnership and governance, costed M&E plans, evaluation and research, and data demand and use.

vii. Across counties, both financial and technical dimensions were low, implying that counties over-depend on stakeholders for various technical and financial aspects of M&E functions.

viii. There was limited understanding of the role and importance of gender in M&E across counties, which suggested that there is a need to integrate gender issues in the ongoing development of M&E structures, including capacity building and training, M&E plans and guidance documents, and sex-disaggregated analysis and use of data.

CHAPTER 4

DISCUSSION, CONCLUSION, AND RECOMMENDATIONS

4.1 Discussion

Following the 2010 revisions of the dispensation of the Constitution, county governments were tasked with the responsibility of planning and delivering healthcare services. The directorate of health, through the CHMT, has the mandate to provide a stewardship role to ensure health programmes, policies, and plans are sound and based on evidence. The above expectations, therefore, make it necessary for a functional M&E system at the county level that is capable of facilitating the capture, management, and use of quality health information.

The ability of counties to carry out M&E-related responsibilities was assessed by looking at the technical, organisational, and behavioural capacity along the 12 capacity areas. The OCI scores show that counties have very limited capacity to undertake the various tasks that are envisioned for a robust M&E. This is underlined by the fact that out of the 17 counties that were assessed, only three had an OCI score of above 40 percent, while more than half had an OCI score of less than 30 percent. These findings suggest a lack of critical capacity to undertake responsibilities relating to the collection, management, analysis, and use of data for programme planning.

While the overall assessment looked at the sum total of capacity in 12 capacity areas, there are structural problems that are responsible for or undermine preparedness for M&E functions at the county level. These include weak organisational structures that should support and spearhead the M&E functions at the county level. For instance, most counties did not have M&E units or the requisite human resources to support M&E. Instead, the M&E functions were often undertaken through an individual member of the CHMT. This person operates in a vacuum, in the absence of a defined structure and a written mandate to articulate the M&E expectations, as well as the requisite staff establishment for such tasks. Other examples of structural weakness relate to limited or absence of strategic leadership for M&E at the county level.

It is important to note that even in counties that reported having staff to carry out M&E, these were mainly HRIOs who were inherited from the previous governance structures. Overall, counties have a shortage of personnel with the requisite M&E skills and competencies to manage the M&E units. The assessment of M&E competencies and skills among staff responsible for M&E duties showed glaring limitations in critical areas such as M&E leadership, data collection, evaluation, and data use.

The assessment further showed that gender mainstreaming in M&E is not well understood at the policy and implementation levels. At the minimum, there were attempts to collect sex-disaggregated data in most cases. However, there is limited awareness of the importance of gender in health, as well as a lack of capacity for integrating gender in M&E strengthening efforts at the county level. More work will be required to ensure that policy documents that articulate the vision for health and the indicators for performance monitoring pay attention to gender in key areas, such as access to care, use of services, and involvement in decision making. Gender mainstreaming of M&E will be needed to increase staff capacity to understand the importance of gender and how it applies to M&E, particularly in M&E plans, sex-disaggregated data analysis, and data use.

Our assessment indicated that, depending on specific cultural contexts, certain counties may be at different levels of gender awareness. Some still grapple with exploitative levels, where the social context enables some to take advantage of gender inequalities and stereotypes, while other counties are at the accommodating stage of trying to work around gender differences, perhaps forced by constitutional requirements or by virtue of their adaptive responses to the changing social and political situations. The analysis will help develop strategies to mainstream gender based on county-specific features.

At the time of the assessment, counties were at the initial stages of developing health sector strategic plans to guide investment decisions for health. It is expected that these strategic plans will establish policies that support M&E functions and define linkages between strategic plans and other relevant guidelines. The findings further showed a glaring weakness in terms of the capacity of the CHMT to develop partnerships and leverage resources from partners and stakeholders generally. Efforts to bring such players together were often *ad hoc* and lacked a coherent strategy to achieve the purpose. For instance, there were no inventories of stakeholders working in the counties, which made it difficult for the CHMTs to harness their various resources. In addition, governance mechanisms, such as TWGs, were largely absent, or in the initial stages of formation. An important finding is that the establishment of these mechanisms was not anchored in policy, and therefore, often seen as peripheral to spearheading the M&E agenda at the county level. In order for the mechanism or forums to be effective, they will need to be legitimised through policy documents, and will require support beyond their formation.

These findings show that counties are facing challenges in their ability to use data for decision making. The disconnect between data generation, performance review, and budgeting, for instance, points to the need for strong accountability mechanisms. These will engender a culture of monitoring, reviewing, and remediation. In addition, the value of non-routine data from surveys, surveillance, and research is less utilised at the county level. In most cases, there are no linkages between the directorate of health at the county level and the institutions that generate such data.

4.2 Conclusion

Findings from this assessment indicate that counties have made several strides in establishing structures to support the implementation of M&E activities at the county level. Good progress has been made especially at the national level in terms of developing policy and guidance notes to support the development and execution of M&E functions at the county level. Despite these gains, the capacity for M&E at the county level is still nascent.

This assessment has explored the level of preparedness of the 17 counties to carry out M&E responsibilities, by looking at the 12 capacity areas that are deemed critical for a sustainable M&E system. Each of the 12 capacity areas was assessed as present at the time of the assessment, the quality dimensions of each component, and whether or not the various capacity areas were designed and supported using county-specific technical and financial resources. Additionally, gender was woven throughout the assessment to ascertain the level of attention to gender in county M&E efforts.

Counties will require investment in priority areas, including the development of policy documents that support the central role of M&E in health system strengthening, establish structures with clear mandate for M&E, and designate personnel with core competencies beyond health records and information management. Besides the development of policies and the attendant structures to operationalise them, counties have limited capacity to coordinate diverse resources from partners and stakeholders to address M&E functions. There is a dire need to establish partnerships at the county level and to create mechanisms that can spearhead various technical aspects of monitoring progress in the implementation of key health priorities outlined in health sector strategic plans. As the counties develop their M&E structures and guidelines, there exists an important opportunity to integrate gender throughout the M&E process.

It is important to note that most counties are still going through challenges related to planning and delivery of healthcare services as stipulated under the new constitutional dispensation. Based on this, it is clear that besides the enactment of policies, addressing staff shortages, and the need for other resources, the development of a sustainable M&E system that not only responds to national and international demands, but also influences county-level decisions, will require long-term support. A sustainable M&E system is needed to implement policies and create synergies between national and county-level efforts.

Importantly, counties require support to use the data and information generated through the M&E system, in order to target the technical and legislative decision making dimensions of county planning and management of public resources.

4.3 Recommendations

Since most counties are at the stage of developing systems for implementation of M&E activities at the county level, there is an opportunity to support them to build systems that are responsive to data demand and use. Specific recommendations to address the identified gaps include to:

- Develop policies such as the strategic plan for health that recognise the value of M&E in system strengthening
- Establish explicit units or structures to address functions for M&E
- Develop and entrench governance structures at the county level that hold stakeholders accountable for delivering evidence-based health programming as enshrined in different policy documents
- Develop a county-specific advocacy agenda for M&E that will help provide visibility for the activities. The advocacy strategy can help develop a culture of data demand and use. The agenda needs to be pegged on measurable and achievable outcomes. Key areas of advocacy could focus on:
    i. Budget allocation for M&E
    ii. Identifying and building capacity of M&E champions to advocate for M&E activities
    iii. Adequacy of M&E staff
    iv. Use of data and creation of data demand use at county level by all actors
    v. Gender mainstreaming in M&E
- Invest in M&E skills among core M&E staff tasked with undertaking M&E roles and responsibilities

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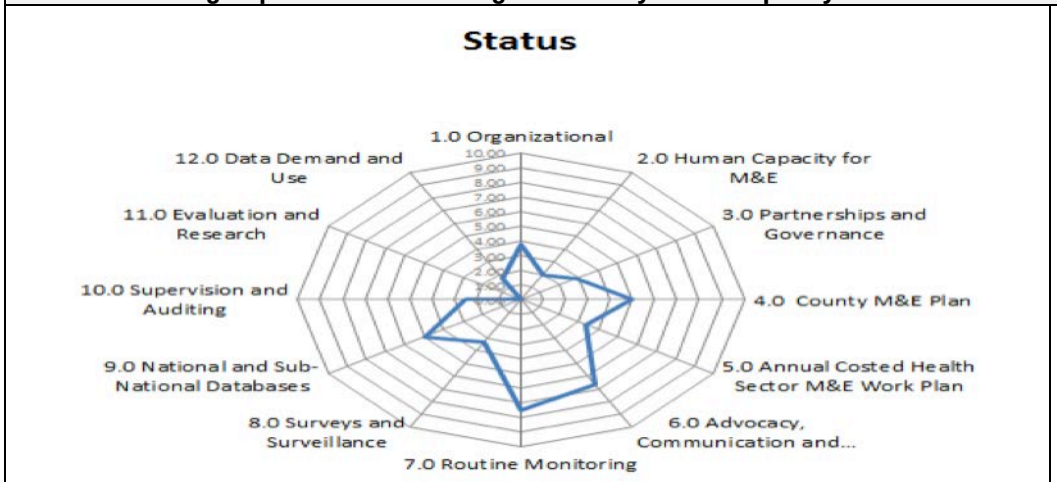
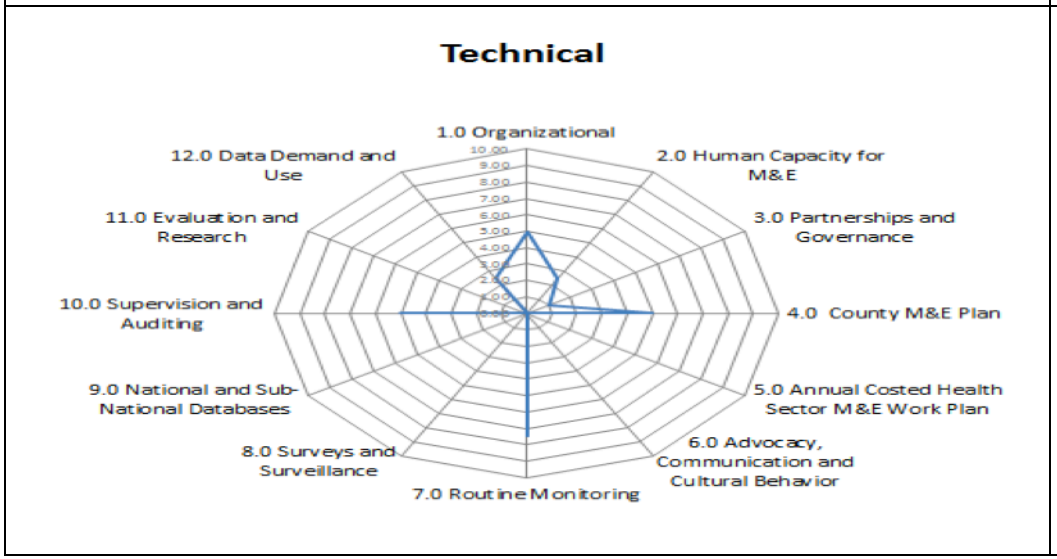
Summary of County-Specific M&E Capacity Status

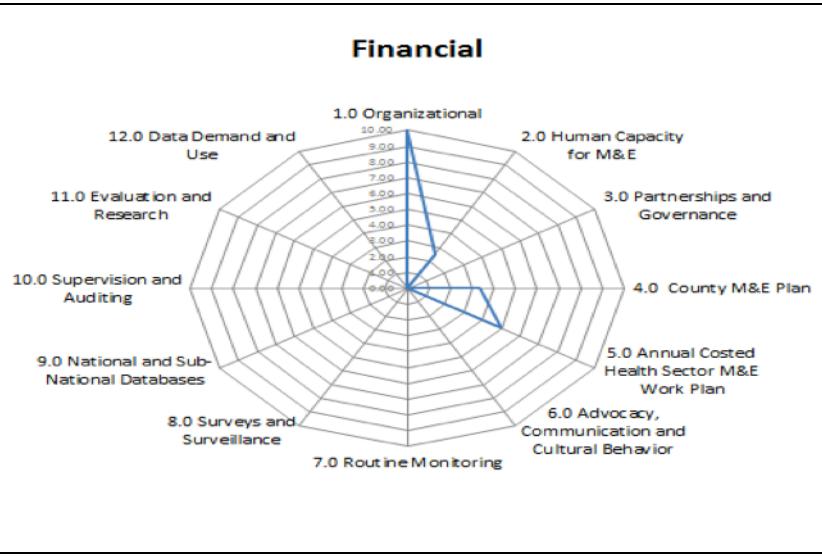
BUNGOMA COUNTY

Overview of M&E Capacity: At the time of the survey, the M&E team comprised an officer referred to as the M&E coordinator while the county health records and information officer served as the custodian of data in the county. The county's capacity to undertake M&E functions was challenged by lack of sustainable financial support from the county government to put in place effective M&E systems, heavy reliance on partners, acute shortage of skilled staff and lack of equipment that would support effective M&E functions.

Results from the group assessment of Bungoma County's M&E capacity







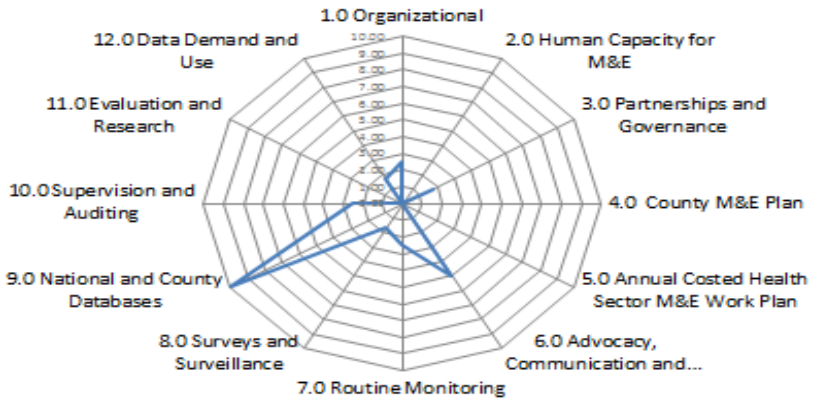
Capacity Area	Key Observations
Organizational Structure	The county did not have fully developed structures (adequate M&E staff, unit and defined roles) to implement M&E functions.
Human Capacity for M&E	Limited core M&E staff have basic qualifications but are not well equipped nor is there a costed human capacity building plan.
Partnerships and Governance	Lacks policies that support good M&E performance. There are standard operating procedures (SOPs) for program-specific subsectors but none for M&E. There is heavy reliance on partners for M&E functions and activities.
County M&E Plan	Existence of a draft M&E plan with support from partners but lacks SOPs for M&E.
Annual Costed M&E Work Plan	Lacks costed M&E work plan.
Advocacy, Communication, Culture, and Behaviour	The county does not have a coordinated advocacy strategy for M&E or a health sector-specific communication strategy.
Routine Monitoring	Existence of tools to support routine monitoring adapted from HMIS but lacks sufficient equipment to support implementation.
Surveys and Surveillance	Has a well-functioning surveillance system for malaria, HIV, and TB but lacks detailed databases for surveys and surveillance activities for other diseases.
County and Subcounty Databases	Gaps in data completeness and timeliness. There are no structures, mechanisms, procedures, and time frames for transmitting, entering, extracting, merging, and transferring data between databases that support the county M&E system.
Supervision and Auditing	The county has a supportive supervision checklist but lacks guidelines to support supervision as well as data quality assurance (DQA) guidelines.
Evaluation and Research	The county does not have an inventory or database of institutions undertaking research and evaluation. There is no county-specific research agenda. Forums for dissemination and discussion of research findings are partner-driven.
Data Demand and Use	Lacks a data use plan and data analysis and presentation guidelines.
Gaps	The county lacks: • Essential guidelines and policies that govern M&E functioning in the county, e.g., costed M&E work plans, capacity-building plans, and guidelines that support effective generation and use of data • Technical and financial sustainability to institutionalize M&E activities in the county • An effective understanding of the role of M&E and embracing a culture of using data for planning
Recommendations	For effective M&E functioning Bungoma County needs to: • Streamline existing structures for M&E to align with clear strategic policy directions • Develop an M&E capacity-building plan supported by a sustainable financial source that does not rely entirely on partners • Develop a strong advocacy component to instill a culture of demand-driven data that can be used for planning

WAJIR COUNTY

Overview of M&E Capacity: The M&E unit is at its infancy stage, with limited staff mandated to undertake M&E functions. The core staff lacks adequate skills and competence to execute M&E functions effectively.

Results from the group assessment of Wajir County's M&E capacity

Status



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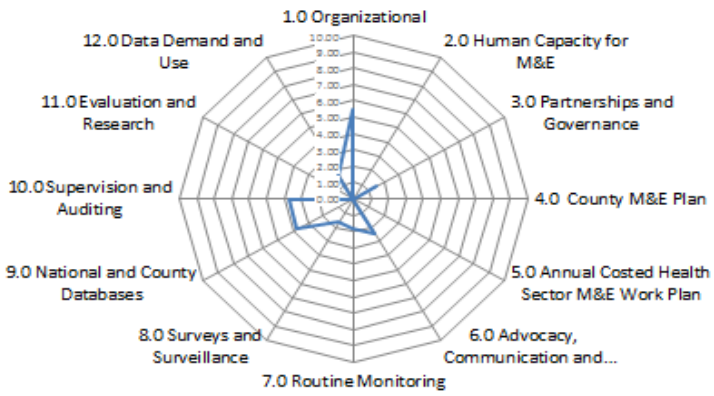


Technical

Financial

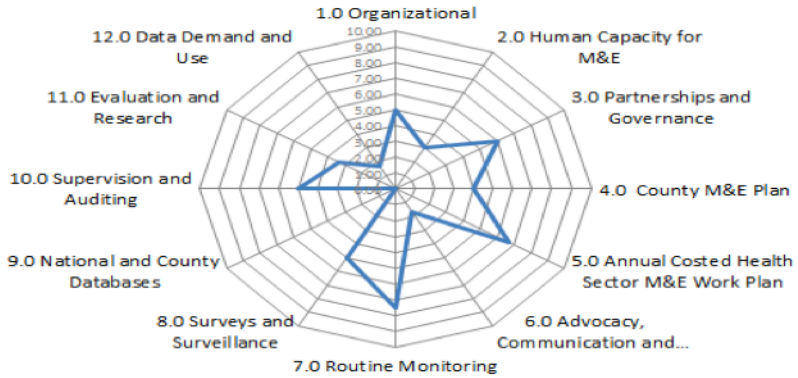
Capacity Area	Key Observations
Organizational Structure	The county lacks governance structures, such as an M&E unit to operationalize M&E functions.
Human Capacity for M&E	The county does not have a costed human capacity-building plan for a functional M&E system.
Partnerships and Governance	There are no county-specific M&E SOPs to guide various structures, including a functional M&E unit. There is no inventory of M&E stakeholders.
County M&E Plan	There is no county M&E plan
Annual Costed M&E Work Plan	
Advocacy, Communication, Culture, and Behaviour	Lacks a coordinated advocacy strategy for M&E or a health sector-specific communication strategy.
Routine Monitoring	Essential tools to support routine monitoring are available but there is a lack of equipment, such as computers, to support Implementation.
Surveys and Surveillance	Although the county has a disease surveillance focal person who coordinates national campaigns, such as polio and measles, among others, it lacks a surveillance inventory and relies on the national reporting system.
County and Subcounty Databases	Has a database platform inherited from HIS but there are gaps in necessary staff or equipment at the subcounty level to manage data.
Supervision and Auditing	Lacks guidelines for supportive supervision and auditing. Data quality perceived to be low and cannot be used for decision making since two of the six subcounties lack equipment to transmit and enter data, which interferes with timeliness, quality, and accuracy of data entered into DHIS 2.
Evaluation and Research	No inventory of institutions undertaking research and evaluation, or a unit or department responsible to coordinate and oversee research activities in the county.
Data Demand and Use	No data use plan but there are departmental data use forums where results from surveys are disseminated with the support of partners.
Gaps	The main gap is insufficient structures and technical capacity to support M&E functions.
Recommendations	For effective M&E functioning, Wajir County needs to: • Develop and sustain necessary structures for M&E functions • Develop an M&E capacity-building plan supported by a sustainable financial plan that does not rely on partners • Develop a strong advocacy component to instill a culture of demand-driven data use for planning

KAKAMEGA COUNTY

Overview of M&E Capacity: The county's M&E capacity is challenged by inadequate financial support from the county government to put in place effective M&E systems, the non-existence of M&E plans, heavy reliance on partners to carry out M&E functions, and an acute shortage of skilled staff required to carry out M&E functions.

Results from the group assessment of Kakamega County's M&E capacity

Status



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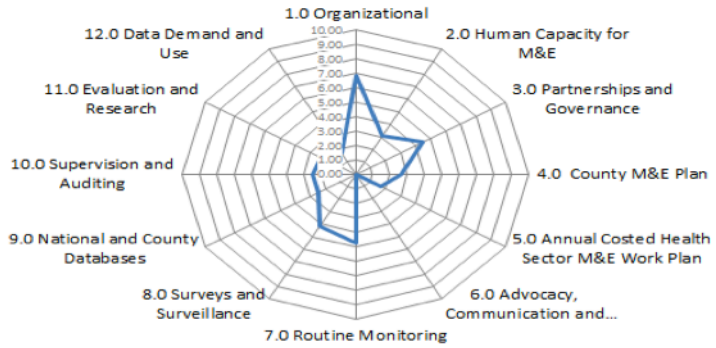

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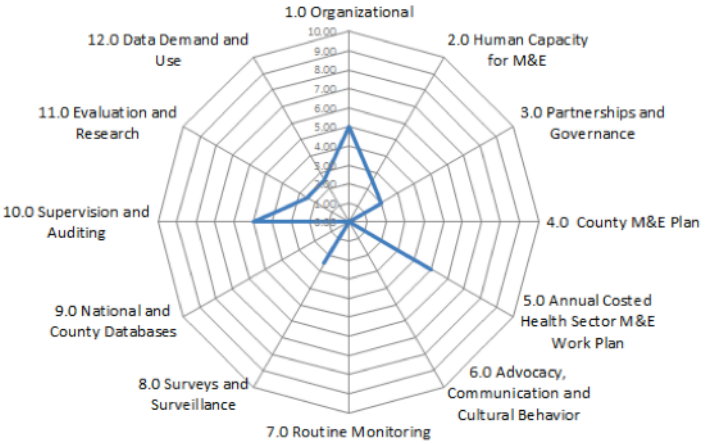


Capacity Area	Key Observations
Organizational Structure	Lacks necessary structures (M&E unit with dedicated team, clear roles and mandates of the unit) to perform M&E functions.
Human Capacity for M&E	Lacks M&E human capacity-building plan or a mechanism to coordinate M&E capacity building.
Partnerships and Governance	Lacks M&E policy to support good M&E performance and practice and lacks an inventory of stakeholders or an established mechanism of communicating and engaging with partners.
County M&E Plan	The M&E plan does not exist.
Annual Costed M&E Work Plan	The county team lacks a costed M&E work plan but has a budget for printing data collection tools in its annual work plans.
Advocacy, Communication, Culture, and Behaviour	Lacks a coordinated advocacy strategy for M&E or a health sector communication strategy.
Routine Monitoring	Essential tools to support routine monitoring are available but are inadequate due to budgetary constraints
Surveys and Surveillance	The county does not have an inventory of surveys conducted but has a functional surveillance system, which collects, reports, and transmits data to the central unit—but which lacks capacity to analyze the data.
County and Subcounty Databases	Has a database platform inherited from HIS but there are gaps in data completeness and adequate equipment at the facility level to manage data.
Supervision and Auditing	The county has guidelines for supportive supervision, including a planning tool, supervision checklist, a scoring mechanism, and a structured report and feedback action plan. However, it does not have policy/procedures/tools for data quality audits.
Evaluation and Research	The county does not have an inventory of institutions undertaking research or a county-specific research agenda.
Data Demand and Use	Due to lack of an M&E plan in place, there is no data use plan or a culture to use the data.
Gaps	The main gaps are: • Insufficient structures to implement M&E activities • Lack of technical capacity to support M&E functions • Lack of a coordinated system that links data generation and use
Recommendations	For effective M&E functioning, Kakamega County needs to: • Build necessary structures for M&E functions • Develop an M&E capacity-building plan that is supported by a sustainable financing mechanism that does not rely on partners • Develop a strong advocacy component to instill a culture of demand-driven data use for planning

GARISSA COUNTY

Overview of M&E Capacity: The county's ability to undertake M&E responsibilities is hampered by administrative challenges of setting up new structures for M&E, which are in their formative stages.

Results from the group assessment of Garissa County's M&E capacity

Status

Quality

Technical

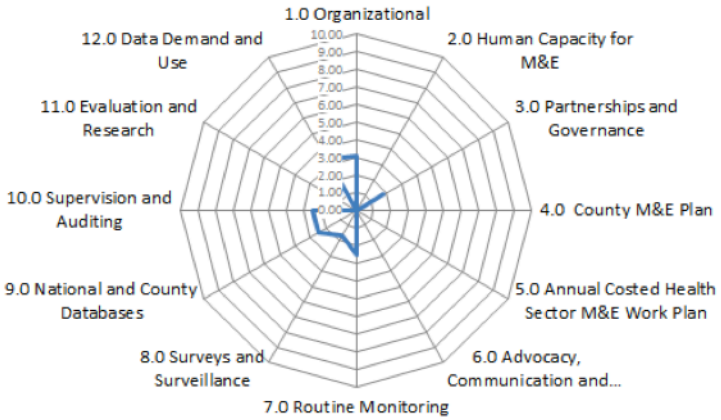
Financial

Capacity Area	Key Observations
Organizational Structure	The M&E unit is at its infancy stage but has no clear guidelines for operations and has inadequate staff.
Human Capacity for M&E	Lacks an M&E human capacity-building plan or a mechanism to coordinate M&E capacity building.
Partnerships and Governance	There are no SOPs that define governance of M&E functions and relations between stakeholders. There is a draft inventory of stakeholders but the operation mechanisms are rudimentary.
County M&E Plan	An M&E plan does not exist.
Annual Costed M&E Work Plan	The county team lacks a costed M&E work plan.
Advocacy, Communication, Culture, and Behaviour	Lacks a coordinated advocacy strategy for M&E or a health sector communication strategy.
Routine Monitoring	Essential tools to support routine monitoring are available but the county needs to strengthen a routine system to track service delivery.
Surveys and Surveillance	The county does not have an inventory of the surveys conducted but has a surveillance system supported by partners.
County and Subcounty Databases	An HIS exists but lacks adequate equipment and supplies, such as Internet services, to link and enter data on time.
Supervision and Auditing	The county has no guidelines for supportive supervision but has an integrated checklist. The county is in the process of adapting the national DQA tool.
Evaluation and Research	The county does not have an inventory of institutions undertaking research or a county-specific research agenda.
Data Demand and Use	The county lacks a data use plan although there are instances where community units use data for decision making via chalk boards as a tool to evaluate performance.
Gaps	Although the county appears to score high in the structural status the main gaps are around: • Lack of technical capacity to support M&E functions • Financial inputs to support the M&E functions
Recommendations	For effective M&E functioning, Garissa County needs to: • Effectively build necessary structures for M&E functions • Develop an M&E capacity-building plan supported by a sustainable financing mechanism that does not rely entirely on partners • Develop a strong advocacy component to instill a culture of demand-driven data use for planning

KILIFI COUNTY	
Overview of M&E Capacity: The county is in the process of setting up an M&E unit but is challenged by generation of poor quality data, the lack of an M&E framework and tools, inadequate funding, insufficient use of data for decision making, and inadequate skills in M&E.	
Results from the group assessment of Kilifi County's M&E capacity	

Status

Quality



Technical

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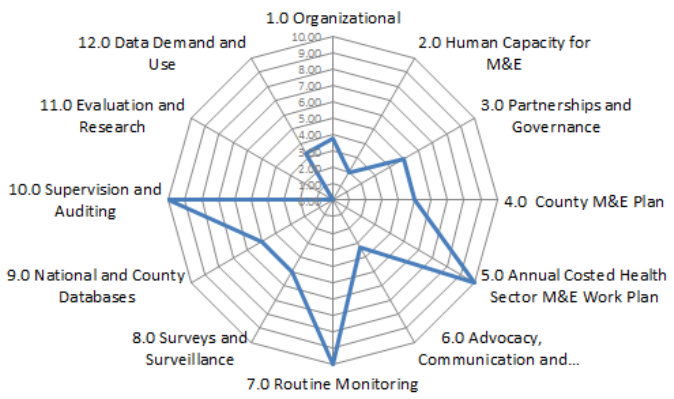
Capacity Area	Key Observations
Organizational Structure	The county has established an M&E unit but lacks clear guidelines to execute its functions. It lacks adequate personnel but has the potential to function better with relevant inputs.
Human Capacity for M&E	The M&E unit staff have qualifications specific to M&E but lack knowledge and skills on managing data and translating it into information and action. The county has a broader human capacity-building plan which is part of the county strategic plan, but does not have any mechanism to coordinate M&E human capacity building to avoid duplication.
Partnerships and Governance	The county has a strategy to support good M&E performance with a standard operating procedure. An inventory of M&E stakeholders for the county is available and well updated. However, the communication systems are partly implemented with external technical support.
County M&E Plan	The county does not have an M&E plan, nor does it have a comprehensive budget for M&E.
Annual Costed M&E Work Plan	There is no costed M&E work plan.
Advocacy, Communication, Culture, and Behaviour	The county lacks a coordinated advocacy strategy for M&E although it has staff with a passion for M&E. The county does not have a health sector communication strategy.
Routine Monitoring	Essential tools to support routine monitoring are available but are inadequate.
Surveys and Surveillance	There is no inventory of the surveys conducted but there is a surveillance system for programs, such as HIV, malaria, nutrition, and infectious disease surveillance and response, which is supported by partners.
County and Subcounty Databases	The county database is updated but not regularly due to lack of adequate equipment.
Supervision and Auditing	The county has guidelines for supportive supervision and tools adapted from the national level. Policy/procedures/tools for data quality audits are available and used to conduct DQA.
Evaluation and Research	The county has a draft research agenda and a research committee in place.
Data Demand and Use	Lacks data use plan but data analysis and presentation guidelines adapted from national government exist.
Gaps	The county appears to have basic structural features for M&E but gaps are around: • Existence of work plans that drive the vision of the M&E activities • The technical capacity to operationalize M&E functions • Financial inputs to support M&E functions
Recommendations	For effective M&E functioning, Kilifi County needs to: • Effectively develop a clear road map for implementing M&E activities that are supported by a budgetary allocation • Develop a strong advocacy component to strengthen a culture of demand-driven data use for planning

KIRINYAGA COUNTY

Overview of M&E Capacity: The county does not have a functional M&E unit in place, with most M&E functions, including coordination, being carried out by the Health Records and Information Office.

Results from the group assessment of Kirinyaga County's M&E capacity

Status



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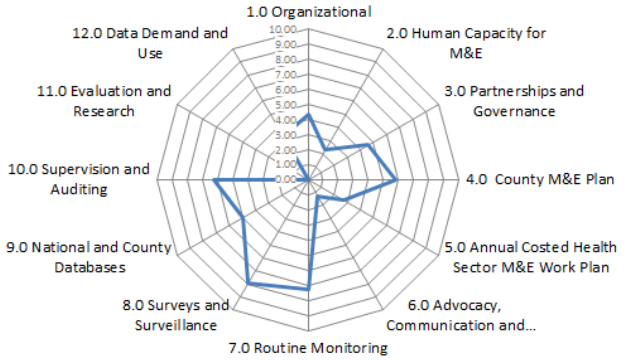

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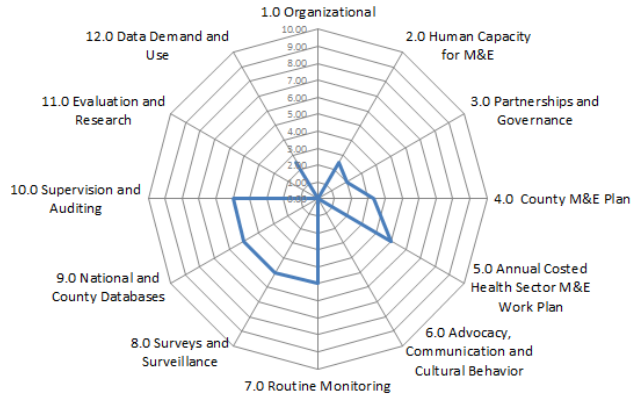


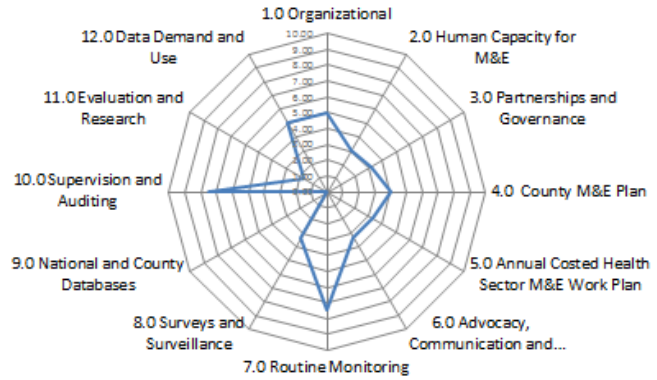
Capacity Area	Key observations
Organizational Structure	The county does not have an M&E unit, with most M&E functions being carried out by the health and information records officers in the county.
Human Capacity for M&E	The county does not have a human capacity-building plan for M&E.
Partnerships and Governance	The county lacks a policy to support M&E in the county as well as clear mechanisms to communicate M&E activities. There is a draft inventory of M&E stakeholders.
County M&E Plan	The county does not have an M&E work plan.
Annual Costed M&E Work Plan	The county team does not have a costed M&E work plan.
Advocacy, Communication, Culture, and Behaviour	The county has a health sector communication strategy adapted from the national level.
Routine Monitoring	Essential tools to support routine monitoring are available but are inadequate.
Surveys and Surveillance	The county has protocols adopted from national guidelines, which are adhered to during surveillance activities.
County and Subcounty Databases	The county uses DHIS but it does not capture all the relevant data elements required by the county.
Supervision and Auditing	The county has guidelines for supportive supervision adapted from the national level. Data quality audits are available but their implementation is less optimal and is dependent on availability of funds and support.
Evaluation and Research	There is no inventory of relevant stakeholders conducting research. However, there exists a research agenda relevant to the needs of the county.
Data Demand and Use	The county lacks a data use plan as well as data analysis and presentation guidelines.
Gaps	The county appears to have basic structural features for M&E but the quality of the structural features is compromised by: • Lack of work plans that drive the vision of M&E activities • Inadequate technical capacity to operationalize M&E functions • Lack of sufficient financial inputs to support M&E functions
Recommendations	For effective M&E functioning, Kirinyaga County needs to: • Effectively develop a clear road map for implementing M&E activities that are supported by a budgetary allocation • Strengthen effective structures to implement M&E functions • Develop strong routine data collection to support the M&E system

KISUMU COUNTY

Overview of M&E Capacity: Kisumu County does not have an M&E unit and the CHMT's ability to undertake its M&E responsibilities is limited by a weak M&E framework and inadequate allocation of funds to support planning processes.

Results from the group assessment of Kisumu County's M&E capacity

Status



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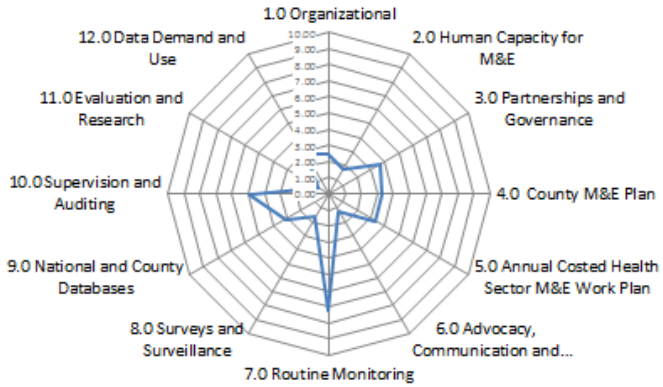

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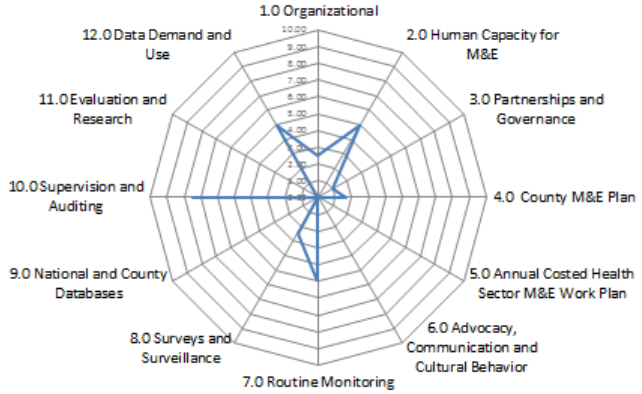

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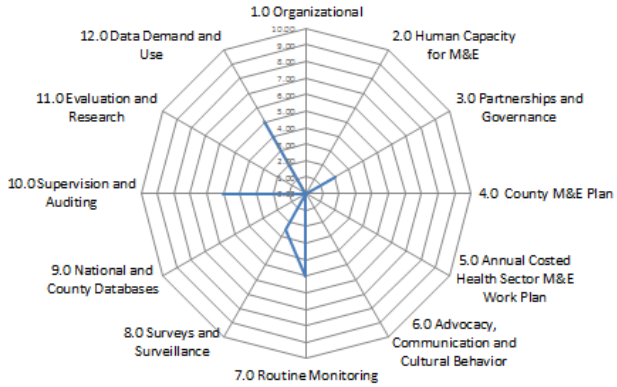


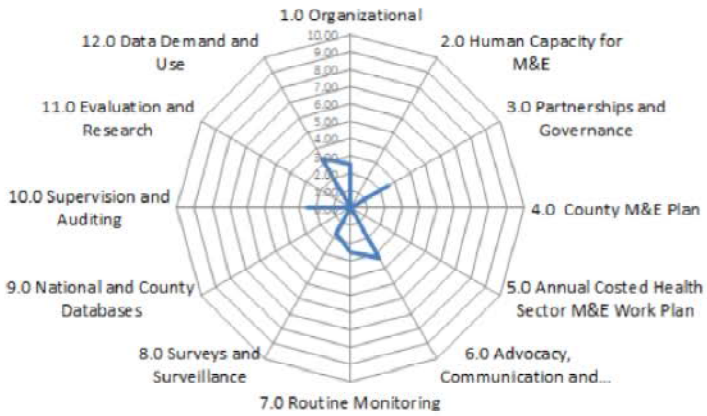
Capacity Area	Key Observations
Organizational Structure	The county does not have an M&E unit.
Human Capacity for M&E	The county does not have a human capacity-building plan for M&E.
Partnerships and Governance	The county lacks a structure to coordinate M&E activities and does not have an inventory of stakeholders supporting M&E activities.
County M&E Plan	The county does not a have stand-alone M&E work plan. The M&E work plan is embedded in the county health sector strategic plan, which does not feed into the county integrated development plan.
Annual Costed M&E Work Plan	The county team does not have a costed M&E work plan.
Advocacy, Communication, Culture, and Behaviour	The county does not have a strong advocacy plan for M&E or a health sector communication strategy.
Routine Monitoring	The county has the potential to conduct routine M&E even though it is suboptimal.
Surveys and Surveillance	The county has surveillance systems supported by partners. However, it does not keep an inventory of the surveys conducted.
County and Subcounty Databases	The county relies on DHIS 2 for managing data but is faced with challenges, including inadequate infrastructure and equipment for data management, and inadequate knowledge and skills in information communication technology (ICT).
Supervision and Auditing	The county has guidelines for supportive supervision adapted from the national level but data audits are largely driven by partners.
Evaluation and Research	There is no inventory of relevant stakeholders conducting research. Although there a research agenda exists, the county does not conduct operations research.
Data Demand and Use	The county has data architecture in the strategic plan but lacks data demand and use plans.
Gaps	The county does not have effective basic structural features for M&E and also lacks: • The technical capacity to operationalize M&E functions • Financial inputs to support the M&E functions • Behavioural orientations towards supporting an M&E system
Recommendations	For effective M&E functioning Kisumu County needs to: • Effectively develop a clear road map for setting an effective M&E system supported by a budgetary allocation • Develop strong capacity-building plans to support the M&E system • Provide an effective road map to implementing M&E functions linked to the county health sector plan

KITUI COUNTY

Overview of M&E Capacity: Although at the county level there is increased demand for data to document progress, evaluate impact, and ensure accountability in the health sector, the county does not have an M&E unit.

Results from the group assessment of Kitui County's M&E capacity

Status



Quality

Technical

Financial

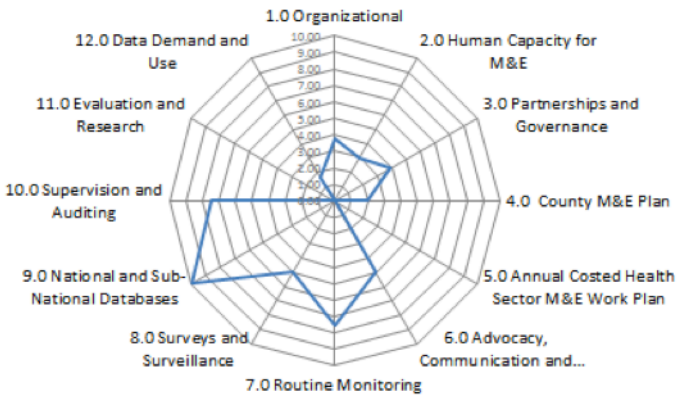
Capacity Area	Key Observations
Organizational Structure	The county does not have an M&E unit.
Human Capacity for M&E	The county does not have a human capacity-building plan for M&E.
Partnerships and Governance	The county lacks a structure to coordinate M&E activities and lacks an inventory of stakeholders supporting M&E activities.
County M&E Plan	The county does not a have stand-alone M&E work plan.
Annual Costed M&E Work Plan	The county team does not have a costed M&E work plan.
Advocacy, Communication, Culture, and Behaviour	The county does not have an advocacy plan for M&E or a health sector communication strategy.
Routine Monitoring	The county has the potential to conduct routine M&E even though it is suboptimal.
Surveys and Surveillance	The county has surveillance systems at the program level but there are no inventories of the surveys conducted.
County and Subcounty Databases	The county relies on DHIS 2 for managing data but is faced with challenges of inadequate ICT infrastructure and equipment for data management and inadequate knowledge and skills in ICT.
Supervision and Auditing	The county has guidelines for supportive supervision adapted from the national level. Data audits are not done routinely.
Evaluation and Research	There is no inventory of relevant stakeholders conducting research.
Data Demand and Use	The county lacks data demand use plans.
Gaps	The county lacks the capacity to implement M&E functions in all areas of interest. The county does not have adequate structural, technical, and financial capacity to operationalize M&E functions.
Recommendations	For effective M&E functioning, Kitui County needs to: • Effectively develop a clear road map for developing an M&E system supported by a budgetary allocation • Develop a capacity-building plan to support the M&E system

MACHAKOS COUNTY

Overview of M&E Capacity: The county does not have effective structures for implementing M&E functions.

Results from the group assessment of Machakos County's M&E capacity

Status



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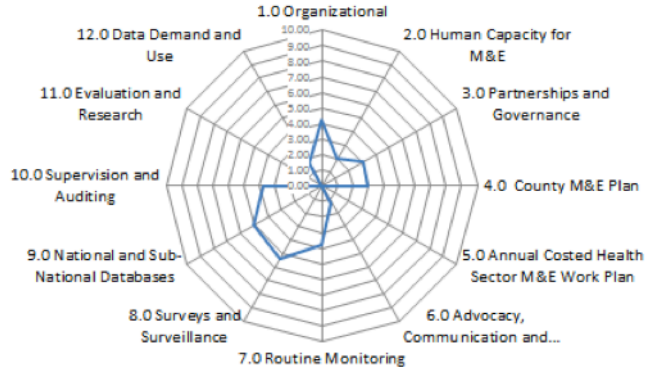

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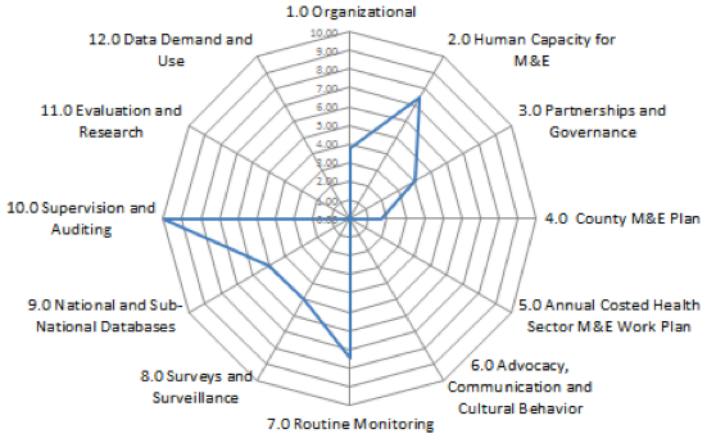


Financial

Capacity Area	Key Observations
Organizational Structure	The county does not have an M&E unit.
Human Capacity for M&E	The county does not have a human capacity-building plan for M&E.
Partnerships and Governance	The county lacks a structure to coordinate M&E activities and does not have an inventory of stakeholders supporting M&E activities.
County M&E Plan	The county does not a have stand-alone M&E work plan.
Annual Costed M&E Work Plan	The county team does not have a costed M&E work plan.
Advocacy, Communication, Culture, and Behaviour	The county does not have an advocacy plan for M&E or a health sector communication strategy.
Routine Monitoring	Routine M&E is largely weak and only relies on what is generated from DHIS.
Surveys and Surveillance	The county has surveillance systems at the program level but there are no inventories of the surveys conducted.
County and Subcounty Databases	The county relies on DHIS 2 to manage data.
Supervision and Auditing	The county has guidelines for supportive supervision adapted from the national level.
Evaluation and Research	There is no inventory of relevant stakeholders conducting research.
Data Demand and Use	The county lacks data demand and use plans.
Gaps	The county lacks the capacity to implement M&E functions in all areas of interest. The county does not have adequate structural, technical, and financial capacity to operationalize M&E functions.
Recommendations	For effective M&E functioning, Machakos County needs to: • Effectively develop a clear road map for developing an M&E system supported by a budgetary allocation • Develop a capacity-building plan to support the M&E system

NAKURU COUNTY

Overview of M&E Capacity: The Nakuru CHMT's ability to undertake M&E responsibilities is hampered by the absence a designated M&E unit, a comprehensive policy to guide M&E performance and operations, and inadequate staffing at the county level for M&E functioning.

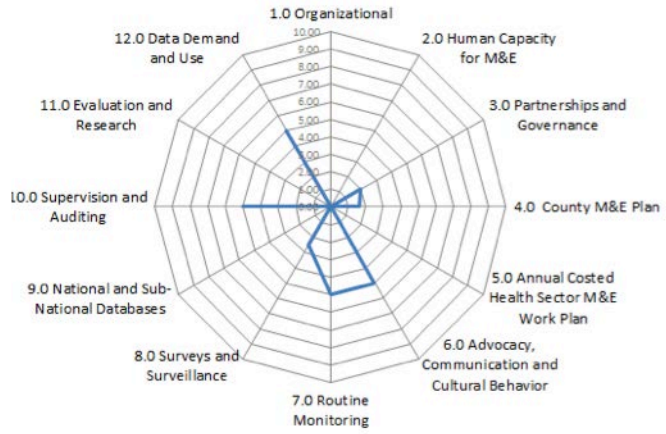
Results from the group assessment of Nakuru County's M&E capacity

Status

Quality

Technical

Financial



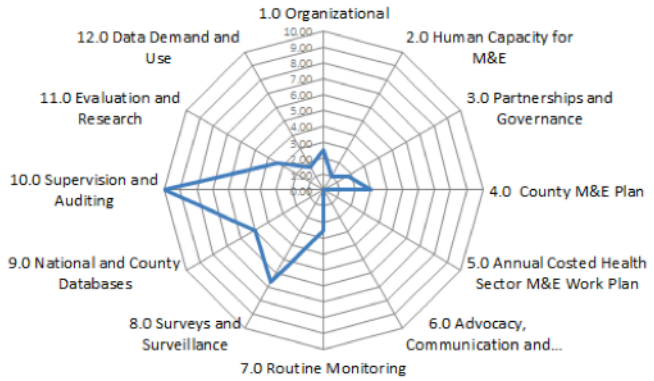
Capacity Area	Key Observations
Organizational Structure	The county has no M&E unit.
Human Capacity for M&E	There is inadequate capacity to fulfill M&E functions.
Partnerships and Governance	The county has an inventory of M&E stakeholders but does not have M&E standard operating procedures or formal and systematic processes to share feedback.
County M&E Plan	The county does not have an M&E plan.
Annual Costed M&E Work Plan	The county does not have a costed M&E work plan.
Advocacy, Communication, Culture, and Behaviour	The county lacks a coordinated advocacy strategy for M&E but has a draft health promotion and communication strategy.
Routine Monitoring	Essential tools to support routine monitoring are available but are inadequate.
Surveys and Surveillance	The county has a surveillance system adapted from the national system. There are no inventories for surveys and surveillance conducted in the county.
County and Subcounty Databases	The county database is based on DHIS with a clear process of communicating/ reporting data collected with standardized tools. However, there are additional databases for different programs that are not linked to the DHIS.
Supervision and Auditing	The county utilizes guidelines for supportive supervision tools adapted from the national level.
Evaluation and Research	There is no research agenda or a research team in place.
Data Demand and Use	The county lacks a data use plan. Dissemination of any data is done in an *ad hoc* manner.
Gaps	Although the basic structural features for M&E exist, the gaps are around an effective roadmap for M&E activities in the form of a costed work plan and a human capacity plan to drive the vision of M&E activities that is supported by a sustainable financial system.
Recommendations	For effective M&E functioning, Nakuru County needs to: • Effectively develop a clear road map for implementing M&E activities that is supported by a budgetary allocation • Develop a capacity-building plan with a strong advocacy component to strengthen a culture of demand-driven data use for planning

NAROK COUNTY

Overview of M&E Capacity: The Narok CHMT does not have an M&E unit nor does it have officers designated as M&E staff. However, some of the M&E functions, such as routine data management, reporting, and reviews are led by the county health records and information officer. The necessary structures for M&E are at their infancy stage, with limited capacity to function effectively.

Results from the group assessment of Narok County's M&E capacity

Status



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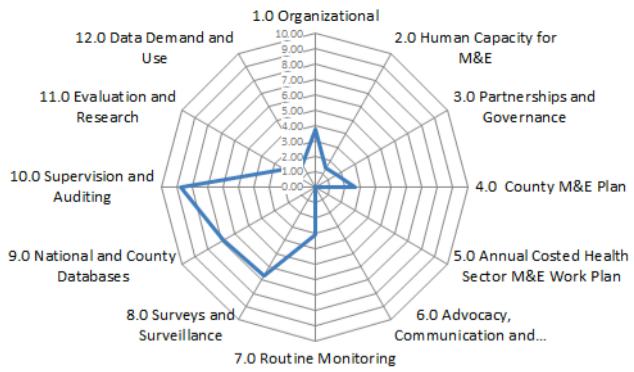


Technical

Financial

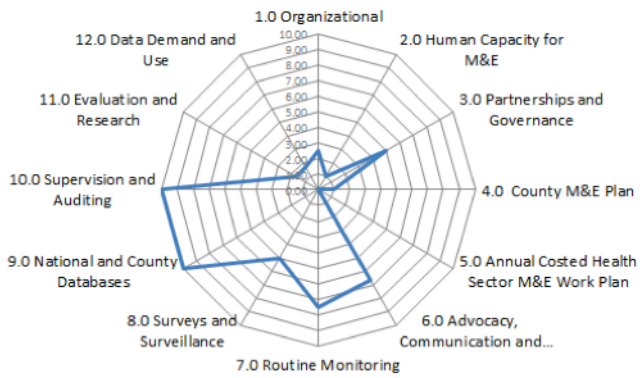
Capacity Area	Key Observations
Organizational Structure	The county has no M&E unit with associated policies/strategies, staffing, and operational procedures.
Human Capacity for M&E	There is limited capacity to fulfill M&E functions.
Partnerships and Governance	The county does not have an inventory of M&E stakeholders, M&E guidelines, or a policy to support M&E performance, and has no standard operating procedures.
County M&E Plan	The county does not have an M&E plan.
Annual Costed M&E Work Plan	The county does not have a costed M&E work plan.
Advocacy, Communication, Culture, and Behaviour	The county lacks an advocacy strategy for M&E.
Routine Monitoring	Essential tools to support routine monitoring are available but there are no guidelines to support its implementation.
Surveys and Surveillance	The county has a surveillance system managed by the national government. There are no inventories for surveys and surveillance conducted in the county.
County and Subcounty Databases	The county DHIS is linked to subcounty level databases. The county database is linked to the national DHIS, except EMR, EIDSR and MFL, which were developed with both the national government and external technical and financial support.
Supervision and Auditing	The county utilizes guidelines for supportive supervision tools adapted from the national level. There are tools for supervision and auditing with mechanisms for feedback.
Evaluation and Research	There is no inventory of research undertaken in the county, and no research agenda for the county.
Data Demand and Use	The county lacks a data use plan and data analysis and presentation guideline. Data are disseminated through stakeholder forums or performance review meetings.
Gaps	With the exception of organizational capacity, there are gaps in almost all capacity areas in terms of technical capacity and financial ability to implement M&E functions.
Recommendations	For effective M&E functioning, Narok County needs to: • Effectively develop a clear road map by developing a costed work plan for implementing M&E activities • Develop a capacity-building plan to ensure a functional M&E system • Strengthen a culture of demand-driven data use for planning

NYERI COUNTY

Overview of M&E Capacity: Nyeri County did not have a functional M&E unit and most M&E functions were carried out by the health records information officer. Overall, the county lacks adequate technical capacity to drive the M&E agenda.

Results from the group assessment of Nyeri County's M&E capacity

Status



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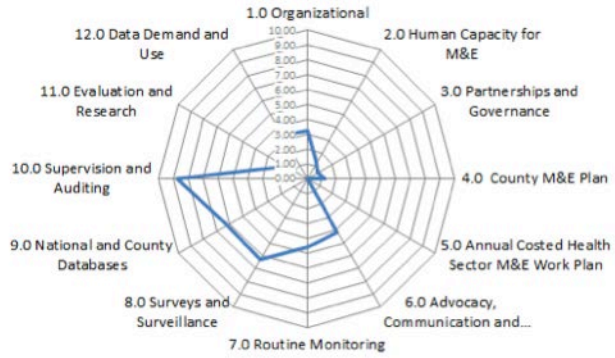


Technical

Financial

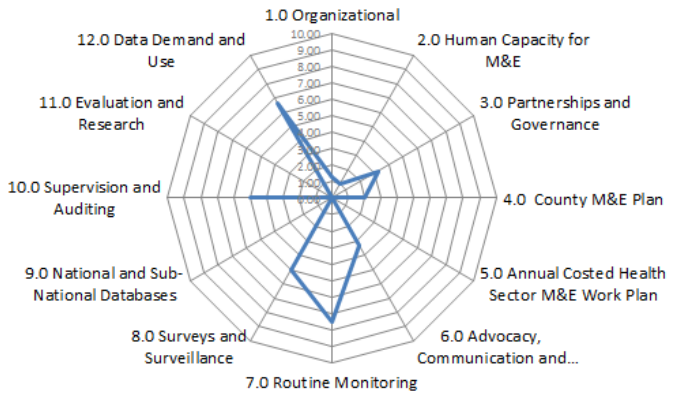
Capacity Area	Key Observations
Organizational Structure	The county has no M&E unit with associated policies/strategies, staffing and operational procedures.
Human Capacity for M&E	There is limited capacity to fulfill M&E functions; some CHMTs can perform M&E functions but to a limited capacity using basic applications and approaches.
Partnerships and Governance	The county has no policy to support M&E in the county, as well as clear mechanisms to communicate M&E activities. There is no inventory of M&E stakeholders.
County M&E Plan	The county does not have an integrated M&E plan.
Annual Costed M&E Work Plan	At the time of the assessment there were no costed M&E work plans.
Advocacy, Communication, Culture, and Behaviour	The county lacks an advocacy strategy for M&E; however, the county has a communication strategy for health promotion, which was adopted from the national level.
Routine Monitoring	Essential tools to support routine monitoring are available but are not sufficient and do not address all areas of interest.
Surveys and Surveillance	The county has a surveillance system but does not have inventories for surveys and surveillance conducted in the county.
County and Subcounty Databases	The county DHIS is the main database used. The database is updated on a monthly basis. However, it does not capture all relevant data elements required by the county as the data base design was not informed by demands of the end users. ICT infrastructure is also not adequate.
Supervision and Auditing	The county conducts supervision visits from the routine data collection points, such as facilities and community units; where they exist, guidelines and tools are adhered to during the exercise.
Evaluation and Research	There is no inventory of research undertaken in the county, but the county has a research agenda relevant to the needs of the county.
Data Demand and Use	The county lacks a data use plan; however, no data analysis and presentation guideline exists.
Gaps	Except for organizational capacity, there are gaps in almost all capacity areas in terms of technical capacity and financial ability to implement M&E functions.
Recommendations	For effective M&E functioning, Nyeri County needs to: • Effectively develop a clear road map by developing a costed work plan for implementing M&E activities • Develop a capacity-building plan to ensure a functional M&E system • Strengthen a culture of demand-driven data use for planning

MERU COUNTY

Overview of M&E Capacity: Meru County lacks capacity to effectively implement M&E functions, as evidenced by lack of specialized staffing, insufficient financial capacity for M&E-related functions, and a perception that M&E functions are peripheral in significance compared to curative and preventive health interventions.

Results from the group assessment of Meru County's M&E capacity

Status



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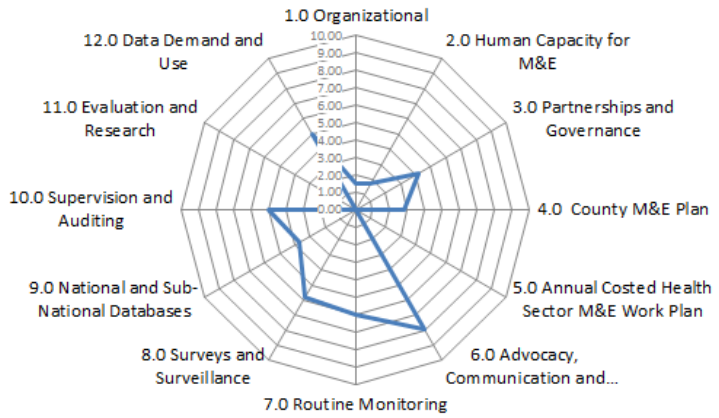


Technical

Financial

Capacity Area	Key Observations
Organizational Structure	The county lacks a functional M&E unit and has an inadequately staffed system skewed towards curative services.
Human Capacity for M&E	The county has inadequate capacity to fulfill M&E functions.
Partnerships and Governance	The county lacks a clear mapping of all the stakeholders and their level of effort and contribution to the health system. The county lacks a strategy or policy to support good M&E performance. Standard operating procedures for HIS are perceived to be those of M&E.
County M&E Plan	The county does not have an integrated M&E plan.
Annual Costed M&E Work Plan	The county lacks a costed M&E work plan.
Advocacy, Communication, Culture, and Behaviour	The county lacks an advocacy strategy for M&E.
Routine Monitoring	Essential tools to support routine monitoring are available but do not address all areas of interest.
Surveys and Surveillance	The county has a surveillance system and has inventories for surveys and surveillance conducted in the county.
County and Subcounty Databases	Availability of IT infrastructure is not adequate but is able to link data to subcounty levels.
Supervision and Auditing	Guidelines and tools for supportive supervision are available. However, DQA appears to be available for HIV/AIDS and immunization indicators only.
Evaluation and Research	The county lacks a health sector research and evaluation agenda.
Data Demand and Use	Ineffective DDU due to incompetence, poor data management skills, lack of motivation among key staff to keep up-to-date records, and a perception that data needs are for pleasing senior managers.
Gaps	There are gaps in almost all capacity areas in terms of technical capacity and financial ability to implement M&E functions. A major gap identified is the lack of a positive attitude towards data use.
Recommendations	For effective M&E functioning, Meru County needs to: • Effectively develop a clear road map by developing a costed work plan for implementing M&E activities • Develop a capacity-building plan to ensure a functional M&E system • Strengthen a culture of demand-driven data use for planning

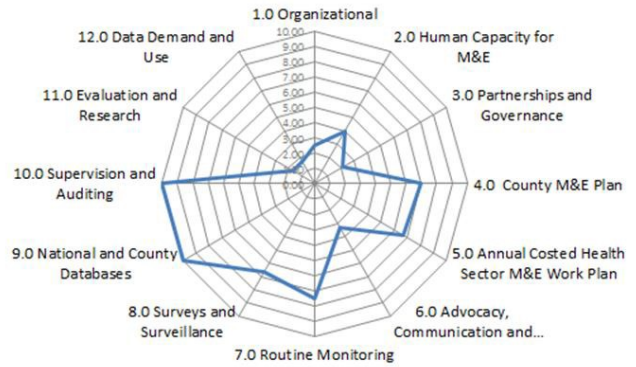
NAIROBI COUNTY	
Overview of M&E Capacity: The county lacks capacity to effectively implement M&E functions, as evidenced by inadequate staffing, insufficient structural capacity for M&E-related functions, and lack of clear guidelines for implementing M&E functions.	
Results	**from the group assessment of Nairobi County's M&E capacity**

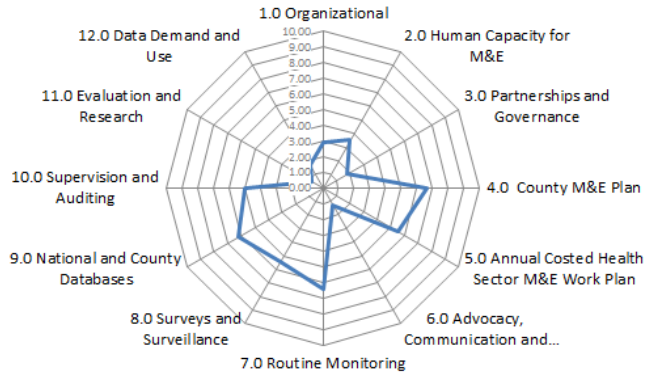
Capacity Area	Key Observations
Organizational Structure	There is no M&E unit in the county and the M&E activities are not aligned with the proposed SP.
Human Capacity for M&E	The county has core staff trained in M&E fundamentals but requires more county and subcounty personnel to be trained in M&E and needs to enhance basic skills and build more skill sets. The county does not have a consolidated capacity-building plan for all personnel.
Partnerships and Governance	The existing map of stakeholders is linked to specific disease programs, thus data on stakeholders is not consolidated. There are no structures or clear mechanisms to communicate M&E activities and decisions.
County M&E Plan	The county does not have an integrated M&E plan for the health SP.
Annual Costed M&E Work Plan	The county does not have a costed M&E work plan although there is an indication that M&E activities are highlighted in the SP and budget estimates provided.
Advocacy, Communication, Culture, and Behaviour	The county lacks an advocacy strategy for M&E. Although the county had created an M&E and OR TWGs internally to champion M&E-related aspects, the teams were not fully effective. The communication section has rudimentary structures in place.
Routine Monitoring	Essential tools to support routine monitoring are available but do not address all areas of interest. There is insufficient infrastructure for supporting routine monitoring.
Surveys and Surveillance	The county has a well-documented surveillance system but lacks a feedback mechanism. The county has no inventories for surveys conducted in the county.
County and Subcounty Databases	There is a perception that county teams are like observers who send data to the national level, but do not use the data for decision making. Thus there is a need to build their capacity so that they can use data to make decisions.
Supervision and Auditing	Guidelines and tools for supportive supervision are not county-specific. However, DQAs are available for different programs and are donor-driven.
Evaluation and Research	The county lacks a health sector research agenda and forums for discussing any research conducted.
Data Demand and Use	There is ineffective data demand and use due to the limited number of trained staff.
Gaps	There are gaps in effective structures for M&E and technical capacity to implement M&E functions. A major gap is observed in data demand and use.
Recommendations	For effective M&E functioning, Nairobi County needs to: • Effectively develop a clear road map by developing an M&E unit with a clear framework for implementing M&E activities • Develop a capacity-building plan to ensure a functional M&E system • Strengthen a culture of demand-driven data use for planning

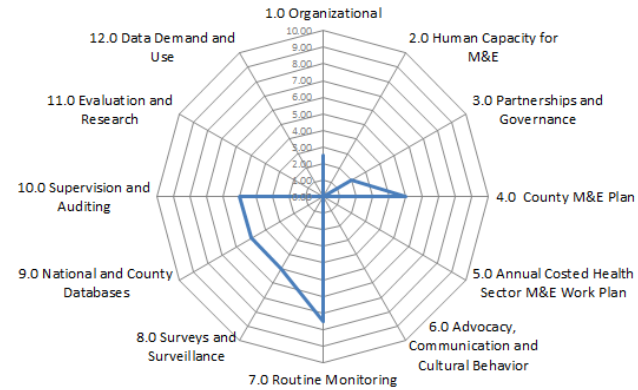
MOMBASA COUNTY

Overview of M&E Capacity: The county lacks capacity to effectively implement M&E functions, as evidenced by inadequate staffing, lack of structural capacity for M&E-related functions and lack of clear guidelines for implementing M&E functions.

Results from the group assessment of Mombasa County's M&E capacity



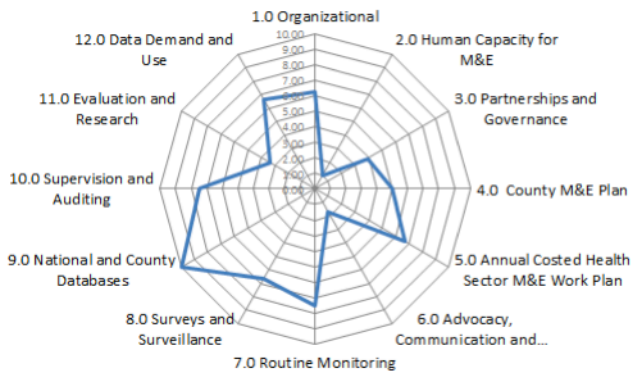




Capacity Area	Key Observations
Organizational Structure	There is no M&E unit in the county; M&E activities are implemented by an M&E coordinator.
Human Capacity for M&E	The county does not have an M&E capacity-building plan but a blanket budget is available for all capacity-building activities. The county lacks a mechanism to coordinate capacity building.
Partnerships and Governance	The county does not have a strategy in place to support good M&E performance. An inventory of M&E stakeholders is unavailable. The county lacks an M&E-related communication plan. Current communication systems and mechanisms are implemented partly with external technical support and with minimal support from the county.
County M&E Plan	The county does not have an integrated M&E plan for the health sector.
Annual Costed M&E Work Plan	The county does not have an integrated costed M&E work plan.
Advocacy, Communication, Culture, and Behaviour	The county lacks a broader advocacy strategy for M&E, although at the program level, there are program-specific advocacy and communication strategies, e.g., for malaria, PMTCT and reproductive health.
Routine Monitoring	Essential tools to support routine monitoring are available but do not address all areas of interest.
Surveys and Surveillance	The county has a surveillance system with partners but only covers communicable diseases.
County and Subcounty Databases	Linkages exist between the county and subcounty databases due to the existence of the DHIS 2. However, structures, mechanisms, procedures and time frame for transmitting, entering, extracting, merging and transferring data between databases that support the county M&E system are only partly available.
Supervision and Auditing	Guidelines and tools for supportive supervision are not county-specific. However, support supervision is irregular. Data quality audits are conducted as per the stipulated policy/procedures but are also not regular.
Evaluation and Research	The county lacks a health sector research agenda, databases for work done and forums for discussing any research conducted.
Data Demand and Use	The county has ineffective data demand use with no data use plan in place and does not disseminate information products to stakeholders.
Gaps	There are gaps in ensuring that M&E structures are effective and the need for an effective team to spearhead M&E functions. A major gap has been observed in data demand and use and evaluation and research.
Recommendations	For effective M&E functioning, Mombasa County needs to: • Effectively develop an effective M&E unit with a clear framework for implementing related activities • Develop a capacity-building plan to ensure a functional M&E system • Strengthen a culture of demand-driven data use for planning

SIAYA COUNTY
Overview of M&E Capacity: The county lacks an effective M&E system. The coordination of stakeholders is suboptimal, There is limited information use, primarily at the source, to guide planning for activities; operations research is not prioritized.
Results from the group assessment of Siaya County's M&E capacity

Status



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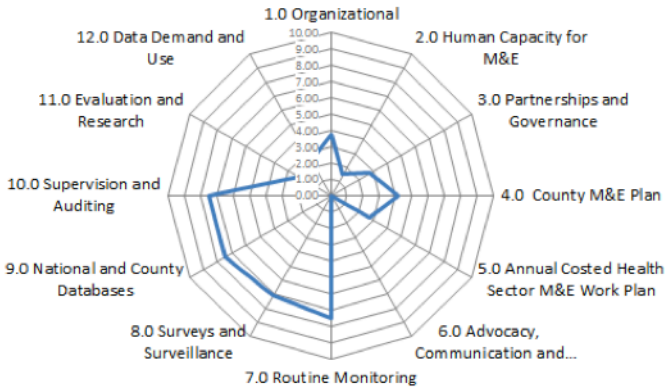

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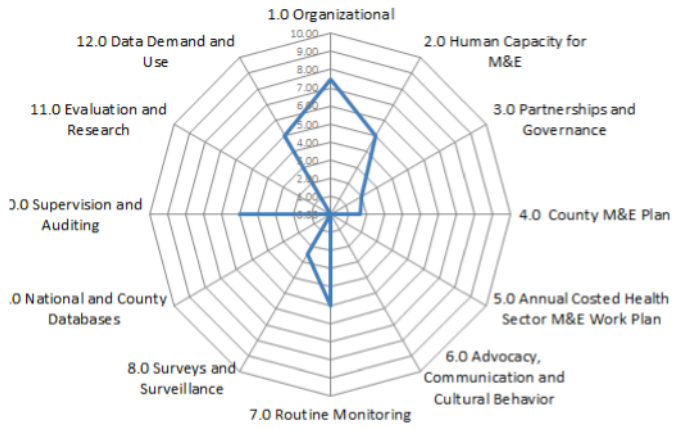


Financial

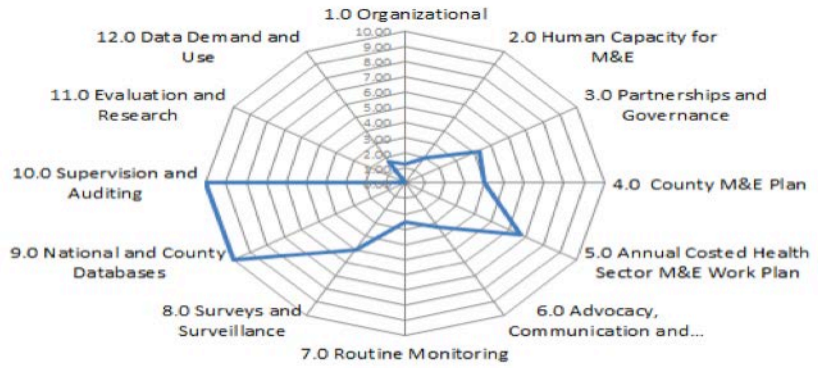
Capacity Area	Key Observations
Organizational Structure	There is no structure in the county to coordinate M&E activities. The strategic plan does not describe M&E functions explicitly. The county relies on partner support to implement M&E functions.
Human Capacity for M&E	The county does not have an M&E capacity-building plan; thus it lacks a mechanism to coordinate capacity-building activities.
Partnerships and Governance	The county does not have a strategy in place to support governance of M&E. It faces several challenges in coordination of partners, including: lack of strong collaboration with other health-related ministries to address cross-cutting issues; partial/incomplete implementation of developed plans; and lack of strategic tools that are necessary in management of M&E. There is no standard operating procedure that defines roles and responsibilities related to M&E functions and activities. The county also lacks an inventory of stakeholders supporting M&E activities in the county.
County M&E Plan	The county does not have an integrated M&E plan that feeds into the county integrated development plan for the health sector. There is heavy reliance on partner support to develop strategic plans, including M&E and annual work plans.
Annual Costed M&E Work Plan	The county does not have an integrated costed M&E work plan.
Advocacy, Communication, Culture, and Behaviour	The county lacks a broader advocacy strategy for M&E. The county integrated strategic plan outlines its M&E framework, which gives overall M&E responsibility to the ministries of communication, economic planning and development. There are no staff in the county who advocate for and support M&E for the county. The county does not have a specific health sector communication strategy.
Routine Monitoring	Routine monitoring recorded high performance in terms of status, quality, and autonomy due to existence of essential tools to support routine monitoring through HMIS. However, the existing tools do not address all areas of interest or procedures to be followed in handling routine monitoring in the health sector. Much effort directed towards data collection in line with national guidelines and SOPs that had been adapted at the county level.
Surveys and Surveillance	The county health sector strategic and investment plan outlines the targets set for conducting data collection exercises through surveillance and research; however it does not give details of how this will be conducted. The county does not keep an inventory of the surveys. Surveillance tools were adopted from the national level and the system was developed by external assistance.
County and Subcounty Databases	Linkages exist between the county and subcounty databases due to the existence of the DHIS 2. However, structures, mechanisms, procedures and time frame for transmitting, entering, extracting, merging, and transferring data between databases that support the county M&E system are not well coordinated. DHIS 2 does not incorporate some data elements that are county- specific.
Supervision and Auditing	Guidelines and tools for supportive supervision are adapted and modified from the tools but not outlined in the AWP or SP. Support supervision is also irregular. Data quality audits are conducted per the stipulated policy/procedures but are not regular.
Evaluation and Research	The county lacks a health sector research agenda, databases for work done, or forums for discussing any research conducted.
Data Demand and Use	The county has ineffective data demand use with no data use plan in place and does not disseminate information products to stakeholders.
Gaps	There are gaps in ensuring that effective M&E structures are in place and supported by effective guidelines. There may be a need for an effective team to spearhead M&E functions. A major gap is in data demand and use, and evaluation and research.
Recommendations	For effective M&E functioning, Siaya County needs to: • Effectively develop an effective M&E unit with a clear framework for implementing related activities • Develop a capacity-building plan to ensure a functional M&E system that takes account of gender issues • Strengthen a culture of demand-driven data use for planning

UASIN GISHU COUNTY

Overview of M&E Capacity: The county lacks capacity to effectively implement M&E functions, as evidenced by lack of a strategic plan with an M&E plan to guide its implementation. There is no M&E unit or staff with the requisite capacity, skills, and knowledge to run the unit. There is weak coordination of partnerships and collaboration, leading to information generated by partners not being utilized to support decisions in the county. The county hosts training institutions; however these have not been effectively tapped for the benefit of the county.

Results from the group assessment of Uasin Gishu County's M&E capacity

Status



Quality

Technical

Financial

Capacity Area	Key Observations
Organizational Structure	There is no structure in the county to coordinate M&E activities as the understanding has been that M&E was a component of HIS.
Human Capacity for M&E	The county does not have an M&E capacity-building plan or coordination mechanisms for organizational development or data demand and use in place.
Partnerships and Governance	The county has a stakeholder inventory for partners in the county which is up-to-date; however, there is no inventory specifically for M&E stakeholders. There are no M&E TWGs or guidelines and policy to acknowledge and support M&E performance and no standard operating procedures or protocols. Regarding M&E communication products, there is the DHIS dashboard for sharing information but the information is never extracted and disseminated to the county for use.
County M&E Plan	The county does not have an integrated M&E plan but utilizes the approved HMIS guidelines.
Annual Costed M&E Work Plan	The county does not have a costed M&E work plan.
Advocacy, Communication, Culture, and Behaviour	The county lacks a broader advocacy strategy for M&E and a county-specific health sector communication strategy.
Routine Monitoring	Tools for data management are in place but not adequate; however they are standard across all tiers depending on the nature of the service delivered. The tools do not capture some essential indicators, such as cervical cancer screening and drug use. There are no M&E guidelines documenting procedures apart from those that are programmatic, e.g., HIV guidelines.
Surveys and Surveillance	There is an updated inventory for surveillance activities in place for the county, which is through the national system via the DDSR website that allows the subcounty disease surveillance officers to upload their information directly to the website and the county disease surveillance officer to visualize the summaries from the website. There is no inventory of institutional surveys at the county level. Disease surveillance reports are not captured in the DHIS as the tools used on the ground differ from those in the DHIS.
County and Subcounty Databases	The county utilizes the national DHIS databases for capturing and storing data, and is up-to-date at the subcounty level. This is effectively done in the three former subcounties which are computerized and well established to carry out this function but not so well established in the three new subcounties due to inadequate IT infrastructure. The databases do not capture all data elements required by the county M&E system as certain key indicators, such as on cervical cancer, are not captured. Also there is no linkage between the IDSR and the national database.
Supervision and Auditing	Checklist for supportive supervision is not customized to fit county and subcounty needs. Supervision is not done routinely due to poor planning at the county level and the challenges that have arisen due to the re-organization taking place in the counties.
Evaluation and Research	There is no inventory/register/database relevant to the county to undertake research and evaluation, no county-specific research agenda, and no county forums for dissemination and discussion of research findings—despite the presence of research institutions.
Data Demand and Use	There is no data use plan in the county; the county disseminates information products to stakeholders and MOH data users and producers through monthly meetings with the in-charges. There are no data analysis and presentation guidelines in place.
Gaps	There are gaps in ensuring that effective M&E structures are in place and supported by effective guidelines. There may be a need for an effective team to spearhead M&E functions. A major gap is in data demand and use and evaluation and research, as well as in streamlining data management and architecture across systems.
Recommendations	For effective M&E functioning, Uasin Gishu County needs to: • Effectively develop an effective M&E unit with a clear framework for implementing related activities • Develop a capacity-building plan to ensure a functional M&E system that takes account of gender issues • Strengthen a culture of demand-driven data use for planning

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