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<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ALOS</td>
<td>Average Length of Stay</td>
</tr>
<tr>
<td>ALs</td>
<td>Artemether Lumefantrine</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>APR</td>
<td>Annual Performance Review</td>
</tr>
<tr>
<td>ARVs</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>AWP</td>
<td>Annual Work Plan</td>
</tr>
<tr>
<td>BCRH</td>
<td>Busia County Referral Hospital</td>
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<tr>
<td>BEmONC</td>
<td>Basic Emergence Obstetric Care</td>
</tr>
<tr>
<td>BMI</td>
<td>Body Mass Index</td>
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<tr>
<td>CASCO</td>
<td>County AIDS and STIs Coordinator</td>
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<td>CCO</td>
<td>County Clinical Officer</td>
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<tr>
<td>CDH</td>
<td>County Director of Health</td>
</tr>
<tr>
<td>CECM</td>
<td>County Executive Committee Member</td>
</tr>
<tr>
<td>CEmONC</td>
<td>Comprehensive Emergency Obstetric and Newborn Care</td>
</tr>
<tr>
<td>CHA</td>
<td>Community Health Assistant</td>
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<tr>
<td>CHAO</td>
<td>County Health Administration Officer</td>
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<tr>
<td>CHC</td>
<td>Community Health Committee</td>
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<tr>
<td>CHEW</td>
<td>Community Health Extension Worker</td>
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<td>CHMT</td>
<td>County Health Management Team</td>
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<tr>
<td>CHRIO</td>
<td>County Health Records and Information Officer</td>
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<td>CHSSIP</td>
<td>County Health Sector Strategic and Investment Plan</td>
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<tr>
<td>CHVs</td>
<td>Community Health Volunteers</td>
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<td>Community Health Workers</td>
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<tr>
<td>CLTS</td>
<td>Community-Led Total Sanitation</td>
</tr>
<tr>
<td>CMCC</td>
<td>County Malaria Control Coordinator</td>
</tr>
<tr>
<td>CMLT</td>
<td>County Medical Laboratory Technologists</td>
</tr>
<tr>
<td>CNO</td>
<td>County Nursing Officer</td>
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<tr>
<td>CPD</td>
<td>Continous Professional Development</td>
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<tr>
<td>CPHO</td>
<td>County Public Health Officer</td>
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<td>CRD</td>
<td>Civil Registration Department</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil Society Organization</td>
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<td>CTLC</td>
<td>County TB and Leprosy Coordinator</td>
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<tr>
<td>CU</td>
<td>Community Unit</td>
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<tr>
<td>DDSR</td>
<td>Division of Disease Surveillance and Response</td>
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<tr>
<td>DDU</td>
<td>Data Demand and Use</td>
</tr>
<tr>
<td>DHIS2</td>
<td>District Health Information System 2</td>
</tr>
<tr>
<td>DQA</td>
<td>Data Quality Assurance</td>
</tr>
<tr>
<td>EMMS</td>
<td>Essential Medicine and Medical Supplies</td>
</tr>
<tr>
<td>EMR</td>
<td>Electronic Medical Record</td>
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<tr>
<td>EPI</td>
<td>Expanded Program on Immunization</td>
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<tr>
<td>FANC</td>
<td>Focused Antenatal Care</td>
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<tr>
<td>FBO</td>
<td>Faith Based Organization</td>
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<td>FP</td>
<td>Family Planning</td>
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<tr>
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<td>Geographical Information System</td>
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<tr>
<td>HCWs</td>
<td>Healthcare Workers</td>
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<td>HEI</td>
<td>HIV Exposed Infant</td>
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<tr>
<td>HF</td>
<td>Health Facility</td>
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<td>HIS</td>
<td>Health Information System</td>
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<td>HMIS</td>
<td>Health Management and Information System</td>
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<td>Health Records and Information Officer</td>
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<td>HSSP</td>
<td>Health Sector Support Programme</td>
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<td>HTS</td>
<td>HIV Testing Service</td>
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<tr>
<td>ICT</td>
<td>Information and Communication Technology</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
</tr>
<tr>
<td>IDSR</td>
<td>Integrated Disease Surveillance and Response</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>IFAS</td>
<td>Iron Folic Acid Supplement</td>
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<tr>
<td>iHRIS</td>
<td>Integrated Human Resources Information System</td>
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<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Illness</td>
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<tr>
<td>IPV</td>
<td>Inactivated Polio Vaccine</td>
</tr>
<tr>
<td>KDHS</td>
<td>Kenya Demographic and Health Survey</td>
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<tr>
<td>KEMSA</td>
<td>Kenya Medical Supplies Authority</td>
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<tr>
<td>KEPH</td>
<td>Kenya Essential Package of Health</td>
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<tr>
<td>KEPI</td>
<td>Kenya Expanded Programme on Immunization</td>
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<tr>
<td>KHSSIP</td>
<td>Kenya Health Sector Strategic and Investment Plan</td>
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<td>KNBS</td>
<td>Kenya National Bureau of Statistics</td>
</tr>
<tr>
<td>KPI</td>
<td>Key Performance Indicators</td>
</tr>
<tr>
<td>LLINs</td>
<td>Long Lasting Insecticidal Nets</td>
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<tr>
<td>LMIS</td>
<td>Logistic Management Information System</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MCH</td>
<td>Maternal Child Health</td>
</tr>
<tr>
<td>MDA</td>
<td>Multi-Drug Administration</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MRI</td>
<td>Magnetic Resonance Imaging</td>
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<tr>
<td>NBU</td>
<td>New Born Unit</td>
</tr>
<tr>
<td>NCD</td>
<td>Non-Communicable Diseases</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>NHIF</td>
<td>National Health Insurance Fund</td>
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<tr>
<td>NHP Plus</td>
<td>Nutrition and Health Program Plus</td>
</tr>
<tr>
<td>ODF</td>
<td>Open Defecation Free</td>
</tr>
<tr>
<td>OPD</td>
<td>Out-Patient Department</td>
</tr>
<tr>
<td>RDQA</td>
<td>Routine Data Quality Assessment</td>
</tr>
<tr>
<td>RDT</td>
<td>Rapid Diagnostic Testing</td>
</tr>
<tr>
<td>SCHMT</td>
<td>Sub-County Health Management Team</td>
</tr>
<tr>
<td>SCHRO</td>
<td>Sub-County Health Records and Information Officer</td>
</tr>
<tr>
<td>SDGs</td>
<td>Sustainable Development Goals</td>
</tr>
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<td>SETH</td>
<td>System Enhancing for Transforming Health</td>
</tr>
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<td>SGBV</td>
<td>Sexual and Gender-Based Violence</td>
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<td>SMOH</td>
<td>Sub-County Medical Officer of Health</td>
</tr>
<tr>
<td>SOPs</td>
<td>Standard Operating Procedures</td>
</tr>
<tr>
<td>SWOT</td>
<td>Strength, Weakness, Opportunity and Threats</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TWG</td>
<td>Technical Working Group</td>
</tr>
<tr>
<td>UHC</td>
<td>Universal Health Coverage</td>
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<td>WHO</td>
<td>World Health Organization</td>
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**Foreword**

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

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

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

---

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

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

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

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

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

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

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

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

Dr. Melsa Lutomia  Dr. Janerose Ambuchi
County Director of Health,  County Director of Health,
Preventive and Promotive Services Curative and Rehabilitative Services
BUSIA COUNTY

BUSIA COUNTY
Executive Summary

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

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

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

1.1 Background

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

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

1.1.1 County Vision

A healthy, productive and internationally competitive County.

1.1.2 County Mission

A progressive, sustainable, technologically driven, evidence-based and client-centered health system with the highest attainable standards of health at all levels of care.
1.2 Rationale for M&E Plan 2018-2023

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

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

1.3 Current Status of M&E in the Health Sector

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

1.3.1 SWOT Analysis

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

<table>
<thead>
<tr>
<th>STRENGTHS</th>
<th>WEAKNESSES</th>
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<tbody>
<tr>
<td>• Availability of policy guidelines and strategic documents (CIDP and CHSSIP).</td>
<td>• Data quality issues—integrity, timeliness, accuracy, completeness.</td>
</tr>
<tr>
<td>• Existence of the M&amp;E Unit—established in 2018.</td>
<td>• Inadequate HIS/ M&amp;E budget.</td>
</tr>
<tr>
<td>• Existence of strong, unified and integrated HIS system—DHIS2 and EMR.</td>
<td>• Inadequate human resources for HIS/ M&amp;E.</td>
</tr>
<tr>
<td>• Increased EMR coverage through scale-up.</td>
<td>• Over-reliance on partner support.</td>
</tr>
<tr>
<td>• Availability of HIS/ M&amp;E technical capacity.</td>
<td>• Data collection and reporting tools shortages.</td>
</tr>
<tr>
<td>• Continuous HIS/ M&amp;E skills building.</td>
<td>• Inadequate HIS ICT infrastructure— inadequate digitization of health records.</td>
</tr>
<tr>
<td>• Active health stakeholder forum.</td>
<td>• Policies and guidelines not fully disseminated.</td>
</tr>
<tr>
<td>• Top leadership support for M&amp;E.</td>
<td>• HIS/ M&amp;E skill gaps.</td>
</tr>
</tbody>
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<thead>
<tr>
<th>OPPORTUNITIES</th>
<th>THREATS</th>
</tr>
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<tbody>
<tr>
<td>• A willingness by the County and partners to carry out operational research.</td>
<td>• The diminishing donor funding stream.</td>
</tr>
<tr>
<td>• Multi-sectoral collaboration to improve health indicators.</td>
<td>• Partner-led health agenda.</td>
</tr>
<tr>
<td>• Availability of sector HIS/ M&amp;E policies.</td>
<td></td>
</tr>
<tr>
<td>• Existence of County M&amp;E Unit at the Department of Planning/ Governor’s Office.</td>
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<tr>
<td>• Good working arrangement with the national government especially capacity strengthening.</td>
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<tr>
<td>• Existence of Kenya M&amp;E curriculum for County level.</td>
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<td>• Functional County online portal/ website.</td>
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<tr>
<td>• National and inter-County learning forums for and sharing best practices and success stories.</td>
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<tr>
<td>• DHIS2 enhancements that have improved data availability, quality, and sharing.</td>
<td></td>
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<tr>
<td>• Implementation at scale of tested mHealth innovations.</td>
<td></td>
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<tr>
<td>• Technical and financial support from health partners.</td>
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</tbody>
</table>
1.4 Alignment of the M&E Plan to Existing Laws and Policies

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

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

**Health Act (2017)** — Section 16 (1) stipulates Kenya health system and M&E-related roles. These roles include providing technical support on M&E for health services standards and delivery, formulating health performance indicators to measure and enhance equitable access to health services, undertaking medical audits on maternal and neonatal deaths to inform the improvement of obstetric and neonatal care, and monitoring the health system for efficiency and standard performance.

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

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

**The Public Finance Management Act (2012)** — Article 166 points out that the accounting officer will prepare quarterly reports for the County government entity. In preparing a quarterly report for a County government entity, the accounting officer shall ensure that the report contains information on the financial and non-financial performance of the entity.

**Additional Health Sector Policies** — The M&E Plan 2018-2023 has been aligned to other existing health sector policies including:

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

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


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

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

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

INPUTS/PROCESSES

- Organisation of service delivery
- Human Resource for health
- Health Infrastructure
- Health Products and Technologies
- Health Information
- Health leadership
- Health Financing
- Health Research

OUTPUTS

- BETTER ACCESS TO SERVICES
- IMPROVED QUALITY OF CARE
- HIGHER DEMAND FOR SERVICES

OUTCOMES

- Eliminate communicable conditions
- Halt/reverse Non Communicable Disease
- Reduce Violence and Injuries
- Provide essential health care
- Minimize risk factor exposure
- Strengthen cross sectoral collaboration

IMPACT

- BETTER HEALTH IN RESPONSIVE MANNER

Source: KHSSIP 2018 - 2023
2 OVERVIEW OF THE HEALTH SECTOR M&E PLAN

2.1 M&E Conceptual Framework

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

2.2 Purpose of the M&E Plan

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

Figure 2.1: Scope of the M&E Framework

Source: KHSSIP 2018 - 2023
2.3 Objectives of the M&E Plan

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

2.4 Focus of the M&E Plan

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

a) Improve information systems at all levels: The health sector should strengthen all the key input information systems to be able to routinely capture coherent facility-level data. These systems include Logistics Management Information System (LMIS), Integrated Human Resources Information System (iHRIS), financial management information system, and Health Management Information System (HMIS). Common data architecture should be used effectively across the systems to ensure and enhance data and information sharing.

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

c) Strengthen linkage between sector monitoring and research: The relationship between health sector performance M&E and research should be cyclical, with one feeding the other routinely. Health sector M&E should continuously generate research questions (on operations and policy), and research should continuously identify possible solutions and/or interventions to problems identified through M&E. Under this Plan, the health sector will define the research agenda to inform the priority operational, strategic and policy
questions that need to be answered with respect to efficiency, effectiveness, equity, quality improvement and financial risk protection amongst others. The M&E Plan outlines strategies for a collaborative relationship with research institutions.

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

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

### 2.5 Stewardship Goals Defined by the M&E Plan

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

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

**b) Improving the performance monitoring and review processes:** Performance monitoring and review process are useful for documenting lessons learned during implementation of the CHSSIP. All performance reviews and evaluations will contain specific, targeted and actionable recommendations—as per the process outlined in the M&E Plan. All target institutions or responsible persons will provide a response to the recommendations within a stipulated timeframe, outlining proposed actions and a timeframe for implementation. All health managers will be required to properly document and closely track the agreed follow-up actions and status of these actions.
c) **Enhancing the sharing of data and promoting information use:** The M&E Plan recognizes the fact that different data is used by different actors for their decision-making processes. Thus, data should be translated into information that is relevant for different audiences at different levels for decision-making. Then packaged for dissemination in formats determined by the needs of these audiences. For the M&E Plan, the information will be disseminated using: electronic web platforms, public display of relevant information at the different levels, quarterly and annual performance review forums, and joint stakeholder forums.

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

1. **Organizational Structures with M&E Functions:** An entity entrusted with the role and responsibility of managing all the M&E tasks is critical for optimal functioning of an M&E system.

2. **Human Capacity for M&E:** Rolling out M&E activities requires sufficient number of staffs and correct skills mix together with a strategy for continuously updating their knowledge and skills.

3. **Partnerships for Planning, Coordinating and Managing the M&E System:** Involvement of stakeholders contributes to effective M&E system.

4. **M&E Frameworks/Logical Framework:** M&E framework is essential as it links the objectives with the processes and enables the M&E expert know what to measure and how to measure it.

5. **M&E Work Plan and Costs:** M&E work plan illustrates how personnel, time, materials and money will be used to achieve the set M&E functions. It also outlines how the resources that have been allocated for the M&E functions will be used to achieve the goals of M&E.

6. **Communication, Advocacy and Culture for M&E:** Refers to presence of relevant policies and strategies within the organization to support M&E functions.

7. **Routine Programme Monitoring:** Data needs to be collected and reported on a continuous basis to show whether the organization is on course to meeting the set objectives.

8. **Surveys and Surveillance:** Surveillance provides regular and timely information on status of indicators for notifiable conditions.

9. **National and Sub-National Databases:** Service delivery data is collected routinely using recommended data tools, then summarised and transmitted to national and sub-national (i.e. County) databases.

10. **Supportive Supervision and Data Auditing:** Data auditing implies that the data is subjected to verification to ensure its reliability and validity. Supportive supervision is important since it ensures the M&E process is run efficiently.

11. **Evaluation and Research:** Evaluation establishes whether the organization has achieved intended results. It informs design of new programs, and enables program improvement and sharing of lessons with stakeholders.

12. **Data Dissemination and Use:** M&E outputs should be shared with relevant stakeholders for program improvement and accountability purposes.
2.6 Components of the M&E System

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

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

2.7 How does M&E relate to the HIS?

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

2.8 The M&E Unit

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

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

2.10 Health Sector Indicators

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

- Each indicator contributes to measuring an element of the results chain: input, process, output, outcome, and impact. All CHSSIP result levels are tracked.
- The indicator list reflects all lifecycle cohorts: pregnancy and new-born, childhood, adolescence, adulthood and elderly.
- The indicators align with existing health sector monitoring commitments.
### Table 2.1: Health Outputs and Outcomes Indicators and Targets

<table>
<thead>
<tr>
<th>Objective</th>
<th>Indicator</th>
<th>Baseline (%) 2016/17</th>
<th>Targets (Where Applicable)</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HEALTH &amp; RELATED SERVICE OUTCOMES</strong></td>
<td>% fully immunized children</td>
<td>(66%) 20,584</td>
<td>2018/19</td>
<td>2019/20</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>70%</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>% of TB patients completing treatment</td>
<td>(83.3%) 959</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>% of HIV + pregnant mothers receiving preventive ARV’s</td>
<td>(95%) 1,532</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>% of pregnant mothers getting IPT2</td>
<td>(64%) 1,9973</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>% of targeted under 1’s provided with LLITN’s</td>
<td>(63%) 19,510</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Proportion (%) of targeted pregnant women provided with LLITN’s</td>
<td>(70%) 22,564</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Proportion (%) of under-5s treated for diarrhoea</td>
<td>19%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>17%</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td># of new outpatient cases attributed to gender-based violence</td>
<td>3,776</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3,588</td>
<td>3,409</td>
</tr>
<tr>
<td></td>
<td># of new outpatient cases attributed to road traffic injuries</td>
<td>4,030</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3,829</td>
<td>3,638</td>
</tr>
<tr>
<td></td>
<td># of new outpatient cases attributed to other injuries</td>
<td>11,261</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>10,698</td>
<td>10,164</td>
</tr>
<tr>
<td></td>
<td>% Women of Reproductive Age screened for cervical cancers</td>
<td>(4.6%) 5,503</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>8%</td>
<td>12%</td>
</tr>
<tr>
<td></td>
<td>Proportion (%) of adult population with body mass index (BMI) over 25</td>
<td>84%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>81%</td>
<td>77%</td>
</tr>
<tr>
<td>Objective</td>
<td>Indicator</td>
<td>Baseline (%) 2016/17</td>
<td>Targets (Where Applicable)</td>
<td>Source</td>
</tr>
<tr>
<td>-----------</td>
<td>----------</td>
<td>---------------------</td>
<td>---------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>% of new outpatients with mental health conditions</td>
<td>480</td>
<td>458</td>
<td>438</td>
<td>412</td>
</tr>
<tr>
<td># of new outpatients with high blood pressure</td>
<td>16,778</td>
<td>15,981</td>
<td>15,184</td>
<td>14,386</td>
</tr>
<tr>
<td>% of deliveries conducted by skilled attendant</td>
<td>(51.9%) 16,865</td>
<td>58%</td>
<td>64%</td>
<td>70%</td>
</tr>
<tr>
<td>% of women of Reproductive Age receiving Family Planning</td>
<td>(47%) 91,568</td>
<td>53%</td>
<td>59%</td>
<td>67%</td>
</tr>
<tr>
<td># of facility based maternal deaths</td>
<td>17</td>
<td>14</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td># of facility based under-5 deaths</td>
<td>177</td>
<td>168</td>
<td>156</td>
<td>144</td>
</tr>
<tr>
<td># of newborns with low birth weight</td>
<td>657</td>
<td>617</td>
<td>577</td>
<td>537</td>
</tr>
<tr>
<td># of facility based fresh still births</td>
<td>299</td>
<td>269</td>
<td>239</td>
<td>209</td>
</tr>
<tr>
<td>% of pregnant women attending 4 ANC visits</td>
<td>(41%) 13,336</td>
<td>49%</td>
<td>57%</td>
<td>65%</td>
</tr>
<tr>
<td>% of adolescent pregnancies among new ANC mothers</td>
<td>(42%) 6,790</td>
<td>37%</td>
<td>32%</td>
<td>27%</td>
</tr>
<tr>
<td>% of infants under-6 months on exclusive breastfeeding</td>
<td>(61%) 19,025</td>
<td>63%</td>
<td>67%</td>
<td>72%</td>
</tr>
<tr>
<td>% of clients screened for eye related conditions</td>
<td>15,125</td>
<td>15,830</td>
<td>16,650</td>
<td>17,420</td>
</tr>
<tr>
<td># of patients who have undergone eye surgery</td>
<td>2,170</td>
<td>2,200</td>
<td>2,340</td>
<td>2,670</td>
</tr>
<tr>
<td>Couple Year Protection due to condom use</td>
<td>4,954</td>
<td>5,449</td>
<td>5,944</td>
<td>6,439</td>
</tr>
<tr>
<td>% of children under-5 whose growth is being monitored</td>
<td>23.10%</td>
<td>26%</td>
<td>29%</td>
<td>35%</td>
</tr>
<tr>
<td>Proportion (% of stunted under-5 children)</td>
<td>9.60%</td>
<td>8.20%</td>
<td>6.80%</td>
<td>5.40%</td>
</tr>
<tr>
<td>Objective</td>
<td>Indicator</td>
<td>Baseline (%) 2016/17</td>
<td>Targets (Where Applicable)</td>
<td>Source</td>
</tr>
<tr>
<td>-----------</td>
<td>----------</td>
<td>----------------------</td>
<td>--------------------------</td>
<td>--------</td>
</tr>
<tr>
<td></td>
<td>% of underweight under-5 children</td>
<td>25.20%</td>
<td>22.70%</td>
<td>20.20%</td>
</tr>
<tr>
<td></td>
<td>Proportion (%) of households with latrines</td>
<td>59.70%</td>
<td>65.80%</td>
<td>71.90%</td>
</tr>
<tr>
<td></td>
<td>Proportion (%) of households with adequate ventilation</td>
<td>70%</td>
<td>75%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Proportion (%) of schools providing complete school health package</td>
<td>6%</td>
<td>17%</td>
<td>28%</td>
</tr>
<tr>
<td></td>
<td>% of children 12 - 59 months dewormed at the health facility</td>
<td>(50.36%) 77,204</td>
<td>58%</td>
<td>65%</td>
</tr>
<tr>
<td></td>
<td>% of children 6 - 59 months receiving 2 doses of vitamin</td>
<td>47.2%</td>
<td>54%</td>
<td>62%</td>
</tr>
<tr>
<td></td>
<td>% of children 6 - 23 months receiving adequate and diverse complementary foods</td>
<td>20%</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>% of pregnant women receiving combined IFAS</td>
<td>(59.8%) 79161</td>
<td>62%</td>
<td>65%</td>
</tr>
<tr>
<td></td>
<td>% of children below-5 years wasted</td>
<td>2%</td>
<td>1.9%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Improving access to services</td>
<td>Proportion (%) of population living within 5km of a health Facility</td>
<td>701,769 (82%)</td>
<td>83%</td>
<td>85%</td>
</tr>
<tr>
<td></td>
<td>Proportion (%) of facilities providing BEOC (80 GoK facilities)</td>
<td>40%</td>
<td>53%</td>
<td>67.50%</td>
</tr>
<tr>
<td></td>
<td>Proportion (%) of facilities providing CEOC (8 facilities GoK)</td>
<td>4 (50%)</td>
<td>6 (75%)</td>
<td>7 (87.5%)</td>
</tr>
<tr>
<td></td>
<td>Bed Occupancy Rate</td>
<td>117%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Proportion (%) of facilities providing immunization services</td>
<td>83%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
### Improving the quality of care

<table>
<thead>
<tr>
<th>Objective</th>
<th>Indicator</th>
<th>Baseline (%)&lt;br&gt;2016/17</th>
<th>Targets (Where Applicable)</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving</td>
<td>TB Cure Rate</td>
<td>50% 58% 66% 74% 82% 92%</td>
<td>HIS</td>
<td></td>
</tr>
<tr>
<td>the quality</td>
<td>Proportion (%) confirmed malaria cases treated with ACT</td>
<td>85% 100% 100% 100% 100% 100%</td>
<td>HIS</td>
<td></td>
</tr>
<tr>
<td>of care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### HEALTH INPUT AND PROCESS INVESTMENT

<table>
<thead>
<tr>
<th>Objective</th>
<th>Indicator</th>
<th>Baseline (%)&lt;br&gt;2016/17</th>
<th>Targets (Where Applicable)</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service</td>
<td>Proportion (%) of maternal audits/death audits</td>
<td>18% 100% 100% 100% 100% 100%</td>
<td>HIS</td>
<td></td>
</tr>
<tr>
<td>Delivery</td>
<td>Malaria inpatient case fatality rate</td>
<td>5% 4% 4% 3.50% 3% 2.50%</td>
<td>HIS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proportion (%) of functional community units</td>
<td>184 (94%) 184 (94%) 190 (97%) 195 (100%) 195 (100%)</td>
<td>HIS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proportion (%) of existing laboratories accredited</td>
<td>0% 17% 23% 29% 35% 50%</td>
<td>HIS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proportion (%) of referred clients reaching referral unit</td>
<td>25% 40% 55% 70% 80% 85%</td>
<td>HIS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proportion (%) of health facilities inspected annually</td>
<td>15% 34% 49% 72% 87% 100%</td>
<td>HIS</td>
<td></td>
</tr>
</tbody>
</table>

### Human Resources for Health

<table>
<thead>
<tr>
<th>Objective</th>
<th>Indicator</th>
<th>Baseline (%)&lt;br&gt;2016/17</th>
<th>Targets (Where Applicable)</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of staffs recruited</td>
<td>441 134 150 150 150 100</td>
<td>HR Reports</td>
<td></td>
</tr>
<tr>
<td></td>
<td># of health workers per 10,000 population</td>
<td>9 12 14 15 16 18</td>
<td>HR Reports</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Staff Attrition Rate</td>
<td>2.50% 2.50% 2.50% 2.50% 2.50% 4.25%</td>
<td>HR Reports</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proportion (%) of staff with job description</td>
<td>0% 100% 100% 100% 100%</td>
<td>HR Reports</td>
<td></td>
</tr>
<tr>
<td></td>
<td># of staffs trained in leadership management</td>
<td>0 25 25 25 25 25</td>
<td>HR Reports</td>
<td></td>
</tr>
<tr>
<td></td>
<td># of staffs on professional training</td>
<td>22 25 25 25 25 25</td>
<td>HR Reports</td>
<td></td>
</tr>
<tr>
<td></td>
<td># of best performing staff awarded</td>
<td>14 14 14 14 14 14</td>
<td>HR Reports</td>
<td></td>
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### Health Products and Technologies

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<th>Baseline (%)&lt;br&gt;2016/17</th>
<th>Targets (Where Applicable)</th>
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<tr>
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<td>Proportion (%) of days per month when essential medicines and medical supplies (EMMS) are out of stock</td>
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<tr>
<td>Health Financing</td>
<td>Proportion (%) of public health funds (government and donor) spent on health products</td>
<td>18%</td>
<td>8.5% 10% 12% 14% 16%</td>
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</tr>
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<td>% of health facilities with essential medicines (order-fill rate)</td>
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<td>100% 100% 100% 100% 100%</td>
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<td># of supply plans developed by the County</td>
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<td>1 1 1 1 1 1</td>
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<td>169,000,000 200,000,000 280,000,000 340,000,000 400,000,000</td>
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<td>27.1% 29.5% 32% 33% 34%</td>
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<td></td>
<td>% of total health expenditure contributed by partners/donor projects/programs</td>
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<td>48.70% 45.20% 41.70% 38.2% 34.70%</td>
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<td>Leadership &amp; Governance</td>
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<td>13% 15% 15% 16% 16%</td>
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<td>Proportion (%) of funds allocated and utilized for maintenance of health facilities</td>
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<td>1,979,519,340 1,850,092,649 2,080,119,573 2,288,131,531 2,496,143,489</td>
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<td>Health Infrastructure</td>
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<tr>
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<td># of warehouses constructed</td>
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<td># of GBV centers constructed</td>
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<td># of Orthopedic workshops constructed (Port Victoria)</td>
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<td># of health centers upgrade to Sub-County hospitals (Amukura, Nambole, Matayos)</td>
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<td>3 of hospitals upgraded to level 5 (Busia County Referral Hospital)</td>
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<td># of SCH upgraded to level 4 (Port Victoria SCH)</td>
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<td># of dispensaries upgraded to health centers</td>
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<td># of facilities under construction completed (Buyosi, Muyafwa, Luliba, Benga, Kapina, Aloyet, Omayembe, Totokakile)</td>
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Objective Indicator Baseline (%) 2016/17 | Targets (Where Applicable) | Source
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<th>Baseline (%) 2016/17</th>
<th>Targets (Where Applicable)</th>
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<td># of refrigeration equipment for mortuaries procured</td>
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<td># of pressure equipment for embalming for the hospitals procured</td>
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<td># of EPI refrigerators purchased</td>
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<td>the regional warehouse</td>
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<td># of radiology equipment (x-ray) machines purchased for the new hospitals</td>
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<tr>
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<td>(Matayos, Alupe, Sio Port, Port Victoria, Khunyangu)</td>
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<td># of imaging equipment (MRI, CT scan) machines purchased for BCRH</td>
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<td># of water testing kits (3 per Sub-County) purchased</td>
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<td># of microscopes procured</td>
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<td># of oxygen plants purchased for the County hospital</td>
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<td>Targets (Where Applicable)</td>
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<td>Proportion (%) of planning units submitting timely, complete and accurate information (AWP reports)</td>
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<td>Proportion (%) of facilities submitting timely and accurate information</td>
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<td>62%</td>
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3 OPERATIONALIZATION OF THE HEALTH SECTOR M&E STEWARDSHIP GOALS

3.1 Support Establishment of a Common Data Architecture

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

3.1.1 Developing a Unified HIS

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

3.1.2 Technical HIS Responsibilities at County Level

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

Development of guidelines

- Comply with national government requirements on health information sharing by the two levels of government.
- Adopt national reporting mechanisms and tools for County HIS.
- Apply national guidelines and tools on data management.
• Legislate on establishment and maintenance of County HIS.
• Enforce mandatory reporting by County health care providers.
• Apply relevant measures on the confidentiality of data.

Data management

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

Evidence generation for health

• Facilitate the generation of data for vital statistics within the County.
• Contribute County data to the national health observatory.
• Implement and maintain a County disease surveillance system as part of the national disease surveillance system.

3.1.3 Data Management

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

• At the household level, data will be collected by the Community Health Volunteers (CHVs)—guided by the household register, which lists all the households in the community unit. The CHV fills in the service delivery data on a community log/diary. This log is presented to a Community Health Extension Workers (CHEW) at the facility to which the Community Unit is attached. The CHEW aggregates all the community logs received into the CHEW summary. For those facilities that have DHIS2 access, the CHEW summary for the facility can be posted at the facility. While for those without, the CHEW summary is posted on DHIS2 at the sub-County.

• At the facility level, all public and private facilities and all partners collect routine service delivery data using standard tools and registers. These are then collated into standardized reporting forms and submitted monthly in DHIS2—or from the Sub-County level for those facilities that do not have access to DHIS2.

• Data flow and dissemination for Busia County including data management hierarchy and feedback is illustrated in Table 3.1.
### Table 3.1: Data Flow and Feedback for Busia County

**Data Management Hierarchy**

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>DATA COLLECTION</th>
<th>COMPILATION</th>
<th>STORAGE</th>
<th>ANALYSIS</th>
<th>REPORTING</th>
<th>USE</th>
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<tbody>
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<td><strong>National</strong></td>
<td>Indicator Development &amp; Tools Development</td>
<td>Data Aggregation</td>
<td>Data Warehousing</td>
<td>National Level</td>
<td>National Reports &amp; Donor Reports</td>
<td>Policy Formulation &amp; Resource Management</td>
</tr>
<tr>
<td>Responsible Person(s)</td>
<td>M&amp;E TWG</td>
<td>HMIS Department &amp; Divisional Heads</td>
<td>HMIS Department &amp; Divisional Heads</td>
<td>HMIS Department &amp; Divisional Heads</td>
<td>HMIS &amp; Divisional Heads</td>
<td>Policy Makers</td>
</tr>
<tr>
<td><strong>County</strong></td>
<td>Indicator Development/Customization &amp; Tools Development</td>
<td>Data Aggregation</td>
<td>Data Storage &amp; Archiving</td>
<td>County Level</td>
<td>County Level</td>
<td>Policy Formulation &amp; Resource Allocation</td>
</tr>
<tr>
<td>Responsible Person(s)</td>
<td>CHMT &amp; TWGs</td>
<td>CHRO</td>
<td>CHRO</td>
<td>CHRO</td>
<td>CHRO</td>
<td>County Government</td>
</tr>
<tr>
<td><strong>Sub-County</strong></td>
<td>Data Verification &amp; Audit</td>
<td>Data Entry &amp; Tabulation</td>
<td>Data Storage &amp; Archiving</td>
<td>Sub-County Level</td>
<td>Sub-County Level</td>
<td>Indicator Monitoring</td>
</tr>
<tr>
<td>Responsible Person(s)</td>
<td>SCHRIO &amp; SCHMT</td>
<td>SCHRIO</td>
<td>SCHRIO</td>
<td>SCHRIO</td>
<td>SCHRIO</td>
<td>SCHRIO</td>
</tr>
<tr>
<td><strong>Facility</strong></td>
<td>Data Capture</td>
<td>Collation &amp; Transmission</td>
<td>Data Storage &amp; Archiving</td>
<td>Facility</td>
<td>Departmental &amp; Facility Data</td>
<td>Resource Management, Health Talks</td>
</tr>
<tr>
<td>Responsible Person(s)</td>
<td>HRIO &amp; Facility Managers</td>
<td>HRIO &amp; Facility Managers</td>
<td>HRIO &amp; Facility Managers</td>
<td>HRIO &amp; Facility Managers</td>
<td>HRIO &amp; Facility Managers</td>
<td>HRIO &amp; Facility Managers</td>
</tr>
<tr>
<td><strong>Community</strong></td>
<td>Data Capture</td>
<td>Collation &amp; Transmission</td>
<td>Data Storage &amp; Archiving</td>
<td>CU</td>
<td>CHA</td>
<td>Community Mobilization &amp; Planning</td>
</tr>
<tr>
<td>Responsible Person(s)</td>
<td>CHA</td>
<td>CHA</td>
<td>CHA</td>
<td>CHA</td>
<td>CHA</td>
<td>CHA</td>
</tr>
</tbody>
</table>
3.1.4 Data Quality Assurance

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

Table 3.2: Data Quality Assurance Roles and Responsibilities

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

Source: The DQA Protocol
3.2 Performance Monitoring and Review Processes

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

Table 3.3: Performance Monitoring in Busia County

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

3.2.1 Quarterly and Annual Performance Reviews

Quarterly performance review reports documenting progress against the implementation of the Annual Work Plans (AWPs) will be produced at all levels. The quarterly reports will be discussed by respective health management teams and key stakeholders in quarterly progress or performance review meetings. The discussions will focus on: the quarterly progress or performance review findings, the agreed upon action points, and progress in the implementation of the action plan from the previous quarterly review meeting.
Annual performance review reports outlining the performance against the CHSSIP goal and objectives will be produced by all planning units in the County. The annual reports will include achievements against the CHSSIP targets, challenges encountered during the period under review, and key priorities for the coming year. It will be developed through a consultative process that is Department–led and will be shared at the annual performance review meeting and with the County Assembly.

### 3.2.2 Mechanisms for Review and Action

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

#### Table 3.4: Mechanisms for Review and Action

<table>
<thead>
<tr>
<th>Planning Unit</th>
<th>Forum</th>
<th>Information Product</th>
<th>Frequency</th>
<th>Probable Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Unit</td>
<td>Community Dialogue Days</td>
<td>Chalkboards MoH S16</td>
<td>Monthly</td>
<td>CHVs, CHEWs, Community Health Committee Members, Community Members</td>
</tr>
<tr>
<td></td>
<td>Barazas</td>
<td>Reports and Others</td>
<td>Monthly</td>
<td>CHVs, CHEWs, Community Health Committee Members, Community Members</td>
</tr>
<tr>
<td>Health Facilities</td>
<td>Data Reviews</td>
<td>Reports and Others</td>
<td>Monthly</td>
<td>Facility In-Charge, Facility Staff, SCHMT (Appointed Member), Facility Committee Member</td>
</tr>
<tr>
<td></td>
<td>Facility Management Committee Meetings</td>
<td>Reports and Others</td>
<td>Quarterly</td>
<td>Facility Committee Member, SCHMT (Appointed Member)</td>
</tr>
<tr>
<td></td>
<td>Quality Improvement Teams (QIT)</td>
<td>Reports and Others</td>
<td>Quarterly</td>
<td>Facility QIT Teams</td>
</tr>
<tr>
<td></td>
<td>AWP Meetings/Development</td>
<td>Reports and Others</td>
<td>Annual</td>
<td>Facility Staff</td>
</tr>
<tr>
<td>Sub-County</td>
<td>Facility In-Charges Meeting</td>
<td>Reports and Others</td>
<td>Monthly</td>
<td>Facility In-Charges, SCHMT</td>
</tr>
<tr>
<td></td>
<td>Stakeholders Meetings</td>
<td>Reports and Others</td>
<td>Quarterly</td>
<td>Facility In-Charges, SCHMT, Hospital Management Committee Members, Facility Management Committee Members, Community Health Committee Members, Sub-County Administrator, Religious Leaders, Youth Representatives, Women Leader, Partners, MCAs, Other Ministries e.g. Ministry of Education</td>
</tr>
<tr>
<td>Planning Unit</td>
<td>Forum</td>
<td>Information Product</td>
<td>Frequency</td>
<td>Probable Participants</td>
</tr>
<tr>
<td>---------------</td>
<td>-------</td>
<td>---------------------</td>
<td>-----------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Data Quality Improvement Teams (DQIT)</td>
<td>Reports and Others</td>
<td>Quarterly</td>
<td>DQIT Members</td>
<td></td>
</tr>
<tr>
<td>Data review Meetings</td>
<td>Reports and Others</td>
<td>Quarterly</td>
<td>SCHMT Facility In-Charges Partners CHMT (Appointed Member)</td>
<td></td>
</tr>
<tr>
<td>International and National Health Commemoration Days and Weeks</td>
<td>Reports and Others</td>
<td>Annual</td>
<td>Community Members Health Workers SCHMT CHMT Community Leaders Sub-County Administration Partners</td>
<td></td>
</tr>
<tr>
<td>Technical Working Groups</td>
<td>Reports and Others</td>
<td>Quarterly</td>
<td>TWG Members (Multi-Disciplinary Team)</td>
<td></td>
</tr>
<tr>
<td>Sub-County Health Management Teams (SCHMT)</td>
<td>Reports and Others</td>
<td>Monthly</td>
<td>SCHMT Members</td>
<td></td>
</tr>
<tr>
<td>Annual Performance Reviews</td>
<td>Reports and Others</td>
<td>Annually</td>
<td>SCHMT Members Partners CHMT Representative</td>
<td></td>
</tr>
<tr>
<td>Annual Work Planning Meetings</td>
<td>Reports and Others</td>
<td>Annually</td>
<td>SCHMT Members Partners CHMT Representative</td>
<td></td>
</tr>
<tr>
<td>County</td>
<td>Stakeholder Bi-Annual Meetings</td>
<td>Reports and Others</td>
<td>Biannually</td>
<td>CHMT and SCHMTS Facility In-Charges Hospital Management Committee Members Facility Management Committee Members Community Health Committee Members Sub-County Administrator Religious Leaders Youth Representatives Women Leader Partners MCAs Other Ministries e.g. Ministry of Education</td>
</tr>
<tr>
<td>CHMT Meetings</td>
<td>Reports and Others</td>
<td>Monthly</td>
<td>CHMT Members</td>
<td></td>
</tr>
<tr>
<td>TWG Meetings</td>
<td>Reports and Others</td>
<td>Quarterly</td>
<td>TWG Members</td>
<td></td>
</tr>
<tr>
<td>County Assembly Health Meetings</td>
<td>Reports and Others</td>
<td>Quarterly</td>
<td>MCAs CECM for Health Chief Officer for Health Director of Health</td>
<td></td>
</tr>
<tr>
<td>County Health Advisory Meetings</td>
<td>Reports and Others</td>
<td>Quarterly</td>
<td>CHMT CECM for Health Chief Officer for Health</td>
<td></td>
</tr>
</tbody>
</table>
3.2.3 Data Sources for Health Sector Monitoring

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

3.2.4 CHSSIP Evaluation

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

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

3.3 Enhance Sharing of Data and Promoting Use of Information

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

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

3.3.2 Enhanced Data Sharing

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

3.3.3 Data Demand and Use Framework

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

- Assessing and improving the data use context.
- Engaging data users and data producers.
- Improving data quality; improving data availability.
- Identifying information needs.
- Building capacity in data use core competencies.
• Strengthening the organization’s data demand and use infrastructure.
• M&E.
• Communicating data demand and use successes.

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

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

4.2 Guiding Documents of the M&E Plan

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

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

4.3 M&E Tools

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

- Code of Conduct for partners supporting the implementation of the CHSSIP.
- Joint supervision checklists and issues tracking log.
- Data change tracking tool.
- Annual work plan implementation monitoring template—See Annex III.
5.1 Key Responsibilities for Health Sector M&E

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

**County Level Responsibilities**

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

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

**Facility Level Responsibilities**

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

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

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

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

<table>
<thead>
<tr>
<th>Stewardship Goal</th>
<th>Entity</th>
<th>Function</th>
</tr>
</thead>
</table>
| **Establishment of a common data architecture** | CHMT/ SCHMT | • Establish M&E TWGs  
• Conduct oversight to manage all health and health-related data from all service providers within their area of jurisdiction.  
• Create and maintain a data repository.  
• Collaborate and work in partnership with other statistical constituencies at the County level to build one County-wide M&E system based on the principles outlined in this document.  
• Compile all reports from the Sub-County health facilities into a single County Health report. |
| **Partners** | | • Support the counties in establishing data collection structures.  
• Work collaboratively with the MoH M&E Unit to provide data, as appropriate, on population-based statistics, and vital events (births and deaths), and health-related research data for comparative analysis and warehousing. |
| **Improve performance and review processes** | CHMT/ SCHMT | • Produce a health sector performance report that includes service delivery metrics.  
• Analyze the quality of all reports received and ensure appropriate follow-up in case of incompleteness or problems with validity, as well as delays from the Sub-County levels. |
| **Partners** | | • Work within the health department M&E plan and guidelines, and meet the reporting requirements as defined by minimum datasets. |
| **Enhancing the sharing of data and promoting the use of information for decision-making** | CHMT/ SCHMT | • Provide technical, material and financial support for M&E to all Sub-Counties.  
• Collate, analyze, disseminate and use health and health-related data from all Sub-County offices and give feedback.  
• Ensure proper information flow from various levels to inform policy formulation, guidelines, and development of protocols, and to address the County’s obligations. (This specifically includes forwarding the County Health Report to the National MoH.)  
• Prepare data analyses for discussion during the CEC and directorate meetings and forum for decision-making.  
• Develop a County Health Report and share with the CEC.  
• Disseminate quarterly reports to Sub-Country health teams and Health Committee, through the CDH. |
| **Partners** | | • Provide support to strengthen the County Health Department M&E Unit in their areas of operation (e.g., through the provision of technical support and capacity building). |
### Facility Level

<table>
<thead>
<tr>
<th>Stewardship Goal</th>
<th>Entity</th>
<th>Function</th>
</tr>
</thead>
</table>
| Establishment of a common data architecture                                     | Facility health Management Team and Partners | • Maintain and update the Health Information System, including records, filing system(s) and registry for primary data collection tools (such as registers, cards, file folders), and summary forms (such as reporting forms, CDs, electronic backups).  
• Safeguard data and information system from any risks, e.g., fire, floods, access by unauthorized persons.  
• Compile all reports from the Technical Officers into a single health facility report. |
| Improve performance and review processes                                          | Facility Management Team and Partners | • Ensure compilation and processing of minutes, inventory, supervision, and other activity reports.  
• Analyze the quality of all reports received from various health service delivery points and ensure follow-up in case of incompleteness, problems with validity, or delays. |
| Enhancing the sharing of data and promoting the use of information for decision-making | Facility Management Team and Partners | • Ensure that every health facility summarizes health and health-related data from the community and health facility; analyses it; disseminates it and uses the information for decision-making; provides feedback, and transmits summaries to the next level.  
• Forward health and health-related reports to the Sub-County level.  
• Provide quarterly feedback to the health providers and the community unit committee.  
• Disseminate quarterly reports to the health facility committee.  
• Disseminate annual report to the health facility committee and Sub-County forum. |

### Community Level

<table>
<thead>
<tr>
<th>Stewardship Goal</th>
<th>Entity</th>
<th>Function</th>
</tr>
</thead>
</table>
| Establishment of a common data architecture                                     | SHMT and Partners                  | • Community Units: Maintain and update its M&E, which shall be shared regularly with household members in a forum as stated in the relevant community strategy.  
• Community health Volunteers: Maintain registers to document daily activities and report regularly to link health facility. Compile all reports from the CHW. |
| Improve performance and review processes                                          | SHMT and Partners                  | • Develop quarterly and annual community health reports for integration into facility reports.                                                                                                                                 |
| Enhancing the sharing of data and promoting the use of information for decision-making | SHMT and Partners                  | • Prepare an analysis of the data for discussion during the staff and committee meetings for decision-making.  
• Forward the committee report to the facility In-Charge.  
• Provide quarterly feedback to the community unit.  
• Disseminate quarterly reports to the community unit.  
• Disseminate annual report to the community unit. |

### 5.2 Partnership and Coordination Framework

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

**Costed M&E Work Plan for 2018 – 2023**

<table>
<thead>
<tr>
<th>Key Activities</th>
<th>Key Performance Indicators/ Deliverables</th>
<th>5 Year Budgets (Kshs)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SERVICE DELIVERY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Dialogue Days</td>
<td>No. of monthly and quarterly reports compiled</td>
<td>1,104,000</td>
</tr>
<tr>
<td>Facility: Data collection, validation, analysis, dissemination</td>
<td>No. of monthly reports compiled, analyzed and disseminated</td>
<td>1,740,000</td>
</tr>
<tr>
<td>Sub-County data review meeting</td>
<td>No of data review meetings held and action plans developed</td>
<td>336,000</td>
</tr>
<tr>
<td>County data review meeting</td>
<td>No of data review meetings held and action plans developed</td>
<td>200,000</td>
</tr>
<tr>
<td>Emergency preparedness planning report</td>
<td>No. of reports on emergencies</td>
<td>110,000</td>
</tr>
<tr>
<td>Therapeutic committee meetings &amp; follow up</td>
<td>No. of therapeutic meetings held and action plans developed</td>
<td>536,000</td>
</tr>
<tr>
<td>Clinical audits (Maternal &amp; Perinatal Deaths, Guidelines, SOPs) Maternal Audits</td>
<td>No. of maternal and perinatal deaths audited and clinical audits</td>
<td>1,208,000</td>
</tr>
<tr>
<td>Quality of service delivery</td>
<td>Exit survey, client satisfaction surveys</td>
<td>845,256</td>
</tr>
<tr>
<td>Referral monitoring activities</td>
<td>No of referral assessments reports developed</td>
<td>98000</td>
</tr>
<tr>
<td><strong>SUB TOTAL</strong></td>
<td></td>
<td>6,177,256</td>
</tr>
<tr>
<td>Key Activities</td>
<td>Key Performance Indicators/ Deliverables</td>
<td>5 Year Budgets (Kshs)</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td><strong>HEALTH INFRASTRUCTURE AND HIS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equip one repository center at the County level/</td>
<td>Functioning repository center</td>
<td>1,000,000</td>
</tr>
<tr>
<td>Host a functional health webpage on the County website/</td>
<td>Functional health webpage</td>
<td>1,000,000</td>
</tr>
<tr>
<td>Undertake biannual inventory update of infrastructure</td>
<td>No of inventory reports developed</td>
<td>226,000</td>
</tr>
<tr>
<td>Generation of infrastructure project monthly reports</td>
<td>No of project reports developed</td>
<td>280,000</td>
</tr>
<tr>
<td>Monthly asset procurement &amp; maintenance report</td>
<td>No of asset maintenance reports developed</td>
<td>50,000</td>
</tr>
<tr>
<td>Monthly motor vehicle inspection and maintenance supervision</td>
<td>No. of inspection reports and maintenance reports</td>
<td>58,000</td>
</tr>
<tr>
<td>Monthly equipment maintenance and annual equipment service follow ups</td>
<td>No. of equipment service reports and maintenance reports</td>
<td>67,500</td>
</tr>
<tr>
<td><strong>SUB TOTAL</strong></td>
<td></td>
<td>2,681,500</td>
</tr>
<tr>
<td><strong>HEALTH PRODUCTS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inventory audit of health products</td>
<td>No of developed inventory audit reports</td>
<td>864,000</td>
</tr>
<tr>
<td><strong>SUB TOTAL</strong></td>
<td></td>
<td>864,000</td>
</tr>
<tr>
<td><strong>HEALTH INFRASTRUCTURE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undertake health expenditure reviews</td>
<td>No of health expenditure reports developed</td>
<td>8,664,000</td>
</tr>
<tr>
<td></td>
<td>Quarterly and annual financial status reports submitted</td>
<td></td>
</tr>
<tr>
<td><strong>SUBTOTAL</strong></td>
<td></td>
<td>8,664,000</td>
</tr>
<tr>
<td><strong>LEADERSHIP AND GOVERNANCE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community: hold quarterly stakeholder meetings and forums</td>
<td>No of quarterly stakeholder forums held with action plans</td>
<td>504,000</td>
</tr>
<tr>
<td>Provide quarterly feedbacks to the link facilities on activities using provided formats</td>
<td>No of feedback</td>
<td>54,000</td>
</tr>
<tr>
<td>Facility: Hold health facility committee meetings</td>
<td>No. of facility committee meetings held</td>
<td>147,000</td>
</tr>
<tr>
<td>Compile facility quarterly performance appraisal reports</td>
<td>No of quarterly performance reports disseminated</td>
<td>5,600</td>
</tr>
<tr>
<td>Key Activities</td>
<td>Key Performance Indicators/ Deliverables</td>
<td>5 Year Budgets (Kshs)</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Carry out monthly Sub-County HMTs</td>
<td>No of Sub-County HMTs held</td>
<td>567,000</td>
</tr>
<tr>
<td>Development of AWP/ APR at County and Sub-County level</td>
<td>Developed, validated and published AWP</td>
<td>900,000</td>
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<tr>
<td>Carry out quarterly CHMT meetings</td>
<td>No of CHMT meetings held with action plans</td>
<td>480,000</td>
</tr>
<tr>
<td>Annual County Health Congress</td>
<td>No of participants in the annual Health Congress</td>
<td>2,000,000</td>
</tr>
<tr>
<td><strong>SUBTOTAL</strong></td>
<td></td>
<td>4,657,600</td>
</tr>
<tr>
<td><strong>HEALTH WORKFORCE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improve skills of staff at all levels on data management (all pillars)</td>
<td>The proportion of staff trained in data management (all staff)</td>
<td>2,920,000</td>
</tr>
<tr>
<td>Encourage exchange programs and benchmarking</td>
<td>No of exchange programme sessions held</td>
<td>834,000</td>
</tr>
<tr>
<td>Annual human resource audits</td>
<td>No of human resource audits held with reports</td>
<td>320,000</td>
</tr>
<tr>
<td><strong>SUBTOTAL</strong></td>
<td></td>
<td>4,074,000</td>
</tr>
<tr>
<td><strong>HEALTH INFORMATION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarterly M&amp;E TWG meeting</td>
<td>No of quarterly TWG meetings held</td>
<td>240,000</td>
</tr>
<tr>
<td>Printing and distribution of revised data collection and reporting tools.</td>
<td>Proportion of facilities with updated reporting tools</td>
<td>519,000</td>
</tr>
<tr>
<td>Improved data demand and use at the Sub-County and County</td>
<td>The proportion of facilities with accurate reporting rates</td>
<td>2,976,000</td>
</tr>
<tr>
<td>data quality audits and verification</td>
<td>No of data quality audits held</td>
<td>1,840,000</td>
</tr>
<tr>
<td>Conduct mid and end term M&amp;E of the strategic plan</td>
<td>No of SP review sessions held</td>
<td>3,121,000</td>
</tr>
<tr>
<td>Conduct mid and end term M&amp;E of the CIDP</td>
<td>No of CIDP review sessions held</td>
<td>1,321,000</td>
</tr>
<tr>
<td><strong>SUBTOTAL</strong></td>
<td></td>
<td>10,017,000</td>
</tr>
<tr>
<td><strong>HEALTH RESEARCH AND INNOVATION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conduct evidence-based research and surveys</td>
<td>No of relevant surveys held</td>
<td>1,920,000</td>
</tr>
<tr>
<td>Operational research</td>
<td>No of operations research</td>
<td>2,000,000</td>
</tr>
<tr>
<td><strong>SUBTOTAL</strong></td>
<td></td>
<td>3,920,000</td>
</tr>
<tr>
<td><strong>GRAND TOTAL</strong></td>
<td></td>
<td>41,055,356</td>
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</table>

**Total Budget:** 222,514,409
## Annex II
### Data Analysis and Use Plan

<table>
<thead>
<tr>
<th>Programmatic Questions</th>
<th>Indicator</th>
<th>Data Source</th>
<th>Method of Analysis</th>
<th>Data Disaggregation</th>
<th>Data Visualization</th>
<th>Frequency</th>
<th>Proposed Actions/ Decisions</th>
<th>Decision maker</th>
<th>Communication Channel</th>
</tr>
</thead>
<tbody>
<tr>
<td>How does the County increase case identification?</td>
<td>% of PLHIV identified</td>
<td>Data Source: MOH 362/ MOH 731/ DHIS2</td>
<td>Trends/ Mapping</td>
<td>Gender/ Age/ Population Type</td>
<td>Graphs/ Tables/ Maps</td>
<td>Quarterly/ Monthly/ Annually</td>
<td>• Strengthen/ scale up</td>
<td>CDH / CASCO</td>
<td>• Feedback meetings, Support supervision, Periodic data review meetings involving all stakeholders</td>
</tr>
<tr>
<td>How does the County retain clients PLHIV on care?</td>
<td>% of PLHIV retained on care</td>
<td>MOH 731/ DHIS2</td>
<td>Trends/ Mapping</td>
<td>Gender/ Age</td>
<td>Graphs/ Tables/ Maps</td>
<td>Annually</td>
<td>• Improve ART uptake and adherence</td>
<td>CASCO</td>
<td>• Stakeholders’ meeting, Sensitization, Training/ OJTs and mentorship</td>
</tr>
<tr>
<td>How does the County ensure PLHIV are virally suppressed?</td>
<td>% of PLHIV ART with suppressed viral load</td>
<td>MOH 731/ DHIS2/ NASCOP DB</td>
<td>Trends</td>
<td>Gender/ Age/ Population Type</td>
<td>Graphs/ Tables/ Charts</td>
<td>Annually</td>
<td>• Form MDT to review patients failing the first-line regimen</td>
<td>CASCO</td>
<td>• Viral load report, Interpretation, Dissemination meeting, Stakeholders' meeting</td>
</tr>
<tr>
<td>How does the County improve the uptake of cervical cancer screening among WRA?</td>
<td>% of WRA screened for cervical cancer</td>
<td>Cancer Register/ MOH 262</td>
<td>Trends</td>
<td>Age</td>
<td>Graphs/ Tables/ Charts</td>
<td>Monthly/ Quarterly</td>
<td>• Increase the number of facilities offering cervical cancer screening</td>
<td>CDH/ County RH Coordinator</td>
<td>• Feedback meetings at all relevant levels, Support supervision (specific to RH) Data review meetings involving all the stakeholders</td>
</tr>
</tbody>
</table>

**MOH 362/MOH 731/DHIS2**

**Trends/ Mapping**

**Gender/ Age/ Population Type**

**Graphs/ Tables/ Maps**

**Quarterly/ Monthly/ Annually**

**• Strengthen/ scale up**

**• Targeted testing e.g. PNS**

**CDH / CASCO**

**Stakeholders’ meeting, Sensitization, Training/ OJTs and mentorship**

**Viral load report, Interpretation, Dissemination meeting, Stakeholders’ meeting**
<table>
<thead>
<tr>
<th>Programmatic Questions</th>
<th>Indicator</th>
<th>Data Source</th>
<th>Method of Analysis</th>
<th>Data Disaggregation</th>
<th>Data Visualization</th>
<th>Frequency</th>
<th>Proposed Actions/ Decisions</th>
<th>Decision maker</th>
<th>Communication Channel</th>
</tr>
</thead>
<tbody>
<tr>
<td>How does the County improve SGBV survivors’ access to PEP within 72 hours?</td>
<td>% of SGBV survivors accessing PEP within 72 hours</td>
<td>MOH 364</td>
<td>Trends</td>
<td>Gender/ Age</td>
<td>Tables/ Charts</td>
<td>Monthly/ Quarterly</td>
<td>• Training the HCWs on care and management of SGBV survivors &lt;br&gt; • Increase the number of SGBV centers within facilities &lt;br&gt; • Sensitization of community health volunteers to enhance timely referrals</td>
<td>CDH/ County RH Coordinator</td>
<td>• Feedback meetings &lt;br&gt; • Quarterly SGBV data review meetings &lt;br&gt; • Support supervision (specific SGBV) &lt;br&gt; • Stakeholders meeting</td>
</tr>
<tr>
<td>How does the County increase number of deliveries by skilled attendant?</td>
<td>% of pregnant women delivering at health facilities</td>
<td>MOH 405 ANC Register/ MOH 333 Maternity Register/ MOH 406 PNC register/ DHIS2</td>
<td>Mapping</td>
<td>Age</td>
<td>Graphs/ Charts</td>
<td>Monthly/ Quarterly/ Annually</td>
<td>• Community mobilization and sensitization &lt;br&gt; • Resource mobilization &lt;br&gt; • Capacity building in customer care &lt;br&gt; • Structural improvement of labor</td>
<td>County RH Coordinator</td>
<td>• Monthly reports &lt;br&gt; • Quarterly RH reports &lt;br&gt; • Quarterly RH bulletin &lt;br&gt; • Quarterly AWP implementation Plan &lt;br&gt; • RH budget report</td>
</tr>
<tr>
<td>How does the County improve the uptake of FP services?</td>
<td>% of WRA receiving FP commodities</td>
<td>MOH 512 FP Register/LMIS/ DHIS2/Survey reports (KDHS)</td>
<td>Trend/ Mapping</td>
<td>Age</td>
<td>Graphs/ Charts/ Tables</td>
<td>Monthly/ Quarterly/ Annually</td>
<td>• Community mobilization and sensitization &lt;br&gt; • Resource mobilization &lt;br&gt; • Capacity building on Long-Acting FP Methods &lt;br&gt; • Male involvement</td>
<td>County RH Coordinator</td>
<td>• Monthly reports &lt;br&gt; • Quarterly RH reports &lt;br&gt; • Quarterly RH bulletin &lt;br&gt; • Quarterly AWP implementation Plan &lt;br&gt; • RH budget report</td>
</tr>
<tr>
<td>How does the County increase the proportion of infants below the age of 6 months who are exclusively breastfed?</td>
<td>% of infants below the age of 6 months who are exclusively breastfed</td>
<td>MOH 407A &amp; B Nutrition Register/ DHIS2/ LMIS/ KDHS/ MOH 406 PNC Register/ Mother Child Booklet/ CHAINS</td>
<td>Mapping</td>
<td>Age/ Gender</td>
<td>Graphs/ Charts</td>
<td>Monthly/ Quarterly/ Biannual/ Annual</td>
<td>• Community mobilization and sensitization &lt;br&gt; • Resource mobilization &lt;br&gt; • Capacity building in exclusive breastfeeding &lt;br&gt; • Breastfeeding corners</td>
<td>County Nutrition Coordinator</td>
<td>• Monthly reports &lt;br&gt; • Quarterly RH reports &lt;br&gt; • Quarterly RH bulletin &lt;br&gt; • Quarterly AWP implementation Plan &lt;br&gt; • Nutrition budget report</td>
</tr>
<tr>
<td>Indicator</td>
<td>Method of Analysis</td>
<td>Data Source</td>
<td>Data Visualization</td>
<td>Data Disaggregation</td>
<td>Proposed Actions/Decisions</td>
<td>Communication Channels</td>
<td>Frequency</td>
<td>Decision maker</td>
<td></td>
</tr>
<tr>
<td>-----------</td>
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<td>------------------------</td>
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<td>----------------</td>
<td></td>
</tr>
<tr>
<td>% of fully immunized children (FIC)</td>
<td>Trends</td>
<td>MOH 512/ Tally Sheet</td>
<td>Graphs/ Charts</td>
<td>Age/Gender</td>
<td>Weekly/Quarterly</td>
<td>County Nursing Officer</td>
<td>Monthly/Quarterly/Annual</td>
<td>County Nutrition Coordinator</td>
<td></td>
</tr>
<tr>
<td>% of households with functional latrines</td>
<td>Trends</td>
<td>MOH 505/ Weekly Surveillance Report/MOH 705A</td>
<td>Charts</td>
<td>County/ Ward</td>
<td>Biannual</td>
<td>County Public Health Officer</td>
<td>Monthly/Quarterly</td>
<td>County Public Health Officer</td>
<td></td>
</tr>
<tr>
<td>% of confirmed cases of malaria among under-fives</td>
<td>Trends/ Mapping</td>
<td>MOH 505/ Weekly Surveillance Report/MOH 705A</td>
<td>Graphs/ Charts</td>
<td>County/ Ward</td>
<td>Monthly/Quarterly</td>
<td>County Malaria Coordinator</td>
<td>Monthly/Quarterly</td>
<td>County Malaria Coordinator</td>
<td></td>
</tr>
<tr>
<td>% of confirmed cases of malaria among under-fives</td>
<td>Trends</td>
<td>MOH 505/ Weekly Surveillance Report/MOH 705A</td>
<td>Charts</td>
<td>County/ Ward</td>
<td>Monthly/Quarterly</td>
<td>County Malaria Coordinator</td>
<td>Monthly/Quarterly</td>
<td>County Malaria Coordinator</td>
<td></td>
</tr>
<tr>
<td>% of households with functional latrines</td>
<td>Trends</td>
<td>MOH 505/ Weekly Surveillance Report/MOH 705A</td>
<td>Charts</td>
<td>County/ Ward</td>
<td>Monthly/Quarterly</td>
<td>County Public Health Officer</td>
<td>Monthly/Quarterly</td>
<td>County Public Health Officer</td>
<td></td>
</tr>
<tr>
<td>% of confirmed cases of malaria among under-fives</td>
<td>Trends</td>
<td>MOH 505/ Weekly Surveillance Report/MOH 705A</td>
<td>Charts</td>
<td>County/ Ward</td>
<td>Monthly/Quarterly</td>
<td>County Malaria Coordinator</td>
<td>Monthly/Quarterly</td>
<td>County Malaria Coordinator</td>
<td></td>
</tr>
</tbody>
</table>

**Programmatic Questions**

1. How does the County reduce the proportion of stunted under-five children?

2. How does the County improve immunization coverage?

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

### Data Management and Reporting Responsibilities

<table>
<thead>
<tr>
<th>Serial Number</th>
<th>Available Reporting Forms</th>
<th>County responsible (Action) Person</th>
<th>Overall responsibility at County</th>
<th>Sub-County Reporting Channel</th>
<th>Hospitals</th>
<th>Primary Health Facility/CU</th>
<th>Overall responsibility at Health Facility</th>
<th>HF Reporting Channel (Where Applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CHA Summary (MOH 515)</td>
<td>County Community Strategy Focal Person</td>
<td>CDH</td>
<td>DHIS2</td>
<td>CHA</td>
<td>CHA</td>
<td>Med Sup/In-charge</td>
<td>Hardcopy/DHIS2</td>
</tr>
<tr>
<td>2</td>
<td>MOH 711 Integrated</td>
<td>County RH Coordinator/DPHN</td>
<td>CDH</td>
<td>DHIS2</td>
<td>Sectional In-charge/HRIO</td>
<td>Facility In-charge</td>
<td>Med Sup/In-charge</td>
<td>Hardcopy/DHIS2</td>
</tr>
<tr>
<td>3</td>
<td>MOH 731-1 HIV CT</td>
<td>CASCO</td>
<td>CDH</td>
<td>DHIS2</td>
<td>Sectional In-charge/HRIO</td>
<td>Facility In-charge</td>
<td>Med Sup/In-charge</td>
<td>Hardcopy/DHIS2</td>
</tr>
<tr>
<td>4</td>
<td>MOH 731-2 PMTCT</td>
<td>CASCO</td>
<td>CDH</td>
<td>DHIS2</td>
<td>Sectional In-charge/HRIO</td>
<td>Facility In-charge</td>
<td>Med Sup/In-charge</td>
<td>Hardcopy/DHIS2</td>
</tr>
<tr>
<td>5</td>
<td>MOH 731-3 C&amp;T</td>
<td>CASCO</td>
<td>CDH</td>
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<td>Hospital Administrative Statistics (HAA)</td>
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<td>MOH 717 Service Workload</td>
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<td>MOH 718 Inpatient M&amp;M</td>
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<td>MOH 710 Immunization</td>
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<td>MOH 706 Laboratory Report</td>
<td>County Lab Coordinator</td>
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<td>Lab In-charge</td>
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<td>Serial Number</td>
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<td>Sub-County Reporting Channel</td>
<td>Hospitals</td>
<td>Primary Health Facility/CU</td>
<td>Overall responsibility at Health Facility</td>
<td>HF Reporting Channel (Where Applicable)</td>
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<td>Quarterly report on Tuberculosis and MDR-TB case-finding</td>
<td>CTLC</td>
<td>CDH</td>
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<td>SCTLC</td>
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<td>Cohort Report for TB</td>
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<td>County Accountant</td>
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<td>Malaria Commodities Form</td>
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<td>Non-Pharmaceutical</td>
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<td>Nursing Officer In-charge</td>
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<td>Division of Occupational Therapy</td>
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<td>Occupational Therapist</td>
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<td>Logistic Management Information</td>
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<td>FP Contraceptives</td>
<td>County RH Coordinator/County Pharmacist</td>
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<td>MCH In-charge</td>
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<td>Maternal Death Review Form</td>
<td>County RH Coordinator/CHRO</td>
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<td>Maternity In-charge/MPDSR Team</td>
<td>Facility In-charge</td>
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<td>Ophthalmology Services</td>
<td>County Ophthalmologist</td>
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<td>DHIS2</td>
<td>Ophthalmologist</td>
<td>Facility In-charge</td>
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<td>Orthopedic Plaster</td>
<td>County Rehabilitative Services Coordinator</td>
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<td>Plaster Technologies</td>
<td>Facility In-charge</td>
<td>Med Sup/In-charge</td>
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**Notes:**
- **Serial Number:** Serial number of the reporting form.
- **Available Reporting Forms:** Type of reporting form.
- **County responsible (Action) Person:** Person responsible for the action.
- **Overall responsibility at County:** Overall responsibility for the reporting form at the county level.
- **Sub-County Reporting Channel:** Sub-county reporting channel.
- **Hospitals:** Hospitals involved in the reporting process.
- **Primary Health Facility/CU:** Primary health facility or catchment unit.
- **Overall responsibility at Health Facility:** Overall responsibility for the reporting form at the health facility level.
- **HF Reporting Channel (Where Applicable):** HF reporting channel where applicable.
Annex IV
AWP Implementation Monitoring Template

<table>
<thead>
<tr>
<th>Activities</th>
<th>Total Amount</th>
<th>Target Quarter for Delivery</th>
<th>Implementation Status (In progress, Cancelled, Completed, On-Going, Delayed, On-Schedule)</th>
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## Annex V
### Summary of Core Health Indicators in the M&E Plan

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Source</th>
<th>Frequency</th>
<th>Responsible Entity</th>
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<tbody>
<tr>
<td>Percentage of full immunized children</td>
<td>No. of children under 1 year who received all antigens</td>
<td>Estimated no of children younger than one year for a given period</td>
<td>MOH 710, MOH 510, MOH 702, Surveys KNBS 2019</td>
<td>Monthly, Annually</td>
<td>CHRIO</td>
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<tr>
<td>Percentage of target population receiving MDA for schistosomiasis</td>
<td>No. of people receiving MDA.</td>
<td>No. of people at risk for NTD in endemic counties</td>
<td>MOH 705 A&amp;B</td>
<td>Monthly</td>
<td>CHRIO</td>
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<tr>
<td>Percentage of TB patients completing treatment</td>
<td>No. of patients completed TB treatment</td>
<td>All TB cases recorded in the TB Registers (within the assessed cohort period)</td>
<td>TB Treatment Register, MOH 711</td>
<td>Monthly</td>
<td>CTLTC</td>
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<tr>
<td>Percentage of HIV positive pregnant mothers receiving preventive ARV drugs</td>
<td>No. of HIV/AIDS positive pregnant women who received antiretroviral medicines</td>
<td>No. of HIV/AIDS pregnant mothers</td>
<td>MOH 405, MOH 333, MOH 406, MOH 711, MOH 731</td>
<td>Monthly</td>
<td>CASCO</td>
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<td>Percentage of eligible HIV clients on ARV drugs</td>
<td>No. of HIV +ve adults and children currently receiving ARV therapy at the end of the reporting period</td>
<td>Estimated No. of HIV +ve adults and children eligible for ARVs</td>
<td>MOH 3618, MOH 731, MOH 711, KAIS 2014</td>
<td>Monthly</td>
<td>CASCO</td>
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<tr>
<td>Percentage of children under 1 year provided with LLTNs</td>
<td>Total No. of &lt;1year children who have received LLINs per year</td>
<td>Estimated No. of infants in the catchment area</td>
<td>MOH 511, MOH 105, malaria netpack record, KNBS 2019, Surveys: DHIS, MICS, MIS</td>
<td>Monthly</td>
<td>CMCC</td>
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<tr>
<td>Percentage of pregnant women attending at least 1 ANC visit and provided with LLTN</td>
<td>Total No. of pregnant women who have received LLINs per year</td>
<td>Estimated No. of pregnant women in the catchment area</td>
<td>MOH 511, MOH 105, malaria net pack record, KNBS Surveys, DHIS, MICS, MIS</td>
<td>Annual</td>
<td>CMCC</td>
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<tr>
<td>Percentage of children under 5years treated for diarrhea</td>
<td>Number of children under 5years treated for diarrhea</td>
<td>Number of children under 5years with diarrhea</td>
<td>MOH 204A, MOH 705A</td>
<td>Monthly</td>
<td>CHRIO</td>
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<td>Percentage of school-age children dewormed</td>
<td>Number of school-age children de-wormed</td>
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<td></td>
<td>Total number of children 2-14years</td>
<td>MOH 105, surveys, reports</td>
<td>Biannual</td>
<td>CHRIO</td>
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<td>Percentage of children 12-59 months dewormed</td>
<td>Number of children 12-59 months de-wormed</td>
<td>Total number of children 12-59 months in the catchment area</td>
<td>MOH 713</td>
<td>Monthly</td>
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<td>Percentage of adult population with body mass index over 25</td>
<td>Number of adults with BMI over 25</td>
<td>Total adult population in the area</td>
<td>Survey</td>
<td>Biennial</td>
<td>CHRIO</td>
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<td>Percentage of women of reproductive age screened for cervical cancer</td>
<td>Number of women of reproductive age screened for cervical cancer</td>
<td>Estimated total number of women of reproductive age</td>
<td>MOH 204 B, MOH 405, MOH 406, FP and cervical cancer service registers</td>
<td>Monthly</td>
<td>RH coordinator</td>
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<tr>
<td>Indicator</td>
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<td>Data Source</td>
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<td>Percentage of new out-patients with mental health conditions</td>
<td>Number of new out-patient cases with mental health conditions</td>
<td>Total number of all cases with the newly diagnosed mental condition</td>
<td>Out-patient registers, MOH 204 A and 204B, MOH 705A, MOH 705B</td>
<td>Monthly</td>
<td>CHRIO</td>
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<tr>
<td>Percentage of new out-patients cases with high blood pressure</td>
<td>Number of cases diagnosed with hypertension in a month</td>
<td>Total number of all newly diagnosed cases for all diseases in a month</td>
<td>MOH 204 B, MOH 705B</td>
<td>Monthly</td>
<td>CHRIO</td>
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<tr>
<td>Percentage of patients with cancer admitted</td>
<td>Number of patients with cancer admitted</td>
<td>Total number of cases admitted in a month</td>
<td>Hospice records, MOH 301, in-patient morbidity, and mortality report</td>
<td>Monthly</td>
<td>CHRIO</td>
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<td>Percentage of new out-patient cases attributed to gender-based violence</td>
<td>Number of new outpatient cases treated for gender-based violence</td>
<td>Total number of outpatient attendance</td>
<td>MOH 363, post-rape care register, MOH 364 sexual gender-based summary form</td>
<td>Monthly</td>
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<tr>
<td>Percentage of new out-patient cases attributed to road traffic injuries</td>
<td>Number of new outpatient cases attributed to a road traffic accident</td>
<td>Total number of outpatient attendance</td>
<td>OPD register MOH 204A, MOH 204B, MOH 705A, MOH 705B</td>
<td>Monthly</td>
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<td>Percentage of new out-patient cases attributed to the injuries</td>
<td>Number of out-patient cases with new injuries other than those caused by a road traffic accident</td>
<td>Total number of outpatient attendance</td>
<td>Out-patient register; MOH 204B, MOH 204A, MOH 301, and MOH 268; MOH 705A &amp; B</td>
<td>Monthly</td>
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<td>Percentage of facility deaths due to injuries</td>
<td>Number of deaths in a facility due to reported injuries</td>
<td>Total number of institutional deaths</td>
<td>Out-patient death register; MOH 204B, MOH 204A, MOH 301, and MOH 268; MOH 705B A &amp; B</td>
<td>Monthly</td>
<td>CHRIO</td>
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<td>Per capita outpatient utilization rate (male to female)</td>
<td>Number of out-patient facility visits for ambulant care per year</td>
<td>Total population in the area</td>
<td>Out-patient registers; MO 204A, MOH 204B, MOH 717</td>
<td>Annually</td>
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<tr>
<td>Percentage of population living within 5km of a facility</td>
<td>Total population living within a 5km radius of a facility</td>
<td>Total population in the area</td>
<td>Survey</td>
<td>Every Five Years</td>
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<td>Percentage of facilities providing BEmONC</td>
<td>Total number of facilities at levels 2-6 providing BEmONC</td>
<td>Total number of facilities at levels 2-6 in the area</td>
<td>Rapid facility surveys, updated MFL</td>
<td>Annually</td>
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<td>Percentage of facilities providing CEmONC</td>
<td>Number of health facilities at levels 4-6 providing CEmONC</td>
<td>Total number of health facilities at levels4-6</td>
<td>Rapid facility surveys, updated MFL</td>
<td>Annually</td>
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<td>Bed occupancy rate</td>
<td>Number of patient bed daysX100</td>
<td>Number of beds in institution times the number of days in the time period under review</td>
<td>MOH-301, Daily bed returns, MOH 717</td>
<td>Daily, monthly</td>
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<td>Percentage of facilities providing Immunizations</td>
<td>Number of level 2–5 health facilities providing immunization services</td>
<td>Total number of level 2–5 health facilities in the area</td>
<td>Rapid facility surveys, updated Master Facility List (MFL)</td>
<td>Annually</td>
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<td>Percentage of deliveries conducted by a skilled attendant</td>
<td>Number of deliveries conducted by skilled personnel</td>
<td>Total number of expected deliveries</td>
<td>MOH 333, MOH 711, MOH 717, KNBS projections 2019</td>
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<tr>
<td>Percentage of women of reproductive age receiving family planning</td>
<td>Number of women receiving family planning services</td>
<td>Total number of women of reproductive age</td>
<td>MOH 512, MOH 711, MOH 717, KNBS projection 2019</td>
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<td>Percentage of facility-based maternal deaths</td>
<td>Number of maternal deaths occurring at the facility</td>
<td>Total number of live births</td>
<td>MOH 333, MOH 711, KNBS projection 2019</td>
<td>Monthly</td>
<td>CHRIIO</td>
</tr>
<tr>
<td>Percentage of facility-based under-five deaths</td>
<td>Number of deaths of children under 5 years occurring at the facility</td>
<td>Total number of children under 5 years</td>
<td>MOH 511, MOH 301, MOH 204A DHS</td>
<td>Monthly</td>
<td>CHRIIO</td>
</tr>
<tr>
<td>Percentage of newborns with low birth weight</td>
<td>Number of newborns with less than 2.5kg body weight</td>
<td>Number of live births whose birth weights were measured</td>
<td>MOH 333, MOH 105</td>
<td>Monthly</td>
<td>CHRIIO</td>
</tr>
<tr>
<td>Percentage of facility-based fresh stillbirths</td>
<td>Number of fresh stillbirths</td>
<td>Total number of deliveries conducted</td>
<td>MOH 333, MOH 717</td>
<td>Monthly</td>
<td>CHRIIO</td>
</tr>
<tr>
<td>Surgical rate for cold cases</td>
<td>Cold surgical cases</td>
<td>Total catchment population</td>
<td>Theatre register, MOH 105, KNBS projection 2019</td>
<td>Monthly</td>
<td>CHRIIO</td>
</tr>
<tr>
<td>Percentage of pregnant women attending four ANC visits</td>
<td>Number of women attending fourth ANC visits</td>
<td>Total number of pregnant women</td>
<td>MOH 406, MOH 105, MOH 711, KNBS projections 2019</td>
<td>Monthly</td>
<td>CHRIIO</td>
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<tr>
<td>Percentage of infants under 6 months on exclusive breastfeeding</td>
<td>Number of children under 6 months on exclusive breastfeeding</td>
<td>Number of infants under 6 months on exclusive breastfeeding</td>
<td>MOH 704, MOH 713, MOH 511, MOH 216</td>
<td>Monthly</td>
<td>CHRIIO</td>
</tr>
<tr>
<td>Couple year protection due to condom use (family planning)</td>
<td>Number of couples sampled using a condom</td>
<td>Total number of couples surveyed</td>
<td>KDHS</td>
<td>Annually</td>
<td>CHRIIO</td>
</tr>
<tr>
<td>Percentage of population with access to safe water</td>
<td>Total population who have treated a safe drinking water source</td>
<td>Estimated population in the area, urban, rural</td>
<td>Household survey, administrative reporting system</td>
<td>Biennial</td>
<td>CHRIIO</td>
</tr>
<tr>
<td>Percentage of children under 5 years who are stunted</td>
<td>Number of children under 5 years attending child welfare clinic (CWC) in the month</td>
<td>Total number of children under 5 years mesure</td>
<td>MOH 511, MOH 216, MOH 704, MOH 713, KNBS projection 2019</td>
<td>Monthly</td>
<td>CHRIIO</td>
</tr>
<tr>
<td>Percentage of children under 5 years who are underweight</td>
<td>Number of children under 5 years attending CWC during them on than surveyed, with weight for age below 2 standard deviations</td>
<td>Total number of children under 5 years weighed in CWC during the month</td>
<td>MOH 511, MOH 206, MOH 704, MOH 713, MOH 105</td>
<td>Monthly</td>
<td>Nutrition Coordinator</td>
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<td>Indicator</td>
<td>Numerator</td>
<td>Denominator</td>
<td>Data Source</td>
<td>Frequency</td>
<td>Responsible Entity</td>
</tr>
<tr>
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<tr>
<td>School enrollment rate</td>
<td>Number of children enrolled in primary schools, secondary schools</td>
<td>Estimated population of school children to been rolled in every level</td>
<td>Primary school, secondary school enrollment register and monthly report to MOE</td>
<td>Biannual</td>
<td>Public Health Officer</td>
</tr>
<tr>
<td>Percentage of households with latrines</td>
<td>Number of households that use an improved sanitation facility, urban and rural</td>
<td>Estimated number of households in the area, urban and rural</td>
<td>MOH 514, MOH 515 household survey, administrative reporting system</td>
<td>Biannual</td>
<td>Public Health Officer</td>
</tr>
<tr>
<td>Percentage of houses with adequate ventilation</td>
<td>Number of houses with adequate ventilation, urban and rural</td>
<td>Estimated houses in the area, urban and rural</td>
<td>Household survey, administrative reporting system</td>
<td>Biannual</td>
<td>Public Health Officer;</td>
</tr>
<tr>
<td>Percentage of schools providing complete school health package</td>
<td>Number of primary and secondary schools providing complete school health package</td>
<td>Total number of schools</td>
<td>MOH 708</td>
<td>Monthly</td>
<td>Public Health Officer</td>
</tr>
<tr>
<td>Tuberculosis cure rate</td>
<td>Number of TB patients with smear-positive results at treatment initiation</td>
<td>Number of TB patients with smear-negative results at the end of 6 months</td>
<td>TB register</td>
<td>Monthly</td>
<td>TB Coordinator</td>
</tr>
<tr>
<td>Percentage of fever tested positive for malaria</td>
<td>Number of malaria RDT positive slide results at treatment initiation</td>
<td>Number of patients tested for malaria</td>
<td>MOH 240</td>
<td>Monthly</td>
<td>Lab Coordinator</td>
</tr>
<tr>
<td>Percentage of maternal death audits</td>
<td>Number of maternal death records reviewed</td>
<td>Total number of maternal deaths reported</td>
<td>MOH 105, maternal death review form</td>
<td>Monthly</td>
<td>Reproductive Health Coordinator</td>
</tr>
<tr>
<td>Number of malaria in-patient case fatalities</td>
<td>Number of patient deaths in malaria cases (per 1,000)</td>
<td>Total number of patient deaths plus discharges due to malaria</td>
<td>MOH 301, MOH 268, DHIS in-patient morbidity and mortality report</td>
<td>Monthly</td>
<td>Facility</td>
</tr>
<tr>
<td>Average length of stay (ALOS)</td>
<td>Number of in-patient days plus half-day patients</td>
<td>Number of in-patient discharge plus deaths</td>
<td>MOH 717, MOH 268, MOH 718; DHIS in-patient morbidity and mortality report</td>
<td>Monthly</td>
<td>Facility in-charge</td>
</tr>
<tr>
<td>Percentage of children registered for birth notification (B1)</td>
<td>Number of children issued birth notification</td>
<td>Total number of births</td>
<td>B1, MOH 333</td>
<td>Monthly</td>
<td>Facility in-charge</td>
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Annex VI
Data Management SOPs

Document: Procedure for Data Collection

<table>
<thead>
<tr>
<th>Document Number:</th>
<th>1</th>
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<tbody>
<tr>
<td>Point of Use:</td>
<td>Health Facility and Community Unit</td>
</tr>
<tr>
<td>Frequency:</td>
<td>Daily</td>
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</table>

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

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

CHECKLIST FOR DATA COLLECTION

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

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

CHECKLIST FOR DATA COLLATION AND VALIDATION BY DATA COLLECTOR

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

CHECKLIST FOR DATA VALIDATION BY SUPERVISOR

- The summarized form/report MUST be counter checked by a second party and signed by the supervisor (facility-in-charge).
- During counterchecking, check the totals in the summary sheet (add all totals for each variable to ensure the calculation is correct).
- A minimum sample (5 days in a month) of the daily registers should be counterchecked and accuracy of data and totals confirmed.
- If inconsistencies are found in this sample, increase the sample days and refer to the data collector to make corrections.
- Notify the data collector of inconsistencies and corrections made and documented.
- Vetted data summary reports should be duly signed, dated and stamped by the facility-in-charge (nursing officer-in-charge or clinical officer-in-charge or medical superintendent).
Document: Procedure for Reporting in DHIS2

Document Number: 3

Point of Use: County, Sub-County and Health Facility

Frequency: Weekly, Monthly and Quarterly

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

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

CHECKLIST FOR REPORTING IN DHIS2

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

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

CHECKLIST FOR DATA ANALYSIS

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

Document: Procedure for Sharing and Use

<table>
<thead>
<tr>
<th>Document Number:</th>
<th>5</th>
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<tbody>
<tr>
<td>Point of Use:</td>
<td>County, Sub-County, Health Facility and Community Unit</td>
</tr>
<tr>
<td>Frequency:</td>
<td>Monthly, Quarterly and Yearly</td>
</tr>
</tbody>
</table>

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

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

**CHECKLIST FOR DATA SHARING AND USE**

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

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