MINISTRY OF HEALTH

DIVISION OF COMMUNITY HEALTH SERVICES

Baseline Capacity Assessment Report on M&E Functions in the Division of Community Health Services

August 2013

PREFACE

Having adequate human, technical and financial capacity is a hallmark for any successful project implementation. This report presents the capacity assessment of staff from the Division of Community Health Services (DCHS) in relation to Monitoring and evaluation (M&E) of the community Health strategy at the national level.

The Ministry of Health recognized the community as the missing interface in healthcare delivery way back in 2006 when it developed the first national community health strategy. This strategy is one of the flagship projects of Kenya's Vision 2030 and sets a package of health services that ought to be implemented at the community level for better health. Suffice it to say, the community is considered as one of structures in the provision of the Kenya Essential Package for Health (KEPH). In operationalizing the strategy implementation, the Ministry of Health (MoH) set up the Division of Community Health Services in 2007. Prior evaluation that was conducted in 2010 revealed that areas that were implementing the community strategy recorded higher percentages in a range of health seeking behavior and scored better health outcomes as compared to their counterparts- a testimony that community health strategy was working.

However, the passing of the new constitution in 2010 which gave birth to devolved governments poses a number of formidable organizational and legislative challenges in the implementation of the community strategy. For instance, the enacted constitution recognizes devolved structures specifically, the county governments as independent. This calls for the need to re-assess the capacity of the Division to execute its mandate of policy formulation and technical guidance to devolved structures. This report provides the Division's capacity to execute its M&E mandate at the national and sub national level in line with Kenya's new constitution.

It is my hope that the capacity gaps identified in this report will rally stakeholders to jointly develop an investment plan with a sole view of capacity building the Division to execute its M&E mandate at the national and county levels. The Government of Kenya will continue playing its role in working with all stakeholders to enhance community health for all.

PROF. FRED SIGOR, CBS

Principal Secretary for Health

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I also thank the research assistants who participated in the assessment and captured what transpired during the capacity assessment for the DCHS. In addition, we recognize the important role played by representatives of our partners and stakeholders. I would like to make a special mention to Eunice Ndung'u (UNICEF), Victor Achieng' (Pathfinder), and Charles Mito (Afya Info) for their insightful perspectives. Last but not least, I extend my gratitude to the PIMA oversight technical teams at the Head Office, especially the technical guidance from Shannon Salentine and editorial support team of Aubrey Pirosko, Lynne Jennrich, and Cindy Young-Turner who worked closely with Dr. Sam Wangila (PIMA Advisor for CHIS/RH) to finalize this report.

Dr. JAMES MWITARI,

Head of DCHS

ACRONYMS AND ABBREVIATIONS

AIM	Assessment Improvement Matrix
APHIA	AIDS, Population and Health Integrated Assistance Program
ACSM	Advocacy, Communication and Social Mobilization
CB	Capacity Building
CHEW	Community Health Extension Worker
CHW	Community Health Worker
CHIS	Community Health Information System
CHMT	County Health Management Teams
COE	Centers of Excellence
COP	Community of Practice
CRVS	Civil Registration and Vital Statistics
DCHS	Division of Community Health Strategy
DDSR	Division of Disease Surveillance and Response
DDU	Data Demand and Use
DHMT	District Health Management Team
DOMC	Division of Malaria Control
DRH	Division of Reproductive Health
GOK	Government of Kenya
HFA	Health for all
HIS	Health Information System
ICC	Interagency Coordinating Committee
IR	Intermediate Result
ITN	Insecticide-treated Net
JPWF	Joint Program of Work and Funding
KEMRI	Kenya Medical Research Institute
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MDR	Maternal Death Review
MEASURE	Monitoring and Evaluation to Assess and Use Results
MESST	Monitoring and Evaluation System Strengthening tool
mHealth	Mobile Health
MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NHSSP I	National Health Sector Strategic Plan I
NHSSP II	National Health Sector Strategic Plan II
OD	Organizational Development
PHC	Primary Health Care
PHMT	Provincial Health Management Team
PMI	The President's Malaria Initiative
PMP	Performance Management Plan
PMST	Provincial Medical Services Team
TA	Technical Assistance
TWG	Technical Working Groups
USAID	U.S. Agency for International Development
USG	United States Government

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EXECUTIVE SUMMARY

BACKGROUND

The overall objective of this baseline assessment was to understand current capacity in the monitoring and evaluation (M&E) performance objectives and gaps in the Division of Community Health Services (DCHS). It was envisioned that identifying performance objectives and gaps is the first step in designing action and implementing plans to strengthen DCHS's capacity for M&E response. The assessment has three specific objectives:

1. Understand, document, and clarify performance objectives for division-level M&E.
2. Determine the current status of performance in key DCHS M&E functional areas.
3. Identify gaps in DCHS's capacity to meet performance expectations.

Several approaches were used to address the assessment objectives: a detailed desk review of strategic DCHS documents to understand, document, and clarify M&E performance objectives and clarify the policy direction on community health at the national level; a detailed assessment tool based on the PRISM model and the Monitoring and Evaluation System Strengthening Tool (MESSET) to assess DCHS capacity to undertake M&E; and key informant interviews with selected DCHS and Ministry of Health (MoH) personnel and key stakeholders, such as UNICEF, Pathfinder and Afya Info. The Kenya Medical and Research Institute (KEMRI) gave ethical approval to conduct the assessment.

KEY FINDINGS

Following is a summary list of the assessment findings:

- The overall organizational capacity index (OCI) for DCHS is 49.5%, which implies that DCHS has considerable capacity gaps in its progress to fulfill its M&E mandate.
- DCHS has a glaring capacity gap in the area of financial autonomy on almost all the functional components of the M&E system that this survey assessed.
- Although notable gaps exist in a wide array of M&E functional components in the area of technical autonomy, DCHS's close partnership and collaboration with stakeholders appeared to largely resolve this gap.
- The individual capacity assessment revealed that DCHS staff members have capacity gaps in M&E, including staff who work directly in the M&E unit; scores on the four dimensions of status, quality, technical, and financial autonomy hovered above the 50% mark.
- DCHS shows capacity gaps in the areas of surveys and surveillance and research and evaluation, which could negatively affect the use of data for decision making.

RECOMMENDATIONS

The following list summarizes recommendations based on the assessment findings:

- DCHS M&E unit's human capacity for M&E is lean. The current use of interns and technical personnel from stakeholders, such as MEASURE Evaluation, should continue.
- Strive to provide basic M&E courses to all DCHS heads of units to increase M&E champions and help the M&E unit reach full execution of its mandate.

- To strengthen routine monitoring, DCHS needs to rely on stakeholders to revise and finalize revisions to Community Health Information System (CHIS) tools, including distribution for timely reporting.
- DCHS needs to seek ways and means to lobby for more resource allocations from the MTEF budget and partners to scale up routine data collection and reporting in the *mHealth* and *eHealth* initiatives to alleviate poor data quality, untimely reporting, and shortage of tools. This will entail negotiation with service providers for concessions on *mHealth* and *eHealth* infrastructure and software for cost effectiveness.
- Changes in the Kenya constitution in 2010 affected governance structures that now require that DCHS realign to major guidelines, such as the strategic and M&E plans to support activities at the subnational level.
- DCHS needs to strengthen supervision at the county and subcounty levels and address problems with data flow and data demand for decision making at the national and subnational levels.
- Quality data for decision making is a priority for evidence-based programming. DCHS needs to train key personnel on data demand and use and, where possible, appoint data demand and use champions, especially at the subnational level.
- Skills in data analysis are critical for M&E personnel, but the assessment shows M&E staff members have limited skills, especially in the use of professional statistical packages like SPSS and Stata. DCHS needs to provide mentoring and supportive supervision, plus training in basic data analysis, to equip staff with basic data analysis skills.
- DCHS needs to develop dashboards on key indicators to help management make fast, reliable decisions.
- The assessment reveals evidence that DCHS has problems with poor quality data; late and untimely reporting; and incomplete, inconsistent, and inaccurate information capture. DCHS needs technical assistance to develop data quality assessments and routine data quality assessments (RDQA) and train staff on the use of the tools.

CHAPTER 1: BACKGROUND OF COMMUNITY HEALTH

1.1 COMMUNITY HEALTH INITIATIVES: A GLOBAL PERSPECTIVE

The role of the community strategy in improving health for all first came to limelight in 1977, when World Health Organization (WHO) member states adopted the Health for All (HFA) concept. A year later, during the famous Alma Ata Declaration in 1978, countries world over recognized primary health as the foundation for achieving health for all by the year 2000. This declaration was ratified by WHO, and several other initiatives have since been formed to reinforce this agenda. Among other things, the Alma Ata Declaration recognized that people have a right to individually and collectively participate in the planning and implementation of their own health care and that primary health care (PHC) forms an important part of the health care system [1].

While the recognition of primary health as an engine for achieving health for all was ratified by countries world over, minimal progress was made in some countries, especially in sub Saharan African countries. Consequently, other global initiatives emerged to re-emphasize the importance of primary health. For example, the Bamako Initiative in 1987, under the sponsorship of UNICEF and WHO, recognized that while countries (mostly in sub Saharan Africa) accepted in principle the core tenets of comprehensive PHC, little progress had been made by the late 1980s because structural and technical resources were lacking, as well as practical implementation strategies.

Consequently, the Bamako Initiative called for an increase in access to primary health care by elevating the effectiveness, efficiency, financial viability, and equity of health services. The core objective was to set up basic integrated services through revitalization of health centers that applied user fees and community co-management of funds. This was accomplished by forming village committees that were part of all the aspects of health facility management [2]. Despite some progress in improving health indicators at the community level in sub Saharan African, the initiative design was heavily criticized, especially for the user fees imposed on poor households and the principle of cost recovery. Similar criticisms were leveled at other initiatives, such as the infamous structural adjustment programs by the World Bank and International Monetary Fund in the late 1980s and 1990s.

A shift from the user fees and cost recovery strategies could be seen in later initiatives, such as the Abuja Declaration of 2000, which called on African governments to allocate at least 15 percent of their gross domestic product to health. Other initiatives, such as the Millennium Development Goals (2000) and the WHO report on Macroeconomics and Health (2001), stimulated renewed interest in the role of community participation in general development as a means to improve health [3]. A common theme in these reports is the intricate linkage between socioeconomic development and health and the need to enhance poverty reduction mechanisms for the general improvement of people's health. Even as we approach 2015, most sub Saharan African countries, including Kenya, are likely to miss meeting their Millennium Development Goal targets.

1.2 IMPLEMENTATION OF COMMUNITY HEALTH STRATEGY IN KENYA: A HISTORICAL PERSPECTIVE

Kenya has been part and parcel of the countries that have ratified international health initiatives since her independence in 1963. Some of these initiatives recognize the primary health care agenda as articulated in the Alma Ata Declaration, the 1987 Bamako Initiative, the International Monetary Fund and World Bank structural adjustment programs on health in the mid-1980s, Millennium

Development Goals established at the Millennium Summit by United Nations countries in 2000, and the Abuja Declaration of 2000. The implementation of some of these initiatives by the Kenya government has had mixed health care results [4]. Further, the heavy burden of HIV/AIDS, malaria, tuberculosis, and childhood illnesses continue to devastate most African economies, which leads to diminished resource allocations for health care. There is, however, hope for health improvement with targeted initiatives such as the PEPFAR funds, Global Fund for HIV/AIDS, Tuberculosis, and Malaria (GFTAM) and The President's Malaria Initiative (PMI).

The establishment of the Kenya Health Policy Framework (KHPF) 1994–2010 ensured a comprehensive health approach and addressed issues of equity, social justice, and democracy. To implement KHPF, Kenya's MoH for the first time came up with a National Health Sector Strategic Plan (NHSSP I), 1999–2004, which addressed some of the pitfalls in Kenya's health system management and service delivery, including improving resource allocations to health, decentralizing health services and management, shifting resources from curative to preventive services, and strengthening governance [5]. Despite this measure, health indicators did not improve. For example, infant and child mortality rates increased from 59 and 89 per 1,000 live births in 1989 to 78 and 115 deaths per 1,000 live births, respectively, in 2003 [6]. This was an increase of 32 and 29%, respectively. Poverty levels, likewise, rose from 47% in 1999 to 56% in 2002, which compounded difficulties to improve community health services.

Because of the deteriorating health trends, the Government of Kenya formulated NHSSP II, 2005–2010. This strategy embraced the PHC approach. The key principles behind this strategy included advocacy for increased equitable access to health services; improved quality, efficiency, and effectiveness of service delivery; enhanced MoH regulatory capacity; increased partnerships in health; and improved financing for the health sector [7]. As a deviation from NHSSP I, which failed to improve health outcomes, the Government of Kenya strengthened the strategy's implementation framework by forming a Joint Program of Work and Funding (JPWF) to guide health services investment decisions at the community level. By 2010, clear reversals could be seen in the once worsening health indicators. For example, infant and child mortality declined from 78 and 115 deaths per 1,000 live births in 2003 to 52 and 74 deaths per 1,000 live births, respectively, in 2008–2009 [8]. Part of this improvement in the health indicators occurred in an era when the Government of Kenya launched a community health strategy in 2006 to provide Level 1 health services with other levels of the health care system, as directed in the KHPF framework.

Kenya's vision 2030 also recognizes the implementation of the community strategy as one of the flagship projects for the realization of the social pillar. Although formulated in 2006, the community health strategy was not implemented until 2008, when MoH introduced the Community Health Information System (CHIS) to support implementation and provide mechanisms for monitoring. The CHIS is a series of tools used at various levels to collect and share data on households, health issues, service provision, and other community response activities.

In the community strategy implementation guidelines for managers [9], the CHIS goal is defined to improve the health status of Kenyan communities through the initiation and implementation of life-cycle-focused health actions at Level 1 by meeting these objectives:

- Provide services at Level 1 for all population cohorts and socioeconomic groups, including differently abled, and take into consideration their priority needs.
- Build capacity of Community Health Extension Workers (CHEW) and Community Health Workers (CHW) to provide services at Level 1. Strengthen health facility and community linkages and form partnerships to implement Level 1 services.

- Strengthen the community to progressively realize individual rights to accessible, quality care and seek accountability from facility-based health services.

Despite these objectives, the M&E unit at the Division of Community Health Services (DCHS) has faced serious challenges [10] including the following:-

- Lack of a nationally accepted and standardized M&E framework and plan for DCHS, which has led to multiple plans and systems imposed by different implementing partners.
- Limited data use in all levels of planning, which has led to limited evidence-based DCHS planning and implementation at the community level.
- Inadequate DCHS resource allocations for M&E, which has limited capacity.
- Lack of systematic and effective data management and quality assurance, which yields incomplete, untimely, and unreliable data.
- Lack of dynamic and comprehensive data collection and reporting tools that respond to emerging information and service needs.

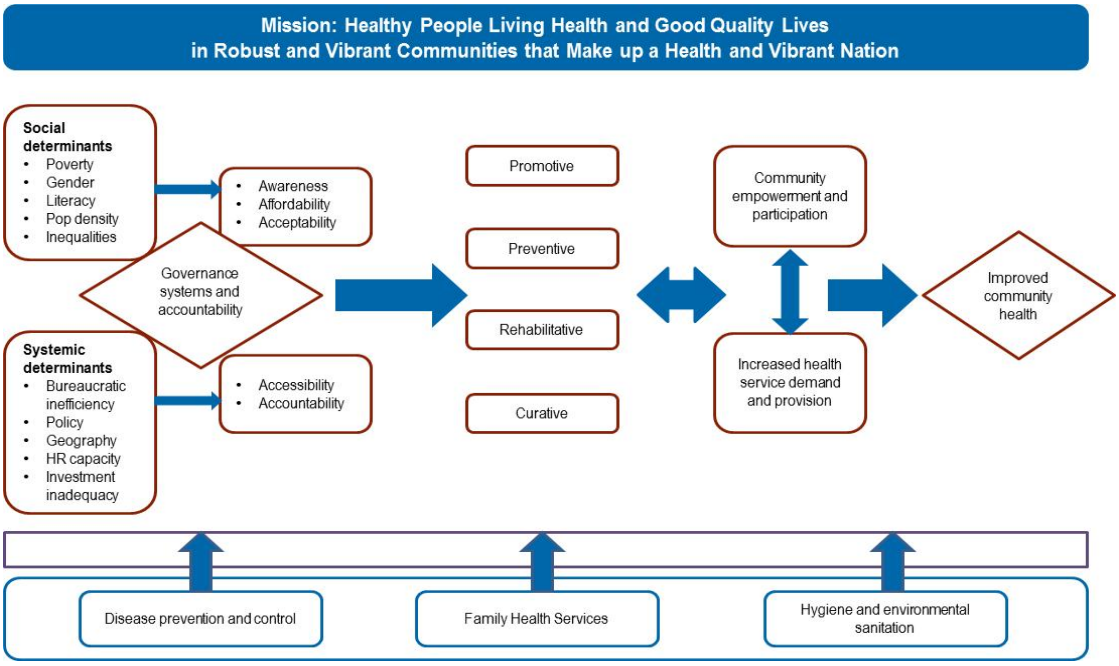
DCHS was initiated without a baseline survey, and thus it has been difficult to measure its contribution. Data flow from households to District Health Information System (DHIS) has been weak, with severe under-reporting and data quality issues. Interviews with relevant DCHS staff revealed that tools were rolled out before users were trained on the use of tools, which adversely affected the quality of data captured in the tools. DCHS has experienced a lack of adequate personnel and capacity to strengthen and sustain M&E systems. Despite these challenges and gaps, a 2010 UNICEF evaluation survey showed that DCHS improved health outcomes at Level 1 in areas where the strategy has been implemented compared to areas where the strategy has not been implemented [11].

To overcome these challenges, DCHS, in collaboration with key stakeholders such as MEASURE Evaluation, has developed a monitoring and evaluation plan for 2013–2017 with the following key M&E objectives:

1. Establish a robust integrated DCHS M&E Plan with the capacity to adequately monitor the implementation of interventions at Level 1 of the health care delivery system.
2. Provide a standard platform for strategic partnership and accountability among stakeholders at all levels and implementing partners, as well as for those providing financial resources for DCHS.
3. Enhance data use for informing evidence-based planning.
4. Identify and document emerging best practices and lessons learned for improvement and scaling up of service provision.
5. Promote health system research, policy, and innovation through documentation and information sharing.
6. Provide a standard mechanism for tracking all relevant indicators to capture performance in disease prevention and control to reduce morbidity, disability, and mortality; in provision of family health services aimed at expanding family planning, maternal, child, and youth services; and in promotion of hygiene and environmental sanitation.

The DCHS M&E plan is summarized in the schematic diagram shown in Figure 1.

Figure 1: Conceptual Framework for the DCHS M&E Plan



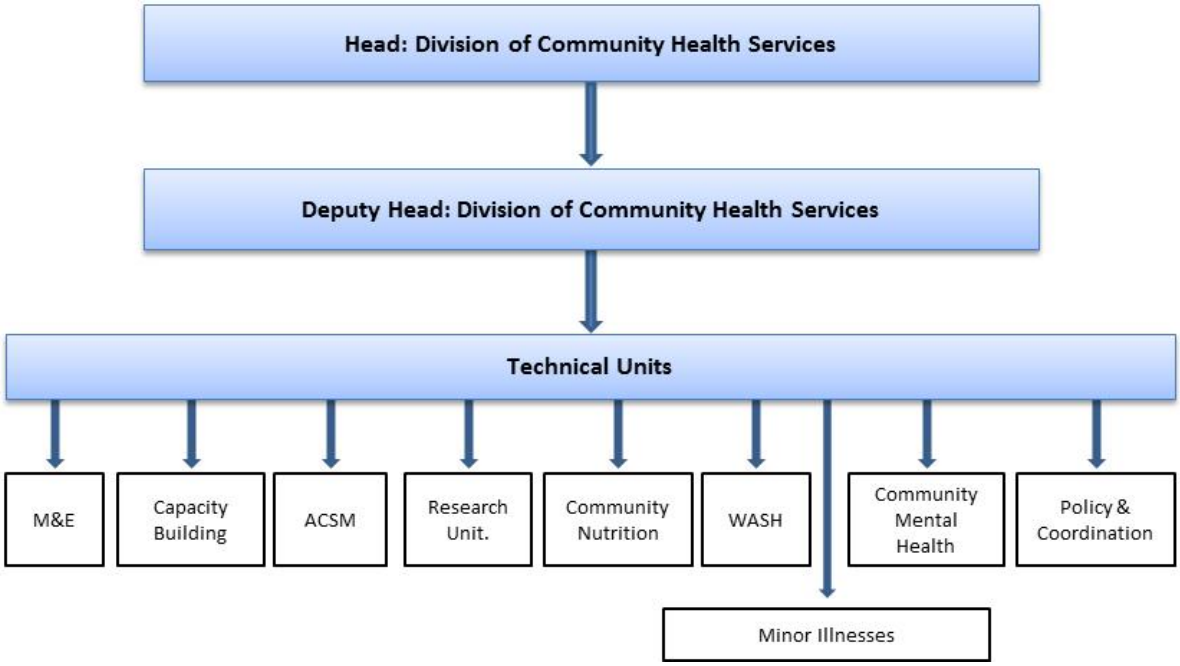
Source: MoH (Forthcoming). Monitoring and Evaluation Plan for Community Health Services 2013-2017, MoH, Nairobi, Kenya

As shown in the diagram, DCHS recognizes that to achieve its mission, it needs to focus on social and systemic determinants of health. If DCHS uses pragmatic approaches to address challenges, it could ultimately empower communities to demand better health from the duty bearers, and, at the same time, empower communities to take charge of their own health needs.

1.3 ORGANIZATIONAL STRUCTURE

The DCHS organogram_is shown in Figure 2. DCHS came into existence in 2008 after MoH formulated a community strategy to oversee the implementation of Level 1 health services from 2006–2010 [12].

Figure 2: Organogram of the Division of Community Health Services



In an interview with relevant DCHS staff, additional background emerged. The Division came into being after being renamed from Health Sector Secretariat in 2008. The organizational structure emerged later and plans and strategies were put into place. Among the strategies was the establishment of the M&E unit, which initially was called CHIS. The functions of the unit are managing data, developing tools, and tracking performance. The unit is also responsible for community research.

Critical changes, especially the enactment of the new constitution, which instituted devolution, have necessitated review of strategy to align with devolved health structures at the national and subnational levels. DCHS, together with key stakeholders, is reviewing community health strategy. We believe the new strategy will not only address emerging structural arrangements in the provision of health care at the community level, but will also address gaps in the current strategy and strengthen the gains made in approaches that have worked.

CHAPTER 2: DESIGN AND METHODOLOGY

2.1 INTRODUCTION

This baseline assessment used a cross-sectional observational study design with a mixed-methods approach. MEASURE Evaluation PIMA Project collected quantitative and qualitative data using an observational checklist and a range of qualitative and quantitative data collection techniques. These methods included key informant interviews (KIIs) and individual as well as group assessment tools. The purpose of this assessment was to understand and document the current organizational and individual capacity of national programs to successfully achieve their performance objectives in program-level monitoring and evaluation. The assessment had three specific objectives:

1. Understand, document, and clarify performance objectives for division-level M&E.
2. Determine the current status of DCHS performance in key M&E functional areas.
3. Identify gaps in DCHS's capacity to meet performance expectations.

2.2 STUDY SITE AND POPULATION

This assessment focused primarily on DCHS at the national level.

MEASURE Evaluation PIMA project conducted interviews with heads of divisions and departments, program managers, M&E personnel, thematic focal points in target programs, and selected M&E stakeholders working with DCHS. The number of DCHS staff that participated in the group assessment was 14, and each of these staff members participated in the individual assessment. MEASURE Evaluation interviewed the Head of the DCHS and the Head of the Division of Primary Health and the Head of the DCHS M&E unit. In addition, focal contacts from UNICEF and Afya Info in charge of community health strategy were interviewed.

2.4 SAMPLING

MEASURE Evaluation identified respondents in DCHS by using a purposive sampling strategy. This approach made it possible to interview only those people who are knowledgeable on the M&E program responsibilities, as well as specific individuals tasked with implementing M&E functions in these programs.

2.5 PROCEDURES

MEASURE Evaluation conducted a detailed desk review of relevant documents and literature on DCHS's M&E capacity. In particular, the review documented the policy environment surrounding the implementation of the primary health care approach from a historical perspective and brought out important gaps in existing documentation about the current status of M&E capacity to inform the assessment.

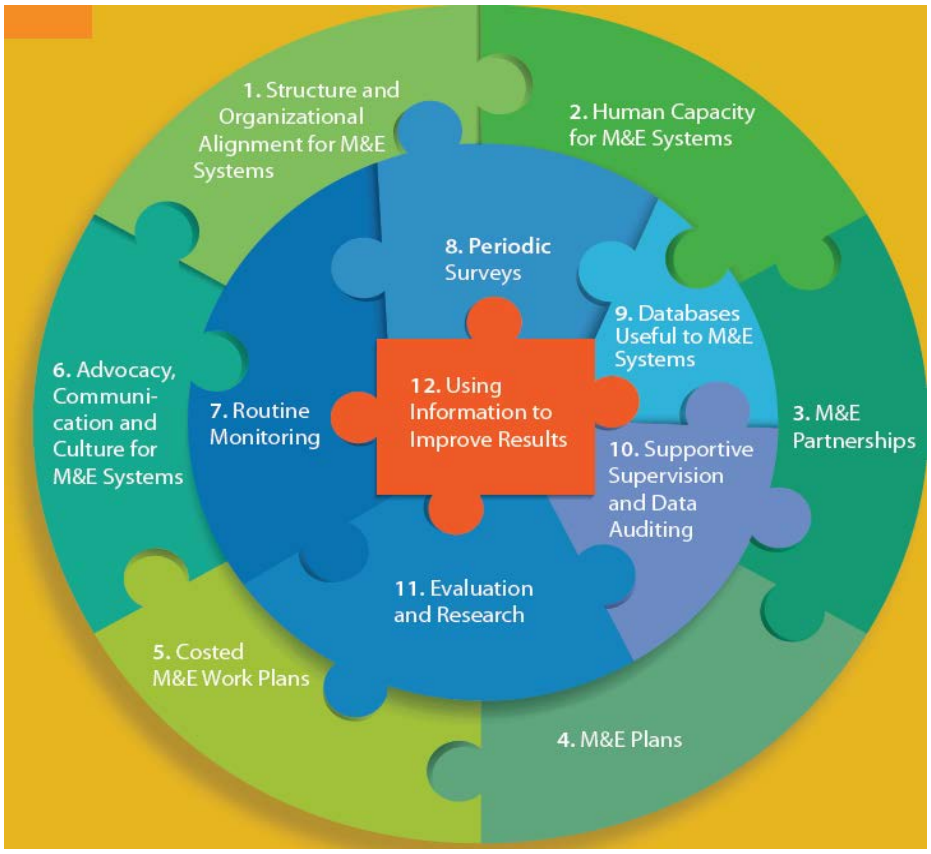
The review focused on these issues:

- An overview of the global and local initiatives on primary health
- History and structure of the institution and M&E activities
- Current status of the institution and M&E activities
- Existing documentation related to M&E capacity
- Existing documentation about the gaps in M&E capacity

MEASURE Evaluation PIMA project used a mixed-methods approach to collect qualitative and quantitative information to supplement the desk review. MEASURE Evaluation PIMA project developed a generic data collection tool that captures various dimensions of capacity—organizational, technical, and behavioral—to provide an overall approach to data collection during the assessment. The group assessment tool incorporates the 12 components of a functional M&E system, as shown in Figure 3. Appendix 2 lists the group assessment tool's results for capacity. This tool was developed similar to several tools used internationally for M&E capacity assessment:

- Global Fund Monitoring and Evaluation System Strengthening Tool (MESST) [13]
- United Nations Joint Program on HIV/AIDs (UNAIDS) components tool [14]
- MEASURE Evaluation's PRISM framework, which looks at organizational, behavioral, and technical aspects to assess routine health information systems [15]
- MEASURE Evaluation's individual competency assessment tool, SCORE-ME [16]

Figure 3: The 12 Components Monitoring and Evaluation System Strengthening Tool



Note: The 12 components of a functional M&E system for HIV programs can be found on the following link: https://www.globalhivmeinfo.org/Pages/HomePage.aspx.

2.6 DATA MANAGEMENT

2.6.1 Data Storage

MEASURE Evaluation used MsExcel 2010 software to develop a database to enter and store quantitative data. The database was accessible only to authorized study investigators and trained

data management personnel. The database was filled online, based on the group consensus, because of drop-down options. DCHS will share summaries from the study with other stakeholders.

2.6.2 Data Analysis

MEASURE Evaluation used simple descriptive statistics, such as means and frequencies, to analyze the quantitative data in MsExcel 2010. Qualitative data was analyzed manually using a thematic approach. The audio recorded interviews and notes from the interviews were transcribed in MsWord 2010. Each transcript had a unique identifier that comprised project code, date, and participant identifier, allowing enhanced confidentiality and anonymity. Subsequently the data were coded into themes emerging from the data for a content analysis. This was done by at least two people, and the results were compared and discussed before arriving at an agreed set of themes that were identified *apriori,* on the basis of literature and document reviews. Unanticipated themes arising from the data were incorporated into a second round of coding with free nodes representing broad categories. Any further arising nodes were created by grouping some of the free nodes into tree nodes by making logical connections and incorporating any emerging themes. The final stage was a layered analysis that entailed identification of the main themes and underlying causes of reported experiences and observations.

Using the group tool, MEASURE Evaluation calculated the organizational capacity index (OCI) by first summing the possible scores on the 12 M&E components for two out of the four dimensions, status and quality. Financial and technical autonomy were excluded in the measure because their effect was not unidirectional; their presence or absence could affect the performance of the division either positively or negatively, and hence their inclusion could have led to spurious results. This was not the case for the status and quality dimensions; their absence could have affected the M&E performance in only a negative way. Further, not all the elements for the 12 components of a functional M&E system asked questions on financial and technical autonomy. MEASURE Evaluation then computed the OCI by dividing the actual score on the 12 M&E functions under the two dimensions of status and quality with the possible maximum score.

2.7 INDIVIDUAL ASSESSMENT

Individual assessments were done for all the participants from DCHS based on the Knowledge, Skills, and Competences (KSC) Capacity-building Framework to ascertain individual capacity gaps and set a benchmark for measuring professional development and improved organizational capacity. DCHS can then focus on developing a comprehensive strategy for individual and organizational capacity building.

2.8 STUDY LIMITATIONS

A limitation of group and individual self-assessments is possible exaggeration of actual scores. The assessment tool was specifically tailored to assess M&E in DCHS, and it limited findings that could be generalized to all MoH divisions. DCHS organizational structure, institutional arrangements, and mandates make it unique among the divisions.

CHAPTER 3: RESULTS

We present the results in two main sections to address the assessment objectives. The first section provides a general overview of DCHS status on M&E components, quality of available M&E components, DCHS's technical capacity to execute various M&E components, and its capacity to internally meet the financial requirements necessary to implement M&E. The second section focuses on capacity of individual M&E components. In both sections, we applied triangulation approaches to improve discussion of the results.

3.1 OVERVIEW OF DCHS ON M&E CAPACITY

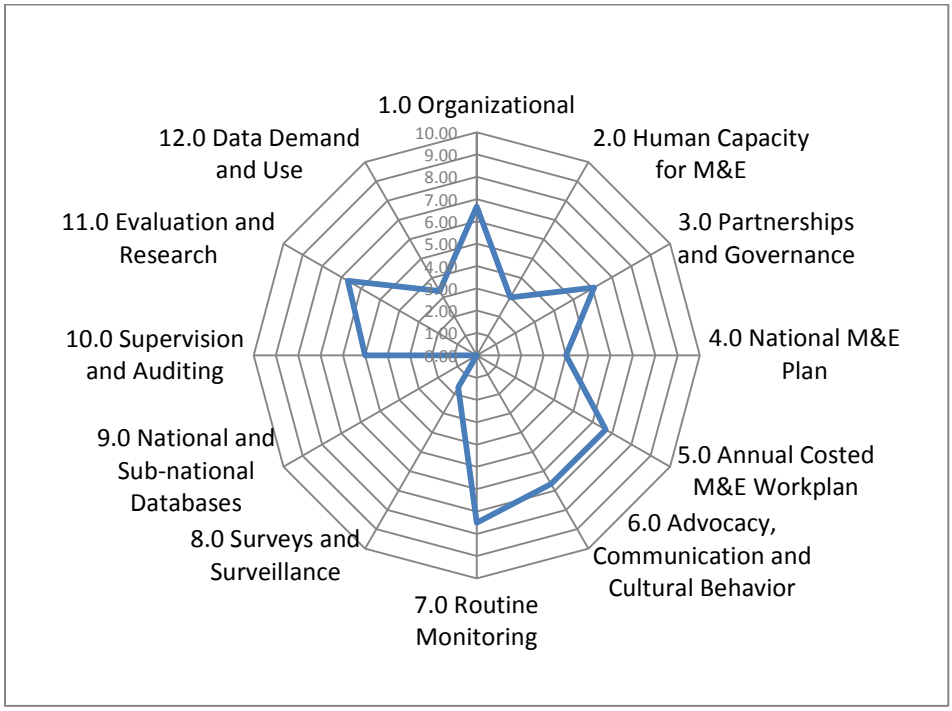
MEASURE Evaluation calculated DCHS's overall capacity to implement M&E functions using the OCI, described in Chapter 2, which is based on actual group assessment scores on the 12 M&E functional components. Results show that DCHS's OCI to perform M&E functions was 49.5%, leaving room for individual and organizational capacity improvement at more than 50% percent to reach maximum performance on its M&E mandate. In the next section we discuss in detail the DCHS performance on the four dimensions of M&E capacity in specific areas that require urgent attention.

We present the DCHS M&E dimensions results in an MsExcel tool for group assessment with customized dashboards. MEASURE Evaluation used a series of questions in four dimensions for each capacity area:

1. *Status*: If a given element exists, such as a national M&E plan
2. *Quality*: If the element conforms to established norms of quality
3. *Technical autonomy*: The extent to which a program can develop and execute the element on its own
4. *Financial autonomy*: The extent to which a program can develop and execute the element with its own resources

Figure 4 shows DCHS's capacity on various M&E functional components. The results show that DCHS's capacity at the time of the assessment was strong for having an annual costed M&E work plan and national and subnational databases.

Figure 4: The Status of DCHS Capacity on Various M&E Functional Components



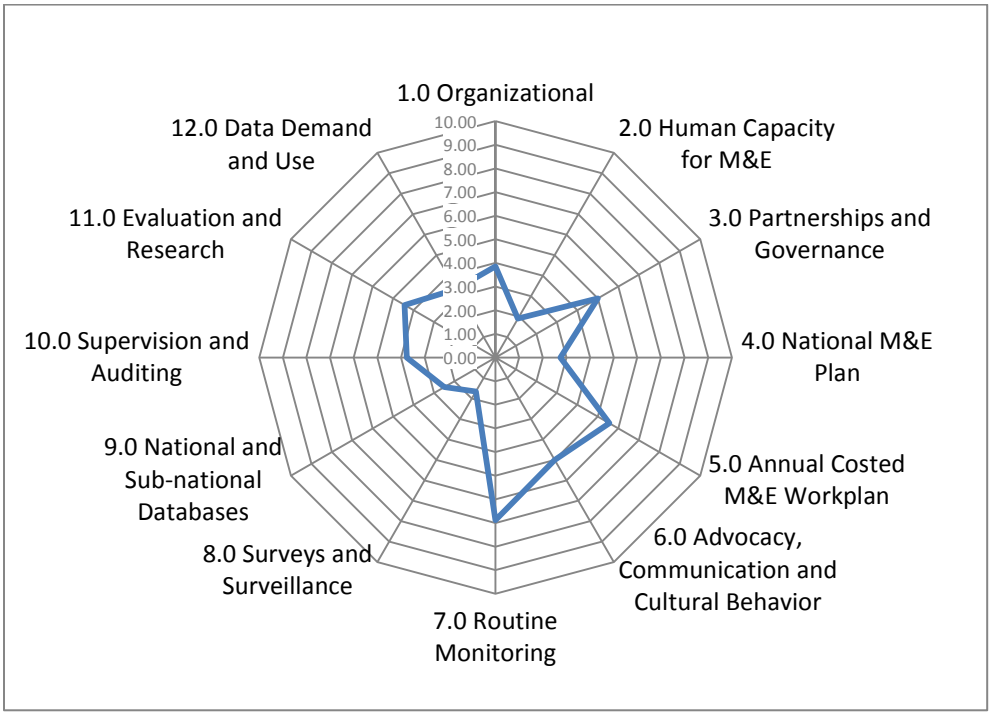
Source: Primary analysis of the DCHS M&E capacity-building baseline assessment in 2013

A desk review of DCHS concurred with these results. For example, the review noted that in conjunction with the partners, in May 2013 DCHS developed a costed Annual Workplan (AWP II) that demonstrated partners' commitment to various planned activities. DCHS launched the CHIS database, popularly called the Master Community Unit Listing (MCUL), May 31, 2013. MCUL, which is a comprehensive list of all functional community units in the country, is intended to be updated monthly. More information is available at http://www.ehealth.or.ke/mcul/default3.aspx.

DCHS is also doing well in the areas of research and evaluation and advocacy, communication, and cultural behavior. A desk review of literature found that DCHS has a clear research agenda that covers nine thematic areas that include cost analysis and human resources for health and policy analysis. The good score can be attributed to the research agenda and DCHS's collaboration with stakeholders to conduct and finalize some research themes. DCHS has a published advocacy and communication strategy covering 2012–2017.

The areas where DCHS measures weakest included routine monitoring, human capacity for M&E, data demand and use, organizational systems, and supervision and auditing. The quality of DCHS M&E services, revealed in the group assessment, showed that DCHS's advocacy, communication, and cultural behavior scored highest. The capacity areas of evaluation and research, annual costed M&E workplan, partnership and governance, and having national and subnational databases all scored moderately strong, with scores ranging 50–80%. The rest of the capacity components were weak with scores below 50%.

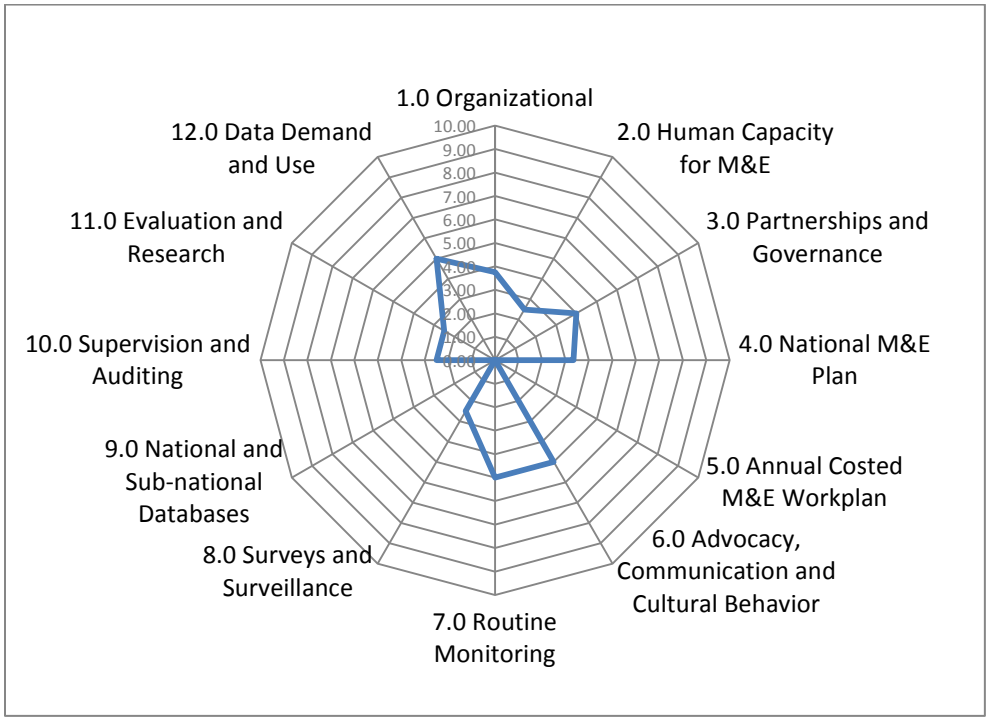
Figure 5: Baseline Assessment of Quality for DCHS's Functional M&E Components



Source: Primary analysis of the M&E capacity building baseline assessment of DCHS capacity in M&E, 2013

Figure 6 shows the DCHS technical capacity to implement the 12 functional M&E components. The results indicate general weakness in all the capacity areas, with no capacity area exceeding 50% of the total score. In some capacity areas, such as national and subnational databases, annual costed M&E workplan, and surveys and surveillance, the internal contribution was almost zero, which implies that DCHS largely depends on external technical support.

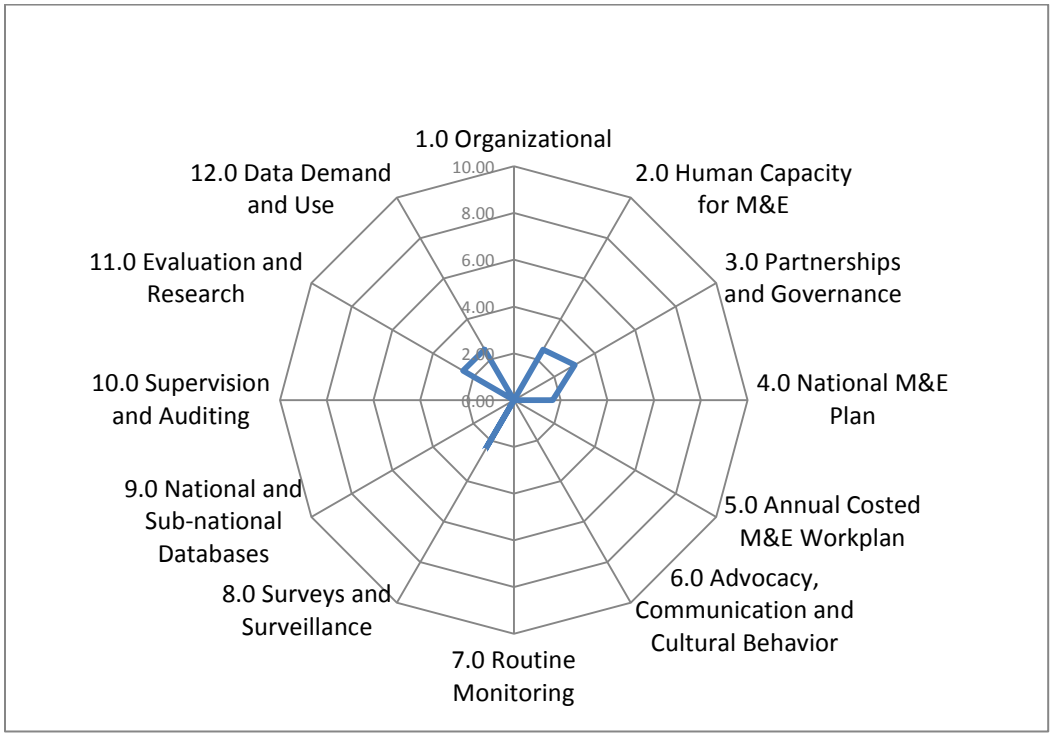
Figure 6: Baseline Assessment of DCHS Technical Aspects on Functional M&E Components



Source: Primary analysis of the M&E capacity building baseline assessment of DCHS capacity in M&E, 2013

Figure 7 shows that none of DCHS's capacity in areas of financial independence exceeds 50%, an indication that most M&E activities are donor dependent. In some capacity areas, such as national and subnational databases, organizational systems, and structures and surveys and surveillance, the internal financial contribution was almost none.

Figure 7: Baseline Assessment of Financial Capacity of DCHS to Perform Functional M&E Components



Source: Primary analysis of the M&E capacity building baseline assessment of DCHS capacity in M&E, 2013

3.2 RESULTS ON INDIVIDUAL CAPACITY AREAS

In this section, we present and discuss the individual capacity areas in four dimensions: status, quality, technical, and financial.

3.2.1 Capacity Area 1: Organizational Capacity

The assessment focus for organizational capacity hinged on DCHS's mission statement and stated objectives. The questions explored whether DCHS has a written mandate for the M&E unit, who holds responsibilities, and which M&E meetings are held and how often.

In the discussion, participants noted that DCHS has a mission statement and stated objectives in the CHIS strategy, CHW manual, M&E plan, communication strategy, and CHS mainstreaming report. The group said the mission and stated objectives of DCHS contribute to the MoH mission and objectives as a whole. The DCHS vision is guided by its motto: *Afya yetu jukumu letu* (our health our responsibility). The text box below summarizes the vision and mission statement of DCHS.

Vision and Mission Statement of DCHS

Vision

Healthy people living healthy and quality lives in robust and vibrant communities that make up a healthy and vibrant nation

Mission statement

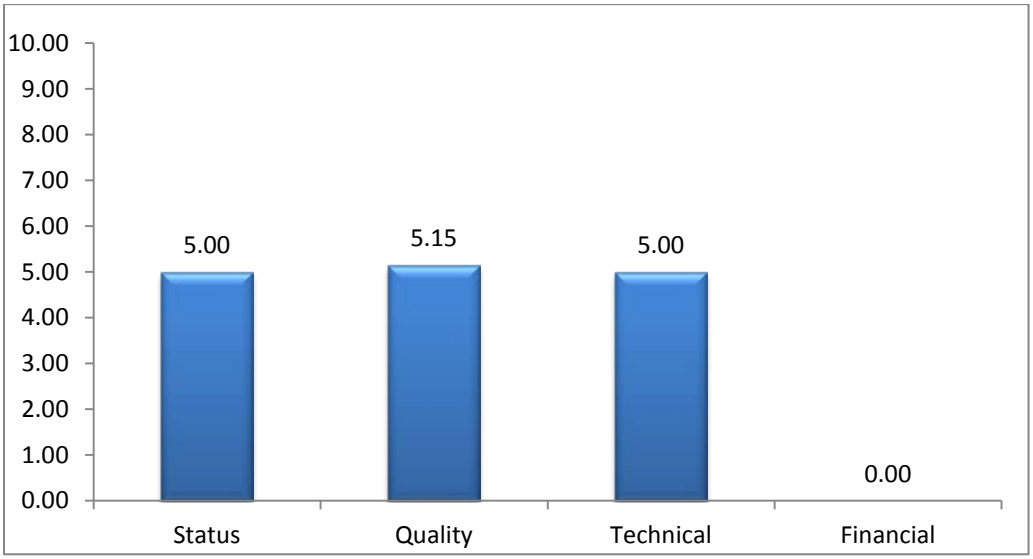
To become the modality for social transformation for development from the community level by establishing equitable, effective and efficient community health services in community units all over Kenya.

Stated objectives of DCHS M&E

1. Establish a robust integrated DCHS M&E plan with capacity to adequately monitor implementation of interventions at Level 1 of the health care delivery system.
2. Provide a standard platform for strategic partnership and accountability among stakeholders at all levels and implementing partners, as well as to those providing financial resources for DCHS.
3. Enhance the data use for informing evidence-based planning.
4. Identify and document emerging best practices and lessons learned for improvement and scaling up of service provision.
5. Promote health system research, policy, and innovation through documentation and information sharing.
6. Provide a standard mechanism for tracking all relevant indicators to capture performance in disease prevention and control to reduce morbidity, disability, and mortality; provide family health services aimed at expanding family planning, maternal, child, and youth services; promote hygiene

While the mission and stated objectives exist, not all staff could articulate them. DCHS also has not developed core values to guide its operation; instead, it uses the wider values of MoH. Neither the mission statement nor the MoH core values are displayed in every DCHS office. The group said that the mission and stated objectives were developed with external technical assistance. Figure 8 shows DCHS's capacity for M&E organizational structures.

Figure 8: Capacity Area 1—Organizational Structures for DCHS M&E



Source: Primary analysis of the M&E capacity-building baseline assessment of DCHS capacity in M&E, 2013

The desk review showed DCHS has nine technical units (see the organogram in Figure 2). The functions of one of these technical units, M&E, have been in place since the community strategy was implemented in 2008. During the key informant interviews, one respondent said,

> *"Initially, when the Division of Community Health Services was formed in 2008 to implement the community strategy that was formulated in 2006, we did not call it the M&E unit…it was called the CHIS unit. It is only later that the name changed to M&E unit but the functions of the unit have basically remained the same."*

The M&E unit meets to discuss specific M&E activities, such as in the TWGs; however, the meetings are irregular and sometimes no minutes are kept.

3.2.2 Capacity Area 2: Human Capacity for M&E

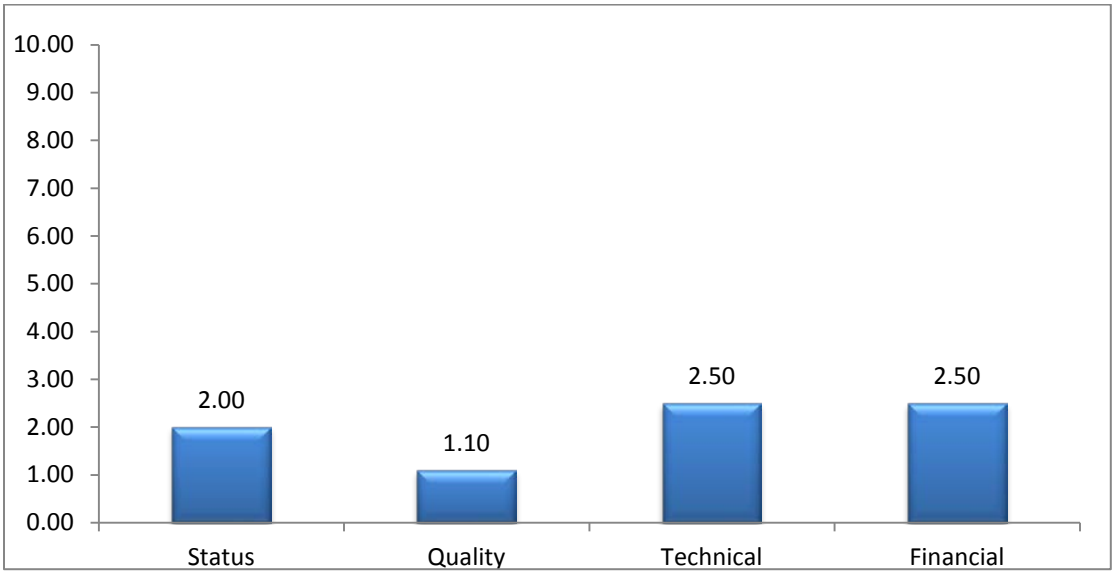
This component of the assessment explored M&E staffing and staff capacity in M&E related skills and competencies. Questions asked about the existence of a human capacity plan and if a plan for organizational development, data demand and use, and validated M&E training.

In the group discussion, participants said the division has only two staff members employed in the M&E unit, which is inadequate to fully execute the M&E mandate. The DCHS team indicated it has staff to fulfill the mandate of M&E, but staff in the M&E unit lack specific M&E professional qualifications. Staff have, however, undergone some short-term training on basic M&E. During the key informant interviews, Simion Ndemo, head of the M&E unit, said:

> *"I was lucky to have been one of the beneficiaries of the two weeks M&E training by MEASURE Evaluation. They [MEASURE Evaluation] sponsored me for this training in Addis Ababa and I have been applying that knowledge to support M&E activities within the Division [DCHS]."*

Group discussions also revealed limited staff knowledge in the area of data collection and analysis. Comments from the interviews indicated that M&E staff can barely use standard statistical packages, such as Stata and SPSS, for analysis. The existing knowledge mentioned by participants entailed doing simple descriptive analysis of DHIS2 data for decision making. The group also mentioned a lack of formal training in the use of GIS to produce simple maps. Further, because of limited skills in analysis, staff members rely on external technical support from partners, such as MEASURE Evaluation, Afya Info, JICA, and UNICEF. Figure 9 shows assessment results for M&E capacity in DCHS.

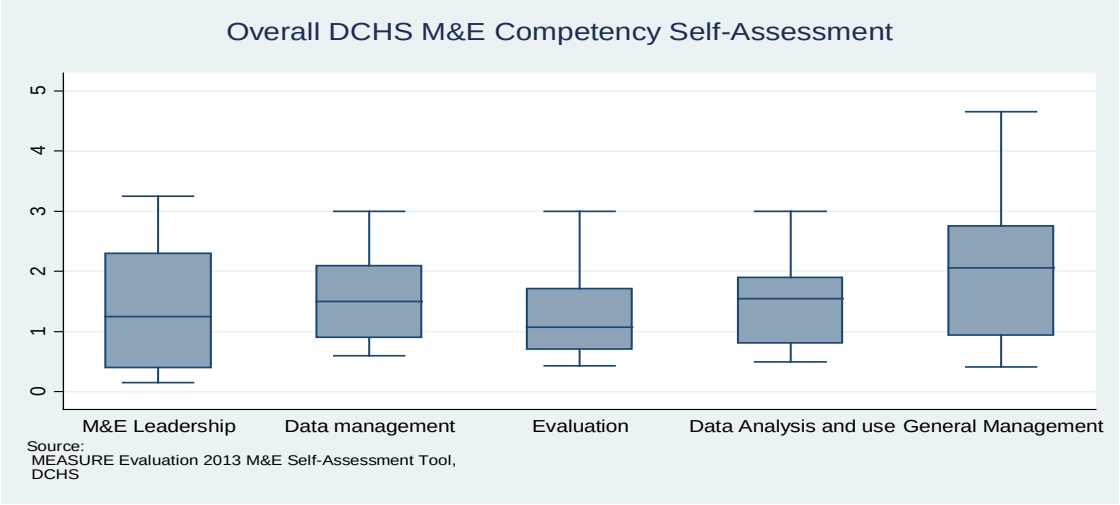
Figure 9: Capacity Area 2—Human Capacity for M&E Functions in DCHS



Source: Primary analysis of the M&E capacity building baseline assessment of DCHS capacity in M&E, 2013

Self-assessment results of individual capacities among DCHS staff show that human capacity to perform M&E functions is low. Figure 10 shows that, based on a score of 5 as the maximum, all components were below 2.5. This means the capacity is below average. This was an overall assessment of all DCHS staff who participated in the group discussion, and it might not reflect a true picture of M&E capacity because some participating staff members do not have M&E responsibilities in their job descriptions.

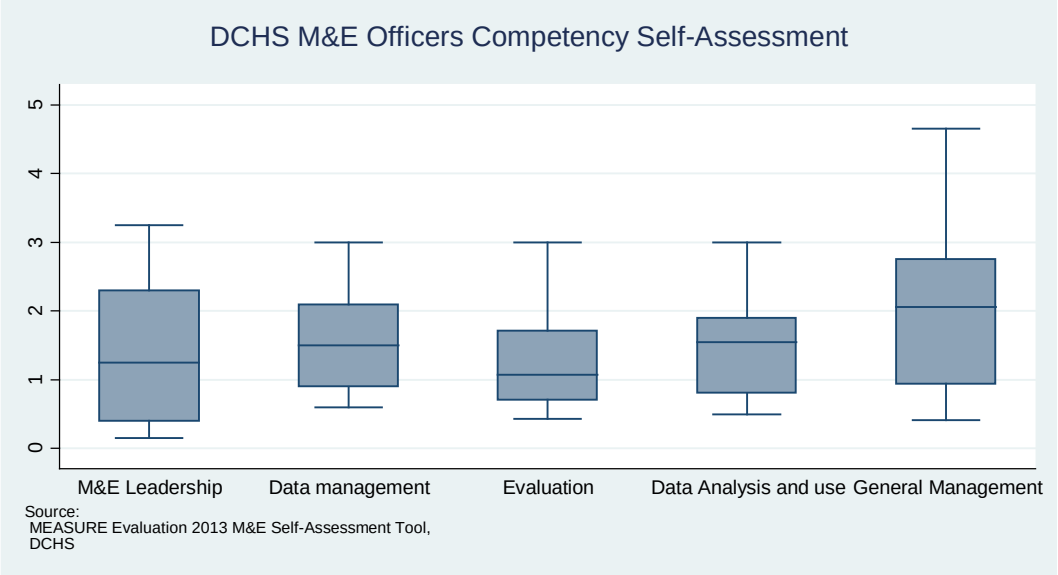
Figure 10: Overall Self-assessment for the DCHS on M&E Competency



Source: Primary analysis of the M&E capacity building baseline assessment of DCHS capacity in M&E, 2013

Figure 11 shows self-assessment on M&E capacity results for staff who work in the M&E unit. Results show no difference in scores from the previous plot; no components scored above 50%.

Figure 11: Self-assessment for the M&E Staff in DCHS on M&E Competency

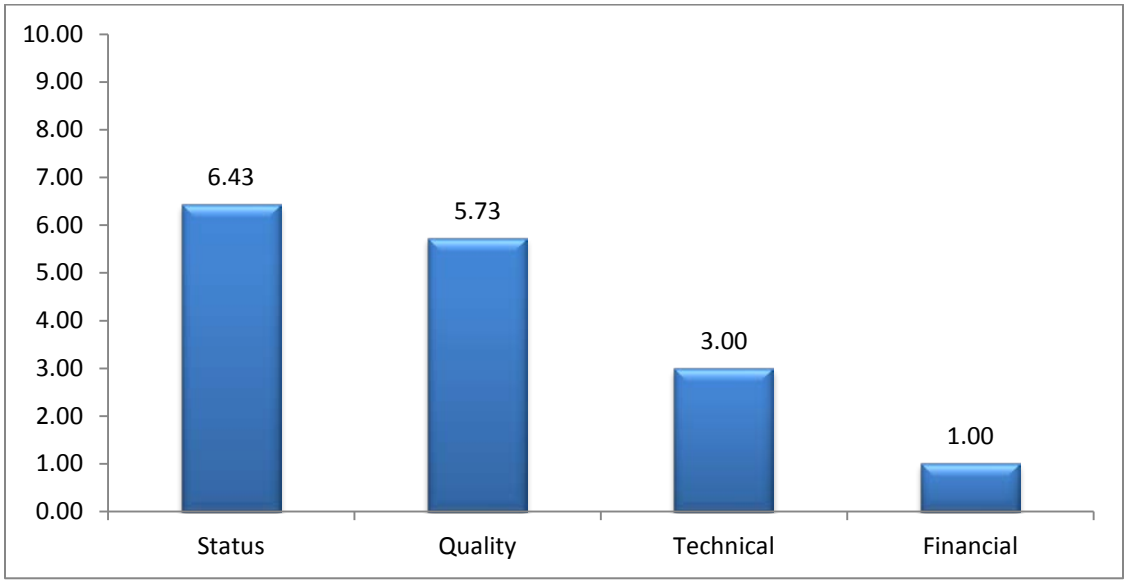


Source: Primary analysis of the M&E capacity building baseline assessment of DCHS capacity in M&E, 2013

3.2.3 Capacity Area 3: Partnership and Governance

This assessment section explored DCHS M&E capacity to coordinate with all stakeholders at the national level, governance structures, and national M&E technical working groups. It also examined the existence of a routine communication channel to facilitate exchange of information among stakeholders, local leadership, and capacity for stakeholder coordination. Figure 12 shows that DCHS is relatively strong in partnership and governance, with a score of 6.4 out of 10 on the status dimension. DCHS partners provide technical assistance in many areas, including development of the M&E plan, tracking tools, costed annual workplans, and revision of the DCHS strategic plan. Some key partners for DCHS are MEASURE Evaluation, UNICEF, JICA, Afya Info, and the APHIA Plus consortia, among others.

Figure 12: Capacity Area 3—Partnership and Governance for M&E in DCHS



Source: Primary analysis of the M&E capacity building baseline assessment of DCHS capacity in M&E, 2013

The group discussion elicited comments on key issues: DCHS has clear governance structures; the Interagency Coordinating Committee (ICC) is the highest decision-making organ. Each of the eight DCHS units (see Figure 2 for the organogram) organizes quarterly TWGs to discuss progress in implementing plans and emerging issues that need to be addressed. The group agreed that DCHS has clear terms of reference in establishing the TWGs. A desk review found that the last TWG on M&E was held May 23, 2013, and several stakeholders attended the meeting, including MEASURE Evaluation, UNICEF, JICA, ICAP, and Afya Info. Minutes of the meeting are available and show that a clear action plan on issues was discussed.

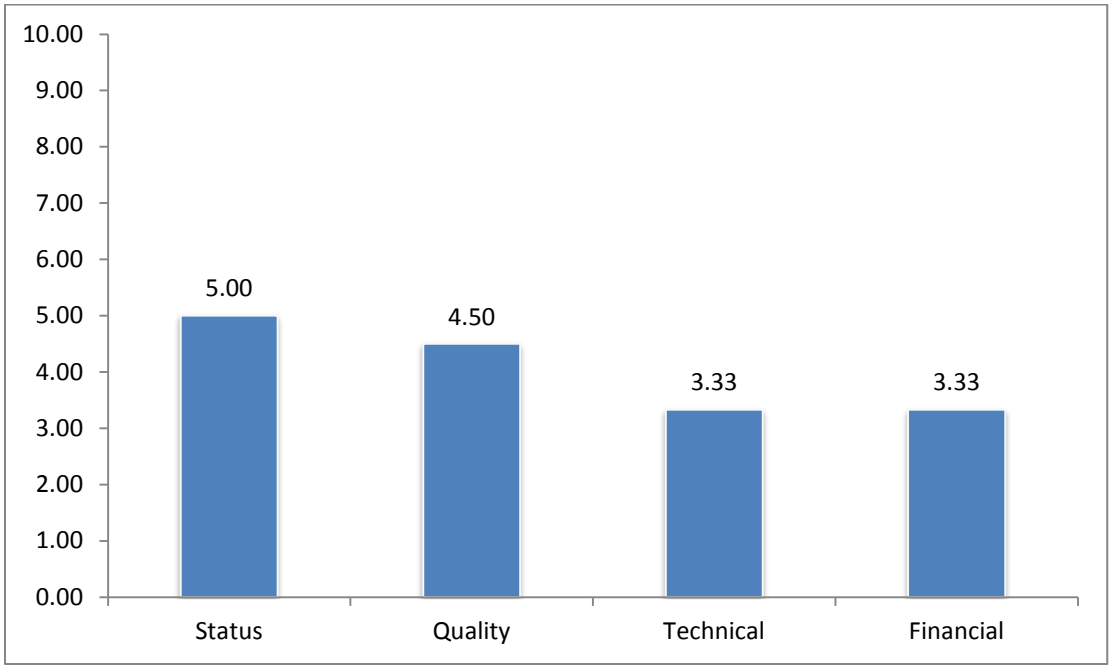
Assessment participants reported that the Division maintains a list of stakeholders and has created a list serve for timely communication through e-mail; however, some participants expressed concern that the list was not updated and the existing list is a general one for all partners that work with DCHS, but no specific partner inventory on community health service M&E is kept. The desk review shows evidence of mechanisms for stakeholder coordination, such as development of joint annual workplans with stakeholders. Results also show DCHS has clear reporting and communication mechanisms for M&E activities; however, participants expressed concern about the timeliness of the reports.

3.2.4 *Capacity Area 4: National M&E Plan in DCHS*

This section explored DCHS's role in eliciting broad stakeholder participation in the development of the national M&E plan. It examined the linkage of the M&E plan to the national CHIS strategy and adherence of the M&E plan to national and international technical standards. The section also sought information to determine if an assessment had been done on the M&E system to guide approaches to strengthen the revised M&E plan.

A desk review noted that when the first Community Health Strategic Plan (2006–2010) was formulated, one of the missing ingredients was the lack of a national M&E plan to track progress. Figure 13 shows assessment results for DCHS capacity for the national M&E plan.

Figure 13: Capacity Area 4—National M&E Plan in DCHS



Source: Primary analysis of the M&E capacity building baseline assessment of DCHS capacity in M&E, 2013

In general, DCHS's capacity scored low in this section, with none of the dimensions exceeding 50%. While DCHS has demonstrated an ability to prepare accurate project workplans, budgets, and schedules, as seen in the costed annual workplans (the current annual workplan was completed jointly with stakeholders in June 2013), participants acknowledged that DCHS has no specific guidelines on reporting M&E activities, and further, that the M&E activities implemented were partially linked to the national multisectoral M&E plan.

A literature review noted that, in liaison with UNICEF in 2010, DCHS assessed the functionality of CHIS in areas where the community strategy had been implemented and compared it to control sites. Results showed that in areas where the community strategy had been implemented, the scores in health parameters were better, compared to areas where the strategy had not been implemented. These scores included improvement in childhood vaccination, use of insecticide-treated nets (ITNs), knowledge and use of family planning methods, use of antenatal care, and facility-based delivery compared to non-CHIS areas.

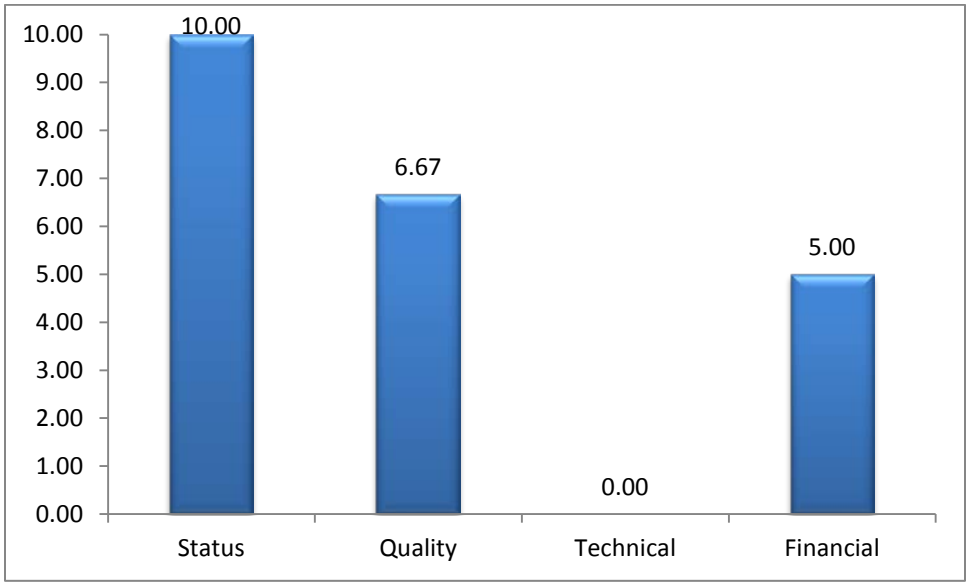
Gaps identified in the M&E system, such as lack of an M&E plan, were addressed in the new M&E plan 2013–2017, which was launched by the Cabinet Secretary for Health on May 31, 2013. Gaps experienced in the implementation of the community strategy are being considered in the continuing development of a new strategic plan that will reflect the changing devolved structures at the subnational level.

3.2.5 Capacity Area 5: Annual Costed Workplan

This component explored the existence of an annual costed workplan and the extent of annual updates. It also examined the linkage between the workplan and the government MTEF budgets. Questions asked if resources are committed for the M&E Annual Workplan and the role of stakeholders in its endorsement and implementation.

Results show DCHS has an annual costed workplan; hence, the high scores on status. DCHS and its strategic partners completed the AWP II for 2013–2014 in May 2013. All the activities in the AWP II are costed, with clear timelines and designated parties responsible for the implementation. Before 2012, these plans were called Annual Operational Plans. Figure 14 shows assessment results for DCHS's capacity for an annual costed M&E Workplan.

Figure 14: Capacity Area 5—Annual Costed M&E Workplan



Source: Primary analysis of the M&E capacity building baseline assessment of DCHS capacity in M&E, 2013

Participants said annual workplans are linked to the MTEF, and they cited cases where MoH had allocated some funds for DCHS activities. Participants noted that in the quality category, annual workplans are updated based on performance monitoring, although no tracking tools are available to verify targets are met. The group noted that AWPs are endorsed by stakeholders through TWGs, ICC, and regional stakeholder forums.

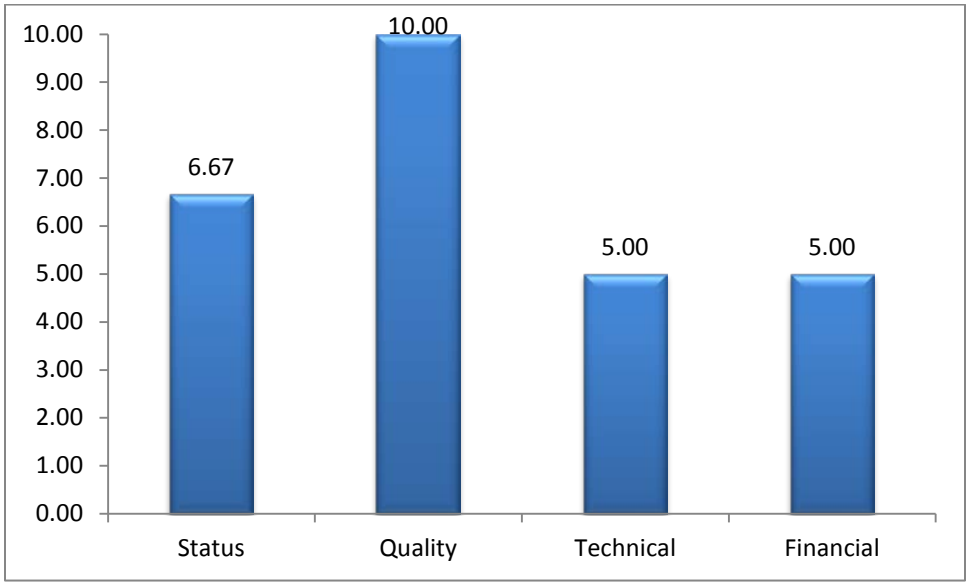
While some resources had been allocated for the implementation of the M&E plan, participants noted the funds are inadequate. Further, they noted that while the financial resources for M&E activities came exclusively from partners, the government contribution was limited to salaries of employed staff, office space, and other related infrastructure.

3.2.6 Capacity Area 6: Advocacy, Communication and Cultural Behavior

This component of the assessment explored DCHS's communication strategy and any specific M&E communication and advocacy plan, articulation of M&E in national policies and strategic plans, and if leadership championed for M&E in DCHS.

Assessment findings show that DCHS has a communication strategy that has been implemented with financial support from the government for the past year. A desk review confirmed that DCHS has a published advocacy and communication strategy for 2012–2017. Participants agreed that the communication strategy addresses all DCHS program areas (see Figure 2 for an organogram). The strategy was developed with technical assistance from partners, an indication that the division lacks technical sustainability. Figure 15 shows the results of the assessment of DCHS capacity for advocacy, communication, and cultural behavior.

Figure 15: Capacity Area 6—Advocacy, Communication, and Cultural Behavior



Source: Primary analysis of the M&E capacity building baseline assessment of DCHS capacity in M&E, 2013

Participants agreed that DCHS leadership has M&E champions, particularly the head of DCHS. Participants also noted that the communication strategy is taken from national policy and strategic plans, in particular, from the Kenya Health Sector Strategic Implementation Plan (KHSSIP), 2013–2017.

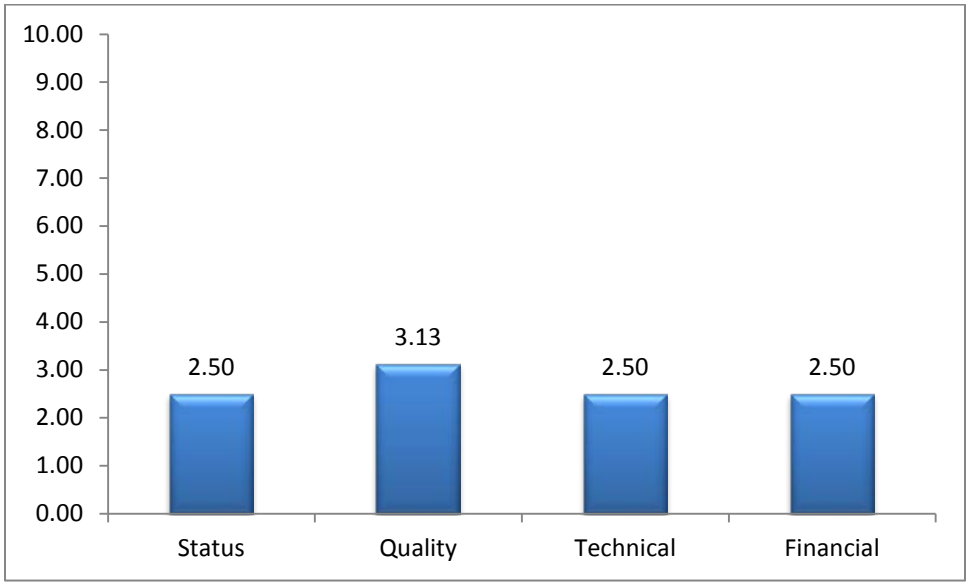
3.2.7 Capacity Area 7: Routine Monitoring

This component of the assessment explored DCHS's capacity for an explicit strategy to collect data and its usage, the existence of data tools and equipment for data management, and routine procedures for data transfer from subnational to national levels.

During group discussions, participants said DCHS has data collection tools, although they are inadequate. Some of the tools the group mentioned are MoH 513, the household register used to collect household information every six months; MoH 515, the monthly community health extension worker summary sheet used to collect information from the community service log; and MoH 516 that serves as the community health information system chalkboard. DCHS has an online database, the master community unit listing, or MCUL, which captures all functional community units in the country.

Because the tools are inadequate, DCHS is sometimes forced to improvise the tools by using photocopies or exercise books to capture data. Participants noted inconsistencies in indicators among different tools, a situation that compromises data quality. Figure 16 shows assessment scores for DCHS's capacity for routine monitoring.

Figure 16: Capacity Area 7—Routine Monitoring



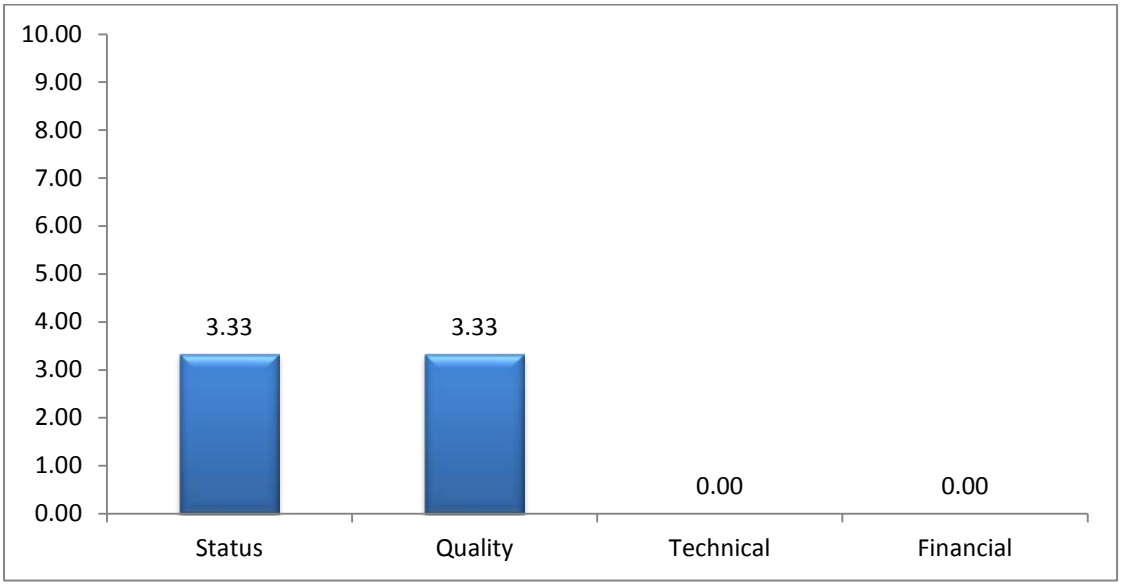
Source: Primary analysis of the M&E capacity building baseline assessment of DCHS capacity in M&E, 2013

Participants noted that the existing tools, which have instructions for filling in data, were developed with technical and financial support from partners. These partners include JICA, UNICEF, MEASURE Evaluation, Afya info, Pathfinder, Mchip and Path, among others. They also noted that DCHS has no national guidelines to document procedures for collecting, recording, collating, and reporting program monitoring CHIS data.

3.2.8 Capacity Area 8: Surveys and Surveillance

This component of the assessment focused on DCHS's capacity for survey and surveillance protocols and the existence of a well-functioning surveillance system and an inventory of completed surveys and surveillance. Figure 17 shows scores for DCHS's capacity for surveys and surveillance.

Figure 17: Capacity Area 8—Surveys and Surveillance



Source: Primary analysis of the M&E capacity building baseline assessment of DCHS capacity in M&E, 2013

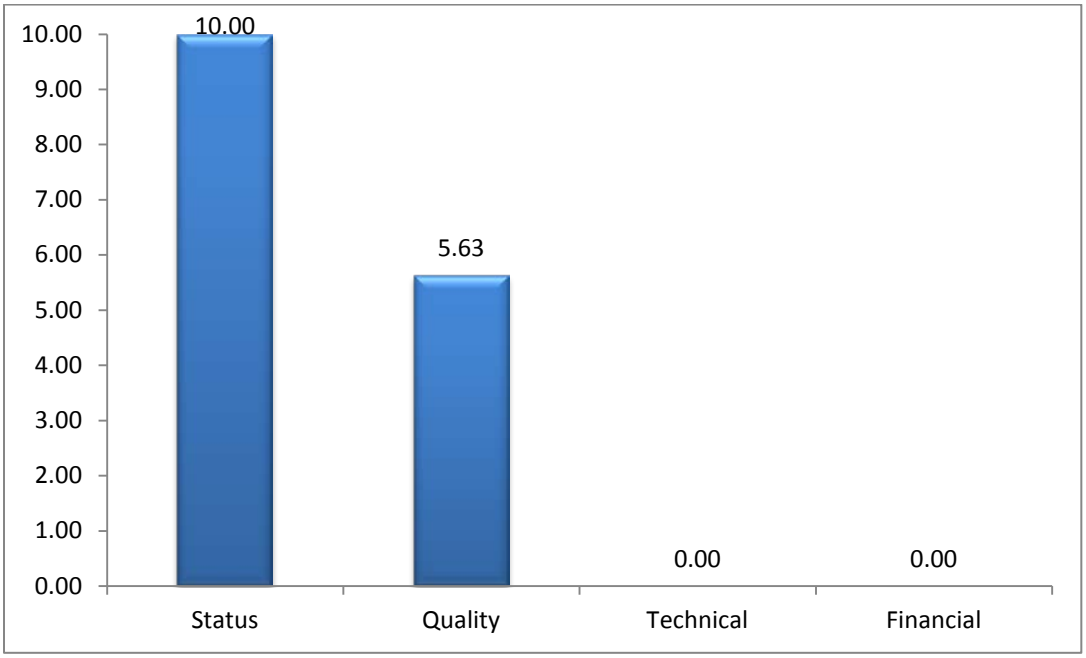
The scores indicate this component is one of DCHS's weakest areas, with none of the dimensions exceeding 50%. Surveys and surveillance activities have been accomplished with relevant stakeholders in the M&E TWG and national technical bodies, although no inventory is available to verify this. DCHS has a protocol for MCUL that was reviewed and approved by the M&E TWG.

3.2.9 Capacity Area 9: National and Subnational Databases

The component explored the existence of national and subnational databases in DCHS that respond to the decision making and reporting needs of different stakeholders. It also explored linkages between national and subnational databases to monitor data consistency and avoid duplication of efforts.

Participants noted the existence of the MCUL database, but expressed concerns about its quality because of the infrequency of updates. Participants said that most indicators of interest to DCHS are captured in the MCUL database, but with gaps in the subnational level, such as limited IT infrastructure and other supplies to link to national databases in DHIS. DCHS has structures and mechanisms in place for entering, merging, extracting, and transmitting data between databases. The structures are clear on who has responsibility for these tasks, although human capacity to accomplish these tasks is limited. Figure 18 shows assessment scores for DCHS's capacity for national and subnational databases.

Figure 18: Capacity Area 9—National and Subnational Databases



Source: Primary analysis of the M&E capacity building baseline assessment of DCHS capacity in M&E, 2013

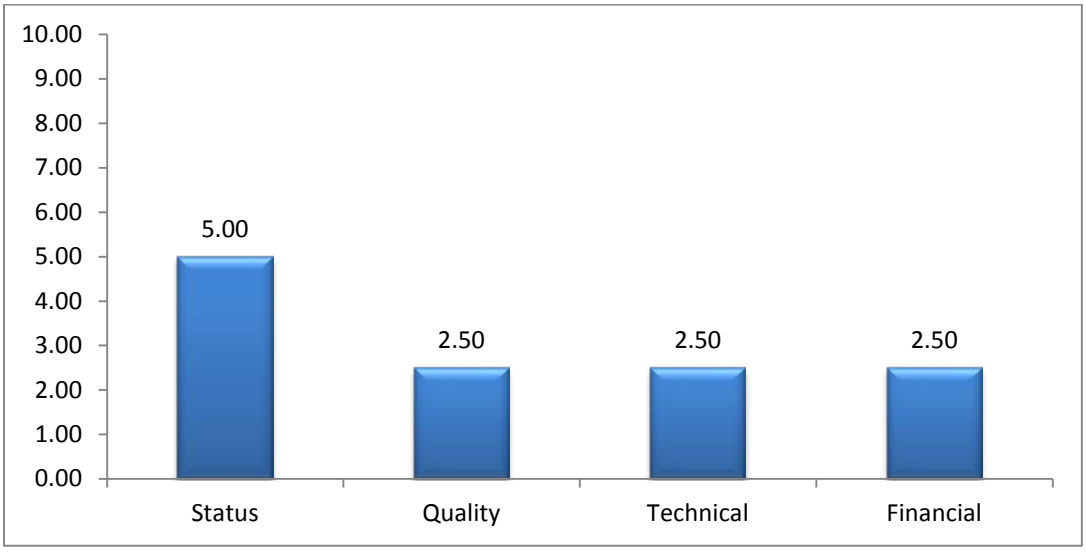
The technical and financial assistance in developing MCUL was designed and financed by Afya Info, which indicates a lack of sustainability.

3.2.10 Capacity Area 10: Supervision and Auditing

This component explored the existence of DCHS's guidelines for supervising routine data at the health facility and community levels. It also examined DCHS's supervisory visits and data quality audit status, report writing, and capacity to provide feedback to local staff.

The assessment shows that DCHS has guidelines and tools for M&E supportive supervision, but usually fails to provide feedback to local staff. Where feedback was given, it was not in accordance with guidelines. Participants commented that the last audit was conducted in April 2013, and not all facets of supervision were audited. The Assessment and Improvement Matrix (AIM) tool was developed in technical and financial collaboration with stakeholders. Participants said they do not have data quality audits in DCHS because no policies and procedures are in place for audits. They also said that at the subnational level, some data quality auditors do not have adequate skills to perform the function. Figure 19 shows assessment scores for DCHS's capacity for supervision and audits.

Figure 19: Capacity Area 10—Supervision and Auditing



Source: Primary analysis of the M&E capacity building baseline assessment of DCHS capacity in M&E, 2013

3.2.11 Capacity Area 11: Evaluation and Research

This component explored the existence of DCHS's inventory of ongoing and completed country-specific research and evaluation and the availability a national evaluation and research agenda, including existence of dissemination forums.

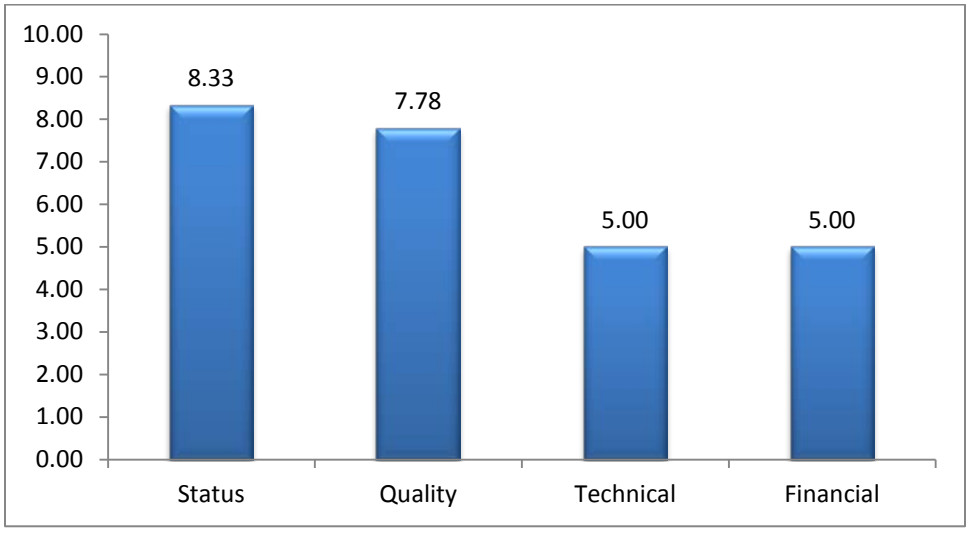
A desk review showed that DCHS has nine thematic areas. Participants said DCHS has a national evaluation and research agenda for CHS, with research themes that focus on diverse topics such as contextual factors that hinder the uptake of CHS, its sustainability factors and approaches, the linkages, human resources for health, M&E systems at the community level, cost effectiveness, factors for scale up, and the effect of CHS in the improvement and delivery of the Kenya Essential Package for Health (KEPH) by cohorts at Level 1.

Participants noted that they have achieved several milestones in rolling out research and evaluation, particularly in partnerships that have enabled them to successfully carry out operations research on human resources for health and the cost effectiveness of community health interventions. Participants also noted that DCHS has an inventory of completed and ongoing country-specific evaluation and research studies and major research institutions and their mandates. The participants also noted that DCHS lacks research-specific forums for disseminating research findings due to lack of internal finances. In addition, the division relies on partners for technical assistance in carrying out its research agenda.

> *"A lot of research has been done on community health services in Kenya although a lot is not documented in the public limelight. If you go to the libraries of institutions such as AMREF, KEMRI and KMTC or even the community health departments at the University of Nairobi and Kenyatta, you will find a lot [of research] that has been done on community health services in Kenya."* An official of DCHS

Figure 20 shows assessment scores for DCHS's capacity for evaluation and research

Figure 20: Capacity Area 11—Evaluation and Research



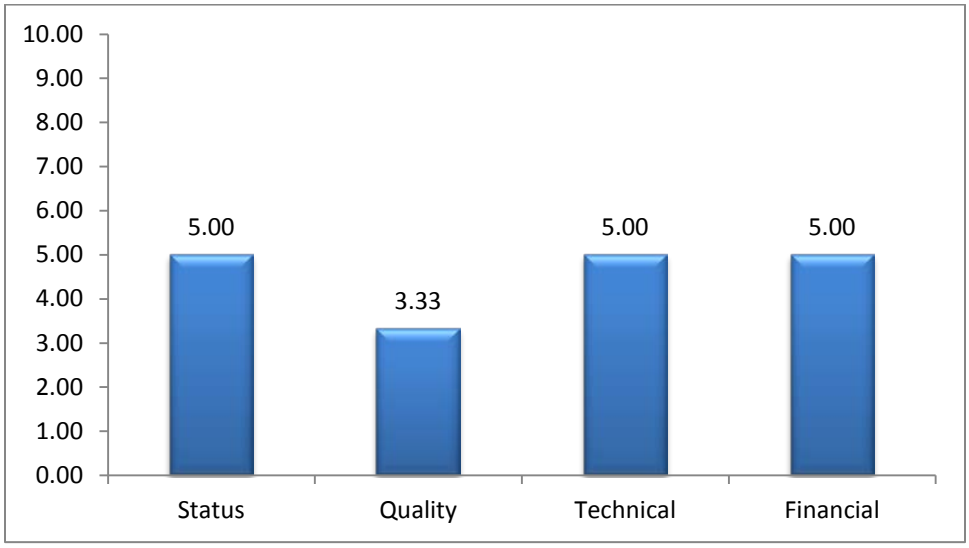
Source: Primary analysis of the M&E capacity building baseline assessment of DCHS capacity in M&E, 2013

3.2.12 Capacity Area 12: Data Demand and Use

This component explored the existence of a data use plan in the M&E and national strategic plans, including a data use calendar to guide a timetable for major data collection efforts and reporting requirements. It also examined DCHS's capacity for analysis of program user-specific data needs to inform evidenced-based planning and decision making (e.g., data referenced in funding proposals and planning documents).

Participants said DCHS has a national data use plan that is stipulated in the M&E plan. It covers dissemination mechanisms for routine and nonroutine data and quarterly coverage reports. Participants also noted that the data use plan is not guided by an initial assessment of data users' needs. DCHS has no data analysis and presentation guidelines. Participants noted that the data use plan and information products are not conducted independently by DCHS; their design and development relies on external assistance from partners such as JICA, MEASURE Evaluation, PATH, Pathfinder International, and UNICEF. Information products are disseminated with partial financial support from stakeholders. Figure 21 shows DCHS's capacity for data demand and use.

Figure 21: Capacity Area 12—Data Demand and Use



Source: Primary analysis of the M&E capacity building baseline assessment of DCHS capacity in M&E, 2013

CHAPTER 5: DISCUSSION

The purpose of this assessment was to understand and document the DCHS current organizational and individual capacities to successfully achieve its performance objectives in program-level monitoring and evaluation. The assessment examined these specific objectives:

1. Understand, document, and clarify performance objectives for DCHS-level M&E.
2. Determine the current performance in key DCHS M&E functional areas.
3. Identify gaps in DCHS's capacity to meet performance expectations.

The baseline assessment was motivated by several factors: First, the Government of Kenya recognizes the community health strategy as one of the nation's flagship programs, and a means to realize Kenya's Vision 2030. Second, the Government of Kenya believes the community health strategy is the best approach to ensure that every Kenyan has a right to better health, as guaranteed by the Kenyan constitution, enacted in 2010. Third, the Government of Kenya's commitment to the implementation of the community health strategy can be seen in the current NHSSP III 2012–2017, which defines Level 1community health services in the revised four levels of service delivery, and implementation of the community strategy is in line with major international public health initiatives that have revitalized the importance of primary health.

To ensure Kenya is on track to achieve its community health strategy, it first must establish a baseline to track progress. To achieve this assessment, a number of triangulation techniques were used, including a desk review of literature on M&E capacity, key informant interviews, and a group assessment of 12 M&E functional capacities. MEASURE Evaluation conducted the assessment by using its PRISM framework that recognizes three performance determinants: organizational, technical, and behavioral.

The desk review showed that DCHS is a relatively new establishment in MoH. It was constituted in 2008 to implement the first Community Health Strategy 2006–2010, one of the main strategies in the implementation of NHSSP II 2005–2010, which defined a new approach, the Kenya Essential Package for Health, through six life-cycle cohorts and six service delivery levels, including Level 1, which focuses on community health services.

Notable outcomes in community health have been observed since the launch of the strategy in 2006. An evaluation conducted by UNICEF (2010) found that even with the short-term implementation of the community strategy, areas where the strategy had been rolled out achieved better health outcomes compared to areas where the strategy had not been implemented. National surveys, such as the Kenya Demographic and Health Survey (KDHS) of 2008–2009, also noted substantive improvements in health outcomes throughout the country compared to the preceding KDHS 2003. These substantive improvements in health outcomes occurred after the formulation of the community strategy in 2006 and establishment of DCHS in 2008. These results are a clear call for increased support for community health services. In the next section we discuss the implications of the key findings in this assessment.

DCHS has enjoyed strong leadership and governance since its inception, which has resulted in major achievements in strengthening policy frameworks on community health. For example, DCHS launched a number of strategic modules in May 2013, including the M&E plan, MCUL, and its accompanying training modules. The existence of the community strategy has guided implementation of CHIS activities. The M&E plan is playing a critical role in guiding DCHS leadership to focus on the key performance indicators in the delivery of Level 1 services. The

communication and advocacy strategy for DCHS is increasing visibility of DCHS and aiding in lobbying for more resource allocation at the national level. The existence of the national database, MCUL, is helping track the number of functional units, their reporting rates, and their rate of increase.

The strong partnership between DCHS and other stakeholders has not only enabled DCHS to get the resources needed for the implementation of its activities, but it also has provided DCHS with the needed technical capability to perform its functions. For example, while staffing in the M&E unit is lean, with only two staff, partnerships with other stakeholders and the use of interns has helped reduce the workload among regular M&E staff and enabled DCHS to provide technically sound guidelines for community health services implementation. Many achievements at Level 1 have resulted from clear policy and implementation guidelines. Efforts to strengthen areas where guidelines do not exist, such as in routine monitoring and data quality, are critical for the acceleration of community health services. Other areas that require urgent attention include providing refresher training on M&E to M&E staff; establishing M&E champions in DCHS; setting up reporting guidelines to ensure that CHIS data are consistent, complete, accurate, and timely; and instituting guidelines for supervision and surveillance.

An overall assessment OCI of 49.5% indicates that major capacity gaps in most of the M&E components still exist in DCHS. A clear costed action plan is necessary to identify in detail the M&E gaps and ways to address them to strengthen capacity. In particular, the areas of financial and technical capacity to implement M&E functions stand out as priority areas in need of strengthening; however, the achievements and gaps in DCHS M&E capacity should be interpreted in the light of methods used for assessment. For example, one major limitation of group and individual self-assessments is the temptation to exaggerate scores. An example in this assessment was the anomaly when non M&E staff scored better than the M&E staff in a number of M&E components. It is possible that M&E staff understated their actual M&E capacity in anticipation for capacity building by the PIMA project.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

While DCHS showed some strong capacity in a few M&E components, other areas urgently need strengthening to realize the DCHS mandate to improve community health. We provide specific recommended action plans in Appendix 1. Following is a summary list of key recommendations:

- Hire personnel with M&E skills for the DCHS M&E unit and continue to use interns and technical personnel from stakeholders, such as MEASURE Evaluation, to carry out the DCHS mandates.
- Provide basic M&E courses for all DCHS unit heads, increase M&E champions throughout DCHS, and help the M&E unit execute its mandate.
- Seek the support of stakeholders to strengthen routine monitoring and revise and finalize the CHIS tools, including pretesting, printing, distribution, and training of users on the new tools for accurate, consistent, and timely reporting.
- Seek ways and means to lobby for more resource allocation from the MTEF budget and partners to scale up *mHealth* and *eHealth* initiatives; negotiate with service providers for concessions on *mHealth* and *eHealth* infrastructure and software for cost effectiveness.
- Realign major guidelines, such as the strategic and M&E plans to support CHS activities at the subnational level based on changes in the governance structures resulting from enactment of the Kenya constitution in 2010.
- Strengthen supervision at the national and subnational levels to address data flow and demand for use in decision making at national and subnational levels.
- Train key personnel on data demand and use; appoint DDU champions, especially at the subnational level, to advocate for DDU; encourage the use of data for decision making for evidence-based programming.
- Provide focused training in basic data analysis, especially in the use of professional statistical packages such as SPSS and Stata; provide mentoring and supportive supervision to equip staff with basic data analysis skills.
- Develop dashboards on key indicators of interest at tier one to help management make fast, reliable evidence-based decisions.
- Provide technical assistance to help DCHS develop data quality assessments and routine data quality assessments; train staff in the use of tools to conduct the assessments; improve data quality and timeliness of reporting; and ensure capture of complete, consistent, and accurate data.

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APPENDIX 1: RECOMMENDED ACTION PLANS FOR STRENGTHENING DCHS M&E CAPACITY COMPONENTS

Capacity Area	Identified Weaknesses or Gaps	Recommendations
1. Organizational Structure	1. Weak institutionalization of the mission and vision statement 2. Lack of division-specific values and ethics 3. Inadequate number of staff in the M&E unit 4. Out-of-date terms of reference for the M&E unit 5. Inadequate performance monitoring tools for the M&E system	1. Institutionalize the mission and vision in the division by displaying it in strategic areas throughout the offices. 2. Adopt MoH ethics and values to be division specific; institutionalize them like the Gemba Kaizen concept in Japan 3. Deploy at least 2 more staff to the M&E unit 4. Review the M&E unit terms of reference and update them in line with DCHS changes 5. Provide performance monitoring tools for the M&E system
2. Human Capacity	1. Inadequate M&E capacity 2. Inadequate financial support for M&E unit 3. Lack of an M&E training curriculum	1. Provide appropriate training on M&E skills 2. Allocate 15% of DCHS budget to M&E unit 3. Develop a human capacity building plan for M&E 4.Develop an M&E curriculum
3. Partnership and Governance	1. Inadequate support for reporting tools 2. Inconsistency in reporting from various program areas and collaborating partners 3. Lack of CHS M&E partner inventory 4. Lack of M&E agenda in other program areas and units in DCHS 5. Inconsistency in holding M&E coordination meetings as required 6. Lack of clear timelines in databases management 7. Lack of DCHS M&E SOPs	1. Collaborate to produce enough data tools 2. Explore use of *eHealth* and *mHealth* to ease pressure on tools printing 3. Pursue consistent reporting and follow ups by all program areas and collaborating partners 4. Develop CHS M&E partner inventory 5. Mainstream the M&E agenda throughout the program 6. Hold regular M&E coordination meetings 7. Specify clear timelines in database management 8. Develop DCHS M&E SOPs in components
4. National M&E Plan	1. No clear reporting guidelines 2. Lack of awareness of M&E plan integration in the multisectoral M&E plan 3. Partially funded activities in AWP 4. Inadequate stakeholder engagement in AWP formulation	1. Develop reporting guidelines 2. Encourage greater involvement of M&E staff in the integration of the DCHS M&E plan to the national multisectoral M&E plan 3. Fully fund all AWP activities 4. Engage all stakeholders in the AWP process
5. Annual Costed M&E Work Plan	2. Committed GOK resources inadequate to implement M&E workplan	1. Mobilize resources and establish stronger partnerships 2. Seek adequate resources for M&E from MTEF

Capacity Area	Identified Weaknesses or Gaps	Recommendations
6.Advocacy, Communication, and Cultural Behavior	1. Inadequate skills and knowledge to develop the advocacy and communication strategy 2. Inadequate GoK financial support to implement the communication strategy	1. Build capacity to develop the advocacy and communication strategy 2. Seek adequate resources from the MTEF to implement the advocacy and communication strategy
7. Routine Monitoring	1. Inadequate essential tools and equipment for data management 2. Inadequate reporting tools 3. Use of unapproved data management tools 4. Delayed integration of the revised tools into DHIS 5. Inadequate capacity to develop essential data collection tools 6. Inadequate GoK financial support for the development of essential tools 7. Lack of national guidelines for recording, collecting, collating, and reporting program monitoring data from the health information system	1. Provide performance monitoring tools for M&E system software and hard copies 2. Strengthen partnership with HMIS as a key stakeholder in CHS 3. Equip DCHS officers with skills in tools development 4. Include budget for development of tools in GoK financing systems 5. Embrace *mHealth* and *eHealth* to reduce the cost of printing tools 6. Develop national guidelines on recording, collecting, collating, and reporting program monitoring data from HIS
8. Survey and Surveillance Inventory	1. Lack of an official inventory of surveys and surveillance activities conducted by or on behalf of DCHS 2. Lack of a functioning surveillance system	1. Develop inventory of surveys and surveillance activities 2. Establish a surveillance system
9. National and Subnational Databases	1. MCUL database has not been updated because the counties lack capacity to use MCUL and have not been given access rights to the database 2. Reporting of Level 1 data is not 100% 3. Inadequate infrastructure such as computers, laptops, printers and cartridges, printing paper, and smartphones 4. Lack of skills on database, design, development, and management	1. Build human capacity in use of MCUL at the subnational level and provide access rights to update the database 2. Provide adequate resources to print and distribute the reporting tools 3. Provide smartphones and airtime and train CHEWs on their usage for ease of reporting 4. Provide computers, laptops, internet, printers and cartridges, and printing paper for community strategy county and subcounty coordinators 5. Train M&E officers on database design, development, and management
10. Supervision and Auditing	1. The monitoring tool lacks a feedback mechanism 2. Inadequate monitoring visits to counties 3. Policy and guidelines for data quality audit are not in place 4. Inadequate skills for data quality auditors at all levels	1. Update and revise the monitoring tool to include feedback mechanisms and use it extensively. 2. Provide adequate finances for monitoring and supervision visits 3. Formulate policy and guidelines for data quality audits 4. Build capacity for data quality auditors at all levels

Capacity Area	Identified Weaknesses or Gaps	Recommendations
11. Evaluation and Research	1. Incomplete inventory, register, and database of research and evaluation 2. Lack of research-specific forums for DCHS to disseminate research findings	1. Provide resources to accelerate the process of completing the inventory, register, and database of institutions undertaking research and evaluation 2. Provide resources for research-specific forums
12. Data Demand and Use	1. Failure of data use plan to be embedded in the national strategic plan 2. User needs not factored in development of data use plan 3. Inadequate funds to disseminate information products 4. Lack of data analysis and presentation guidelines 5. Lack of DCHS website	1. Embed data use plan in the national strategic plan, and ensure it is included in the national M&E plan 2. Include user needs in the data use plan 3. Strengthen dissemination forums 4. Seek funds to develop data analysis and presentation guidelines and build capacity in DCHS officers 5. Allocate funds to develop and manage DCHS website

APPENDIX 2: CAPACITY AREAS ASSESSED BY THE GROUP ASSESSMENT TOOL AND THE MAIN AREAS OF FOCUS

Capacity Area		Main Focus of Questions
1	**Organizational**	• Leadership: Effective leadership for M&E in the organization • Human Resources: Job descriptions for M&E staff, adequate number of skilled M&E staff, defined career path in M&E • Organizational Culture: National commitment to ensure M&E system performance • Organizational Roles and Functions: Well-defined organizational structure, including a national M&E unit; M&E units or M&E focal points in other public, private, and civil society organizations; written mandates for planning, coordinating, and managing the M&E system; well-defined M&E roles and responsibilities for key individuals and organizations at all levels • Organizational Mechanisms: Routine mechanisms for M&E planning and management, stakeholder coordination, and consensus building, and for monitoring the performance of the M&E system; incentives for M&E system performance • Organizational Performance: The organization achieves its annual workplan objectives for M&E
2	**Human Capacity for M&E**	• Defined skill set for individuals at national, subnational, and service-delivery levels • Workforce development plan, including career paths for M&E • Costed plan for building human capacity • Standard curricula for organizational and technical capacity building • Local or regional training capacity, including links to training institutions • Supervision, in-service training, and mentoring
3	**Partnership and Governance**	• National M&E Technical Working Group • Mechanism to coordinate all stakeholders • Local leadership and capacity for stakeholder coordination • Routine communication channel to facilitate exchange of information among stakeholders
4	**National M&E Plan**	• Broad-based participation in developing the national M&E plan • Explicitly linked to the National Strategic Plan • M&E plan adheres to international and national technical standards • M&E system assessments and recommendations for system strengthening are addressed in the M&E plan
5	**Annual M&E Costed Workplan**	• M&E workplan contains activities, responsible implementers, timeframe, activity costs, and identified funding • M&E workplan explicitly links to the workplans and government MTEF budgets • Resources (human, physical, financial) are committed to implement the M&E workplan • All relevant stakeholders endorsed the national M&E workplan • M&E workplan is updated annually based on performance monitoring

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