



REPUBLIC OF KENYA

MINISTRY OF HEALTH

**GUIDELINES FOR THE  
INSTITUTIONALIZATION OF  
MONITORING AND EVALUATION  
(M&E) IN THE HEALTH SECTOR**

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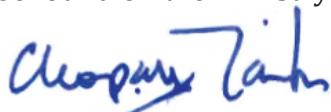
# Foreword

Monitoring and evaluation (M&E) has gained increasing significance in the health sector during the last decade, partly due to increasing public demand for measurement and accountability in the use of health sector resources. The Constitution of Kenya 2010 and attendant legislation have raised the public's expectations about the ability of national and county governments to put in place measures that increase transparency, accountability and public participation in the implementation of health programs. Both the Kenya Health Policy 2014-2030 and the Kenya Health Sector Strategic Plan 2014-2018 have integrated the requirements of a robust M&E system to ensure systematic tracking of investments and progress while promoting a culture of evidence-based planning and decisionmaking. Kenya's Ministry of Health has set out to strengthen M&E systems within the health sector through a wide range of capacity development initiatives. The Health Sector M&E Framework 2014-2018 enables all actors to work within convergent efforts to achieve the targets set within the Kenya Health Sector Strategic Plan 2014-2018. Despite these positive milestones, several studies and assessments have documented capacity gaps in implementing a fully functional M&E system in the health sector.

These guidelines seek to bridge this gap by: providing a comprehensive policy framework for M&E; exploring the definition and scope of M&E as a profession; defining the 12 components of a well-functioning M&E system; and providing a step-by-step guide on how an institution or program may establish and manage a functional M&E system under each of the 12 components.

When the 12 components are fully implemented in the health sector, we expect a significant improvement in the quality of data available, better analysis of the same and increased demand for data and information use to inform planning and decisionmaking.

I therefore urge all stakeholders at the national and county levels to make reference to and apply these guidelines to build a vibrant and effective M&E system that will contribute to evidence-based planning and improve the effectiveness of the overall health system. This document can be found on the Ministry of Health's website ([www.health.go.ke/](http://www.health.go.ke/)).



**Dr. CLEOPA MAILU, EGH**

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# Acknowledgements

The development of the Guidelines for the Institutionalization of Monitoring and Evaluation (M&E) in the Health Sector is a culmination of the efforts of all health sector stakeholders that were spearheaded by the Division of M&E, Health Research Development and health Informatics (MEHRDI) in the Ministry of Health. A national taskforce was appointed by the Principal Secretary to oversee and coordinate the technical and consultative processes in the development of the guidelines through the M&E technical working group. The standards and procedures outlined in this document are aimed at operationalizing the health sector's M&E framework, as well as setting the minimum threshold for establishing enduring M&E functions in health institutions and programs at the national and county levels.

The Ministry of Health acknowledges the contributions of the USAID-funded MEASURE Evaluation PIMA project, which provided funding and ongoing technical oversight to this process, the World Health Organisation (WHO), the United Nations Population Fund (UNFPA), the German International Cooperation (GIZ), the Japan International Cooperation Agency (JICA) and other partners who provided invaluable technical support and financial resources towards the development of these guidelines.

Invaluable efforts and commitments went into this endeavour. I wish to appreciate the constructive input and oversight exercised by members of the health sector's M&E technical working group (M&E TWG). Working together with the national taskforce, their incisive contributions, expertise and direct engagement have shaped this document. My sincere gratitude also goes to the 47 county governments, development partners and civil society organizations (CSOs) who participated in, interrogated and validated this document.

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**Dr. NICHOLAS MURAGURI**

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## Abbreviations

AIDS	acquired immunodeficiency syndrome
CBOs	community-based organizations
CEC	county executive committee
CHMT	county health management team
CME	continuous medical education
CSOs	civil society organizations
DDIU	data demand and information use
DHIS2	District Health Information Software version2
DPs	development partners
DPHK	development partners for health in Kenya
DSS	decision support system
EMRs	Electronic Medical Records Systems
FBOs	faith-based organizations
FY	financial year
GIZ	German International Cooperation
GoK	Government of Kenya
HDC	Health Data Collaborative
HIS	health information systems
HIV	human immunodeficiency virus
HMTs	health management teams
HODs	heads of departments
HSCC	health sector coordinating committee
ICC	inter-agency coordinating committee
IFMIS	integrated financial management information system
iHRIS	integrated human resource information system
IPs	implementing partners
JICA	Japan International Cooperation Agency
KDHS	Kenya Demographic and Health Survey
KEMRI	Kenya Medical Research Institute

KEMSA	Kenya Medical Supplies Agency
KHSSP	Kenya Health Sector Strategic and Investment Plan
KHMFL	Kenya Health Master Facility List
LMIS	Logistics Management Information System
M&E	monitoring and evaluation
MDGs	Millennium Development Goals
MEHRDI	M&E, Health Research Development and Health Informatics
MoH	Ministry of Health
MTEF	medium-term expenditure framework
MTPs	medium-term plans
NASCOP	National AIDS & STI Control Programme
NGOs	non-governmental organizations
NIMES	National Integrated M&E System
OCI	Organizational Capacity Index
PBB	program-based budgeting
SAGA	semi-autonomous government agency
SDGs	Sustainable Development Goals
SOPs	standard operating procedures
TWG	technical working group
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

# CHAPTER 1

## 1.0 BACKGROUND AND CONTEXT

### 1.1 Introduction

The Constitution of Kenya 2010 mandates the Ministry of Health to provide quality health services, to promote equity in access to these services, and to ensure financial risk protection. The ministry is also responsible for overall governance and stewardship of all health-related activities and among all actors in the health sector.

The Constitution also establishes monitoring and evaluation (M&E) as a key component in operationalizing activities to ensure transparency, integrity and access to information, and in promoting accountability principles at all levels of health care service delivery.

M&E is a key component of any program that aims to continuously improve and provide better outputs and outcomes for its beneficiaries. In the health sector, several studies have highlighted the need to strengthen the M&E systems for effective implementation of health programs. The health sector has made a concerted effort to improve its approach to M&E, which is supported by the provisions of the Constitution of Kenya 2010 and subsequent devolution laws.

### 1.2 The purpose of the guidelines

The Guidelines for the Institutionalization of Monitoring and Evaluation (M&E) in the Health Sector are expected to define a common standard for defining M&E and to describe a sound and functional M&E system, including its organizational structures, staffing and partnerships. The purpose of these guidelines is to ensure improved availability of quality information and its use to improve planning and decisions in the health sector. This will further support the goals of the Government of Kenya to fulfill the right of its citizens to the highest attainable health standards.

Specifically, the guidelines will: contribute to a shared definition of key M&E terminology used in the health sector; ensure the design of a shared institutional vision for M&E and accountability; describe the key defining characteristics of a well-functioning M&E system; provide basic tools and guidelines on how to assess M&E capacity as a first step in determining priority capacity needs in each institution; guide institutions and departments that want to establish an M&E function in their respective organizational structures or organograms; determine the skills needed to manage the M&E function; support advocacy efforts to ensure dedicated funding and resources for core M&E activities in the health sector; and establish mechanisms to strengthen partnerships and governance for M&E.

### **1.3 The Process of developing these guidelines**

The process of developing the Guidelines for the Institutionalization of Monitoring and Evaluation (M&E) in the Health Sector was initiated by the Ministry of Health (MoH) through a formal appointment of a national taskforce comprising both state and non-state actors. The taskforce developed a conceptual framework and a zero draft of the guidelines during a four-day workshop held in July 2015. The workshop was led by the MoH's Health Sector M&E Unit and brought together representatives drawn from M&E focal points in key health programs, counties and development partners working in the health sector.

This draft was subjected to internal review by various user departments. Thereafter, the second draft was circulated to stakeholders within the health sector and their input was consolidated. A consultant was enlisted to take over subsequent development processes that led to the first technical review workshop in February 2016.

The revised draft was then circulated simultaneously to key stakeholders, including MoH departments and health programs, health institutions, county departments of health and both development and implementing partners working to strengthen M&E systems in the health sector. Input from these sources was collated and a comprehensive final draft was developed after a national dissemination workshop in May 2016.

### **1.4 Target audience for the guidelines**

These guidelines are intended to assist actors in the health sector to gather, synthesize and analyze data and use this information to improve health sector performance.

The actors at the national level include the national Ministry of Health (departments, divisions, referral and teaching hospitals, health programs, units and parastatals), as well as non-state actors from non-governmental organizations (NGOs), faith-based organizations (FBOs) and the private sector.

The actors at the county level include departments of health, county executive committees (CECs) for health, hospitals and lower-level health facilities, including community units. The non-state actors at this level include development and implementing partners and private health organizations that are involved in the design, support and implementation of M&E and other projects and programs being implemented across the various tiers/levels of care.

These guidelines will serve as a reference for staff. Table 1 lists the three categories of target beneficiaries of these guidelines.

**Table 1: Target groups for Institutionalization of M&E Guidelines**

Entities	Description
National Ministry of Health	Office of the Director of Medical Services, departments, divisions and units in the Ministry of Health, health programs, national referral hospitals, regulatory boards and parastatals within the Ministry of Health
County Departments of Health	Department of Health, county executive committees (CECs) for health, county referral hospitals, level 3 and 4 hospitals (primary and secondary referral hospitals), implementing partners, primary care facilities (dispensaries and health centers/facilities)
Non-state actors	Development partners, civil society organizations, implementing partners, faith-based organizations (FBOs), private health providers, non-governmental organizations (NGOs)
Communities	All community units and community-based organizations (CBOs)

## 1.5 Guiding principles

The design principles of these guidelines are grounded in fundamental accountability mechanisms in service delivery, as enshrined in the Constitution of Kenya 2010 and the mandate of the Ministry of Health to build a progressive, responsive sustainable, technologically-driven, evidence-based and client-centered health system for accelerated attainment of the highest standard of health for all in a devolved system. The principles are summarized below.

### Principles guiding the design of these guidelines

Principles that will guide the design of these guidelines:

- Harmonized sector data and reporting systems to establish common data architecture, which is a prerequisite for achieving a single M&E system for the health sector.
- Improved governance, transparency and accountability, with the highest standards of ethical behavior, honesty and professional integrity, in the health sector.
- Stronger partnerships and working relationships with all stakeholders in the health sector so that counties and health programs can achieve their strategic objectives in the health sector.
- Ensure that there is a consistency in the utilization of M&E instruments and data collection methods and that information is obtained from different sources (triangulation) to ensure credible and valid data.
- Create a culture of learning based on utilizing M&E information as a basis for decisionmaking and accountability in management and governance.

## **Constitutional, legal and policy framework for M&E in the health sector**

The Health Sector M&E Framework is anchored within the Constitution of Kenya 2010 and existing Kenyan laws and policies. Article 43 of the Constitution of Kenya guarantees the right to the highest attainable standard of health, including reproductive health. Transparency, accountability and public participation are enshrined in Articles 10 and 201 of the Constitution. In addition, Article 132 (1) (c) (i) of the Constitution states that once every year, the President shall “report, in an address to the nation, on all the measures taken and the progress achieved in the realisation of the national values, referred to in Article 10”.

The Health Sector M&E guidelines, therefore, identify the need to monitor health service delivery in order to track progress towards achieving the right to health. These guidelines are in line with the following laws and policies:

**Health Bill 2014** – The Health Bill 2014 has stipulated a national health system and M&E-related roles. The M&E-related roles include: providing technical support on health services standards and delivery; formulating health performance indicators to enhance equitable access to health services; undertaking medical audits on maternal and neonatal deaths to inform improvement of obstetric and neonatal care; and monitoring the national health system for efficiency and standard performance. The Bill also requires the Director General of Health to prepare quarterly and annual reports, which are submitted to the Cabinet Secretary for Health, who in turn submits them to the National Assembly.

**County Government Act 2012** – Article 47 of the County Government Act requires the County Executive Committee to develop a performance management plan and a five-year county integrated plan. Progress on implementation of the plans will be documented in the annual county performance report, which the governor of the county is required to submit to the County Assembly. The county health management team (CHMT) is expected to participate in and provide input to the development of the performance plan. Additionally, the CHMT will submit the county-level health sector performance to the CEC for incorporation in the annual county performance report, which is in turn submitted to the County Assembly for consideration. In addition, Article 97 emphasizes the need for public sharing of performance progress.

**Intergovernmental Relations Act 2012** – Article 7 of this Act underscores a need for a national and county government Summit. The summit is intended to: evaluate the performance of the national or county governments and recommend actions; receive progress reports and provide advice as appropriate; and monitor implementation of national and county development plans, and recommend appropriate action.

**The Public Finance Management Act 2012** – Article 166 of the Public Finance Management Act points out that the accounting officer will prepare quarterly reports for the county government entities. 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.

**National and international commitments** – Kenya's Vision 2030 outlines the country's long-term development agenda and, in particular, strategies for the country to achieve middle-income status by 2030 through the implementation of medium-term plans (MTPs). The health sector directly monitors four relevant Millennium Development Goals (MDGs) under Vision 2030, which include: MDG 4: Child health; MDG 5: Maternal health; and MDG 6: HIV and AIDS, Tuberculosis and malaria. It also bears indirect responsibility in the achievement of MDG 1: End poverty and hunger, MDG 3: Gender equality, and MDG 7: Environmental sustainability. As the country transits to the new UN Sustainable Development Goals (SDGs), emphasis is shifting to universal health coverage as the new credo for health targeting and planning seeking to promote unfettered access to health services regardless of ability to pay. Hence the health sector bears monitoring responsibilities on SDG 3 on good health and well-being and SDG 6 on clean water and sanitation.

**The National Integrated M&E System (NIMES)-2004** is a government system domiciled at the Ministry of Devolution and Planning. The system was designed to build an M&E system for reporting at both national and the devolved levels that covers all public sector organizations and non-state actors and development partners, NGOs, FBOs, and CSOs. The system interacts to provide timely information for decisionmaking.

**Kenya Health Policy 2014-2030** – The policy spells out a robust M&E system that tracks progress made in achieving health sector policy objectives in a responsive, efficient, transparent and accountable manner.

**Health Information System Policy (2014-2030)** – The health sector M&E has adopted existing health information system (HIS) tools and uses the national health information system and a unified database, District Health Information Software version2 (DHIS2), which is the MoH's routine aggregated reporting system, to enhance harmonized data collection, analysis and dissemination, as stipulated in Kenya's health policy.

**Health Sector Monitoring and Evaluation Framework (2014)** – Guided by the existing health sector policies, the Health Sector M&E Framework is a management and governance tool that assists the entire health sector to maintain a clear focus on the goals of the Kenya Health Sector Strategic and Investment Plan (KHSSP) 2014-2018, focusing the attention of stakeholders and guiding efforts towards the ultimate goal of the sector: to attain the highest possible standard of health by being responsive to the needs of the population.

## **1.6 Status of monitoring and evaluation in the health sector**

Following the completion of the Kenya Health Sector Strategic and Investment Plan 2014-2018, the Health sector M&E Framework was developed to provide a harmonized and robust monitoring and performance measurement mechanism. The national Ministry of Health has

established a Sector M&E Unit to support policy alignment, coordination and capacity building of different health sector agencies in order to create a unified and robust M&E system. The inter-governmental sub-committee on health has established a working group on M&E and support supervision to enable it track capacity strengthening and performance across the 47 counties.

Investments by the Ministry of Health and other initiatives by stakeholders to strengthen the M&E system include: the development of guidelines covering key M&E milestones and activities in the health sector; streamlining data collection and developing protocols for data quality assurance; defining data flow conduits; generating sector performance review reports; and ensuring that sector-wide annual health congresses and summits are held regularly to increase accountability, information sharing and learning. The sector has made significant investments to create a strong foundation for an effective health information system, which is critical for a strong M&E system, including:

- Completing a compendium of health sector indicators so that data will be collected using common metrics across all levels of government, within all programs and among different health stakeholders. The second generation indicators' manual is currently under review and will be aligned to incorporate findings and proposals from the KHSSP's mid-term review.
- A number of technological advancements have been made to strengthen the infrastructure for a sound health information system, including:
  - Deployment of a Master Health Facility List, which is an active inventory of all health facilities with unique code and geographic coordinates
  - Deployment of the DHIS2, a web-based application for facility-based routine reporting of standard metrics
  - Strengthening of key information systems, such as the Kenya Medical Supplies Authority (KEMSA), Enterprise Resource Planning System, the integrated human resource information system (iHRIS), the Logistics Management Information System (LMIS), and Electronic Medical Records Systems (EMRs).

Despite these milestones, a number of challenges remain to be addressed. For instance, Kenya is yet to develop an overarching M&E policy to guide investments in building and sustaining effective M&E systems for the health sector, which makes it difficult to allocate budgets and to hold leaders to account for the implementation of M&E milestones. Hence M&E activities are not often prioritized and depend on unpredictable funding by development partners.

With the support of the USAID-funded MEASURE Evaluation PIMA project, a baseline M&E capacity assessment in 17 counties was conducted. The assessment revealed critical M&E challenges, including minimal M&E coordination, weak partnership and governance arrangements, absence of costed M&E plans, and minimal advocacy for M&E in the counties, which led to inadequate investments in core M&E activities in the counties' budgets. Similarly,

there was no strategy in place to promote a widespread culture of data demand and information use at all levels.

Thirdly, M&E activities are disjointed, with weak structures for partnership and coordination. Currently, program and disease-based M&E systems operate separately; they do not share data and information with each other. Most of these M&E systems satisfy the reporting needs of funding agencies and implementing partners, but seldom meet the information needs of the government and the health sector as a whole. Many large-scale data collection efforts (such as household or facility surveys) are conducted within the health sector to bridge the gap that should typically be filled by robust routine health information systems.

There is also inadequate expertise (both in numbers and in the skills mix) to ensure effective implementation of core M&E activities. Finally, the prevailing absence of a unified approach to monitoring programmatic and sector performance has led to duplication of efforts, inefficiencies, lagging capacity in the analysis of health sector performance and in the implementation of comprehensive M&E, all of which are reflected in a weak culture of data demand and information use for decisionmaking.

# CHAPTER 2

## 2.0 COMPONENTS OF THE M&E SYSTEM IN THE HEALTH SECTOR

### 2.1 Overview

A well-designed M&E system ensures that quality data is regularly collected during and after the implementation of a project/program, as outlined in the strategic plans. The data collected guides project/program implementation teams and informs decisions to be taken by actors in the health sector. To achieve a sustainable M&E system, competencies and capacities are required and assessed based on the following dimensions: technical skills; managerial skills; existence and quality of data systems; available technology; available fiscal resources; and institutional experience.

Capacity is needed to develop, support, and sustain a functional M&E system, and where capacity is inadequate or lacking, staff need to be trained in modern data collection, monitoring methods, and analysis. Partnerships should be built at the beginning by engaging stakeholders to embrace varied interests, roles and responsibilities.

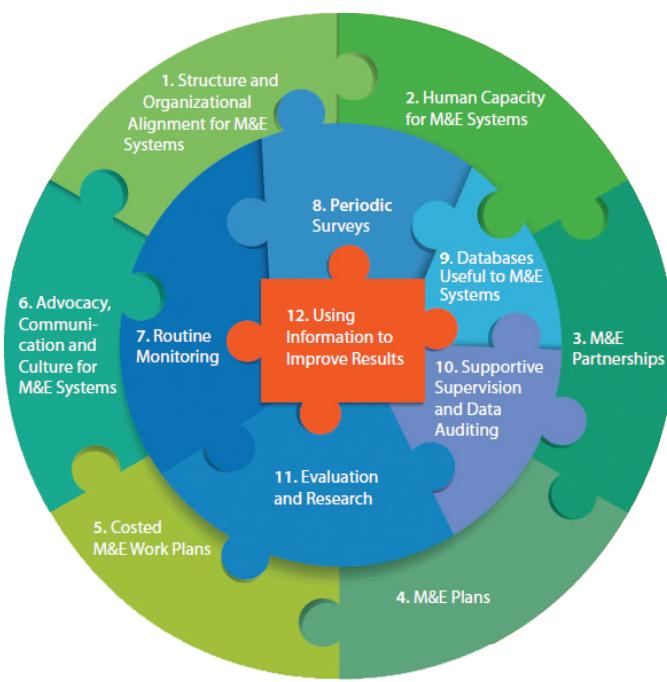
### 2.2 Developing a shared institutional vision for M&E and accountability

Both policymakers and health leaders are guided by the constitutional requirement for transparency and accountability in planning, allocation, and utilization of public resources in the health sector. A unified M&E system that is cascaded through all levels of health care is a critical pillar in developing a shared institutional vision for M&E and accountability. A unified vision for M&E can be realized in a situation where the leadership has gained stakeholder support and accomplished the following:

- Clarified the roles and responsibilities of the M&E leaders and managers at all levels;
- Aligned M&E deliverables and outputs to other core processes and structures within the organization, program or sector;
- Stakeholders demonstrate ownership and actively contribute to resolving challenges and achieving M&E goals; and
- Linkage with other institutional accountability processes, such as financial management and account systems or systems for staff performance assessment

In this section, detailed step-by-step information is provided on how an institution could advance its efforts in establishing and managing an M&E system based on the 12 components of a functional M&E system (see Figure 1).

**Figure 1: Components of a well-functioning M&E system**



*Source: Adapted from Gorgens M. and Kusek J. Z. (2010). Making Monitoring and Evaluation Systems work: A Capacity Development Toolkit*

Components 1, 2, 3, 4, 5 and 6 relate to people, partnerships, and planning support for data production and use. These components constitute the enabling environment for a functional and dependable M&E system. The components show people with skills working together to plan, budget, and cost a well-functioning M&E system and their motivations for maintaining functional components of the system.

Components 7, 8, 9, 10 and 11 relate to data management processes that involve collection, capture, and verification of types of M&E data. These components generate data essential to the M&E system. Even with the most perfect enabling environment, M&E systems may not be operational or used to manage results unless data are generated, synthesized, analyzed and disseminated. Component 12 focuses on an M&E system's capacity for data analysis to create information as a means of informing and empowering decisionmaking across all levels. It represents the bull's eye in making and keeping an M&E system functional. If we are not using data and information from an M&E system, there will be no motivation to invest resources in building the system.

### 2.3 Assessing baseline M&E capacity in the health sector

In planning a strategy to strengthen the M&E system in the health sector, a critical step lies in conducting a systematic baseline assessment of M&E capacities disaggregated by staff cadre and level, health organization, department, unit or institution. The purpose of establishing M&E capacities is to:

- Guide collective reflection about the status of M&E capacities
- Identify specific M&E performance areas requiring improvement
- Increase transparency in using resources for M&E capacity strengthening
- Promote comparison within the sector on M&E performance
- Generate data for measuring improvements resulting from capacity building initiatives
- Use findings to develop capacity building plans to strengthen performance of M&E functions

### **2.3.1 Scope of M&E capacity assessment**

The health sector in Kenya has adopted the M&E Capacity Assessment Tool that focuses on the twelve components of M&E capacity in capturing key competencies for effective and efficient implementation of health programs and projects.

The M&E Capacity Assessment Tool is applied to assess the following 12 functional areas:

#### **M&E Capacity Areas**

- Capacity Area 1: Operates within a robust and integrated organizational structure for M&E
- Capacity Area 2: Deploys adequate and competent human resources to drive M&E
- Capacity Area 3: Operates within an effective partnerships and governance mechanism
- Capacity Area 4: Is anchored upon an overarching national M&E plan
- Capacity Area 5: Is delivered through a jointly agreed annual costed M&E plan
- Capacity Area 6: Is sustained and promoted through advocacy and communication
- Capacity Area 7: Is driven by robust systems for routine monitoring
- Capacity Area 8: Incorporates investments to conduct periodic surveys and surveillance
- Capacity Area 9: Promotes the use of unified and robust national and sub-national databases
- Capacity Area 10: Provides for routine supervision and quality auditing
- Capacity Area 11: Invests in evaluation and research
- Capacity Area 12: Promotes widespread data demand and information use

In each of these capacity areas, the tool attempts to establish the following four dimensions of system performance: 1) status – the extent to which an attribute either exists or is being partially implemented; 2) quality – a qualitative scale that determines the actual performance of the attribute being assessed; 3) the financial ability of the health sector or unit to implement M&E roles without technical or financial support from external agencies/NGOs/donors; 4) the technical ability of the health sector or unit to implement M&E roles without technical or financial support from external agencies/NGOs/donors.

### **2.3.2 Steps to conduct an M&E capacity assessment**

The following steps will be taken to ensure a comprehensive and systematic assessment of M&E capacity in health sector organizations:

#### ***Step 1: Preparatory activities and stakeholder engagement***

This entails the formation of a taskforce to oversee the M&E capacity assessment. The first activity for this taskforce is to design a comprehensive assessment plan, including consensus on methodology, data types, data sources, key informants, range of literature required and the scope of the assessment. The taskforce will develop an assessment operational plan specifying the data collection plan and calendar, stakeholder engagement meetings and validation meetings. The taskforce will review the M&E Capacity Assessment Tool and customize it to the unique needs of the organization, unit or department.

#### ***Step 2: Data collection***

Based on the data collection plan, the assessment will rely on three types of data: 1) reviews of existing documentation where the institutional profile, strategic plan, thematic strategies, human resources plans and policies, recent reports, publications and recommendations from other recent assessments regarding M&E capacities come into play; 2) focus group discussions comprising key institutional stakeholders in M&E; and 3) interviews with key informants who will include M&E focal persons, institutional leaders, key stakeholders/partners working in aspects of M&E for the organization. The tools will explore the experiences and challenges around performance measurement and factors affecting the performance of M&E units or projects, while observation checklists will allow the reviewers to discern actual investments in infrastructure or activities that promote a well-functioning M&E system.

#### ***Step 3: Data analysis and reporting***

The M&E Capacity Assessment Tool automatically generates useful dashboards and preliminary results from the data. The dashboard shows the distribution of the overall scores and for each of the 12 functional areas by dimension (status, quality and autonomy). It provides visual representation of the gaps in the M&E capacity for each functional unit. In this electronic template graphs and bar charts could also be used to present the data in simpler formats.

#### ***Step 4: Validation and adoption***

Validation is coordinated by the taskforce working together with the respective M&E technical working groups, depending on the level and types of organization. Results and findings from the analysis is relayed back to the same health sector focus group/program/M&E unit assessed. The Organization Capacity Index (OCI) is calculated by adding actual scores under each capacity area, divided by the maximum possible score.

## **2.4 Components of a fully functional M&E system**

Strong M&E systems increase transparency and accountability as a result of the use of data and information to inform planning and decisionmaking. The main purpose of an M&E system is to generate and process information to enable an organization's decisionmakers to use available evidence when making decisions that can lead to improved health outcomes.

### **2.4.1 Component 1: Structure and Organizational Alignment of an M&E System**

Robust organizational structures for M&E are critical for the realization of a well-functioning M&E system. Organizational structures in M&E provide effective leadership, coordination and alignment of all players in the health sector through one common goal and by leveraging scarce resources. The structures should incorporate effective leadership for M&E, job descriptions for M&E staff, and adequate number of skilled M&E staff with well-defined career paths in M&E. Clear organizational roles and functions must be defined and should include: a well-defined and agreed organizational structure with M&E focal points; well-written mandates for planning, coordinating and managing the M&E system; well-defined M&E roles and responsibilities of key individuals and organizations at all levels; routine mechanisms for the planning and management of stakeholder coordination and incentives for improved performance within the M&E system.

Organizations in the health sector require a unifying vision of what M&E systems should be established and what it will require to establish them. Significant alignment is required to ensure broad-based leadership support to establish a functional M&E system. Health leaders at the Ministry of Health, county departments of health and other organizations in the health sector need to work with their respective stakeholders to mobilize resources to facilitate the establishment and implementation of vibrant M&E systems.

#### **Steps aligning organizational systems and structures to support an effective M&E system**

##### ***Step 1: Develop leadership vision for M&E***

Leadership support and advocacy is critical in establishing a functional M&E system. Health leaders within the national Ministry of Health, county departments of health, health programs and other health sector institutions have a key role in mobilizing the entire institution to support investments to build an M&E system. When leadership support is weak, even the best designed system may lack the resources to implement it and to increase its performance. The leadership must have a shared vision of what an M&E system will look like and what benefits it will bring to the Ministry of Health, county departments of health, health programs and other health sector institutions.

## ***Step 2: Establish baseline M&E capacities in the organization***

An organization seeking to strengthen its M&E system will need to carry out an assessment of its capacity. The Ministry of Health has adopted the M&E Capacity Assessment Tool and customized to the unique needs of the health sector. The tool assesses the capacity of the respective institutions focused on the 12 components of a well-functioning M&E system. It establishes the status of M&E capacities in the health sector disaggregated by staff cadre and level and health organization, department, unit or institution. The purpose of establishing M&E capacities is to use the findings to:

- Guide collective reflection about the extent of M&E capacities
- Identify specific M&E performance areas requiring improvement
- Increase transparency in using resources for M&E capacity strengthening
- Promote comparison within the sector on M&E performance
- Generate data for measuring the baseline and improvements to guide capacity building initiatives
- Develop capacity building plans to strengthen performance of M&E functions
- Leverage on identified strengths

The steps to establish M&E capacities include:

- Ensuring broad-based support for the assessment and formal leadership endorsement of the team that will oversee this task
- Developing and implementing a comprehensive data collection plan using the customized M&E capacity assessment tools
- Collecting data through document reviews and interviews with health leaders and other stakeholders
- Analyzing data and presenting it using dashboards that are built into the tool. A composite measure of performance, the OCI, will be computed to enable comparison of performance with peer organizations and to track progress over time

## ***Step 3: Establish an M&E function in the organizational structure/organogram***

In most health sector organizations, M&E functions are implemented by different officers who have other official roles. It is, therefore, imperative that these roles are consolidated and properly aligned with a specific position within the organogram. Organizations or programs seeking to establish an M&E unit/function will need to consider a number of factors, such as:

- The extent to which formal leadership support has been expressed for this initiative
- Availability of a minimum set of skills needed to staff this function
- Clear linkages within the organogram to ensure it does not operate outside the formal

structure

- Resources to implement key M&E activities

The principles to guide the design of an appropriate organogram for M&E include:

- The M&E unit/function should be directly linked to the highest decisionmaking organs in the organogram
- The M&E unit should have a range of skills needed to implement the 12 components of an M&E system; quite often these skills are not possessed by just one or two persons
- The structure should demonstrate opportunities for clear career growth for the officers
- The M&E function must work collaboratively with the planning and budgeting functions; while some organizations give the M&E function separate and equal placement within the organization, all M&E units shall co-locate the M&E function within the budget or planning functions

#### ***Step 4: Develop a job description for each post with M&E functions in the organization***

Once the structure is formally adopted, it is important to clearly define the M&E roles and responsibilities of officers at different levels of the organization. These roles and responsibilities could be allocated along the following continuum:

- Governance – board members and stakeholder coordination committees who retain ultimate responsibility for institutional performance
- Managerial – key M&E leaders with managerial oversight responsibilities over the entire M&E system, including directors of M&E and health care planning
- Technical – M&E officers involved in technical processes involving the 12 components, including M&E system analysts, health records and information management officers, epidemiologists, economists, statisticians, health informatics and health information and communication technologists
- Operational – frontline data collection teams in health programs, semi-autonomous government agencies, regulatory bodies, communities, civil society organizations and health facility core staff with M&E responsibilities i.e. a wide range of staff who could have delegated roles along the 12 dimensions

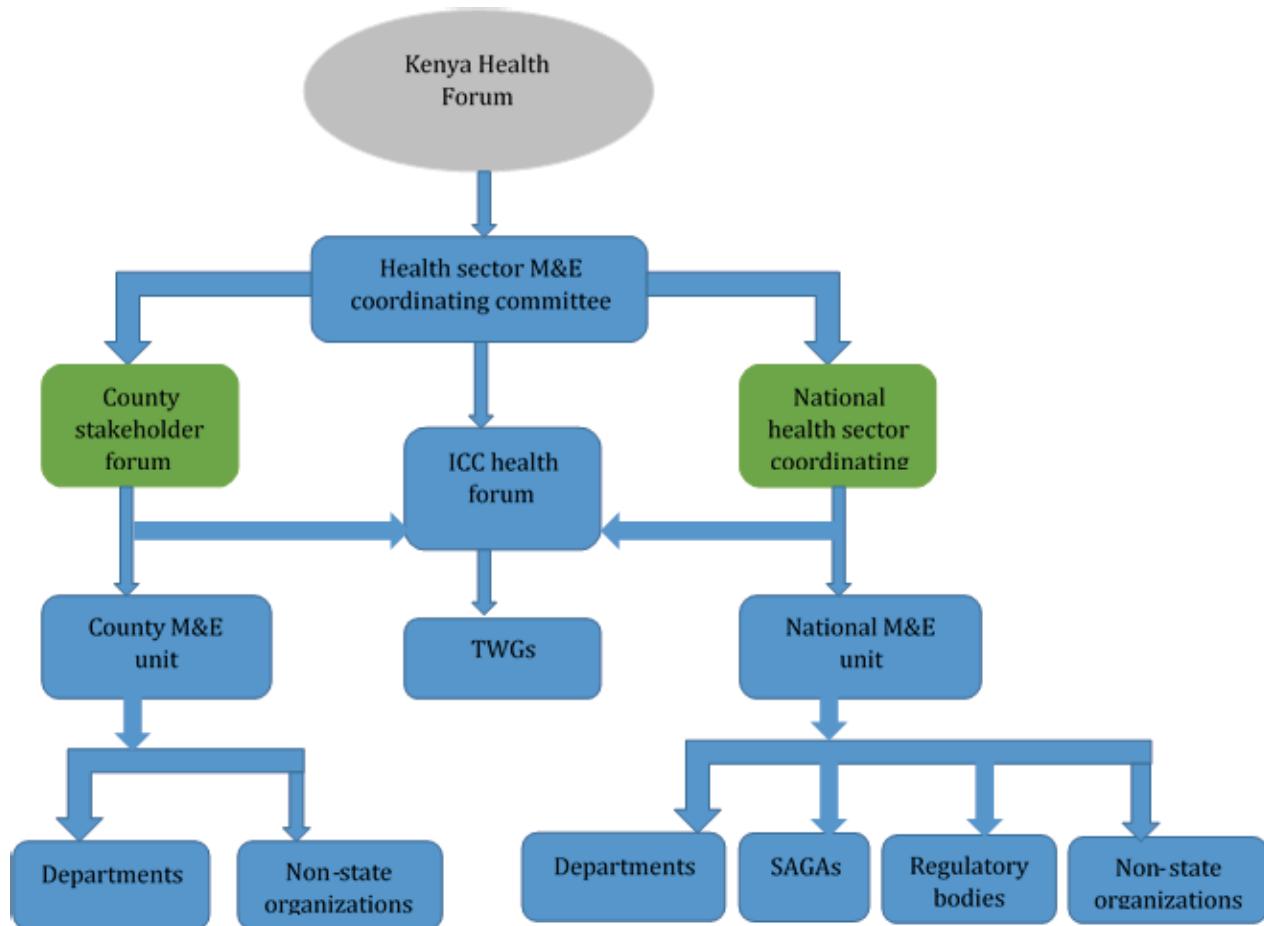
In designing job descriptions, consideration should be given to:

- Clear reporting lines
- Appropriate skills obtained to undertake each of the designed roles, both from formal training, on-the-job training and post-training experience
- Clearly defined job description for M&E officers
- Ability of the organization to fund the expanded establishment

## **Step 5: Gain top management approval for the M&E plan and proposed organizational structure**

The proposed structure of the M&E system will require the approval of top management. Figure 2 shows how the national and county M&E organogram can be achieved within the health sector's organizational partnership structure.

**Figure 2: National and county M&E organogram**



### **National level**

At the national level, the M&E units of government departments and semi-autonomous government agencies (SAGAs) report to the national M&E unit, which reports both to the Health Information and Research Inter-agency Coordination Committee (ICC) and the National Health Sector Coordinating Committee that comprises the national Ministry of Health, civil society organizations through the Health NGOs Network (HeNNET), development partners for health in Kenya (DPHK), the Kenya Private Sector Alliance (KPSA), professional associations and county health departments. The national M&E unit also becomes the secretariat of the Health Sector M&E Coordinating Committee.

## **County level**

The county M&E units should work in close collaboration and in mutual relationships with the national M&E unit, and have similar reporting channels at the county department of health. At the county level, all departments/directorates of health and non-state actors shall report to the county M&E unit. The county M&E unit shall, in turn, report to both the Health information ICC and the county stakeholders' forum.

Both national and county governments shall establish health M&E unit functions as: providing a forum for joint planning, coordination and monitoring of specific investments in the sector; bringing all key sub-sector partners together for joint planning, oversight and decisionmaking in M&E; enabling partners to become jointly responsible for planning, monitoring, performance reviews, reporting and dissemination; holding all sector partners jointly accountable for achieving results; harmonizing the number of separate meetings with individual partners; enabling harmonization of inputs and better coordination of investments in the sector partnership for more effective use of all available resources to support M&E functions and to reduce duplication of efforts and critical gaps; and providing easy access to coordinated technical assistance, joint reviews, joint monitoring and support for priority actions.

### ***Step 6: Implement the change management plan and the new organizational structure***

People often resist change; failure to take into account the main causes of resistance to change could lead to under-performance or weak structures for M&E. When fully implemented, this component will guarantee effective leadership support for M&E through established organizational and program M&E system capacities and adequate number of skilled M&E staff with clear and relevant job descriptions that take into account opportunities for career growth. It will also ensure that M&E functions are articulated in the organizational structures (possibly an M&E unit is created) and that M&E priorities are integrated into planning and policy documents.

#### **2.4.2 Component 2: Human Capacity for M&E Systems**

The functioning of an M&E system depends on both the capacity and performance of the people implementing it at different levels. This human capacity is critical to ensuring a well-functioning M&E system. The people must, however, be equipped with the right kind and range of skills that will enable them to implement and deliver the complete package of M&E responsibilities, as explained in this manual.

Organizations working to implement this component will need to develop a costed human capacity building plan, a workforce development plan, M&E career paths, and ongoing technical capacity building for staff at all levels. A mix of in-service training and mentorship programs and coaching all play a big role in expanding the human capacity needed for M&E.

Capacity building in this component will focus on systems and structures, as well as on organizational mechanisms that drive an organization to implement its mandate. However, the most important capacity in implementing change lies in human capacity development. This entails the development of skills and the effective use of managerial, professional and technical staff and volunteers (for example, through training) to achieve desired results. It involves identifying the appropriate people to be trained, providing an effective learning environment for training and education, in-service and field supervision for continued skills transfer, and long-term mentoring.

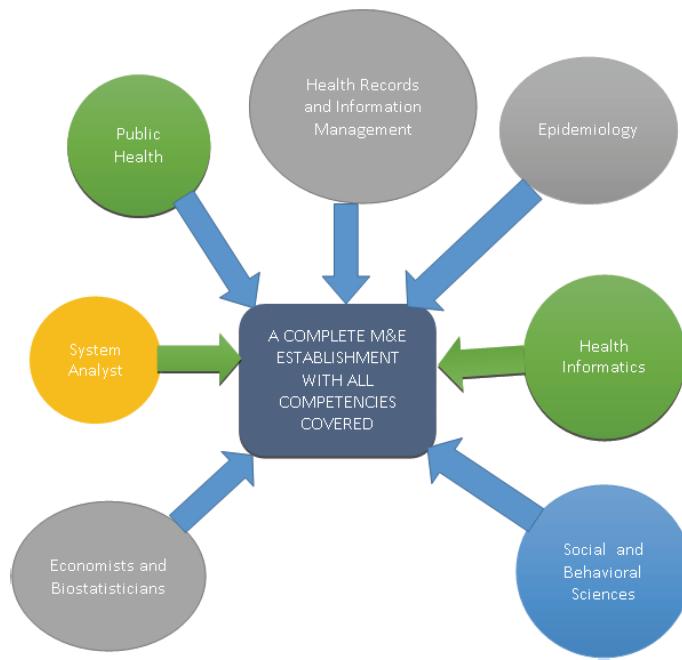
A wide range of competencies and skills are needed to implement M&E activities at different levels of the health system. These skills and numbers will vary based on the complexity of the organizational function, M&E roles and performance expected at each level. Nonetheless, it is necessary to have dedicated and adequate numbers of M&E staff with competencies to deliver their mandate.

### **Who is an M&E professional?**

In the arena of health systems, M&E is a comparatively new field and the understanding of what an M&E system should look like and the personnel needed to implement it remains mostly abstract. What has been more challenging to stakeholders is the concept of drawing data from one single M&E system. While there is a great demand for skilled professionals and capacity in building M&E systems, this demand outstrips supply due partly to inadequate opportunities for training and continuous professional development in core M&E functions. For instance, it is only in the last five years that colleges and training institutions in Kenya began viewing M&E as a distinct profession.

In the Kenyan context, and as shown in Figure 3, professionals needed to establish and sustain a well-functioning M&E system in the health sector include: health records information management officers, health records information assistants, epidemiologists, health economists and statisticians, systems analysts, health information and communication technologists and health informatics. However, there is poor coordination and utilization of the available skilled personnel in most of the M&E competency areas. As a result, M&E functions are often taken up by existing recognized cadres who may not have the comprehensive competences needed to strengthen a complete M&E system.

**Figure 3: Existing cadres in the civil service**



### **Requisite competencies and skills for M&E professionals**

Any professional tasked to undertake M&E functions should have the requisite skills, knowledge and technical capacity to implement M&E activities. He or she must be able to do one or more of the following:

- Comprehend M&E concepts and the importance of M&E
- Develop/use M&E tools with special reference to national health programs and policies
- Develop and design an M&E framework
- Develop and implement an M&E plan
- Identify, develop and evaluate indicators
- Link indicators with data sources
- Collect, analyze, manage and interpret data
- Assess and maintain quality of data
- Design and conduct periodic surveys and surveillance on emerging issues
- Write reports
- Communicate and disseminate M&E information
- Evaluate designs and conduct an evaluation
- Manage and lead the M&E team by critically appraising the M&E system
- Identify appropriate principles and guidelines to ensure ethical use of M&E that will allow M&E data to support decisionmaking and advocacy

- Design M&E systems within social, economic or cultural contexts
- Engage stakeholders at all levels

## **Who is responsible for human resource capacity development for M&E?**

Capacity development including for M&E is entirely the responsibility of the national government. However, counties are at liberty to support and train M&E officers if they have the funding.

### **Roles and responsibilities for M&E at different levels**

In order to determine the skills and numbers needed at each level of the health sector, there is a need to define the specific M&E functions/responsibilities of the respective levels. This is further informed by the respective organizational structures for M&E, as discussed above. In Annex 3, a detailed listing of core M&E roles and responsibilities is articulated in detail and is broken down by the level and mandate of:

#### **National government**

- National Ministry of Health (the Health Sector M&E Unit)
- National level (health programs/divisions/departments/projects)
- National level SAGA health regulatory bodies
- National M&E coordinating groups including the M&E TWGs

#### **County government**

- County Department of Health (County M&E unit or focal point)
- County referral facility (M&E unit/focal point)
- Community level

#### **Non-state actors**

- Development partners for health in Kenya
- Implementing partner organizations
- Health sector networks and umbrella bodies
- Private sector health providers
- Faith-based health service units

### **Steps to address human capacity gaps in the M&E system**

#### ***Step 1: Clarify the organizational context and vision for M&E***

This will require asking the following key questions:

- Who is the leader and what does he/she expect from the M&E system?

- What is the M&E vision for this organization?
- Who else is interested in M&E performance and what do they expect?
- Is M&E defined as a cadre/function within the formal organizational structure?

***Step 2: Specify core M&E roles within the context of the organization/department***

Define the deliverables and outcomes of the M&E. These should be measurable and specific. Define three to five items that the M&E function at different levels must deliver to the organization/department. These deliverables often include capabilities/competencies required for the M&E function (staff/unit) to fulfil its mandate.

***Step 3: Develop a set of core M&E competencies needed at all levels***

Identify critical competencies needed to meet the M&E functions described above. Assess the current state of competencies. This is a consensus process and should bring together as many stakeholders as possible to articulate this professional's value addition.

***Step 4: Develop a simple staffing plan for M&E***

A staffing plan will specify the numbers, categories of cadres, qualifications, competencies and other requirements to support a fully functional M&E system at different levels.

***Step 5: Enlist the right human resources***

Recruiting M&E professionals is quite challenging. Few courses cover the M&E competencies described above and there has been limited interest in M&E.

***Step 6: Develop a supervision and performance management plan for M&E***

To ensure that the performance of M&E staff meets the needs and expectations of the organization, a performance management mechanism that is linked to the overall organization-wide system needs to be in place. The performance management plan needs to specify how supervision of M&E staff will happen, how skill gaps will be bridged and strategies for on-going mentorship to improve performance.

***Step 7: Design a human capacity development plan to address gaps***

Work with stakeholders to design a costed workforce development plan for M&E professionals. In order to develop a good workforce development plan, it will be necessary to seek the input and perspective of health training institutions that can help in addressing short- and long-term staffing gaps. Human capacity building should: focus on all levels; have measurable performance objectives; have a capacity building plan with clearly defined outputs; and include ways to track progress over time.

## **Expected results**

When this component is successfully implemented, the following results may be evident: the existence of an M&E workforce that is adequately skilled and able to effectively and efficiently complete all activities defined in the organization's M&E work plan; defined skill sets for people responsible for M&E functions; human capacity assessment, including career paths for M&E staff; a human capacity development plan; local and/or regional training institutions that offer good quality M&E training course; and supervision, in-service training, and mentoring as mechanisms for continuous capacity building.

### **2.4.3 Component 3: M&E Partnerships and Governance**

The current health sector partnership framework is guided by the Kenya Health Sector Strategic and Investment Plan 2014-2018, and is intended to improve efficiency and effective implementation of the interventions/activities for the health sector. The framework aims at providing an enabling environment to achieve harmony and synergy among all health stakeholders to improve the health of the population. The partnership principles focus on country ownership, alignment, harmonization, managing for results, and mutual accountability. This approach is anchored on joint planning, budgeting and monitoring frameworks for service delivery. These principles are harmonized across the health system by the Constitution of Kenya. A common M&E system is one of the key elements of the partnership framework.

The M&E partnerships support communication, coordination and harmonization of efforts to achieve the ideals of quality service delivery in the health sector. The M&E partnerships should be aligned to the Kenyan Constitution 2010 with regards to the provision of universal health coverage.

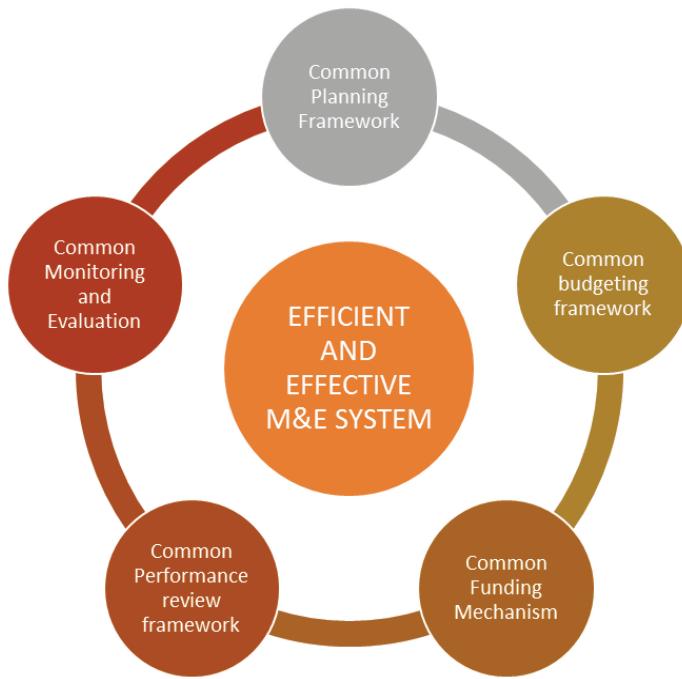
#### **Benefits of M&E partnerships**

The benefits of M&E partnerships include: a well-structured partnership arrangement, increased communication, and shared accountability; coordination of efforts, harmonization and aligned reporting procedures; description and mobilization of technical and financial support for implementing M&E priorities; commitment to regularity of sharing consolidated feedback within a shorter time frame; and development of strategies to explore possible solutions to challenges and provide support to the health sector.

#### **Mechanisms for establishing M&E partnerships**

An effective and efficient M&E system has five critical key elements of partnerships that will facilitate working around one common M&E. The elements are: a common planning framework; a common budgeting framework; a common funding mechanism; a common performance review framework; and a common monitoring and evaluation system. Figure 4 demonstrates the mechanisms for establishing M&E partnerships.

**Figure 4: Mechanisms for establishing M&E partnerships**



### **Formats for M&E Strong Partnership**

A health unit, department or sector coordinating forum can establish or support the establishment of partnerships for a strong M&E system. Partnerships could be in the following formats:

- Task force – people drawn from different institutions, units or organizations to fulfill a specific, goal or objective.
- M&E TWG – consists of stakeholders from different organizations who meet on a regular basis to discuss technical M&E developments and approve key M&E documentation. Such groups have fixed membership and usually consist of stakeholders from all sectors.
- Benchmarking – this allows groups of nominated persons from one entity to visit similar groups in other entities that have similar interests to learn and exchange ideas/views or benchmark on how they operate their programs.
- Joint evaluation – involves more than one partner jointly undertaking an evaluation of a program/project.
- Joint M&E missions/trips: involves more than one partner (all of whom support the organization in one or more aspects of its M&E system) agreeing and planning joint M&E trips.

### **Sustaining M&E partnerships**

Sustenance of M&E partnerships in the health sector should be inclusive and coordinated and should capture universal access to quality health care delivery across the segments of the population. M&E partnerships can be sustained through: M&E activities that are based on trust and openness; M&E activities that are accountable and that respect the rights and responsibilities

of stakeholders; M&E activities that are flexible and adaptable to changing priorities; M&E activities that involve joint value adding objectives; M&E activities that are synchronized to improve effectiveness for quality outcomes; and M&E activities that are anchored on priority-setting for sustained quality health care delivery.

## National and county coordination structures

As per the Constitution of Kenya 2010, M&E partnerships will be aligned with national and county coordination structures. The partnerships will respect devolved structures to improve efficiency in health care delivery using a functional M&E system. The structural arrangements will include:

- Development of a Partnership Forum to strengthen accountability and universal health coverage in line with Kenya's Vision 2030
- Strengthening the Government of Kenya's Coordination Group with the aim of providing a monthly forum for the review of support and challenges in achieving universal health coverage
- Strengthening the Donor Coordination Group with the aim of providing a monthly forum for the synchronization of efforts to increase the effectiveness and efficiency of external assistance
- Strengthening the Aid Effectiveness Group with the aim of mobilizing stakeholders to participate in quarterly reviews to increase the effectiveness and efficiency of support to the health sector
- Strengthening the Health Sector Intergovernmental Consultative Forum with the aim of increasing active engagement, consultation, cooperation and accountability between national and county health sector initiatives
- Strengthening the Health Sector Coordinating Committee (HSCC) technical working groups at the national and county levels with the aim of providing joint M&E of investments and priorities in the health sector
- Encouraging partners to become jointly responsible for monitoring, reviews and reporting
- Encouraging health sector partners to be jointly accountable for achieving results through set priorities and targets
- Encouraging access to coordinated technical assistance and support for priority activities

## Aligning stakeholders to support M&E capacity building

To have a functioning M&E system in place, it is important to build an enabling environment for all stakeholders (i.e. secure staffing and work, secure funding, cultivating an M&E culture and, stakeholder coordination). Stakeholder coordination is one of the critical drivers of convergence in the health sector and is currently articulated through the "three ones" principle that requires

all stakeholders to operate within one planning framework, one funding mechanism and one M&E framework. It is important that policymakers are engaged more at the macro level as this will help to avoid challenges and to gain political commitment, which may have an effect on the development and implementation of the three ones. This will also ensure that M&E in the health sector is allocated sufficient national and international resources and that there is increased participation at all levels in the building or sustenance of a unified M&E system.

## **Stakeholder mapping and analysis**

Stakeholder mapping enables establishment of a complete inventory of stakeholders an organization/program/unit is working with and helps it to gain a broader view of which stakeholders could support or oppose interventions to strengthen the organization/program/unit's scope. The data collected enables analysis of the stakeholders, including their relative contributions Stakeholders should facilitate capture and analysis of this information mapping and enable better decisions about how to achieve the results. This entails defining potential roles for stakeholders, identifying the resources stakeholders will bring and identifying the level of commitment of the stakeholder.

### **a) Defining potential roles of stakeholders**

- Consider how stakeholders can influence your activities in the short and long term. Think about their immediate influence and the influence they have on other potential stakeholders. Different perspectives from a wide variety of stakeholders can enhance the accuracy, appropriateness, and effectiveness of the activities and interventions.
- Determine the level of participation of each stakeholder. Questions posed during this discussion might be: What do we see as each person's role in this process? What is their expected participation? Some stakeholders may have a vested interest in specific activities.

### **b) Identify the resources that stakeholders will bring to the process**

- Identifying the resources that stakeholders bring to your activities may help expand the scope of the activities.
- Consider what each stakeholder can contribute to an activity. Beyond financial resources, stakeholders may provide an entry point to high-level policymakers that would be helpful to you during the initial and implementation stages of the activity, while others may allow you to create greater public awareness through access to media channels or may offer valuable technical inputs to the design of the activity.

### **c) Identify the level of commitment of the stakeholder**

- The level of stakeholder commitment will strongly affect how that stakeholder cooperates with or hinders an activity. Discuss how the stakeholder may support or

oppose the activity, to what extent, and why.

- If the stakeholders are committed to the activity, the probability that they will facilitate your work is higher.
- Consider who may put up barriers to the activity and predict what they may be so that you can develop strategies for handling them.

## **Complete the plan and engage your stakeholders**

The stakeholder analysis provides clarity on the potential contributions of stakeholders or the challenges different partners and stakeholders may pose. After the analysis is completed, you can now define the optimum group to engage with and hence develop a costed stakeholder engagement plan.

### **a) Set up the optimum stakeholder group**

- Review the data entered into the stakeholder analysis matrix and discuss the relative priority of stakeholders to get involved in the activity. As more stakeholders with unique perspectives and priorities are included, —the likelihood of finding inconsistent or competing interests may increase.
- Carefully consider the relative value of each person's involvement versus the added time and costs of expanding the number of stakeholders.
- Core stakeholders should be engaged throughout the implementation, not just at the beginning and the end. This raises awareness of the activity and facilitates the use of data and information produced by the activity.
- Consider identifying “tiers” of stakeholders for different levels of involvement and different times in the activity.

### **b) Create a stakeholder engagement plan**

- Brainstorm on the roles each stakeholder can play in the activity, and define the specifics of how you will engage the stakeholder in each sub-activity. Start by listing the steps in your intervention and discussing whether the stakeholder can contribute to this step. Consider the importance of involving stakeholders in a meaningful way. Activity engagement can build ownership of the data and information generated by the activity.
- Describe to the stakeholders your plans for their continued involvement and provide them with feedback on the results and impact of the activity, while fully acknowledging their contributions.
- Determine a plan for the management of the stakeholder engagement process. An individual or entity should be appointed and tasked with reviewing the documents and

convening activity leadership to review and revise the plan. Ask the following questions: How will the process be managed from here on? How often will the engagement plan be reviewed and revised? You can help articulate this process and thereby ensure the continued usefulness of the stakeholder engagement plan as a perpetual management tool and not simply a one-time exercise.

- The stakeholder engagement plan is dynamic and flexible. It should be reviewed at various points throughout an activity and stakeholder involvement should be revised based on your experiences working with them.

**c) Track stakeholder engagement throughout the project**

- During the implementation of an activity, document contributions (both negative and positive) of stakeholders and their impact on how information has been used for decisionmaking;
- Where possible, include external validation, such as through newspaper articles, newsletters, and memos from finance and planning officials. This effort helps to create continued awareness and appreciation of the importance of collaborative efforts and the key role of stakeholder involvement in the implementation of health activities.

**Coordinating M&E technical working groups**

M&E TWGs consist of representatives from all of the key entities involved in planning, producing, managing, and supporting a health information system. It is now well-established that health information system dynamics and challenges are far too complex and cut across too many organizational and sectoral lines to be handled by a single entity.

These guidelines will help M&E leaders, managers and champions to form M&E TWGs. (A champion is someone in a leadership position who sees the pressing need for a TWG to address a key M&E problem or set of problems. Depending on the context, such a person could be a Ministry of Health leader, an executive director of a non-governmental or faith-based organization, or a bilateral or multilateral M&E leader or supporter.)

**Specific objectives**

The M&E TWG will support the implementation of the county/program level M&E framework, which generally seeks to:

- Improve information systems at all levels
- Improve birth and death registration and reporting
- Strengthen the linkage between sector monitoring and research
- Strengthen disease surveillance and response
- Carry out critical health surveys

- Support the establishment of a common data architecture
- Manage data and statistics
- Enhance sharing of data
- Improve performance monitoring and review processes

### **Forming/sustaining an effective M&E TWG**

Based on experiences gathered by implementing stakeholder leadership groups in diverse parts of the health system, the following basic steps are recommended:

#### ***Step 1: Generate consensus with the Ministry of Health and stakeholders on the need for an M&E TWG***

Obtain documented support of the MoH at the leadership level for the establishment of the TWG. Identify and engage strategic partners in the formation of the M&E TWG (including non-MoH actors). Develop initial TWG goals, membership, and possible funding support. Generate an inclusive list of members and take actions that will help foster a partnership mentality.

#### ***Step 2: Plan and conduct the initial technical working group meeting***

Send the agenda and meeting materials well in advance. During the meeting, review and refine the TWG's goals and membership. Discuss and obtain agreement on key operating procedures. After the meeting, promote transparency through good communication.

#### ***Step 3: Develop and agree on key operating procedures***

These include: group membership/composition; TWG mandate (or terms of reference); linkages to appropriate governing bodies; health sector coordination structures; and decisionmaking.

#### ***Step 4: Provide effective leadership***

Foster shared ownership of the M&E challenges and desired outcomes from the very beginning. Demonstrate commitment to participatory and shared leadership. Identify the potential of the TWG to help unlock institutional and sectoral challenges that MOH alone or individual partners may not be able to address. Communicate this vision in inspiring ways. Understand and address the differing interests of each stakeholder entity and work to facilitate communication and interaction among the different groups.

#### ***Step 5: Provide necessary support to ensure that the TWG's work continues and is sustainable***

This can be done by advocating for an effective secretariat. It is prudent to acknowledge any other key partner that may wish to take up this role and potentially agree to share the mandate.

## ***Step 6: Use effective communication practices***

Build trust through developing and using good communication practices to ensure clarity around agreements reached and to sustain transparency.

## ***Step 7: Persist in sustaining clear goals, planning, and monitoring progress***

Develop a simple work plan and monitoring process and periodically use benchmarks or indicators to monitor progress.

The primary aim of the M&E TWG is to support the health sector or department or program to realize the objectives set out in its broad institutional strategic plan. Hence the first outcome of an effective TWG is ensuring that a clear M&E framework that is supported by an M&E plan is in place. Depending on the context, TWGs can take on a range of specific M&E issues, including advocacy for a new M&E policy, the M&E plan, data-driven decisionmaking, and production of health profiles, bulletins, and performance review reports, dissemination of best practices, health research, and routine program reviews.

### **An effective M&E TWG can:**

- Increase the likelihood of successfully implementing new M&E initiatives that individual stakeholders might not be able to undertake on their own
- Facilitate information and knowledge-sharing, which promotes overall M&E strengthening and contributes to individual and organizational goals
- Expand capabilities and possibilities to “do more with less,” thereby enhancing what a single stakeholder’s resource base usually permits
- Leverage resources and avoid duplication of investments and activities
- Advocate for M&E across lines and raise the public profile of the challenge being addressed
- Redefine and strengthen the relationships among government M&E stakeholders and among the government and a broad range of non-state actors

### **The Kenya Health Data Collaborative initiative**

Kenya has signed off on and is one of the primary drivers of the global health data collaborative (HDC) – an initiative launched at M4Health Measurement Summit in June 2015, which focused on measurement and accountability in health. The Five-point Call to Action from this conference defined what countries must do to increase the efficiency of investments in health data in support of strengthening a country-led health information platform.

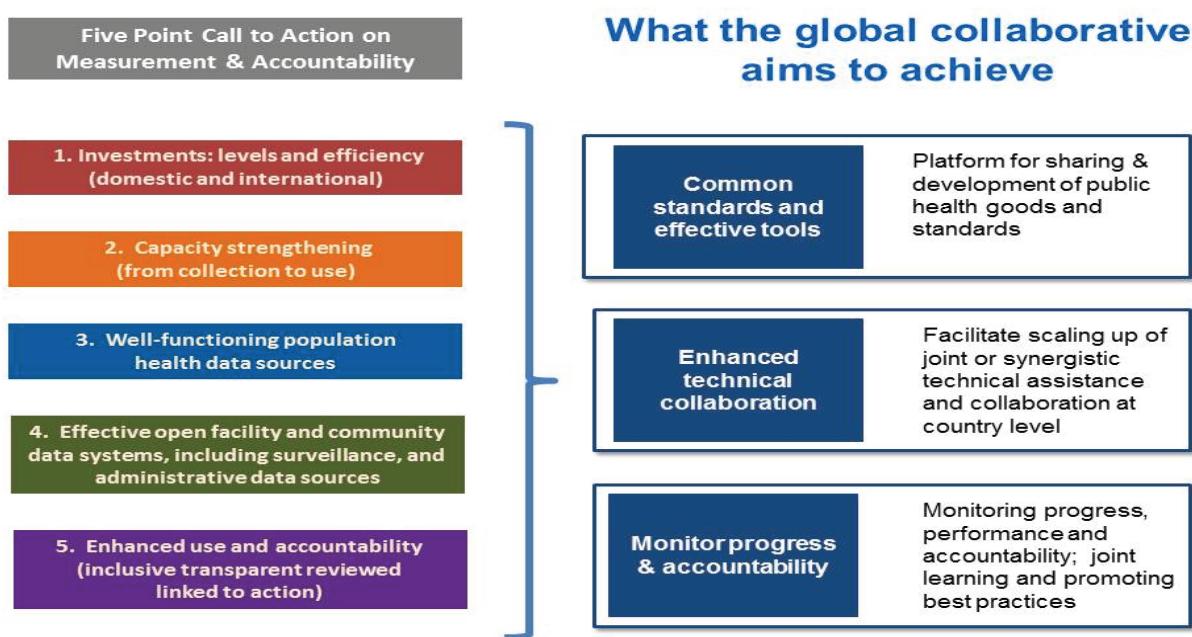
The HDC initiative was launched in Kenya and has aligned itself to the Health Partnerships and Coordination Framework developed by the Ministry of Health to guide counties and stakeholders on the same. The initiative promotes partnership while focusing actors on a set of concrete collective actions to reduce fragmentation and to better align support to national and

county government systems for performance measurement and accountability.

The main aims of the Kenya HDC are:

- To ensure an integrated national M&E plan, structures and systems;
- To support alignment of parallel systems into integrated systems;
- To build institutional capacity in critical areas of data quality, analytics, and data use for decisionmaking and policy adjustments; and
- To ensure that the different health stakeholders at the global, national, sub-national or county levels are able to work together more effectively to make better use of resources

**Figure 5: The role of the Kenya HDC in implementing the five-point call to action**



The role and function of the Collaborative at the subcounty, county, national and global/regional levels is to leverage existing national-/county-led coordination mechanisms (e.g. Swaps, country compacts, Kenya Partnership's framework, etc.) while, the role of the Collaborative at all levels include:

- Mobilizing well-coordinated support for one national agreed platform on health data (this includes support for national plans, coordination mechanisms, indicators, tools, technology, reporting, accountability, learning agenda and institutional capacity).
- Advocating for greater domestic investment in national/county measurement systems (based on examples from good/best practices).
- Providing a platform for learning and sharing best practices, operationalizing the data revolution, and harmonizing tools and effective communication of standards, methods and tools.

- Facilitating global and regional coordination in support of one country-led platform on health data and helping to deal with the tension between the demand for donor - attributable results and the country's development needs.
- Monitoring progress on data and accountability during the SDGs era.

#### **2.4.4 Components 4&5: M&E Plan and a Costed M&E Work Plan**

Once a health organization develops a medium-term or strategic plan, it creates an opportunity to develop a comprehensive M&E plan that will enable the implementation of its M&E system. Thereafter, the health organization can proceed to develop a costed M&E work plan.

An M&E plan is a comprehensive narrative document on all M&E activities. It describes the key M&E questions to be addressed: what indicators are to be measured; how, how often, from where the indicator data will be collected; whether baselines, targets, and assumptions are included; how the data will be analyzed or interpreted; how or how often reports on the indicators will be developed and distributed; and how the 12 components of the M&E system will function. An M&E plan describes the purpose of the system, and how the system will operate.

An M&E plan, together with a costed M&E work plan, are critical dimensions of the M&E system.

A national or sector M&E plan is a special type of M&E plan that focuses on how a national M&E system (e.g. for the Kenya Health Sector Strategic Plan, among others) would work. A strong M&E system is only possible when M&E plans from different institutions are linked and aligned with each other. A national M&E plan, therefore, defines the key M&E questions to be addressed at the national level, which all actors in the health sector are working to answer through their diverse documentation strategies. Respective health programs, institutions and initiatives may develop their own M&E plans that are drawn from and feeding into the one overarching M&E plan or framework.

#### **The purpose of an M&E plan**

- An M&E plan provides a common vision of what a successful M&E system will look like
- An M&E plan is used as a benchmark against which to measure progress in implementing the M&E system
- An M&E plan standardizes and validates the mandates, authorities, and responsibilities of M&E stakeholders
- An M&E plan assigns specific responsibilities to specific organizations
- An M&E plan can be the basis for deciding which M&E activities to implement
- A national M&E plan provides a common framework to guide the implementation of health programs.

The M&E work plan is a joint and costed work plan for all M&E activities within a financial year. It contains not only the M&E activities of the government, but also those of development partners, umbrella organizations, and organizations implementing M&E activities. All activities are costed and the funding source of those activities are indicated where funds have been committed.

### **The purpose of an M&E work plan**

Given that an M&E work plan contains a complete set of activities to operationalize the M&E system, its purpose is to be:

- A progress monitoring tool for the M&E TWG as to the status of the M&E system
- A resource mobilization tool
- A capacity building tool
- A management tool for the M&E unit to organize the staff members working in the unit, and to post the profiles of staff members in the unit
- A weekly feedback tool for M&E unit staff members to provide updates on their activities in the previous week or month.

A costed M&E work plan is derived from the M&E plan and presents a detailed budget to facilitate activities. In particular, this budget shows the key M&E tasks, responsibilities, time frames, and costs. Quite often the costed work plan is placed as an annex within the M&E plan.

### **The difference between an M&E plan and an M&E work plan**

The M&E plan is a narrative document that describes, in detail, how the M&E system will operate. An M&E work plan is an activity-based budget showing M&E tasks, responsibilities, time frames, and costs. The M&E work plan presents a costed list of activities for implementing an M&E plan that makes all 12 components of the M&E system function. An M&E work plan can be (and often is) an annex within an M&E plan.

### **Contents of an M&E plan**

An M&E plan should provide background information, define what the M&E system will measure (indicators linked to the objectives of the strategic/program plan being monitored and evaluated), and how the M&E system will operate to enable these measurements to take place. The contents include: general background information; results framework or the logical framework with program objectives and indicators; and how the M&E system will be managed.

### **Frameworks for M&E planning**

There are several types of frameworks used in M&E planning whose purpose is to: clarify assumptions, goals, and interrelationships between factors relevant to the project or program;

define objectives; select activities; define levels of performance and desired results in terms of planned activities and realistic, objective impacts; M&E plans incorporating program managers' assumptions and objectives in a given context; and a schematic design displaying the directional linkages between key program elements and/or planned results, and other relevant factors.

### Sample M&E framework

**Table 2: Simple logic model for developing and implementing an M&E plan**

Inputs	Processes	Output	Outcomes
<ul style="list-style-type: none"> <li>• Human resources</li> <li>• Understanding of the program</li> <li>• Authority and mandate</li> <li>• Stakeholders</li> </ul>	<ul style="list-style-type: none"> <li>• Advocacy</li> <li>• Assess strategic information needs</li> <li>• Assess information system capabilities</li> <li>• Achieve consensus and commitment</li> <li>• Develop mechanism for M&amp;E plan review</li> <li>• Prepare document for final approval</li> </ul>	<ul style="list-style-type: none"> <li>• M&amp;E plan document</li> </ul>	<p><u>Short-term</u></p> <ul style="list-style-type: none"> <li>• M&amp;E system for obtaining strategic information for decisionmaking</li> </ul> <p><u>Long-term</u></p> <ul style="list-style-type: none"> <li>• Evidence-based decisions to improve programs</li> </ul> <p><u>Impacts</u></p> <ul style="list-style-type: none"> <li>• Improved health status</li> </ul>

Use this sample to develop a costed or budgeted M&E work plan.

**Table 3: Costed M&E work plan template**

Activity number and description	Current implementation status	Time frame for implementation				Documents required for activity to be completed	Person responsible	Cost description	Cost calculation	Cost (for each year of implementation)	Funding source						
		Qtr		Qtr													
		1	2	3	4												

**Source:** World Bank GAMET/UNAIDS

## **Steps in developing and reviewing an M&E Plan**

### ***Step 1: Leadership and stakeholder buy-in and support***

Obtain senior-level buy-in and funding to develop the M&E plan. Stakeholder participation enables key actors in the M&E process to: advocate for the need for M&E; understand program goals and objectives; identify user needs and perspectives; learn about existing data collection systems and their quality; understand indicators that are being collected and used (or not used); and determine capacity for collecting and using data.

### ***Step 2: Establish the scope of the M&E plan and design an appropriate framework to guide the planning process***

First, determine your organization's objectives in the program area derived from key sector/development objectives. Then translate the problem statement, the program goals and the objectives into M&E frameworks. Review program documents with stated goals and objectives and ensure that key factors that may influence program implementation and success are identified. Finally, determine the specific elements to be monitored.

### ***Step 3: Assess the status of your organization's M&E system***

In particular, assess information system capabilities to address strategic information needs. These capabilities are assessed by determining methods by which data will be collected, analyzed and reported (e.g. DHIS2, surveys, sentinel surveillance systems, project information systems/records and new data collection). In addition, determine whether any special studies will be conducted and what design will be used (e.g. qualitative, quantitative or combination of both).

### ***Step 4: Develop indicators and data sources to track progress towards achieving set goals and objectives***

An efficient process for developing or reviewing indicators follows these steps: 1) Clarify the objectives or results and identify what needs to be measured; 2) Brainstorm on a list of possible indicators for your goals, objectives or results and where this information will come from (data sources); 3) Consider data collection in terms of the type of data and methods of data collection from the data sources. Then, assess each potential indicator from a technical perspective and select the most relevant indicators based on the assessment; 4) Determine whether baseline values for the indicators exist. Record these baseline values for the indicators (even if baseline values do not exist), and circulate these widely for information and review by all stakeholders. 5) Compile protocols for the project indicators and refine the indicators and protocols. Finalize the indicator selection and documentation.

### ***Step 5: Allocate responsibilities for the implementation of the M&E plan***

Key responsibilities for the implementation of the plan include: monitoring the routine data (who will collect, analyze and report data?); planning for special studies (who will oversee data collection, conduct analysis and reporting?); and identifying if anyone else is planning similar studies or evaluations

The organization's unit/department/office responsible for M&E will oversee the whole process of implementing an M&E system. The office or persons responsible will ensure that the M&E plan for the organization is implemented and coordinated. The specific roles of the M&E unit will generally include: consensus-building among all stakeholders; coordination between various program components and between other stakeholders (to avoid duplication of data collection efforts); developing a strategic plan for the collection of indicators collaboratively with partners involved at all levels; data management; reporting; and information dissemination and review.

### ***Step 6: Set clear performance targets acceptable to key stakeholders***

When setting targets it is important to focus on what can realistically be achieved given the resources and the program context, current baseline, past trends, emerging needs and gaps in services and capacity and logistics. Useful information for setting targets include past trends, expert opinions, research findings, what has been accomplished elsewhere, and client expectations. The following steps are taken in setting targets: focus on what the program should achieve; orient stakeholders to the task to be accomplished; motivate individuals; and monitor whether anticipated progress is being made.

### ***Step 7: Define a process for reporting and a data dissemination and utilization plan***

M&E planning is only worthwhile when the various categories of health data users have an interest in the data and are actually using it to inform planning and decisionmaking. It is important to consider and put in place clear measures to promote both demand and use of data for decisionmaking. Three critical dimensions must be taken into account:

- Define users of M&E findings
- Define feedback mechanism to meet user needs
  - Strategically-timed user meetings/workshops
  - Annual report and review meetings
  - Database to manage data and facilitate access and use (e.g. program information management system - PIMS, decision support system - DSS)
- Advocate for, communicate about, and build capacity for the new M&E system

## **Step 8: Planning for mid-term reviews of the M&E plan**

In most cases, an M&E plan is tied to an overarching program or organizational strategy or planning document. Reviews of the M&E plan could be occasioned by, among others, programmatic changes that can affect the M&E plan's performance monitoring and impact evaluation, internal M&E capacity adjustments, and a need for flexibility and regular review of program results.

An M&E plan is a living document and will always need to be adjusted when a program/strategy/plan is modified.

### **Assessing whether the M&E plan is working**

M&E managers need to assess whether the M&E plan is working to achieve its core objective of improving evidence-based decisionmaking in the health sector. The main question they must ask is: *Are M&E findings being disseminated and used by stakeholders for decisionmaking and program improvement?*

### **Expected results**

When components 4 and 5 are fully implemented, the following expected results can be realized:

- Documented participation of stakeholders in the development of an overarching M&E plan
- The indicators are derived and linked to the strategic/program objectives of the institution
- Sector-specific sub-national and organizational M&E plans are all linked to the national M&E plan
- The M&E plan describes specific steps to implementing all the 12 components of the M&E system
- The plan and its revisions are informed by findings from periodic M&E system assessments

#### **2.4.5 Component 6: Advocacy, Communication and Culture for M&E**

Inculcating a positive culture for M&E is an important step in establishing an enabling environment for an organization's M&E system. Advocacy and communication are critical tools in entrenching a culture of evidence-based planning and decisionmaking. Advocacy refers to a deliberate process intended to educate, sensitize, influence and change opinion. Advocacy can motivate action, for example, by creating and implementing a favourable health policy. It motivates the advocate to take the lead and do more than what would otherwise be required routinely. The advocate should have a sense of urgency and should challenge the status quo in promoting evidence-based decisionmaking in the health systems.

Communication is a process of exchanging information using various means or media. M&E requires effective communication to facilitate exchange of the critical information required for knowledge management and decisionmaking.

M&E has a clear purpose to help a program or organization be more successful, or to identify and resolve problems. To motivate someone to be positive about M&E and to support the M&E system, one needs to make M&E relevant and valuable to their jobs or team. If you can see M&E from their perspective, and explain how M&E could help them do their job better or achieve their goals, you are much more likely to convince them of its value.

Many organizations develop advocacy and communication strategies but often leave out the need to advocate and communicate the need for evidence-based decision making. A positive M&E culture can be created when advocacy and communication effort leads to a shared set of values, conventions, or social practices about M&E. In Kenya, the health information system has been seen more to serve compliance requirements than to fulfil the persistent need for quality evidence to inform day-to-day decisions in the management of the health system.

With the establishment of new structures for managing health care services under a devolved system of governance, a systematic plan is needed to entrench a positive M&E culture whereby M&E is accepted, welcomed, encouraged and valued by all players.

### **Communication channels for M&E advocacy and culture change**

There is no single communication channel that works best for any advocacy effort. Creating a positive culture for M&E will take time, diplomacy and effort. It requires a good understanding of people's behaviour patterns or the way they do things relating to M&E. M&E advocacy and communication are definitely not *one size fits all*. The main types of communication channels are:

- Personal communication: identifies, equips and supports an *M&E champion* (e.g., a high-level official who can promote M&E among his or her peers); conducts strategic meetings with different stakeholders (e.g. heads of all umbrella organizations); and arranges business breakfasts with key stakeholders and the media to help the media become M&E *literate* (training the media in M&E would help ensure that they are able to interpret and report on M&E results)
- Printed materials: information packs about the M&E system; brochures on the program monitoring system; key aspect reminders on summary postcards; and captivating fliers.
- Standard Power Point presentations: summarizes M&E system and provides standard presentation with notes so that persons involved in M&E can confidently speak and explain the program's M&E system to others
- Radio messages: radio messages could remind program implementers to submit their program monitoring forms in time

## **Leading advocacy and communications efforts**

In a typical organizational setting, M&E advocacy and communication is a management function. The Health Sector M&E Unit in the national Ministry of Health will lead sector-wide communication about the M&E system. Units or departments responsible for M&E, including the county health management teams, national health programs and other health sector institutions will oversee all communication and advocacy efforts regarding M&E. The appointed focal person for M&E in the organization should be knowledgeable about the subject of M&E and the critical advocacy issues that need to be addressed through a structured communication approach.

## **Target audiences for advocacy and communication and efforts**

The target audiences are determined by the messages to be conveyed to stakeholders in an organization and beyond. The target audiences are likely to include both internal and external stakeholders, such as:

- Internal target audiences for M&E advocacy and communications are the organizations' managers and the health workforce.
- External target audiences for M&E advocacy and communications are parliamentary/County Assembly Health Committee members, county governments (County Executive Committee and County Assembly Committees), civil society organizations; private sector organizations; academic and research institutions, and development and implementing partners or donors.

## **Steps to implement advocacy and communication for M&E**

### ***Step 1: Identify M&E capacity challenges that need to be addressed through advocacy and communication***

Identify the M&E capacity challenges that need to be addressed through advocacy and communication and prioritize them according those that will have the greatest impact and those that will have the smallest impact.

### ***Step 2: Segment target audiences***

Based on the challenges defined in Step 1, segment individuals and groups that need to be influenced in order to achieve the advocacy and communication objectives.

### ***Step 3: Form a team of advocates comprising organizations and individuals with specific M&E advocacy and communication roles and responsibilities***

### ***Step 4: Lead the team in advocacy and communication messaging by adopting key messages for each of the target audiences and the best strategies to reach them***

**Step 5: Select advocacy approaches and communication channels based on the understanding of key target audiences**

**Step 6: Design communication materials relevant to the information needs of each of the target audiences**

**Step 8: Develop an advocacy work plan and budget**

**Step 9: Mobilize resources and implement the advocacy work plan**

**Step 10: Organize the advocates to monitor, evaluate and report on the advocacy work**

### **When to conduct advocacy and communication for M&E**

Ideally, M&E advocacy and communication are continuous processes to be conducted at the organizational and individual levels. However, there are calendar activities in the health sector that are scheduled and can be used as opportunities for M&E advocacy and communication. These platforms include:

- The Annual Health Congress/Summit
- National Programmatic Conferences (for example, the National HIV and AIDS Conference, the National Malaria Forum etc.)
- County health stakeholders' forums
- Scientific conferences convened by different sectors and programs
- National M&E conference convened by the National AIDS & STI Control Programme (NASCOP)

In the health sector, specific forums for stakeholder engagement at the national and county levels could provide a fixed calendar for routine advocacy on matters related to M&E.

**Table 4: Sample of M&E messages for advocacy and communication**

<b>Sample M&amp;E messages for advocacy and communication</b>
a) Monitoring and evaluation is not a policing function - use specific examples that are relevant to your audience to reinforce this message
b) M&E helps programs to improve and achieve results by enabling sound and quality decisions
c) M&E systems create data and information that recognize and correct problems and encourage and reward success
d) 7-10% of program staff and funding should be dedicated to M&E
e) There are agencies/ministries/organization/units responsible for coordinating, monitoring and evaluating a program
f) Report information regularly to enable the coordinating agency to fulfil its role

- g) Parallel M&E and information systems weaken the quality of an M&E system to provide comprehensive information about health problems*
- h) With an M&E system in place, stakeholders should expect and demand progress reports*
- i) Address the identified capacity needs to be built for a monitoring and evaluation system to be successful*
- j) Funders (county, national and international) need the M&E system to demonstrate achievement of results*

### **Expected results from this component when it is fully implemented**

- Health managers, policymakers and stakeholders demonstrate knowledge and commitment to support the functioning of the M&E system
- M&E is entrenched as part of key organizational strategies, policies and planning documents
- M&E champions exist among policymakers and decisionmakers in the health system
- Targeted and structured advocacy activities are implemented according to the plan
- Resources from the organization's budget are allocated to implement key M&E activities
- Health managers, policymakers and other stakeholders show increased demand for and use of data
- Existence of parallel reporting and information systems and of double reporting are minimized

#### **2.4.6 Component 7: Routine Monitoring and Performance Reviews**

Routine monitoring is the continuous tracking and reporting of priority information about a program or project, its inputs and intended outputs, outcomes and impacts while performance review is the degree to which an intervention or organization operates according to specific criteria or standards or guidelines or achieves results in accordance with stated goals or plans.

In Kenya, planning and budgeting is guided by the Medium Term Expenditure Framework (MTEF), a three-year rolling revenue and expenditure budget plan for the government both at the national and the county levels. The concept of the “three year rolling” timeline consists of the following:

- The current budget year (X): the budget for the current financial year.
- The next budget year (X+1): the target period of the current budget process i.e. the year the current budget process is being prepared for.
- The following two outer years (X + 2) and (X+3): these are estimates of the likely expenditure to provide services beyond the next budget year.

Procedurally, determination of the health sector’s priorities for the next subsequent financial year (FY) (x+1) should be dependent on a systematic review of the previous year (x-1) performance/

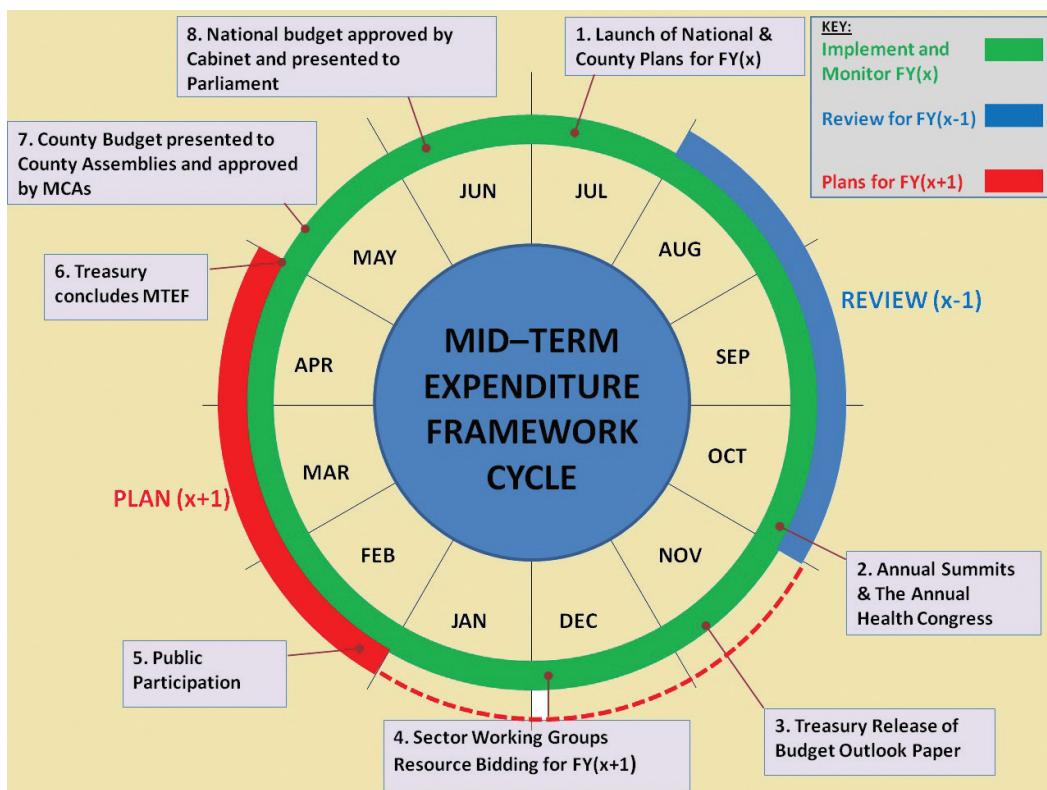
achievement. However, this cycle is always broken and does not conform to the MTEF cycle. The reviews aid programming of interventions, promote use of evidence to determine priority setting and enhance accountability in resource allocation.

Organizations seeking to influence the budget and planning cycles of the Ministry of Health will need to acquaint themselves with this critical calendar, but most importantly, preparation is needed in the following areas:

- Structured and convincing arguments to influence the logic for planning and budget allocation
- Adequate knowledge of the datelines for making input
- Critical voices needed to facilitate the performance review and planning

Figure 5 below demonstrates the linkages and key steps between the MTEF calendar, the performance review and the planning cycle.

**Figure 6: Health sector performance review, planning and implementation cycle**



#### Key milestones in the MTEF and performance review cycle

- i. The approved budgets for the current FY (X) for both national and county governments are launched in July of every financial year. The launch allows the start of the implementation of the activities of both governments through a work plan, as entrenched in the Constitution (no spending without a plan).

- ii. As the entities continue implementing year (X), a performance review process should be initiated from August of the same year (X). The review is for the year (X-1) and informs the year (X+1). The performance reviews is aimed at identifying achievements against the targets for year (X-1), factors that impact on the achievements and identify priorities, and interventions and projects for the year (X+1). This process should be steered by an already constituted M&E governance structure at both the national and county levels. At the county-level, performance reviews start with the lowest planning units at the subcounty level, including community units, health facilities and the subcounty health management teams.
- iii. In the month of September every year, counties, through their county departments of health, consolidate the subcounties' reports into county- specific health review reports; this should be followed by a mini summit for stakeholders at the county level to agree on the priorities.
- iv. In the month of October every year, a consolidation of performance review reports from planning entities at the national and county levels is done to form an annual health sector performance review report. This activity should be steered by the M&E unit at the national level and should precede the Annual Health Congress or Annual Health Summit in November. To ensure completeness of the report, continuous engagement with stakeholders is required until the final report is signed off.
- v. The Annual Health Sector Summit is held in November every year. The summit draws members from different stakeholders and is purposely meant to authenticate the review report plus the priorities identified for the year (X+1). Financing schemes of the already agreed priorities for the year (X+1) are discussed and gaps are identified. The process ties well with the release of the budget outlook papers for year (X+1) and allows sectors to fit the priorities as per the ceiling. At all levels that is, national and county summit forum, communiqués on the commitments should be drafted and signed by all stakeholders.
- vi. Sectors (planning entities) should request development partners to consider funding programs that are a priority but which are not funded by the national treasury.

### **Criteria for program and activities prioritization**

Determination and selection of the key programs, projects and activities at all levels should adhere to the principles of equity, social accountability, efficiency, participation, people-centeredness and should further be guided by the following:

- Linkage of the program with objectives of Vision 2030 and MTPs
- Linkage to government flagship projects and interventions
- Degree to which the program addresses core poverty interventions

- Degree to which the program addresses the core mandate and expected outputs and outcomes of the program
- Linkage of the program with other programs
- Cost-effectiveness and sustainability of the program
- Response to the requirements and furtherance of the implementation of the Constitution
- Emerging and re-emerging health issues (e.g. disaster management, disease surveillance, outbreak investigations)
- Continuity of the already ongoing projects and programs

The programs identified should follow the program-based budgeting (PBB) approach adopted by the Kenyan government since FY 2014/15 with clear program goals, objectives, outcomes, outputs, and inputs comprehensively costed.

### **Public participation for health sector accountability**

The Constitution of Kenya under article 196 underscores facilitation of public participation in all processes to ensure accountability. Table 3 discusses the roles and responsibilities of different players under the MTEF and performance review processes.

**Table 5: Role-sharing within the health sector's accountability cycle**

<b>Stakeholder category</b>	<b>Role in the health sector accountability cycle</b>
National Ministry of Health and County Department of Health	<ul style="list-style-type: none"> <li>✓ Establish effective internal controls to limit misuse of resources</li> <li>✓ Build a strong M&amp;E system to enable the tracking of performance, finances and impact of allocations to health</li> <li>✓ Conduct timely production of health sector reviews and reports</li> <li>✓ Develop popular versions of key documents to make them useful for the “common” citizen</li> </ul>
Community-based organizations	<ul style="list-style-type: none"> <li>✓ Organize social accountability initiatives through citizens' reports, score cards, citizens' budget initiatives, citizens' charters, social audits etc.</li> </ul>
Political parties	<ul style="list-style-type: none"> <li>✓ Articulate a medium-term vision for health through manifestoes</li> <li>✓ Represent citizens' views/feedback on quality of health services</li> </ul>
Faith-based organizations	<ul style="list-style-type: none"> <li>✓ Establish a transparent roadmap for collaboration with the government</li> <li>✓ Implement health programs, including those involving corporate social responsibility</li> </ul>

NGOs /CSOs	<ul style="list-style-type: none"> <li>✓ Build capacities at all levels to strengthen accountability</li> <li>✓ Provide resources to facilitate citizen action to hold health leaders to account</li> </ul>
Development partners	<ul style="list-style-type: none"> <li>✓ Provide resources within the framework of mutual accountability under the Paris Declaration</li> <li>✓ Provide opportunities for cross-country learning</li> </ul>
Private sector bodies	<ul style="list-style-type: none"> <li>✓ Finance and implement health programs, including those involving corporate social responsibility</li> </ul>

### Mending the broken accountability cycle

Even though performance reviews have been part and parcel of the health sector's annual milestones, reviews have been done far off their schedules, and have not formed the basis for health sector budgeting. As a result, policymakers have found it hard to lobby for additional resources to fund health services.

Lack of evidence to inform budgeting and planning can only be addressed when the cycle of planning, implementation and reviews is implemented within the MTEF time frames. In order to address this situation, the following actions need to be prioritized:

- Develop and disseminate an annual health sector accountability calendar and tools for stakeholders
- Strengthen the capacity of the MoH's M&E Unit to oversee health sector accountability and county-level M&E capacity development
- Disseminate the Guidelines for the Institutionalization of Monitoring and Evaluation in the Health Sector, stipulating calendar, roles, indicators and products
- Strengthen collaboration with non-state health leaders to build culture of citizen participation in health sector management
- Strengthen social accountability by providing space for citizens to participate in health planning, budgeting and decisionmaking processes
- Strengthen links between health sector performance reviews and the annual performance contracting processes

### Resource mobilization for the M&E function

Critical M&E activities in the health sector are spelt out in strategic documents, such as the Kenya Health Sector Strategic Plan and annual work plan documents developed by various health units, facilities and health programs. At the county level, the county health sector strategies and programs articulate the scope for M&E. Both national and county governments are expected to develop M&E plans to enable them to implement the overarching M&E mandates.

However, there has been limited resource allocation by both levels of government to implement these activities. Instead these activities have been left to rely on unpredictable, intermittent and limited funding by development partners. As a result, most of the activities fall behind schedule or are completed when they cannot inform the next level of planning and decisionmaking. In most cases these activities are not done at all. Without a dedicated unit to coordinative M&E activities and funding set aside to implement them, M&E cannot fulfil the key expectations of the health system.

Typical activities that a health organization must plan and budget for to implement the M&E system include: remuneration for M&E officers and consultants; development of data collection and reporting tools; procurement of infrastructure for data collection (computers, PDMA devices etc.) and processing, including appropriate software; providing operational data support supervision and mentorship; budgeting for costs for meetings and forums, such as data review meetings, performance review meetings, and M&E TWG meetings; conducting research and evaluations; and budgeting for costs of information products, such as county health profiles, dashboards, bulletins etc.

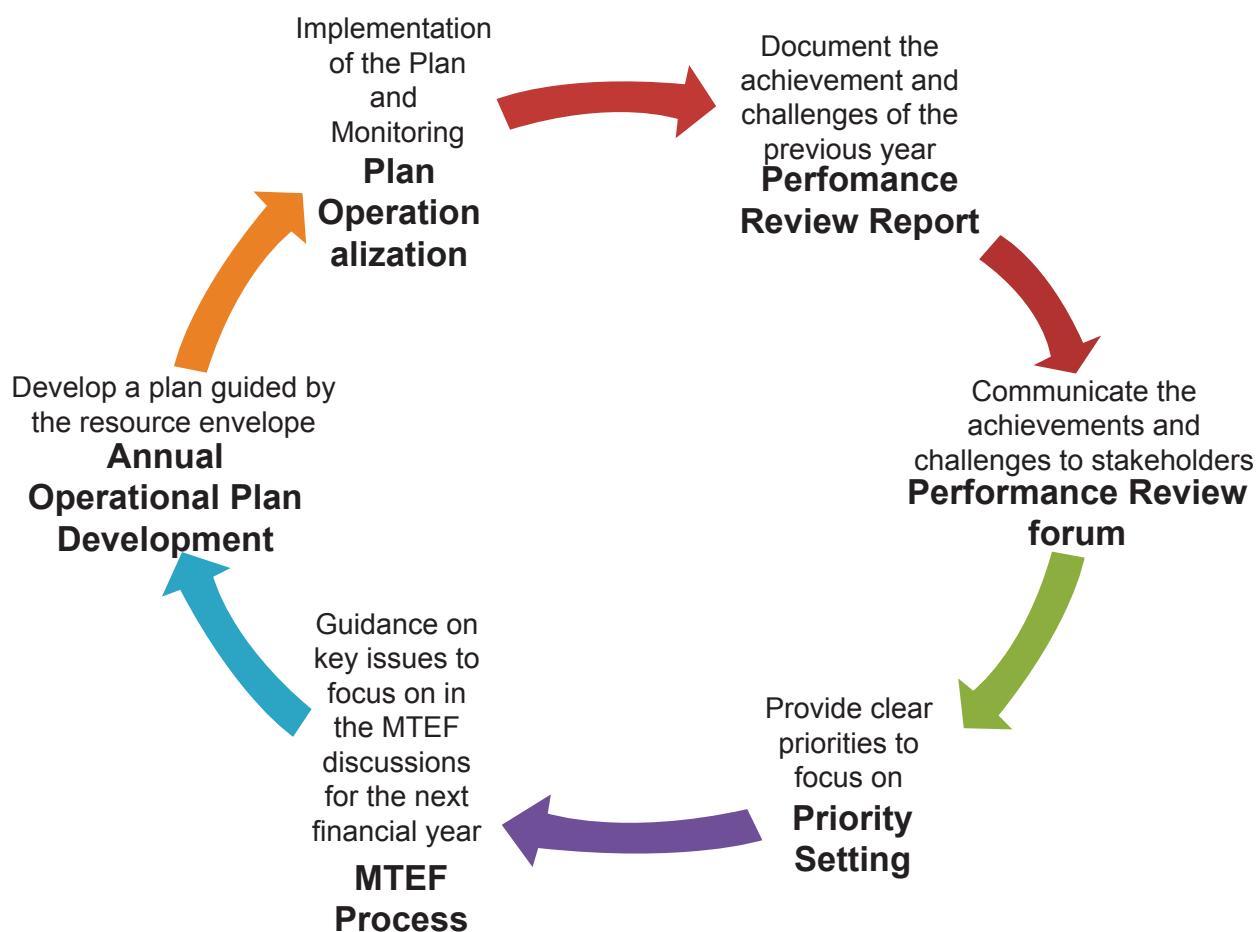
The ownership and sustainability of an M&E system is achieved when senior-level buy-in and advocacy for the M&E plan is supported, which leads to greater allocation of resources for key M&E activities. The recommendation is that at least 5% of the health budget be allocated to support M&E activities at all entities or levels.

In order to ensure regular budget allocation to guarantee M&E activities, the following interventions are proposed:

- Dedicated budget lines for M&E in the annual budget estimates of the ministry, department or program
- Formal engagement of the planning institution in the process of planning for the M&E unit. In particular, ensure that there are formal commitments followed up by official letters after the plan is completed
- Use the platform of the M&E technical working groups to advocate for more resources for M&E activities
- As a rule of thumb, ensure that at least 5% of the approved budget is dedicated to implementing core M&E activities
- Ensure that plans are completed at least two months prior to commencement of implementation to allow time for resource mobilization to support core M&E activities
- Ensure that annual and periodic health stakeholder forums are used as platforms for mobilizing support for subsequent activities, which should be costed and presented as clear financing gaps

- The process of planning, review and reporting is presented in a cyclical diagram as summarized and shown in Figure 7. It entails developing a plan guided by the resource envelope and priorities from the review (annual work plan development) followed by implementation of the plan and monitoring (plan operationalization). Achievements and challenges of the previous year are documented through the performance review report, which is then communicated through performance review forums; this forms a basis for focusing on clear priorities and key issues in the MTEF discussions for the next financial year.

**Figure 7: Cyclical process of reporting, review and planning**



#### 2.4.7 Component 8: Periodic Surveys and Surveillance

This section describes surveys and surveillance that provide additional data to the M&E system besides those available from routine systems and research. Surveys are time-consuming and expensive; as such most surveys are conducted every 3-5 years. Surveys are conducted to answer key program-oriented questions, to inform planning, policies and guidelines, and to develop standard operating procedures (SOPs).

## **Surveys**

A survey is a method of collecting data from respondents — who can either be a selected sample of the population or targeted organizations (or facilities). It may involve gathering information either at a point in time (cross-sectional survey) or tracking a group of people over a period of time (longitudinal survey or panel data). Information gathered through surveys can include factual information, levels of knowledge, attitudes, personality types, beliefs and preferences. For many national-level surveys, standard protocols have been developed to ensure that the survey gets conducted in the same way every time. This enables trend analysis and comparisons over time. At both levels of the government, different surveys that should be planned for to inform planning and policy directions include, but are not limited, to the surveys indicated in Table 6.

**Table 6: Surveys and assessments**

S/No	Surveys	Period	Type	Nature of survey
1	Kenya Demographic and Health Surveys (KDHS)	5 Years	Population-based	Sample
2	Kenya Malaria Indicator Surveys (MIS)	5 Years	Population-based	Sample
3	Kenya Aids Indicator Surveys (KAIS)	5 Years	Population-based	Sample
4	National Health Accounts (NHA)	5 Years	Population-based	Sample
5	County Health Account (CHA)	5 Years	Population-based	Sample
6	Kenya Household Expenditure and Utilization Survey (KHEUS)	5 Years	Population-based	Sample
7	Service Availability Readiness Assessment and Mapping (SARAM)	5 Years	Facility-based	Census
8	Kenya Service Provision Assessment (KSPA)	5 Years	Facility-based	Sample
9	Client Satisfaction Survey	2 Years	Institution-based	Sample

## **Surveillance**

Surveillance can be biological or behavioral. Biological surveillance involves collecting specific biological data through repeated cross-sectional surveys in a representative population. Behavioral surveillance is repeating cross-sectional surveys of behavior in a representative population. Surveillance is often used to collect information about the prevalence of a specific disease among populations being surveyed, either populations that are more or less representative of the population or specific populations at high risk of the disease. Surveillance should be done to guide immediate action, to describe and monitor health events, to prioritize resources, to plan, implement and evaluate programs, and to evaluate public policy and direction for research. The following are examples of surveillance in Kenya:

- Sentinel surveillance
- Demographic surveillance systems

- Drug resistance surveillance
- Behavioral surveillance
- Disease-specific surveillance

Before any surveys and surveillance are conducted, a technical working group should be formed to guide the entire process. The members of the TWG will be multidisciplinary, comprising state and non-state actors. A survey or surveillance protocol should be developed. Where applicable, ethical approval or non-research determination should be obtained from authorized institutions such as Kenya Medical Research Institute (KEMRI), Kenyatta national hospital, AMREF and the National Commission for Science, Technology and Innovation (NACOSTI), among others. Relevant global, national or county indicators should be considered in all surveys and surveillance. The results of every study should be published and disseminated to potential users as per the different target audiences.

#### **2.4.8 Component 9: Unified database for the M&E System**

A database is a systematically organized or structured repository of indexed information (usually as a group of linked data files) that allows easy retrieval, updating, analysis and output of data stored in a computer. It could be in the form of graphics, reports, scripts or tables and could represent almost every kind of information.

The establishment of a unified national database makes it easier to generate information needed for planning and decisionmaking. Several databases exist in the health sector, unfortunately, they often operate in silos and eventually result in inefficiency, duplication of efforts and wastage of finances. Ideally, data sources in the health sector are supposed to be synchronized to inform the health sector on performance trends. A unified national database enhances information sharing and helps to stop the creation of parallel systems.

#### **Establishing a unified health sector database**

Setting up a unified health sector database that will receive information from different sub-systems is important for a functional M&E system. This allows ease of doing business and reduces the turnaround time in reporting the indicators that are being monitored in the sector.

Kenya has adopted DHIS2 as the main reporting system at the national and county level. DHIS2 is a web-based system that uses open source software that allows data to be keyed in at the facility level or at the subcounty level to produce information products that can be shared by all the actors in the health sector. Sub-systems that are expected to feed DHIS2 are EMRs, iHRIS, LMIS, integrated financial management information system (IFMIS), KEMSA and Kenya Master Health Facility List (KMHFL).

A successful database system within the M&E system should ensure that the following are adhered to and made available:

- Effective infrastructure (computers, internet facilities, etc.)
- Training of personnel/staff and end-users of the system
- Integrity and security features of the system through administrator-controlled features
- Review of indicators to conform to the demand of stakeholders and emerging issues
- Information sharing as envisaged in the Constitution of Kenya

### **Enhanced sharing of data and statistics**

Establishing common data architecture as a platform for data sharing is a necessity for the M&E system. Common data architecture ensures that information is generated and managed in a coordinated manner, i.e. that data has standard nomenclature (naming conventions) and coding systems across all databases. This includes use of defined standards for exchange of patient information and aggregate-level data across different information systems.

Data architecture comprises models, policies, rules or standards and operating procedures governing the type of data to be collected, and how it is stored, arranged, integrated, and put to use in data systems and in organizations. The construction of common data architecture is based on existing policies, strategies, rules and regulations governing the health sector. Similarly, mechanisms for developing common data architecture, enhancing data sharing and use of information and performance monitoring review are required within health care system.

Common data architecture is, therefore, a critical pillar of any M&E system. With common data architecture, organizations have solid criteria for processing data operations and making possible a good data flow design in the system. This common data architecture serves as a repository for health information and should, to greatest extent, be compatible with other data sources, such as routine reporting, research, population surveys, among others. Data platforms should include data tools, e-platforms including DHIS2, KMHFL, IFMIS, iHRIS, LMIS, Integrated Population Registration System (IPRS).

### **Why a common data repository**

The benefits of having common data architecture in an organization are:

- It provides a unified platform for a comprehensive health information system
- It provides a platform for sharing data and a metadata repository to orchestrate data management
- It simplifies and standardizes data exchange with internal and external stakeholders
- It delivers consistent and accurate data across the health care delivery system

- It achieves ministry-wide objectives related to better data exchange standards and policies
- It strengthens health sector data exchange relationships with other government agencies
- It improves archiving and data security
- It enables data analysis and interpretation
- It ensures backup

**The requirements of establishing common data architecture include:**

- Data requirements (reports, persistent queries and data warehousing)
- Organizational requirements (data that is fully integrated and seamlessly accessible to people operating in the organization)
- Technology requirements (acquiring appropriate hardware and software to implement the architecture once the whole system is in place)
- Common tools and data sets (availability of standardized tools for reporting)
- Common indicators (agreed indicators, subject to review)
- Common reporting and feedback mechanisms

**Data governance**

Data governance refers to the overall management of the availability, usability, integrity and security of the data used in an institution. Proactive data governance is necessary to ensure confidentiality, integrity, accessibility, availability, and quality assurance. Establishing data governance is the responsibility of the institutions/entities defining the organization's vision, policies, and practices, gaining support of the stakeholders, implementing the program, and monitoring success. By clearly outlining policies, standard procedures, responsibilities, and controls surrounding activities, a data governance program helps to ensure that information is collected, maintained, used, and disseminated while protecting the individuals' rights to privacy, confidentiality, and security, and producing timely and accurate statistics for decisionmaking.

**Table 7: Attributes of data governance**

Elements	Definition
<b>Data quality</b>	Identifying strategies for preventing, detecting and correcting errors and misuse of data is essential to maintaining high quality data. A proactive approach to data governance requires establishing data quality standards, and regular monitoring and updating of data management strategies to ensure that the data are accurate, relevant, timely, and complete for the purposes of decisionmaking.

Elements	Definition
<b>Data security and risk management</b>	Ensuring security of sensitive data (i.e. data that carry the risk of harm from an unauthorized or inadvertent disclosure) and personally identifiable information. Minimizing the risk of unauthorized disclosure is a priority for an effective data governance program. Therefore, there must be a data security plan for the institution.
<b>Policy and standards</b>	To help ensure that the data governance program addresses organizational needs, it is necessary to clearly specify the “rules of engagement,” or policies and standards that guide the data governance program’s implementation. These include vision and goals of the organization regarding data standards, data management processes, decisionmaking jurisdiction, responsibilities, enforcement and controls. The data governance approach should be consistent with the organization’s overall mission and stakeholders’ expectations.
<b>Communication and awareness</b>	Increasing access to data among all members of the organization, external stakeholders, members of the community, and especially patients, is a critical function of the data governance program.
<b>Compliance</b>	Processes aiming to operationalize and ensure that data governance policies, organizational rules, stewardship processes, workflows, and cross-functional roles and responsibilities are adhered to.
<b>Technology and infrastructure</b>	Necessitating requisite operational application systems supporting data governance processes. This should include infrastructure, equipment, machines and capacity required for the smooth operation of the organization.

**Figure 8: Attributes of data governance**



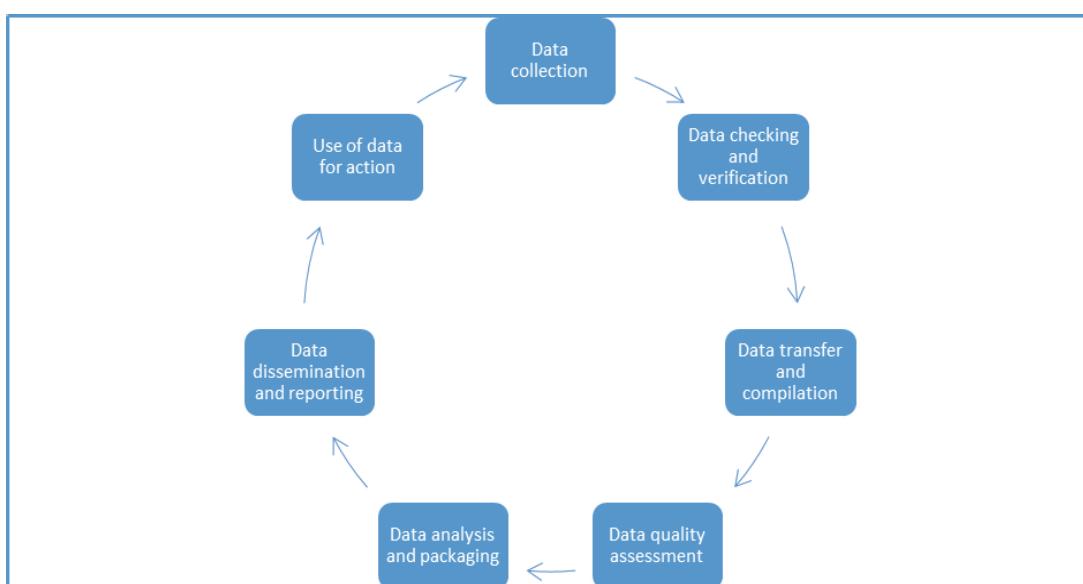
## 2.4.9 Component 10: Data Auditing and Support Supervision

### Data management

Effective data management improves the performance of an organization's health care systems. Collecting, analyzing, interpreting, storing, disseminating and providing feedback on specific performance indicators allows health care professionals to monitor steps taken towards universal healthcare and identify the shortfalls, areas of adjustment, and track outcomes of the systems.

Data for communication and sharing should be presented in formats that help users to understand the key issues. Providing summaries of the data, interpreting key findings and presenting complex information in simple charts and maps will greatly assist users. The cyclical process of transforming raw data into knowledge that can be used to support health and development decisionmaking is presented in Figure 9.

**Figure 9: Cycle of data collection, management, analysis, dissemination and use**



### Data quality checks

It is imperative for data to be checked before it is analyzed and disseminated for further use. Poor data normally leads to poor information and eventually leads to misleading information (garbage in garbage out). Any generated data should be checked based on the following parameters:

- Check for any potential source of bias that should be described or reported in the dataset e.g. missing values.
- Check for under-reporting, misreporting or mismatch in the coding of data.

- Review and understand the source of errors and biases, and adjust and reconcile under-reporting of data from different sources.
- Ensure simplicity in presentation; many reports are full of detailed tables and statistics that are difficult to interpret (remove redundant facts).
- Do a data cleaning and plausibility check for potential outliers to ensure data quality assurance.
- Check for possible duplication of variables in the datasets.

## **Data quality audit**

Undertaking data quality assessment should not be viewed as a fault-finding exercise designed to identify errors and apportion blame. Instead, the purpose should be to engage with planning and reporting units and the producers and users of data at all levels in order to identify weaknesses in the data and to correct problems.

An assessment of micro data quality can start with the information recorded at the health-facility level and aggregated up through the reporting chain. Although this can provide important information, it does not cover two important sources of error: unrecorded occurrences and erroneously recorded occurrences. Some, but not all, of these errors can be detected by studying the data. Gaining an understanding of what is happening in the process of service delivery and documentation of occurrences is an important aspect of studying data quality. To achieve this, it will be necessary to talk to those who deliver services and produce reports at the health facility level.

As ongoing efforts are needed to ensure data quality, the regular assessment of data quality should be an integral activity of health information and statistical systems. It is almost impossible for data to continuously meet demands. Therefore, periodic audits need to be institutionalized and conducted on a quarterly basis.

The sample frame to be used in data quality assessment should meet the following criteria:

- Assurances of integrity
- Methodological soundness
- Accuracy and reliability
- Serviceability
- Accessibility

## **Characteristics of good quality data**

Credible information is useful for an organization for evidence-based decisions. Data quality aspects should adhere to the following principles:

- **Timeliness** – data are up-to-date/current and available on time e.g. data are entered into the system as soon as they are received by a designated reporting officer.
- **Accuracy** – the data measure what they are intended to measure e.g. an absolute CD4 count of 156 is the actual CD4 count of the patient
- **Reliability** – the data collected, stored, and reported by the HIS are based on protocols and procedures that do not change according to who is using them and when or how often they are used e.g. all age group cut-offs are the same on all forms and reports
- **Data granularity** – data are in the correct and appropriate level of detail e.g. 100 is the value 99.6 or 100.4
- **Precision** – the data has sufficient detail e.g. data on age group (i.e. 0-11 months, 1-5 years, 6-14 years, 15-34 years) is less precise than the individual's actual age (i.e. 11 months, 1 year, 18 years, 62 years, etc.)
- **Completeness** – the information system from which the results are derived is appropriately inclusive
- **Confidentiality** – personal data is not disclosed inappropriately and data in hard copy or electronic form are treated with appropriate levels of security
- **Integrity** – data is protected from deliberate bias or manipulation for political or personal reasons e.g. intentionally entering 100 cases of measles instead of 1 case in DHIS2
- **Validity** – findings should truly represent the phenomenon you are claiming to measure
- **Conformity** – are there expectations that data values conform to specified formats? If so, do all the values conform to those formats? Maintaining conformance to specific formats is important in data representation, presentation, aggregate reporting, searches, and establishing key relationships;
- **Consistency** – the data value is reliable and the same across applications; the values presented (e.g. population estimates) must be trusted and well-documented
- **Data currency** – data are up-to-date; availability of current data impacts the analysis of data e.g. ICD-9 is needed but ICD-10 is currently available
- **Accessibility** – the extent to which data is available or easily and quickly retrieved
- **Security** the extent to which access to data is appropriately restricted to maintain security

## **Data analysis**

Data analysis is a process of inspecting, cleaning, transforming, and modelling data with the goal of discovering useful information, suggesting conclusions, and supporting decisionmaking.

### **Key actions for improving data management and quality**

- Establish a data archive for the long-term safeguarding of records.
- Compile and tabulate micro data according to established international standards.
- Regularly assess both micro data and aggregated data for quality and reliability by conducting assessments of coverage, completeness, accuracy, consistency and plausibility.
- Be transparent with users about the limitations of the data, for example, by making such limitations explicit in statistical reporting.
- Establish mechanisms for data sharing, such as a data repository that is regularly backed up.
- Develop a code of practice to ensure that standards of confidentiality are maintained without impeding data dissemination.
- Make data more accessible to users by providing analytical summaries that present data using simple charts and maps.
- Introduce information and communication technologies to improve data visualization and accessibility.
- Build skills and capacities by training individuals in data analysis and presentation. Draw upon expertise in academic and research institutions to support the enhanced analysis of available data and to promote broader understanding of analytical techniques.
- Promote a culture of evidence-based decisionmaking by increasing collaboration between data producers and users, and encouraging improved mutual understanding.

## **Support supervision**

The Constitution of Kenya establishes monitoring and evaluation through support supervision of service delivery as an important component of operationalizing activities to ensure transparency, integrity, access to information and accountability to the citizens. In the spirit of mutual engagement between the two levels of government, joint support supervision will be conducted between the national and county government. Similarly, the same will be cascaded within county facilities by county health managers.

Support supervision of services provide an opportunity to both national and county governments to take stock of the gains made during the process, as well as identify any gaps that may exist and which may potentially hinder smooth running of services, and hence compromise quality of services provided to Kenyans.

## **Benefits of supportive supervision**

Some of the benefits of support supervision include:

- It produces information that could be used to improve health facilities' performance across the country.
- It facilitates quality improvement by involving service providers in identifying and resolving problems through mentoring and joint problem solving.
- It assist service providers in interpretation and internalization of the reform agenda, with a view to channelling resources to key reform areas.
- It provides information on quality aspects of health care services in public health facilities.
- It enhances clinical, nursing, administrative, leadership professional skills, knowledge and attitudes in order to provide quality healthcare.
- It aids in professional growth and development and improves clinical outcomes.
- It provides mentorship to hospital managers on the implementation of health reforms in line with performance contracts, annual work plans, strategic plans and Vision 2030.
- It informs policy decisions by the Ministry.

## **Steps to conduct support supervision**

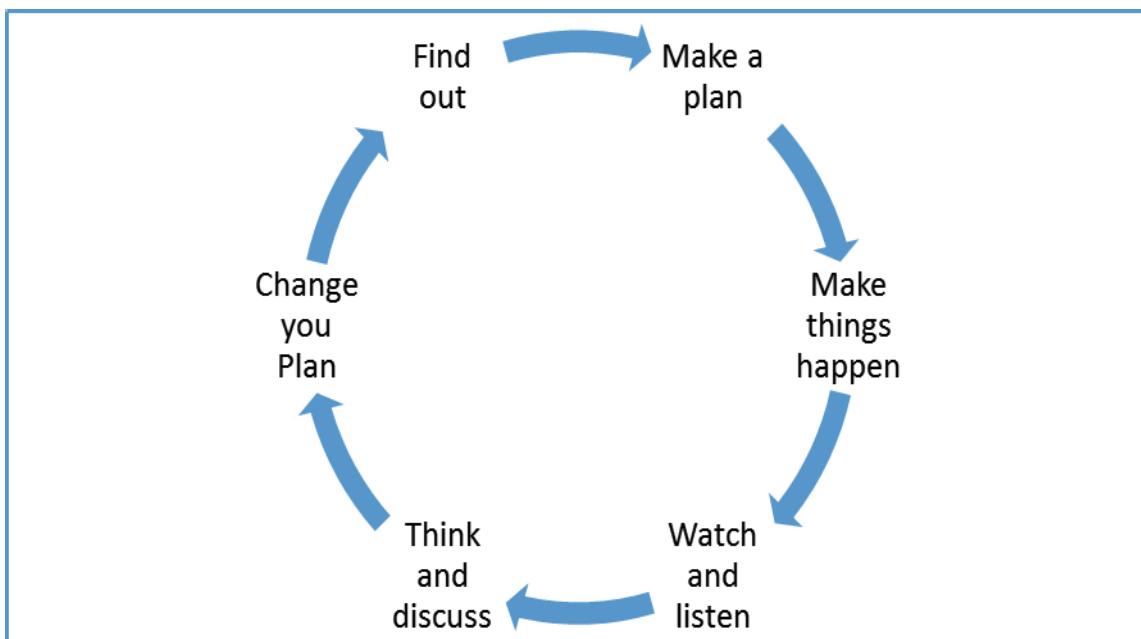
The key steps that should guide the process of conducting support supervision are:

- Identify the key areas to be supervised, either at the hospital or in lower level facilities.
- Design or review the supervisory tool(s).
- Adopt the supervision tool.
- Identify (sampling) the facilities to be visited.
- Decide on the budget for the activity.
- Identify researchers/supervisors.
- Train researchers/supervisors.
- Conduct the supervision in the selected facilities.
- Analyze the data.
- Present the preliminary findings to stakeholders.
- Factor inputs from stakeholders into the report.
- Finalize, print and disseminate the report.

#### 2.4.10 Component 11: Research and Evaluation

**Research** is a systematic investigation designed to develop or contribute to generalized knowledge. It includes developing, testing, and evaluating the research. A broader way of thinking about M&E is Action Research. Action Research is a term for a variety of methodologies that at their core are cycles of planning, action and reflection. This is a useful approach when thinking about how to integrate your M&E into ongoing plans and activities. There are many Action Research methodologies which could be used as part of M&E. A schematic way of thinking about research in an M&E system is shown in Figure 10.

**Figure 10: Institutionalizing research in M&E systems**



Research activities are streamlined within the M&E system by setting up a TWG or designating a small committee from the already constituted M&E governance structure. The membership of this group should be able to either contribute to peer analysis or bring user perspectives to the work of the organization. In particular, the TWG/committee should oversee/undertake the following:

- Prepare an annual research plan that identifies research priorities based on the national situation and information needs.
- Provide an in-depth analysis of surveys and census data.
- Prepare an analysis of the implementation of recommendations of key reports.
- Build capacities for the conducting of the research, particularly among implementing units.
- Set up a research observatory/inventory of completed and ongoing country-specific evaluation and research studies.

- Arrange for a national conference or forum for dissemination and discussion of the research and/or evaluation study.

## Membership

The membership of this group should be drawn from renowned organizations or bodies that include, but not limited to, the following:

- KEMRI
- Research and training institutions
- Health programs
- Kenya Institute of Public Policy Research and Analysis (KIPPRA)
- Kenya National Bureau of Statistics (KNBS)
- Community-based organizations
- Civil society organizations
- Health institutions
- The M&E unit in the organization that plays the role of the secretariat.

**Evaluation** is the periodic, retrospective assessment of an organization, project or program that might be conducted internally or by external independent evaluators. There are several types of evaluation that are categorized by stages of the project cycle and by subject. Each agency has its own evaluation system in which the types and the timing of evaluations to be conducted are stipulated. Evaluation can be classified into four types: ex-ante evaluation; mid-term evaluation; terminal evaluation; and ex-post evaluation (Table 8). The institution/organization must decide which type of evaluation to undertake.

**Table 8: Evaluation types by stages of the project cycle**

Evaluation Type	Timing	Purpose
Ex-ante	Before the commencement of an intervention	To determine the necessity and conformity of an intervention To clarify the details of an intervention and to establish indicators
Mid-term evaluation	At the mid-point of implementation	To examine the progress of an intervention To revise the original plan and/or operational structure
Terminal evaluation	Upon completion of the intervention	To review an intervention by focusing on its efficiency, effectiveness and sustainability and determine if follow-up is necessary or not
Ex-post evaluation	After completion of an intervention	To review an intervention by focusing on its impact and sustainability To obtain lessons and recommendations for improving interventions

## Types of evaluation

Evaluation is also classified by subject, such as project level, program level, sector level, thematic level, country program level, and policy level. The definitions of the major evaluation types by subject are summarized below.

**Table 9: Evaluation by type**

Type	Definitions
Project-level evaluation	Evaluation of an individual development intervention designed to achieve specific objectives within specified resources and implementation schedule
Program-level evaluation	Evaluation of a set of interventions, which usually cover a number of related projects or activities in one country, and which seek to attain specific development objectives
Sector program evaluation	Evaluation of a single sector or sub-sector, such as health, education, primary education, etc.
Thematic evaluation	Evaluation of selected aspects, such as gender or the environment, of various development interventions, or evaluating a range of sector program in different countries
Policy-level evaluation	Evaluation of a country's development policy or sector development policy

## Methods of conducting an evaluation

A variety of evaluation methods and approaches are introduced below. Some of the tools and approaches are complementary and can be combined while some of them are substitutes. The choice of appropriate methods or tools in any given context will depend on a range of considerations, such as the intended use of M&E results, the main audience for the findings, how quickly the information is needed, and the funds available for M&E. The institution can then choose from the following methods:

- **Logical framework approach:** The Logical Framework clarifies the objectives of any project, program or policy, as well as the causal links among inputs, processes, outputs, outcomes and impact. It also helps identify indicators at each stage with which the performance and achievements are measured.
- **Rapid appraisal methods:** Rapid appraisal methods are quick, low-cost ways of gathering the views and feedback of beneficiaries and other stakeholders to respond to decisionmakers' needs for information.
- **Participatory evaluation:** Participatory evaluation is an evaluation method in which representatives of project implementing agencies and other stakeholders work together in designing, carrying out and interpreting an evaluation.

- **Cost-benefit and cost-effectiveness analysis:** Cost-benefit and cost-effectiveness analysis are tools for assessing whether or not the costs of any activity can be justified by the outcomes and impact. Cost-benefit analysis measures both inputs and outputs in monetary terms. Cost-effectiveness analysis estimates inputs in monetary terms and outcomes in non-monetary quantitative terms (such as improvements in health indicators).
- **Impact evaluation:** Impact evaluation is a systematic identification of the effects of a development activity on individual households, institutions and the environment. Impact evaluations can range from large-scale sample surveys in which project populations and control groups are compared before and after the activity, and possibly at several points during the intervention, to small-scale rapid assessments and participatory appraisals where estimates of the impact are obtained through interviews, case studies and available secondary data.
- **Meta-evaluation;** Meta-evaluation is a type of evaluation designed to aggregate findings from a series of evaluations. Meta-evaluation can be used to denote the evaluation of an evaluation to judge its quality and/or assess the performance of the evaluators.

#### **2.4.11 Component 12: Data Demand and Information Use (DDIU)**

Quality data is fundamental to health systems. A data demand and use strategy begins with an assessment that helps stakeholders, policymakers, and M&E practitioners to identify where interventions are needed to increase demand and use. Once we have identified specific needs, we employ core tools to stimulate data demand, to build capacity to use data, and thereby to enhance data-informed decisions in the health sector. Health data and information lack value unless they are used to inform decisions. As such, interventions that increase local demand for information and promote/facilitate its use are critical to improving the effectiveness and sustainability of the health system.

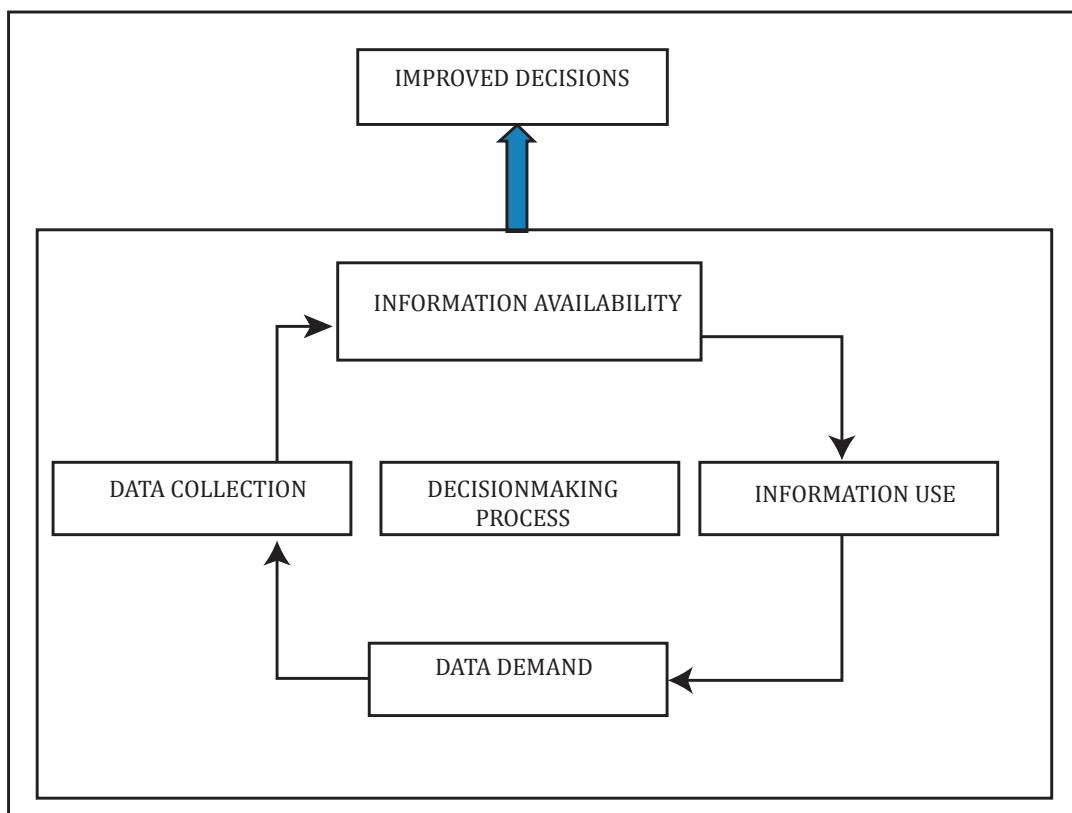
The concepts presented here are based on the assumption that fostering *evidence-based decisionmaking* is the primary function of national and subcounty M&E systems and is vital to the effectiveness of the health system as a whole. Evidence-based decisionmaking promotes transparency in the decisionmaking process and allows for accountability of health decisionmakers. When publicly available data and information are used for decisions, all stakeholders can question the basis for such decisions and challenge public officials to defend their decisions. Similarly, better availability and use of information also permits improved accountability by allowing stakeholders and potential beneficiaries to monitor the outcomes of decisions. In this regard, the value of DDIU extends far beyond the health sector and, at its most fundamental level, is fully consistent with the aims and objectives of many public sector reform programs, and with the guiding principles of improved democratic governance.

## Conceptual framework for evidence-based decisionmaking

Evidence-based decisionmaking is enhanced by a sound demand for health information, by the collection and analysis of health data, by making information available to decisionmakers, and finally, by facilitating the use of information to improve the health system's performance.

Figure 11 presents a framework for DDIU as a cycle that connects demand to use through the intermediate steps of data collection and analysis and by ensuring the availability of health information. In this framework a clear and consistent link exists between the use of health information and the commitment to improve the quality of data upon which it is based. The more positive experiences a decisionmaker has in using information to support a decision, the stronger will be the commitment to implementation and to accountability of the decisions made.

**Figure 11: Data demand and information use framework**



## Determinants of data demand and use

### 1. Technical determinants

A system without a sound technical design, well-trained people, and clear norms and standards cannot produce the information needed for making decisions. Consequently, the path to improving the use of health information should focus on: upgrading technical skills; changing the design of the data flow; revamping the technology used to improve the availability and quality of data; and ensuring that information is based on technically sound data that is understood by potential users.

## Determinants at the system and individual levels

The wider environment in which health system decisions are made includes institutions and stakeholders that influence data users, as well as data collectors. The following areas need to be considered to ensure the efficient and timely flow of data and information: structural constraints, such as poor roads; telecommunications capacity; quantities of appropriate human resources; and internal organization and culture of the health system.

## Behavioral determinants

Health data are collected and used by people who play professional and individual roles in the health system. Although building the capacity of these people is at the centre of data and information use strengthening, behavioral aspects of capacity are often the most difficult to identify and confront in a meaningful way. Behavioral influences on data demand and use often involve intangible concepts, such as motivation, attitudes, the values related to health information that people hold, job performance, responsibilities, and hierarchy. Influencing many of these behavioral factors will require interventions that go beyond simple training in improving knowledge and skills in understanding data and using information.

## Evidence-based decisionmaking and policy and program decision stages

Table 10 outlines the general steps in evidence-based decisionmaking. Each stage involves a set of discrete decisions that require data and information (third column). In developing a DDIU strategy for any particular national or sub-national setting, it is important to recognize these stages and the role of information in each of them.

**Table 10: DDIU in the context of evidence-based decisions and program stages**

<b>Stage</b>	<b>Decisions</b>	<b>Types of data needed</b>	<b>Stakeholders</b>
<i>1. Problem identification and recognition</i>	Priority-setting, advocacy, target-setting	Situation analysis, routine/surveillance data, population-based survey	Public health officials, civil society, opinion leaders
<i>2. Selection of the response</i>	Selection of intervention, operational plan, program budgets	Literature review, secondary analysis of existing data, (including on cost- effectiveness), special studies, operations and formative research, and research synthesis (if new data are needed)	Public health policy officials, service providers, beneficiaries

<i>3. Implementation and program monitoring</i>	Maintain operational plan and continue funding budget, mid-course adjustments	Process monitoring and evaluation, quality assessments, outputs monitoring	Service providers, program managers, civil society
<i>4. Evaluation</i>	Scale up program, discontinue pilot and test alternative intervention	Outcome evaluation studies, surveys, routine sources and surveillance	Public health officials, civil society, opinion leaders

# CHAPTER 3

## 3.0 IMPLEMENTATION ARRANGEMENTS

In order to effectively implement these guidelines, the following set of actions are required at leadership and operational levels.

### A. Leadership alignment to oversee implementation

- Orientation on the guidelines: convene a session with the executive leaders at the Ministry of Health level; orientation of the heads of department (HODs) on the content of this document and its application in converging health sector M&E investments.
- At the national level, convene a meeting bringing together national MOH officials, HODs, heads of divisions and units, SAGAs, development partners and top county health officials to orient them
- County level buy-in will be facilitated through the M&E and Supervision TWG of the Inter-governmental Forum, which will assume the responsibility for mobilizing the top leadership in each county to support the M&E reform agenda.

### B. Dissemination of the guidelines

- Develop dissemination materials, such as popular versions of the guidelines, annotated diagrams, PowerPoint presentations and infographics that enable simplified communication with stakeholders at different levels. Documents and guides and other hyperlinked documents will be availed and other organizations will be allowed to hyperlink them.
- Dissemination will be done through pre-arranged forums/meetings held at those institutions seeking to minimize the amount of resources to be used in these processes.
- At the county level, dissemination meetings will be held in each county and will bring together county health officials, subcounty health management teams and implementing partners.
- At the subcounty level, there will be meetings for the subcounty health officials, facility in-charges, community unit in-charges and implementing partners. Facilities will be expected to disseminate the guidelines through the routine Continuous Medical Education (CME) platforms and adopt them as a best practice.

### C. Implement formative technical interventions

Formative activities to roll out these guidelines will include:

- Conducting sector-wide M&E capacity assessment to align capacity building programs in order to address the most critical constraints

- M&E change management action plan, which is informed by the findings of the M&E capacity assessment, will be developed in consultation with stakeholders
- Support for counties, health programs and other organizations to develop and periodically review M&E plans as the primary document of reference for assessing how well or not the system is improving
- Support the establishment of vibrant M&E TWGs at all levels

#### **D. Advocate for additional resources to implement the guidelines**

In order to ensure sustainability for M&E reforms in the health sector, there is a need to invest in strong and vibrant technical coordination platforms that can sustain the agenda for change at all times and at all levels. Using the platform of the health data collaborative and other TWGs for engaging leadership at MOH and at the county level, advocacy should commence through a stakeholders' roundtable on M&E, which will also be used to develop an annual capacity improvement plan with full resource commitment by different partners and stakeholders.

At the national level, the health sector M&E TWG should convene development partners around the HDC roadmap for M&E strengthening within the framework of the collaborative.

#### **E. Strengthen coordination for M&E at the national and county levels**

In order to sustain the momentum for reform, create an enduring platform for M&E advocacy and oversight. M&E TWGs will be critical platforms for mobilizing support for sector-wide M&E priorities. When fully functional, they will provide mechanisms for mutual accountability among stakeholders implementing different components of the M&E system.

#### **F. Design and roll out a comprehensive capacity development plan** targeting actors at all levels.

Once the guidelines are endorsed and adopted by the intergovernmental forum and the respective leadership at the national and county levels, consensus will be needed on the *Costed M&E Capacity Improvement Plan*. This plan will become the basis for advocacy and engagement with the government at the national and county levels to increase allocations and direct investments to M&E capacity strengthening. It will also offer the basis for convergence and reduce duplicitous investments in M&E capacity building.

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# GLOSSARY OF M&E TERMINOLOGIES

In this guideline, the following terms are used and defined as follows:

**Accountability**—individuals/institutions are responsible for their actions and may be asked to justify them.

**Activity**—main tasks or interventions (outputs, indicators and targets).

**Actors**—all entities or institutions, both in the public and private sector, involved in the provision of health care services.

**Accountability**—responsibility for the use of resources and the decisions made, as well as the obligation to demonstrate that work has been done in compliance with agreed-upon rules and standards and to report fairly and accurately on performance results vis-a-vis mandated roles and/or plans.

**Activity**—actions taken or work performed through which inputs such as funds, technical assistance, and other types of resources are mobilized to produce specific outputs.

**Baseline**—the status of services and outcome-related measures, such as knowledge, attitudes, norms, behaviors, and conditions before an intervention, against which progress can be assessed or comparisons made.

**Benchmark**—a reference point or standard against which performance or achievements can be assessed. *Note: A benchmark refers to the performance that has been achieved in the recent past by other comparable organizations, or what can be reasonably inferred to have been achieved in similar circumstances.*

**Data**—specific quantitative and qualitative information or facts that are collected and analyzed.

**Effectiveness**—the extent to which a program/intervention has achieved its objectives under normal conditions in a real-life setting.

**Efficacy**— the extent to which an intervention produces the expected results under ideal conditions in a controlled environment.

**Efficiency**—a measure of how economic inputs (resources, such as funds, expertise, and time) are converted into results.

**Evaluation**—the rigorous, scientifically-based collection of information about a program/intervention's activities, characteristics, and outcomes that determine the merit or worth of the program/intervention. Evaluation studies provide credible information for use in improving programs/interventions, identifying lessons learned, and informing decisions about future resource allocation.

**Evaluation** – an assessment undertaken to determine the degree to which a program/project/operation has successfully met its goals and objectives. It is a periodic assessment of the relevance, efficiency, effectiveness, impact, and sustainability of a project, program, or intervention. It also includes forming an opinion with a view to determining the quality of one or more tasks. Evaluation is linked to monitoring. Monitoring provides the basis for evaluation, which involves answering two questions: “Has the project or program activity met its objectives?” and “What accounts for its level of performance?” Evaluation tells managers whether project/program activities are moving toward or away from project/program objective or management goals, and why. It provides lessons learned and recommendations for future improvement.

The key features of an evaluation are:

Measuring effects; requires a scientific methodology for the evaluation

The effects; emphasize outcomes and impacts

Comparison of effects with goals; requires explicit criteria for judging whether goals and objectives have been achieved.

**Goal**—a broad statement of a desired, usually longer-term, outcome of a program/intervention. Goals express general program/intervention intentions and help guide the development of a program/intervention. Each goal has a set of related and specific objectives that, if met, will collectively permit the achievement of the stated goal.

**Health information system**—a data system, usually computerized, that routinely collects and reports information about the delivery and cost of health services and patient demographics and health status.

**Health sector**—comprises public, private for-profit and private not-for-profit institutions delivering or using health care services.

**Impact**—the long term, cumulative effect of programs/interventions over time on what they ultimately aim to change, such as a change in HIV infection rates or AIDS-related morbidity and mortality. *Note: Impact at the population level is rarely attributable to a single program/intervention, but a specific program/intervention may, together with other programs/interventions, contribute to make an impact on the population.*

**Indicator**—a quantitative or qualitative variable that provides a valid and reliable way to measure achievement, assess performance, or reflect changes connected to an intervention. *Note: Single indicators are limited in their utility in understanding program effects (i.e. what is working or is not working, and why?). Indicator data should be collected and interpreted as part of a set of indicators. Indicator sets alone cannot determine the effectiveness of a program or a collection of programs; for this, good evaluation designs are necessary.*

**Inputs**—the financial, human, and material resources used in a program/intervention.

**Input and output monitoring**—involves tracking of information about program/intervention inputs (i.e. resources used in the program/intervention) and program/intervention outputs (i.e. results of the program/intervention activities). *Note: Data on inputs and outputs usually exist in program/intervention documentation (e.g. activity reports and logs) and client records that compile information about the time, place, type and amount of services delivered, and about the clients receiving the services.*

**Intervention**—a specific activity or a set of activities intended to bring about change in some aspect(s) of the status of the target population (e.g. HIV risk reduction, improving the quality of service delivery, etc.).

**Logical framework**— a management tool used to improve the design of interventions. It involves identifying strategic elements (inputs, outputs, activities, outcomes, impact) and their causal relationships, indicators, and the assumptions or risks that may influence success or failure. It thus facilitates planning, execution, and monitoring and evaluation of an intervention.

**Monitoring**—is the process of collecting, analyzing, and reporting data on a project or program's inputs, activities, outputs, outcomes and impact, as well as external factors, to track whether actual investments in the program have resulted in achievements. These data, when analyzed, pinpoint progress or constraints as early as possible, allowing managers to adjust the project or program's activities as needed. Monitoring aims to provide managers, decisionmakers and other stakeholders with regular feedback on progress in the implementation of activities specified in the development plans. Monitoring is a continuous or regular collection and analysis of information about implementation to review progress; it compares actual progress with what was planned, (e.g. deadlines, deliverables, recruitments, activities and outputs) so that adjustments can be made in the implementation. Monitoring is an internal activity that is the responsibility of those who manage implementation. It thus represents a good management practice.

The key questions monitoring should address are:

“Are we doing what we are supposed to be doing?”, rather than “Should we be doing this?”

Is the activity being implemented well and on time?

Have the outputs been delivered as planned and is their quality as specified?

**M&E plan**—a multi-year implementation strategy for the collection, analysis and use of data needed for program/project management and accountability. The plan describes the data needs linked to a specific program/project, the M&E activities that need to be undertaken to satisfy the data needs, the specific data collection procedures and tools, the standardised indicators that need to be collected for routine monitoring and regular reporting, the components of the M&E

system that need to be implemented and the roles and responsibilities of different organizations/individuals in their implementation; and how data will be used for program/project management and accountability. The plan indicates resource requirement estimates and outlines a strategy for resource mobilization.

**M&E work plan**—an annual, costed M&E plan that describes the priority M&E activities for the year and the roles and responsibilities of organizations/individuals in their implementation, the cost of each activity and the identified funding identified, and a timeline for the delivery of all products/outputs. The work plan is used for coordinating M&E activities and assessing progress of M&E implementation throughout the year.

**Objective**—a statement of a desired program/intervention result that meets the criteria of being Specific, Measurable, Achievable, Realistic, and Time-phased (SMART).

**Operational research**—systematic and objective assessment of the availability, accessibility, quality, and/or sustainability of services designed to improve service delivery. It assesses only factors that are under the control of program/project managers, such as improving the quality of services, increasing training and supervision of staff members, and adding new service components.

**Outcomes**—medium-term results for specific beneficiaries that are the consequence of achieving specific outputs. Outcomes should relate clearly to an institution's strategic goals and objectives set out in its plans. Outcomes are “what we wish to achieve”. Outcomes are often further categorized into immediate/direct outcomes, intermediate outcomes or high-level outcomes.

**Outputs**—the results of program/intervention activities; the direct products or deliverables of program/intervention activities, such as the number of HIV counselling sessions completed, the number of people served or the number of condoms distributed.

**Performance**—the degree to which an intervention or organization operates according to specific criteria/standards/guidelines or achieves results in accordance with stated goals or plans.

**Program**—an overarching national or sub-national response to a disease. A program generally includes a set of interventions marshalled to attain specific global, regional, country, or subnational objectives; it involves multiple activities that may cut across sectors, themes and/or geographical areas.

**Program evaluation**—a study that intends to control a health problem or improve a public health program or service. The intended benefits of the program are primarily or exclusively for the study participants or the study participants' community (i.e. the population from which the study participants were sampled). Data collected are needed to assess and/or improve

the program or service, and/or the health of the study participants or the study participants' community. Knowledge that is generated does not typically extend beyond the population or program from which the data are collected.

**Qualitative data**—data collected using qualitative methods, such as interviews, focus groups, observation, and key informant interviews. Qualitative data can provide an understanding of social situations and interaction, as well as people's values, perceptions, motivations, and reactions. Qualitative data are generally expressed in narrative form or through pictures or objects (i.e. not numerically).

**Quantitative data**—data collected using quantitative methods, such as surveys. Quantitative data are measured on a numerical scale, can be analyzed using statistical methods, and can be displayed using tables, charts, histograms and graphs. *Note: The aim of a quantitative study is to classify features, count them, and construct statistical models in an attempt to explain what is observed.*

**Relevance**—the extent to which the objectives, outputs, or outcomes of an intervention are consistent with the beneficiaries' requirements, the organizations' policies, the country's needs, and/or global priorities.

**Reliability**—consistency or dependability of data collected through the repeated use of a scientific instrument or a data collection procedure used under the same conditions.

**Research**—a study that intends to generate or contribute to generalizable knowledge to improve public health practice i.e. the study intends to generate new information that has relevance beyond the population or program from which the data are collected.

**Results** — the outputs, outcomes, or impact (intended or unintended, positive and/or negative) of an intervention.

**Stakeholder** — a person, group, or entity who has a direct or indirect role and interest in the goals or objectives and implementation of a program/intervention.

**Surveillance** — the ongoing, systematic collection, analysis, interpretation, and dissemination of data regarding a health-related event for use in public health action to reduce morbidity and mortality and to improve health. Surveillance data can help predict future trends and target needed prevention and treatment programs.

**Sustainability (of a program/project)**—the likelihood that political and financial support for a program/project will remain even after initial funding or sponsorship has been exhausted.

**Target group**—specific group of people who are to benefit from the results of the intervention.

## ANNEXES

- ANNEX 1: Proposed structures for M&E at different levels
- ANNEX 2: Scope and responsibilities for M&E functions at the national level
- ANNEX 3: Scope and responsibilities for M&E functions at the county level
- ANNEX 4: Scope and responsibilities for M&E functions at the facility level
- ANNEX 5: Scope and responsibilities for M&E functions at the community level
- ANNEX 6: Health actors and M&E functions across all levels

### **ANNEX 1: Proposed structures for M&E at different levels**

	National level	County level	Service delivery level
Public sector	National M&E human resource capacity; a functional M&E unit should have at least 5 full-time persons i.e. 1) a manager/coordinator, 2) a health information manager/officer 3) a health economist or statistician 4) an epidemiologist/researcher and 5) a social scientist/communication specialist	Decentralized coordinating: the M&E team should be linked to the county and subcounty government structures. It should have at least 3 full-time persons i.e. 1) a coordinator/manager 2) a health information manager/officer and 3) a health economist/statistician/social scientist.	National referral hospitals should have a similar composition, with at least 3 full-time staff at county and subcounty levels i.e. 1) a coordinator/manager 2) a health information manager/officer and 3) a health economist/statistician/social scientist. Health centers, dispensaries and clinics should have at least one full-time health information manager/officer.
	Programs/projects, semi-autonomous government agencies (SAGAs) and municipalities/cities should have a program focal point, and/or an M&E officer that regularly provides quarterly reports to the M&E unit.	All programs at the county level should have a designate focal point person that will provide quarterly reports to the M&E team described above.	All health facility departments/wards need to have a designated focal point person who provides daily/monthly reports to the health information system unit.
	Key Ministry of Health implementing programs should have an M&E unit with 3 full-time persons 1) an epidemiologist/statistician 2) a health information manager/officer responsible for routine data 3) a communication/social scientist/researcher specialist	The local key implementing county/subcounty management team needs to have at least 3 full-time staff 1) Two persons responsible for the management of the information system 2) one person responsible for data capture and quality control	All service-providing Units (e.g. health facilities and community units) should have a person responsible for data recording, collation, reporting and quality control

	<b>National level</b>	<b>County level</b>	<b>Service delivery level</b>
<b>Civil Society sector</b>	Other government ministries/departments whose implementation activities involve health-related activities should have a focal point person with M&E responsibilities that link with the M&E unit.	Local coordinating teams/officers or health sectors at the county and subcounty levels (e.g. health-related activities in the education sector) should have a focal person responsible for collating, reporting and verifying M&E data as part of the health information system and maintaining a parallel information system that provides information to the county M&E team.	Other facilities that provide government health services (e.g. schools) should have part-time focal persons tasked with recording, summarizing, reporting, analyzing and verifying the quality of data and submitting the reports to the nearest health facility.
	An umbrella organization(s) for civil society organizations e.g. HeNNET needs to have a focal point within the M&E unit who compiles reports associated with health and health- related services for beneficiaries, which are submitted to the M&E unit and to the health sector M&E TWG at both the national and county levels.	Regional/county offices of civil society organizations coordinating activities or umbrella organizations in countries with vast geographical areas may also have sub-national coordinating offices, which should have a person responsible for collating, reporting and verifying M&E data as part of the organization's monitoring systems and also as part of data capture and quality control. This person should provide quarterly progress reports to the county M&E team.	Civil society organizations providing services directly to health facilities and community units should have a part-time focal person tasked with recording, summarizing, reporting, analyzing and verifying the quality of data, and on the day of service or monthly, submit reports to the link health facility.
<b>Private sector</b>	An umbrella organization for private sector health providers needs to have a focal point with M&E responsibilities who provides information on a quarterly basis to the M&E unit and to the health sector M&E TWG at both national and county levels.	Regional offices of the private sector health providers' coordinating activities need to have a person responsible for collating, reporting and verifying M&E data as part of the organization's monitoring systems.	All private enterprises or businesses should be mainstreamed into the operations of service provisions and ensure that focal persons tasked with recording, summarizing, reporting, analyzing and verifying the quality of data received submit reports weekly and monthly to the subcounty levels. Large hospitals should ensure that they have at least 3 critical health information managers to collect necessary health information that is submitted as per the requirements of the government.

	National level	County level	Service delivery level
National Research Sector	National Research Council, university research institutes, Ethical Review Boards, etc. Each of these entities should have an M&E focal point who provides the M&E unit with analytical information to be used for decisionmaking processes on a quarterly basis.	Research institutions collect, collate and analyze information from the county or subcounty level. All analyzed information from the sites in the counties and subcounties should be shared with the beneficiaries, counties and subcounties for informed decisionmaking.	All information products from research institutions should be analyzed and shared with the beneficiaries at the facility and community levels to derive actions.

## ANNEX 2: Scope and responsibilities for M&E functions at the national level

National Level: Health Sector M&E Unit	
Stewardship Goal	National-level functions at the Health Sector M&E Unit to cascade priorities across the health delivery system
Establishment of a common data architecture	<ul style="list-style-type: none"> <li>Define standards for sharing aggregate and patient-level data.</li> <li>Coordinate the development of data requirements for the health sector.</li> <li>Create and maintaining a repository of health-related data.</li> <li>Conduct oversight functions in management of health-related data across levels to inform policymaking.</li> </ul>
Improve performance and review processes	<ul style="list-style-type: none"> <li>Use aggregate data to analyze, disseminate and use health-related findings for the establishment of health sector priorities.</li> <li>Align KHSSP from MoH departments, SAGAs, national hospitals, CHMTs and others, to provide feedback for sustained accountability.</li> <li>Compile reports at the national level to track implementation of the strategic plan.</li> <li>Interrogate the quality of reports received and follow up for validity and reliability.</li> <li>Provide technical support to all national-level operational units, counties, SAGAs, and national referral hospitals.</li> </ul>
Enhance sharing of data and promote use of information for decisionmaking	<ul style="list-style-type: none"> <li>Develop M&amp;E-related guidelines and policies.</li> <li>Prepare and disseminate national annual and quarterly performance review reports.</li> <li>Institutionalize data flow to meet national and international reporting obligations.</li> <li>Build capacity in M&amp;E at different tiers of the health system.</li> <li>Prepare and share the Annual State of Health reports to be disseminated during the Health Congress.</li> </ul>

<b>National Level: Partners (development partners (DPs), implementing partners (IPs), NGOs, FBOs)</b>	
<b>Stewardship Goal</b>	<b>Partner functions at the national level</b>
Establishment of a common data architecture	<ul style="list-style-type: none"> <li>Provide technical, material and financial support to strengthen monitoring and evaluation at SAGAs and national referral hospitals.</li> <li>Promote a national integrated health information system for decision making.</li> <li>Collaborate with the MoH M&amp;E unit to provide data from health-related research for decisionmaking.</li> </ul>
Improve performance and review processes	<ul style="list-style-type: none"> <li>Work within the existing M&amp;E framework and meet defined reporting requirements.</li> </ul>
Enhance sharing of data and promote use of information for decisionmaking	<ul style="list-style-type: none"> <li>Strengthening national-level M&amp;E Unit operations</li> <li>Participate in the dissemination of data, research findings and performance reports.</li> </ul>

### **ANNEX 3: Scope and responsibilities for M&E functions at the county level**

<b>County Level: County Health Management Team (CHMT)</b>	
<b>Stewardship Goal</b>	<b>CHMT M&amp;E functions</b>
Establishment of a common data architecture	<ul style="list-style-type: none"> <li>Establish M&amp;E TWGs for oversight in the management of health care using accurate data.</li> <li>Create a functional data repository for health.</li> <li>Build a county-level M&amp;E system.</li> <li>Compile county health report</li> </ul>
Improve performance and review processes	<ul style="list-style-type: none"> <li>Produce a health sector performance report interrogating subcounties for quality of the reports i.e. follow up for completeness, validity and reliability.</li> <li>Provide technical, material and financial support to M&amp;E at the subcounty level.</li> <li>Collate, disseminate and use health-related data from the subcounties</li> </ul>
Enhance sharing of data and promote use of information for decision-making	<ul style="list-style-type: none"> <li>Ensure flow of communication to inform policy formulation.</li> <li>Prepare findings for discussions during the CEC directorate meetings and forums for decisionmaking.</li> <li>Share county health reports with the CEC.</li> <li>Share quarterly feedback with CEC and the national level.</li> <li>Disseminate quarterly results in health care delivery.</li> </ul>
<b>County Level: Partners</b>	
<b>Stewardship Goal</b>	<b>Partner functions at the county level</b>
Establishment of a common data architecture	<ul style="list-style-type: none"> <li>Support counties in establishing data collection and management structures.</li> <li>Collaborate with MoH M&amp;E Unit in providing data for policy formulation and decisionmaking.</li> </ul>
Improve performance and review processes	<ul style="list-style-type: none"> <li>Work within the health sector M&amp;E framework and guidelines to meet reporting requirements.</li> </ul>

Enhance sharing of data and promote use of information for decisionmaking	<ul style="list-style-type: none"> <li>• Strengthening MoH M&amp;E Unit operations</li> </ul>
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#### ANNEX 4: Scope and responsibilities for M&E functions at the facility level

<b>Facility Level: Facility Health Management Teams (HMTs)</b>	
<b>Stewardship Goal</b>	<b>Facility management team M&amp;E functions</b>
Establishment of a common data architecture	<ul style="list-style-type: none"> <li>• Maintain and update the health information system for effective management of the health care delivery system.</li> <li>• Protect the data and information system from risks arising from unauthorized persons or calamities.</li> <li>• Compile reports into health facility reports for decisionmaking processes.</li> </ul>
Improve performance and review processes	<ul style="list-style-type: none"> <li>• Compile and process minutes, inventory, and supervision and activity reports.</li> <li>• Establish quality of reports from health facility units and follow up for completeness, validity and reliability.</li> </ul>
Enhance sharing of data and promote use of information for decisionmaking	<ul style="list-style-type: none"> <li>• Summarize health and health-related data for improved decisionmaking and feedback.</li> <li>• Discuss data during staff and board meetings for decisionmaking.</li> <li>• Forward health and health-related reports to the subcounty level.</li> <li>• Give quarterly feedback to the health providers and community unit committee.</li> <li>• Disseminate quarterly reports to the health facility committee.</li> <li>• Disseminate annual reports to the health facility committee and subcounty forum.</li> </ul>

#### ANNEX 5: Scope and responsibilities for M&E functions at the community level

<b>Community Level: Community Health Management Team</b>	
<b>Stewardship Goal</b>	<b>Facility Management Team Functions</b>
Establishment of a common data architecture	<ul style="list-style-type: none"> <li>• Update M&amp;E results with community units consisting of households.</li> <li>• Maintain community health worker registers to document community health workers' daily activities and who they report to.</li> </ul>
Improve performance and review processes	<ul style="list-style-type: none"> <li>• Develop quarterly and annual community health reports for integration into facility reports.</li> </ul>
Enhance sharing of data and promote use of information for decisionmaking	<ul style="list-style-type: none"> <li>• Discuss data during staff and committee meetings for improved decisionmaking processes.</li> <li>• Forward committee reports to the facility management.</li> <li>• Provide quarterly feedback to community units.</li> <li>• Disseminate quarterly reports to community units.</li> <li>• Disseminate annual reports to community units.</li> </ul>

## ANNEX 6: Health actors and M&E functions across levels

	<b>Data Collection</b>	<b>Data Validation</b>	<b>Data Analysis</b>	<b>Information Dissemination</b>	<b>Information Use</b>
Routine Information	Division of Health Informatics and M&E MoH service delivery units IPsDisease programmes	Division of Health Informatics andM&E MoH service delivery units	Division of Health Informatics and M&E MoH service delivery units	Division of Health Informatics and M&E M&E Dept. of Technical Planning	Division of Health Informatics and M&E Service delivery units including HMTs National Health Observatory, Partners (DPHK, IPs)
Vital Statistics	Registration departments, SAGAs	SAGAs		National Health Observatory	National Health Observatory, Partners (DPHK IPs), Service delivery units, NIMES
Health Research	Kenya Medical Research Institution	Kenya Medical Research Institution	National Health Observatory	National planning authority M&E unit	National Health Observatory, Service delivery units, DPHK, IPS, NIMES
Surveys			National Health Observatory	KNBS, National AIDS Control Council, Disease programmes M&E unit	National Health Observatory, Service delivery units, DPHK, IPs, NIMES
Surveillance	DDSR	DDSR	DDSR	DDSR M&E unit	National Health Observatory, DPHK, IPs

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