

REPUBLIC OF KENYA



MINISTRY OF HEALTH

**KENYA HEALTH SECTOR
MONITORING AND EVALUATION (M&E)
CAPACITY ASSESSMENT REPORT**

JUNE 2020

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Citation: Health Sector Monitoring and Evaluation Capacity Assessment report using Monitoring and Evaluation Capacity Assessment Tools (MECAT)

Published by:

Division of Health Sector Monitoring and Evaluation

Ministry of Health

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FOREWORD

The Constitution of Kenya 2010 and various other legislations have raised the public's expectations on the level of transparency, accountability and public participation exhibited by National and County Governments in the planning and implementation of health programs. The Kenya Health Policy 2014-2030 and the Kenya Health Sector Strategic Plan 2018-2023 have integrated the establishment of a robust and unified Monitoring and Evaluation System to ensure systematic tracking of investments and progress. This is aimed at promoting a culture of evidence-based planning and decision making as the Country accelerates efforts towards achievement of Universal Health Coverage by 2022.

One M&E Framework for the Health Sector is intended to mobilize all stakeholders in the health sector in Kenya to support and work towards a common goal that promotes generation, analysis, dissemination and use of quality health information for informed decision making. The main purpose is to establish a mechanism that allows partners to align their technical and financial commitments around strong nationally owned Health Information Systems and a common Monitoring and Evaluation framework and plan.

The Ministry is working towards ensuring that the quality of health data generated and used to guide decisions is reliable and able to properly guide allocation of resources. As a result, data collection, collation, reporting, and use processes are continuously being improved, with efforts to strengthen health information systems (HIS) focusing on improved health sector Monitoring and Evaluation (M&E), beginning with standardized baseline capacity and performance assessments.

This report presents the current existing National and County capacities in M&E systems, as well as highlighting the gaps that may hinder the health sector from developing good performance measurements and track progress towards identified goals.

I urge all stakeholders at the National and County levels to make reference to this report to support progressive establishment of functional HIS/M&E units at all levels.



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ACKNOWLEDGEMENT

The Monitoring and Evaluation (M&E) Capacity Assessment Report was developed through a consultative process that consisted of guided assessments at the various levels in the sector, where administration of the assessment tool allowed for consensus building. Detailed information was gathered from Stakeholders that included Semi-Autonomous Government Agencies (SAGAs), Departments and Divisions at the National level, and the County Health Departments for Health. The process was driven by the Monitoring and Evaluation Technical Working Group (HIS TWG) and technical support with a consultant from KEMRI.

In completing this work, I recognize the effort of the M&E Technical Working for the coordination, technical input and commitment during the process of developing this report. The invaluable effort by members of the National taskforce that oversaw the data collection and coordinated the technical and consultative processes in the development of the report through the M&E technical working group is highly appreciated. In this regard, I wish to extend my gratitude to Dr. Helen Kiarie, Wanjala Pepela, Dr. Elizabeth Wangia, David Njuguna, Rose Muthee, Dr. Mutile Wanyee, Antony Komen, Paul Bartilol, Leonard Cosmas and Dr. Serah Gitome who worked tirelessly to ensure collection and analysis of massive amount of information that was generated from the respondents, in addition to engagement of stakeholders in putting this report together.

All heads of Departments and Divisions, Programme managers, Government parastatals (KEMRI, KNH, MTRH, NHIF, KEMSA), the County Health Leadership and the County Health Management Teams are appreciated for their participation and invaluable inputs during the development process.

I wish to acknowledge the contributions by the World Bank who provided funding for this work through the THS-UC project as well the World Health Organization (WHO) and MEASURE evaluation who developed the MECAT assessment tools that formed the foundation of this work.

Finally, 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), who, working together with the national taskforce contributed their expertise that shaped this document. My sincere gratitude also goes to the 47 County Governments and their stakeholders for dedicatedly committing their time and energy into this exercise by critically analyzing their capacities, and providing very informative reports that will facilitate the establishment of a strong Monitoring and Evaluation system.



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EXECUTIVE SUMMARY

Introduction: The Ministry of Health (MoH) is legally mandated to provide quality, accessible health services in accordance with Article 43 of the Constitution of Kenya, which guarantees the right to the highest attainable standard of health including reproductive health (Constitution Kenya 2010). To track its progress towards fulfilling this mandate, the MoH must monitor the delivery of Health services to the Kenyan population. The need to track progress and foster evidence-based planning and decision-making has informed the establishment of a monitoring and evaluation framework as stipulated in the Health Act 2017 (Health Act 2017). Operationalization of the Health Sector M&E Framework 2014-2018 enabled the tracking of Health sector performance targets. This framework formed the basis for various state and non-state actors to define baselines and the targets set within the Kenya Health Sector Strategic Plan 2018- 2023. The current M&E plan 2018- 2023 further consolidates efforts of various stakeholders towards common measurement and accountability goals. The collection of key strategic information to track progress and measurement of results to report on targets set in the Kenya Health Policy (KHP) 2014-2030 requires a well-established and coordinated M&E system.

Despite this establishment of a health sector M&E framework and other efforts to strengthen M&E in the sector, capacity gaps remain the biggest challenge in the implementation of a fully functioning M&E system in the health sector. Strengthening of the M&E system will facilitate effective tracking of implementation of the health interventions. In order to understand the specific M&E capacity gaps that exist in its M&E system, the Ministry of Health together with stakeholders implemented the Monitoring and Evaluation Capacity Assessment. The assessment was initiated by the M&E technical working group, who mandated a sub-task team led by the Ministry of Health M&E division to facilitate implementation of the assessment at all levels. The overall objective of the M&E capacity assessment was to understand the current capacity of the Kenya health sector in meeting M&E objectives, identify gaps and determine M&E capacity to inform strengthening interventions to optimize performance.

Methodology: A mixed-methods approach was used to provide a comprehensive picture of the Ministry of Health (MoH) Monitoring and Evaluation (M&E) capacity at national and county levels. A desk review of various documents was carried out to provide context about the MoH M&E system, M&E plans and performance expectations. Quantitative methods were used to collect data from stakeholders and organizational M&E capacity teams, where group capacity assessments were carried out with 301 participants drawn from all levels of the sector including counties, national level and the semi-autonomous agencies. This assessment was done using an M&E capacity assessment tool that allowed for using consensus scoring of assessment areas. Qualitative methods were used to collect data from key informants at the National level, with this data being used to triangulate the findings from the quantitative assessments.

This assessment generally collected data based on the 12 M&E capacity areas namely: organizational structures with M&E, human capacity for M&E, M&E partnerships, M&E plan, costed M&E work-plan, M&E advocacy, communications and culture, routine programme

monitoring, surveys and surveillance, M&E databases, supervision and data auditing, evaluation and research, data dissemination and use. The tool also measured four dimensions across the 12 capacity areas to determine each entity's ability to perform specific M&E functions and meet its objectives. These four dimensions were status, quality, technical autonomy and financial autonomy.

Findings were summarized in the form of charts and spider graphs and reported according to national and county levels.

Key findings: Generally, most counties scored below average (50%) in having well-functioning M&E systems. Only a quarter of counties (12 counties) scored 50% and above. These included; Tharaka-Nithi, Makueni, Isiolo, Nairobi, Mombasa, Kwale, Vihiga, Busia, Kilifi, Kericho, Tana River, and Lamu. The strongest capacities were in National and County databases, routine monitoring, supervision and auditing, and partnerships and governance while the weakest capacities were in human resources for M&E and evaluation and research. A similar picture emerged at the National level where the strongest capacities were found to be in the areas of routine monitoring and partnership and governance with the weakest capacity areas being human capacity and evaluation and research. Most of the components of the 12 capacity areas existed at both the national and county levels but the internal technical and financial capacity to implement these components was severely lacking.

The M&E system was found to be fairly well-organized with an overarching national M&E directorate under which the department and division for M&E falls. This structure supports programs as well as the county M&E units. Most of the M&E units at the national level had clear objectives with a lead M&E officer. Despite this, the M&E units were poorly integrated with the national M&E division and there was little interoperability between the different M&E units. At the county level, the organizational structure was poor with less than half of the counties having approved M&E mission statements or objectives. There is therefore need to streamline the health sector M&E system through establishment of clear reporting lines and communication channels between the national and county M&E units.

The human resource capacity for M&E was very poor at both the National and County levels. Most of the M&E units were grossly understaffed compounded by a lack of the requisite training in M&E related work, often resulting in failure to meet the set objectives. A few of the better-funded M&E units relied on external technical expertise to carry out their M&E work thus bringing into question the sustainability of such units in the long run. There is need therefore for the Government to allocate adequate resources to employ well-qualified M&E staff and provide on-job training in the various aspects of M&E-related work.

In terms of financing, over-reliance on donor support was prevalent across both the National and County levels due to lack of consistent and adequate Government financial allocation to M&E. In addition, the donor support was not well coordinated across the health sector resulting in some of the M&E units being much better-resourced than others. In addition, even units that received good external support were vulnerable to funding changes from time to time and this greatly affected the overall output of the health sector M&E system. The MoH needs to map out the various partners/stakeholders supporting M&E and match the donor support to specific M&E priority needs to ensure that partner support is optimized and utilized efficiently for the entire health sector.

The capacity for conducting evaluations and research scored very poorly at both National and County levels due to lack of well-trained personnel and funding constraints. A few of the M&E Units sought the help of donors to carry out evaluations but this was not sustainable in the long-run due to changing donor priorities and shrinking donor funds. The Government hence needs to allocate more resources to bolster the sector's capacity to carry out evaluations and research. In addition, there is need for the MoH to partner with existing research institutions both in the private and public sector as a way of improving the capacity to conduct evaluations.

The capacity on data use scored higher at the national level as compared to the county levels largely due to low data use skills and funding constraints. There is subsequently need for continuous capacity building in data use to ensure that the large amount of data generated within the health sector are utilized at all levels to inform decision-making and policy development.

1 BACKGROUND

1.1 Introduction

The Constitution of Kenya mandates the Ministry of Health to give quality health services, promote equity in access and ensure financial risk protection to all Kenyans. In this respect, implementation of UHC was initiated in four Counties as one of the Big Four agenda of Government, with an overall aim of achieving UHC for all Kenyans by 2022. The key aspirations are that by 2022, in Kenya;

- Each person can access a package of health services that addresses most of their health needs;
- Essential health interventions are provided to all areas of the country including hard-to-reach areas;
- All Kenyans are protected from potential financial catastrophe arising from use of health services. Special focus is given to the poor and vulnerable; and
- There is adequacy of health resources/there is an appropriate resource base for delivery of health services.

The Constitution has also identified 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 therefore remains a key component of any program that aims to continuously improve and provide better outputs and outcomes for its beneficiaries. This is especially in tracking the progress and lessons learnt from the implementation of the Universal Health Coverage and other health interventions. 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 has been supported by the provisions of the Constitution of Kenya 2010 and subsequent devolution laws. To this end, an M&E framework has been developed to ensure that the sector tracks financial and non-financial aspects of service delivery as outlined in Public Finance Management Act 2012. The Framework will:

- Ensure that the health sector performance monitoring & evaluation focuses on the UHC agenda and KHSSP goals
- Ensure sharing of information with all stakeholders
- Provide strategic information needed for evidence-based decisions at both national and county/sub-county levels

In order for the health sector to realize these objectives, establishing a single functional M&E system for the sector is critical, as it will help improve efficiency, transparency and accountability. This requires optimal capacities for M&E at all levels, and identification of gaps in functional M&E units should be done for effective planning. It is also important to note that M&E mechanisms will be used as a basis for tracking UHC implementation in the health sector, including leveraging on programs and Health Information Systems [HIS], while

renewing the global commitment on primary health care (PHC) to achieve UHC and the Sustainable Development Goals (SDGs). For this reason, an M&E Capacity assessment was conducted in all counties, National MOH and SAGAs to establish the available capacities for M&E.

1.2 The purpose of the M&E Capacity assessment

The main purpose of the M&E capacity assessment was to establish the existing capacities to support the Institutionalization of Monitoring and Evaluation (M&E) in the Health Sector in order to facilitate building sound M&E systems; This was through documenting the current M&E organizational and individual capacities needed to successfully implement performance review mechanisms in the Health Sector at National and County levels.

The overall aim of the assessment was to guide improved availability of quality information, and foster its use in guiding decision making in the health sector.

This assessment is expected to provide baseline information to strengthen institutionalization of the M&E guidelines which aims to:

- Contribute to a shared definition of key M&E capacity terminologies used in the health sector
- Ensure that we design a shared institutional vision for M&E for increased accountability
- Describe the key capacity based on the 12 Components of a well-functioning M&E system
- Guide institutions, departments and counties on how to establish an M&E function in their respective organizational structures or organograms
- Guide institutions on 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
- Help establish mechanisms to strengthen partnerships and governance for M&E

The assessment is a first step in determining priority capacity needs in each County, SAGA and Department/program.

The assessment had three specific objectives:

- Understand and document the status of M&E institutionalization in Kenya;
- Determine the current performance in key M&E functional areas for Kenyan health sector;
- Identify gaps in M&E capacity to meet performance expectations of the health sector in Kenya.

1.3 The M&E capacity assessment process

The process was initiated by the Ministry of Health (MoH)'s Division of M&E through a technical training of all planning units (Counties, National Departments /programmes and

SAGAs). Assessment using the MECAT tool formed part of these training sessions. Each planning entity formed a technical team for the assessment, comprising of both state and non-state actors. The taskforce then applied the tool either through consultative meetings and establishing consensus while others completed the tool and shared with relevant stakeholders. At the county level, the County Health Directors were mandated to oversee this process, while the County Health Records and Information Officers (CHRIOs) were tasked with coordination of the data collection, compilation and analysis.

The assessment process was consultative in nature with all stakeholders engaged. A consultant was enlisted to consolidate the findings into a report independently. Reviews of preliminary findings were done via sharing in stakeholder workshops, comprising both the M&E TWG and the health Information ICC, where inputs were given and later incorporated to improve the assessment report.

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 incorporated into the final report.

1.4 Target audience for the report

This report is intended to assist all stakeholders in the health sector to identify existing capacities for M&E, identify gaps and use this baseline information to strengthen M&E units in a bid to improve health sector performance tracking mechanisms. The report also provides strategic baseline information for development of the M&E business case to guide optimal funding.

2 DESIGN AND METHODOLOGY

2.1 Introduction

The M&E baseline capacity assessment used a cross-sectional observational study design with a mixed methods approach. Quantitative data was collected using a group-administered tool that facilitated discussions among stakeholders while qualitative data was collected using key informant interviews.

2.2 Study site, population and sampling

The group assessment focused primarily on M&E capacities at the County health departments and National planning entities (Departments/Directorates, Programs/Divisions and SAGAs), focusing on the units conducting M&E work. The County and National level teams were first trained on M&E institutionalization guidelines including the implementation of the M&E assessment. Key informant interviews were carried out at National level with selected development partners and National level officers (at MOH and representative SAGAs), who are core in making critical decisions for M&E. The key informants were purposively sampled based on knowledge of the health sector M&E system. These included heads of Departments/Directorates, Divisions, Program managers, Health Records and Information

Officers, M&E personnel and thematic focal points in Semi-Autonomous Government agencies (SAGAs). A total of three hundred and one (301) participants' participated in the quantitative group assessment at both the National and County levels, while 20 respondents participated in the key informant interviews.

Interviews were conducted with the following:

MOH; Directorate of Health Sector Coordination & Intergovernmental Relations, Directorate of Health Services, Directorate of Health Policy, Research and Monitoring and Evaluation, Directorate of Public Health, National Tuberculosis program, Division of Vaccine and Immunization, Division of Reproductive Health, Division of Disease Surveillance, Division of Nutrition, National AIDS and STI Control Program, Division of Malaria, Division of Community Health, Division of Health Information Services, Division of Neonatal health, and the Division of Health Promotion.

Development Partners; World Health Organization (Kenya Office)

SAGAs, Boards and councils; Kenya Medical Practitioners and Dentist's Board, National Health Insurance Fund and National AIDS Control Council.

2.3 Study tools

Data collection was done using a standard M&E capacity assessment toolkit (MECAT) (Appendix III), that was developed by the WHO and MEASURE Evaluation. The tool, which was customized for use in the Kenyan setting, consists of some excel-based assessment workbooks. The tool collected data on the 12 M&E capacity areas namely: organizational structures for M&E, human capacity for M&E, M&E partnerships, M&E plan, costed M&E work-plan, M&E advocacy, communications and culture, routine programme monitoring, surveys and surveillance, M&E databases, supervision and data auditing, evaluation and research, and data dissemination and use.

Interview guides for the key informant interviews were developed on the basis of the results of the document review and focused on the 12 capacity areas that were assessed in the group assessment tool.

The tools were administered between July – November 2018 for counties and January - March 2019 for National level departments, programmes and SAGAs

2.4 Study procedures

A number of approaches were used during the baseline assessment.

Stakeholder engagement; This involved consultations during M&E technical working Groups to ensure consensus building. Deliberations were held on the rationale, objectives, and intended outcomes of the exercise.

Desk review; A comprehensive desk review of relevant documents and literature was done to provide information on the history, structure and current status of M&E in Kenya. Results of the desk review revealed important gaps in M&E capacity, which further guided the development of the assessment protocol and data collection instruments. Findings from the

desk review were incorporated in the introduction, discussion and recommendations sections of this report.

Quantitative data collection; This was done through group assessments within organizations in a participatory meeting with representation from all stakeholders. The Monitoring and Evaluation Capacity Assessment Tool (MECAT) was used to establish the status of each of the 12 components of an M&E system. The customized tool captured this information and weighted the scores within the four dimensions; status, quality, technical autonomy, and financial autonomy for each of the 12 components. Status indicates existence or otherwise of specific elements that constitute a capacity area, while quality is a measure of how robust these elements are for the established norms or standards. Technical autonomy is the ability of the institution to develop and execute M&E functions without depending on external support. Financial autonomy is the ability of the institution to fund specific M&E functions without depending on external funding.

Each of the 12 components had specific questions that targeted different areas of M&E. Responses to questions under each key competency area were captured in the Excel workbook. The final score for each question was arrived at through group consensus, with discussions facilitated by the moderator of each session. Where consensus was not apparent, a democratic process of voting was applied. Textual information that qualified a response was included in a comment box provided, which added a depth of important information to consider in discussions of necessary actions to be taken. A total of 301 respondents were involved in the group assessment.

Qualitative interviews

To triangulate and strengthen the findings of the quantitative process results, key informant interviews were conducted with 20 interviewees to understand the expected capacity and performance of the National M&E functions, as well as to get insights from stakeholders and partners on the capacities and gaps in M&E. This process was also aimed at understanding the relevance of the M&E activities to partner organizations and contextualize the external barriers or facilitators of a well-established M&E system. Key informant interviews assessed stakeholder views on the 12 M&E capacities, and in addition assessed other parameters such as performance expectations, utilization of M&E data and key personnel supporting implementation of M&E activities among others. Audio-recorded interviews were transcribed and analyzed using themes aligned to the 12 M&E capacity areas. Content analysis was used to determine other themes that emerged from the interviews and these were coded accordingly.

The results of the interviews generated further insights into issues that affect a unified M&E system on the basis of the respondents' views and opinions.

2.5 Data Management and Analysis

Completed study tools were submitted electronically and stored in an access-controlled computer that was only accessible to participants in the group assessments, authorized study investigators, and trained data management personnel. Summaries from the assessment were shared and discussed with the national M&E Division before the report was developed.

Quantitative data responses from the group assessment tools was analyzed using simple scoring for each question. The results of the four dimensions were reported on a 10-point scale, where 0, the least, implied no capacity, and 10, the highest, implied a high level of capacity. The 12 capacity areas of the assessment were scored using a series of statements based on three response scales:

- ✓ 3-point scale (Yes Mostly, Yes Partly, Not at All)
- ✓ 4-point scale (Strongly Agree, Agree, Disagree, Strongly Disagree), (Less than 1 Year, 1–2 Years, 2–3 Years, Greater than 3 Years)
- ✓ 5-point scale (Weekly, Monthly, Quarterly, Biannually, and annually).

Overall scores for each capacity area were automatically analyzed and displayed in easy-to-interpret dashboards. Scores were normalized to a scale of 10. Simple descriptive statistics such as means and frequencies were used to analyse the quantitative data in MS Excel. Qualitative data, or notes entered in the workbook to explain various responses in MS Excel 2010-16, were analyzed manually.

Notes from the key informant interviews were typed in MS Word 2010, and the data were subsequently coded into themes aligned to the 12 capacity areas. At least two people coded the themes, and the results were compared and discussed. Unanticipated themes arising from the data were incorporated into a second round of coding, with tree nodes representing broad categories. Any further arising nodes were created by grouping some of the free nodes into tree nodes by making logical connections and incorporating emerging themes. The final stage was a layered analysis that entailed identification of the main themes and underlying causes of reported experiences and observations presented in the excel dashboard.

A draft report developed and subjected to internal review by various user departments, SAGAs and counties. The draft findings were discussed within the M&E TWG and thereafter a second improved draft was shared and circulated to stakeholders within the health sector via a HIS ICC. Received inputs from these processes were consolidated into the final report.

2.6 Study limitations

This study, being a self-assessment at group level had a major limitation with a high likelihood of participants to exaggerate actual scores due to the social desirability. The absence of an independent/external moderator during the group assessments may have also compromised objectivity.

The group-based assessment employed a whole system approach with inputs from all stakeholders, including the private sector incorporated through the assessments done at the planning unit level. It is important to note that the assessment did not look at M&E performance of individual (private or public) health facilities, and thus these findings can only be inferred with regard to the entirety of the planning unit assessed (County, Directorate, SAGAs) rather than individual facilities. Because this tool was specifically tailored to assess M&E capacities in the Ministry of Health at County and National levels, findings may be generalized to the entire health sector, due to the fact that the organizational structure, institutional arrangements, and mandates are different at the two levels but with one common goal.

3 RESULTS

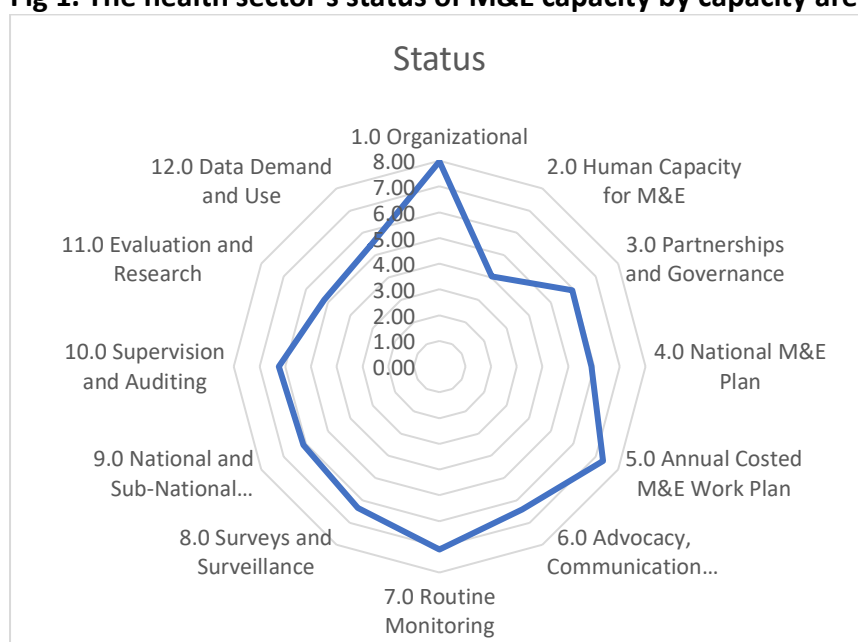
3.1 Overall Health Sector Capacity Assessment

Five broad categories of the Health Sector underwent the group M&E Capacity assessments as follows: The County health departments, National MoH departments, MoH programs, Semi-autonomous government agencies (SAGAs) and regulatory councils/boards. The overall capacity of the health sector by the four dimensions of status, quality, technical autonomy and financial autonomy was as follows:

Status

In terms of whether specific elements that constitute a capacity area existed, the average score across the entire health sector was fair at 6.17. Eleven out of the 12 capacity areas scored above 5 with organizational capacity scoring the highest at 7.98, followed by annual costed M&E work plans at 7.33 and Routine Monitoring at 7.11 (Fig. 1). Human Capacity for M&E scored the lowest at 4.06 followed by Evaluation & Research at 5.18.

Fig 1. The health sector's status of M&E capacity by capacity areas



Quality

When assessing how the existing elements measured according to specific standards, the average score across the health sector was 5.78 meaning that the capacity elements present adhered to set standards to a certain extent. The capacity areas that scored the highest in quality were: National & County databases at 6.81, Advocacy, Communication and Cultural behaviour at 6.63 and Organizational capacity at 6.39 (Fig 2). On the other hand, Human capacity for M&E (4.41) and Evaluation and Research (4.72) scored the lowest in this dimension.

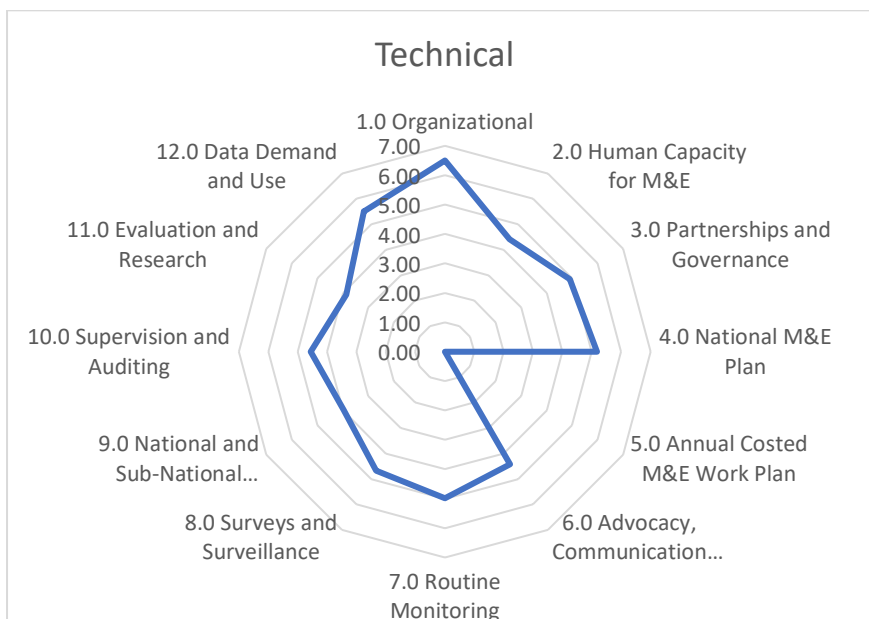
Fig 2. The health sector's quality of M&E capacity by capacity areas



Technical Autonomy

The average internal technical capacity for executing M&E functions across the health sector was low at 4.42. Only three capacity areas scored above 5 with the highest technical autonomy being found in organizational capacity (6.5), Data Demand & Use (5.51) and National M&E Plan (5.18). On the other hand, the health sectors' lowest technical autonomy was in annual costed M&E work plans at 0 and evaluation and research at 3.86 (Fig 3).

Fig 3. The health sector's technical autonomy by capacity areas



Financial Autonomy

The average internal financial capacity to execute M&E functions was very low across the health sector at 3.23 implying that there was inadequate internal funding to execute various M&E functions. All the 12 components scored less than 5 in this dimension with the highest score being in the National and County databases at 4.2 followed by Data Demand & Use (4.09) and Routine Monitoring at 4.04 (Fig 4.). The internal financial capacity was lowest for Advocacy, Communication and Cultural behavior (1.86) and Evaluation and Research (2.17).

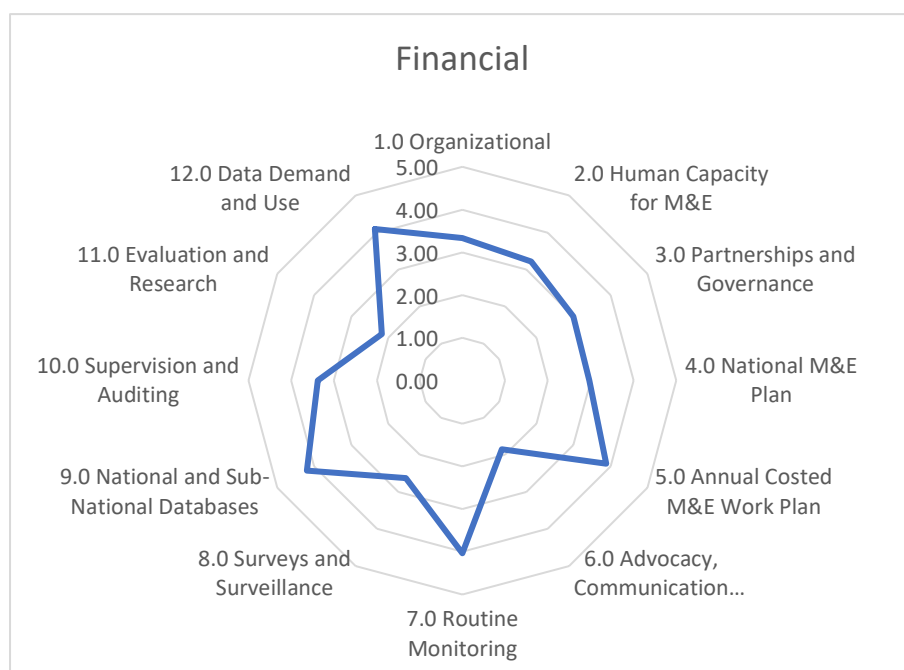


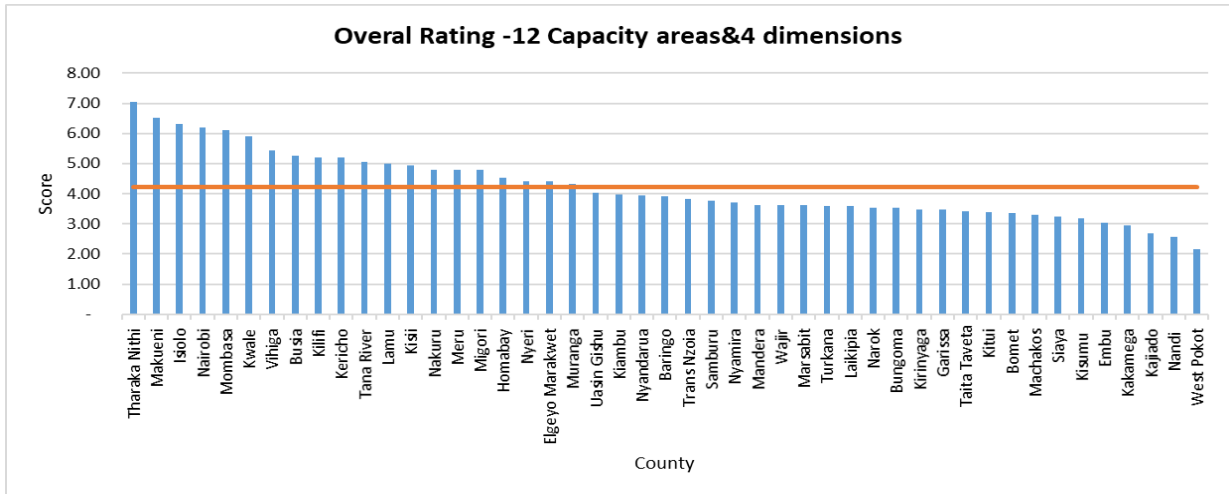
Fig 4. The health sector's financial autonomy by capacity areas

3.2 Results of the counties' capacity assessment

Overall capacity by the four dimensions

After aggregating the county scores across the four dimensions of status, quality, technical autonomy and financial autonomy, the average score for all the 12 capacity areas was low at 4.23. Only 12 out of the 47 counties (25%) had an average score of 5 and above, with the highest capacity being found in Tharaka-Nithi county at 7.0 and the lowest in West Pokot County at 2.15 (Fig.5). The detailed individual County scores for each of the four dimensions per capacity area are shown in Appendix IV

Fig. 5: County's overall M&E capacity



Status

In terms of whether specific elements that constitute a capacity area existed, the average score across all the 47 counties was fair at 5.47. Five capacity areas scored above 5, with routine monitoring and national & county databases scoring the highest at 7.55 and 8.51 respectively (Fig.6). Human Resource capacity for Monitoring, Evaluation and Research scored the lowest at 4.0. Half of the counties scored 5 and above in terms of the status of the 12 capacity areas with Nandi County scoring the lowest at 3.32 as shown in Figure 7.

Fig. 6: County’s status of M&E capacity by capacity areas

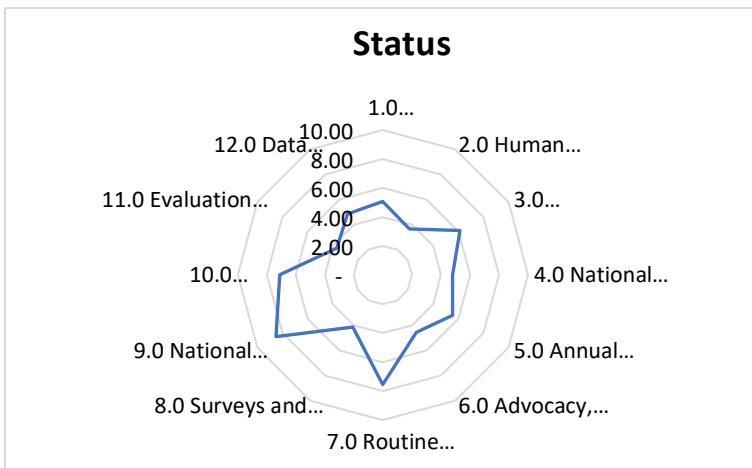
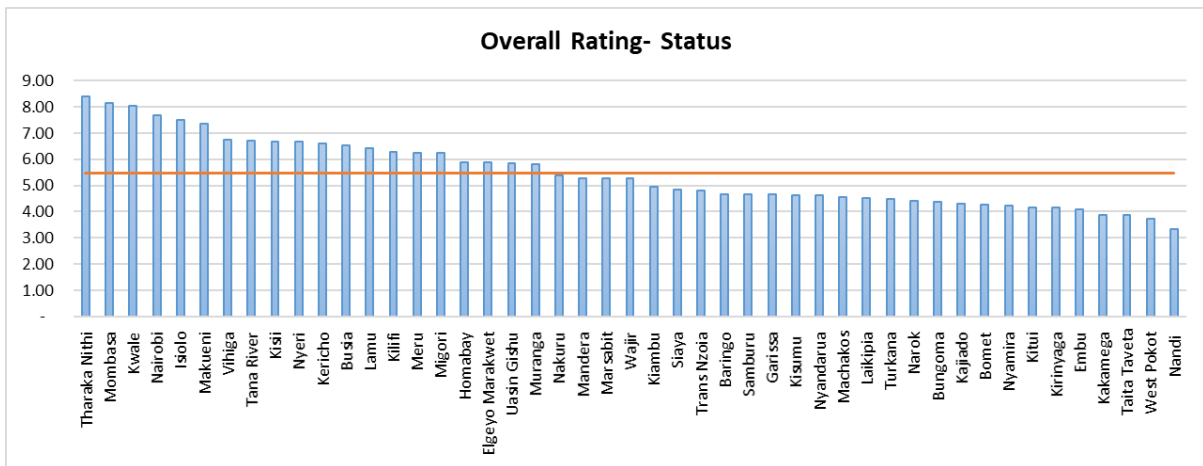


Fig. 7: County-specific rating of status of M&E capacity



Quality

When assessing how the existing elements measure according to specific standards, the average score was 4.52. The capacity areas that scored the highest in the quality dimension were: National and County Databases at 8.19, Routine Monitoring at 6.82 and Supervision and Auditing at 6.28. Organizational capacity scored the lowest at 2.53 followed by Annual Costed M&E work plans at 2.79. Twenty-one counties scored above 5.0 indicating fair robustness of the existing capacity elements to specific standards. Isiolo county (8.13) and Nairobi county (7.73) scored the highest in this dimension while Nandi county scored the lowest at 1.81. Figure 8 shows the overall rating of quality per capacity area while figure 9 shows the county-specific ratings of quality of M&E capacity.

Fig. 8: County’s quality of M&E capacity by capacity area

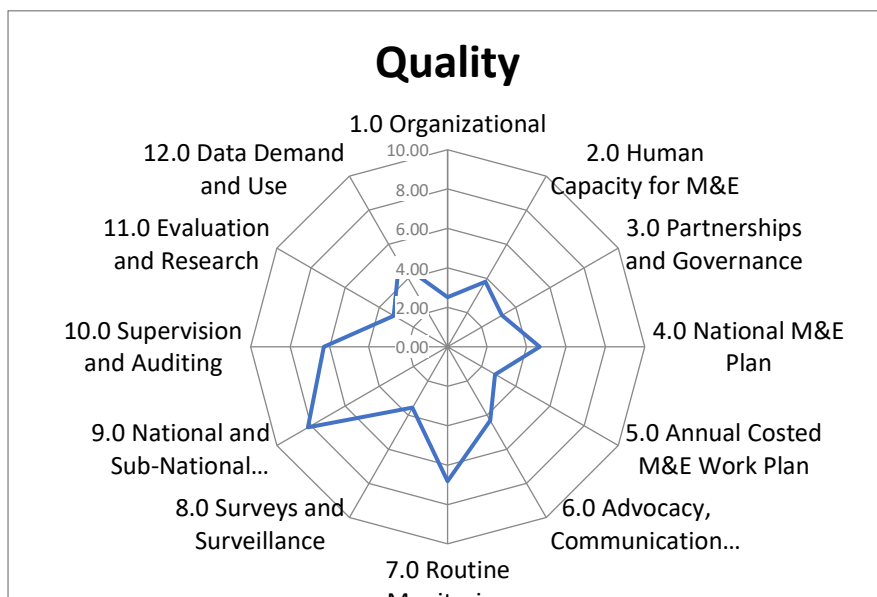
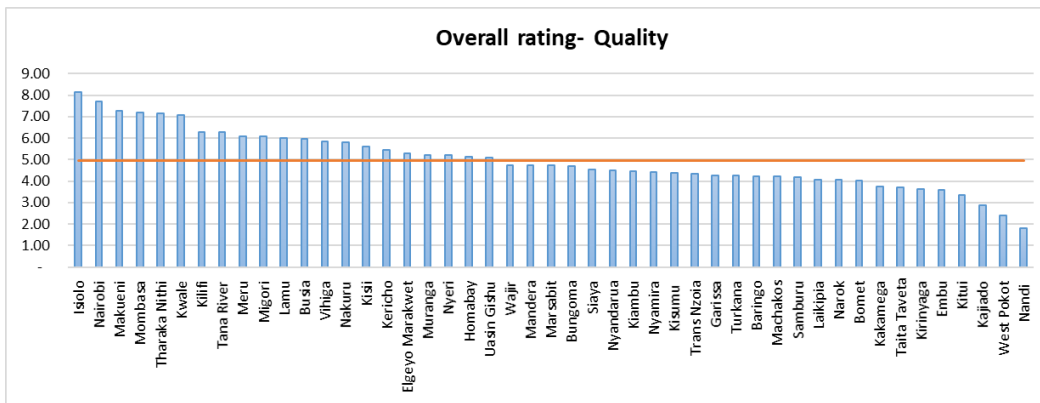


Fig. 9: County-specific rating of quality of M&E capacity



Technical autonomy

On average, the counties had low internal technical capacity for executing M&E functions as evidenced by a score of 3.27. None of the 12 capacity areas scored above 5 with the highest technical autonomy score being found in Surveys & Surveillance (4.82), Routine Monitoring (4.63) and Data Demand & Use (4.57). The technical capacity for developing annual costed M&E work plans was the lowest at 0 followed by evaluation and research which scored 2.18 (Fig. 10). Looking at the county-specific scores, only Tharaka Nithi and Makueni had a technical autonomy score of above 5.0 while Kajiado had the lowest at 1.46 (Fig.11).

Fig. 10: The health sector’s M&E capacity for technical autonomy by capacity area

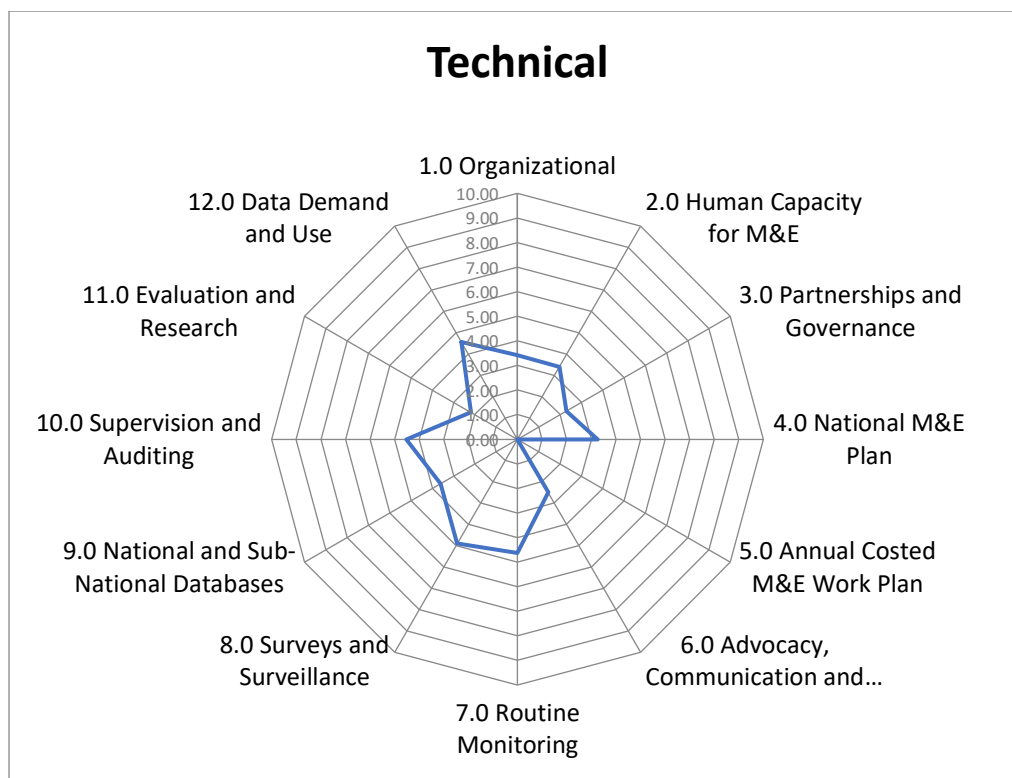
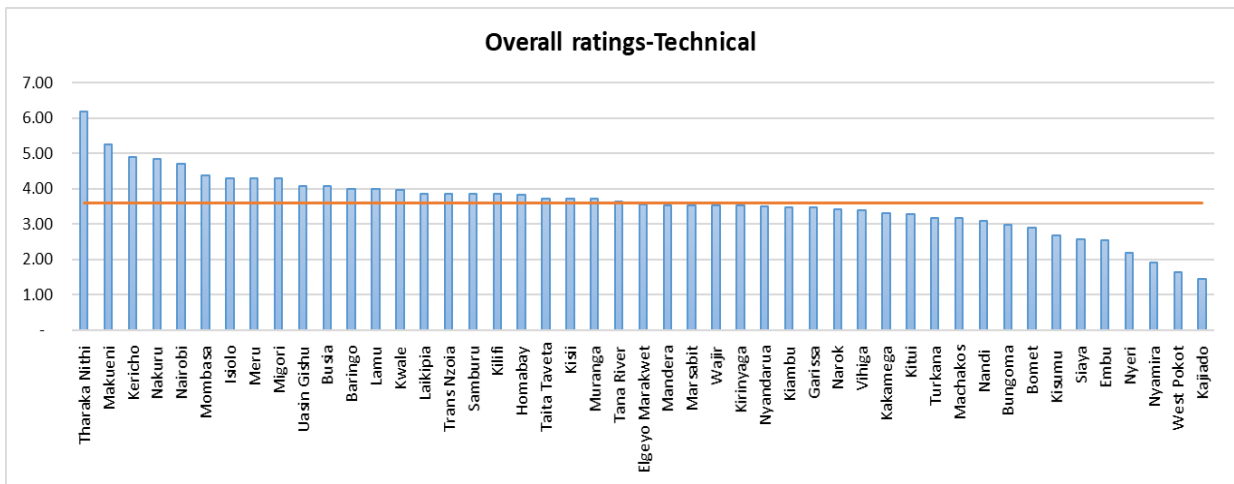


Fig. 11: County-specific rating of M&E capacity for technical autonomy



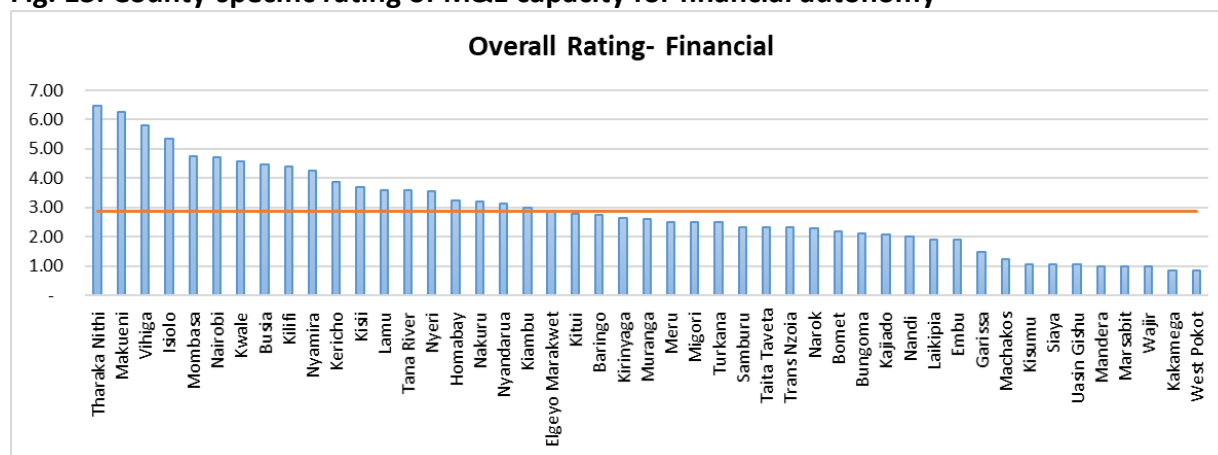
Financial autonomy

The average internal financial capacity to execute M&E functions scored the lowest among all the four dimensions at 2.17. The internal financial capacity was lowest for Advocacy, Communication & Cultural behaviour (1.25) and Evaluation & Research (1.79) while the highest capacity was for National and County databases (5.21) and Routine Monitoring (5.0). Eight capacity areas scored below 3.0 implying heavy reliance on external financial support to carry out M&E activities (Fig. 12). Most counties reported low internal financial autonomy for developing and executing M&E functions with only 4 counties namely Tharaka Nithi, Makueni, Vihiga and Isiolo scoring above 5.0 The counties scoring the lowest were Kakamega at 0.85 and West Pokot at 0.83 (Fig. 13).

Fig. 12: The health sector’s M&E capacity for financial autonomy by capacity area



Fig. 13: County-specific rating of M&E capacity for financial autonomy



Detailed results of the 12 M&E capacity components

Component 1: Organization of an M&E system

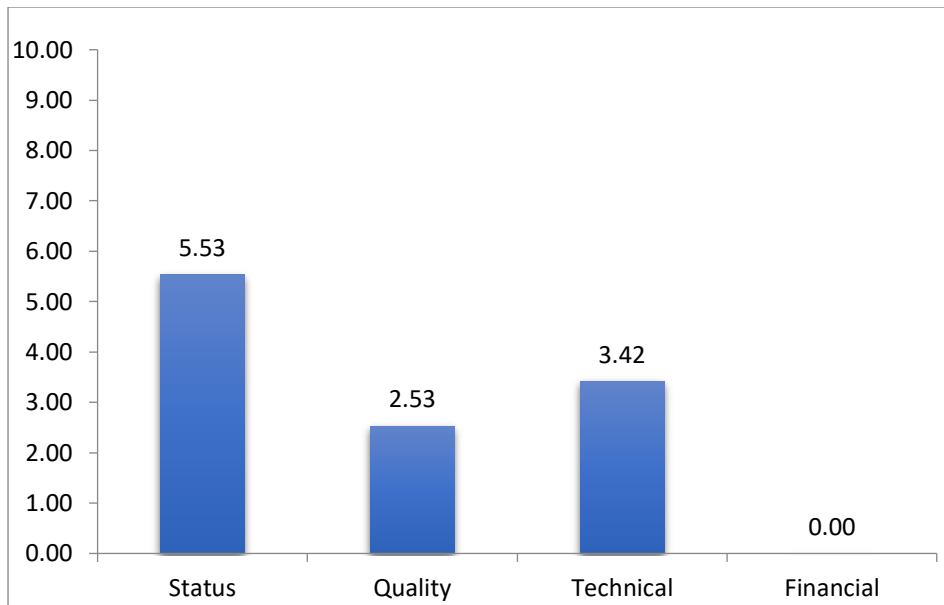
This component assesses the organization of an M&E system through the following domains:

- i. Presence of a mission statement or stated objectives
- ii. Presence of values and ethics statements
- iii. Presence of an M&E unit/division/directorate
- iv. Regular M&E unit meetings

The overall rating for organizational capacity of an M&E system in terms of the quality of the organizational structures and financial assistance in development of these structures, was at 52%.

Presence of a mission statement, values and ethics statements and regular M&E Unit meetings was average giving a status score of 5.53 (Fig. 14). However, the quality of these elements was poor at 2.53 indicating that they did not meet the required standards. There was very low internal technical and financial capacity for developing these statements at the County level.

Fig. 14: Overall rating of counties' organizational capacity for M&E



Eighteen out of 47 counties had an approved mission statement, 13 had it in draft, while 16 counties had no mission statements.

The counties that scored the highest in this capacity area were: Kamba 7.50, Kakamega 7.40, Kericho 7.08, Mombasa 7.08 and Tharaka Nithi 7.08. The counties that scored the lowest in this capacity area were: Laikipia 1.53, Samburu 1.53, Taita Taveta 1.38, Elgeyo Marakwet 1.33 and Trans Nzoia 0.57.

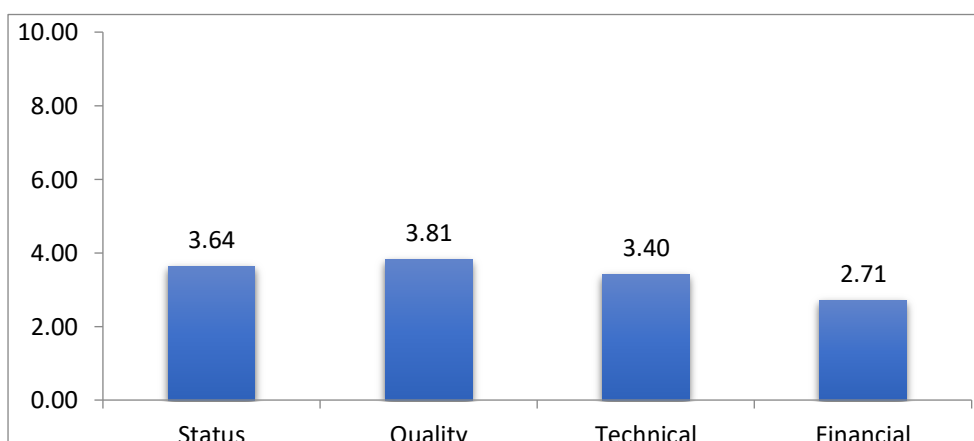
Component 2: Human Capacity for M&E

Human capacity for M&E had a score of 41%. This was assessed under 5 main domains:

- i Assessment of the M&E staff skills and competencies
- ii Availability of a costed Human Capacity Building Plan
- iii Availability of a costed Human Capacity Building Plan for organizational development
- iv Availability of a costed Human Capacity Building Plan for data demand and information use
- v Availability of a validated M&E training curriculum.

Most of the technical and financial capacity was through the assistance of partners, thus a low score of 3.4 and 2.7 respectively (Fig. 15).

Fig. 15: Overall rating of counties' human capacity for M&E



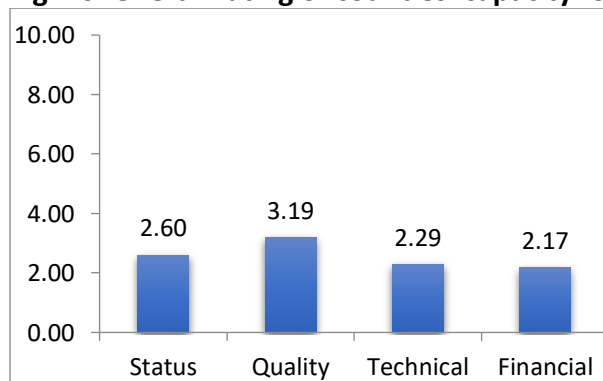
Availability of staff within the M&E units scored highest at 7.55, however, in terms of quality of these staff, most of the staff did not have qualifications specific to M&E. The capacity of staff to collate, process and analyze data; make recommendations developed using health data for decision making by national programs; and use GIS applications to produce simple graphics/map products was suboptimal. In terms of reliability on technical assistance to accomplish their routine tasks, the M&E staff seemed to be averagely dependent on this technical assistance. The government support for training regarding M&E was suboptimal. Figure 11a shows ratings of specific components by the four dimensions of status, quality, technical and financial autonomy.

The counties that scored the highest in this capacity area were: Vihiga 8.35, Makueni 7.65, Kilifi 5.86, Tharaka Nithi 5.76 and Mombasa 5.63. The counties that scored the lowest in this capacity area were: Marsabit 1.44, Wajir 1.44, Laikipia 1.19, and Nakuru 1.13 and West Pokot 0.

Component 3.0: Partnerships and Governance

This assessment section explored county capacity to coordinate with all stakeholders at the county level, governance structures, and County M&E technical working groups. It also examined the existence of a routine communication channel to facilitate exchange of information among stakeholders, local leadership, and capacity for stakeholder coordination. Figure 16 shows that there is overall weak partnership and governance in the M&E system, with a score of 2.6 out of 10 on the status dimension. The results further showed a low financial support of a score of 2.17 and technical assistance of 2.29. Specific deficiencies in this capacity area included low quality of strategies/policies for M&E functions and standard operating procedures, weak internal technical capacity to develop strategies/policies and standard operating procedures (SOPs), and low financial support for technical working groups (TWGs).

Fig. 16: Overall rating of counties’ capacity for partnership and governance



The counties that scored the highest in this capacity area were: Kisii 7.72, Kericho 7.16, Kiambu 6.94, Nakuru 6.78 and Murang’a 6.59. The counties that scored the lowest in this capacity area were: Nyeri 3.07, Nyamira 2.83, Kirinyaga 1.92, West Pokot 1.22 and Kajiado 0.71.

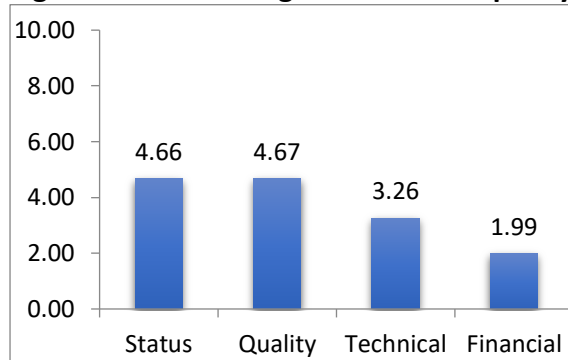
Component 4.0: National M&E Plan

This section explored county role in eliciting broad stakeholder participation in the development of the County M&E plan. It examined the linkage of the M&E plan to the National HIS strategy and adherence of the M&E plan to national and international technical standards.

The section also sought information to determine if an assessment had been done on the M&E system to guide approaches to strengthen the revised M&E plan.

The results showed that at least there was availability of county stakeholder participation in development of the plan at 4.66 out of the possible score of 10 but internal financial capacity for the same was very low at a score of 1.99 (Fig.17). Existence of a national multi-sectoral M&E plan was low. Financial capacity for preparing work plans, schedules and budgets was higher than for other activities within this capacity area.

Fig. 17: Overall rating of counties' capacity for national M&E plan



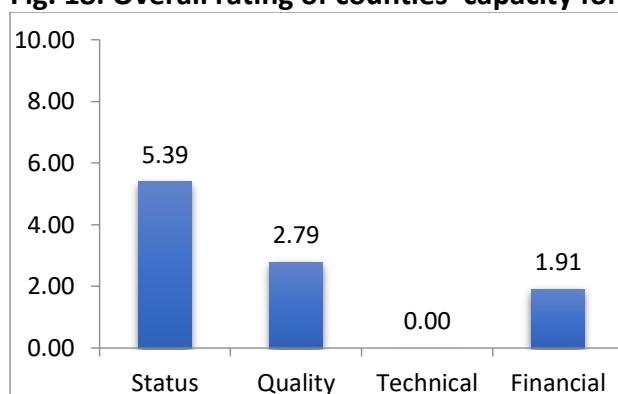
The counties that scored the highest in this capacity area were: Tharaka Nithi 8.75, Isiolo 6.96, Kisii 6.48, Makueni 6.25 and Kiambu 6.13. The counties that scored the lowest in this capacity area were: Nandi 0.63, Nyamira 0.38, Kajiado 0, Taita Taveta 0 and West Pokot 0.

Component 5: Annual Costed M&E plan

This component explored the existence of an annual costed M&E plan and the extent of annual updates. It also examined the linkage between the work plan and the government medium term expenditure framework (MTEF) budgets. Questions asked if resources are committed for the M&E Annual Work plan (AWP) and the role of stakeholders in its endorsement and implementation.

In terms of status, counties generally had an annual costed work plan where all the activities in the AWP were costed, with clear timelines and designated parties responsible for the implementation hence a status score of 5.39 (Fig, 18). However, there was no internal technical capacity for developing the costed M&E work plans implying that most counties operated without the costed M&E work plans.

Fig. 18: Overall rating of counties' capacity for annual costed M&E plan

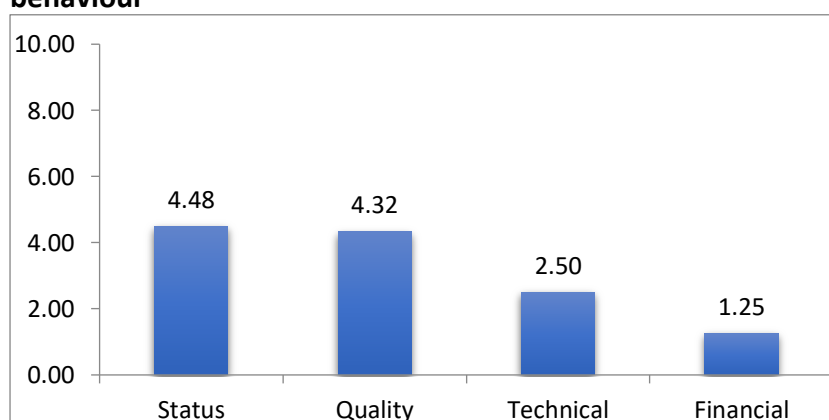


The counties that scored the highest in this capacity area were: Isiolo 7.50, Nyeri 6.39, Lamu 5.97, Tharaka Nithi 5.42 and Kajiado 5.42. The counties that scored the lowest in this capacity area were: Narok 0, Nyandarua 0, Taita Taveta 0, Turkana 0 and West Pokot 0.

Component 6.0: Advocacy, Communication and Cultural Behaviour

This component of the assessment explored county communication strategy and any specific M&E communication and advocacy plan, articulation of M&E in national and county policies and strategic plans, and if leadership championed for M&E in the counties. Overall capacity for advocacy, communication and cultural behavior was rated low at 35%. Assessment findings showed that counties have a communication strategy in place, M&E championship by the leadership and that they strived for inclusion of M&E strategies in national policies and strategies hence a status score of 4.48 (Fig. 19). However, the Counties relied on external technical and financial expertise to develop their communication and advocacy strategies indicating lack of sustainability in this area.

Fig. 19: Overall rating of counties' capacity for Advocacy, Communication and Cultural behaviour



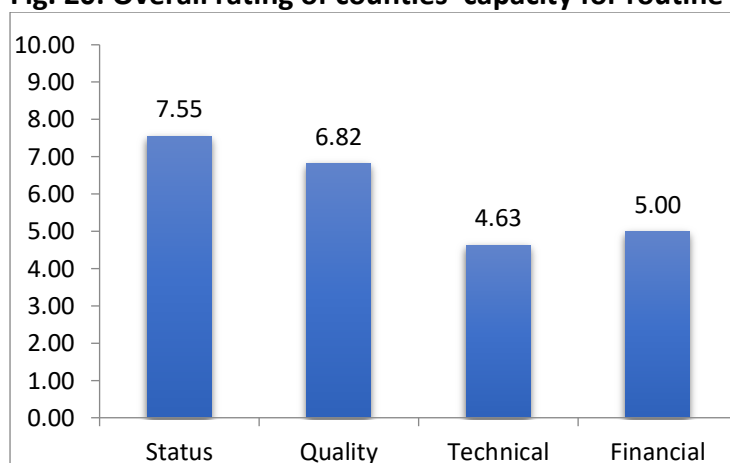
The counties that scored the highest in this capacity area were: Vihiga 9.69, Tharaka Nithi 6.88, Isiolo 6.77, Kericho 6.77 and Nakuru 6.56. The counties that scored the lowest in this capacity area were: Bomet 0.42, Embu 0.42, Mandera 0.42, Marsabit 0.42 and Nandi 0.42.

Component 7: Routine Monitoring

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

The availability of tools for reporting in Health Facilities was high but not adequate as evidenced by a score of 7.55 (Fig.20). This resulted from inadequate tools with counties sometimes being forced to improvise the tools by using photocopies. Comparatively, the counties had low internal technical and financial capacity for routine monitoring as evidenced by a score of 4.63 (technical autonomy) and 5 (financial autonomy).

Fig. 20: Overall rating of counties' capacity for routine monitoring

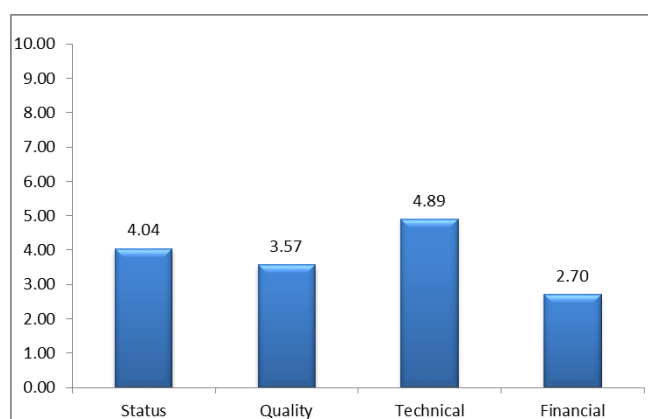


The counties that scored the highest in this capacity area were: Makueni 7.66, Kwale 7.50, Mombasa 7.50, Uasin Gishu 7.19 and Isiolo 7.03. The counties that scored the lowest in this capacity area were: Nandi 4.53, Nyamira 4.53, West Pokot 4.22, Garissa 3.60 and Kakamega 2.03.

Component 8.0: Surveys and Surveillance

This component of the assessment focused on counties' capacity for survey and surveillance protocols, the existence of a well-functioning surveillance system and an inventory of completed surveys and surveillance. The capacity for surveys and surveillance was sub-optimal at 4.04, with the quality being lower at 3.57 (Fig. 21). Despite an internal technical capacity to conduct surveys of 4.89, the financial capacity for the same was very low at 2.7. Specific deficiencies in this component related to capacity for developing protocols and inventories for surveys/surveillance.

Fig. 21: Overall rating of counties' capacity to conduct surveys and surveillance.



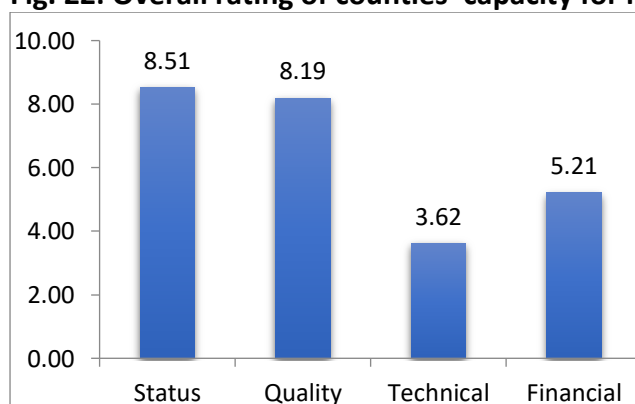
The counties that scored the highest in this capacity area were: Tharaka Nithi 7.40, Kilifi 7.19, Isiolo 7.09, Nakuru 6.77 and Nairobi 6.77. The counties that scored the lowest in this capacity area were: Kiambu 0, Kitui 0, Mandera 0, Marsabit 0 and Wajir 0.

Component 9.0: National and County Databases

This component explored the existence of national and county databases in counties and National level departments and programs that facilitate the decision-making and reporting needs of different stakeholders. It also explored linkages between national and county databases to monitor data consistency and avoid duplication of efforts.

The status and quality components scored highly at 8.5 and 8.1 respectively indicating the presence of a robust and reliable reporting database (Fig. 22). Financial sustainability dimension scored an average of 5.2 indicating moderately funded data systems. The counties' technical capacity was lowest at 3.6 implying that counties relied on partners and the national government for the development and maintenance of the databases.

Fig. 22: Overall rating of counties' capacity for national and county databases



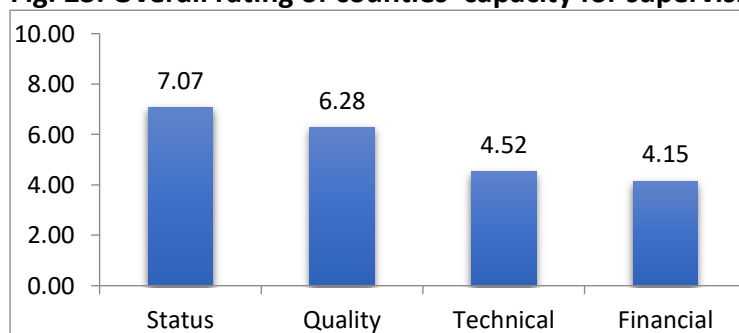
The counties that scored the highest in this capacity area were: Elgeyo Marakwet 8.60, Kwale 8.44, Mombasa 8.44, West Pokot 8.13 and Machakos 7.50. On the other hand, Siaya 2.50, Bungoma 0.94, Kakamega 0.94, Kiambu 0.47 and Nandi 0 scored the lowest in this capacity area.

Component 10.0: Supervision and Auditing

This component explored the existence of guidelines for supervising routine data collection at the health facility and community levels. It also examined the County Health Management Team (CHMT) supervisory visits and data quality audit status, report writing, and capacity to provide feedback to local staff.

Many Counties reported to have guidelines and tools for M&E supportive supervision giving a status score of 7.07; the quality of the audits system was fairly reliable at a score of 6.28 (Fig. 23). However, both financial and technical capacities were below 5.0 indicating some level of involvement of external technical assistance and stakeholders for technical and financial support.

Fig. 23: Overall rating of counties' capacity for supervision and auditing



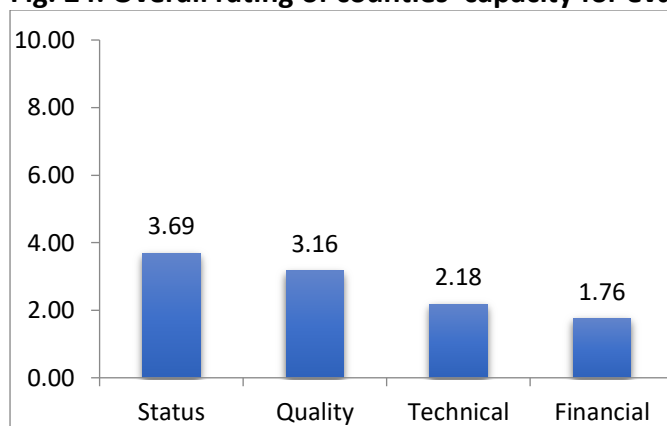
The counties that scored the highest in this capacity area were: Lamu 10.00, Tana River 10.00, Homabay 8.44, Tharaka Nithi 7.81 and Machakos 7.50, while the counties that scored the lowest in this capacity area were: Marsabit 3.13, Wajir 3.13, Nyeri 2.50, Turkana 2.50 and Nandi 1.88.

Component 11: Evaluation and Research

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

The results documented poor performance in this component with all the dimensions scoring below the average score as follows: status - 3.69, quality - 3.16, technical autonomy - 2.18 and financial autonomy - 1.76 (Fig. 24). Specific weaknesses identified included low capacity for inventory or database of institutions undertaking research and evaluation as well as low capacity for a division-specific research agenda.

Fig. 24: Overall rating of counties' capacity for evaluation and research



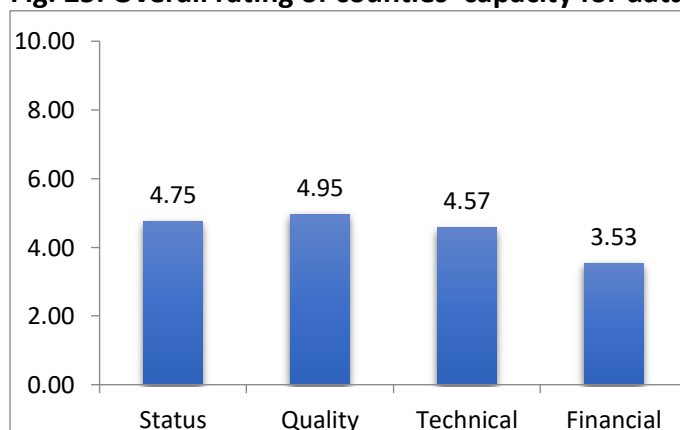
The counties that scored the highest in this capacity area were: Tharaka Nithi 8.61, Nairobi 6.94, Isiolo 6.53, Nyandarua 5.42 and Kiambu 4.79. The counties that scored the lowest in this capacity area were: Machakos 0, Nyamira 0, Tana River 0, Uasin Gishu 0, and West Pokot 0.

Component 12: Data Demand and Use

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

There was an overall trend in embracing data demand and use in the counties for decision making. However, all aspects were below the average score but consistent within the same range of between 3 and 5 (Fig. 25). Capacity for data use plan was low across all the four dimensions.

Fig. 25: Overall rating of counties' capacity for data demand and use



The counties that scored the highest in this capacity area were: Kwale 8.61, Mombasa 8.61, Makueni 8.40, Kilifi 8.33 and Tharaka Nithi 8.13. The counties that scored the lowest in this capacity area were: Trans Nzoia 2.09, Bomet 2.08, Embu 2.08, Samburu 2.08 and Turkana 2.08.

3.3 Results of the Ministry of Health (MoH) Departments capacity assessment

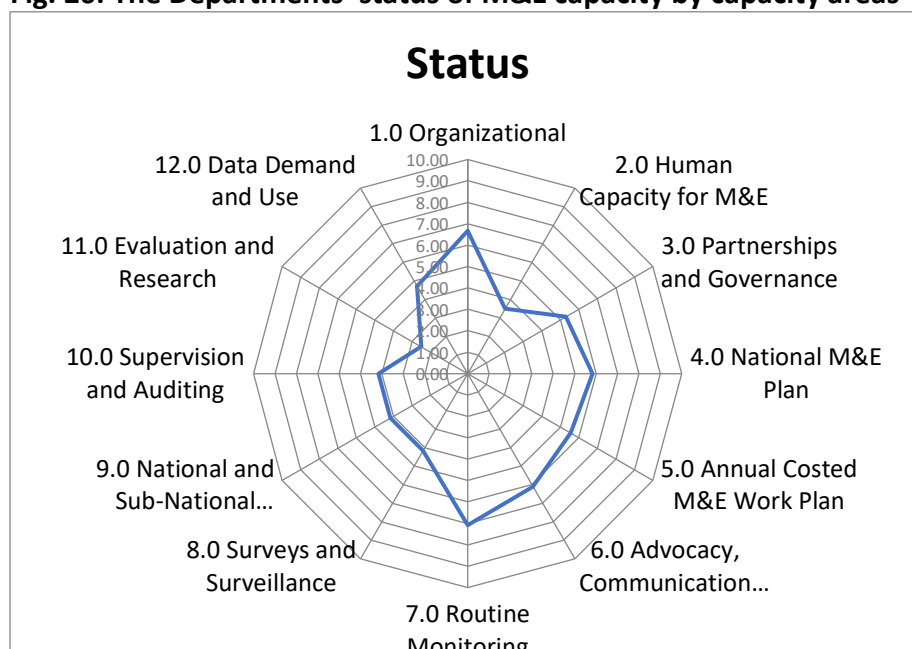
Overall capacity by the four dimensions

Six MoH departments took part in the MECAT group assessments namely: Departments of Administration, Universal Health Coverage, Intergovernmental and Health Sector coordination (IGF & HSC), Health Standards and Quality Regulation (DHSQAR), Policy & Planning and Curative and Rehabilitative Health Services. After aggregating the Departments' scores across the four dimensions of status, quality, technical autonomy and financial autonomy, the average score for all the 12 capacity areas was 4.24. Only two out of the six Departments interviewed had an average score above 5, with Policy & Planning having the highest capacity score of 7.69, followed by Health Standards and Quality Regulation with 7.36. The detailed individual MoH Department scores for each of the four dimensions per capacity area are shown in Appendix V.

Status

In terms of whether specific elements that constitute a capacity area existed, the average score across all the Departments interviewed was 4.98 meaning that only some of the elements of the 12 capacity areas were present. Six capacity areas scored above 5, with routine monitoring having the highest score at 87.08, followed by organizational capacity at 6.67 and Advocacy, communication & Culture at 6.11 (Fig 26). Evaluation & Research (2.5) and Human Capacity for M&E (3.5) scored the lowest in this dimension.

Fig. 26: The Departments' status of M&E capacity by capacity areas

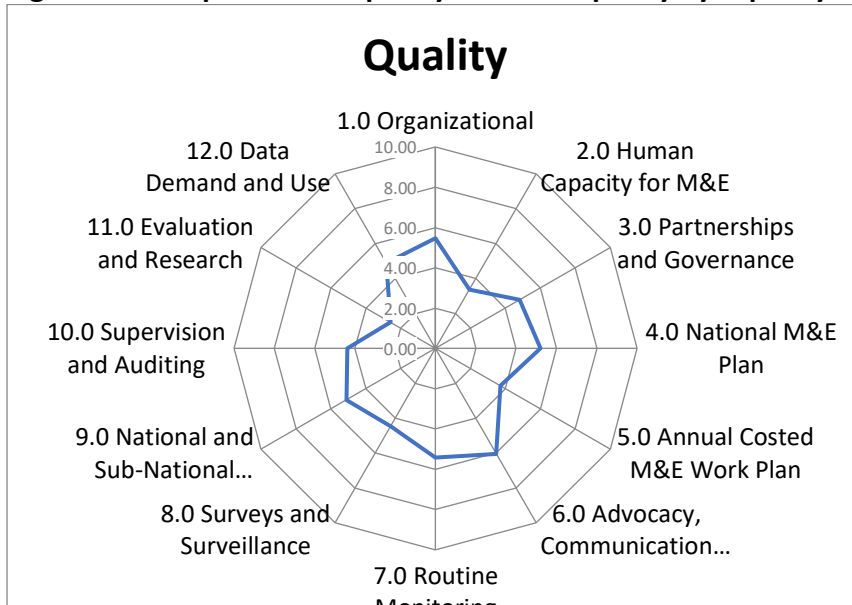


Quality

When assessing how the existing elements measured according to specific standards, the average score was 4.62 meaning that the capacity elements present did not adhere very well to set standards. Four capacity areas scored above 5.0 as follows: Advocacy, Communication

and Cultural Behaviour (6.04), Organizational Capacity (5.47), Routine Monitoring (5.42) and National and County Databases at 5.10. On the other hand, Evaluation & Research (2.59) and annual costing M&E work plans (3.7) scored the lowest in this dimension (Fig 27).

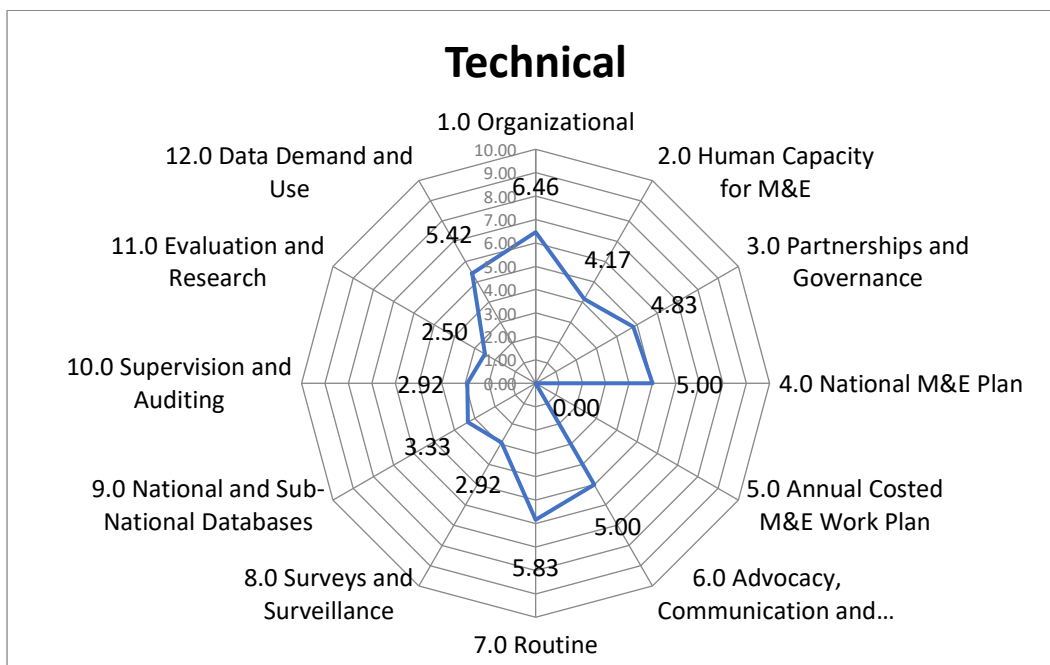
Fig. 27: The Departments’ quality of M&E capacity by capacity area



Technical autonomy

The Departments’ internal technical capacity for executing M&E functions was low as evidenced by an average score of 4.03. Only three capacity areas were scored at above 5.0 as follows: Organizational Capacity (6.46), Routine Monitoring (5.83) and Data Demand & Use (5.42). On the other hand, the technical capacity was lowest for annual costing M&E work plans at 0 and Evaluation & Research at 2.5 (Fig. 28).

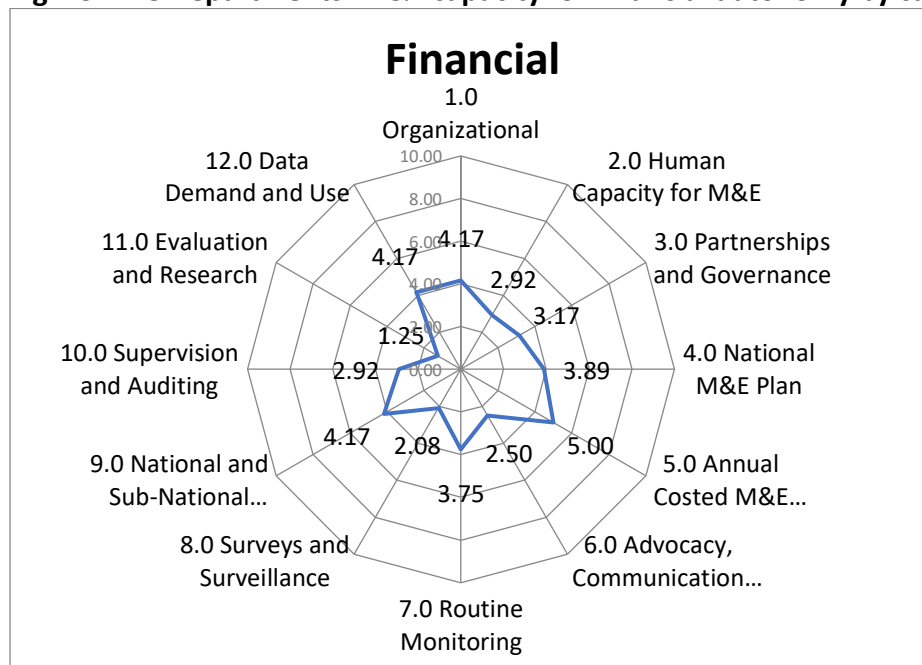
Fig. 28: The Departments’ M&E capacity for technical autonomy by capacity area



Financial autonomy

The average internal financial capacity to execute M&E functions scored the lowest among all the four dimensions at 3.33 implying that there was inadequate internal funding to execute various M&E functions. The highest scoring capacity areas in this dimension were annual costed M&E work plans (5.0), Organizational Capacity (4.17), National and County databases (4.17) and Data demand & Use (4.17). The capacity areas that scored the lowest were: Evaluation & Research at 1.25 and Surveys & Surveillance at 2.08 (Fig. 29).

Fig. 29: The Departments' M&E capacity for financial autonomy by capacity area



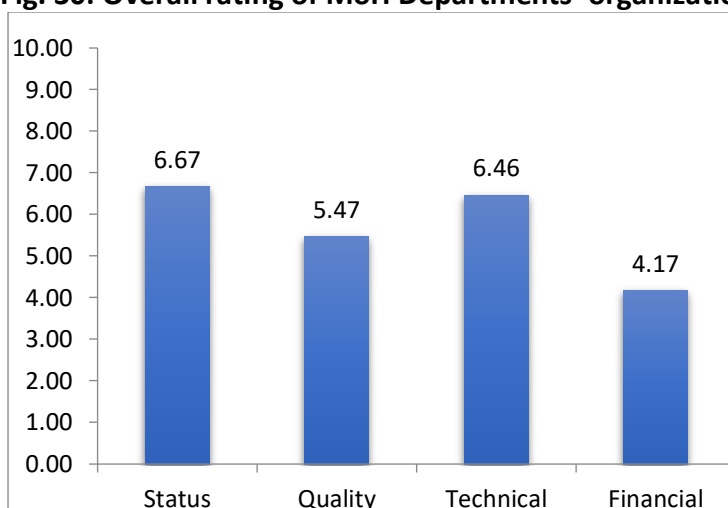
Detailed results of the 12 M&E capacity components among the Departments

Component 1: Organization of an M&E system

The overall rating for organizational capacity of an M&E system in terms of the presence, quality, technical and financial capacity was at 58%.

There was fairly good existence of mission statement/objectives and values and ethics statements as evidenced by a status score of 6.67 (Fig 30). However, the quality of these statements lagged behind at a score of 5.47 implying that they did not adhere very well to the set standards. The departments had good internal capacity but they lacked sufficient internal funding to develop the statements (financial capacity score of 4.17).

Fig. 30: Overall rating of MoH Departments' organizational capacity for M&E

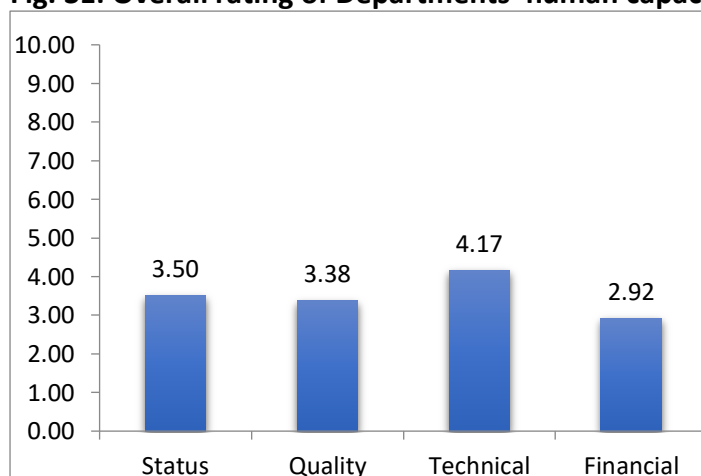


The Departments that scored the highest in this capacity area were DHSQAR (9.38) and Policy & Planning (7.81) while UHC scored the lowest at 2.71.

Component 2: Human Capacity for M&E

The overall rating of human capacity for M&E was very poor at 37%. There was average existence of staff M&E skills and competencies but the departments lacked costed human capacity building plans e.g. for organizational development and data demand and use, hence a status score of 3.5 (Fig 31). Similarly, the quality of the existing human capacity elements was poor. This meant that departments did not regularly take part in structured human capacity building. Despite having a fair level of internal technical ability, there was very little internal financial investment in human capacity for M&E hence a score of 2.92 in the financial dimension.

Fig. 31: Overall rating of Departments' human capacity for M&E

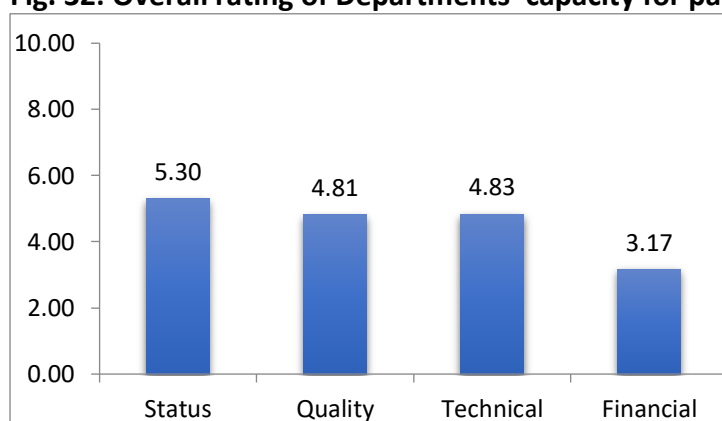


The Departments that scored the highest in this capacity area were DHSQAR (7.58) and Policy & Planning (6.76) while IGF & HSC and Administration scored the lowest at 0.

Component 3.0: Partnerships and Governance

Overall Departments' capacity for partnership and governance was average at 49%. The departments scored 5.3 perhaps due to low existence of standard operating procedures defining M&E roles and responsibilities, lack of strategies/policies to support M&E functions and lack of clear mechanisms for communicating M&E activities (Fig 32). Nevertheless, there was good existence of national M&E technical working groups. The quality and technical capacity dimensions scored 4.81 and 4.83 respectively, with specific gaps being lack of updated inventories of M&E stakeholders and inadequate mechanisms for M&E reporting. There was very low internal financial support for partnership and governance activities.

Fig. 32: Overall rating of Departments' capacity for partnership and governance

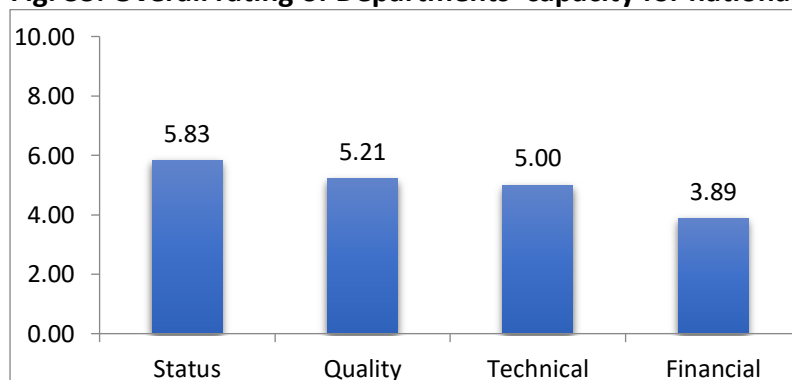


The Departments that scored the highest in this capacity area were Policy & Planning (7.97) and DHSQAR (7.54) while Administration scored the lowest at 2.29.

Component 4.0: National M&E Plan

Overall, the Departments had an average capacity to develop national M&E plans at 52%. Despite having a high ability to prepare project work plans, budgets and schedules as well as strong presence of a national multisectoral M&E plan, the Departments reported low existence of M&E plans for the department and M&E system assessment, giving an average score of 5.83 on the status dimension and 5.21 on the quality dimension (Fig 33). The internal technical capacity was average while the financial capacity for carrying out M&E assessments and development of M&E plans for the department was poor.

Fig. 33: Overall rating of Departments' capacity for national M&E plan

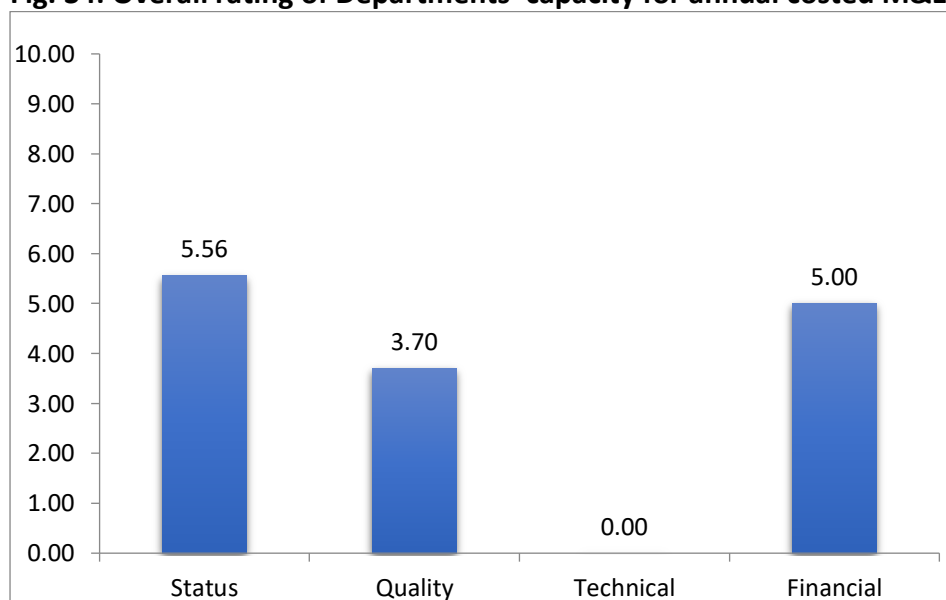


The Departments that scored the highest in this capacity area were DHSQAR (9.65) and Policy & Planning (8.63) while Administration scored the lowest at 2.13.

Component 5: Annual Costed M&E plan

The Departments’ overall capacity for development of annual costed M&E plans was suboptimal at 46%. Existence of costed M&E activities with identified sources of funding was low but on the other hand there was fair linkage to the Medium Term Exchange Framework (MTEF), hence a status score of 5.56 (Fig 34). However, the annual costed M&E plans were of low quality and there was lack of internal technical capacity to develop the plans meaning that the departments relied on external support for these activities. The internal financial capacity was average at 5.0 with the main activities supported being linkage of the M&E plans to the MTEF.

Fig. 34: Overall rating of Departments’ capacity for annual costed M&E plan

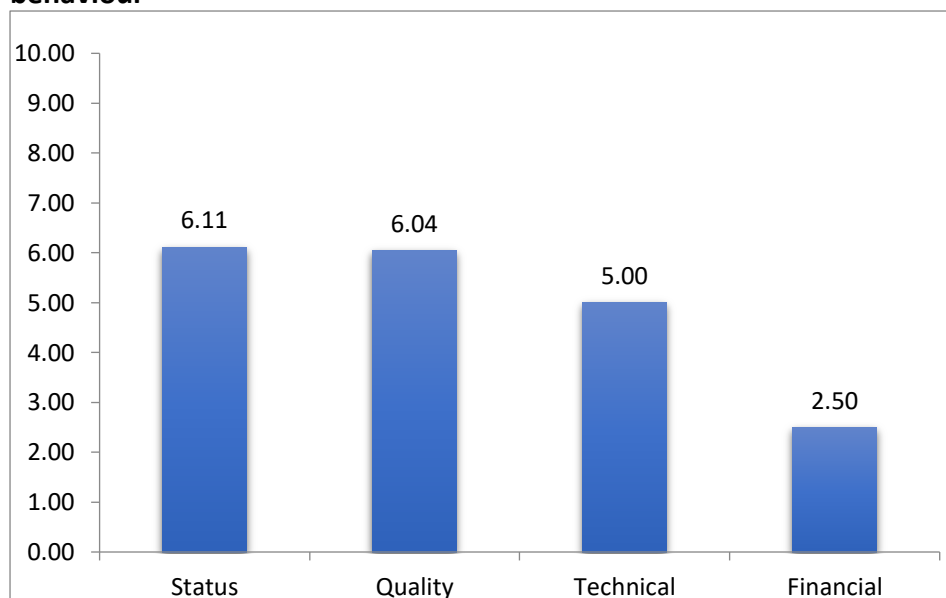


The Departments that scored the highest in this capacity area were IGF & HSC (6.39) and DHSQAR (5.83) while Administration and Curative departments scored the lowest at 0 each.

Component 6.0: Advocacy, Communication and Cultural Behaviour

The Departments’ overall capacity for advocacy, communication and cultural behavior was average at 52%. There was good presence of championship for M&E activities by the leadership, program specific communication strategies and inclusion of strategies into the national policies contributing to a score of 6.11 in the status dimension and 6.04 in the quality dimension (Fig.35). Specific deficiencies in this component related to poor technical and financial capacities for M&E championships and inclusion of M&E issues and strategies and products in the national policies indicating low sustainability of the advocacy and communication strategies and plans.

Fig. 35: Overall rating of departments' capacity for advocacy, communication and cultural behaviour

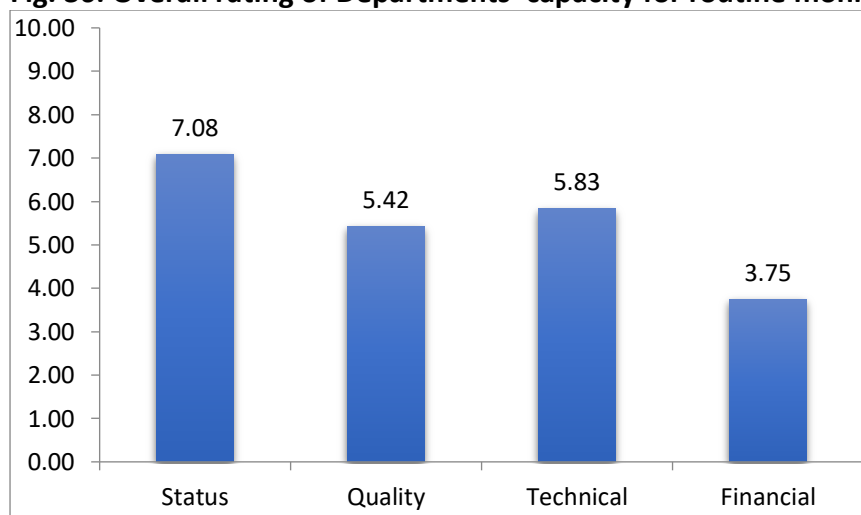


The Departments that scored the highest in this component were Policy & Planning (8.44) and DHSQAR (8.02) while Administration scored the lowest at 1.46.

Component 7: Routine Monitoring

Overall, the Departments' capacity for routine monitoring was 52%. There was high availability of guidelines for managing program monitoring data as well as essential tools and equipment for data management, giving a status score of 7.08 (Fig. 36). On the other hand, internal financial capacity for routine monitoring was very low at 3.75 indicating that the departments were not well funded to carry out routine monitoring despite having the necessary technical capacity to do so.

Fig. 36: Overall rating of Departments' capacity for routine monitoring

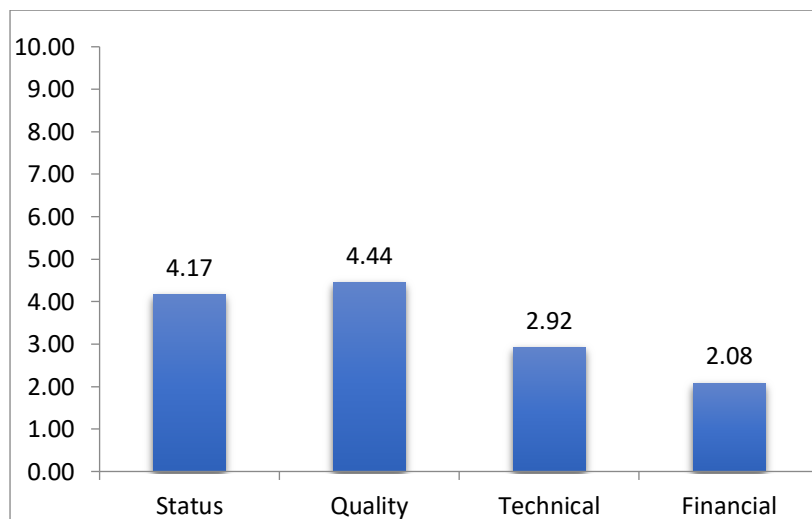


The Departments that scored the highest in this capacity area were Policy & Planning (8.28) and DHSQAR (7.5) while Administration scored the lowest at 0.

Component 8.0: Surveys and Surveillance

The Departments' overall capacity for surveys and surveillance was very low at 38%. There was low existence and poor quality of surveillance inventories and functioning surveillance system giving a score of 4.17 on the status dimension and 4.44 on the quality dimension (Fig. 37). Internal technical and financial capacity for this component were very low implying that the Departments hardly carried out any surveys and surveillance activities.

Fig. 37: Overall rating of Departments' capacity to conduct surveys and surveillance.

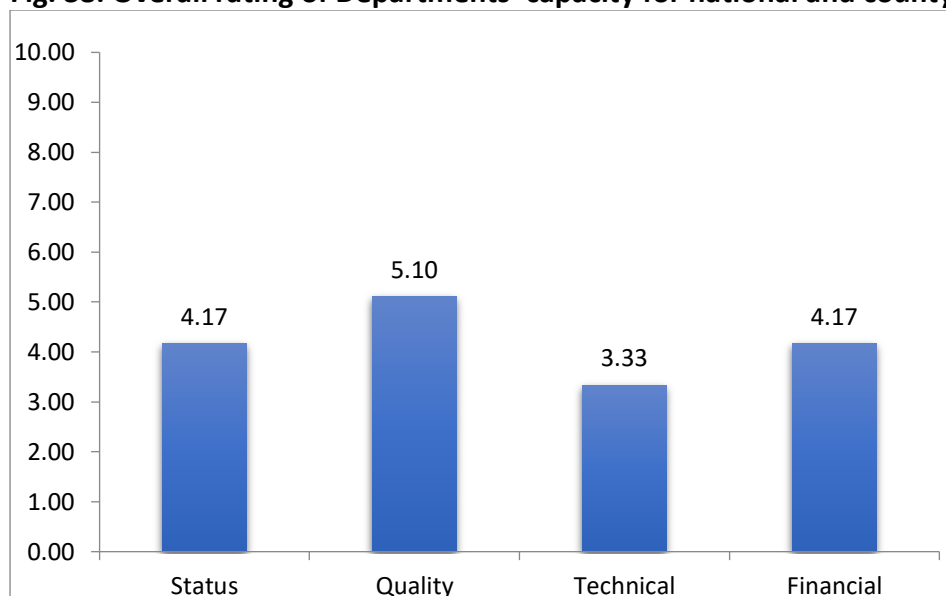


The Departments that scored the highest in this capacity area were Policy & Planning (8.75) and DHSQAR (7.5) while Administration scored the lowest at 0.

Component 9.0: National and County Databases

The overall capacity for national and county-level databases was 50%. The Departments did not have adequate databases for electronically capturing and storing data generated nor were the databases well linked to the national M&E system as evidenced by a status score of 4.17 (Fig.38). this means that the Departments lacked a well-coordinated structure for collecting data necessary for M&E activities. The internal technical and financial ability to develop databases was also low indicating that the Departments did not have robust databases in place.

Fig. 38: Overall rating of Departments' capacity for national and county databases

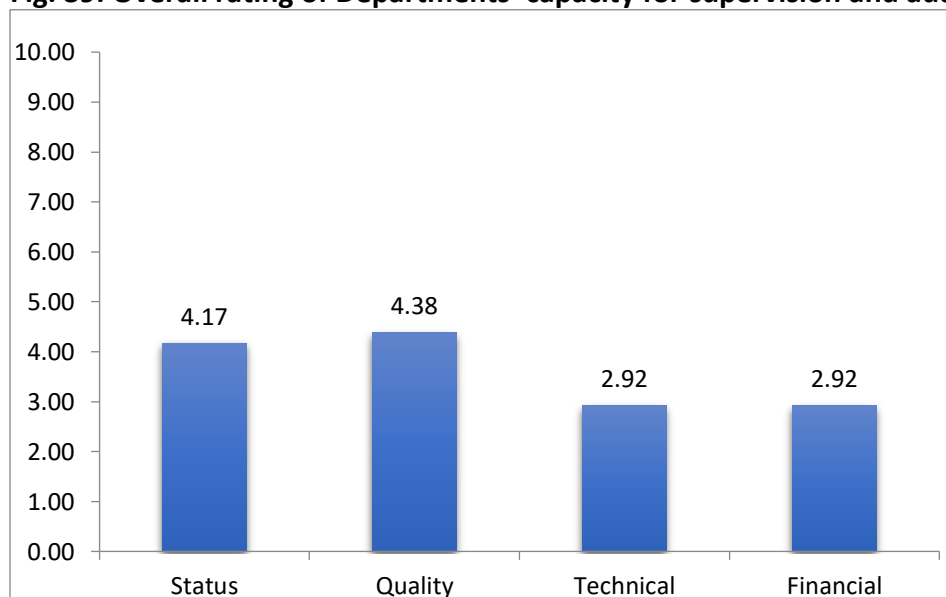


The Departments that scored the highest in this capacity area were DHSQAR (8.28) and Policy & Planning (5.63) while Administration scored the lowest at 0.42.

Component 10.0: Supervision and Auditing

The Departments' overall capacity for supervision and auditing was very low at 38%. The existence of guidelines and tools for M&E supportive supervision as well as data quality audits was sub-optimal giving a status score of 4.17 (Fig. 39). There was very poor internal technical and financial capacity for supervision and auditing implying that the departments hardly carried out any data quality audits.

Fig. 39: Overall rating of Departments' capacity for supervision and auditing

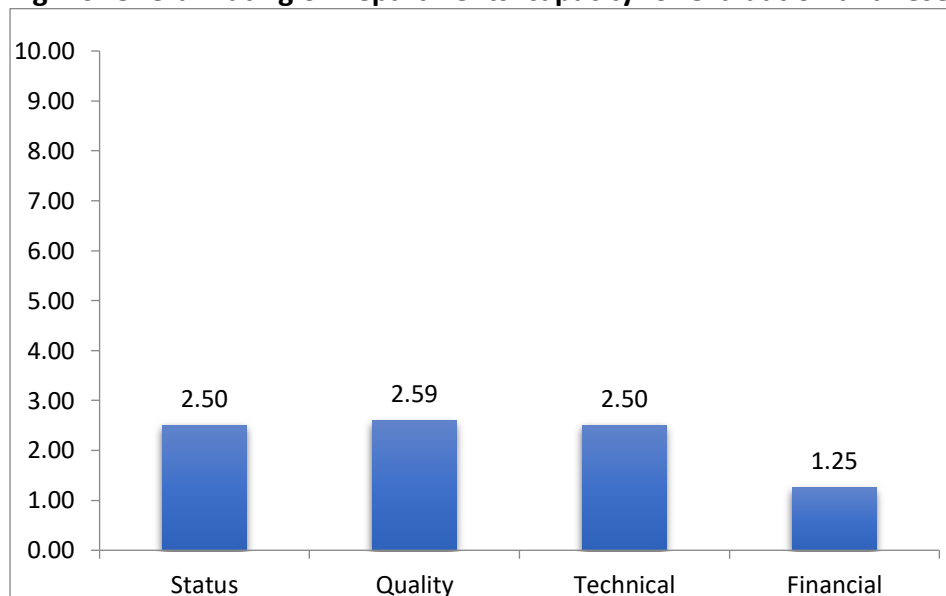


The Departments that scored the highest in this capacity area were Policy & Planning (8.13) and DHSQAR (8.13) while Administration and Curative scored the lowest at 0.

Component 11: Evaluation and Research

Overall, the Departments scored very poorly in the area of evaluation and research at 24%. The Departments lacked an inventory of ongoing and completed research and evaluation as well as department-specific research agenda giving a score of less than 3 in both the status and quality dimensions (Fig.40). There was hardly any internal technical and financial capacity for conducting evaluation and research.

Fig. 40: Overall rating of Departments' capacity for evaluation and research

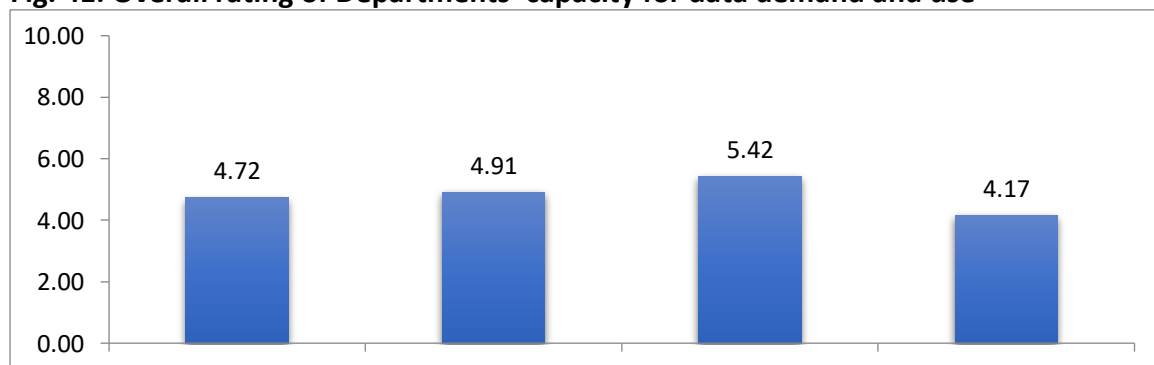


The Departments that scored the highest in this capacity area were Policy & Planning (7.71) and (2.92) while DHSQAR, Curative and UHC all scored 0.

Component 12: Data Demand and Use

The overall score for data demand and use across the Departments was 49%. The departments reported some existence of a national data use plan and dissemination of information products (status score of 4.72) implying there was some level of data demand and use for decision making (Fig. 41). On the other hand, existence of data analysis and presentation guidelines was low. Specific deficiencies pertained to low financial support for data use plans and data analysis and presentation.

Fig. 41: Overall rating of Departments' capacity for data demand and use



The Departments that scored the highest in this capacity area were DHSQAR (8.96) and Policy & Planning (8.75) while Administration and Curative departments scored the lowest at 0 each.

3.4 Results of the Ministry of Health Programs

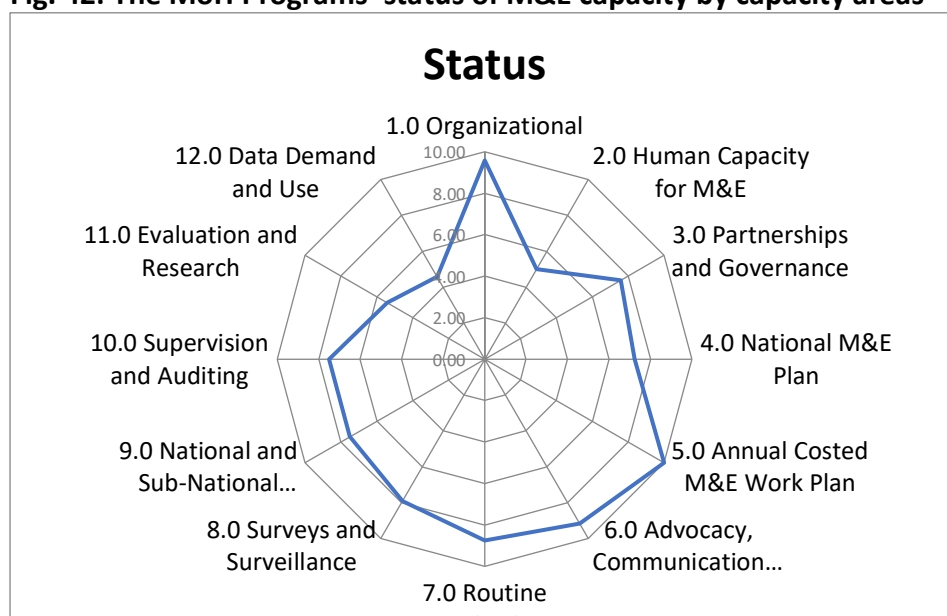
Overall capacity by the four dimensions

Four MoH programs took part in the MECAT group assessments namely: National malaria Control Program, National AIDS&STI Control Program, TB program and Department of Reproductive & Maternal Health (DRMH). After aggregating the Programs' scores across the four dimensions of status, quality, technical autonomy and financial autonomy, the average score for all the 12 capacity areas was 5.62. Two out of the four Programs interviewed had an average score of 5 and above, with Malaria program having the highest capacity score of 8.14 followed by the TB program at 5.14. The detailed individual Programs scores for each of the four dimensions per capacity area are shown in Appendix VI.

Status

In terms of whether specific elements that constitute a capacity area existed, the average score across all the Programs interviewed was fairly high at 7.52 meaning that most of the elements of the capacity areas were present. Nine capacity areas scored above 5 with annual costed M&E work plans scoring the highest at 10, followed by organizational capacity at 9.58 and advocacy, communication and cultural behaviour at 9.17 (Fig.42). Data demand and Use scored the lowest at 4.58.

Fig. 42: The MoH Programs' status of M&E capacity by capacity areas



Quality

When assessing how the existing elements measured according to specific standards, the average score was 7.26 meaning that the capacity elements present adhered well to set standards (Fig. 43). The capacity areas that scored highest in quality were: Advocacy,

Communication and Culture at 9.38, Surveys and Surveillance at 8.75 and National & County databases at 8.75. Evaluation and Research (4.79) and Data demand and use (5.0) scored the lowest.

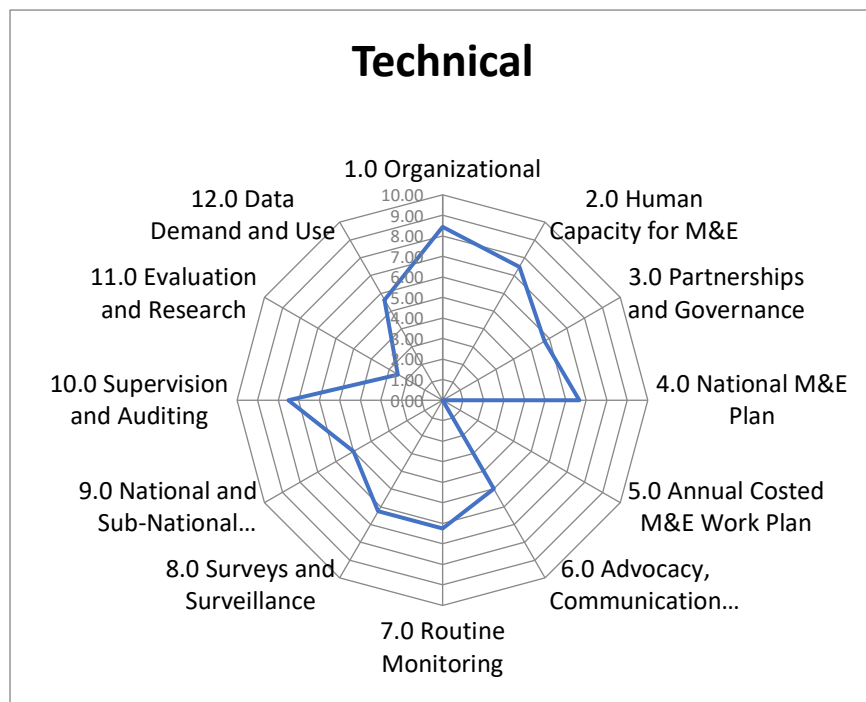
Fig.43: The Programs' quality of M&E capacity by capacity area



Technical autonomy

The Programs' internal technical capacity for executing M&E functions was average at 5.24. The highest technical autonomy was in organizational capacity (8.44), human capacity for M&E (7.5) and supervision and auditing (7.5). On the other hand, the programs' lowest technical autonomy was in annual costed M&E work plans at 0 and evaluation and research at 2.5 (Fig. 44).

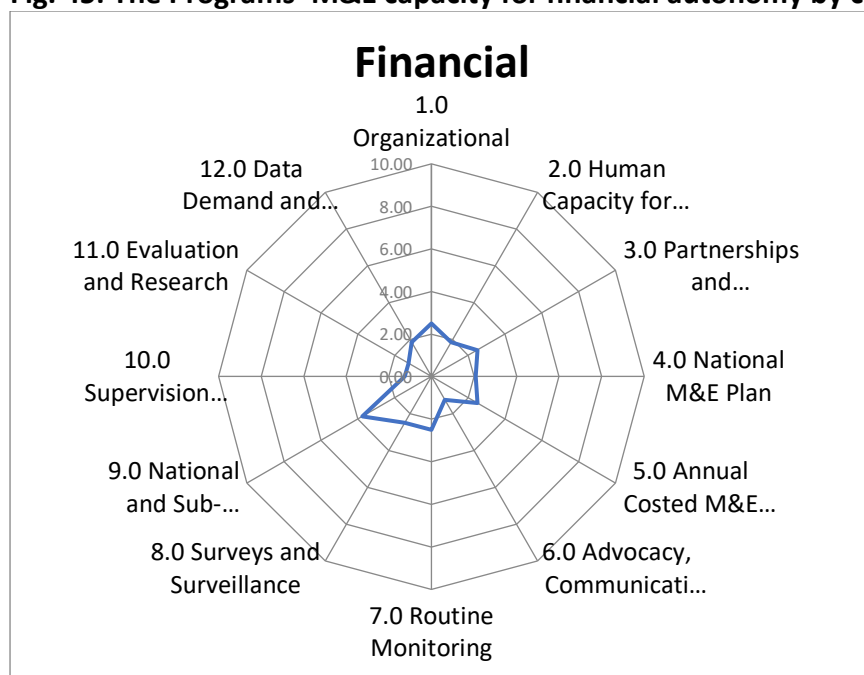
Fig. 44: The Programs' M&E capacity for technical autonomy by capacity area



Financial autonomy

The average internal financial capacity to execute M&E functions was very low at 2.15 implying that there was inadequate internal funding to execute various M&E functions. All the 12 components scored less than 4 in this dimension with the highest being the National and County databases at 3.75 (Fig. 45). The internal financial capacity was lowest for Advocacy, Communication and Cultural behavior (1.25) and supervision & auditing (1.25).

Fig. 45: The Programs' M&E capacity for financial autonomy by capacity area



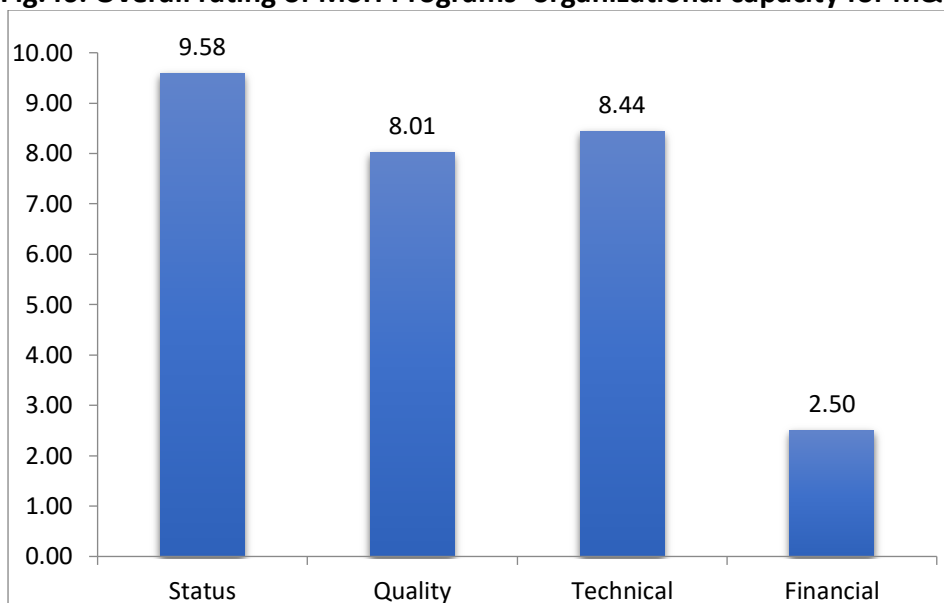
Detailed results of the 12 M&E capacity components among the MoH Programs

Component 1: Organization of an M&E system

The overall rating for organizational capacity of an M&E system in terms of the presence, quality, technical and financial capacity was high at 81%.

There was a high existence of mission statements/objectives, M&E units and values and ethics statements (status score of 9.58) and these elements adhered very well to the set standards giving a quality score of 8.01 (Fig.46). The Programs had good internal technical capacity but were severely lacking in internal funding implying that they relied on external financial support for activities under this component (financial capacity score of 2.5).

Fig.46: Overall rating of MoH Programs' organizational capacity for M&E

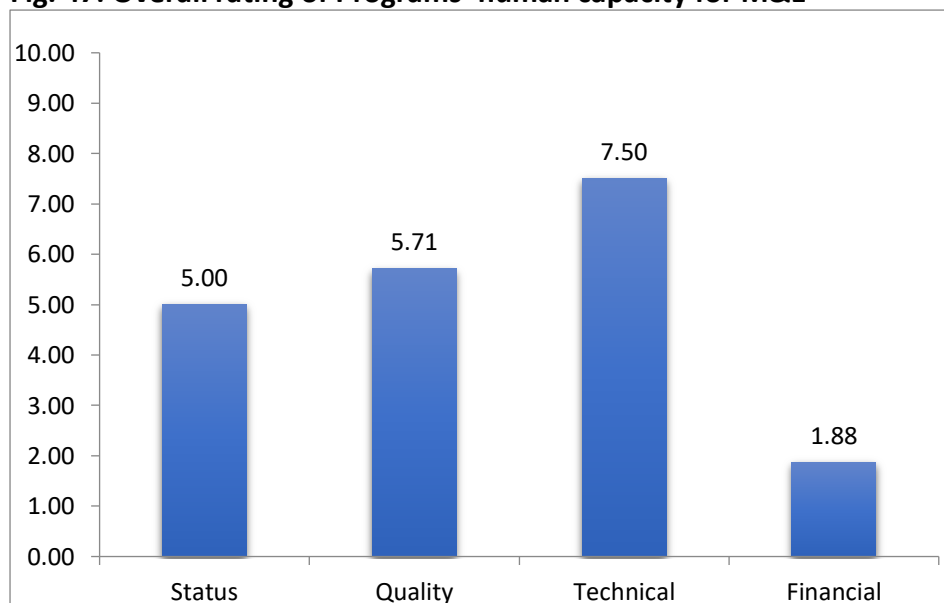


The Programs that scored the highest in this capacity area were: Malaria (8.44) and TB (8.13).

Component 2: Human Capacity for M&E

The overall rating of human capacity for M&E was 57%. There was strong existence of staff M&E skills and competencies but average presence of costed human capacity building plans and validated training curriculum hence a status score of 5.0 (Fig. 47). Similarly, the quality of the existing human capacity elements was average implying some gaps in human capacity building for M&E. Despite having a high level of internal technical autonomy, the Programs hardly had any internal funding for M&E human capacity development (financial autonomy score of 1.88).

Fig. 47: Overall rating of Programs' human capacity for M&E

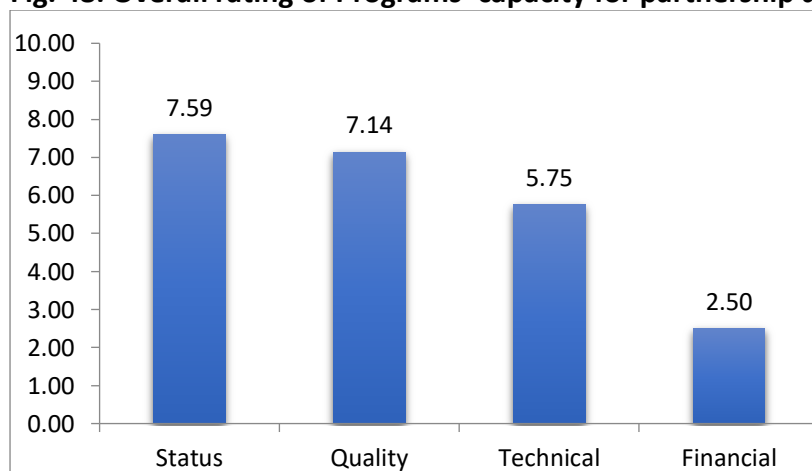


The Programs that scored the highest in this capacity area were: Malaria (8.75) and TB (4.31).

Component 3.0: Partnerships and Governance

Overall Programs' capacity for partnership and governance was fairly good at 65%. The Programs has a strong presence of national M&E technical working groups and stakeholder commitment to support M&E activities but average existence of standard operating procedures and strategies/policies to support M&E functions, thus a status score of 7.59 (Fig. 48). The technical capacity dimension scored 5.75 with specific gaps being low support for M&E strategies development and lack of clear mechanisms for M&E reporting. There was very low internal financial support for partnership and governance activities.

Fig. 48: Overall rating of Programs' capacity for partnership and governance

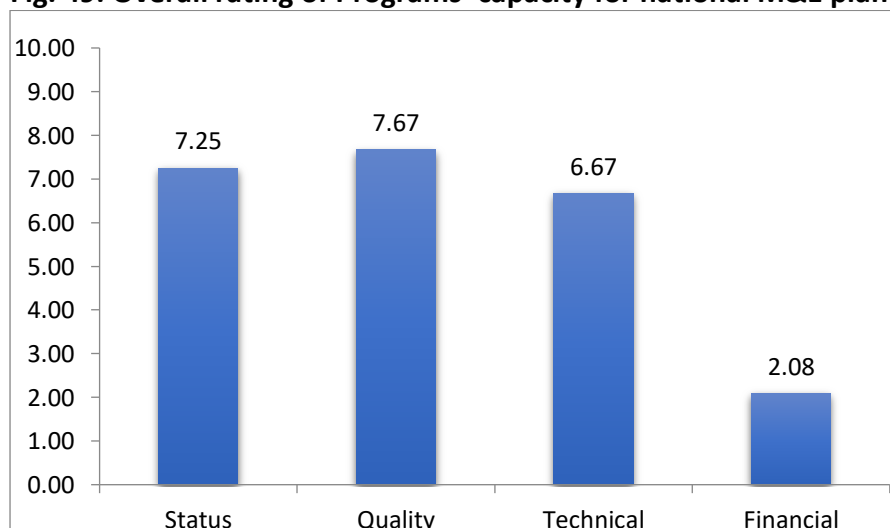


The Programs that scored the highest in this capacity area were: Malaria (7.68) and DRMH (5.26).

Component 4.0: National M&E Plan

Overall, the Programs had fairly good capacity to develop national M&E plans at 64%. There was a high ability to prepare project work plans, budgets and schedules, strong presence of a national multisectoral M&E plan, and strong existence of M&E plans for the program and M&E system assessment, giving an average status score of 7.25 and quality score of 7.67 (Fig. 49). However, the Programs had very low internal financial capacity for developing national M&E plans despite having the necessary technical capacity internally.

Fig. 49: Overall rating of Programs' capacity for national M&E plan

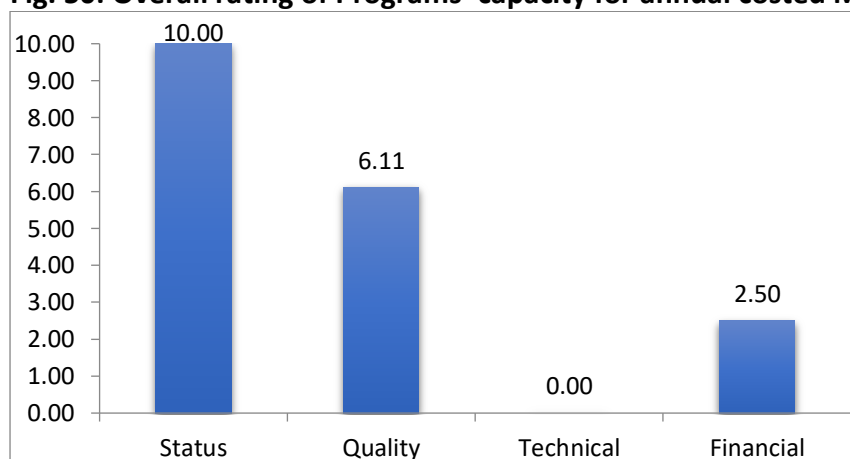


The Programs that scored the highest in this capacity area were: Malaria (8.33) and NASCOP (6.58).

Component 5: Annual Costed M&E plan

The Programs’ overall capacity for development of annual costed M&E plans was high at 75%. A costed M&E plan existed in all assessed programs with activities mapped to identified sources of funding, linkage to the Medium Term Exchange Framework (MTEF) and committed resources for implementation of M&E work plans contributing a status score of 10 (Fig. 50). However, the quality of the costed M&E plans was comparatively lower at a score of 6.11 with the main gaps being in commitment of resources to implement work plans. The programs lacked internal technical capacity to develop the plans meaning that they relied on external support for these activities. The internal financial capacity was also very low at 2.5 with the main activities supported being linkage of the M&E plans to the MTEF.

Fig. 50: Overall rating of Programs’ capacity for annual costed M&E plan

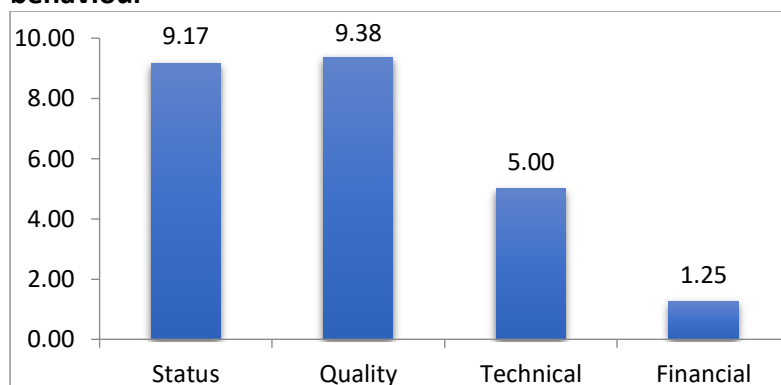


The Programs that scored the highest in this capacity area were: Malaria (6.25) and NASCOP (5.0).

Component 6.0: Advocacy, Communication and Cultural Behaviour

The overall capacity for advocacy, communication and cultural behavior across the Programs was high at 77%. There was high existence of championship for M&E activities by the leadership, program specific communication strategies and inclusion of strategies into the national policies contributing to a score of 6.11 in the status dimension and 6.04 in the quality dimension (Fig.51). Specific deficiencies in this component related to poor technical and financial capacities for M&E championships and inclusion of M&E issues and strategies and products in the national policies indicating low sustainability of the advocacy and communication strategies and plans.

Fig. 51: Overall rating of Programs' capacity for advocacy, communication and cultural behaviour

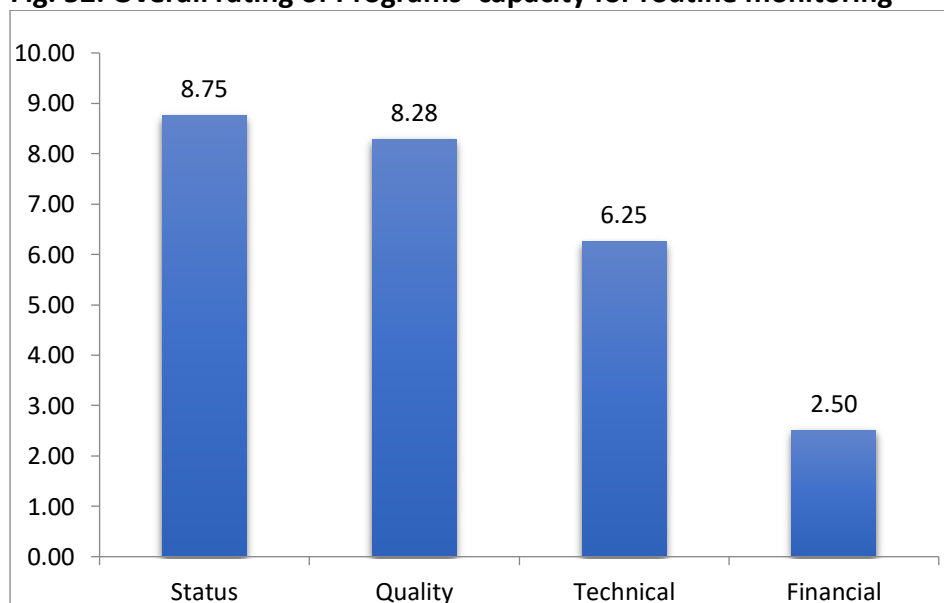


The Programs that scored the highest in this component were: Malaria (7.5) and TB (5.94).

Component 7: Routine Monitoring

Overall, the Programs' capacity for routine monitoring was 71%. There was high availability of guidelines for managing program monitoring data as well as essential tools and equipment for data management, giving a status score of 8.75 (Fig. 52). The quality of these guidelines and tools was high (8.28) and there was adequate technical capacity within the Program to develop them (6.25). However, the internal financial capacity for routine monitoring was very low at 2.50 indicating that the programs relied on external funding to carry out routine monitoring activities.

Fig. 52: Overall rating of Programs' capacity for routine monitoring

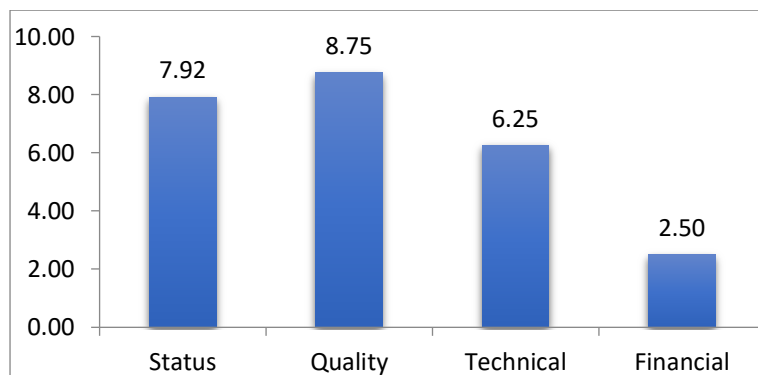


The Programs that scored the highest in this capacity area were: Malaria (8.59) and DRMH (6.25).

Component 8.0: Surveys and Surveillance

The Programs' overall capacity for surveys and surveillance was fairly good at 70%. There was high existence of surveillance inventories and functioning surveillance system yielding a status score of 7.92 (Fig. 53). In addition, these inventories and surveillance systems were of high quality hence a score of 8.75. The programs had good technical capacity for conducting surveys and surveillance but were very poorly funded giving a score of 2.5 on the financial dimension.

Fig. 53: Overall rating of Programs' capacity to conduct surveys and surveillance.

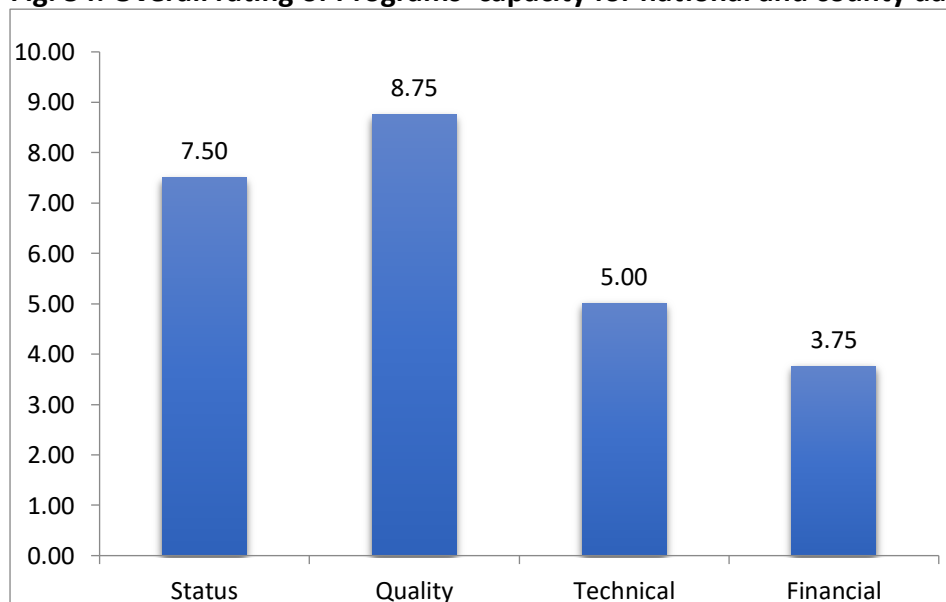


The Programs that scored the highest in this capacity area were: Malaria (8.75) and DRMH (7.6).

Component 9.0: National and County Databases

The overall capacity for national and county-level databases was 76%. The Programs reported that they had databases that were well linked to the national M&E system as evidenced by a status score of 7.5 and that these databases were of high quality yielding a score of 8.75 (Fig. 54). However, the internal technical and financial ability to develop databases lagged behind at 5 and 3.75 respectively suggesting that there was reliance on external technical and financial support to develop and maintain databases.

Fig. 54: Overall rating of Programs' capacity for national and county databases

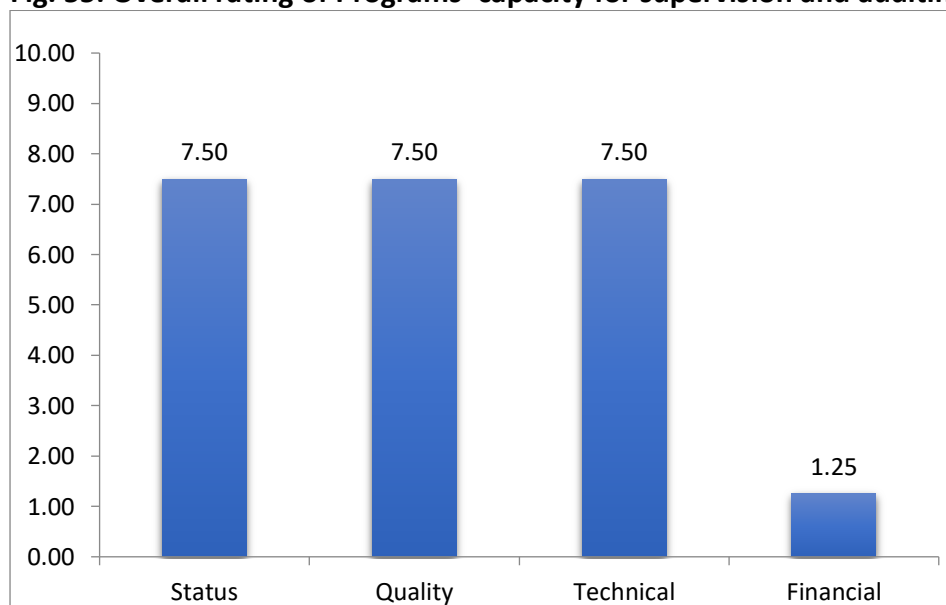


The Programs that scored the highest in this capacity area were: Malaria (10) and TB (6.25).

Component 10.0: Supervision and Auditing

The Programs' overall capacity for supervision and auditing was 63%. There was high presence of guidelines and tools for M&E supportive supervision as well as data quality audits giving a status score of 7.5 (Fig. 55). Similarly, these guidelines and tools were reported to be of high quality and there was good internal technical capacity for developing supervision guidelines and carrying out data quality audits. However, there was very poor internal financial capacity indicating that supervision and auditing were not undertaken optimally.

Fig. 55: Overall rating of Programs' capacity for supervision and auditing

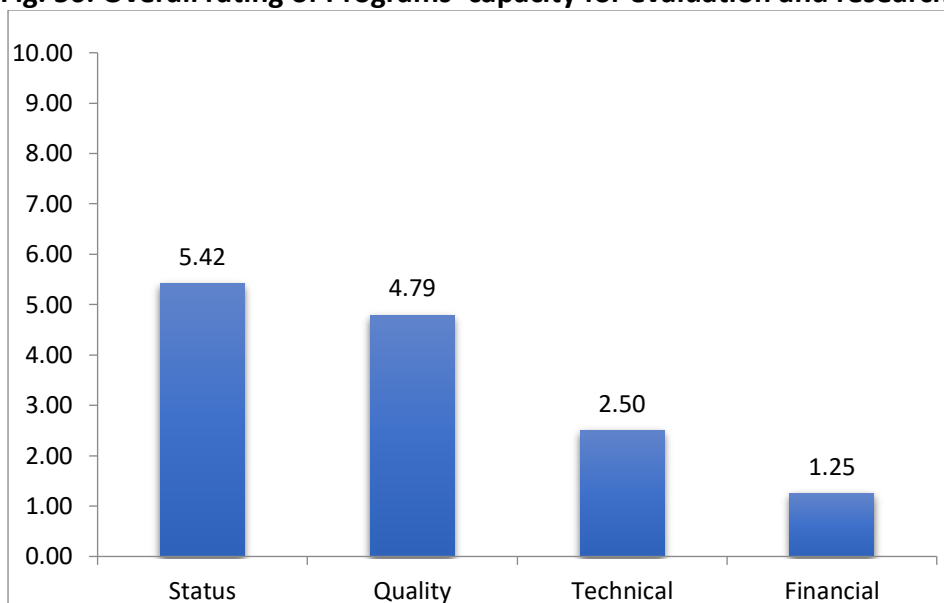


The Programs that scored the highest in this capacity area were: Malaria (8.13) and TB (7.5).

Component 11: Evaluation and Research

Overall, the Programs scored poorly in the area of evaluation and research at 40%. Though the Programs reported having division-specific research agenda, the existence of an inventory of ongoing and completed research and evaluation as well as a national research dissemination forum was low hence a status score of 5.42. (Fig. 56). There was very low internal technical and financial capacity implying that the Programs relied on external support to conduct evaluation and research.

Fig. 56: Overall rating of Programs' capacity for evaluation and research

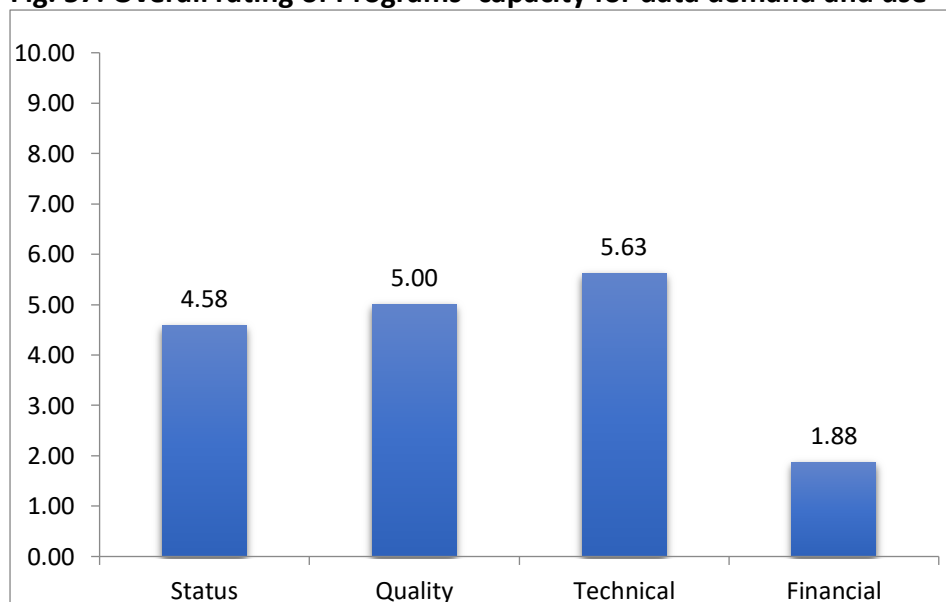


The Programs that scored the highest in this capacity area were: Malaria (7.5) and DRMH (3.68).

Component 12: Data Demand and Use

The overall score for data demand and use across the Programs was low at 43%. The programs reported high existence of plans for dissemination of information products but there was hardly any national data use plans or data presentation and analysis guidelines, hence a status score of 4.58 (Fig. 57). The internal technical capacity was average at 5.63 implying there was some level of data demand and use for decision making. Specific deficiencies pertained to extremely low financial support for data use plans and data analysis and presentation guidelines.

Fig. 57: Overall rating of Programs' capacity for data demand and use



The Programs that scored the highest in this capacity area were: Malaria (7.71) and NASCOP (3.54).

3.5 Results of the semi-autonomous government agencies (SAGAs) capacity assessment

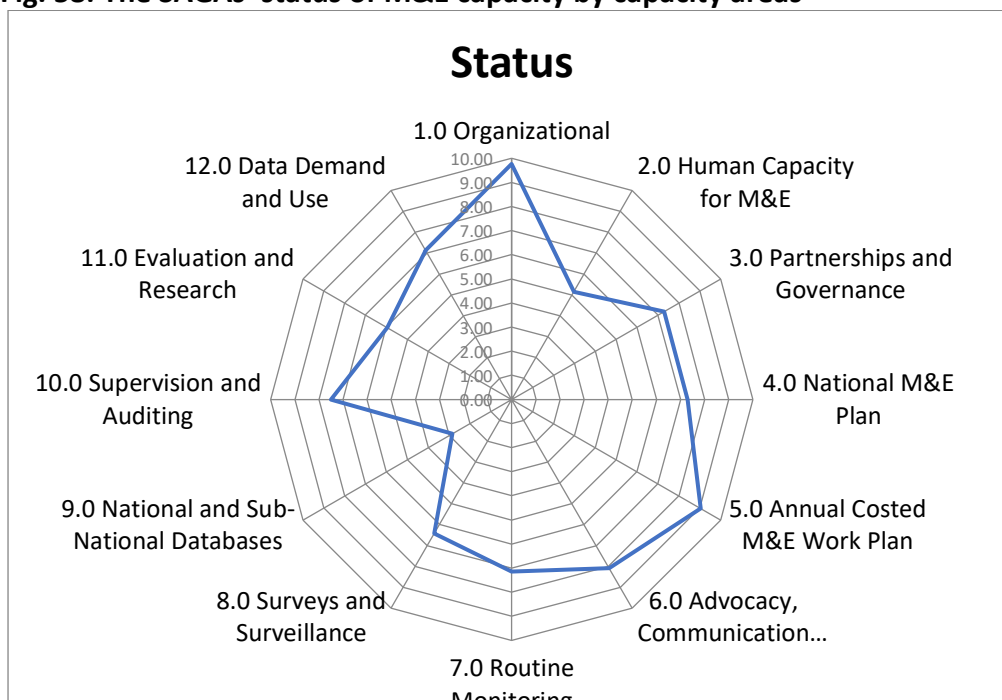
Overall capacity by the four dimensions

Six semi-autonomous government agencies (SAGAs) took part in the MECAT group assessments namely: Kenya Medical Training College (KMTC), Kenyatta National Hospital (KNH), Kenya Medical Supplies Agency (KEMSA), Kenya Medical Research Institute (KEMRI), Moi Teaching and Referral Hospital (MTRH) and National Hospital Insurance Fund (NHIF). After aggregating the SAGAs' scores across the four dimensions of status, quality, technical autonomy and financial autonomy, the average score for all the 12 capacity areas was 5.66. Four out of the six SAGAs interviewed had an average score of 5 and above, with KMTC having the highest capacity score of 6.85, followed by KEMSA (6.8), KEMRI (6.34), MTRH (5.55), NHIF (4.47), and lastly KNH (1.89). The detailed individual SAGA scores for each of the four dimensions per capacity area are shown in Appendix VII.

Status

In terms of whether specific elements that constitute a capacity area existed, the average score across all the SAGAs interviewed was fairly good at 6.97 meaning that most of the elements of capacity areas were present. Eleven capacity areas scored above 5, with Organizational capacity scoring the highest at 9.76, followed by annual costed M&E work plans at 9.05 and Advocacy, Communication & Cultural Behaviour at 8.10 (Fig. 58). National & County databases scored the lowest at 2.86.

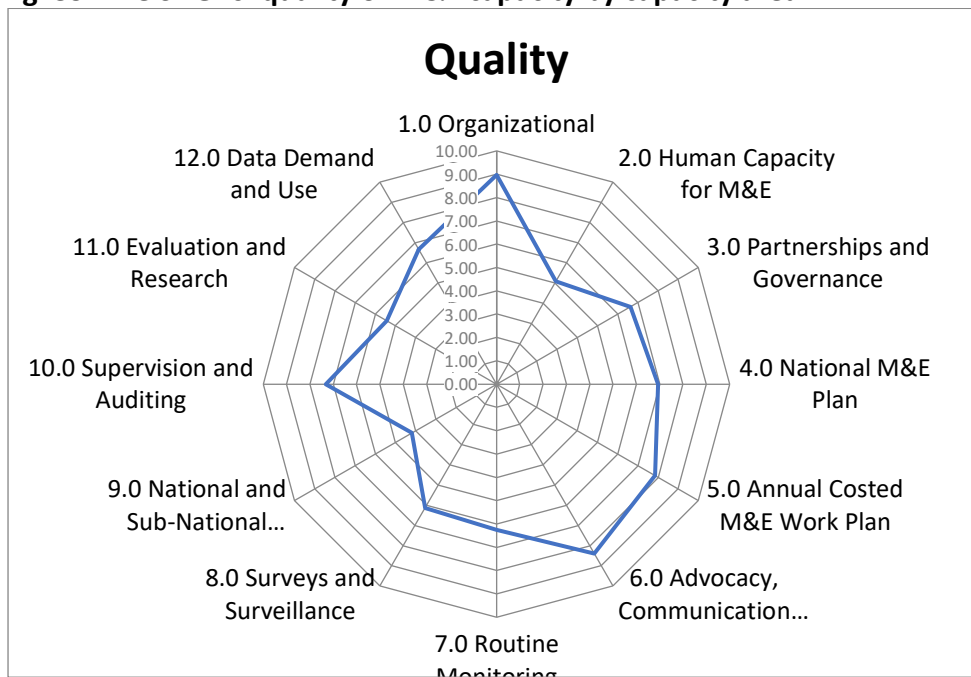
Fig. 58: The SAGAs' status of M&E capacity by capacity areas



Quality

When assessing how the existing elements measured according to specific standards, the average score was 6.66 meaning that the capacity elements present adhered to set standards fairly well. In total 11 capacity areas scored above 5 with the highest scores being in Organizational Capacity (8.97), Advocacy, Communication & Cultural Behaviour (8.39) and Annual Costed M&E work-plan (7.86). On the other hand, the capacity areas that scored the lowest was National and County Databases at 4.2 (Fig. 59).

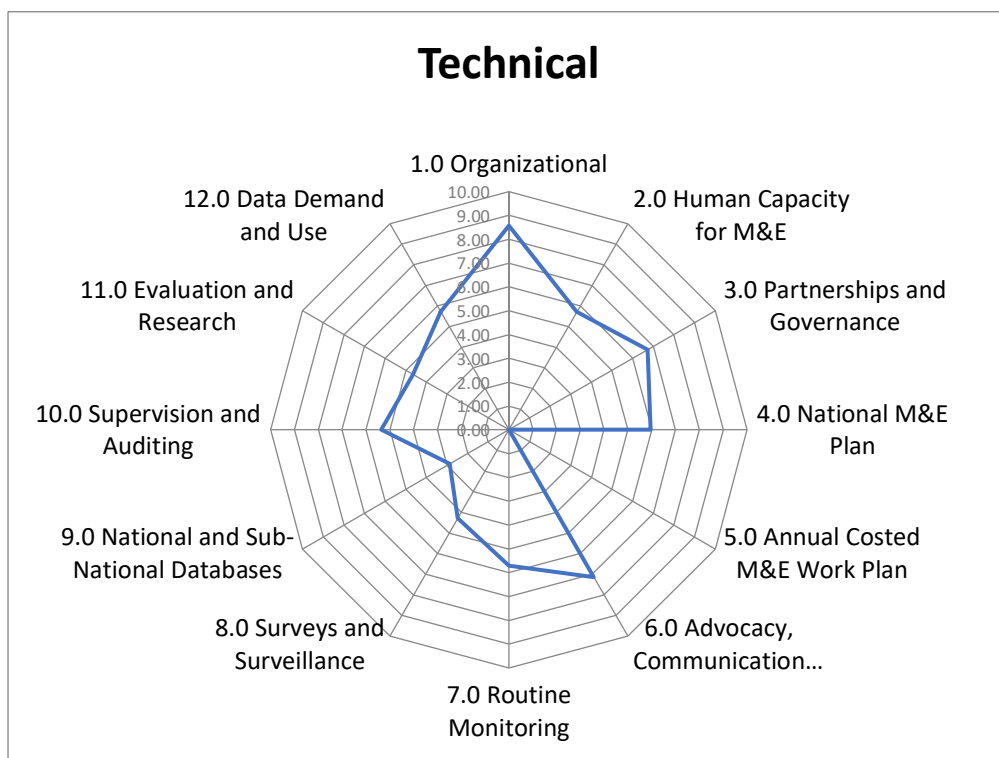
Fig. 59: The SAGAs' quality of M&E capacity by capacity area



Technical autonomy

The SAGAs had an average internal technical capacity for executing M&E functions as evidenced by a score of 5.22. The technical capacity was highest for Organizational capacity (8.57), Advocacy, Communication & Cultural Behaviour (7.14) and Partnerships & Governance at 6.71 (Fig 60). Conversely, the lowest technical capacity was in Annual Costed M&E work plan at 0 and National & County Databases at 2.86.

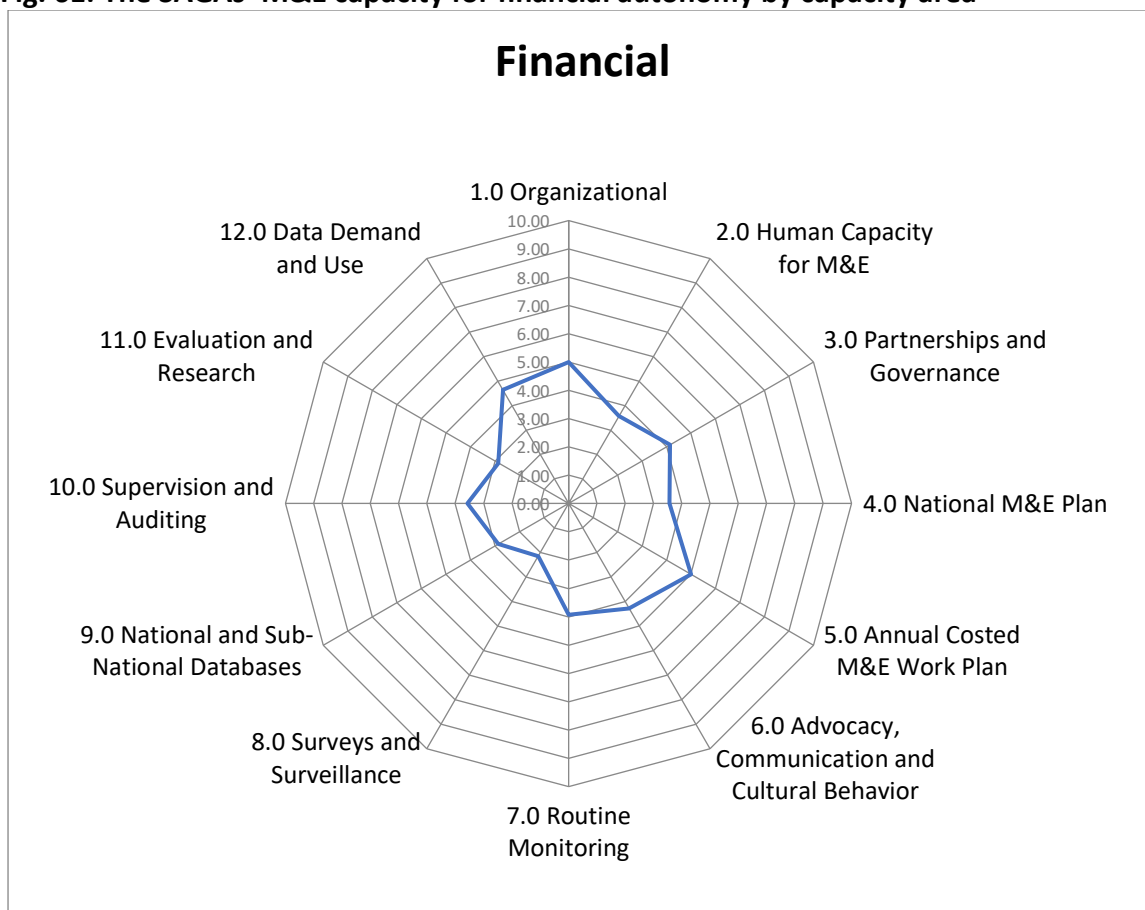
Fig. 60: The SAGAs' M&E capacity for technical autonomy by capacity area



Financial autonomy

The average internal financial capacity to execute M&E functions scored the lowest among all the four dimensions at 3.8 implying that there was inadequate internal funding to execute various M&E functions. All the capacity areas scored below 5 with the exception of two namely: organizational capacity (5) and annual costed M&E work plans (5.0). This implies that the SAGAs were poorly financed to carry out M&E functions. The internal financial capacity was lowest for Surveys & Surveillance at 2.14, National and County databases at 2.86 and Evaluation & Research at 2.86 (Fig. 61).

Fig. 61: The SAGAs' M&E capacity for financial autonomy by capacity area



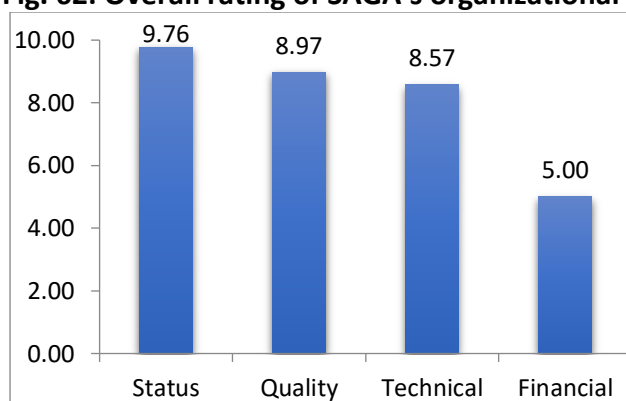
Detailed results of the 12 M&E capacity components among the SAGAs

Component 1: Organization of an M&E system

The overall rating for organizational capacity of an M&E system in terms of the presence, quality, technical and financial capacity was at 88%.

Mission statements were present in almost all assessed SAGAs as well as values and ethics statements giving a status score of 9.76 (Fig. 62). These elements adhered very well to the set standards as evidenced by a quality score of 8.97. There was also high internal capacity to develop these mission statements (score of 8.57). However, the internal financial capacity to develop these items was just average at 5.0.

Fig. 62: Overall rating of SAGA’s organizational capacity for M&E

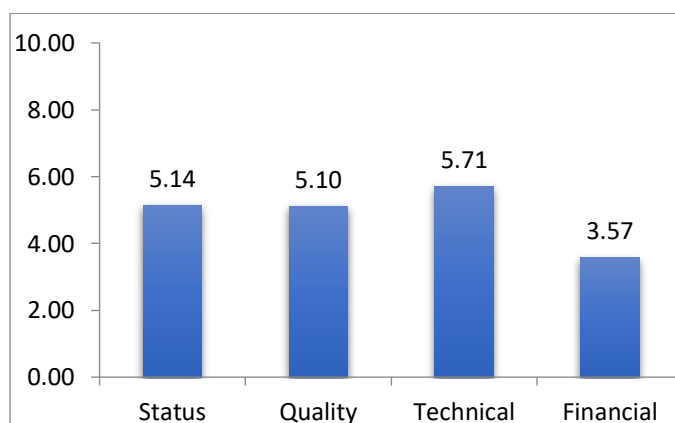


The SAGAs that scored the highest in this capacity area were: MTRH (9.96) and KEMSA (9.10)

Component 2: Human Capacity for M&E

The overall rating for human capacity for M&E in terms of the presence, quality, technical and financial capacity was at 53%. Status, quality and technical capacity for this component were average. The main strengths were in staff M&E skills and competences while the deficiencies were in presence and quality of validated human capacity training curriculum. Most of the financial capacity was through external assistance thus a low score of 3.57 (Fig. 63).

Fig. 63: Overall rating of SAGAs’ human capacity for M&E

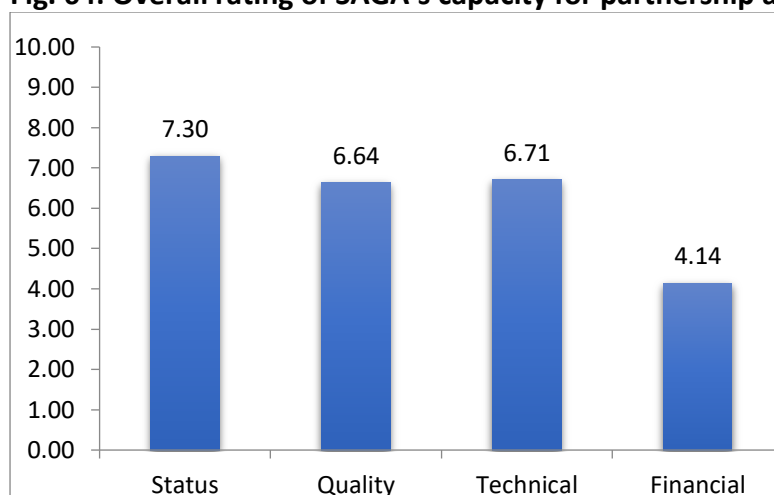


The SAGAs that scored the highest in this capacity area were: KEMSA (8.76) AND KMTC (7.09)

Component 3.0: Partnerships and Governance

Overall SAGA’s capacity for partnership and governance was scored at 63%. Figure 64 shows that the SAGAs have good partnership and governance in the M&E system, with a score of at least 6 out of 10 on the status, quality and technical capacity dimensions. However, the financial dimension was poor at 4.14. Specific deficiencies in this capacity area included lack of clear mechanisms to communicate M&E activities as well as low presence and support for national M&E technical working groups.

Fig. 64: Overall rating of SAGA’s capacity for partnership and governance

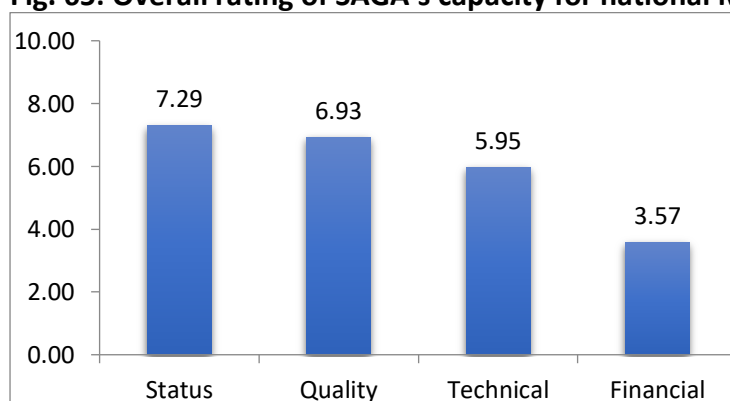


The SAGAs that scored the highest in this capacity area were: KEMSA (8.81) and MTRH (6.89).

Component 4.0: National M&E Plan

This section explored SAGA’s role in eliciting broad stakeholder participation in the development of the SAGA’s M&E plan. Overall, the SAGA’s had a slightly higher than average capacity to develop M&E plans at 66%. The SAGAs scored highly on the status (7.29) and quality (6.93) dimensions (Fig. 65) This was because of a strong ability to prepare accurate project work plans, budgets and schedules as well as clear guidelines on when reports should be received or distributed. However, M&E system assessment was poor. In addition, there was low financial support for development of the M&E plans as evidenced by a score of 3.57.

Fig. 65: Overall rating of SAGA’s capacity for national M&E plan



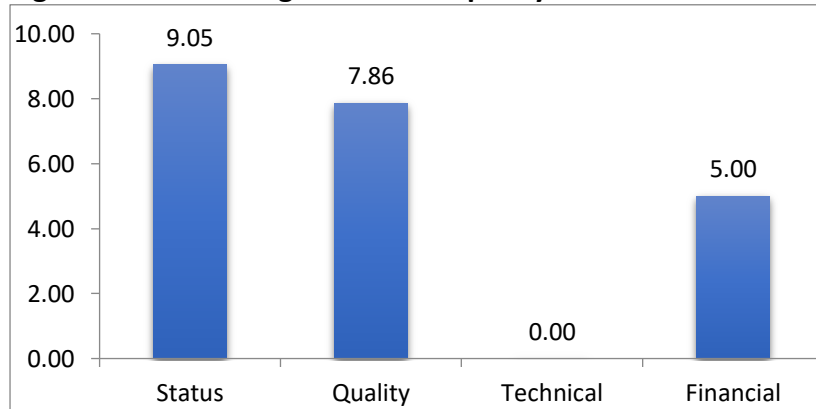
The SAGAs that scored the highest in this capacity area were: KEMSA (8.0) and NHIF (7.29).

Component 5: Annual Costed M&E plan

This component explored the existence of an annual costed M&E plan and the extent of annual updates. The SAGAs’ overall capacity was high at 81%. The SAGAs generally had strong presence of costed M&E activities which were well linked to the Medium Term Exchange Framework (MTEF) as evidenced by a score of 9.05 and 7.86 in the status and quality dimensions respectively (Fig. 66). The SAGAs had high commitment to implement the work

plans. However, there was no internal technical capacity for developing the costed M&E work plans implying that SAGAs relied on external technical support for this.

Fig. 66: Overall rating of SAGAs’ capacity for annual costed M&E plan

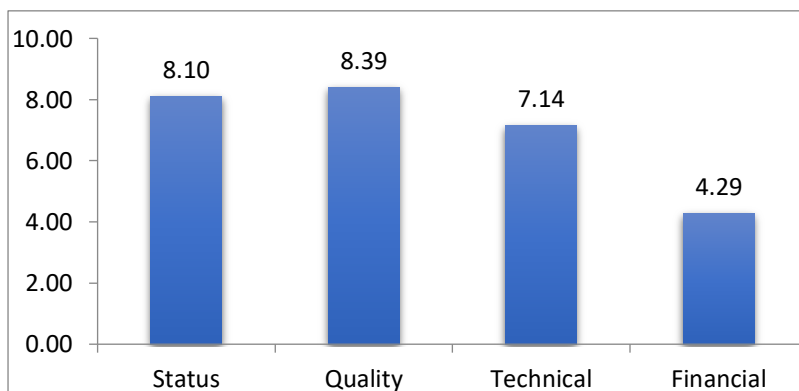


The SAGAs that scored the highest in this capacity area were: KEMSA (7.08) and KEMRI (6.67).

Component 6.0: Advocacy, Communication and Cultural Behaviour

The SAGAs’ overall capacity for advocacy, communication and cultural behavior was high at 75%. There was strong presence of championship for M&E activities by the leadership and program specific communication strategies contributing to a status score of 8.1 and a score of 8.39 in the quality dimension (Fig.67). Specific deficiencies in this component related to poor inclusion of M&E issues, strategies and products in the national policies and strategic documents. In general, there was good internal technical capacity for advocacy and communication strategies but the financial capacity scored low at 4.29, an indication of low sustainability of these strategies and plans.

Fig. 67: Overall rating of SAGAs’ capacity for advocacy, communication and cultural behaviour



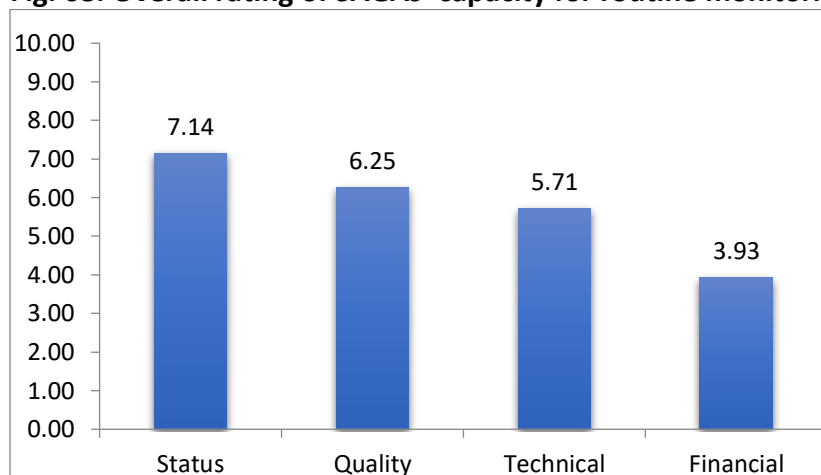
The SAGAs that scored the highest in this component were: KEMSA (9.27) and KEMRI (8.02)

Component 7: Routine Monitoring

Overall, the SAGAs had an average capacity for routine monitoring at 59%. The SAGAs reported high availability of essential tools and equipment for data management as well as

guidelines for managing program monitoring data (Fig. 68). On the other hand, internal financial capacity for routine monitoring was suboptimal at 3.93 indicating that the SAGAs may not be able to carry out routine monitoring at the required capacity.

Fig. 68: Overall rating of SAGAs' capacity for routine monitoring

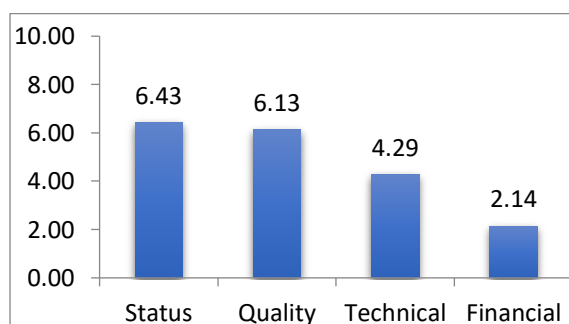


The SAGAs that scored the highest in this capacity area were: KEMSA (7.5), KMTC (6.88) and MTRH (6.88).

Component 8.0: Surveys and Surveillance

The average capacity for surveys and surveillance was 53%. There was good presence of surveillance inventories and protocols as evidenced by a status score of 6.43 and a quality score of 6.13 (Fig. 69). However, the deficiencies in this M&E component included poor functionality of surveillance systems and low internal technical (4.29) and financial capacity (2.14). This indicates that the SAGAs relied on external support to carry out surveys and surveillance.

Fig. 69: Overall rating of SAGAs' capacity to conduct surveys and surveillance.



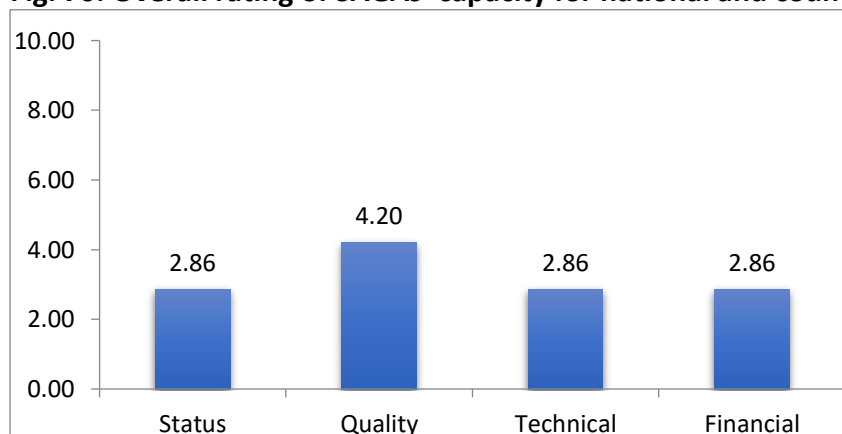
The SAGAs that scored the highest in this capacity area were: KEMRI (7.5) and KMTC (7.19).

Component 9.0: National and County Databases

This component explored the existence of national and county-level databases in SAGAs that respond to the decision-making and reporting needs of different stakeholders. The average capacity for national and county-level databases was very low at 38% (Fig. 33). The SAGAs did not have adequate databases for electronically capturing and storing data generated as evidenced by a status score of 2.86 (Fig. 70). In addition, whatever databases they had were not linked to the national M&E system. The internal technical and financial ability to develop

databases was also very poor at less than 3.0 indicating that the SAGAs did not have robust databases in place.

Fig. 70: Overall rating of SAGAs' capacity for national and county databases

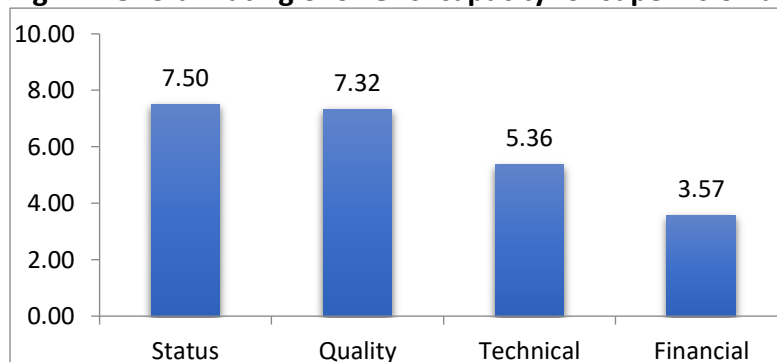


The SAGAs that scored the highest in this capacity area were: KMTC (5.63) and KEMRI (5.47).

Component 10.0: Supervision and Auditing

The SAGAs' overall capacity for supervision and auditing was 62%. SAGAs reported to have guidelines and tools for M&E supportive supervision giving a status score of 7.5 (Fig. 71). Some of the deficiencies in this component included low existence of data quality audits due to low internal technical capacity for the same. Similarly, internal financial capacity was low at 3.57 indicating reliance of the SAGAs on stakeholders for financial support (Fig 34).

Fig. 71: Overall rating of SAGAs' capacity for supervision and auditing

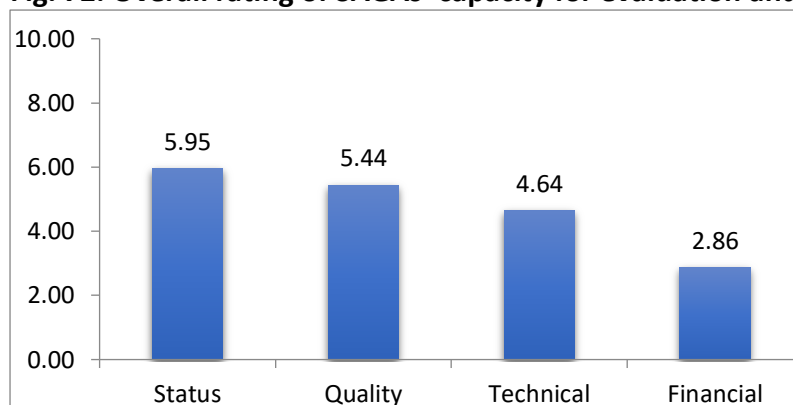


The SAGAs that scored the highest in this capacity area were: KEMSA (9.69) and KEMRI (7.5).

Component 11: Evaluation and Research

On average, the SAGAs scored 50% in evaluation and research. There was low existence and quality of SAGAs' inventory of ongoing and completed research and evaluation both of which were scored at less than 6 (Fig.72). Similarly, the availability of a national evaluation and research agenda was just average. Many SAGAs lacked a national forum for disseminating research findings. Internal technical and financial capacity for conducting evaluation and research was weak at 4.64 and 2.86 respectively.

Fig. 72: Overall rating of SAGAs' capacity for evaluation and research

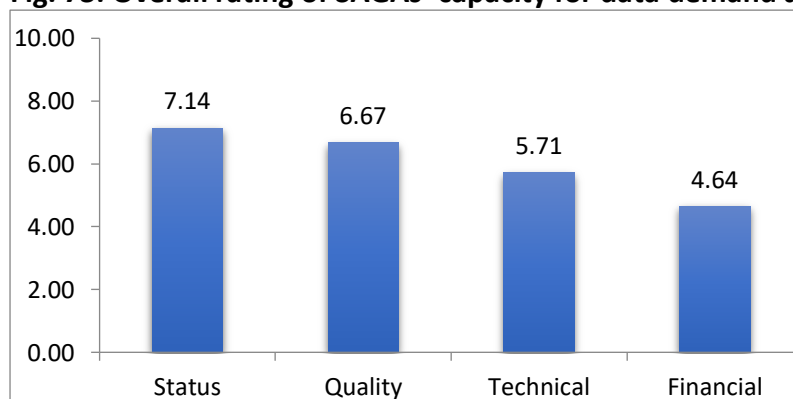


The SAGAs that scored the highest in this capacity area were: KEMSA (7.57) and KEMRI (7.57).

Component 12: Data Demand and Use

The overall score for data demand and use across the SAGAs was above average at 61% (Fig. 73). The SAGAs reported existence of a national data use plan and dissemination of information products (status score of 7.14) implying there was some level of data demand and use for decision making. On the other hand, existence of data analysis and presentation guidelines low. Specific deficiencies pertained to low financial support for data demand and use.

Fig. 73: Overall rating of SAGAs' capacity for data demand and use



The SAGAs that scored the highest in this capacity area were: MTRH (10.00) and KMTC (7.64)

3.6 Results of the Councils' capacity assessment

Overall capacity by the four dimensions

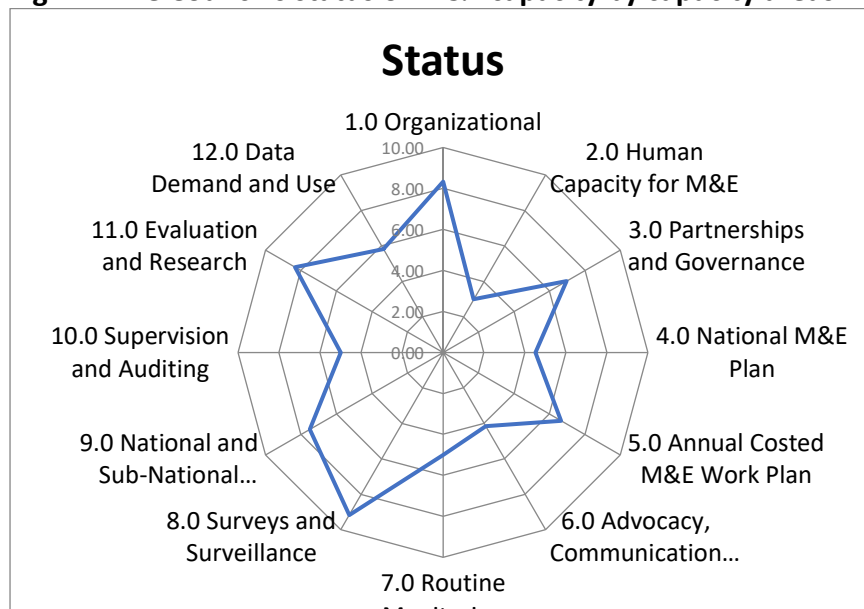
Only two councils took part in the MECAT group assessments namely: The Pharmacy and Poisons Board (PPB) and Kenya Nuclear and Radiation Agency (KNRA). After aggregating

the two organizations' scores across the four dimensions of status, quality, technical autonomy and financial autonomy, the average score for all the 12 capacity areas was 5.06. The detailed individual organizations' scores for each of the four dimensions per capacity area are shown in Appendix VIII.

Status

In terms of whether specific elements that constitute a capacity area existed, the average score across all the Councils interviewed was 6.21 meaning that most of the elements of capacity areas were present. Seven capacity areas scored above 5 with surveys and surveillance scoring the highest at 9.17, followed by organizational capacity at 8.33 and evaluation and research at 8.33 (Fig. 74). Human capacity for M&E scored the lowest at 3 followed by advocacy, communication and culture at 4.17.

Fig. 74: The Council's status of M&E capacity by capacity areas



Quality

When assessing how the existing elements measured according to specific standards, the average score was 5.85 meaning that the capacity elements present to some extent adhered to set standards. Six of the 12 components scored above 5.0 with Surveys and Surveillance scoring the highest at 8.54 followed by National & County databases (7.81) and Data demand and Use at 7.78 (Fig. 75). On the other hand, the components that scored the lowest were National M&E plan (3.17) and Routine monitoring (3.44).

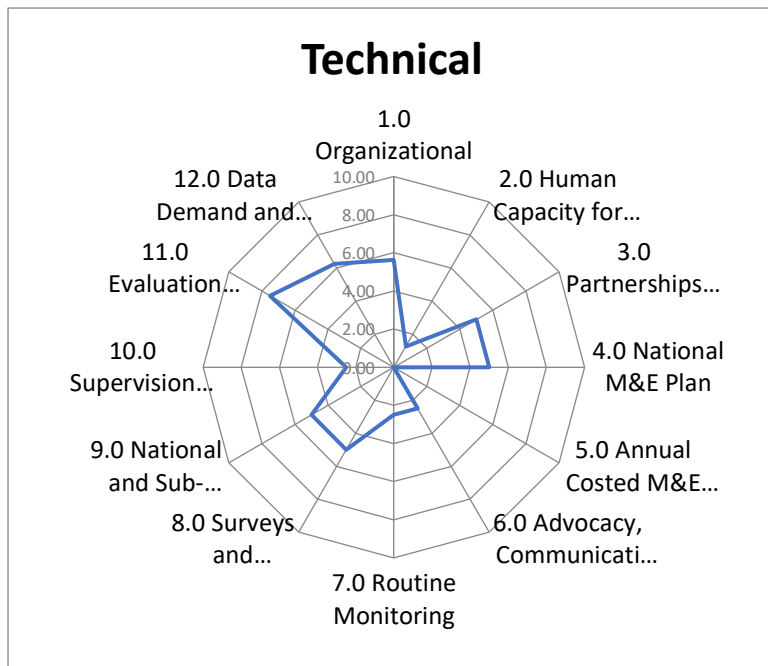
Fig. 75: The Councils' quality of M&E capacity by capacity area



Technical autonomy

The Councils had a low internal technical capacity for executing M&E functions as evidenced by a score of 4.01 with only three components scoring above 5.0. The highest technical autonomy was in Evaluation and Research (7.5), Data demand & Use (6.25) and Organizational capacity (5.63). On the other hand, the Councils' lowest technical autonomy was in annual costed M&E work plans at 0 and human capacity for M&E at 1.25 (Fig.76).

Fig. 76: The Councils' M&E capacity for technical autonomy by capacity area



Financial autonomy

The average internal financial capacity to execute M&E functions was low at 4.17 implying that there was inadequate internal funding to execute various M&E functions. Data Demand and Use scored the highest at 6.25 while six other components (Organizational capacity, Human capacity for M&E, Annual costed M&E work plan, Routine monitoring, National & County Databases and Supervision & Auditing) scored 5.0 as shown in Fig. 77. The internal financial capacity was lowest for Advocacy, Communication and Cultural behavior (0) and Partnerships & Governance (3.0).

Fig. 77: The Councils' M&E capacity for financial autonomy by capacity area



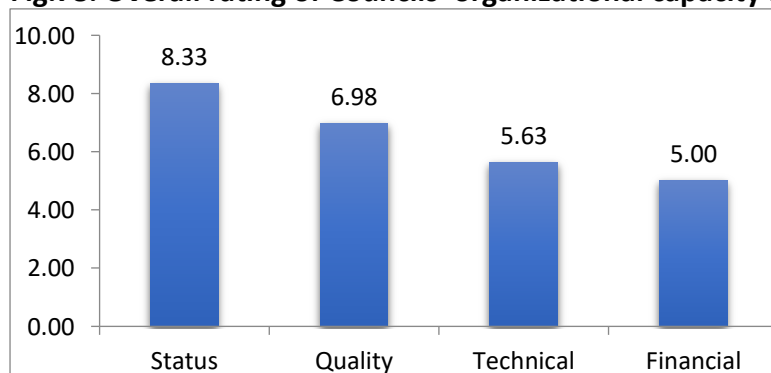
Detailed results of the 12 M&E capacity components among the Councils

Component 1: Organization of an M&E system

The overall rating for organizational capacity of an M&E system in terms of the presence, quality, technical and financial capacity was 67%.

The Councils had high existence of mission statements/objectives, M&E units and values and ethics statements (status score of 8.33) and these elements adhered to the set standards giving a quality score of 6.98 (Fig.78). The internal technical and financial capacity to develop these elements were average at a score of 5.63 and 5.0 respectively.

Fig.78: Overall rating of Councils' organizational capacity for M&E

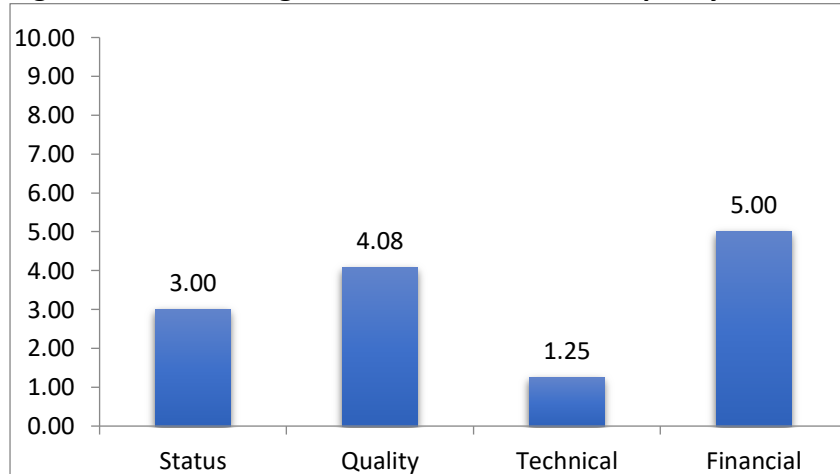


Component 2: Human Capacity for M&E

The overall rating of human capacity for M&E was very low at 38%. There was very low existence of staff M&E skills and competencies, costed human capacity building plans and

validated training curriculum hence a status score of 3.0 (Fig. 79). Similarly, the quality of the existing human capacity elements was low at a score of 4.08 implying that the Councils did not regularly carry out human capacity building for M&E. There was hardly any internal technical capacity for capacity building (score of 1.25). On the other hand, there was some level of internal financial support (score of 5.0) mainly for Staff skills/competencies and development of training curriculum.

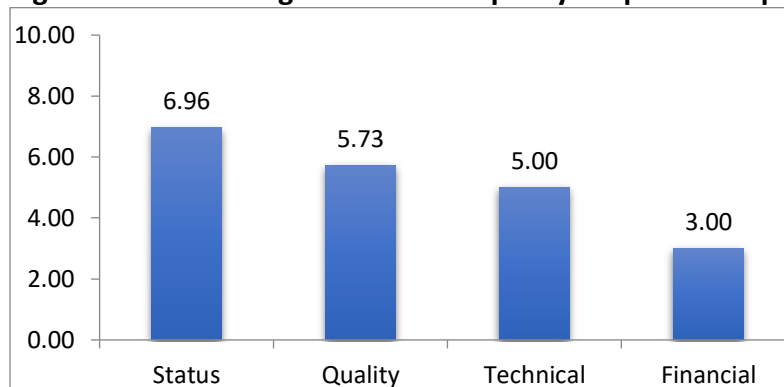
Fig. 79: Overall rating of the Councils’ human capacity for M&E



Component 3.0: Partnerships and Governance

Overall Councils’ capacity for partnership and governance was fair at 59%. There was good presence of national M&E technical working groups, updated inventories of stakeholders and stakeholder commitment to support M&E activities thus a status score of 6.96 (Fig.80). The technical capacity dimension scored 5 with specific gaps being low capacity for development of M&E strategies and standard operating procedures for M&E roles/responsibilities as well as lack of clear mechanisms for M&E reporting. There was very low internal financial support for partnership and governance activities.

Fig. 80: Overall rating of Councils’ capacity for partnership and governance

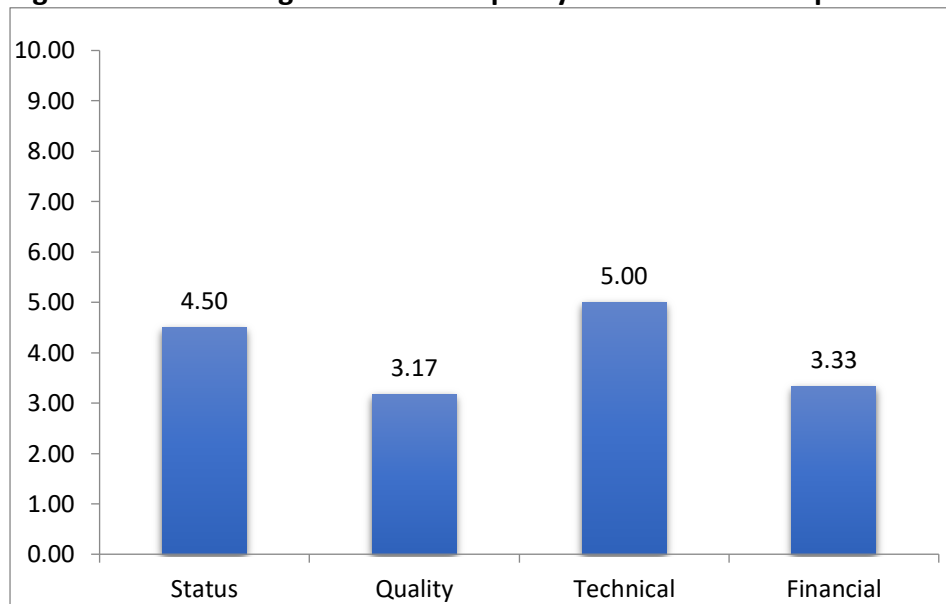


Component 4.0: National M&E Plan

Overall, the Councils had average capacity to develop national M&E plans at 49%. There was high capacity for preparing project work plans, budgets and schedules and strong existence of M&E plans but low existence of M&E system assessment giving an average status score of 4.5 (Fig. 81). The quality of these elements was very low at 3.17 meaning that they did not adhere

well to set standards. Similarly, the Councils had very low internal financial support for developing national M&E plans.

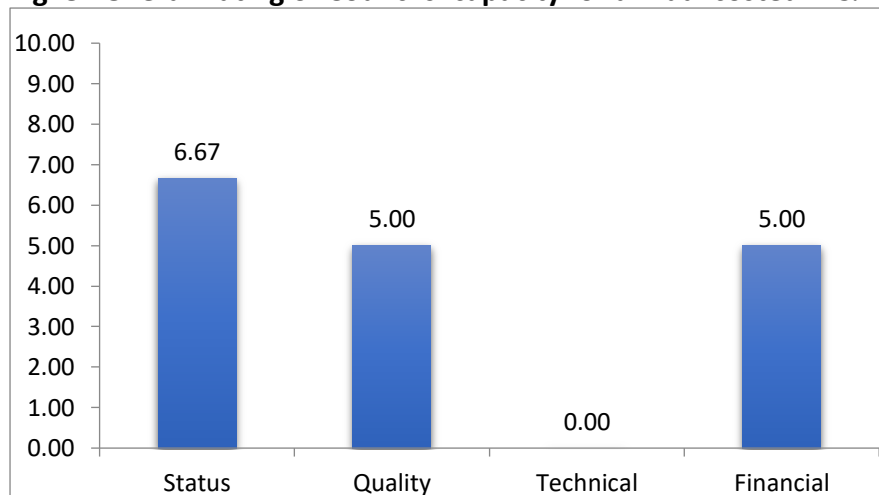
Fig. 81: Overall rating of Councils' capacity for national M&E plan



Component 5: Annual Costed M&E plan

The Councils' overall capacity for development of annual costed M&E plans was average at 56%. There was high existence of costed M&E activities with identified sources of funding but average linkage to the MTEF hence a status score of 6.67 (Fig.82). However, the quality of the costed M&E plans was comparatively lower at a score of 5.0. The Councils lacked internal technical capacity to develop the costed M&E plans meaning that they relied on external support for these activities. The internal financial capacity was also average with the main activity supported being linkage of the M&E plans to the MTEF.

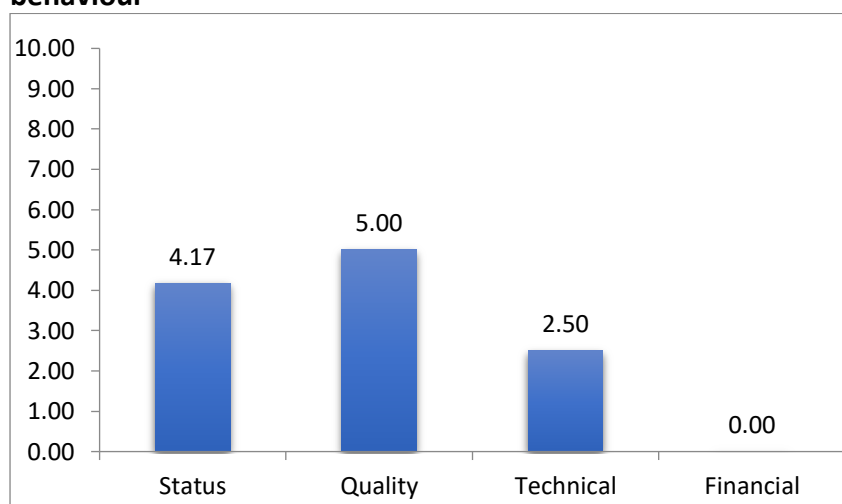
Fig. 82 Overall rating of Councils' capacity for annual costed M&E plan



Component 6.0: Advocacy, Communication and Cultural Behaviour

The overall capacity for advocacy, communication and cultural behavior across the Councils was low at 46%. There was high existence of championship for M&E activities by the leadership, but low existence of organization-specific communication strategies and inclusion of strategies into the national policies contributing to a status score of 4.17 (Fig.83). Specific deficiencies in this component related to very low internal technical and financial capacities indicating that the advocacy and communication strategies and plans were not sustainable.

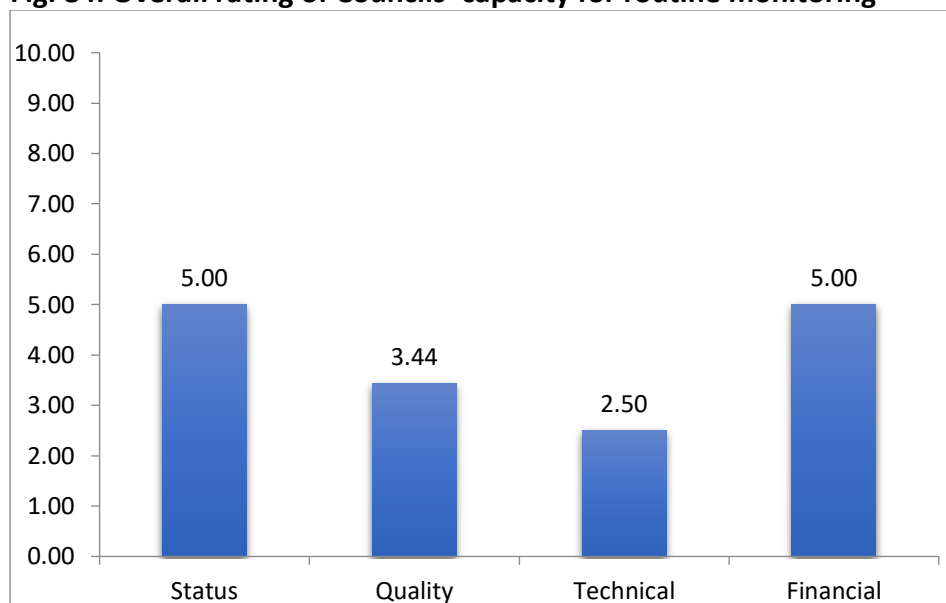
Fig. 83: Overall rating of Councils' capacity for advocacy, communication and cultural behaviour



Component 7: Routine Monitoring

Overall, the Councils' capacity for routine monitoring was low at 39%. There was some availability of guidelines for managing program monitoring data as well as essential tools and equipment for data management, giving a status score of 5.0 (Fig.84). However, the quality of these guidelines and tools was low (3.44) and there was inadequate technical capacity within the Councils to develop them (2.5). The internal financial capacity for routine monitoring was average indicating that the departments had some resources for carrying out routine monitoring activities but were hindered by the low technical expertise.

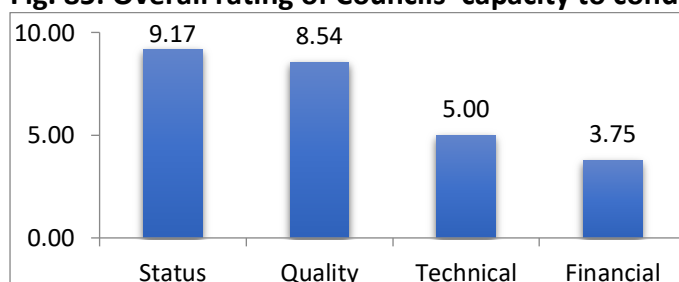
Fig. 84: Overall rating of Councils' capacity for routine monitoring



Component 8.0: Surveys and Surveillance

The Councils' overall capacity for surveys and surveillance was fairly good at 72%. There was high existence of surveillance inventories, protocols for carrying out surveillance and functioning surveillance system yielding a status score of 9.17 (Fig.85). In addition, these inventories and surveillance systems were of high quality hence a score of 8.54. However, the Councils had low technical and financial capacity for conducting surveys and surveillance indicating some reliance on external support.

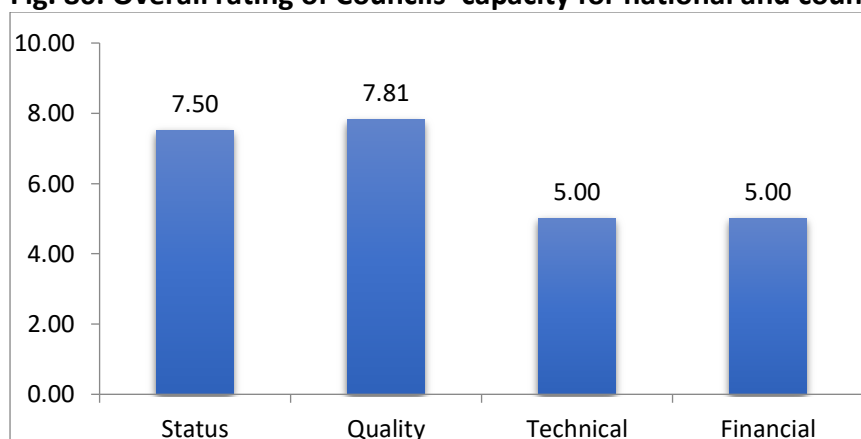
Fig. 85: Overall rating of Councils' capacity to conduct surveys and surveillance.



Component 9.0: National and County Databases

The overall capacity for national and county-level databases was 72%. The Councils reported that they had databases that were well linked to the national M&E system as evidenced by a status score of 7.5 and that these databases were of fairly good quality yielding a score of 7.81 (Fig.86). However, the internal technical and financial ability to develop databases lagged behind at 5.0 respectively suggesting that there was reliance on external technical and financial support to develop and maintain databases.

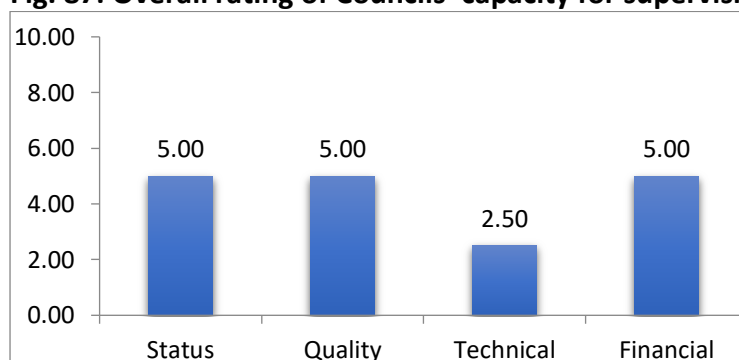
Fig. 86: Overall rating of Councils' capacity for national and county databases



Component 10.0: Supervision and Auditing

The Councils' overall capacity for supervision and auditing was 45%. There was average existence of guidelines and tools for M&E supportive supervision as well as data quality audits giving a status score of 5 (Fig. 87). Similarly, these guidelines and tools were average quality. Internal technical capacity for developing supervision guidelines and carrying out data quality audits was very low at 2.5 despite their being some internal financial support for these activities.

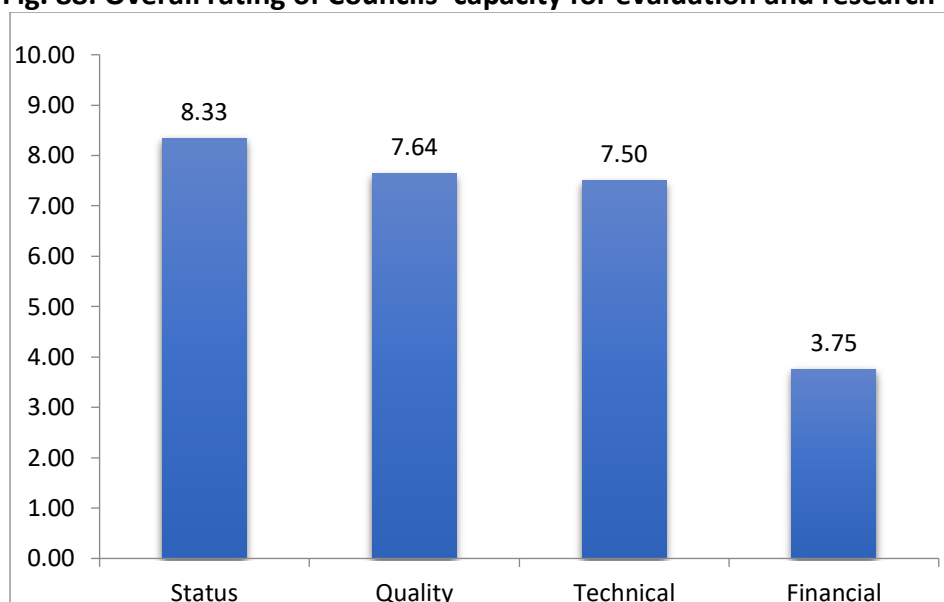
Fig. 87: Overall rating of Councils' capacity for supervision and auditing



Component 11: Evaluation and Research

Overall, the Councils scored well in the area of evaluation and research at 72%. There was strong existence of research agenda, inventory of research institutions and a national research dissemination forum giving a status score of 8.33 (Fig.88). The quality of these elements was high and so was the internal technical capacity for carrying out evaluation and research. However, there was very low internal financial capacity for these activities implying that the Councils relied on external resources to conduct evaluation and research.

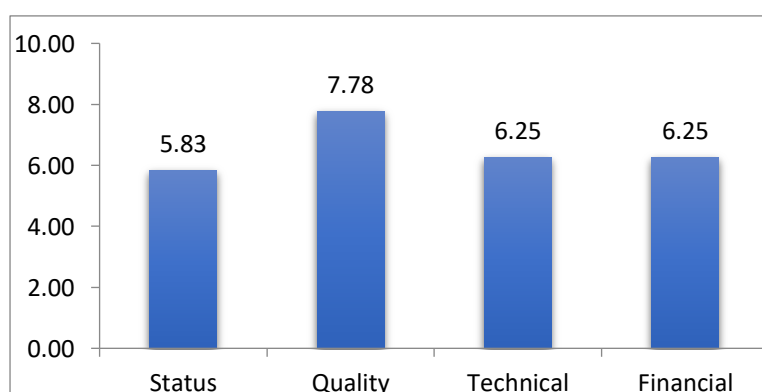
Fig. 88: Overall rating of Councils' capacity for evaluation and research



Component 12: Data Demand and Use

The overall score for data demand and use across the Councils was 69%. The councils reported high existence of plans for dissemination of information products but low existence of national data use plans and data presentation/analysis guidelines, hence a status score of 5.83 (Fig 89). However, the existing elements were of good quality hence a score of 7.78. The internal technical and financial capacity for data demand and use was fairly good at 6.25 respectively.

Fig. 89: Overall rating of Councils' capacity for data demand and use



3.7 Results of the Qualitative Interviews at the national level

Twenty planning entities took part in the key informant interviews and were drawn from the MoH Administration, Directorate of Health Sector Coordination & Intergovernmental Relations, Directorate of Health Services, Directorate of Health Policy, Research and Monitoring and Evaluation, Directorate of Public Health, National Tuberculosis program, Division of Vaccine and Immunization, Division of Reproductive Health, Division of Disease Surveillance, Division of Nutrition, National AIDS and STI Control Program, Division of

Malaria, Division of Community Health, Division of Health Information Services, Division of Neonatal health, Division of Health Promotion, the World Health Organization (Kenyan Office), Kenya Medical Practitioners and Dentist's Council, National Health Insurance Fund and National AIDS Control Council. For purposes of this report, a planning entity includes a County, or a Directorate, Department, Division or Program at the national level. The interviews focused on the current M&E capacity in the various MoH directorates and divisions at the national level, the challenges facing them and their proposed solutions. The following key themes emerged from the interviews.

Organizational capacity of the MoH M&E needs to be strengthened and streamlined
Respondents stated that the organizational capacity for M&E was existent and that various planning entities within the MoH were headed by well-trained and competent leaders. However, there were gaps in communication and interoperability between various planning units resulting in inadequacies in M&E functions. In addition, low capacity for evaluating the planning entities' M&E performance resulted in failure to follow through with activities, meet set objectives, and identify opportunities for improvement.

Most of the MoH's directorates and divisions had an M&E entity and a lead M&E officer. In some instances, specific divisions had their own M&E entities that served the needs of that division rather than the entire directorate. The functionality of the M&E entities varied with most of the entities only partially meeting their host directorate's or division's needs. Functionality was hampered by various challenges such as funding constraints, human resource inadequacies and lack of harmonization of the data collection processes. Respondents felt that the M&E entities could be greatly strengthened by increasing the number of M&E staff, training the staff on M&E and clearly designating staff to carry out M&E functions under specific job descriptions. Increased government funding allocation to M&E entities and investing in robust information technology infrastructure to ensure timely data transmission were seen as ways of further strengthening the M&E entities.

A majority of the planning entities reported that they had M&E objectives. These objectives mainly related to data collection, data dissemination, generation of reports, strengthening of data management and usage, availing data for decision-making and tracking the health sector's performance. The alignment of the M&E activities to the MoH's mission statement was described as fair but that it was often hindered by funding constraints and inadequate technical expertise to carry out M&E activities. In addition, the District Health Information System (DHIS2) lacked some indicators resulting in paucity of data in certain pertinent areas.

Various respondents had different views on how the MoH M&E system should be structured. Specifically, some directorates felt that rather than have an M&E entity at the Directorate level, each of the Divisions within a Directorate should be facilitated to have their own M&E entities and then the M&E entities feed some key indicators to the Heads of Directorates via a dashboard. This would avoid duplication of efforts at the Directorate level. Other directorates felt that there was no clear M&E structure within which to operate. In this regard, they suggested that the MoH M&E system should be centralized under the national M&E Division. This division could then be strengthened by seconding well-trained and qualified M&E officers to coordinate M&E activities.

Slightly more than half of the planning entities felt that they were well integrated with the national Division of M&E. Unclear reporting structures, inadequate guidance from the MoH and infrequent meetings with the national MoH division contributed to poor integration. In addition, the MoH divisions that had very well resourced M&E entities tended to function like silos with minimal linkage to the national M&E division. Integration could be strengthened by the national M&E division first of all providing clear operation guidance and reporting structures to the other planning entities. Wider consultation and inclusion of all the planning entities in the planning stages could help streamline M&E across the health sector and address discrepancies in indicators measured or data collected by the different planning entities. Respondents also suggested that frequent review meetings between the national M&E division and other M&E entities could help address some of the operational challenges arising in the implementation of M&E activities. There was need for the MoH to come up with governance tools such as data management manuals and electronic data access guidelines to be utilized by all within the health sector.

Inadequate human resource capacity for M&E at the national level

Nearly all the planning entities stated that inadequate staffing was a major hindrance to carrying out M&E functions. Many of the staffs who carried out M&E functions had not been clearly designated to serve as M&E officers which meant that they had other main duties and were only informally requested to assist with M&E. The challenge with this kind of arrangement was that the staffs were susceptible to transfers or being diverted to carry out other more pressing roles thus diminishing M&E performance.

There was no guidance from the MoH on the staff cadres needed in an M&E planning entity. Nevertheless, staff carrying out M&E functions at the national level were fairly well qualified with many possessing a degree or master's level of training. However, they lacked specific M&E-related skills. Often, staff with no M&E background were required to carry out M&E functions with no prior training and this would result in resistance or disinterest in the work.

M&E staffs' training varied from no specific training in M&E to a few who had masters' level training in the field of M&E. Some of the staffs carrying out M&E functions were very passionate about the work but lacked specific training or skills making their work output low. It was felt that with specific M&E short courses training, such staff could be empowered to undertake M&E functions competently. Planning entities felt that there was need to conduct short-courses training in the following key M&E areas: short courses and advanced degrees in M&E, how to develop and measure indicators, how to use DHIS2, data analytics, data visualization and presentation, programming and software development, advanced statistical packages such as STATA and R, the twelve (12) M&E capacity areas, how to make information packages, technical reports and policy briefs, and Geographical Information Systems (GIS).

Suggestions for meeting the human resource needs for M&E included hiring of more staff, formally appointing M&E officers and giving them clear job descriptions as well as guidance on how to undertake M&E functions. There was need for the MoH to develop a training package to ensure that the training offered to M&E staff was standardized across the entire health sector. The human resource capacity could be expanded by availing resources to facilitate M&E activities e.g. collation of reports, convening meetings to review data/reports, etc.

Over-reliance on external financial and technical support for M&E activities

Partners played an important role in helping the MoH achieve its M&E objectives by ensuring that its M&E plans were well aligned with the national health strategies, rallying up various stakeholders to come up with initiatives such as the Kenya health data collaborative initiative, and mobilizing and aligning resources within a common M&E framework. Partners were very willing to provide funding for M&E activities. At the national level, partners provided cross-cutting technical and financial support as per the MoH's request. They also provided additional support to core MoH mandates e.g. assessments, supervision, monitoring, development of strategies and maintenance of healthcare standards through supervision of health facilities and healthcare providers. Partners were actively involved, both technically and financially, in the development of the national M&E plans in line with the national health strategies such as the Kenya Health Sector Strategic Plan 2014-2018, Kenya Health Policy 2014-2030 and the Universal Health Coverage Road Map. Partners invested between USD 10,000 – 1,000,000 to fund M&E activities depending on the MoH's request and funds available.

At the planning entity level, the M&E Units that were functioning at a higher capacity than others were almost entirely reliant on funding from partners. This came with challenges since some partners opted to fund what was of interest to them rather than the Ministry's or the planning entity's priorities. Another challenge was that lack of a clear and costed M&E plan affected planning units' resource mobilization from donors/partners because it was difficult for the donors to see how the resources were utilized and what impact they achieved.

Partner funding was not well coordinated or optimized across the health sector. Some planning entities were very well resourced while others were poorly supported. The well-resourced planning entities tended to function in a siloed manner serving only the needs of their specific divisions or programmes. Respondents felt that there was need to coordinate the partner resources such that they would be optimized for the entire health sector's M&E work.

Given that many planning entities did not have staff who were specifically trained to carry out M&E functions, partners provided technical capacity to fill this gap either by providing their own personnel or providing financial support to employ an M&E expert on a contract basis.

Due to funding withdrawal or failure to secure funding, some divisions were from time to time unable to achieve their M&E objectives. Partners, on their part, felt that funding constraints could be addressed by partnering with the Ministry of Health on various activities in order to bring down the costs.

Implementation and adherence to Monitoring and Evaluation plans

Only a half of the planning entities interviewed had an M&E plan, with the majority stating that it was costed. Most of the M&E plans were fairly well linked to the national health strategies from which the indicators were derived. Respondents felt that greater involvement in the national decision-making and policy or strategy formulation as well as availing of resources by the government would contribute to even better linkage of the M&E plans to the national strategies.

Regardless of whether an M&E plan was in place or not, nearly all the programs had a budget for their M&E activities. Only a half of the respondents had information on the actual budget amounts. Budget amounts for M&E activities varied widely. For instance, NASCOP had an annual M&E budget of USD 12 million while the Division of Malaria allocated 14% of its

annual budget to M&E functions. On the other hand, the Division of Community Health had an annual M&E budget of USD 5 million while the Division of Neonatal health stated they had a budget of USD 750,000 for their M&E activities. Only in very few instances were these budgets adequately funded and they represented more of a wish-list than an actual budget. Funding, where available, was almost entirely by MoH partners with the government largely providing salaries and physical space for some of the employees. Planning entities felt that this was not a sustainable funding mechanism as the health sector did not have control over availability of external funding. In instances where there was a discrepancy between the donor's M&E interests and those of the MoH, the donor's interests took priority. This sometimes led to failure of the planning entity to meet the set objectives.

The main hindrance to implementation of the annual M&E work plan was lack of adequate funds for certain activities or funding cessation from donors. Other factors that interfered with planned M&E activities included emergencies such as disease outbreaks, healthcare workers' strikes, changes in healthcare policies, presidential directives to offer a particular health service, unplanned activities from partners, inadequate skilled capacity etc.

Capacity for evaluation and research lags behind that of routine monitoring

Most planning entities reported that they carried out routine monitoring of data either on a monthly, bi-monthly, quarterly, annual or bi-annual basis. Data for routine monitoring was mainly collected from the counties and transmitted to the national level through the DHIS2(KHIS). The national Division of Health Informatics then facilitated data access to the various planning entities as needed. While this structure served the monitoring functioning fairly well, sometimes certain indicators were not included in the DHIS2 and hence those aspects of monitoring were not carried out. Some programs have established stand-alone platforms for capturing additional indicators not captured in DHIS2 e.g. TIBU for TB and HIV Situation Room (HIV). The main challenges facing routine monitoring revolved around lack of clarity on the national and county responsibilities. For instance, it was not clear whose mandate it was to print the data collection tools and registers. Some counties would go for long periods of time without data collection tools resulting in information on key indicators missing in the national database.

Another challenge was the lack of standardized and updated tools and electronic medical registers (EMR) being used across the counties and health facilities resulting in data quality issues. Respondents suggested that the MoH Division of Health Informatics should take up the role of printing the data collection tools at the national level and circulating them to all the counties to ensure standardization. In the long run, the MoH would need to transition to using standardized electronic data capture forms including the EMR at the county and sub-county levels.

Many of the respondents indicated that they did not carry out evaluations largely due to lack of financial support and capacity to do so. They noted that evaluations and research are more complex and resource-intensive than monitoring because they require extensive planning. Inadequate training and expertise to carry out evaluations also hindered the execution of evaluations and research. Technical support from partners filled the training and human resource gaps in the planning entities where evaluations were carried out regularly. MoH partners stated that they invested in evaluation and research by prioritizing support for

evaluations, documentation of lessons learned, impact assessments and evaluation of national strategic plans.

Research agenda setting

A majority of the planning entities did not have capacity to carry out any research. For the planning entities that reported carrying out research, the agenda was largely determined by either a technical working group, a strategic research team within the planning entity or a committee of experts. Other entities undertook research based on interventions that failed to achieve an impact, while others relied on the partners to set the agenda.

Research agenda prioritization varied across the planning entities and was not aligned to the national research-for-health priority agenda. Due to over-reliance on external financial and technical support, research agenda prioritization was often left to the partners. In other cases, the planning entities relied on specific strategic frameworks or the technical working groups to determine which research activities took precedence in any given time period. Other factors that influenced which research activities were given priority included specific gaps in healthcare within the MoH, new technologies that need to be adopted such as a new effective drug, the larger MoH agenda, county needs and thematic areas of interest such as if an area is found to have high mortality due to a particular disease/diseases.

Low information technology capacity for M&E activities

The MoH had a national database in use, the DHIS2(KHIS), under which all the key health information is collected and accessed by various consumers within the health sector. Many planning entities reported that lack of hardware such as computers, inadequate software and poor internet connectivity affected data collection using the DHIS2(KHIS). Some MoH divisions, adopted partner-funded data systems to meet some of the data gaps not catered for under the DHIS2(KHIS). However, donor-supported data systems were vulnerable to funding changes and hence not sustainable in the long run. Some respondents suggested that the MoH needed to ensure availability of a comprehensive open-source national database for collecting all health data as per the recommendation of the Health Act 2017. In addition, there was need to invest in data back-up systems to be used both at the national and county levels to guard against data loss. Respondents also suggested that replacing paper-based data collection systems with electronic ones could help minimize delays and improve data quality.

Data supervision, management and data quality audits

Data supervision capacity at the national level varied greatly due to funding constraints and lack of human resource capacity. For instance, well-funded M&E units in some of the planning entities were able to carry out data supervisions regularly while others left that role to the MoH division of health informatics. Use of paper-based data collection methods caused delays in data submission and subsequent validation. Also, bureaucracy between the national and county levels hindered effective data supervision. Some of the planning entities worked around this by mentoring the counties to carry out their own data supervision but it was not always possible to monitor how well this was being done.

Data quality audits tended to be a function of the MoH divisions rather than the directorates. More than half of the divisions reported that they carried out data quality audits (DQAs). The frequency of these audits ranged from quarterly to biennially. Results of the DQAs were disseminated through various fora such as data review meetings with counties, data quality workshops, online platforms e.g. MoH website, online score-cards, reports, email, phone calls

or social media platforms. Findings from the DQAs were used to improve the data collection mechanisms, resolve data discrepancies or inconsistencies, increase the uptake of certain services, and for decision-making and policy development. The main hindrance to performing data quality audits was lack of financial and technical capacity. Other challenges cited included slow or no internet connectivity causing delays in data transmission, data loss due to poor back-up systems, manual recording of data at the county levels resulting in delays and discrepancies that affected data quality.

Sub-optimal data demand, use and decision-making particularly at the county level

A majority of the planning entities reported that they disseminated information every now and then. This information was disseminated to a wide range of consumers namely the counties, MoH partners and donors, other planning entities within the national MoH, the parliament, the council of governors, policy makers, the President's office, the general public, Christian health associations and labour unions.

Different planning entities adopted different channels of dissemination information. Some of the information dissemination methods/channels used included data or performance review meetings, national or county health fora and major dissemination events, reports circulated to the counties and other stakeholders, bulletins, posters, online platforms such as websites, score-cards, information portals, etc., social media platforms, letters and emails, policy briefs and radio spots. Funding constraints prevented wider dissemination of information, tracking of use and impact assessment.

Disseminated information was largely used for decision-making processes, policy-making, advocacy, resource mobilization for instance in case of disease outbreaks, informing data supervision, and tailoring interventions and resources to county-specific needs or disease burden.

Data use at the county level was poor due to low awareness of the usefulness of data, lack of control over data collected centrally and inadequate requisite data analysis and interpretation skills. Suggestions on enhancing data use included staff capacity-building particularly in data analytics and policy development, use of electronic data collection systems, easing data access by creating a common research data portal that is categorized by disease and institutionalizing plans for research and publication. To address funding constraints, partners could work directly with the counties to finance data dissemination and use.

4 DISCUSSION

The overall M&E capacity of the entire health sector based on the four dimensions of status, quality, technical capacity and financial autonomy to undertake M&E was average. In terms of the 12 components of a well-functioning M&E system, the health sector's strongest capacity was in organizational structure, carrying out routine monitoring and National & County Databases. The sector's weakest M&E capacity was in Annual Costed M&E Plans, Human capacity for M&E and Evaluation & Research. This implies that while the health sector may be able to adequately monitor its activities, evaluation of its systems and processes lags behind which may result in missed opportunities for continued improvement while envisioned M&E objectives may not be achieved fully due to limited human capacities.

Counties had strong capacity in the National and County databases, Routine Monitoring and Supervision & Auditing. The weakest capacity at the County level was in Partnerships & Governance, Evaluation & Research and Annual Costed M&E plans. This indicates that while Counties have well established systems for data collection and use, there are gaps in linkage with stakeholders as well as mechanisms to evaluate long term impact of the various strategies in place at this level. At the national level, the MoH Departments' strongest M&E capacity was in Organizational Structures, Routine Monitoring and National & County Databases while the weakest capacity was in Human Capacity for M&E, Surveys & Surveillance and Evaluation & Research. This reveals that MoH departments had strong systems for M&E including for data collection and collation, while inadequate human capacities limited proper implementation. The seemingly weak evaluation and research capacity may be due to the fact that this function is anchored within the department responsible for M&E and research at MoH, and therefore other departments would still participate in this anchored role/capacity. The MoH programs had the strongest capacity in Organizational Structures, Routine Monitoring and Surveys & Surveillance while their weakest capacity was in Annual Costed M&E work plans, Data demand & Use and Evaluation & Research. Programs demonstrate anchorage of systems for M&E, including data collection, while there is a risk of inadequate data use to inform decisions mainly due to lack of guidelines for data analysis and use; impact assessment may also be compromised due to weak capacities in this area.

The SAGAs strongest capacity was in Organizational structures for M&E, Advocacy, Communication & Cultural behaviour and Partnerships & Governance while the lowest capacity was in Surveys & Surveillance, Evaluation & Research and National & County databases. This implies that M&E systems and collaboration mechanisms were well anchored within the SAGAS while systems to aggregate large data sets were mostly absent. This augurs well with the functionality of most SAGAs, who routinely do not handle a lot of data but are more organizational and collaborative in nature. Lastly, the regulatory bodies/councils' highest M&E capacity was in Evaluation & Research, Surveys & Surveillance and Data Demand & Use while the lowest capacity was in Routine Monitoring, Human Capacity for M&E and Advocacy, Communication and Cultural Behavior. Boards and councils' strengths anchor well within their mandate of regulation while weaknesses in this area particularly in human capacities may compromise the quality of the M&E function.

The Kenyan health sector M&E system consists of a National M&E Division/Department, with M&E units in some of the MoH directorates, departments and programs as well as in the counties. At the national level, most of the directorates and programs have M&E objectives in place, and either an M&E unit or lead M&E officer. At the county level, less than half of the counties had an approved M&E mission statement or objectives implying there is weak organizational structure for M&E. The existing M&E objectives are well aligned with the national strategic health plans and policies. However, the various M&E units are not well

integrated with the national M&E division and there is little interoperability between the units. This suggests that there may be a lot of duplication of M&E activities and measurement of indicators by various M&E Units as they all collect data from the same population and health facilities. Program M&E Units tend to function singly and independent of the national division. There is need to unify and streamline M&E services across the different levels as per the health sector monitoring and evaluation framework.

Human resource capacity for M&E was quite low at most levels including the national, county and SAGA levels. At the county level, existence of costed human capacity building plans for various M&E aspects e.g. data demand and use was low. Most counties did not have a validated M&E training curriculum implying that training was carried out in an unstructured manner with no clear objectives or training outcomes. Thus, even though most of the M&E units had staff, they were ill-equipped to carry out critical functions such as collating and analyzing health data and subsequently using it for evidence-based decision making. At the national level, the M&E units were grossly understaffed and M&E officers lacked clear designation of roles. The staff present had inadequate training in M&E-related work. There was no clear annual plan for building the capacity of staff. Many planning entities relied on partners to provide technical expertise and meet the human resource gaps. Amongst the SAGAs and regulatory councils, there was inadequate staff skills and competences for M&E functions. In addition, they lacked validated human capacity training curricula. There is need for the MoH to dedicate resources to employ more skilled M&E officers. There is also need to develop a standardized training curriculum and package to be used by all planning entities within the health sector. Short courses in M&E, data analysis and visualization, advanced statistical packages, programming and software development, developing information packages, technical reports and policy briefs, and Geographical Information Systems (GIS) would go a long way in building the capacity of the current staff in M&E Units. Thirdly, the MoH needs to provide clear job descriptions and specify a defined career path in M&E in order to motivate staff to take up roles in the field of M&E.

Most of the M&E units were heavily reliant on partners for technical and financial support at both the National, County, SAGA and regulatory council levels. To minimize M&E Units' exposure to financial vulnerability and inability to meet their objectives, there is need to increase government allocation of funds and harmonize the funding mechanism. This could be done by channeling government funding to the various M&E Units through the national M&E Division.

It was noted that there was no clear national mechanism of coordinating partner support. Planning entities engaged partners directly to support specific activities. This resulted in some entities receiving much higher funding compared to others. Partners tended to fund what was of interest or priority to them resulting in some of the M&E functions not being implemented. In addition, the MoH did not have a laid-down procedure of mapping various partners and stakeholders and matching partner support to specific M&E units' needs. To ensure that partner support is optimized and utilized efficiently for the entire health sector, the MoH needs to map the various partners/ stakeholders and engage them in round-table consultations on the priority M&E areas for funding.

The capacity for annual costed M&E work plans and national multi-sectoral M&E plan was average across the health sector. This was consistent with the fact that M&E activities for the sector were not well coordinated at the national level. In addition, although several assessments of the M&E systems had been carried out at the national and county levels, these were largely uncoordinated resulting in duplications. This means that opportunities for improving the system were not being systematically identified and utilized accordingly. There is need to

harmonize M&E planning into a single planning framework coordinated by the National M&E Department. All stakeholders should be represented at the annual M&E planning activities. The M&E plan can then be cascaded down to the various M&E Units at the national and county levels for implementation. Financing of M&E plans was very low again resulting in counties and national entities seeking external funding support from partners. This poses a major threat to implementation of M&E plans due to instances of funding changes or withdrawal.

Harmonized planning, budgeting and review is critical for proper functioning of the health system. The “Three One’s principle” (i.e. One planning framework; one budgeting framework and one M&E framework), together with the operationalization of the Partnership Framework will ensure improved overall efficiency, transparency and accountability of the health sector. The overall goal is to determine the health sector’s priorities for the subsequent financial year and aid programming of interventions, promote the use of evidence to determine priority setting and enhance accountability in resource allocation. Figures 90-92 illustrate the cyclical planning, budgeting and review processes that can be implemented at the County, National and SAGA levels.

The capacity for routine monitoring was relatively high at the county and national levels, indicating strong monitoring systems, particularly for service delivery data and specifically based on the National wide use of the robust national database, the KHIS/DHIS2, for routine health data collection from the counties. However, low information technology capacity as evidenced by poor internet connectivity, lack of computers and poor data back-up systems hinders timely and efficient data collection and transmission. A few of the MoH departments and programs that felt key relevant indicators were missing in the DHIS2 found it necessary to adopt partner-supported databases to complement the DHIS2. With a bit of tweaking, the DHIS2 can be expanded to accommodate the relevant indicators from different counties and health programs thus minimizing the need for other smaller databases. The MoH can then focus its resources on building IT capacity e.g. purchase of more computers, installation of robust data back-up systems and adoption of electronic data capture systems to reduce delays.

On the other hand, the capacity for evaluations and research was very low due to lack of expertise, funding constraints and lack of a comprehensive national research and evaluation agenda. Partners bridge most the evaluation and research gaps at the County, National and SAGA levels but this is unsustainable and largely dependent on the availability of the partner’s technical and financial support. The government needs to invest human and financial resources in conducting regular evaluations. Secondly, the MoH should hold consultative forums with all the key players in the health sector to come up with a national research and evaluation agenda that is cascaded to the county level. Thirdly, collaboration with nationally mandated research institutes e.g. KEMRI, KNBS, etc. and academic institutions can potentially bolster the MoH’s capacity for research and evaluations.

Data demand and Use was higher at the SAGAs and Councils compared to the MoH Departments, programs and counties. At the national level, information generated from data was largely used for decision-making and policy development by various stakeholders including the MoH and its partners, the counties, the parliament, the council of governors, other policy makers, the President’s office and the general public. Low awareness of data usefulness and funding constraints were the main challenges facing data use at the county level. There is need to equip county staff with skills in data analysis and interpretation and development of information packages and policy briefs. The MoH needs to engage the Council of Governors

in ongoing discussions on how best to overcome the bureaucratic processes that hinder cascading of data use skills from the national to county levels.

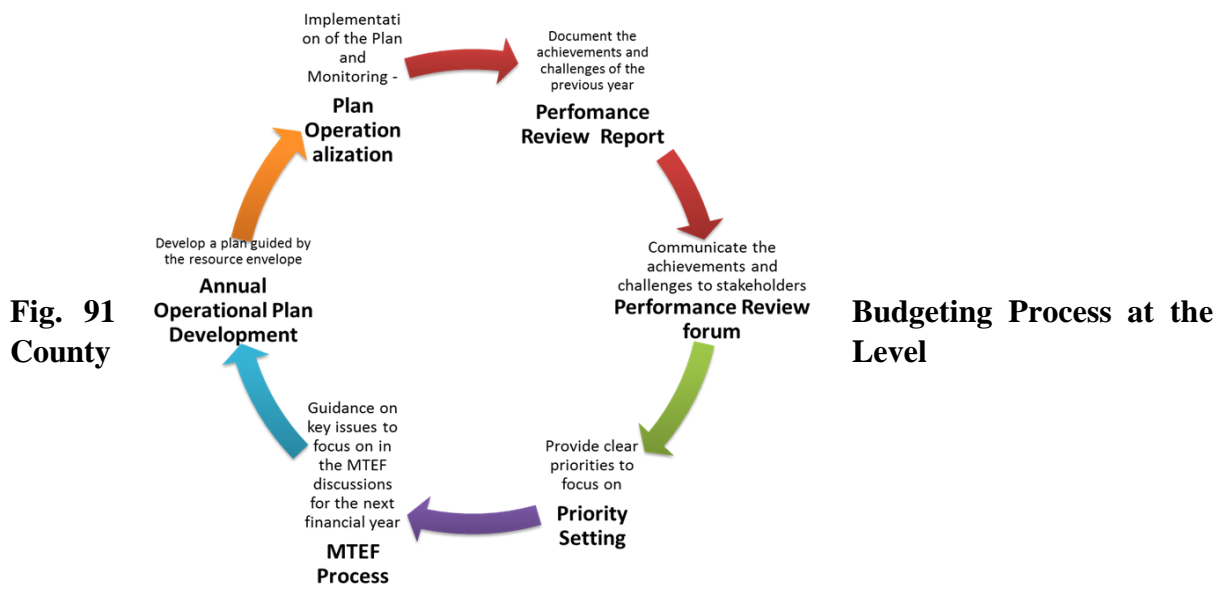
5 CONCLUSION

A well-functioning M&E system is essential to the MoH's ability to efficiently and effectively execute its planned activities as indicated in the Kenya Health Sector Strategic and Investment Plan. Based on the results of this baseline assessment, the following are the recommended actions to strengthen M&E capacity at the national and county levels in line with the MoH's guidelines for institutionalization of M&E in the health sector:

Capacity Area	Recommended actions
Capacity 1: Organizational structures with M&E	<ul style="list-style-type: none"> • Establish a unified M&E system for the whole health sector • Develop clear job descriptions for each of the M&E positions through material development workshops • Establish clear written down reporting lines and standard operating procedures at the county and national levels and a system for linking the two • Advocate for higher exchequer allocation to M&E of at least 14% of the MoH budget
Capacity 2: Human Capacity for M&E	<ul style="list-style-type: none"> • Designate existing staff to be M&E officers. Once this is done, any staffing gaps can be filled by hiring more personnel. At a minimum, each M&E Unit should have at least one clearly designated M&E officer. • Capacity building for staff through short-courses on M&E, data analytics and information packaging/policy formulations • Establish costed human capacity building plans
Capacity 3: Partnerships & Governance	<ul style="list-style-type: none"> • Map all health sector partners and stakeholders • Sector-wide coordination of partner support • Quarterly meetings for the health sector M&E coordinating committee • Develop data governance tools through workshops and stakeholder meetings • Develop a standardized on-job M&E training curriculum to be used across the health sector
Component 4: National M&E Plan	<ul style="list-style-type: none"> • Annual updating of the national M&E work plan based on performance monitoring
Capacity 5: Annual costed M&E Plan	<ul style="list-style-type: none"> • Consultative stakeholder meetings coordinated by the national M&E Division to develop the national costed M&E work plan - annual meeting with representation from both the county and national levels • Annual M&E plans developed to be cascaded to the national and county M&E units for implementation

Capacity Advocacy, Communication and Cultural Behaviour	6:	<ul style="list-style-type: none"> • Financial allocation to support development of advocacy and communication strategies • Increase in-house technical expertise for development of M&E advocacy and communication strategies
Capacity Routine Monitoring	7:	<ul style="list-style-type: none"> • Enhance internet connectivity and data back-up systems • Purchase of computers/tablets for electronic data collection and transmittal
Capacity Surveys and Surveillance	8:	<ul style="list-style-type: none"> • Infrastructure support e.g. necessary hardware and software for proper functioning of surveillance systems • Harmonize protocols for surveys and surveillance across the entire health sector
Capacity National and County databases	9:	<ul style="list-style-type: none"> • Software development and annual licensing • Hosting of data in secure servers on-site and off-site • Purchase servers and install robust data back-up systems
Capacity Supervision and Auditing	10:	<ul style="list-style-type: none"> • Capacity building for staff on supervision and auditing through training and hiring of more staff
Capacity Evaluation & Research	11:	<ul style="list-style-type: none"> • Capacity building for staff through training • Mapping of local evaluation and research capacity, including major research or academic institutions and their focus of work; the MoH to partner with these institutions to carry out evaluations
Capacity Data Demand & Use	12:	<ul style="list-style-type: none"> • Capacity building for staff – training on data analysis and development of information packages or policy formulation

Fig. 90 Cyclical Process of Reporting, Review and Planning



County Department of Health – MTEF Cycle Management Calendar

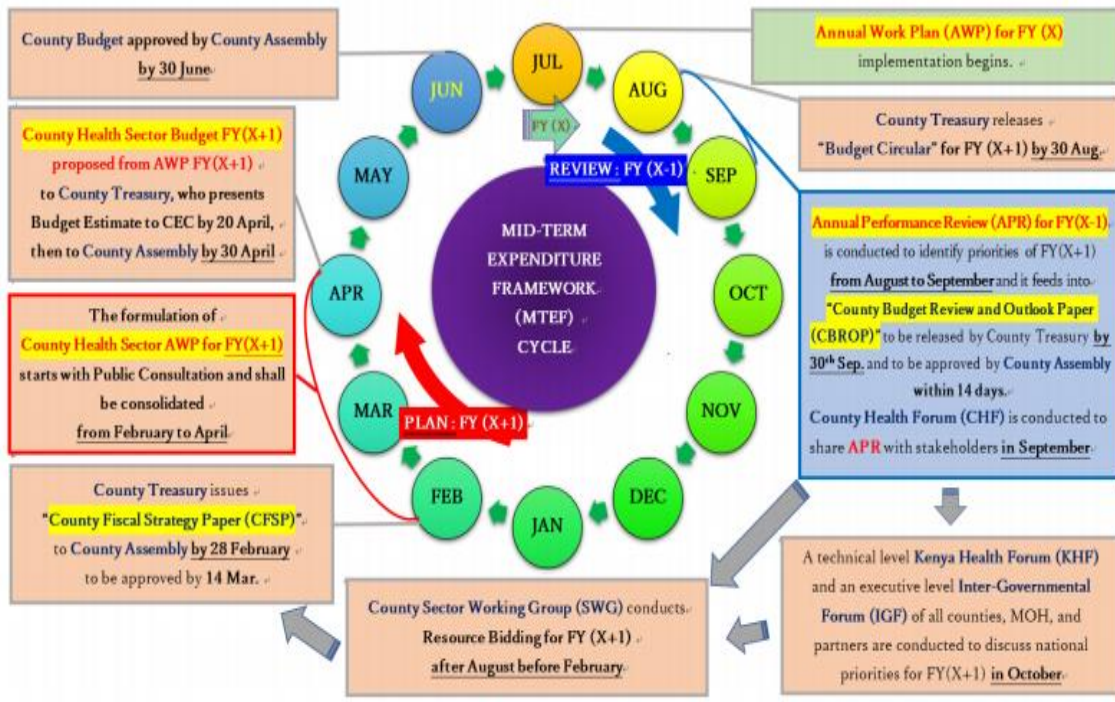
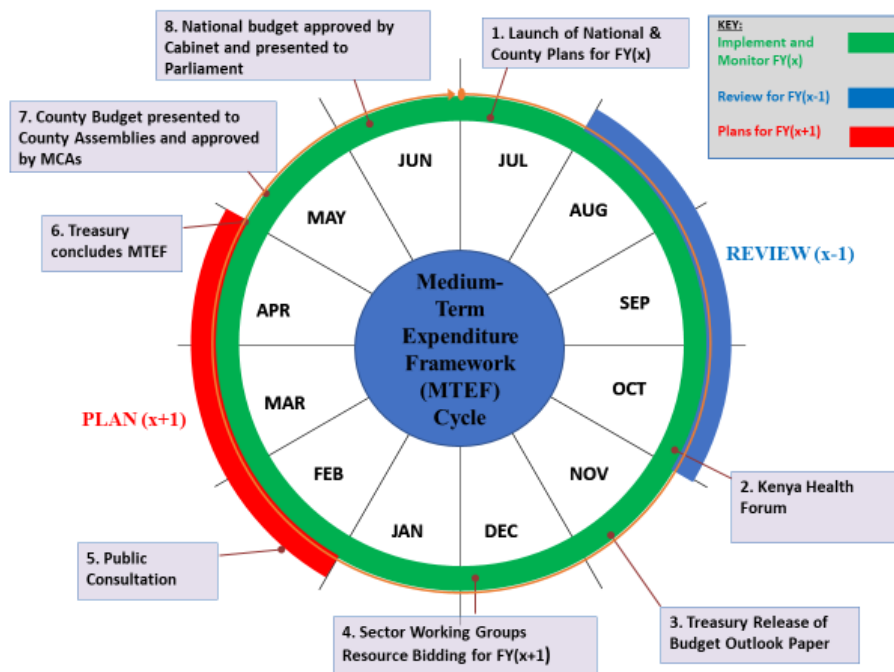
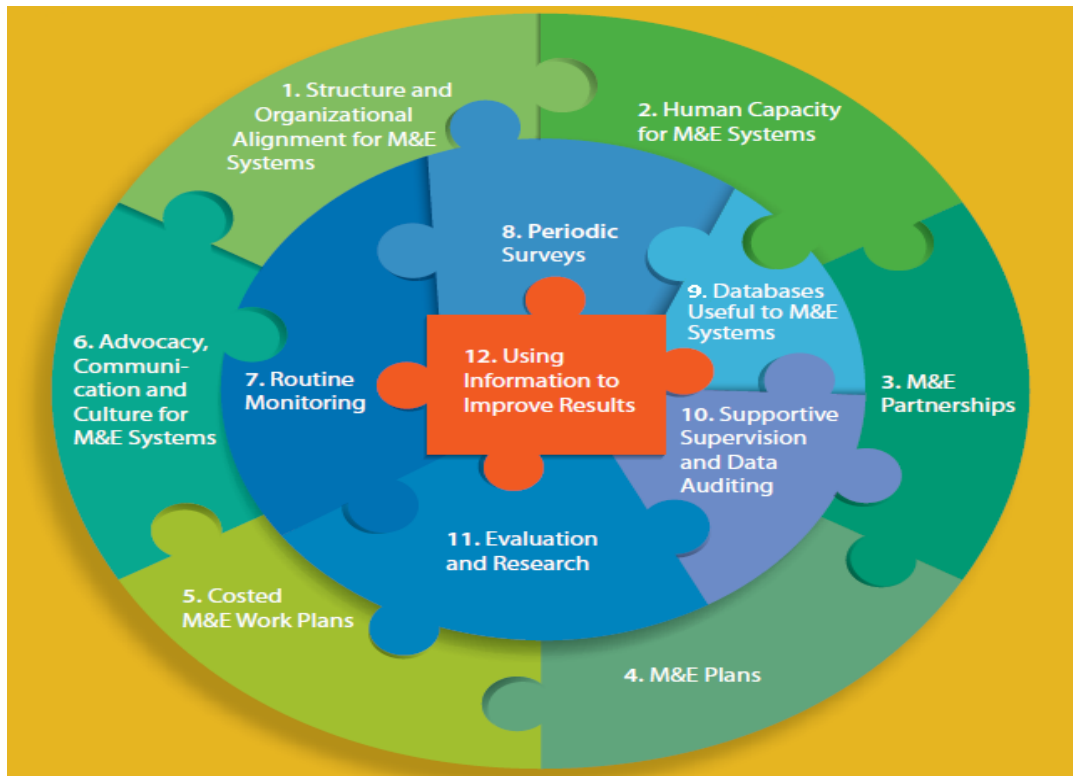


Fig. 92
County

Department of health – MTEF Cycle Management Calendar



APPENDIX 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 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 decision-making 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.

APPENDIX II - THE 12 CAPACITY AREAS AND THEIR MAIN FOCUS FOR THE ASSESSMENT

Capacity Area	Main focus
Capacity 1: Organizational structures with M&E	<ul style="list-style-type: none"> ● Leadership: Effective leadership for M&E in key organizations ● Human Resources: Job descriptions for M&E staff; adequate number of skilled M&E staff; defined career path in M&E ● Organizational Culture: National commitment to ensure M&E system performance ● Organizational Roles and Functions: Well-defined organizational structure, including a national HIV M&E unit; M&E units or M&E focal points in other public, private and civil society organizations; written mandates for planning, coordinating and managing the M&E system; well-defined M&E roles and responsibilities for key individuals and organizations at all levels ● Organizational Mechanisms: Routine mechanisms for M&E planning and management, for stakeholder coordination and consensus building and, for monitoring the performance of the M&E system; incentives for M&E system performance ● Organizational Performance: Key organizations achieve their annual work plan objectives for M&E
Capacity 2: Human Capacity for M&E	<ul style="list-style-type: none"> ● Defined skill set for individuals and organizations at national, sub-national (county), and service-delivery levels ● Work force development plan, including career paths for M&E ● Costed human capacity building plan ● Standard curricula for organizational and technical capacity building ● Local and/or regional training capacity, including links to training institutions ● Supervision, in-service training and mentoring
Capacity 3: Partnerships & Governance	<ul style="list-style-type: none"> ● National M&E Technical Working Group ● Mechanism to coordinate all stakeholders. ● Local leadership and capacity for stakeholder coordination. ● Routine communication channel to facilitate exchange of information among stakeholders
Component 4: National M&E Plan	<ul style="list-style-type: none"> ● Broad-based participation in developing the national M&E plan. ● Explicitly linked to the National Strategic Plan. ● The M&E plan adheres to international and national technical standards ● An M&E system assessment has been completed and recommendations for system strengthening have been addressed in a revised M&E plan
Capacity 5: Annual costed M&E Plan	<ul style="list-style-type: none"> ● The M&E work plan contains activities, responsible implementers, timeframe, activity costs and identified funding ● The M&E work plan explicitly links to the work plans and government Medium Term Expenditure Framework (MTEF) budgets ● Resources (human, physical, financial) are committed to implement the M&E work plan ● All relevant stakeholders endorsed the national M&E work plan ● The M&E work plan is updated annually based on performance monitoring
Capacity 6: Advocacy, Communication	<ul style="list-style-type: none"> ● The communication strategy includes a specific M&E communication and advocacy plan. ● M&E is explicitly referenced in national policies and the National Strategic Plan ● ‘M&E champions’ among high-level officials are identified and are actively endorsing M&E actions

and Cultural Behavior	<ul style="list-style-type: none"> • M&E advocacy activities are implemented according to the M&E advocacy plan • M&E materials are available that target different audiences and support data sharing and use
Capacity 7: Routine Monitoring	<ul style="list-style-type: none"> • Data collection strategy is explicitly linked to data use • Clearly defined data collection, transfer, and reporting mechanisms, including collaboration and coordination among the different stakeholders • Essential tools and equipment for data management (e.g., collection, transfer, storage, analysis) • Routine procedures for data transfer from sub-national (county) to national levels
Capacity 8: Surveys and Surveillance	<ul style="list-style-type: none"> • Protocols for all surveys and surveillance based on international standards • Specified schedule for data collection linked to stakeholders' needs, including identification of resources for implementation • Inventory of surveys conducted • Well-functioning surveillance system (program dependent)
Capacity 9: National and sub-National (County) databases	<ul style="list-style-type: none"> • Database(s) designed to respond to the decision-making and reporting needs of different stakeholders • Linkages between different relevant databases to ensure data consistency and to avoid duplication of effort • Well-defined and managed national database to capture, verify, analyze, and present program monitoring data from all levels and sectors
Capacity 10: Supervision and Auditing	<ul style="list-style-type: none"> • Guidelines for supervising routine data collection at facility- and community-based levels • Routine supervision visits, including data assessments and feedback to local staff • Periodic data quality audits • Supervision reports and audit reports
Capacity 11: Evaluation & Research	<ul style="list-style-type: none"> • Inventory of completed and ongoing country-specific evaluation and research studies • Inventory of local evaluation and research capacity, including major research institutions and their focus of work • National evaluation and research agenda • Guidance on evaluation and research standards and appropriate methods • National conference or forum for dissemination and discussion of research and evaluation findings
Capacity 12: Data Demand & Use	<ul style="list-style-type: none"> • The program National Strategic Plan and the national M&E plan include a data use plan • Analysis of program data needs and data users • Data use calendar to guide the timetable for major data collection efforts and reporting requirements • Evidence of information use (e.g., data referenced in funding proposals and planning documents)

APPENDIX III - GROUP ASSESSMENT EXCEL-BASED TOOL



MINISTRY OF HEALTH
MONITORING AND EVALUATION CAPACITY ASSESSMENT TOOL

Assessment of the capacity of MoH and MOI programs to identify and respond to M&E information needs at national and sub-national levels

[Capacity 1: Organizational structures with M&E](#)

[Capacity 2: Human Capacity for M&E](#)

[Capacity 3: Partnerships & Governance](#)

[Component 4: National M&E Plan](#)

[Capacity 5: Annual costed M&E Plan](#)

[Capacity 6: Advocacy, Communication and Cultural Behavior](#)

[Capacity 7: Routine Monitoring](#)

[Capacity 8: Surveys and Surveillance](#)

[Capacity 9: National and sub-National databases](#)

[Capacity 10: Supervision and Auditing](#)

[Capacity 11: Evaluation & Research](#)

[Capacity12: Data Demand & Use](#)

[Dashboards](#)

[Overall Dashboards](#)

[Action Plan](#)

May 2013

APPENDIX IV – COUNTY-SPECIFIC SUMMARIES PER DIMENSION AND M&E CAPACITY AREA

	Status	Quality	Technical	Financial
Baringo				
1.0 Organizational	1.67	3.21	1.25	-
2.0 Human Capacity for M&E	4.00	4.05	2.50	2.50
3.0 Partnerships and Governance	5.00	5.63	6.00	3.00
4.0 National M&E Plan	3.00	3.00	3.33	-
5.0 Annual Costed M&E Work Plan	6.67	2.22	-	-
6.0 Advocacy, Communication and Cultural Behavior	5.00	3.75	5.00	5.00
7.0 Routine Monitoring	5.00	5.00	5.00	5.00
8.0 Surveys and Surveillance	3.33	2.50	10.00	2.50
9.0 National and Sub-National Databases	10.00	9.38	5.00	5.00
10.0 Supervision and Auditing	7.50	7.50	5.00	5.00
11.0 Evaluation and Research	3.33	2.78	2.50	2.50
12.0 Data Demand and Use	1.67	1.67	2.50	2.50
Bomet				
1.0 Organizational	1.67	2.58	2.50	-
2.0 Human Capacity for M&E	2.00	2.20	2.50	2.50
3.0 Partnerships and Governance	6.79	6.46	4.00	3.00
4.0 National M&E Plan	5.00	4.67	3.33	3.33
5.0 Annual Costed M&E Work Plan	-	-	-	-
6.0 Advocacy, Communication and Cultural Behavior	1.67	-	-	-
7.0 Routine Monitoring	7.50	8.13	5.00	5.00

8.0 Surveys and Surveillance	3.33	2.08	5.00	-
9.0 National and Sub-National Databases	10.00	9.38	5.00	5.00
10.0 Supervision and Auditing	5.00	5.00	2.50	2.50
11.0 Evaluation and Research	6.67	6.11	2.50	2.50
12.0 Data Demand and Use	1.67	1.67	2.50	2.50
Bungoma				
1.0 Organizational	6.67	8.75	7.50	-
2.0 Human Capacity for M&E	1.00	1.40	5.00	2.50
3.0 Partnerships and Governance	6.43	6.35	4.00	3.00
4.0 County M&E Plan	5.00	3.67	1.67	-
5.0 Annual Costed M&E Work Plan	6.67	3.33	-	5.00
6.0 Advocacy, Communication and Cultural Behavior	5.00	5.00	-	-
7.0 Routine Monitoring	5.00	6.88	5.00	2.50
8.0 Surveys and Surveillance	3.33	3.33	5.00	5.00
9.0 National and Sub-national Databases	-	3.75	-	-
10.0 Supervision and Auditing	10.00	8.75	5.00	5.00
11.0 Evaluation and Research	-	-	-	-
12.0 Data Demand and Use	3.33	5.00	2.50	2.50
Busia				
1.0 Organizational	10.00	7.50	5.00	5.00
2.0 Human Capacity for M&E	5.00	7.10	5.00	5.00
3.0 Partnerships and Governance	5.71	5.10	3.00	3.00
4.0 County M&E Plan	5.00	5.67	3.33	3.33
5.0 Annual Costed M&E Work Plan	10.00	3.89	-	5.00
6.0 Advocacy, Communication and Cultural Behavior	5.00	8.75	5.00	5.00

7.0 Routine Monitoring	7.50	8.13	5.00	5.00
8.0 Surveys and Surveillance	6.67	7.08	5.00	5.00
9.0 National and Sub-national Databases	10.00	6.88	5.00	5.00
10.0 Supervision and Auditing	5.00	5.00	5.00	5.00
11.0 Evaluation and Research	3.33	1.67	2.50	2.50
12.0 Data Demand and Use	5.00	5.00	5.00	5.00
E/Marakwet				
1.0 Organizational	1.67	2.38	1.25	-
2.0 Human Capacity for M&E	3.00	2.80	5.00	5.00
3.0 Partnerships and Governance	5.00	4.90	4.00	2.00
4.0 County M&E Plan	5.00	5.83	5.00	-
5.0 Annual Costed M&E Work Plan	10.00	1.11	-	-
6.0 Advocacy, Communication and Cultural Behavior	5.00	5.00	10.00	-
7.0 Routine Monitoring	7.50	7.50	2.50	7.50
8.0 Surveys and Surveillance	6.67	7.92	2.50	5.00
9.0 County and Sub-County Databases	10.00	9.38	5.00	10.00
10.0 Supervision and Auditing	10.00	10.00	2.50	5.00
11.0 Evaluation and Research	-	-	-	-
12.0 Data Demand and Use	6.67	6.67	5.00	-
Embu				
1.0 Organizational	3.33	3.77	5.00	-
2.0 Human Capacity for M&E	3.00	2.40	2.50	2.50
3.0 Partnerships and Governance	6.43	6.04	4.00	1.00
4.0 county M&E Plan	4.00	3.17	1.67	1.67
5.0 Annual Costed M&E Work Plan	-	-	-	-

6.0 Advocacy, Communication and Cultural Behavior	1.67	-	-	-
7.0 Routine Monitoring	7.50	5.63	5.00	5.00
8.0 Surveys and Surveillance	-	-	-	-
9.0 county and Sub-county Databases	10.00	9.38	5.00	5.00
10.0 Supervision and Auditing	5.00	5.00	2.50	2.50
11.0 Evaluation and Research	6.67	6.11	2.50	2.50
12.0 Data Demand and Use	1.67	1.67	2.50	2.50
Garissa				
1.0 Organizational	8.33	8.21	6.25	-
2.0 Human Capacity for M&E	2.00	1.40	2.50	-
3.0 Partnerships and Governance	8.21	8.13	7.00	2.00
4.0 National M&E Plan	5.00	4.67	3.33	3.33
5.0 Annual Costed M&E Work Plan	3.33	-	-	-
6.0 Advocacy, Communication and Cultural Behavior	3.33	5.00	-	-
7.0 Routine Monitoring	2.50	4.38	5.00	2.50
8.0 Surveys and Surveillance	3.33	3.33	5.00	-
9.0 National and Sub-National Databases	10.00	8.75	5.00	5.00
10.0 Supervision and Auditing	5.00	2.50	2.50	2.50
11.0 Evaluation and Research	3.33	3.33	-	-
12.0 Data Demand and Use	1.67	1.67	5.00	2.50
Homa Bay				
1.0 Organizational	5.00	7.17	6.25	5.00
2.0 Human Capacity for M&E	3.00	3.90	2.50	2.50
3.0 Partnerships and Governance	6.79	6.35	4.00	3.00
4.0 National M&E Plan	6.00	4.67	3.33	3.33

5.0 Annual Costed M&E Work Plan	6.67	2.22	-	-
6.0 Advocacy, Communication and Cultural Behavior	5.00	5.00	-	-
7.0 Routine Monitoring	10.00	6.88	5.00	5.00
8.0 Surveys and Surveillance	3.33	3.33	5.00	5.00
9.0 National and Sub-National Databases	10.00	8.75	5.00	5.00
10.0 Supervision and Auditing	10.00	8.75	7.50	7.50
11.0 Evaluation and Research	1.67	0.83	-	-
12.0 Data Demand and Use	3.33	3.89	7.50	2.50
Isiolo				
1.0 Organizational	5.00	8.75	5.00	-
2.0 Human Capacity for M&E	5.00	5.25	2.50	2.50
3.0 Partnerships and Governance	7.50	4.38	4.00	4.00
4.0 National M&E Plan	10.00	7.83	5.00	5.00
5.0 Annual Costed M&E Work Plan	10.00	10.00	-	10.00
6.0 Advocacy, Communication and Cultural Behavior	8.33	8.75	5.00	5.00
7.0 Routine Monitoring	7.50	8.13	5.00	7.50
8.0 Surveys and Surveillance	6.67	9.17	5.00	7.50
9.0 National and Sub-National Databases	5.00	8.75	5.00	5.00
10.0 Supervision and Auditing	10.00	8.75	2.50	5.00
11.0 Evaluation and Research	6.67	9.44	5.00	5.00
12.0 Data Demand and Use	8.33	8.33	7.50	7.50
Kajiado				
1.0 Organizational	3.33	-	2.50	5.00
2.0 Human Capacity for M&E	4.00	3.70	2.50	2.50
3.0 Partnerships and Governance	2.86	-	-	-

4.0 National M&E Plan	-	-	-	-
5.0 Annual Costed M&E Work Plan	10.00	6.67	-	5.00
6.0 Advocacy, Communication and Cultural Behavior	3.33	5.00	-	-
7.0 Routine Monitoring	10.00	5.00	2.50	2.50
8.0 Surveys and Surveillance	-	-	-	-
9.0 National and Sub-National Databases	10.00	7.50	5.00	5.00
10.0 Supervision and Auditing	5.00	5.00	2.50	2.50
11.0 Evaluation and Research	-	-	-	-
12.0 Data Demand and Use	3.33	1.67	2.50	2.50
Kakamega				
1.0 Organizational	8.33	7.50	8.75	5.00
2.0 Human Capacity for M&E	2.00	2.20	2.50	-
3.0 Partnerships and Governance	3.93	4.79	5.00	1.00
4.0 County M&E Plan	4.00	5.67	3.33	1.67
5.0 Annual Costed M&E Work Plan	6.67	3.89	-	-
6.0 Advocacy, Communication and Cultural Behavior	3.33	2.50	-	-
7.0 Routine Monitoring	2.50	3.13	2.50	-
8.0 Surveys and Surveillance	1.67	0.83	5.00	-
9.0 National and Sub-national Databases	-	3.75	-	-
10.0 Supervision and Auditing	7.50	5.00	5.00	-
11.0 Evaluation and Research	-	-	-	-
12.0 Data Demand and Use	6.67	5.56	7.50	2.50
Kericho				
1.0 Organizational	8.33	7.50	7.50	5.00
2.0 Human Capacity for M&E	3.00	4.20	5.00	2.50

3.0 Partnerships and Governance	9.29	8.33	8.00	3.00
4.0 County M&E Plan	7.00	5.83	3.33	3.33
5.0 Annual Costed M&E Work Plan	6.67	3.33	-	5.00
6.0 Advocacy, Communication and Cultural Behavior	8.33	8.75	5.00	5.00
7.0 Routine Monitoring	10.00	6.88	5.00	5.00
8.0 Surveys and Surveillance	5.00	3.33	7.50	7.50
9.0 National and Sub-national Databases	10.00	8.13	5.00	5.00
10.0 Supervision and Auditing	5.00	3.75	5.00	-
11.0 Evaluation and Research	-	-	-	-
12.0 Data Demand and Use	6.67	5.56	7.50	5.00
Kiambu				
1.0 Organizational	8.33	6.65	5.00	10.00
2.0 Human Capacity for M&E	5.00	6.10	5.00	-
3.0 Partnerships and Governance	9.29	6.46	6.00	6.00
4.0 National M&E Plan	5.00	6.17	8.33	5.00
5.0 Annual Costed M&E Work Plan	-	-	-	-
6.0 Advocacy, Communication and Cultural Behavior	3.33	2.50	-	-
7.0 Routine Monitoring	10.00	8.13	5.00	5.00
8.0 Surveys and Surveillance	-	-	-	-
9.0 National and Sub-National Databases	-	1.88	-	-
10.0 Supervision and Auditing	10.00	8.75	5.00	5.00
11.0 Evaluation and Research	6.67	5.00	5.00	2.50
12.0 Data Demand and Use	1.67	1.67	2.50	2.50
Kilifi				
1.0 Organizational	8.33	7.50	5.00	5.00

2.0 Human Capacity for M&E	5.00	5.95	6.25	6.25
3.0 Partnerships and Governance	5.00	2.50	5.00	-
4.0 County M&E Plan	3.00	4.17	-	1.67
5.0 Annual Costed M&E Work Plan	6.67	3.33	-	5.00
6.0 Advocacy, Communication and Cultural Behavior	3.33	5.00	-	-
7.0 Routine Monitoring	7.50	7.50	5.00	5.00
8.0 Surveys and Surveillance	8.33	7.92	7.50	5.00
9.0 County and Sub-County Databases	10.00	7.50	5.00	5.00
10.0 Supervision and Auditing	5.00	7.50	5.00	7.50
11.0 Evaluation and Research	5.00	6.67	2.50	2.50
12.0 Data Demand and Use	8.33	10.00	5.00	10.00
Kirinyaga				
1.0 Organizational	1.67	3.21	1.25	5.00
2.0 Human Capacity for M&E	3.00	3.75	2.50	2.50
3.0 Partnerships and Governance	2.86	2.81	2.00	-
4.0 National M&E Plan	4.00	2.67	1.67	1.67
5.0 Annual Costed M&E Work Plan	-	-	-	-
6.0 Advocacy, Communication and Cultural Behavior	5.00	5.00	5.00	-
7.0 Routine Monitoring	7.50	5.00	5.00	5.00
8.0 Surveys and Surveillance	3.33	2.08	10.00	2.50
9.0 National and Sub-National Databases	10.00	8.13	5.00	5.00
10.0 Supervision and Auditing	7.50	7.50	5.00	5.00
11.0 Evaluation and Research	3.33	1.67	2.50	2.50
12.0 Data Demand and Use	1.67	1.67	2.50	2.50
Kisii				

1.0 Organizational KISII COUNTY	5.00	5.71	5.00	5.00
2.0 Human Capacity for M&E	3.00	3.00	2.50	2.50
3.0 Partnerships and Governance	9.29	7.60	7.00	7.00
4.0 National M&E Plan	8.00	7.92	5.00	5.00
5.0 Annual Costed M&E Work Plan	10.00	2.22	-	-
6.0 Advocacy, Communication and Cultural Behavior	5.00	5.00	-	-
7.0 Routine Monitoring	7.50	8.13	5.00	5.00
8.0 Surveys and Surveillance	3.33	3.33	2.50	2.50
9.0 National and Sub-National Databases	10.00	7.50	5.00	5.00
10.0 Supervision and Auditing	7.50	7.50	5.00	5.00
11.0 Evaluation and Research	5.00	2.50	2.50	2.50
12.0 Data Demand and Use	6.67	6.67	5.00	5.00
Kisumu				
1.0 Organizational	5.00	6.25	6.25	5.00
2.0 Human Capacity for M&E	1.00	1.40	2.50	2.50
3.0 Partnerships and Governance	7.86	6.77	5.00	-
4.0 National M&E Plan	6.00	5.42	3.33	-
5.0 Annual Costed M&E Work Plan	3.33	3.33	-	-
6.0 Advocacy, Communication and Cultural Behavior	3.33	5.00	-	-
7.0 Routine Monitoring	7.50	7.50	5.00	-
8.0 Surveys and Surveillance	3.33	3.33	2.50	-
9.0 National and Sub-National Databases	5.00	5.00	-	-
10.0 Supervision and Auditing	10.00	5.00	5.00	2.50
11.0 Evaluation and Research	-	-	-	-
12.0 Data Demand and Use	3.33	3.33	2.50	2.50

Kitui				
1.0 Organizational	6.67	6.75	7.50	5.00
2.0 Human Capacity for M&E	3.00	2.20	2.50	2.50
3.0 Partnerships and Governance	6.07	5.63	6.00	5.00
4.0 National M&E Plan	5.00	4.67	3.33	3.33
5.0 Annual Costed M&E Work Plan	-	-	-	-
6.0 Advocacy, Communication and Cultural Behavior	1.67	-	-	-
7.0 Routine Monitoring	7.50	5.63	5.00	5.00
8.0 Surveys and Surveillance	-	-	-	-
9.0 National and Sub-National Databases	10.00	8.75	5.00	5.00
10.0 Supervision and Auditing	5.00	2.50	5.00	2.50
11.0 Evaluation and Research	3.33	2.22	2.50	2.50
12.0 Data Demand and Use	1.67	1.67	2.50	2.50
Kwale				
1.0 Organizational	8.33	8.75	3.75	5.00
2.0 Human Capacity for M&E	6.00	6.50	2.50	2.50
3.0 Partnerships and Governance	6.07	5.83	3.00	-
4.0 National M&E Plan	7.00	6.33	3.33	-
5.0 Annual Costed M&E Work Plan	10.00	5.56	-	5.00
6.0 Advocacy, Communication and Cultural Behavior	8.33	10.00	5.00	-
7.0 Routine Monitoring	7.50	7.50	5.00	10.00
8.0 Surveys and Surveillance	10.00	5.83	5.00	5.00
9.0 National and Sub-National Databases	10.00	8.75	5.00	10.00
10.0 Supervision and Auditing	10.00	6.25	5.00	7.50
11.0 Evaluation and Research	3.33	4.17	2.50	2.50

12.0 Data Demand and Use	10.00	9.44	7.50	7.50
Laikipia				
1.0 Organizational	1.67	3.21	1.25	-
2.0 Human Capacity for M&E	2.00	2.75	-	-
3.0 Partnerships and Governance	5.00	5.42	6.00	3.00
4.0 National M&E Plan	3.00	3.00	1.67	-
5.0 Annual Costed M&E Work Plan	6.67	2.22	-	-
6.0 Advocacy, Communication and Cultural Behavior	5.00	3.75	5.00	-
7.0 Routine Monitoring	5.00	5.00	5.00	5.00
8.0 Surveys and Surveillance	3.33	2.08	10.00	2.50
9.0 National and Sub-National Databases	10.00	9.38	5.00	5.00
10.0 Supervision and Auditing	7.50	7.50	7.50	2.50
11.0 Evaluation and Research	3.33	2.78	2.50	2.50
12.0 Data Demand and Use	1.67	1.67	2.50	2.50
Lamu				
1.0 Organizational	6.67	7.50	3.75	-
2.0 Human Capacity for M&E	5.00	5.45	5.00	5.00
3.0 Partnerships and Governance	4.29	5.21	5.00	3.00
4.0 County M&E Plan	6.00	5.83	6.67	-
5.0 Annual Costed M&E Work Plan	10.00	8.89	-	5.00
6.0 Advocacy, Communication and Cultural Behavior	5.00	5.00	-	-
7.0 Routine Monitoring	10.00	5.63	2.50	10.00
8.0 Surveys and Surveillance	5.00	5.42	7.50	2.50
9.0 County and Sub-County Databases	10.00	8.13	-	5.00
10.0 Supervision and Auditing	10.00	10.00	10.00	10.00

11.0 Evaluation and Research	-	-	-	-
12.0 Data Demand and Use	5.00	5.00	7.50	2.50
Machakos				
1.0 Organizational	1.67	-	5.00	-
2.0 Human Capacity for M&E	2.00	1.90	5.00	-
3.0 Partnerships and Governance	6.43	5.42	3.00	-
4.0 National M&E Plan	2.00	2.00	-	-
5.0 Annual Costed M&E Work Plan	-	-	-	-
6.0 Advocacy, Communication and Cultural Behavior	6.67	5.00	-	-
7.0 Routine Monitoring	10.00	8.75	5.00	2.50
8.0 Surveys and Surveillance	3.33	3.33	2.50	2.50
9.0 National and Sub-National Databases	10.00	10.00	5.00	5.00
10.0 Supervision and Auditing	7.50	7.50	10.00	5.00
11.0 Evaluation and Research	-	-	-	-
12.0 Data Demand and Use	5.00	6.67	2.50	-
Makueni				
1.0 Organizational	8.33	7.50	6.25	5.00
2.0 Human Capacity for M&E	8.00	7.60	7.50	7.50
3.0 Partnerships and Governance	6.07	6.35	5.00	6.00
4.0 County M&E Plan	5.00	6.67	6.67	6.67
5.0 Annual Costed M&E Work Plan	10.00	5.00	-	5.00
6.0 Advocacy, Communication and Cultural Behavior	8.33	7.50	5.00	5.00
7.0 Routine Monitoring	7.50	8.13	7.50	7.50
8.0 Surveys and Surveillance	6.67	8.75	5.00	5.00
9.0 National and Sub-national Databases	10.00	10.00	5.00	5.00

10.0 Supervision and Auditing	5.00	7.50	5.00	10.00
11.0 Evaluation and Research	5.00	4.44	2.50	2.50
12.0 Data Demand and Use	8.33	7.78	7.50	10.00
Mandera				
1.0 Organizational	5.00	5.71	7.50	-
2.0 Human Capacity for M&E	3.00	2.75	-	-
3.0 Partnerships and Governance	5.71	6.35	5.00	2.00
4.0 National M&E Plan	7.00	5.67	5.00	-
5.0 Annual Costed M&E Work Plan	3.33	-	-	-
6.0 Advocacy, Communication and Cultural Behavior	1.67	-	-	-
7.0 Routine Monitoring	7.50	7.50	5.00	5.00
8.0 Surveys and Surveillance	-	-	-	-
9.0 National and Sub-National Databases	10.00	9.38	5.00	5.00
10.0 Supervision and Auditing	5.00	5.00	2.50	-
11.0 Evaluation and Research	6.67	4.44	5.00	-
12.0 Data Demand and Use	8.33	10.00	7.50	-
Marsabit				
1.0 Organizational	5.00	5.54	7.50	-
2.0 Human Capacity for M&E	3.00	2.75	-	-
3.0 Partnerships and Governance	5.71	6.35	5.00	2.00
4.0 National M&E Plan	7.00	5.67	5.00	-
5.0 Annual Costed M&E Work Plan	3.33	-	-	-
6.0 Advocacy, Communication and Cultural Behavior	1.67	-	-	-
7.0 Routine Monitoring	7.50	7.50	5.00	5.00
8.0 Surveys and Surveillance	-	-	-	-

9.0 National and Sub-National Databases	10.00	9.38	5.00	5.00
10.0 Supervision and Auditing	5.00	5.00	2.50	-
11.0 Evaluation and Research	6.67	4.44	5.00	-
12.0 Data Demand and Use	8.33	10.00	7.50	-
Meru				
1.0 Organizational	5.00	7.50	6.25	-
2.0 Human Capacity for M&E	4.00	6.00	5.00	5.00
3.0 Partnerships and Governance	7.50	7.60	6.00	1.00
4.0 National M&E Plan	6.00	5.67	6.67	1.67
5.0 Annual Costed M&E Work Plan	10.00	5.00	-	5.00
6.0 Advocacy, Communication and Cultural Behavior	6.67	5.00	-	-
7.0 Routine Monitoring	7.50	9.38	5.00	5.00
8.0 Surveys and Surveillance	5.00	4.58	5.00	5.00
9.0 National and Sub-National Databases	5.00	8.13	5.00	-
10.0 Supervision and Auditing	10.00	5.00	7.50	2.50
11.0 Evaluation and Research	1.67	2.50	-	-
12.0 Data Demand and Use	6.67	6.67	5.00	5.00
Migori				
1.0 Organizational	5.00	7.50	6.25	-
2.0 Human Capacity for M&E	4.00	6.00	5.00	5.00
3.0 Partnerships and Governance	7.50	7.60	6.00	1.00
4.0 National M&E Plan	6.00	5.67	6.67	1.67
5.0 Annual Costed M&E Work Plan	10.00	5.00	-	5.00
6.0 Advocacy, Communication and Cultural Behavior	6.67	5.00	-	-
7.0 Routine Monitoring	7.50	9.38	5.00	5.00

8.0 Surveys and Surveillance	5.00	4.58	5.00	5.00
9.0 National and Sub-National Databases	5.00	8.13	5.00	-
10.0 Supervision and Auditing	10.00	5.00	7.50	2.50
11.0 Evaluation and Research	1.67	2.50	-	-
12.0 Data Demand and Use	6.67	6.67	5.00	5.00
Mombasa				
1.0 Organizational	8.33	8.75	6.25	5.00
2.0 Human Capacity for M&E	7.00	8.00	5.00	2.50
3.0 Partnerships and Governance	6.07	5.83	3.00	2.00
4.0 National M&E Plan	7.00	6.33	3.33	-
5.0 Annual Costed M&E Work Plan	10.00	5.56	-	5.00
6.0 Advocacy, Communication and Cultural Behavior	8.33	10.00	5.00	-
7.0 Routine Monitoring	7.50	7.50	5.00	10.00
8.0 Surveys and Surveillance	10.00	5.83	5.00	5.00
9.0 National and Sub-National Databases	10.00	8.75	5.00	10.00
10.0 Supervision and Auditing	10.00	6.25	5.00	7.50
11.0 Evaluation and Research	3.33	4.17	2.50	2.50
12.0 Data Demand and Use	10.00	9.44	7.50	7.50
Muranga				
1.0 Organizational	6.67	6.65	7.50	-
2.0 Human Capacity for M&E	3.00	2.65	2.50	2.50
3.0 Partnerships and Governance	8.21	8.13	7.00	3.00
4.0 National M&E Plan	7.00	5.67	5.00	3.33
5.0 Annual Costed M&E Work Plan	-	-	-	-
6.0 Advocacy, Communication and Cultural Behavior	1.67	-	-	-

7.0 Routine Monitoring	10.00	8.13	5.00	5.00
8.0 Surveys and Surveillance	3.33	3.33	2.50	2.50
9.0 National and Sub-National Databases	10.00	9.38	5.00	5.00
10.0 Supervision and Auditing	10.00	7.50	5.00	5.00
11.0 Evaluation and Research	6.67	6.11	2.50	2.50
12.0 Data Demand and Use	3.33	5.00	2.50	2.50
Nairobi				
1.0 Organizational	6.67	8.75	7.50	5.00
2.0 Human Capacity for M&E	6.00	7.15	5.00	2.50
3.0 Partnerships and Governance	5.71	4.79	4.00	4.00
4.0 County M&E Plan	4.00	6.33	5.00	5.00
5.0 Annual Costed M&E Work Plan	10.00	6.67	-	5.00
6.0 Advocacy, Communication and Cultural Behavior	5.00	6.25	5.00	5.00
7.0 Routine Monitoring	10.00	7.50	5.00	5.00
8.0 Surveys and Surveillance	8.33	8.75	5.00	5.00
9.0 National and Sub-National Databases	10.00	8.75	5.00	5.00
10.0 Supervision and Auditing	10.00	10.00	5.00	5.00
11.0 Evaluation and Research	10.00	7.78	5.00	5.00
12.0 Data Demand and Use	6.67	10.00	5.00	5.00
Nakuru				
1.0 Organizational	5.00	6.96	8.75	-
2.0 Human Capacity for M&E	2.00	2.50	-	-
3.0 Partnerships and Governance	8.21	7.92	6.00	5.00
4.0 National M&E Plan	5.00	6.33	3.33	3.33
5.0 Annual Costed M&E Work Plan	-	-	-	-

6.0 Advocacy, Communication and Cultural Behavior	5.00	6.25	10.00	5.00
7.0 Routine Monitoring	7.50	8.13	5.00	5.00
8.0 Surveys and Surveillance	6.67	5.42	10.00	5.00
9.0 National and Sub-National Databases	10.00	10.00	5.00	5.00
10.0 Supervision and Auditing	5.00	5.00	2.50	2.50
11.0 Evaluation and Research	6.67	6.11	2.50	2.50
12.0 Data Demand and Use	3.33	5.00	5.00	5.00
Nandi				
1.0 Organizational	1.67	-	3.75	5.00
2.0 Human Capacity for M&E	6.00	2.50	2.50	2.50
3.0 Partnerships and Governance	4.64	3.85	5.00	5.00
4.0 National M&E Plan	-	-	0.83	1.67
5.0 Annual Costed M&E Work Plan	6.67	2.78	-	-
6.0 Advocacy, Communication and Cultural Behavior	1.67	-	-	-
7.0 Routine Monitoring	5.00	3.13	10.00	-
8.0 Surveys and Surveillance	3.33	3.33	2.50	2.50
9.0 National and Sub-National Databases	-	-	-	-
10.0 Supervision and Auditing	2.50	-	5.00	-
11.0 Evaluation and Research	3.33	1.11	2.50	2.50
12.0 Data Demand and Use	5.00	5.00	5.00	5.00
Narok				
1.0 Organizational	5.00	6.02	7.50	-
2.0 Human Capacity for M&E	2.00	2.65	2.50	2.50
3.0 Partnerships and Governance	6.79	5.10	7.00	4.00
4.0 National M&E Plan	5.00	4.50	1.67	3.33

5.0 Annual Costed M&E Work Plan	-	-	-	-
6.0 Advocacy, Communication and Cultural Behavior	1.67	-	-	-
7.0 Routine Monitoring	7.50	6.88	5.00	5.00
8.0 Surveys and Surveillance	1.67	1.25	5.00	-
9.0 National and Sub-National Databases	10.00	9.38	5.00	5.00
10.0 Supervision and Auditing	5.00	5.00	2.50	2.50
11.0 Evaluation and Research	6.67	6.11	2.50	2.50
12.0 Data Demand and Use	1.67	1.67	2.50	2.50
Nyamira				
1.0 Organizational	1.67	-	2.50	5.00
2.0 Human Capacity for M&E	4.00	2.10	2.50	2.50
3.0 Partnerships and Governance	4.29	3.02	3.00	1.00
4.0 National M&E Plan	1.00	0.50	-	-
5.0 Annual Costed M&E Work Plan	3.33	3.33	-	5.00
6.0 Advocacy, Communication and Cultural Behavior	3.33	5.00	5.00	-
7.0 Routine Monitoring	5.00	8.13	2.50	2.50
8.0 Surveys and Surveillance	5.00	4.58	5.00	5.00
9.0 National and Sub-National Databases	10.00	8.75	-	10.00
10.0 Supervision and Auditing	5.00	7.50	2.50	10.00
11.0 Evaluation and Research	-	-	-	-
12.0 Data Demand and Use	8.33	10.00	-	10.00
Nyandarua				
1.0 Organizational	6.67	6.27	6.25	5.00
2.0 Human Capacity for M&E	3.00	3.90	2.50	2.50
3.0 Partnerships and Governance	5.36	5.63	5.00	1.00

4.0 National M&E Plan	3.00	4.67	3.33	1.67
5.0 Annual Costed M&E Work Plan	-	-	-	-
6.0 Advocacy, Communication and Cultural Behavior	1.67	-	-	-
7.0 Routine Monitoring	7.50	6.88	5.00	5.00
8.0 Surveys and Surveillance	3.33	3.33	10.00	2.50
9.0 National and Sub-National Databases	10.00	10.00	-	10.00
10.0 Supervision and Auditing	5.00	5.00	2.50	2.50
11.0 Evaluation and Research	6.67	5.00	5.00	5.00
12.0 Data Demand and Use	3.33	3.33	2.50	2.50
Nyeri				
1.0 Organizational	6.67	7.50	3.75	-
2.0 Human Capacity for M&E	2.00	1.50	5.00	2.50
3.0 Partnerships and Governance	6.07	2.19	4.00	-
4.0 County M&E Plan	8.00	7.33	3.33	5.00
5.0 Annual Costed M&E Work Plan	10.00	5.56	-	10.00
6.0 Advocacy, Communication and Cultural Behavior	3.33	5.00	-	-
7.0 Routine Monitoring	10.00	6.25	-	5.00
8.0 Surveys and Surveillance	8.33	5.83	-	-
9.0 National and Sub-National Databases	10.00	7.50	-	10.00
10.0 Supervision and Auditing	2.50	2.50	2.50	2.50
11.0 Evaluation and Research	6.67	5.28	-	-
12.0 Data Demand and Use	6.67	6.11	7.50	7.50
Samburu				
1.0 Organizational	1.67	3.21	1.25	-
2.0 Human Capacity for M&E	4.00	4.05	2.50	2.50

3.0 Partnerships and Governance	5.00	5.63	6.00	3.00
4.0 National M&E Plan	3.00	3.00	1.67	-
5.0 Annual Costed M&E Work Plan	6.67	2.22	-	-
6.0 Advocacy, Communication and Cultural Behavior	5.00	3.75	5.00	-
7.0 Routine Monitoring	5.00	5.00	5.00	5.00
8.0 Surveys and Surveillance	3.33	2.08	10.00	2.50
9.0 National and Sub-National Databases	10.00	9.38	5.00	5.00
10.0 Supervision and Auditing	7.50	7.50	5.00	5.00
11.0 Evaluation and Research	3.33	2.78	2.50	2.50
12.0 Data Demand and Use	1.67	1.67	2.50	2.50
Siaya				
1.0 Organizational	5.00	6.25	5.00	5.00
2.0 Human Capacity for M&E	1.00	1.40	2.50	2.50
3.0 Partnerships and Governance	7.14	6.77	5.00	-
4.0 National M&E Plan	6.00	5.75	3.33	-
5.0 Annual Costed M&E Work Plan	3.33	1.67	-	-
6.0 Advocacy, Communication and Cultural Behavior	3.33	5.00	-	-
7.0 Routine Monitoring	7.50	7.50	5.00	-
8.0 Surveys and Surveillance	3.33	3.33	2.50	-
9.0 National and Sub-National Databases	5.00	5.00	-	-
10.0 Supervision and Auditing	10.00	5.00	2.50	2.50
11.0 Evaluation and Research	3.33	3.33	2.50	-
12.0 Data Demand and Use	3.33	3.33	2.50	2.50
Taita Taveta				
1.0 Organizational	1.67	2.58	1.25	-

2.0 Human Capacity for M&E	4.00	4.05	2.50	2.50
3.0 Partnerships and Governance	5.00	5.63	6.00	3.00
4.0 National M&E Plan	-	-	-	-
5.0 Annual Costed M&E Work Plan	-	-	-	-
6.0 Advocacy, Communication and Cultural Behavior	5.00	3.75	5.00	-
7.0 Routine Monitoring	5.00	5.00	5.00	5.00
8.0 Surveys and Surveillance	3.33	2.08	10.00	2.50
9.0 National and Sub-National Databases	10.00	9.38	5.00	5.00
10.0 Supervision and Auditing	7.50	7.50	5.00	5.00
11.0 Evaluation and Research	3.33	2.78	2.50	2.50
12.0 Data Demand and Use	1.67	1.67	2.50	2.50
Tana River				
1.0 Organizational	8.33	7.50	5.00	5.00
2.0 Human Capacity for M&E	5.00	5.45	5.00	5.00
3.0 Partnerships and Governance	4.64	5.10	3.00	3.00
4.0 County M&E Plan	6.00	6.17	3.33	-
5.0 Annual Costed M&E Work Plan	10.00	10.00	-	-
6.0 Advocacy, Communication and Cultural Behavior	5.00	5.00	-	-
7.0 Routine Monitoring	10.00	5.63	2.50	10.00
8.0 Surveys and Surveillance	6.67	5.42	7.50	2.50
9.0 County and Sub-County Databases	10.00	10.00	-	5.00
10.0 Supervision and Auditing	10.00	10.00	10.00	10.00
11.0 Evaluation and Research	-	-	-	-
12.0 Data Demand and Use	5.00	5.00	7.50	2.50
Tharaka Nithi				

1.0 Organizational	8.33	7.50	7.50	5.00
2.0 Human Capacity for M&E	5.00	5.55	7.50	5.00
3.0 Partnerships and Governance	8.21	6.46	5.00	5.00
4.0 National M&E Plan	10.00	8.33	6.67	10.00
5.0 Annual Costed M&E Work Plan	10.00	6.67	-	5.00
6.0 Advocacy, Communication and Cultural Behavior	10.00	7.50	5.00	5.00
7.0 Routine Monitoring	7.50	7.50	5.00	7.50
8.0 Surveys and Surveillance	8.33	6.25	7.50	7.50
9.0 National and Sub-National Databases	5.00	7.50	5.00	5.00
10.0 Supervision and Auditing	10.00	8.75	5.00	7.50
11.0 Evaluation and Research	10.00	6.94	10.00	7.50
12.0 Data Demand and Use	8.33	6.67	10.00	7.50
Transzoia				
1.0 Organizational	-	1.04	1.25	-
2.0 Human Capacity for M&E	4.00	4.05	2.50	2.50
3.0 Partnerships and Governance	5.00	5.63	6.00	3.00
4.0 National M&E Plan	3.00	3.00	1.67	-
5.0 Annual Costed M&E Work Plan	10.00	2.22	-	-
6.0 Advocacy, Communication and Cultural Behavior	5.00	6.25	5.00	-
7.0 Routine Monitoring	5.00	6.25	5.00	5.00
8.0 Surveys and Surveillance	3.33	2.08	10.00	2.50
9.0 National and Sub-National Databases	10.00	9.38	5.00	5.00
10.0 Supervision and Auditing	7.50	7.50	5.00	5.00
11.0 Evaluation and Research	3.33	2.78	2.50	2.50
12.0 Data Demand and Use	1.67	1.67	2.50	2.50

Turkana				
1.0 Organizational	5.00	5.08	6.25	5.00
2.0 Human Capacity for M&E	4.00	3.90	-	2.50
3.0 Partnerships and Governance	8.21	6.88	6.00	1.50
4.0 National M&E Plan	5.00	4.67	3.33	3.33
5.0 Annual Costed M&E Work Plan	-	-	-	-
6.0 Advocacy, Communication and Cultural Behavior	1.67	2.50	-	-
7.0 Routine Monitoring	7.50	6.88	7.50	5.00
8.0 Surveys and Surveillance	1.67	1.67	-	2.50
9.0 National and Sub-National Databases	10.00	9.38	5.00	5.00
10.0 Supervision and Auditing	2.50	2.50	5.00	-
11.0 Evaluation and Research	6.67	6.11	2.50	2.50
12.0 Data Demand and Use	1.67	1.67	2.50	2.50
U/Gishu				
1.0 Organizational	5.00	-	6.25	-
2.0 Human Capacity for M&E	3.00	2.65	7.50	2.50
3.0 Partnerships and Governance	7.14	5.83	7.00	-
4.0 County M&E Plan	5.00	6.00	3.33	-
5.0 Annual Costed M&E Work Plan	6.67	4.44	-	-
6.0 Advocacy, Communication and Cultural Behavior	6.67	7.50	5.00	-
7.0 Routine Monitoring	10.00	8.75	5.00	5.00
8.0 Surveys and Surveillance	6.67	6.25	7.50	-
9.0 county and Sub-county Databases	10.00	10.00	-	5.00
10.0 Supervision and Auditing	5.00	3.75	5.00	-
11.0 Evaluation and Research	-	-	-	-

12.0 Data Demand and Use	5.00	6.11	2.50	-
Vihiga				
1.0 Organizational	1.67	-	5.00	5.00
2.0 Human Capacity for M&E	10.00	8.40	5.00	10.00
3.0 Partnerships and Governance	7.14	6.88	4.00	3.00
4.0 National M&E Plan	2.00	3.00	1.67	1.67
5.0 Annual Costed M&E Work Plan	10.00	4.44	-	5.00
6.0 Advocacy, Communication and Cultural Behavior	10.00	8.75	10.00	10.00
7.0 Routine Monitoring	10.00	8.13	2.50	7.50
8.0 Surveys and Surveillance	5.00	4.17	5.00	5.00
9.0 National and Sub-National Databases	10.00	10.00	-	10.00
10.0 Supervision and Auditing	5.00	6.25	2.50	5.00
11.0 Evaluation and Research	3.33	3.33	2.50	2.50
12.0 Data Demand and Use	6.67	6.67	2.50	5.00
Wajir				
1.0 Organizational	5.00	5.71	7.50	-
2.0 Human Capacity for M&E	3.00	2.75	-	-
3.0 Partnerships and Governance	5.71	6.35	5.00	2.00
4.0 National M&E Plan	7.00	5.67	5.00	-
5.0 Annual Costed M&E Work Plan	3.33	-	-	-
6.0 Advocacy, Communication and Cultural Behavior	1.67	-	-	-
7.0 Routine Monitoring	7.50	7.50	5.00	5.00
8.0 Surveys and Surveillance	-	-	-	-
9.0 National and Sub-National Databases	10.00	9.38	5.00	5.00
10.0 Supervision and Auditing	5.00	5.00	2.50	-

11.0 Evaluation and Research	6.67	4.44	5.00	-
12.0 Data Demand and Use	8.33	10.00	7.50	-
West Pokot				
1.0 Organizational	3.33	1.54	2.50	-
2.0 Human Capacity for M&E	-	-	-	-
3.0 Partnerships and Governance	1.43	1.46	2.00	-
4.0 National M&E Plan	-	-	-	-
5.0 Annual Costed M&E Work Plan	-	-	-	-
6.0 Advocacy, Communication and Cultural Behavior	3.33	-	-	-
7.0 Routine Monitoring	10.00	6.88	-	-
8.0 Surveys and Surveillance	3.33	3.33	5.00	-
9.0 National and Sub-National Databases	10.00	7.50	5.00	10.00
10.0 Supervision and Auditing	10.00	7.50	-	-
11.0 Evaluation and Research	-	-	-	-
12.0 Data Demand and Use	3.33	0.56	5.00	-

APPENDIX V – MOH DEPARTMENT-SPECIFIC SUMMARIES PER DIMENSION AND M&E CAPACITY AREA

	Department	Status	Quality	Technical	Financial
Organizational capacity	DHSQAR	10.00	7.50	10.00	10.00
	Policy & Planning	10.00	8.75	7.50	5.00
	IGF & HSC	6.67	7.50	10.00	5.00
	ADMIN	6.67	7.50	6.25	0.00
	Curative	3.33	6.25	2.50	0.00
	UHC	3.33	0.00	2.50	5.00
Human capacity	DHSQAR	7.00	8.30	7.50	7.50
	Policy & Planning	9.00	8.05	5.00	5.00
	UHC	4.00	2.50	10.00	5.00
	Curative	1.00	1.40	2.50	0.00

	ADMIN	0.00	0.00	0.00	0.00
	IGF & HSC	0.00	0.00	0.00	0.00
Partnerships & Governance	Policy & Planning	8.21	8.65	10.00	5.00
	DHSQAR	7.86	7.29	8.00	7.00
	UHC	5.71	4.90	3.00	4.00
	IGF & HSC	3.57	2.50	3.00	1.00
	Curative	2.86	2.92	2.00	2.00
	ADMIN	3.57	2.60	3.00	0.00
National M&E Plan	DHSQAR	10.00	8.58	10.00	10.00
	Policy & Planning	10.00	9.50	10.00	5.00
	UHC	5.00	5.33	3.33	1.67
	IGF & HSC	4.00	2.92	1.67	3.33
	Curative	4.00	3.42	1.67	1.67
	ADMIN	2.00	1.50	3.33	1.67
Annual costed M&E work plans	IGF & HSC	10.00	5.56	0.00	10.00
	DHSQAR	6.67	6.67	0.00	10.00
	Policy & Planning	10.00	6.67	0.00	5.00
	UHC	6.67	3.33	0.00	5.00
	ADMIN	0.00	0.00	0.00	0.00
	Curative	0.00	0.00	0.00	0.00
Advocacy, communication & cultural behaviour	Policy & Planning	10.00	8.75	10.00	5.00
	DHSQAR	8.33	8.75	5.00	10.00
	Curative	5.00	3.75	10.00	0.00
	UHC	3.33	7.50	5.00	0.00
	IGF & HSC	6.67	5.00	0.00	0.00
	ADMIN	3.33	2.50	0.00	0.00
Routine monitoring	Policy & Planning	10.00	8.13	10.00	5.00
	DHSQAR	10.00	7.50	7.50	5.00
	Curative	7.50	6.88	7.50	2.50
	UHC	7.50	5.63	5.00	5.00
	IGF & HSC	7.50	4.38	5.00	5.00
	ADMIN	0.00	0.00	0.00	0.00

Surveys and surveillance	Policy & Planning	10.00	10.00	10.00	5.00
	DHSQAR	10.00	10.00	5.00	5.00
	IGF & HSC	1.67	1.67	2.50	2.50
	Curative	1.67	3.33	0.00	0.00
	UHC	1.67	1.67	0.00	0.00
	ADMIN	0.00	0.00	0.00	0.00
National & County databases	DHSQAR	10.00	8.13	5.00	10.00
	Policy & Planning	5.00	7.50	5.00	5.00
	Curative	5.00	6.25	5.00	5.00
	IGF & HSC	5.00	3.13	5.00	5.00
	UHC	0.00	3.75	0.00	0.00
	ADMIN	0.00	1.88	0.00	0.00
Supervision and auditing	Policy & Planning	10.00	10.00	7.50	5.00
	DHSQAR	10.00	10.00	5.00	7.50
	UHC	2.50	3.75	2.50	2.50
	IGF & HSC	2.50	2.50	2.50	2.50
	ADMIN	0.00	0.00	0.00	0.00
	Curative	0.00	0.00	0.00	0.00
Evaluation & Research	Policy & Planning	8.33	10.00	7.50	5.00
	IGF & HSC	3.33	3.33	2.50	2.50
	ADMIN	3.33	2.22	5.00	0.00
	UHC	0.00	0.00	0.00	0.00
	Curative	0.00	0.00	0.00	0.00
	DHSQAR	0.00	0.00	0.00	0.00
Data demand & Use	DHSQAR	8.33	10.00	7.50	10.00
	Policy & Planning	10.00	10.00	10.00	5.00
	UHC	5.00	5.00	10.00	5.00
	IGF & HSC	5.00	4.44	5.00	5.00
	ADMIN	0.00	0.00	0.00	0.00
	Curative	0.00	0.00	0.00	0.00

APPENDIX VI – MOH PROGRAM-SPECIFIC SUMMARIES PER DIMENSION AND M&E CAPACITY AREA

	Program	Status	Quality	Technical	Financial
Organizational capacity	Malaria	10.00	8.75	10.00	5.00
	NASCOP	8.33	7.50	7.50	0.00
	TB	10.00	8.75	8.75	5.00
	DRMH	10.00	7.50	7.50	0.00
Human capacity	Malaria	8.00	9.50	10.00	7.50
	NASCOP	4.00	5.05	7.50	0.00
	TB	5.00	4.75	7.50	0.00
	DRMH	3.00	3.55	5.00	0.00
Partnerships Governance	Malaria	8.93	9.79	6.00	6.00
	NASCOP	7.50	6.67	6.00	0.00
	TB	7.14	5.83	5.00	2.00
	DRMH	6.79	6.25	6.00	2.00
National M&E Plan	Malaria	10.00	10.00	5.00	8.33
	NASCOP	8.00	8.33	10.00	0.00
	TB	8.00	7.33	6.67	0.00
	DRMH	3.00	5.00	5.00	0.00
Annual costed M&E work plans	Malaria	10.00	10.00	0.00	5.00
	NASCOP	10.00	5.00	0.00	5.00
	TB	10.00	2.78	0.00	0.00
	DRMH	10.00	6.67	0.00	0.00
Advocacy, communication & cultural behaviour		10.00	10.00	5.00	5.00
	Malaria				
	NASCOP	8.33	8.75	5.00	0.00
	TB	10.00	8.75	5.00	0.00
Routine monitoring	DRMH	8.33	10.00	5.00	0.00
	Malaria	10.00	9.38	7.50	7.50
	NASCOP	10.00	8.13	5.00	0.00
	TB	7.50	8.13	5.00	0.00
Surveys and surveillance	DRMH	7.50	7.50	7.50	2.50
	Malaria	10.00	10.00	7.50	7.50
	NASCOP	6.67	8.75	5.00	0.00
	TB	6.67	6.67	2.50	0.00
National & County databases	DRMH	8.33	9.58	10.00	2.50
	Malaria	10.00	10.00	10.00	10.00
	NASCOP	5.00	6.25	0.00	0.00
	TB	10.00	10.00	5.00	0.00

	DRMH	5.00	8.75	5.00	5.00
Supervision and auditing	Malaria	10.00	10.00	7.50	5.00
	NASCOP	5.00	5.00	7.50	0.00
	TB	10.00	10.00	10.00	0.00
	DRMH	5.00	5.00	5.00	0.00
Evaluation & Research	Malaria	10.00	10.00	5.00	5.00
	NASCOP	0.00	0.00	0.00	0.00
	TB	6.67	4.44	0.00	0.00
	DRMH	5.00	4.72	5.00	0.00
Data demand & Use	Malaria	8.33	10.00	7.50	5.00
	NASCOP	3.33	3.33	7.50	0.00
	TB	3.33	3.33	2.50	2.50
	DRMH	3.33	3.33	5.00	0.00

APPENDIX VII – SAGA-SPECIFIC SUMMARIES PER DIMENSION AND M&E CAPACITY AREA

		Status	Quality	Technical	Financial
Organizational capacity	KEMRI	10.00	8.75	8.75	0.00
	KEMSA	10.00	8.90	7.50	10.00
	KMTC	8.33	8.44	6.25	5.00
	KNH	10.00	8.69	10.00	0.00
	NHIF	10.00	9.58	7.50	0.00
	MTRH	10.00	9.83	10.00	10.00
Human capacity	KEMRI	7.00	7.3	5.00	2.50
	KEMSA	7.00	8.05	10.00	10.00
	KMTC	8.00	7.85	7.50	5.00
	KNH	2.00	1.10	5.00	0.00
	NHIF	0.00	0.00	0.00	0.00
	MTRH	8.00	7.70	5.00	5.00
Partnerships & Governance	KEMRI	3.93	1.67	4.00	2.00
	KEMSA	9.29	8.96	8.00	9.00
	KMTC	8.21	7.92	6.00	5.00
	KNH	3.57	3.02	4.00	0.00
	NHIF	8.57	9.79	7.00	0.00
	MTRH	7.50	6.04	8.00	6.00
National M&E Plan	KEMRI	9.00	6.00	5.00	6.67
	KEMSA	9.00	8.00	6.67	8.33
	KMTC	6.00	8.33	6.67	5.00
	KNH	2.00	2.83	0.00	0.00
	NHIF	10.00	9.17	10.00	0.00

	MTRH	5.00	4.17	3.33	0.00
Annual costed M&E work plans	KEMRI	10.00	6.67	0.00	10.00
	KEMSA	10.00	8.33	0.00	10.00
	KMTC	10.00	10.00	0.00	5.00
	KNH	3.33	0.00	0.00	0.00
	NHIF	10.00	10.00	0.00	0.00
	MTRH	10.00	10.00	0.00	5.00
Advocacy, communication & cultural behaviour		8.33	8.75	5.00	10.00
	KEMRI				
	KEMSA	8.33	8.75	10.00	10.00
	KMTC	10.00	10.00	5.00	5.00
	KNH	5.00	2.50	0.00	0.00
	NHIF	10.00	10.00	10.00	0.00
	MTRH	5.00	8.75	10.00	0.00
Routine monitoring	KEMRI	5.00	3.13	5.00	5.00
	KEMSA	10.00	7.50	7.50	5.00
	KMTC	10.00	7.50	5.00	5.00
	KNH	0.00	0.00	0.00	0.00
	NHIF	7.50	8.75	7.50	2.50
	MTRH	10.00	7.50	5.00	5.00
Surveys and surveillance	KEMRI	10.00	10.00	5.00	5.00
	KEMSA	1.67	0.00	0.00	0.00
	KMTC	10.00	8.75	5.00	5.00
	KNH	3.33	2.92	5.00	0.00
	NHIF	8.33	10.00	5.00	0.00
	MTRH	3.33	2.92	5.00	0.00
National & County databases	KEMRI	5.00	6.88	5.00	5.00
	KEMSA	0.00	0.00	0.00	0.00
	KMTC	5.00	7.50	5.00	5.00
	KNH	0.00	1.25	0.00	0.00
	NHIF	0.00	3.75	0.00	0.00
	MTRH	0.00	0.00	0.00	0.00
Supervision and auditing	KEMRI	10.00	10.00	5.00	5.00
	KEMSA	10.00	8.75	10.00	10.00
	KMTC	7.50	7.50	5.00	5.00
	KNH	0.00	0.00	0.00	0.00
	NHIF	10.00	10.00	5.00	0.00
	MTRH	5.00	5.00	5.00	0.00
Evaluation & Research	KEMRI	10.00	7.78	7.50	5.00
	KEMSA	6.67	6.11	10.00	7.50
	KMTC	10.00	10.00	5.00	5.00
	KNH	1.67	0.83	0.00	0.00
	NHIF	0.00	0.00	0.00	0.00
	MTRH	6.67	6.67	5.00	0.00
Data demand & Use	KEMRI	8.33	9.44	5.00	5.00

	KEMSA	8.33	5.56	2.50	5.00
	KMTC	6.67	8.89	10.00	5.00
	KNH	3.33	1.67	5.00	0.00
	NHIF	3.33	1.11	0.00	0.00
	MTRH	10.00	10.00	10.00	10.00

APPENDIX VIII – REGULATORY COUNCIL-SPECIFIC SUMMARIES PER DIMENSION AND M&E CAPACITY AREA

				Status	Quality	Technical	Financial
1.0 Organizational			PPB	8.33	7.50	6.25	0.00
			KNRA	8.33	7.50	5.00	10.00
2.0 Human Capacity for M&E			PPB	0.00	0.00	0.00	0.00
			KNRA	6.00	8.15	2.50	10.00
3.0 Partnerships and Governance			PPB	7.86	6.15	7.00	0.00
			KNRA	6.07	5.31	3.00	6.00
4.0 National M&E Plan			PPB	6.00	4.17	3.33	0.00
			KNRA	3.00	2.17	6.67	6.67
5.0 Annual Costed M&E Work Plan			PPB	3.33	1.67	0.00	0.00
			KNRA	10.00	8.33	0.00	10.00
6.0 Advocacy, Communication and Cultural Behavior			PPB	5.00	5.00	5.00	0.00
			KNRA	3.33	5.00	0.00	0.00
7.0 Routine Monitoring			PPB	0.00	0.00	0.00	0.00
			KNRA	10.00	6.88	5.00	10.00
8.0 Surveys and Surveillance			PPB	8.33	7.92	5.00	0.00
			KNRA	10.00	9.17	5.00	7.50
9.0 National and Sub-National Databases			PPB	10.00	10.00	5.00	0.00
			KNRA	5.00	5.63	5.00	10.00
10.0 Supervision and Auditing			PPB	0.00	0.00	0.00	0.00
			KNRA	10.00	10.00	5.00	10.00
11.0 Evaluation and Research			PPB	8.33	7.78	10.00	0.00
			KNRA	8.33	7.50	5.00	7.50
12.0 Data Demand and Use			PPB	5.00	5.56	7.50	2.50
			KNRA	6.67	10.00	5.00	10.00