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MINISTRY OF HEALTH

A BUSINESS CASE FOR STRENGTHENING THE KENYA HEALTH SECTOR MONITORING AND EVALUATION SYSTEM

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Foreword:

The Kenya Health Policy 2014-2030 and the Kenya Health Sector Strategic Plan 2018-2023 highlights the importance of a robust M&E system in ensuring systematic tracking of investments and progress, while promoting a culture of evidence-based planning and decision making. To correctly measure progress, strong and well supported M&E systems need to be in place. One of the basic requirements of a functional M&E system is a well-costed M&E plan that takes into account the operating environment. The components of a well-functioning M&E system are contained in the Guidelines for Institutionalization of Monitoring and Evaluation (M&E) in the health sector.

In order to evaluate how well these components have been implemented in the health sector, a capacity assessment was conducted to inform the health sector monitoring and evaluation system on areas of strengthening in order to build a robust M&E system that will ably track the progress of KHSSP 2019-2023. To this end a costed M & E system in cognizance of the 12 components that need to be strengthened in order to achieve its mandate was developed. The objective of this report therefore is to provide the resources needed for a robust M&E system in Kenya's health sector as spelt out in the M&E institutional guidelines.

A costed M&E system with the 12 components in place will ensure that the government and partners provide resources in a coordinated manner to fully fund the key areas without duplication of efforts. In this case, M&E systems can utilize limited resources in the most effective and efficient ways to achieve results. Further, it will facilitate stakeholders at different levels to consolidate their efforts in supporting one plan, one financing mechanism for M&E and one monitoring framework. This will eventually support transformation of the health systems for universal coverage.

When those components are well strengthened, resourced and fully implemented in the health sector, the expectation is a significant improvement in the quality of data available, better analysis and increased demand for data and information use to inform strategies, planning and decision making in the health sector.

This assessment is a useful resource for reference in developing a resource mobilization strategy for M&E systems or their subset.

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Acknowledgment

The business case for Kenya Health Sector Monitoring and evaluation was developed through a consultative process that consisted of guided assessments at the various levels in the sector via stakeholder engagements. 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.

The development of this document was achieved through the tireless effort and commitment of a technical team that included: Dr. Helen Kiarie, Dr. Moses Muriithi, Dr. Janette Karimi, Dr. Lilly M. Nyagah, Dr. Elizabeth Wangia, Dr. Mutile Wanyee, Pepela Wanjala, David Njuguna, Rose Muthee, Leonard Cosmas, Anthony Komen, Fridah Ngatha, Cynthia Kyule, Timothy Owiti and Felix Mwendwa.

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Acronyms

AHO: African Health Observatory

APRM: African Peer Review Mechanism

CDC: Centers for Disease Control and Prevention

CHIS: Community Health Information Systems

CHWs: Community Health Workers

CIDPs: county integrated development plan

CIMES: County Integrated Monitoring and Evaluation System

DHIS: District Health Information Software

DQAs: Data Quality Assessments

EMR: electronic medical record
ERSWEC: Economic Recovery Strategy for Wealth and Employment Creation
FBOS: Faith-based organizations
GIZ: The German Society for International Cooperation
HIGDA: Health Informatics Governance and Data Analytics
HIS: Health Information Systems
HRH: Human Resources for Health
IT: Information Technology
JICA Japan International Cooperation Agency
KHO: Kenya Health Observatory
KHP: Kenya Health Policy
KHSSP: Kenya Health Sector Strategic Plan
KNBS: Kenya National Bureau of Statistics
MECAT: Monitoring and Evaluation Capacity Assessment
M&E: Monitoring and Evaluation
MDP: Ministry of Devolution and Planning
MoH: Ministry of Health
MTPs: Medium Term Plans
NEPAD: New Partnership for African Development
NGOs: Non-Governmental Organizations
NHIS: National Health Information System
NIMES: National Integrated Monitoring and Evaluation System
PHC: Primary Health Care
SDGs: Sustainable Development Goals
SWOT: Strengths, Weakness, Opportunities and Threats
TWGs: Technical Working Groups
UHC: Universal Health Care
UNFPA: United Nations Population Fund
UNICEF: United Nations International Children's Emergency Fund.
USAID United States Agency for International Development
WHO: World Health Organization

Executive Summary

Introduction and setting: A well-functioning M&E system facilitates assessment of progress in implementation of the various commitments to the population relating to improvement and/or sustenance of their health well being. These commitments are outlined in the Vision 2030 and its Medium Term Frameworks, Kenya Health Policy, the Kenya Health Sector Strategic plan and the

Universal Health Coverage roadmap among others. Investment in an M&E system ensures improved efficiency in implementation of strategies and interventions and in turn improves chances of success. This has the overall result of improved health outcomes, improved accountability and transparency in the sector among others.

Kenya has progressively tracked the progress of the health sector targets by operationalizing the M&E framework. The Ministry of Health has finalized the midterm review of the Kenya Health Sector Strategic Plan (KHSSP 2018 – 2023), in which the main identified priorities for Health Information Management/M&E Systems included to develop and implement guidelines and standards to guide EMR roll out in counties; to progressively digitize reporting tools at all the levels to reduce manual data collection; to operationalize functional County Department of Health M&E units in all counties and to strengthen country-level capacity for data analysis and information use for decision making.

To assess the strength of the health sector M&E systems, a SWOT on the twelve components of a well-functioning M&E system was conducted through an M&E systems capacity assessment, key informant interviews and stakeholders' meetings. Gaps and priorities were identified for interventions and activities needed to strengthen the Health Sector M&E system.

Methodology: To build on a case for investment need to strengthen the current health sector M&E system, four steps were adopted; ***firstly***, detailed desk review including a report on capacity assessment of M&E system, which was done to identify the key function, gaps and processes of M&E system; ***secondly,*** Stakeholders meetings and other consultative meetings with M&E stakeholders; ***thirdly***, summarizing the key component of a well-functioning M&E system together with prioritized interventions and activities for each of the M&E system components as discussed and agreed with stakeholders and ***fourthly,*** developing cost assumptions for the interventions agreed upon and assessing both national and county resource requirements.

Activity-based- costing (ABC) was adopted in estimating the financial resource requirement for strengthening the health sector M&E system.

Summary of key cost estimates of the HIS/M&E system

The total resource need for strengthening the national M&E system is approximately Ksh. **5.8** billion, which is distributed within a five years period (2020/21 to 2024/25). The amount ranges from **Ksh.743 million** to **Ksh. 2.1 billion per fiscal year**.

Strengthening a unified and robust national and sub-national database is the key cost driver for this five years' period with an estimated resource need of **Ksh.3.3 billion.** Under this capacity area, Infrastructure provisions and Capacity building on the electronic health records including the DHP in scale up of electronic health records at all levels of care takes most of the resource need in strengthening databases.

Routine supervision and quality audit was the second area that needed significant resources for strengthening at **Ksh.691 million** over the five years' period. with systems for data quality audits needing the most resources.

Strengthening a robust and integrated **organizational structure for M&E** will require an estimated **Ksh 505 million** for the five-year period.

Human resources strengthening will require **Ksh 125 million** with broad areas of investment being development of capacity building strategies for health workers as well as training and capacity building of staff at all levels in various health information and M&E strategic areas.

To strengthen **effective partnerships and governance** mechanisms, approximately **Ksh.71 million** will be needed while strengthening development of an overarching national M&E plan that is linked to the health sector strategic plan is expected to cost **Ksh. 52 million**.

Having a **robust system of monitoring** will cost the health sector at the national level approximately **Ksh.131 million** to strengthen.

To strengthen **periodic survey and surveillance** has most of its cost drivers in the first two fiscal years with total resource need for strengthening it being approximately **Ksh. 64 million** over the five-year period.

To strengthen promotion of widespread **data demand, information use** will cost this M&E system approximately **Ksh. 335 million** over the five-year period.

A **generic county** estimate generated to predict how much financial resources would be needed to strengthen health sector M&E systems in one county. The projected resource need for **each county** to establish a well-functioning M&E system is approximately **Ksh. 941 million**. Consequently, the total resource requirement for **all the 47 counties** would amount to approximately **Ksh. 44 billion.** The **total resources needed to strengthen both National and Counties** M&E systems was therefore estimated at **Ksh. 50 billion,** which is approximately 5% of the total health sector budget for the 5 year period.

The result also provides an estimated financial resource needed for the M & E engagement plan. The engagement plan is expected to facilitate resource mobilization over the five-year period (2020/2021 to 2024/2025), and it is expected to cost approximately **Ksh.22million.**

1.0 Background

The Kenya Vision 2030 outlines the national level long-term objectives of the country to achieve middle-income status by 2030. A series of 5-year Medium Term Plans (MTPs) translates this long-term objective into medium-term priorities, objectives, and programs. The government's efforts towards successful achievement of these priority programs is tracked through key performance indicators included in the M&E plans for the sector including M&E sections of County Investment and Development Plans (CIDPs) and MTPs.

National Level Monitoring and Evaluation

The Ministry of Devolution and Planning (MDP) is mandated to implement the National Integrated Monitoring and Evaluation System(NIMES) as part of the governance reforms of the national government. NIMES was conceptualized as the mechanism for the Government of Kenya to monitor the implementation of the Economic Recovery Strategy and was officially launched for implementation in September 2007.

The overarching goal of the NIMES is to: provide the government with reliable mechanisms to measure progress towards national development goals as well as the efficiency and effectiveness of public programs and policies; provide the government with the needed policy implementation feedback to efficiently allocate its resources over time; set the basis for a transparent process by which the government and the international donor community can undertake a shared appraisal of results; and create smooth release of external support, including budgetary support. (National Monitoring and Evaluation Policy 2012)

NIMES therefore aims at strengthening governance by; improving transparency, strengthening accountability relationships and building a performance culture within the two levels of government to support better policy making, budgeting and management. It is designed to ensure regular reporting on implementation progress of the country's priority policies, projects and programs outlined in key policy documents such as MTPs, CIDPs, the National Accountability Management Framework, Performance Contracts and the performance appraisal system. It is also designed to report on the Government's commitments to other inter-national frameworks such as the Sustainable Development Goals (SDGs), the New Partnership for African Development (NEPAD), and the African Peer Review Mechanism (APRM).

Guidelines for implementation of NIMES were developed but institutionalization was a challenge in the absence of a national M&E policy (2012). The policy provides a framework for strengthening the coverage, quality and utility of the assessment of public policies, programs and projects. It proposes that finances for monitoring and evaluation be clearly allocated within the national budget. Allocation of resources for M&E will promote institutionalization of M&E hence more availability of data to enable evidence-based decision making and also promote accountability. The National M&E Policy sets the basis for a transparent process by which the citizenry and other development stakeholders can undertake a shared appraisal of results and outlines the principles for a strong M&E system as an important instrument for driving the achievements of programs underpinning the Kenya Vision 2030. This policy will apply to all public policies, strategies, programs and projects managed by ministries, departments, and agencies, county governments, parastatals and executing agencies of public programs.

Health Sector Monitoring and evaluation

The Health Sector Monitoring and Evaluation mechanisms provide systematic follow-up and review at the various levels to support accountability and measurements. Accountability being paramount at all levels, measuring progress is now enshrined in the Kenyan laws including the County Government Act 2012, the Public Finance Management Act 2012, and Data Protection Act 2019 among others.

The health sector monitoring and evaluation mechanisms, below, have provided a means of systematic follow-up and review at the various levels to support measurement, accountability and prioritization of evidence-based interventions for planning in the health sector:

- The Kenya Health Policy 2014-2030 has committed to progressively work towards achieving the highest standards of health. To achieve this, well-coordinated teams need to supervise, review and collect key strategic information which is critical to track progress and measure results.
- The Kenya Health Sector Strategic plan (KHSSP) is a 5-year strategic plan towards implementation of the Kenya Health Policy 2014-2030. It is developed 5 yearly through the stewardship of the Ministry of Health. The current KHSSP 2018-2023 provides a framework to guide the health sector priorities, implementation and arrangements at all levels including partnership arrangement for this period.

- The Health Sector M&E Plan 2018-2023 has also been developed to track progress of the health sector performance as envisioned in the Kenya Health Strategic Plan. It provides a framework for measuring performance of the sector against the input, output, outcome and impact level indicator targets. It also monitors select indicators in implementation of primary health care to achieve universal health care.
- The M&E institutionalization guidelines have been developed to support strengthening and institutionalization of M&E systems including establishment of functional M&E units both at the national and the county levels. Formation and reactivation of M&E units is crucial for the coordination and collaboration towards quality strategic health information.
- The Health Sector Data Analytics Guidelines are also being developed to guide the process of data generation, collation, quality assessment and improvement, analysis and data sharing to ensure the data is translated into information that meets the needs of the different stakeholders.

1.1 Situational Analysis

Situational analysis on Health Sector Monitoring and Evaluation was conducted through three levels. The first level was an in-depth desk review regarding operations and functioning of the health sector M&E system in the Kenyan context, the second level was on the capacity assessment that was ongoing at the time of this assignment while the third level was the interaction with the various stakeholders through key informant interviews. The following section provides the results of the situation analysis.

Health Sector Monitoring and Evaluation Capacity Assessment

Monitoring and Evaluation Systems require twelve main components, as proposed by UNAIDS, in order to function effectively and efficiently to achieve the desired results[1]. These form the basis for a Health Sector M&E capacity assessment for both national and county levels. The 12 M&E capacity areas are; 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. This assessment was done using an M&E capacity assessment tool (for more details see draft MECAT MOH 2020). This section will highlight the existing gaps that were observed for each capacity area and hence the focus for further strengthening:

1. **Organization of an M&E system:** Although the M&E objectives of the various M & E units were aligned to the national strategic plans and policies they were found to be poorly integrated with the National M&E division with minimal or no interoperability between them.
2. **Human Capacity for M&E partnerships:** There was limited technical capacity to carry out monitoring and evaluation, with no standard curriculum for capacity building. Many units did not have standard operating procedures defining M&E roles and responsibilities, strategies/policies to support M&E function and lacked clear mechanisms for communicating M&E activities. There was also very little internal financial investment in human capacity for M&E.
3. **Partnerships and Governance: The existence of strong technical and financial support from partners.** There was a lack of updated inventories of M&E stakeholders and inadequate mechanisms for M&E reporting. There was also very low internal financial support for partnership and governance activities.
4. **National M&E Plan:** Although the departments had M&E plans, most were not costed**.** Poor financial capacity for carrying out M&E assessments and development of M&E plans for the department was also cited as a challenge.

[1] UNAIDS. (2009). *12 components monitoring & evaluation system strengthening tool.* Retrieved from website: http://www.unaids.org/en/media/unaids/contentassets/documents/document/2…

5. **Annual Costed M&E plan:** There was lack of internal technical capacity to develop M&E plans and therefore few or no annual cost M & E plans.
6. **Advocacy, Communication and Cultural Behavior:** Sustainability of advocacy and communication strategies and plans was a challenge due to poor technical and financial capacities for M&E championships, inclusion of M&E issues, strategies and products in the national policies.
7. **Routine Monitorin**g: Internal financial capacity for routine monitoring was low indicating that the departments were not well funded to carry out routine monitoring despite having the necessary technical capacity to do so.
8. **Surveys and Surveillance:** Technical capacity to develop protocols for surveys and surveillance at both levels of government was cited as a challenge. Additionally, surveillance inventories and systems were found to be either absent or of low quality
9. **National and County Databases:** While we observed the presence of robust and reliable databases, their maintenance was largely done by partners. Departments lacked a well-coordinated structure for collecting data necessary for M&E activities**.**
10. **Supervision and Auditing:** Most departments were found to have SOPs, guidelines and tools for supervision. However, there were limited resources for DQAs.
11. **Evaluation and Research:** There was limited internal technical and financial capacity for conducting evaluation and research. Departments lacked an inventory of ongoing and completed research and evaluation as well as department-specific research agenda.
12. **Data Demand and Use**: There was a low existence of data analysis and presentation guidelines. Specific deficiencies pertained to low financial support for data use plans, data analysis and presentation.

1.2Strength, Weakness/Challenges, opportunities and Threats (SWOT)

The identification of strength and weakness or challenges for the M&E potential implementation has guided prioritization of interventions aimed at achieving the key KHSSP 2018-2023. The following section summarizes the SWOT analysis based on the assessment and key informant interviews:

a. **Strengths.**

Existence of the National Health Information System to provide timely, reliable and accessible quality health service information for evidence-based decision-making in order to maximize utilization of the scarce resources in the health sector. The achievements of NHIS include development of documents such as: Health Information Policy, Health Information Strategic

Plan, Health Sector Indicators and Standard Operating Procedure Manual, Standardized data sets – minimum data collection and reporting tools, Data Quality Assurance Protocol and Training curriculums.

M&E plans are aligned to the national health strategies e.g. Kenya Health Sector Strategic Plan (KHSSP), UHC roadmap and Primary Health Care (PHC). This allows for monitoring as provided in the strategic plan objective. Again the M&E plan provides an assessment that will inform the health sector on the achievement of the stated targets.

Though the majority of the key informants did not know the exact amount defaulted for M&E activities, they all noted that their units have a budget for this activity. This points to the prioritization that M&E system is given as a component of the health sector activities. This also implies that a unit can advocate for more funds once it has shown how it has spent the money.

NHIS has also developed interoperability standards and integration of systems. MoH has developed various policy documents and guidelines including revised HIS policy 2014-2030, HIS strategic plan 2014-2018, e-Health strategy, Health Sector Indicators Manual, EMR standards and guidelines, m-Health guidelines and System interoperability guidelines. Other achievements include the use of one master health facility and community unit list, one national aggregate data system DHIS2 which can be used to produce quarterly and annual health sector statistical reports using the information based on the system.

Health sector M&E plans in many instances are aligned to the KHSSP implementation and tend to last at least the five-year of Health strategic plan. Regular updates of the M&E plan will be done based on modification and/or inclusion of new interventions during the implementation period. The M&E plan will be adjusted to accommodate new interventions to achieve any of the program-specific objectives. A mid-term review of the strategic plan was conducted in 2021

Adoption of National Roadmap for the Kenya Health Data Collaborative. To strengthen country data and accountability systems, the Kenya Health Data Collaborative was launched with the aim of improving health data, and decision making data for the health sector in the country easy to access, analyze and use for performance improvement.

The Ministry of Health will oversee the development of a sector-wide calendar of key M&E activities aligned to the health sector accountability cycle. This will ensure the alignment of

resources and activities to meet the needs of different actors in the health sector. This calendar will cover the key phases of program implementation and accountability cycle.

Other notable strengths for Health Sector M&E plan operationalization include;

- All routine data collected in the health sector is done and stored in one health information system (DHIS)
- The health system utilizes standard tools for data collection and reporting
- MoH conducts regular data quality assessments
- Counties perform quarterly data review meetings which is a step towards data manifestations and current updates.
- NHIS system cleaning is being performed to ensure efficient data capture.

b. Weaknesses:

The current challenges that M&E system faces in its operationalization can be traced through its twelve components. The following is a list of identified weaknesses that need to be addressed if the M&E system is to operate efficiently: -

Poor integration of M&E implementation for public projects and programs at national and county levels. The linkages are weak and there is a lack of harmonization among various M&E systems within each county. This has led to inadequate harmonization of the multiple data collection and reporting systems at the county level. In addition, there has been little or no stakeholder participation in the M&E preparation and reporting process in most counties.

Tied with this challenge is the fact that the health sector produces a lot of information products, but in spite of this achievement the ***dissemination and use of resulting policy documents and innovations has been limited*** and there is still much ground to be covered especially in their institutionalization at the sub-national level. This can be attributed to inadequate requisite skills at different levels of government and among Non-State Actors to use data for informed decision-making.

Limited technical skills in data cleaning manipulation and analysis among the HRIOs and data managers. Further, there is inadequate human resource to support county, sub-counties and facilities to analyze and use quality data for planning and program performance among others.

Despite collecting a lot of data at the facility level through service delivery registers, tally sheets and monthly summary reporting forms, most of that data is either incomplete or of poor quality to support decision making

Existence of proliferation of data collection tools most of which have been developed by the public health sector without sufficient stakeholder consultation. As a result, there is poor coordination and linkages between the different data collection systems leading to significant duplication and/or omission of key data sets in monitoring health interventions or even in the evaluation of the impact of health interventions.

Despite progress notable with M&E system in Kenya, challenges continue to limit the ability of Kenya's health information systems to provide the data and accurate statistics required for decision making due to the following reasons: -

- Low investments in building sustainable and comprehensive data and information systems for informed policy making and planning.
- Low capacity in the production and use of quality health data and statistics for monitoring health interventions both at national and county levels.
- Existence of numerous program/disease-based M&E systems that often operate in isolation.
- Limited adherence by all stakeholders to the principles and code of conduct on reporting as per the Health Sector Strategic Plan.
- Most HIS/M&E activities depend on donor funding which is limited to specific regions and diseases and often unpredictable.
- Poor adherence to HIS guidelines, policies and standards
- Legal provisions on confidentiality of electronic patient information not yet implemented.
- Parallel management structures by different health programs for health information systems (DQAs, reviews, surveys, financial management)
- Inadequate guidance for information generation, use and sharing due to absence of guidelines on information generation and sharing to targeted audience and use.

- Difficulties in data collection from other MDAs (NHIF, FDA, Ministry of Education, etc.) due to lack of Health Information System legal framework that is aligned to the Health Policy in line with the Health Act.
- Non-reporting by some health service providers (e.g. private for profit providers) due to lack of a guided minimum dataset reporting for all health institutions as per the Health Act.
- Some information systems being developed do not reference the Guidelines and Standards for Interoperability in their development due to absence of implementation of the Kenya Health Enterprise Architecture.
- Inadequate capacity to utilize the health information capacity
- There is no robust tool for DQA that is supported by a comprehensive health information data validation framework (paper and digital).
- No easy access to health data as much as the Kenya Health Observatory for assuring comprehensive availability of health information exists but is not implemented.
- There is limited use of data for policy development, monitoring and evaluation due to the fact that operationalization of the guidelines for evidence use in policy making is not yet actualized.
- The accountability cycle is poorly implemented due to weak tracking on implementation of recommendations from key health fora e.g. Annual Health Summit, Kenya Health Forum, devolution conference, county stakeholder meetings, etc. for improved governance and leadership.
- Data demand and use is limited by absence of user-friendly dashboards
- Some counties do not have adequate structures to manage health information due to non-existence of established operating and supported HIS-M&E coordination structures.

c. Opportunities:

The National and County M&E units or equivalent will be responsible for overall oversight of M&E activities at the respective levels. Functional linkage of the health sector to the overall national inter-sectoral government M&E will be through the M&E directorate at the National Treasury and Ministry of Planning. Health sector M&E units at the national and county level will be

responsible for the day-to-day implementation and coordination of the M&E activities to monitor this strategic plan.

The County M&E units will take lead in the joint performance reviews at subnational level. The county management teams will prepare the quarterly reports and in collaboration with county stakeholders, organize county quarterly performance review forums. The national M&E unit will organize for the annual health forum, which will bring together all stakeholders in health to jointly review the performance of the health sector for the year under review. The purpose of the joint assessments will be to review performance, determine priorities, develop action plans and assess expenditure for the subsequent period.

CIMES is being developed to support CIDP implementation and to provide solutions to these M&E challenges currently being experienced by policy and decision-makers at the county level. CIMES reports will provide essential input needs for the preparation of NIMES.

The implementation of the M&E framework will be spearheaded by the Ministry of Health in collaboration with development partners and stakeholders at national and county levels. This will ensure successful implementation of the M&E system in the health sector. The implementers are agencies/institutions that are involved in supporting or implementing M&E activities in specific target areas of the KHSSP and respective organizational annual work plans. These will include: line ministries, civil societies and private sector organizations. The implementers will be reporting through relevant monitoring systems on programmatic activities.

Specifically, the implementers will be responsible for:

- Aligning all M&E activities to realize the goals of this plan as well as the institutional M&E goals articulated in sectorial, programmatic and county-specific M&E Plans.
- Routine monitoring and evaluation
- Using existing systems/developing M&E sub systems that utilize existing structures at all levels of the health information system.
- Promotion of utilization of data collected for decision-making within the institution.
- Support the respective client institutions to comply with mandatory reporting requirements in line with the Health Act, 2017 and other policies.

Development partners are willing to support the National M&E Framework and the subsequent strengthening of the M&E systems. They will be expected to provide substantive technical and financial support to ensure that the systems are functional. They are expected to ensure that their reporting requirements and formats are in line with the indicators outlined in the M&E framework. They are to synchronize efforts with existing development partners and stakeholder efforts based on an agreed upon one country-level M&E system. In addition, they will utilize existing reports in decision making, advocacy and engaging with other partners for resource mobilization.

The roles of the community units have been redefined in terms of identifying and notifying the health authority of all health and demographic events including M&E that occurs in the community. These events will be reported through community main actors, for example, the CHWs, teachers and religious leaders through a well-developed reporting guideline, Community Health Information System (CHIS), developed by the Division of Community Health.

Funding for M&E framework is being aligned to the respective roles and processes envisaged for each category of stakeholder. With its primary oversight role in the implementation of this plan, the Division of Health Sector Monitoring and Evaluation will be the focal point for resource mobilization activities for M&E in the Health Sector. At the county level, the county departments of health will play a similar role in consultation with their respective departments of finance and planning. Primary sources of funding will include MoH and county allocations, as well as contributions in cash and kind from development partners, NGOs and the private sector. It is proposed that organizations, departments and units, allocate at least 10% of their resources to monitoring and evaluation activities.

The Constitution of Kenya 2010, The Kenya Vision 2030 (Kenya's Development Blueprint), The Kenya Health Policy 2014-2030 and The Kenya Health Sector Strategic Plan (KHSSP 2014-2018) lay emphasis on the need to have a strong monitoring and evaluation system for improved accountability and efficiency among other things. The convergence between Kenya's policy and strategic direction on HIS/M&E and the global initiative to improve health measurement and accountability provide the basis of organizing the Kenya Health Data Collaborative Conference that M&E system can ride on in terms advocating for more strengthening.

PEPFAR is aligning investments to scale up interventions that are most effective in the areas and populations with the highest burden of HIV/AIDS and strengthening the Health Information System is a critical part of ensuring overall health systems are strong. PEPFAR has particularly noted

that a robust HIS would be useful in integrating analysis across disease domains to identify system bottlenecks within areas as well as linking logistics HRIS, quality and performance data for efficient resource allocation among other benefits.

USAID provides essential technical and financial support to national- and county-level governments to strengthen health information systems as part of the realization of Vision 2030. Some examples of the USAID's work in this regard include: the alignment of performance needed to help Kenya HIS, the Malaria indicator surveys and mobilization of resources for Kenyan health data. USAID has pledged to continue supporting initiatives that aim at strengthening inclusion and alignment of development partner initiatives in supporting the health sector in this area, promoting the tracking of data and information on the progress on SDGs and improving quality of data for decision making.

The GIZ is providing technical advice to health care facilities and administrations on improving health information systems as part of their overall commitment to health systems strengthening in Kenya. At global level, GIZ is working closely with HDC where the main focus is data. For Kenya, GIZ has promised to support strengthening the DHIS to make it more reliable and supportive of the service delivery efforts at the facility level and more so, in measuring outcomes reliably to manage health at various levels.

The CDC-Kenya currently supports the development and implementation of population and facility-based disease surveillance systems that provide for data collection, analysis, and reporting in order to assess the disease burden in communities, identify outbreaks, and evaluate the impact of health interventions. Hence this is a great opportunity for M&E system strengthening.

The Ministry of Health takes cognizant of the current challenges and has taken leadership and coordination of designing the Kenya Health Observatory Platform. The Kenya Health Observatory (KHO) has been designed to address these challenges and link to the African Health Observatory (AHO). The Health Observatory is designed as a combination of a web-based portal and physical interaction of decision-makers, scientists and other experts aimed at improving the availability and use of information and evidence for policy and decision-making.

d. Threats

Kenya is among the African countries currently experiencing a crisis in the area of human resources for health (HRH). The major causes of the crisis include: inadequate and inequitable distribution of health workers; high staff turnover; weak development, planning and management of the health workforce; deficient information systems; high migration and high vacancy rates; insufficient education capacity to supply the desired levels of health workers needed by the market; inadequate wages and working conditions to attract and retain people into health work particularly in rural underserved areas. This shortage affects most of the available health worker categories (WHO 2013).

For many Counties however, while devolution is looked upon as the answer to the persistent regional disparities in the distribution of health services and inequities in resource allocations, many decision-makers at the **County Government still prefer to invest in physical infrastructure at the expense of health information and management systems which means** that historically, underinvestment in health information systems has left gaps in data collection, dissemination, analysis and use. This has further made the **hosting of NHIS financially unsustainable to the detriment of fostering the capture of critical data over time**.

Other notable threats include:

- ***According to Key informant interviews, though internet connectivity has been on the rise in most of the M&E units, about 50% tend to be unreliable for data*** transmission threatening data sharing. Availability of stable power in many counties' M&E units was also cited to threatened advances in the area of technology.
- ***Sometimes the M&E plan of activities is affected by unforeseen activities or event*s** as alluded to by one of the key informants. "We find ourselves doing activities that had not been planned for due to lack of control of surveillance e.g. Ebola outbreaks. Whenever there is an emergency you drop what you are doing and attend to it".
- ***Obsolete technology and computer packages*** is a key threat to the analysis of data. This implies that up-to-date computer hardware and software is a big issue especially at the county level where paper-based data collection at the site causes delays in data validation.
- **Over-reliance on partner support in terms of technology, capacity building and training** has threatened the sustainability of most M&E activities. Some activities are not implemented due to withdrawal of funds by donors.

1.3 Justification for M&E Business case

Monitoring and evaluation has gained increasing significance in the health sector during the last decade, partly due to increasing public demand for measurement and accountability in the use of health sector resources. Adequate data is necessary to help governments better understand health inequalities and thus identify appropriate targets and interventions to reduce them. The routine availability of data on health inequalities is also useful for keeping the issue on the policy agenda and for monitoring the effect of agreed strategies and interventions in order to measure health inequalities between social groups.

Investment Case for Monitoring and Evaluation

Monitoring and evaluation is critical in any program cycle. Monitoring is continuous systematic collection and analysis of information as a project progresses with the aim of improving the efficiency and effectiveness of a project organization to meet set targets.

Evaluation is comparison of actual project impacts against the agreed strategic plan. Also helps to better understand if the target group was reached and how targets were achieved. Investing in Monitoring and evaluation in Kenya at national and county level is fundamental for the following reasons:

1. **Assess progress in implementation of the Kenya Health Policy in the context of Universal Health Coverage and improve efficiency in implementation**

His excellency the President Uhuru Kenyatta set forth his big 4 agenda among which is to ensure universal health coverage. This translates into ensuring delivery of affordable quality health care and reduction of out-of-pocket spending for the citizens.

The Kenya Health Policy, 2014–2030 gives directions to ensure significant improvement in overall status of health in Kenya in line with the Constitution of Kenya 2010, the country's long-term development agenda, Vision 2030 and global commitments. It denotes the government's commitment to ensuring that the country attains the highest possible standards of health, in a manner responsive to the needs of the population. The KHP implementation is done in successive 5 years Kenya health

sector strategic plans. Kenya is currently implementing the Kenya Health Sector Strategic plan 2018 - 2023 which is the second such five-year plan for implementation of the Kenya Health Policy 2014–2030. It is premised on the need to accelerate the achievement of UHC and incorporates the priorities and targets of the Kenya Health Policy, Sustainable Development Goals and the African Union Agenda 2063.

The realization of UHC is to be measured with specific set indicator targets outlined in the Kenya M&E Plan for the KHSSP 2018-2023. Primary health care has been identified as the main driver to achieve universal health coverage in Kenya. The Kenya Primary Health Care (PHC) Strategy has focused on reorganization of the health service delivery systems to ensure health promotion and disease prevention rather than curative services only. The PHC strategy also envisions strengthening the community units and services, ensuring high-quality primary health care services including diagnosis and treatment services, and strengthening the linkage between the community and the primary health facilities. This is envisioned to take place by formation of primary care networks, managed by a multidisciplinary team, which will respond to the community health education, health promotion and disease management needs.

Monitoring and evaluation will be key in assessing performance of various aspects of primary health care and universal health coverage as below

- Documenting successes /best practices and challenges of implementing PHC/UHC
- Assessing the efficiency in the processes of implementation of UHC using Primary Care Networks
- Assessing achievement of desired outputs and outcome of UHC measuring against anticipated targets
- Assess achievement UHC overall goals i.e. the population-level impact
- Enabling Health Technology Assessment which will cover both the direct, intended consequences of technologies and interventions and their indirect, unintended consequences

The above will enable continuous improvement by feeding back the finding of the monitoring process to improve strategy and activities to realize efficiency in implementation of the draft UHC road map, the PHC strategy and other strategies in order to realize the UHC targets. As such, monitoring and evaluation will not only assess progress in implementation of UHC, but also inform and guide implementation of successive UHC policy and strategies

2. **Improve chances of the Kenya Health Sector Strategic Plan(KHSSP) success and improved health outcomes**

Continuous monitoring has been shown to be a key factor in the success of a project and should be planned for from the initial planning stages of program planning or policy and strategy formulation. Monitoring and evaluation together provide the necessary data to guide strategic planning, to design and implement programs and projects, and to allocate and re-allocate resources in better ways.[2]

Monitoring and evaluation therefore in enabling strategic planning and reorganization where necessary promotes more efficient and effective program implementation building on lessons learnt. Studies have shown that the chance of achieving project success seems to be enhanced by understanding what is involved in the project, maintaining an understanding of any changes to that scope, consistently monitoring the progress of the project, keeping those interested in the project informed, and having an effective team to work on the project. Monitoring and controlling was also found to be relevant in management of project scope, time, cost, quality, human resources, communication and risks[3]. This further asserts the need to invest in monitoring and evaluation in terms of building and training M&E teams to give necessary feedback to programs and stakeholders to improve chances of success through early interventions or change of strategy given the early M&E outcomes seen. Strong Monitoring and evaluation of the KHSSP will increase its chances of successful implementation and therefore achievement of the Kenya health policy goal. This is through:

- Monitoring progress of implementation of KHSSP through achievement of indicator targets.
- Early identification of bottlenecks which enable review or change of strategies
- Prioritize Key intervention program areas given monitoring of high morbidity and mortality causes
- Identify inequalities amongst different demographic populations in order to give targeted interventions
- Identifying regional disparities in health outcomes for targeted interventions

3. **Ensure Accountability and Transparency**

[2] Gage and Dunn 2009, Frankel and Gage 2007, https://www.globalhealthlearning.org/course/m-e-fundamentals

[3] Papke-Shields, K. E., Beise, C., & Quan, J. (2010). Do project managers practice what they preach, and does it matter to project success? International Journal of Project Management, 28(7), 650-662.

Monitoring and evaluation (M&E) has gained increasing significance in the health sector during the last decade, partly due to increasing public demand for measurement and accountability in the use of health sector resources.

National and subnational planning entities need robust and effective M&E systems to enable them to account for monies spent in program implementation. This enables continued access financing from the national government, development partners and implementing partners. Accountability is also important in building public trust in the health programs, institutions and governance systems

4. Address Gaps realized in the Kenya Health Sector M&E Capacity Assessment

Three major aspects have been singled out in relation to strength of monitoring and evaluation in project management according to literature review. These include strength of the monitoring team, approaches to M&E and stages in project[4]. A Monitoring and evaluation capacity assessment was carried out to gauge the capacity of the Kenya National and County M&E units. The national and county governments were assessed across 12 capacity areas necessary for a well-functioning M&E unit. These include;

1. Organization of an M&E system
2. Human Capacity for M&E
3. Partnerships and Governance
4. National M&E Plan
5. Annual Costed M&E plan
6. Advocacy, Communication and Cultural Behavior
7. Routine Monitoring
8. Surveys and Surveillance
9. National and County Databases
10. Supervision and Auditing
11. Evaluation and Research
12. Data Demand and Use

The findings showed that the human resource capacity for M&E and research was constrained both the National and County levels. Most of the M&E units were grossly understaffed compounded by a lack of requisite training in M&E related work, often resulting in failure to meet the set objectives. Additionally, though the components of the 12 M&E capacity areas existed at both the national and county, the internal technical and financial capacity to implement these components was lacking

[4] Kamau, Charles & Bin, Humam. (2015). Efficacy of Monitoring and Evaluation Function in Achieving Project Success in Kenya

implying that there was inadequate internal funding to execute various M&E functions. 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. Given the key role played by human resource capacity to provide M&E, and the benefits shown by strong M&E systems shown above, then it is imperative that the national and county governments prioritize funding to strengthen M&E.

In order to invest adequately in monitoring and evaluation, M&E system need more strengthening. Hence there is a need to establish how much resources are to strengthen all the M&E system capacity areas at national and county levels. This will enable planning for routine M&E activities and periodic surveys. Having the costing will enable the national and county governments to identify amounts needed for M&E to rationalize allocation. It will also enable partners to identify areas to support without duplication of efforts. The subsequent chapters indicate the resource requirements to build and institutionalize a robust M&E system.

Developing M&E business case will facilitate stakeholders at different levels to consolidate their efforts in supporting one plan, one financing mechanism for M&E and one monitoring framework. This will eventually support transformation of the health systems for universal care.

The objective of this report therefore is to provide an analysis of the operating environment for M&E in Kenya, identify gaps, prioritize key areas and develop a case to justify investment in M&E by showing how much it cost to track health sector progress in line with the Kenya Health Sector Strategic and Investment Plan 2018-2023.Costed M&E system will highlight financial gap that partners and other development partners can realistically support to make health sector indicators more evidence- based.

2.0 Methodology

An effective M&E system requires a well defined and costed M&E plan to facilitate its functions. The aim of this section is to provide a brief description of how costing elements of the prioritized interventions were derived.

Steps on building the Investment Case for the M&E system in the Health Sector

The following are the steps used to do cost determination for strengthening the 12 components of an M&E system for the period 2021 - 2025

1. **Desk review;** Comprehensive review of documents was done to identify the key interventions that are linked to a functional M&E system. This review facilitated in development of the SWOT analysis, which in turn helped in the design of the data collection tool. We reviewed key documents including: the KHSSP 2018-2023, Health sector M&E plan, the MECAT report, NIMES, Health sector M&E guidelines among others.

2. **Stakeholders' meetings with M&E focal persons at the Ministry of Health**. This was done at different stages including during the development of the Health sector strategic plan, KHSSP 2018-2023. We conducted a review of the M&E systems and consolidated priorities and gaps from the various stakeholders to inform the operating environment. Prioritized interventions formed the building blocks for the costing activity. These meetings also allowed for collection of information regarding budget description and cost assumptions. Key informant interviews were conducted with 20 interviewees while discussions were also held with the M&E TWG to gain more insights. Among the stakeholders engaged were: M&E focal persons at the Ministry of Health Directorates and programs, Semi-Autonomous Government Agencies (SAGAs), Academia/Universities, WHO, USAID, JICA, UNICEF, HIGDA, UNFPA, County Government and private sector.

3. **Costing the key components of the M&E system;** The prioritized interventions for each of components of an M&E system were costed using the activity-based costing framework. Activity-based costing is a type of micro-costing approach that entails a bottom-up approach to costing interventions. Each intervention was broken down into the corresponding activities, and budget assumptions developed for these activities with inputs from experts and stakeholders. Activity costs included such things as training, surveys, advocacy, campaigns, meetings, documentation and equipment for the various activities outlined. This step provided prioritized resources needed for strengthening monitoring and evaluating systems for a period of 5 years.

The table below outlines the template used to develop these costings for the twelve components.

Table1.1: Costing framework for the M&E system

Capacity Areas	Priority Interventions	Activities	Budget description

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

Note: A fully populated costing sheet/ table is annexed in the document

In the costing analysis, three data inputs were used; i) quantity in need of the services ii) coverage targets and iii) unit costs. The estimated cost per activity was computed using the following formula: ***Cost per activity or service (ksh) = population x coverage target x unit cost.*** In the case of activities that did not relate to the population, the cost was calculated by multiplying quantity by the unit costs.

One of the limitations of this cost estimation process was the inability to provide specific M&E system strengthening issues at each county, given the heterogeneous nature of counties.

3.0 Estimated Financial Resources Requirement for Strengthening the Kenya Health Sector M&E System.

In estimating the resources needed for strengthening the M&E in the Health sector, the twelve components of a well-functioning M&E system are considered. The resources needed are to some extent aligned to the 2020 to/2025 health sector strategic plan. This section presents the total resources needed and which is in turn disaggregated in terms of the components of a well-functioning M&E system.

Table 1.2 provides the aggregate resource needs for all the 12 components. The table shows that the promotion of the use of unified and robust national and sub-national databases (capacity area 9) is the main cost driver for strengthening the health sector M&E system under the ministry of health. Another notable capacity area that seems to drive cost during this period is routine supervision and quality auditing(capacity area 10).

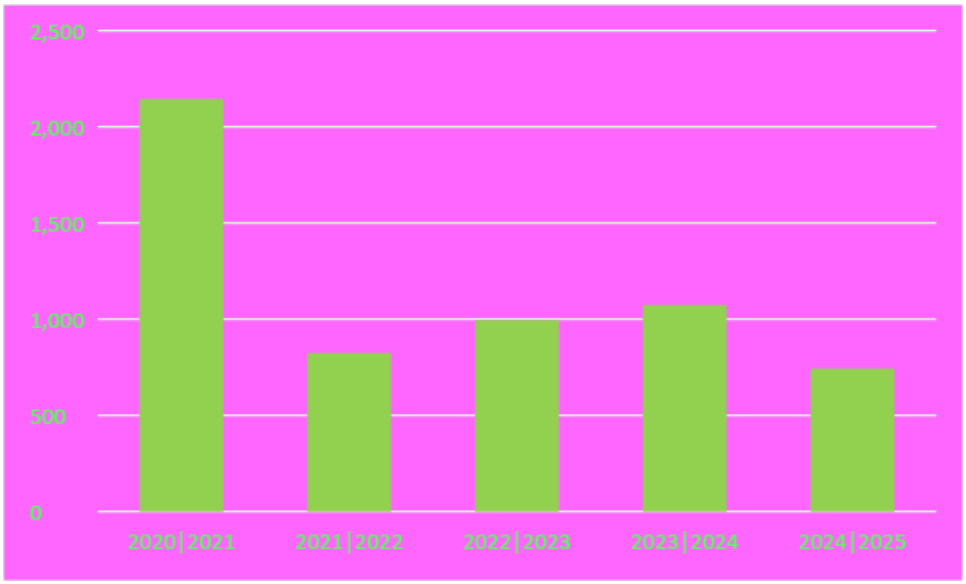
Table 1.2: Summary of Estimated M&E System Strengthening Resource Needs by Components in Millions of Kenya Shillings

	2020|2021	2021|2022	2022|2023	2023|2024	2024|2025	Total 5 - year
Capacity Area 1: Operates within a robust and integrated organizational structure for M&E	152	99	90	83	81	505
Capacity Area 2: Deploys adequate and competent human resources to drive M&E	33	40	9	36	7	125
Capacity Area 3: Operates within an effective partnerships and governance mechanism	15	13	13	12	13	66
Capacity Area 4: Is anchored upon an overarching national M&E plan	44	-	-	-	-	45
Capacity Area 5: Is delivered through a jointly agreed annual costed M&E plan	13	-	-	-	-	13
Capacity Area 6: Is sustained and promoted through advocacy and communication	60	50	50	50	50	258
Capacity Area 7: Is driven by robust systems for routine monitoring	12	12	45	26	36	131
Capacity Area 8: Incorporates investments to conduct periodic surveys and surveillance	21	32	4	4	4	64
Capacity Area 9: Promotes the use of unified and robust national and sub-national databases	1,520	390	369	681	322	3,282
Capacity Area 10: Provides for routine supervision and quality auditing	126	89	300	87	89	691

Capacity Area 11: Invests in evaluation and research	78	49	49	49	57	284
Capacity Area 12: Promotes widespread data demand and information use	83	55	62	55	81	335
Engagement Plan	-	8	5	5	5	22
GRAND TOTAL (KSH)	2,161	838	995	1,087	743	5,824

Figure 1.1 shows the total resource need for the M&E sector strengthening by fiscal years. The amount ranges from around a high of Ksh.2145 million to low of around Ksh.743 million per year. The resource needed for strengthening the national M&E system is approximately Ksh.5.82 billion. The figure shows that most of the resources are likely to be needed at the beginning of the strategic period. This is driven by the fact that at the start of the strategic period, there is likelihood of having many activities that are expected to address M&E plans and which will require some level of strengthening.

Figure 1.1: Total Resource Need for the M&E Sector in Terms of Fiscal Period in Millions of KSH.



The following section provides a brief description of the twelve components in terms of the key drivers for each. Table 1.3 shows capacity area one which provides the resource need for the organization and operation of the M&E system. Two key interventions under this capacity area are identified as, the strengthening of the HIS coordination and organization and the strengthening of the legal and regulatory systems to support the Health information system. The cost driver for this component is coordination and organization of the health information system which amount to approximately Ksh. 468 million with its leading activity being mentoring counties on M&E Institutionalization which is estimated to cost about Ksh.375 million on its own.

Table 1.3 Capacity Area 1: Operates within a Robust and Integrated Organizational Structure for M&E System in Millions of KSH.

Intervention	Activities	Total
Strengthen M&E/HIS coordination and organizational structures at all levels	Establish, operationalize and support HIS-M&E coordination structures at all levels	22
	Mentor SAGAs, Boards and Councils on M&E Institutionalization	10
	Mentor Counties on M&E Institutionalization	372
	Establish / strengthen National and County HIS / M&E organizational structures	44
	Conduct quarterly HIS-ICC meetings	1
	Establish baseline M&E capacities --(MECAT assessment)	18
Strengthen legal and regulatory systems to support HIS-M&E functions	Develop Health Information System legal framework aligned to the Health Policy 2014- 2030 and the Health ACT, 2017	18
	Review HIS Policy in line with the Health Act 2017 and Data Protection Act 2019	8
	Develop a policy for mandatory allocation of finances to strengthening of HIS-M&E by all actors	9
	Develop a minimum dataset for reporting for all health institution cf. the Health Act	2
Grand total		505

Figure 1.2 shows the amount of financial resources needed to strengthen the M&E system within each fiscal period. It is notable that more money is needed in the first period in order to make the system more functional. As expected, last year had less demand for strengthening purposes.

Figure 1.2: Total Resource Need for Capacity One by Fiscal Year in Millions of KSH.

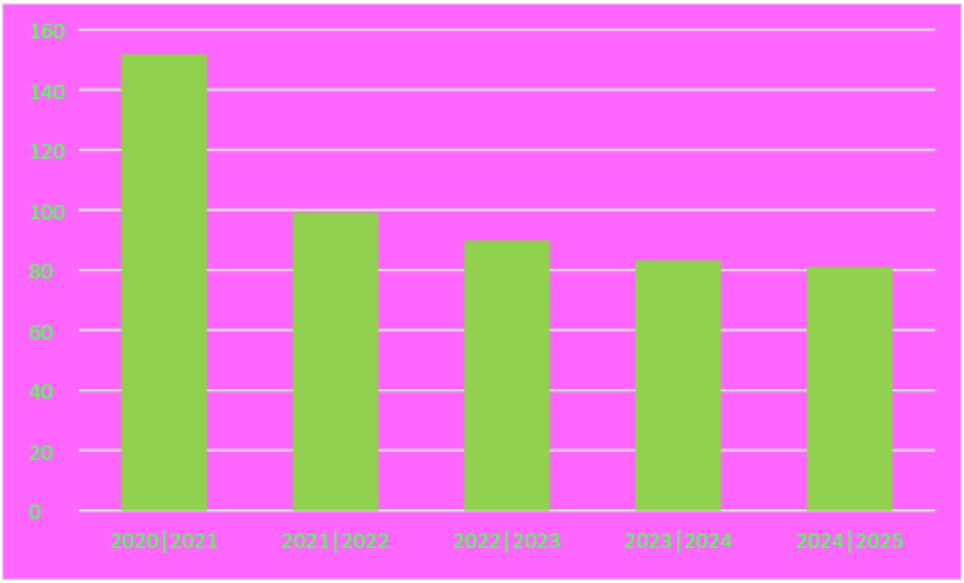


Table 1.4 shows the resource need for strengthening capacity area two. This area is concerned with the development of human resources for M&E. The broad intervention areas were identified as developing a capacity building strategy for all M&E system capacities and competency based capacity strengthening plan by capacity building of health workers. The cost drivers for this areas were capacity building for staff estimated at Ksh.52 million

Table 1.4: Capacity Area 2: Deploys Adequate and Competent Human Resources to Drive M&E in Millions of KSH.

Intervention	Activities	Totals
Develop a capacity building strategy for all M&E system capacities	Develop a competency based capacity strengthening plan for Data Analysis, data demand and information use, Surveys & Surveillance, M&E, Report writing skills, policy briefs	4

	Develop a capacity building strategy for health information (Reporting in KHIS, Indicator development, reporting tools, DQAs)	5
	Develop a capacity building strategy for health information electronic systems (EMRs, EHR, MCHULL, MFL, DHIS)	6
	Develop a capacity building strategy on Medical Certification	3
competency based capacity strengthening plan by capacity building of health workers	Build capacity for staff	52
	Conduct a joint meeting with academia on Medical certification and use of ICD.	3
	Develop a curriculum for Medical certification for academic institutions	52
	Grand Total	125

Figure 1.3 shows the estimated financial need for the M&E system capacity area strengthening by fiscal period. The second and third fiscal years are the two periods where resources will be expended more due to the fact that training programmes require to be first and foremost targeting. It requires identification of those who need training and the institutions that will offer this training depending on the training need. The fourth year appears not to have major activity that relates to this capacity area.

Figure 1:3 Total Estimated Financial Resource Need for M&E Capacity Area two by Fiscal Year in Millions of KSH.

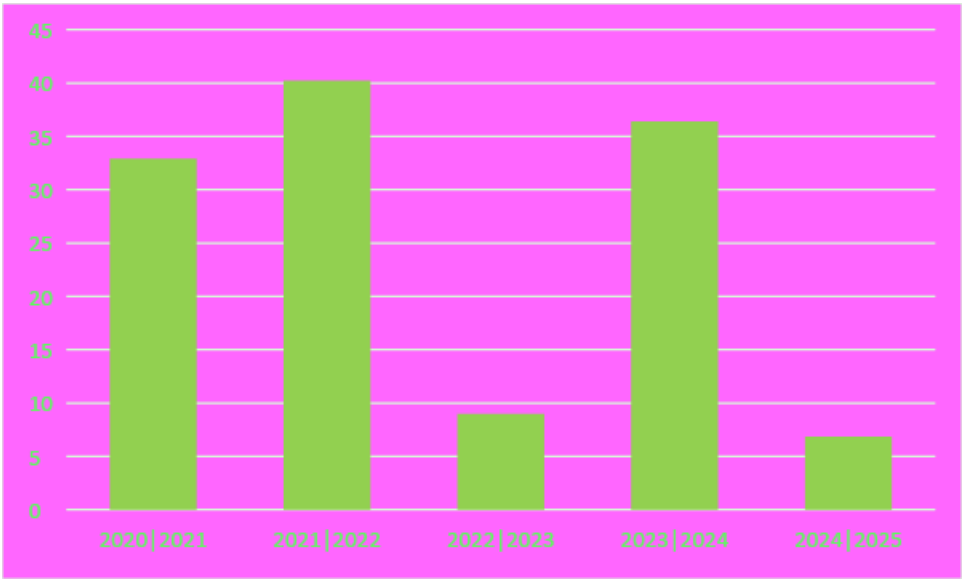


Table 1.5 shows how much it costs to strengthen capacity area three which consists of operating ***within effective partnerships and governance mechanisms for an M&E system***. The main cost driver under this capacity area is by an activity of intergovernmental collaborative meetings which falls second intervention, that is, institutionalization of the partnership framework mechanisms for joint stakeholder reviews. This activity will cost approximately Ksh. 52 million

Table 1.5: Capacity Area 3: Operates Within Effective Partnerships and Governance Mechanism in Millions of KSH.

Interventions	**Activities**	**Totals**
Institutionalize use of guidelines for HIS/M&E systems	Review guidelines for reporting, review and dissemination of Health information	2
	Develop guidelines for Electronic medical record systems	2
	Develop guidelines for notification of vital event	2
	Develop an data analytics guidelines for all levels	5

	Develop Data governance guidelines	1
	.Leverage on PPP to mobilize resources through collaboration for the implementation of HIS-SH meeting at National level	5
Institutionalize the partnership framework mechanisms for joint stakeholder reviews	Intergovernmental collaborative meetings-National HIS/M&E meetings during intergovernmental meetings in Nairobi-quarterly	52
Harmonize population estimates used in the health sector	Develop a guideline based on the Kenya Statistics Act to ensure the use of population data from KNBS at all levels	3
Grand Total		71

Figure 1.4 shows the distribution of resources needed for strengthening partnership through the fiscal period. The third period of the strategic plan attracts more resources for strengthening this component of the M&E system.

Figure 1.4: Distribution of Resource Need Effective Partnerships and Governance Mechanism in Millions of KSH.

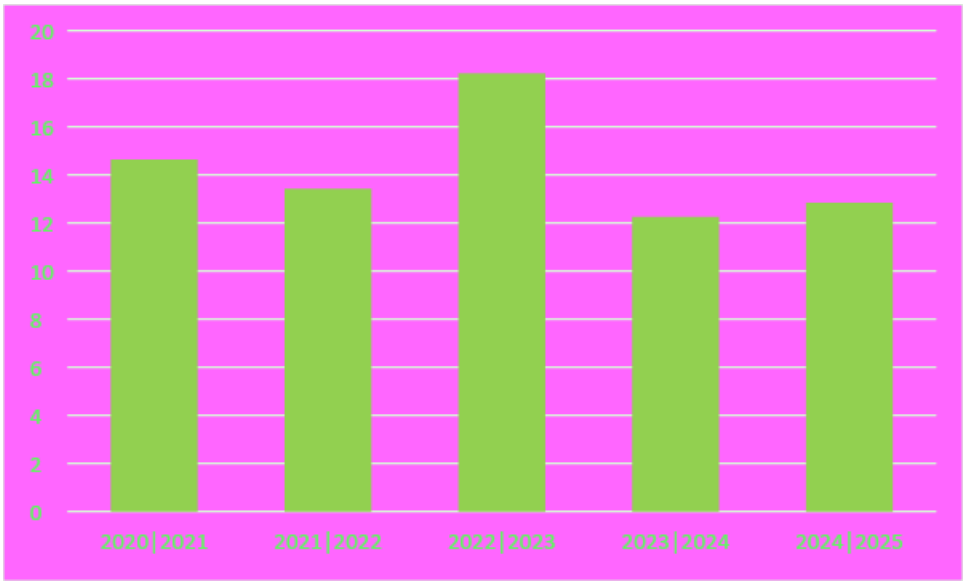


Table 1.6 shows resource needs for strengthening the national M&E plan which is mainly used in developing the plan that will act as a roadmap to M&E system activities. Hence this component is concerned with the development of an ***overarching national M&E plan*** that is linked to the health sector strategic plan. The preparedness of M&E activities through stakeholder's engagement takes the chunk of the resources for this component. The main activities driving this cost includes the numerous stakeholder's meetings and capacity assessment. As noted this is done within the first period of the health strategic plan so as to capture the key indicators that need to be tracked over the strategic plan period.

Table 1.6 Capacity Area 4: Is Anchored Upon an Overarching National M&E Plan in Millions of KSH.

Interventions	**Activities**	**Totals**
Develop a comprehensive Monitoring & Evaluation plan for tracking commitments in the Health strategies	Develop a sector M&E plan with stakeholder engagement, actual M&E plan development including indicators and data sources	**25**
	Development of program and departmental M&E plans	**8**
	Development of County M&E plans	**11**
	Review of the M/E plan	**8**
Grand total		**52**

Table 1.7 provides estimates of resource need for accomplishing a costed M&E plan. The M&E plan needs to have estimated resources that will facilitate the accomplishment of its roles. A cost M&E plan will also act as a financial proposal for the M&E system for the health strategic plan period/ therefore, a cost M&E plan should reflect the aspiration of the plan itself with prioritization done through stakeholders' meetings. Just like in the M&E plan, the key cost driver falls under stakeholders meeting that prioritizes on the activities that need to be cost as well as firming on the budget estimates.

The resource need for this capacity area is supposed to take place in the first period of the strategic plan so that it can guide on the resource need for the M&E plan.

Table 1.7 Capacity Area 5: Is delivered through a jointly agreed annual-costed M&E Plan in Millions of KSH.

Intervention	**Activities**	**Totals**
Develop Costed M&E Plan	Development of activities to be costed	10.365
	Actualizing M&E Plan Cost	2.25
	Grand Total	12.615

Table 1.8 shows the estimated resource needed to strengthen capacity area six on advocacy and communication. This function is continuous implying that it is expected to be carried out over the whole period of the strategic plan. Regional and national advocacy meetings for costs approximately Ksh. 230 million becoming the main cost driver activity for this capacity area.

Table 1.8 Capacity Area 6: Is Sustained and Promoted Through Advocacy and Communication in Millions of KSH.

Interventions	**Activities**	**Totals**
Develop an M&E communication and advocacy plan	1. Identify M&E capacity challenges that need to be addressed through advocacy and communication	11.58

	2. Form a team of advocates comprising organizations and individuals with specific M&E advocacy and communication roles and responsibilities	0.03
	3. Develop an advocacy work plan and budget	5.89
	5. Designing communications materials relevant based on the relevant target audience	6.00
	4.Organize the advocates to monitor, evaluate and report on the advocacy work	4.09
	Regional and national advocacy meetings in M&E	230.23
Grand total		**257.81**

Figure 1.5 shows estimated resource need for strengthening advocacy and Communication throughout the fiscal M&E system strategic plan period. As expected, there are multiple strengthening activities in the initial phase which includes development of advocacy strategy for the M&E system that should feed on the M&E plan. Subsequent periods have almost equal share of resource estimates because the bulk of strengthening will be expected to be undertaken in the initial phase.

Figure 1.5 Total estimated financial resources needed for M&E capacity area six by fiscal Year in Millions of KSH.

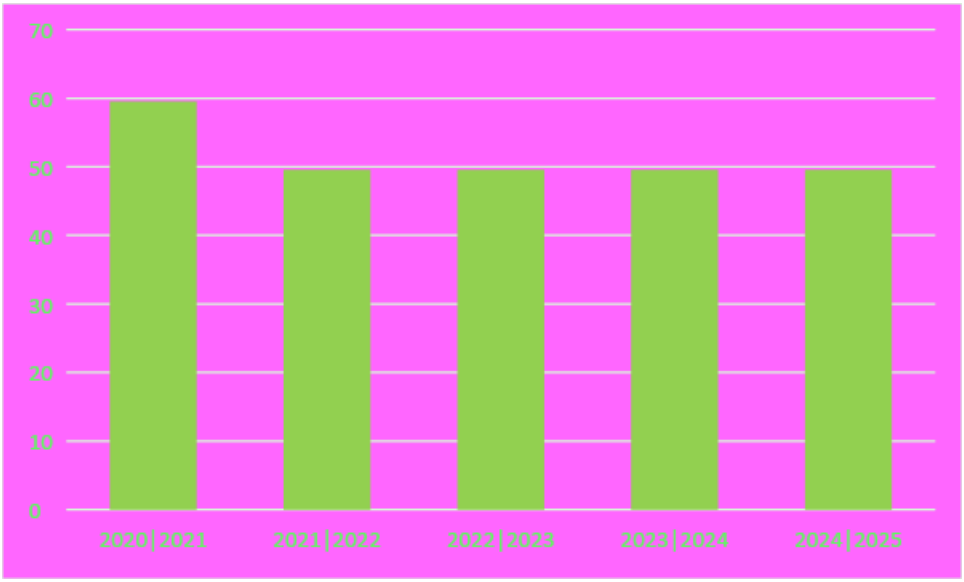


Table 1.9 shows the estimated resources needed for strengthening routine monitoring in the M&E system. There are three activities that are estimated to drive this capacity area in terms of strengthening. These three activities are, one, updating the reference indicator matrix /manual to incorporate all reporting needs in the sector, two, updating/develop reporting tools to capture service delivery data from routine and non-routine sources and three, developing a guideline based on the Kenya Statistics Act to ensure the use of population data from KNBS at all levels.

Table 1.9 Capacity Area 7: Is Driven by Robust Systems for Routine Monitoring in Millions of KSH.

Interventions	Activities	Total
Design, develop and avail comprehensive data collection tools in line data requirements in all strategic documents guiding the sector (This should adhere to the 2-yearly review cycle of indicators & data collection tools in the HIS policy)	1. Update the reference indicator matrix /manual to incorporate all reporting needs in the sector	25
	2. Update/develop reporting tools to capture service delivery data from routine and non-routine sources	31

	Review the routine and non-routines data sources	14
	3. Harmonize/update indicators in the KHIS indicators with the indicator manual and M&E plans-	14
Harmonize population estimates used in the health sector	Develop a guideline based on the Kenya Statistics Act to ensure the use of population data from KNBS at all levels	47
Grand Total		131

Figure 1.6 shows the distribution of estimated required resources for strengthening the routine monitoring with the M&E system and by fiscal year. The routine monitoring is expected to be done throughout the period though aggressive routine appears to be in the third and last year of the M&E plan

Figure 1.6 Total Estimated Financial Resource Need for M&E Capacity Area Seven by Fiscal Year in Millions of KSH.

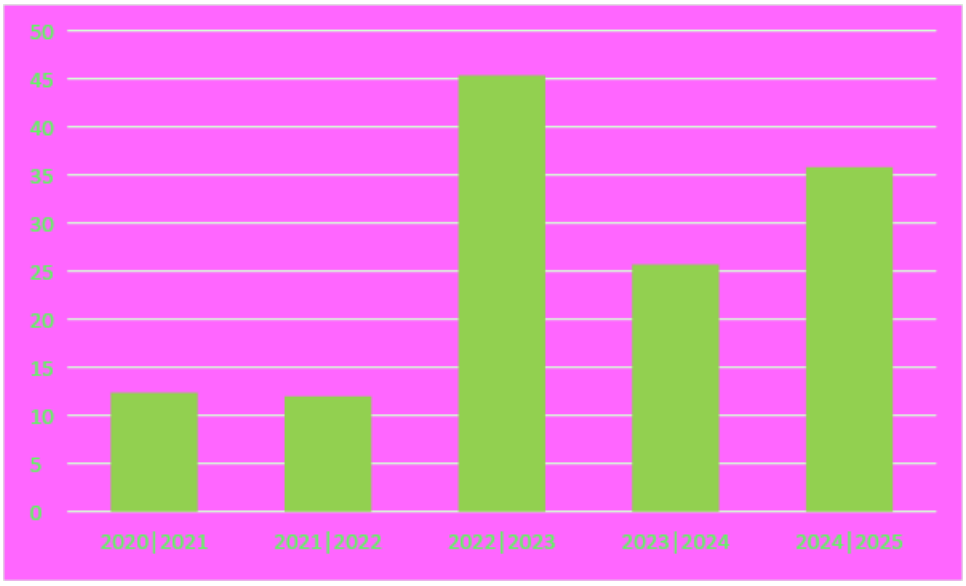


Table 2.0 reports the estimated financial need for strengthening periodic surveys and surveillance within the M&E system. Disease surveillance and response updating strategy and guidelines response activity is estimated to be the main cost driver at around ksh. 31.6 million. Figure 1.7

shows that strengthening of surveillance and survey is done in the first and second year in order to ensure that the large surveys and surveillance are undertaken within the third, fourth and fifth years.

Table 2.1 Capacity Area 8: Incorporates Investments to Conduct Periodic Surveys and Surveillance in Millions of KSH.

Interventions	Activities	Total
Develop a coordinated plan for implementing health related surveys (timing, inclusion of cross-cutting indicators)	Develop a 5-year plan for surveys based on stipulated timing	14.3
	Develop a minimum requirement for data elements for all surveys	5.1
Preparedness to undertake national surveillances	Enhance surveillance and epidemic response;	12.6
upgrading strategy and guidelines for Disease surveillance and responses	Disease surveillance and response updating strategy	31.6
Grand Total		63.6

Figure 1.7 Total estimated Financial Resource Need for M&E Capacity Area Eight by Fiscal Year in Millions of KSH.

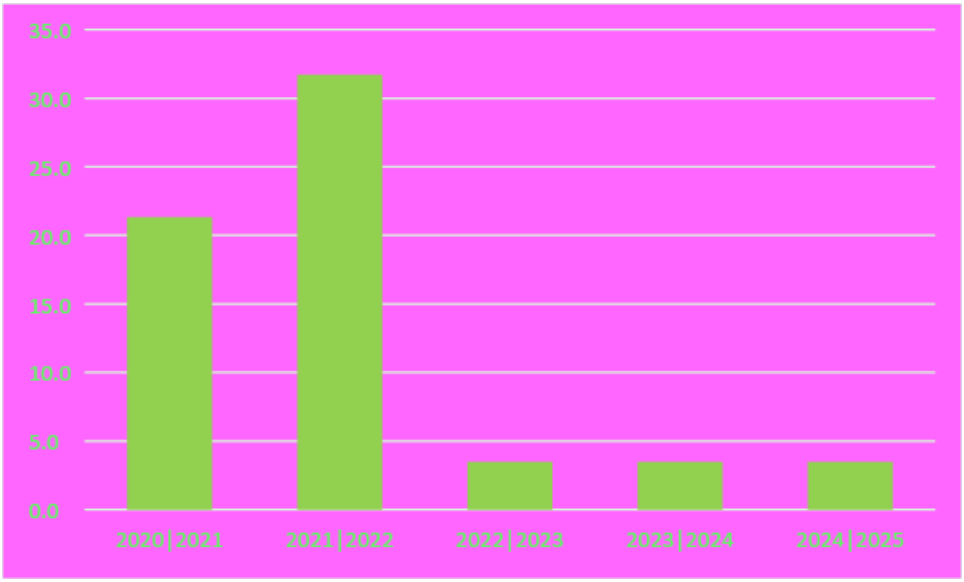


Table 2.2 reports the estimated resource requirement for strengthening or up-scaling the use of unified and robust national and sub-national databases. Two activities areas in the second intervention are estimated to be the cost driver for this capacity area strengthening. These activities are, one, integrating parallel (Disease) reporting systems with the KHIS and two, hosting of HIMS systems (DHIS2, MFL, DSL, DHP in the Provision of infrastructure for upscaling community health reporting is key driving cost at Ksh 1.2 billion. This capacity area was cited as the leading cost driver for the whole M&E system strengthening. As notable in figure 1.8, most of the activities are concentrated in year one and four.

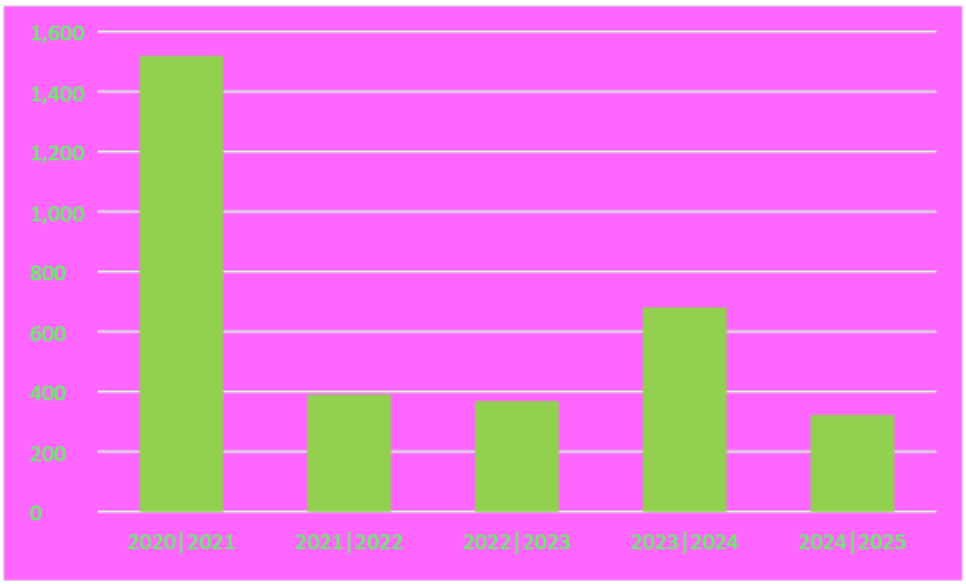
Table 2.2 Capacity Area 9: Promotes the Use of Unified and Robust National and Sub-National Databases in Millions of KSH.

Interventions	**Activities**	**Total**
Scale up of electronic records at all levels of care	System Development	16
	Infrastructure development	40
	Purchase adequate data backup servers--	85

	Effective infrastructure	74
	Capacity building on the electronic Health records including the DHP	665
Scale up and enhance capacity of HMIS systems	Enhance the capacity of KHIS through regular system upgrades	11
	Integrate all the health information subsystems with the KHIS	360
	Maintenance of KHIS though regular systems check ups	10
	Enhance the analytical capacity for optimal use of KHIS	66
	Hosting of HIMS systems (DHIS2, MFL, DSL , DHP in the cloud)--cost @ 0.5M per year	3
	Enhancement of the disease specific Surveillance systems for HIV,TB & Malaria	74
Establish /scale up IT based system for collecting information on Vital Events in collaboration with CRD (multisectoral approach)	Harmonize vital events data collection tools with the Digital Health Platform (DHP)/(MOH tools)	2
	Digitize jointly reviewed / developed vital events data collection tools	4
	Integrate CRVS system including geospatial mapping, health communications and platforms for self-monitoring and reporting at all levels to the DHP.	14
Automate use of ICD to improve underlying cause of death	Automate ICD based on decision tables-Cost TA and 3 Workshops	61
Strengthen capacity for reporting Vital Statistics	Training of personnel/staff and end users on the system.	107
	.Review VA indicators	5
	.Maintenance and regular updating of the KHRIO	40

Scale up development/ maintenance and us of data warehousing systems	Develop cross system analytics systems (e.g Data Service Layer)	6
Scaling up of Community health reporting	Developing the electronic Community Health Information system (eCHIS)	21
	Integrate the Verbal Autopsy into the eCHIS	3
	Capacity building of the CHWs,CHEWs and CHVs	303
	Infrastructure provision	1,200
Setting up Cancer Registries in Kenya	Developing the electronic Cancer Registry system	21
	Integrate the Cancer Registries into KHIS	25
	Capacity building of the Health workers	60
	Infrastructure and connectivity	8
Grand total		**3,282**

Figure 1.8 Total Estimated Financial Resources Need for M&E Capacity Area nine by Fiscal Year in Millions of KSH.



The resource estimation for the strengthening of routine supervision and quality auditing is reported in table 2.3 on capacity area 10. Developing and carrying out an assessment of the implementation and institutionalization of the DQA protocol which is under the second intervention on revising and disseminating DQA protocol is the cost driver at Ksh.195 million. This is a continuous process that assumes the same level of activities for each period within the strategic plan apart from year three when estimated cost is above the other years as shown in figure 1.9. The key cost drivers under this capacity area is in the activities of development and carrying out an assessment of the implementation and institutionalization of the DQA protocol and conducting biennial national data quality audits.

Table 2.3 Capacity Area 10: Provides for Routine Supervision and Quality Auditing in Millions of KSH.

Interventions	Activities	Total (Ksh)
Establish a comprehensive health information data validation mechanism	1.Develop a comprehensive health information data validation framework (paper and digital)	15
	2. Disseminate the comprehensive health information data validation framework	5
	3.Conduct quarterly data review meetings	150
Institutionalize Data quality Audits at all levels	1.Conduct annual national Integrated data quality audits including TB,HIV,Malaria and RMNCAH	16
	2. Disseminate DQA findings in all counties	149
Revise and disseminate the DQA protocol	1.Revise the DQA protocol	3
	2.Disseminate the DQA protocol	37
	3.Develop and carry out an assessment of the implementation and institutionalization of the DQA protocol	195
	4. Conduct Annual NHIS system cleaning	44
Establish Mechanisms to safeguard Data integrity and security	1. Develop a code of practice to ensure that standards of confidentiality are maintained without impeding data dissemination.	3
	2.Establish a data archiving mechanism for long-term safeguarding of records	5
Institutionalize Support supervision at all levels	1.Develop a Support supervision framework	6
	2.Conduct Support supervision	3

Grand total		**629**

Figure 1.9 Total estimated financial resources needed for M&E capacity area ten by fiscal Year in Millions of KSH.

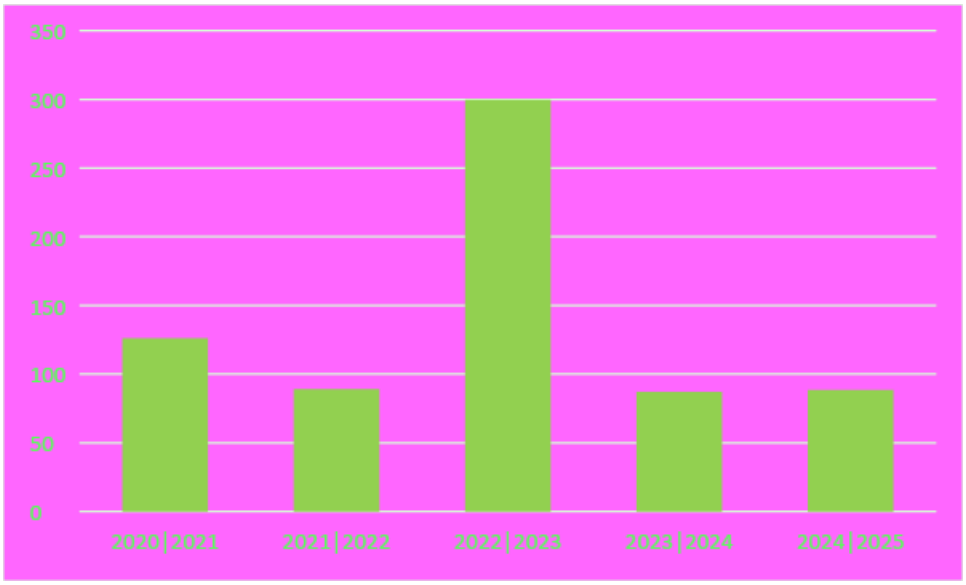


Table 2.4 reports the estimated resources for strengthening and up-scaling evaluation and research for the M&E system. The two interventions are mapping research need and capacity development to understand and apply research into policy. The activity on training health workers on evidence use in policy and strategy development is the cost driver for this capacity area at Ksh.143 million. The trend of estimated resources needed over the strategic plan period seem to be very close over the years in terms of the amount needed to strengthen this component of M&E system as shown in figure 1.10 apart from year one when the cost is expected to be much more than the other years.

Table 2.4 Capacity Area 11: Invests in Evaluation and Research in Millions of KSH.

Interventions	**Activities**	**Total (Ksh)**

Mapping of research needs	Carry out systematic reviews and documentation on priority health topics	38
	Landscape mapping of all research and publications	21
	Develop a National research agenda-	15
Capacity development in research	Train health workers on evidence use in policy and strategy development	143
	Develop Research protocols annually	66
	Develop a National research Evaluation plan	4
Grand Total		**288**

Figure 1.10 Total estimated financial resources needed for M&E capacity area eleven by fiscal Year in Millions of KSH.

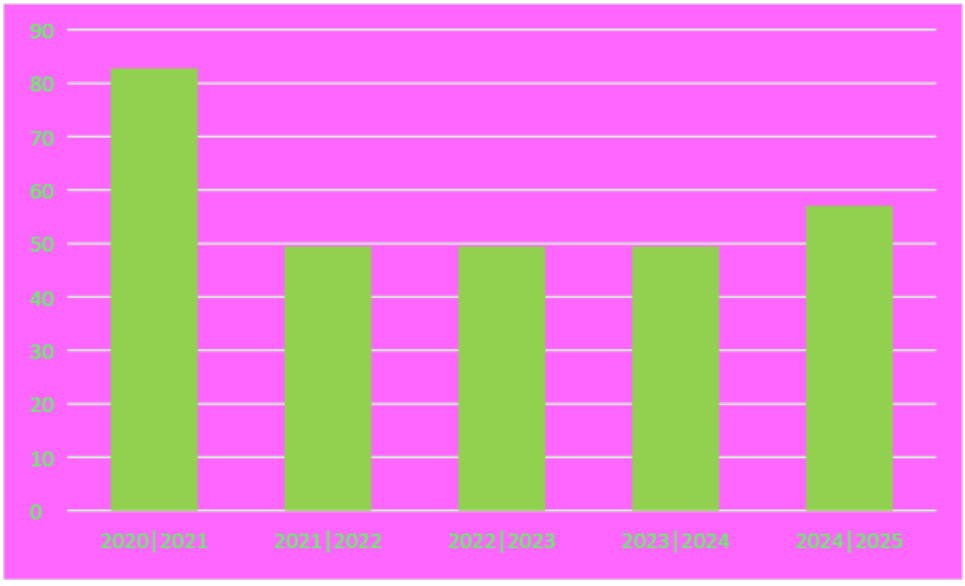


Table 2.5 provides estimated resource needs for strengthening widespread data demand and information use within the M&E system. The key cost driver activities are within the first intervention which is institutionalization of performance reviews at all levels. These activities are performing quarterly performance review meetings at sub-county and county level and enhancing

the analytical capacity for optimal use of DHIS. Figure 2.11 shows the trend of estimated resource distribution. The distribution seems to suggest a uniform need for this capacity strengthening over the strategic plan period

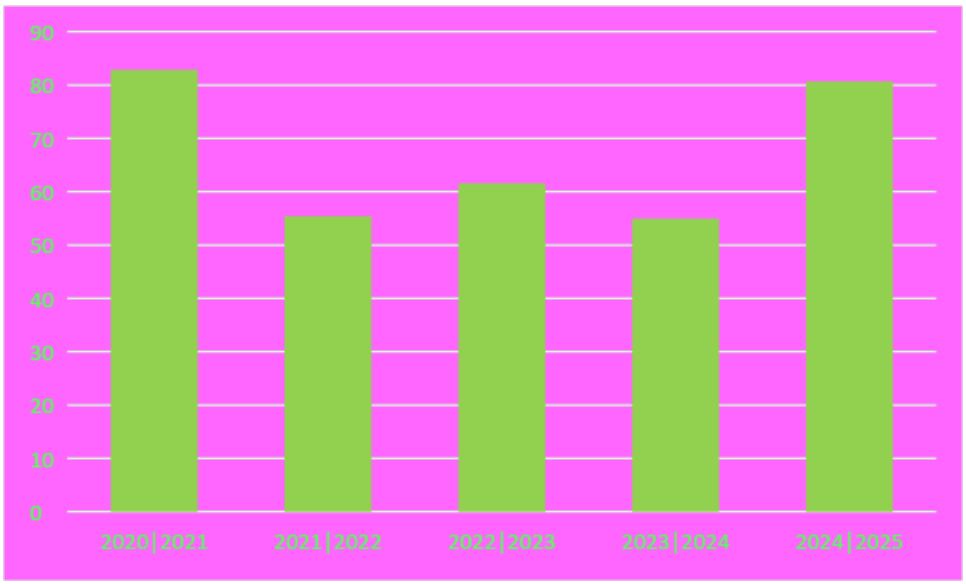
Table 2.5 Capacity Area 12: Promotes Widespread Data Demand and Information Use in Millions of KSH.

Interventions	**Activities**	**Total**
Institutionalize performance reviews at all levels	Update and disseminate performance reviews guidelines	14
	Perform biannual performance review meetings at national level	36
	Perform quarterly performance review meetings at sub-county and county level	93
	Perform Annual performance review Forums at 10 regional blocks	11
	Perform National Annual performance review Forums	11
	Conduct Joint review missions to validate reports-	55
	Develop an analysis framework, and guidelines	5

Strengthen institutional capacity for comprehensive analysis	Enhance the analytical capacity for optimal use of DHIS	53
	Thematic Dashboards development	9
	Develop mechanisms to increase access and use of thematic Dashboards	3
	Enhance the capacity of the Kenya Health Observatory as a one stop shop for current data and Statistics on Health	11
Streamline use of data in policy development, monitoring and evaluation	Make an inventory of relevant guidelines and policies, and develop a strategy to monitor implementation of these policies	4
	Operationalize the guidelines for evidence use in policy making	6
	Develop a framework to monitor and evaluate policy implementation	5
	Consolidate best practices & innovations in the sector	20
Grand Totals		**335**

Figure 2.1 shows the distribution of resource needs over the life of the current strategic plan. Spread across the duration of the strategic plan unlike other capacity areas where priorities were concentrated within one or two periods of the strategic plan though the first and last year would require more resources.

Figure 2.1 Total Estimated Financial Resources Need for M&E Capacity Area Twelve by Fiscal Year in Millions of KSH.



The capacity area with the costing reported in this section was as result of discussion with the stakeholders and key informant interviews conducted in Nairobi to identify the priority areas that should go hand in hand with improving the performance of the M&E system. The meeting with the stakeholders and key informant interview provided some insight on the challenges affecting the performance of the M&E system in which prioritization was then made based on these weaknesses as much as the current opportunities were used to ensure that once resource need for the identified priorities was determined it will help in assessing any finance gap that would exist in order to mobilize resources towards achievement of the M&E goal of monitoring the strategic plan

3.1 M&E Estimated Financial Need per County

The estimation of financial need for the counties in Kenya was done by identifying counties' needs in terms the twelve components of a well-functioning M&E system. In order to arrive at this, several counties that had participated in the stakeholders meeting for the development of the strategic plan were involved in identifying the gaps and priority areas for their health information system. This information, together with the capacity assessments, was used to estimate M&E financial need that would go hand in hand with sustaining and up-scaling functioning of the M&E system in a sample county. However, this is an indicative cost given the heterogeneous nature of counties and their unique challenges depending on the level of technology diffusion with respect to M&E tools and human resource capacity. Equally, the success of M&E functionality depends on the support of the county

government. The twelve components are a guide for the county governments to assess the key components that they need to prioritize to run a well-functioning M&E system.

According to a single county M&E resource need estimates shown in table 2.5, investment to conduct periodic surveys and surveillance (capacity area 8 is the main cost driver for county M&E system. This is not surprising because most of the county M&E systems are highly underfunded hence a lot of investment is needed to make them functional. Compared to national M&E, a single county estimate is close to 3% of the national M&E cost. This is due to the volume of work that the National M&E is expected to cover each year of which the key being robustness of routine monitoring, which is a national activity that demands heavy investment.

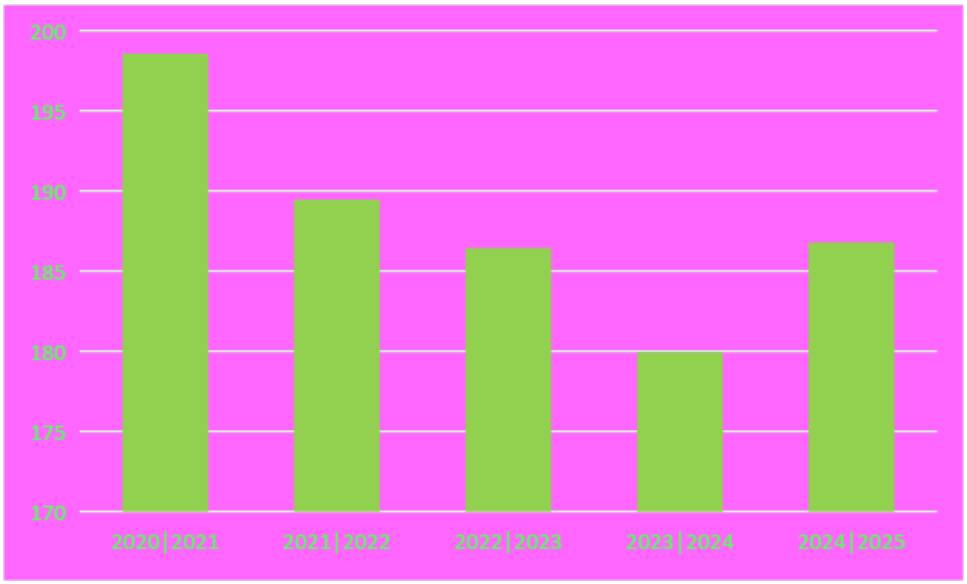
Table 2.6 Estimated M&E financial need per County in Millions of KSH.

M&E Capacity Areas Costing	2020|2021	2021|2022	2022|2023	2023|2024	2024|2025	**Total**
Capacity Area 1: Operates within a robust and integrated organizational structure for M&E.	2.82	2.82	2.82	2.82	2.82	**14.08**
Capacity Area 2: Deploys adequate and competent human resources to drive M&E.	7.89	7.89	7.89	7.89	7.89	**39.45**
Capacity Area 3: Operates within an effective partnerships and governance mechanism.	0.44	0.44	0.44	0.44	0.44	**2.20**
Capacity Area 4: Is anchored upon an overarching national M&E plan.	5.00	-	-	-	-	**5.00**
Capacity Area 5: Is delivered through a jointly agreed annual costed M&E plan.	5.00	-	-	-	-	**5.00**
Capacity Area 6: Is sustained and promoted through advocacy and communication.	15.50	15.50	15.50	15.50	15.50	**77.50**
Capacity Area 7: Is driven by robust systems for routine monitoring.	38.63	30.83	38.33	30.83	38.68	**177.30**
Capacity Area 8: Incorporates investments to conduct periodic surveys and surveillance.	72.20	87.90	77.39	77.39	77.39	**392.27**
Capacity Area 9: Promotes the use of unified and robust national and sub-national databases.	12.80	0.80	0.80	1.80	0.80	**17.00**

Capacity Area 10: Provides for routine supervision and quality auditing.	7.50	7.50	7.50	7.50	7.50	**37.50**
Capacity Area 11: Invests in evaluation and research.	38.97	38.97	38.97	38.97	38.97	**194.85**
Capacity Area 12: Promotes widespread data demand and information use.	7.96	7.96	7.96	7.96	7.96	**39.80**
Total	**198.56**	**189.46**	**186.45**	**179.95**	**186.80**	**941.22**

Figure 2.2 shows distribution of M&E resource needs over the strategic plan period. As noted in the figure, there is a need for heavy investment in M&E during the first year of the strategic plan. This is necessitated by the challenges that the county M&E systems are currently facing with regards to their functionality. As expected, the cost cascades downwards as one approaches the end of the period only to increase at the end of the strategic plan. The last year's cost is mainly driven by numerous monitoring and evaluation that are associated with assessing the impact of various interventions within the five years' period**.**

Figure 2.2 County Estimated M&E Resource based on 2018/2023 Health Sector Strategic Plan in Millions



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Combining the two resource needs, that is, the national M&E resource need and the county resource need, one is able to gauge the total resource needs that could go to the M&E system in the health sector. Using the total current estimate on a single county resource need of Ksh. 941 million and applying it to the 47 Counties gives approximately Ksh. 44 billion of resource for the entire

strategic plan period for all the counties. This, combined with the national estimate of about Ksh. 5.8 billion for the entire strategic plan period, is Ksh. 50 billion for the entire period of five years for both county and national M&E combined. Given that the health sector resource need for 2020/2025 strategic plan is approximately Ksh. 950 billion, the proportion of M&E resource need is approximately 5% of the total health sector resource estimate. This estimates resources required to strengthen the M&E system in Kenya to be effective at monitoring the KHSSP goals.

4.0 Stakeholders Engagement Plan for the M&E System

A Stakeholder Engagement Plan is a formal strategy to communicate with M&E stakeholders to achieve their support with respect to the activities in the M&E plan. This plan needs to specify the frequency and type of communications, media, contact persons and locations of communication events. It is crucial to incorporate stakeholder engagement as part of the strategic planning process. To have a functioning M&E system in place, it is important to build an enabling environment for all stakeholders (i.e. secure staffing and work, secure funding, cultivating an M&E culture and stakeholder coordination).

Stakeholder coordination is one of the critical drivers of convergence in the health sector and is currently articulated through the "three ones" principle that requires all stakeholders to operate within one planning framework, one funding mechanism and one M&E framework. Engaging policymakers at the macro level helps to gain political commitment which may have an effect on the development and implementation of the "three ones". This will also ensure that M&E in the health sector is allocated sufficient resources at both National and County levels, and that there is increased participation at all levels in the building or sustenance of a unified M&E system**.**

Steps to consider in building M&E stakeholder's engagement plan.

1. **Stakeholder mapping and analysis**

   Stakeholder mapping enables establishment of a complete inventory of stakeholders and organization/program/unit the stakeholder is working with and helps to gain a broader view of which stakeholders could support or oppose interventions to strengthen the organization/program/unit's scope. The data collected enables analysis of the stakeholders, including their relative contributions.

2. **Defining potential roles of stakeholders**

   This aspect of stakeholder engagement entails considering how stakeholders will influence activities in the short and long term. It is important to think about their immediate influence and the influence they have on other potential stakeholders. This will help in determining stakeholder's level of participation especially their roles in the whole process. It is important to gauge their level

of expectation as some stakeholders might be having vested interest which might jeopardize the performance of the M&E system. Define the purpose of the engagement well in advance and ensure that all stakeholders understand.

3. Identification of stakeholder resources

M&E systems require a significant amount of resources most of which are sourced from stakeholders. Assessing the relative contribution that the stakeholders make in the whole process of M&E plan is a priority exercise. Identifying the resources that stakeholders bring to the M&E activities may help expand the scope of the activities. Consider what each stakeholder can contribute to an activity. Additionally, beyond financial resources, stakeholders may provide an entry point to high-level policymakers that would be helpful during the initial and implementation stages of the activity, while others may allow you to create greater public awareness through access to media channels or may offer valuable technical inputs to the design of the activity.

4. Identify the level of commitment of the stakeholder

Though identification of the role of stakeholder is paramount, it matters to consider the level of stakeholder's commitment. This generally strongly affects how stakeholder cooperates with or hinders an activity. If the stakeholders are committed to the activity, the probability that they will facilitate a specific undertaking is higher. There is a need to consider who may put up barriers to the activity and predict what they may be so that you can develop strategies for handling them. The stakeholder analysis provides clarity on the potential contributions of stakeholders or the challenges different partners and stakeholders may pose. After the analysis is completed, you can now define the optimum group to engage with and develop a cost stakeholder engagement plan.

5. Set up the optimum stakeholder group

In real sense, it is not practical to engage all the stakeholders in the process of M&E due to cost implications and meaningful deliberation. Therefore, an optimum group needs to be established. This involves reviewing the data entered into the stakeholder analysis matrix and discussing the relative priority of stakeholders to get involved in the activity. As more stakeholders with unique perspectives and priorities are included, the likelihood of finding inconsistent or competing interests' increases. Consider carefully, the relative value of each person's involvement versus the added time and costs of expanding the number of stakeholders. Core stakeholders should be

engaged throughout the implementation, not just at the beginning and the end. This raises awareness of the activity and facilitates the use of data and information produced by the activity. Always consider identifying "tiers" of stakeholders for different levels of involvement and different times in the activity. Engaging stakeholders early increases ownership. Thus it is important to plan early to ensure maximum amount of time for stakeholder engagement. Manage expectations from the beginning, that is, be clear about the levels of engagement, the role of participants at different stages of the process and how their input will be key in the whole process of M&E.

6. Roles of each a stakeholder engagement plan

The purpose of stakeholders in the process of M&E is mainly to get support in terms of both financial and in-kind. Once the groups are formed the next stage is to brainstorm on the roles each stakeholder can play in the activity, and define the specifics of how engagement is carried out under the M&E sub-activities. Start by listing the steps in your intervention and discussing whether the stakeholder can contribute to this step. The importance of activity engagement is that it can build ownership of the data and information generated under each sub-activity. It is also critical to describe to the stakeholders the plans for their continued involvement and provide them with feedback on the results and impact of the activity, while fully acknowledging their contributions. A key aspect of this step is to think of how the whole process of engagement plan will be carried out in terms of leadership, review of the plan over time and ensuring that the engagement is not a one-time exercise. The stakeholder engagement plan is dynamic and flexible. It should be reviewed at various points throughout an activity and stakeholder involvement should be revised based on gathered experiences while working with them.

7. Track stakeholder engagement throughout the project

Stakeholder engagement is a costly exercise hence no amount of resources should be spent on an engagement that is not productive. In line with this argument during the implementation of an activity the contribution of stakeholders whether positive or negative should be clearly documented in terms of their impact on how information has been used for decision making. This effort helps to create continued awareness and appreciation of the importance of collaborative efforts and the key role of stakeholder involvement in the implementation of health activities.

Resource Requirement for an Engagement Plan.

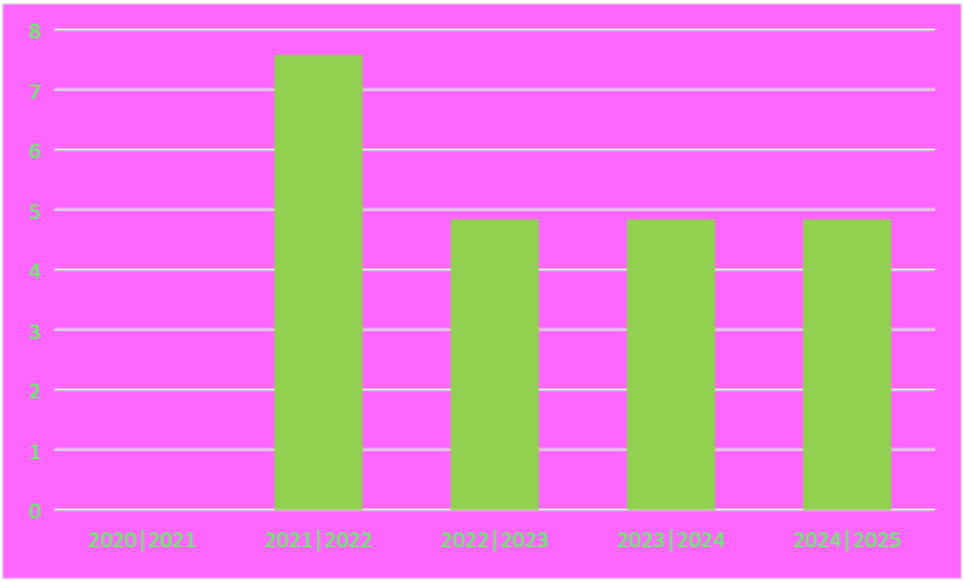
The determination of resource requirements for this engagement plan was done based on the assumption that M&E stakeholders need to meet at least quarterly at the national level. Another assumption was that there is a need to have some technical working groups to guide the whole process of engagement. The assumption under the technical working group was that they would meet at least once in a month. Table 2.6 reports the resource requirement needed to support this engagement mechanism at National and County levels. The key intervention is the formation of an engagement plan which is actualized over the five-year strategic plan. The key activities under this intervention include, stakeholder mapping and analysis, setting up the optimum stakeholder group, creating a stakeholder engagement plan and actualizing the engagement plan.

Table 2.7. The Estimated Budget Needed to Engage Stakeholders in Millions of KSH.

Interventions	**Activities**	
Engagement plan development	Stakeholder mapping and analysis	1.45
	Set up the optimum stakeholder group	0.05
	Create a stakeholder engagement plan	2,688
	Actualizing the engagement plan	20,81
	Grand total	**22,098**

Figure 2.3 reports the total estimated financial resource need for an engagement plan aimed at ensuring continuous participation of the stakeholders in the M&E process. According to the figure, the resource needs cut across the five year period. Year two resource need is more than all the other periods implying that this period includes the activity of forming the stakeholders' optimum groups.

Figure 2.3 Total Estimated Financial Resource Need for stakeholders' engagement in Millions of KSH.



5.0 Conclusions

The total resource need for strengthening the national M&E system is approximately **Ksh. 5.8 billion**. This budget forms a proportion of approximately 5 percent of the total health sector budget, aligning with the recommended global guidance that the M&E budget should comprise between 5 to 10 percent of any country's/institution's budget. This resource need is distributed within the five years with the budget ranging from Ksh.743 million to Ksh. 2.1 billion per fiscal year.

Strengthening unified and robust national and sub-national databases is the key cost driver for this five years' period with a resource need of Ksh.3.3billion. Infrastructure provisions and Capacity building on the electronic Health records including the DHP in scale up of electronic health records at all levels of care in turn take most of the strengthening databases resource need.

Routine supervision and quality audit was the second cost driver, estimated at Ksh.691 million for the five years' period.

These two areas form the bedrock of a health information system by ensuring data is collected and that quality of that data is assured through regular and systematic quality audits.

Areas that had less cost implications included development and costing of M&E plans as well as systems for periodic surveys. Notably, these areas lean more on systems support as opposed to

strengthening, and rely heavily on working systems that consolidate high quality information. They tie in the products of a working system to systematically assure continuous tracking of progress at all levels.

Given that the MECAT assessment found that human resources had most gaps in terms of capacity and skills set, investment in adequate and well trained human resources to support the M&E systems is paramount.

There is therefore a need to focus on building efficient systems for data collection and data quality, as well as ensure the support systems to enhance processing and use of this data to make decisions are also in place and functional.

The report also provides an estimated financial resource need for M&E engagement plan of Ksh.22 million. The engagement plan is expected to support resource mobilization efforts at both National and County levels throughout the 5 year period (2020/2021 to 2024/2025).

6.0 Key Recommendations

The result of the resource estimate provides some guidance on the areas that need prioritization if the M&E system is to become fully functional. The following are the recommendations from this review;

1. Each implementation unit at National (MOH directorates, programs and SAGAs) and County level needs to set aside dedicated resources for the M&E systems. These should consist between 5-10% of the implementing units budget.
2. Of the 12 components of an M&E system, the national databases require significant focus in investments strengthening with progressive investments over the five year period.
3. This however must go in tandem with other areas including strengthening human resource capacities, operationalizing other support systems such as M&E plans as well as systems to enhance use of data generated by these databases.
4. There is need to evaluate available resources that are currently available for strengthening each of the capacity areas. Consequently, a funding landscape for the M&E system is needed. This will help provide an estimate of the resource gap that the sector will need to mobilize to strengthen the M&E system at all levels. This will also facilitate stakeholders and partners to

appreciate the magnitude of resources needed to close the gap in building a resilient M&E system in line with their areas of operation or interest. The funding landscape will also provide an early signal to the resources available for the overall M&E strategy to inform prioritization.

5. With one of the limitations of this cost estimation process being the inability to provide specific M&E system strengthening issues at each county, and given the heterogeneous nature of counties, providing a uniform strengthening remedy across all counties could be misleading. Therefore, it is recommended that individual assessments for each county be done to generate county specific M&E strengthening needs.

ANNEX 1

References

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- Kenya Health Act 2017
- Kenya Health Policy 2014-2030

ANNEX 2:

Costed Capacity areas by Fiscal Years

Capacity Area 1: Operates Within a Robust and Integrated Organizational Structure for M&E

Intervention	Activities	2020|2021	2021|2022	2022|2023	2023|2024	2024|2025	Totals
Strengthen M&E/HIS coordination and organizational structures at all levels (e.g TWGs, ICC etc)	Establish, operationalize and support HIS-M&E coordination structures at all levels	4	4	4	4	4	22
	Mentor SAGAs, Boards and Councils on M&E Institutionalization	2	2	2	2	2	10
	Mentor Counties on M&E Institutionalization	74	74	74	74	74	372
	Establish / strengthen National and County HIS / M&E organizational structures	44	0	0	0	0	44
	Conduct quarterly HIS-ICC meetings	0	0	0	0	0	1
	Establish baseline M&E capacities -- (MECAT assessment)	18	0	0	0	0	18
Strengthen legal and regulatory systems to support HIS-M&E functions	Develop Health Information System legal framework aligned to the Health Policy 2014- 2030 and the Health ACT, 2017	0	18	0	0	0	18
	Review HIS Policy in line with the Health Act 2017 and Data Protection Act 2019	8	0	0	0	0	8
	Develop a policy for mandatory allocation of finances to strengthening of HIS-M&E by all actors	0	0	9	0	0	9
	Develop a minimum dataset for reporting for all health institution cf. the Health Act	0	0	0	2	0	2
Grand total		**152**	**99**	**90**	**83**	**81**	**505**

Capacity Area 2: Deploys Adequate and Competent Human Resources to Drive M&E

Intervention	Activities	2020|2021	2021|2022	2022|2023	2023|2024	2024|2025	Totals
Develop a capacity building strategy for all M&E system capacities	Develop a competency based capacity strengthening plan for Data Analysis, data demand and information use, Surveys & Surveillance, M&E, Report writing skills, policy briefs	0	4	0	0	0	4
	Develop a capacity building strategy for health information	0	0	5	0	0	5
	Develop a capacity building strategy for health information electronic systems (EMRs, EHR, MCHULL, MFL, DHIS)	0	6	0	0	0	6
	Develop a capacity building strategy on ICD Use	0	0	0	0	0	0
competency based capacity strengthening plan by capacity building of health workers	.Develop a capacity building strategy on Medical Certification	0	0	0	3	0	3
	Build capacity for each staff	16	12	4	16	4	52
	Conduct a joint meeting with academia on Medical certification and use of ICD.	0	0	0	0	3	3
	Develop a curriculum for Medical certification for academic institutions	16	19	0	17	0	52
	Grand Total	33	40	9	36	7	125

Capacity Area 3: Operates Within an Effective Partnerships and Governance Mechanism

Interventions	Activities	2020|2021	2021|2022	2022|2023	2023|2024	2024|2025	Totals
Institutionalize use of guidelines for HIS/M&E systems	Review guidelines for reporting, review and dissemination of Health information	2	0	0	0	0	2
	Develop guidelines for Electronic medical record systems	0	0	2	0	0	2
	Develop an data analytics guidelines for all levels	0	0	0	2	0	2
	Develop guidelines for notification of vital event	0	0	5	0	0	5
Institutionalize the partnership framework mechanisms for joint stakeholder reviews	Develop Data governance guidelines	0	0	1	0	0	1
	Leverage on PPP to mobilize resources through collaboration for the implementation of HIS-SH meeting at National level	2	0	0	0	2	5
	Intergovernmental collaborative meetings- National HIS/M&E meetings during intergovernmental meetings in Nairobi- quarterly	10	10	10	10	10	52
Harmonize population estimates used in the health sector							
	3. Develop a guideline based on the Kenya Statistics Act to ensure the use of population data from KNBS at all levels	0	3	0	0	0	3
	Grand Total	15	13	13	10	13	71

Capacity Area 4: Is Anchored Upon an Overarching National M&E Plan

Interventions	**Activities**	**2020|2021**	**2021|2022**	**2022|2023**	**2023|2024**	**2024|2025**	**Total**
Develop a comprehensive Monitoring & Evaluation plan for tracking commitments in the Health strategies	Develop a sector M&E plan (stakeholder engagement, actual M&E plan development including indicators and data sources)	25	0	0	0	0	25
	.Development of program and departmental M&E plans	8	0	0	0	0	8
	Development of County M&E plans	11	0	0	0	0	11
	Review of the M&E plan	8	0	0	0	0	

	Grand Total	52	0	0	0	0	44

Capacity Area 5: Is delivered through a jointly agreed annual costed M&E Plan

Interventions	Activities	2020|2021	2021|2022	2022|2023	2023|2024	2024|2025	Total
Develop Costed M&E Plan	Development of activities to be costed	10.37	-	-	-	-	10
	Actualizing M&E Plan Cost	2.25	-	-	-	-	2
	Grand Total	12.62	-	-	-	-	13

Capacity Area 6: Is Sustained and Promoted Through Advocacy and Communication

Interventions	Activities	2020|2021	2021|2022	2022|2023	2023|2024	2024|2025	Total
Develop an M&E communication and advocacy plan	Identify M&E capacity challenges that need to be addressed through advocacy and communication	2.32	2.32	2.32	2.32	2.32	11.58
	Form a team of advocates comprising organizations and individuals with specific M&E advocacy and communication roles and responsibilities	-	0.03	-	-	-	0.03
	Develop an advocacy work plan and budget	5.89	-	-	-	-	5.89
	Designing communications materials relevant based on the relevant target audience	1.20	1.20	1.20	1.20	1.20	6.00

	Organize the advocates to monitor, evaluate and report on the advocacy work	4.09	-	-	-	-	4.09
	Regional and national advocacy meetings in M&E	46.05	46.05	46.05	46.05	46.05	230.23
	Grand Total	59.54	49.59	49.56	49.56	49.56	257.81

Capacity Area 7: Is Driven by Robust Systems for Routine Monitoring

Interventions	**Activities**	**2020|2021**	**2021|2022**	**2022|2023**	**2023|2024**	**2024|2025**	**Total**
Design, develop and avail comprehensive data collection tools in line data requirements in all strategic documents guiding the sector (This should adhere to the 2-yearly review cycle of indicators & data collection tools in the HIS policy)	1. Update the reference indicator matrix /manual to incorporate all reporting needs in the sector	6	0	0	19	0	25
	2. Update/develop reporting tools to capture service delivery data from routine and non-routine sources	0	0	31	0	0	31
	Review the tools	0	0	7	0	7	14
	3. Harmonize/update indicators in the KHIS indicators with the indicator manual and M&E plans-	0	0	7	7	0	14
Harmonize population estimates used in the health sector	Develop a guideline based on the Kenya Statistics Act to ensure the use of population data	6	12	0	0	29	47

	from KNBS at all levels						
	Grand Total	12	12	45	26	36	131

Capacity Area 8: Incorporates Investments to Conduct Periodic Surveys and Surveillance

Interventions	Activities	2020|2021	2021|2022	2022|2023	2023|2024	2024|2025	Total
Develop a coordinated plan for implementing health related surveys	Develop a minimum requirement for data elements for all surveys	-	5.15	-	-	-	5.15
Preparedness to undertake national surveillances	Enhance surveillance and epidemic response;	12.57	-	-	-	-	12.57
upgrading strategy and guidelines for Disease surveillance and responses	Disease surveillance and response updating strategy	3.51	17.53	3.51	3.51	3.51	31.55
	Grand Total	21.34	31.73	3.51	3.51	3.51	63.58

Capacity Area 9: Promotes the Use of Unified and Robust National and Sub-National Databases

Interventions	**Activities**	**2020|2021**	**2021|2022**	**2022|2023**	**2023|2024**	**2024|2025**	Total (Ksh)
Scale up of electronic records at all levels of care	System Development	16	0	0	0	0	16
	Infrastructure development	0	40	0	0	0	40
	Purchase adequate data backup servers--	0	0	85	0	0	85

	Effective infrastructure (Computers, servers, internet, tablets)	0	0	0	74	0	74
	Capacity building on the electronic Health records including the DHP	133	133	133	133	133	665
Scale up and enhance capacity of HMIS systems	Enhance the capacity of KHIS through regular system upgrades	2	2	2	2	2	11
	Integrate all the health information subsystems with the KHIS	0	0	0	360	0	360
	Maintenance of KHIS though regular systems check ups	2	2	2	2	2	10
	Enhance the analytical capacity for optimal use of KHIS	0	0	66	0	0	66
	Hosting of HIMS systems (DHIS2, MFL, DSL , DHP in the cloud)--cost @ 0.5M per year	1	1	1	1	1	3
	Enhancement of the disease specific Surveillance systems for HIV,TB & Malaria	0	0	0	0	74	74
Establish /scale up IT based system for collecting information on Vital Events in collaboration with CRD (multisectoral approach)	Harmonize vital events data collection tools with the Digital Health Platform (DHP)/(MOH tools)	1	0	0	0	1	2
	Digitize jointly reviewed / developed vital events data collection tools	4	0	0	0	0	4
	Integrate CRVS system including geospatial mapping, health communications and platforms for self-monitoring and reporting at all levels to the DHP.	0	14	0	0	0	14
Automate use of ICD to improve underlying cause of death	Automate ICD based on decision tables-Cost TA and 3 Workshops	0	61	0	0	0	61

Strengthen capacity for reporting Vital Statistics	Training of personnel/staff and end users on the system.	54	54	0	0	0	107
	Review VA indicators	0	0	0	0	5	5
Scale up development/ maintenance and us of data warehousing systems	Maintenance and regular updating of the KHRIO	8	8	8	8	8	40
	Develop cross system analytics systems (e.g Data Service Layer)	6	0	0	0	0	6
Scaling up of Community health reporting	. Developing the electronic Community Health Information system (eCHIS)	21	0	0	0	0	21
	Integrate the Verbal Autopsy into the eCHIS	0	3	0	0	0	3
	. Capacity building of the CHWs,CHEWs and CHVs	61	61	61	61	61	303
	Infrastructure provision	1,200	0	0	0	0	1,200
Setting up Cancer Registries in Kenya	Developing the electronic Cancer Registry system	0	0	0	21	0	21
	Integrate the Cancer Registries into KHIS	0	0	0	0	25	25
	Capacity building of the Health workers	12	12	12	12	12	60
	Infrastructure and connectivity	0	0	0	8	0	8
		0	0	0	0	0	0
Grand total		1,520	390	369	681	322	3,282

Capacity Area 10: Provides for Routine Supervision and Quality Auditing

Interventions	**Activities**	**2020|2021**	**2021|2022**	**2022|2023**	**2023|2024**	**2024|2025**	**Total (Ksh)**

Establish a comprehensive health information data validation mechanism	Develop a comprehensive health information data validation framework (paper and digital)	0	0	15	0	0	15
	Disseminate the comprehensive health information data validation framework	0	0	0	0	5	5
	.Conduct quarterly data review meetings	30	30	30	30	30	150
Institutionalize Data quality Audits at all levels	Conduct annual national Integrated data quality audits including TB HIV ,Malaria and RMNCAH	16	16	16	16	16	16
	Disseminate DQA findings in all counties	30	30	30	30	30	149
Revise and disseminate the DQA protocol	Revise the DQA protocol	3	0	0	0	0	3
	Disseminate the DQA protocol	37	0	0	0	0	37
	.Develop and carry out an assessment of the implementation and institutionalization of the DQA protocol	0	0	195	0	0	195
	Conduct Annual NHIS system cleaning	9	9	9	9	9	44
Establish Mechanisms to safeguard Data integrity and security	Develop a code of practice to ensure that standards of confidentiality are maintained without impeding data dissemination.	3	0	0	0	0	3
	.Establish a data archiving mechanism for long-term safeguarding of records	0	5	0	0	0	5
Institutionalize Support supervision at all levels	Develop a Support supervision framework	0	0	6	0	0	6
	Conduct Support supervision	0	0	0	3	0	3
	Grand total	126	89	300	87	89	629

Capacity Area 11: Invests in Evaluation and Research

Interventions	Activities	2020|2021	2021|2022	2022|2023	2023|2024	2024|2025	Total (Ksh)
Mapping of research needs	Carry out systematic reviews and documentation on priority health topics	8	8	8	8	8	38
	Landscape mapping of all research and publications	21	0	0	0	0	21
	Develop a National research agenda-	8	0	0	0	8	15
Capacity development in research	Train health workers on evidence use in policy and strategy development	29	29	29	29	29	143
	Develop Research protocols annually	13	13	13	13	13	66
	Develop a National research Evaluation plan	4	0	0	0	0	4
Grand Total		83	49	49	49	57	288

Capacity Area 12: Promotes Widespread Data Demand and Information Use

Interventions	Activities	2020|2021	2021|2022	2022|2023	2023|2024	2024|2025	Total (Ksh)
Institutionalize performance reviews at all levels	Update and disseminate performance reviews guidelines	4	0	0	4	7	14
	Perform biannual performance review meetings at national level	7	7	7	7	7	36
	Perform quarterly performance review meetings at sub-county and county level	19	19	19	19	19	93
	Perform Annual performance review Forums at 10 regional blocks	0	0	0	0	11	11
	Perform National Annual performance review Forums	0	0	0	11	0	11
	Conduct Joint review missions to validate reports-	18	0	18	0	18	55

Strengthen institutional capacity for comprehensive analysis	Develop an analysis framework, and guidelines	5	0	0	0	0	5
	Enhance the analytical capacity for optimal use of DHIS	11	11	11	11	11	53
	Thematic Dashboard development	0	9	0	0	0	9
	Develop mechanisms to increase access and use of thematic Dashboards	0	0	3	0	0	3
	Enhance the capacity of the Kenya Health Observatory as a one stop shop for current data and Statistics on Health	11	0	0	0	0	11
Streamline use of data in policy development, monitoring and evaluation	Make an inventory of relevant guidelines and policies, and develop a strategy to monitor implementation of these policies	0	0	0	0	4	4
	Operationalize the guidelines for evidence use in policy making	0	6	0	0	0	6
	Develop a framework to monitor and evaluate policy implementation	5	0	0	0	0	5
	Consolidate best practices & innovations in the sector	4	4	4	4	4	20
Grand Totals		83	55	62	55	81	335

ANNEX 3
Some Budget assumptions

Item	**Cost (KSHS)**	**Assumption Notes**
Fuel	45 liter per km	Per Kms Ref AA rates inclusive of minor repairs
Transport refund		
Within counties	2,000	round trip
Within Sub counties	1,000	round trip

Across Counties	4,000	round trip
CHVs transport	1,000	round trip
Special counties (hard to reach areas)		
Within counties	3,000	round trip
Across Counties	10,000	round trip
Flights - Domestic	30,000	return
Flights - International	200,000	return
Airport transfer	7,000	return
Full board		
Cities	15,000	per person per day (KCB rate)
Towns	10,000	per person per day (NCE Machakos
Others	8,000	per person per day
Conference Package		
cities	5,000	per person per day
towns	4,000	per person per day
others	3,000	per person per day
Stationary	250	per head
Stationary (Inclusive of certificates)	500	per person
Refreshments office meetings	500	per person
Lunch Office meetings	1,500	per person
Hall Hires, PAS and LCD		
Hall hire Cities	10,000	per day
Hall hire Towns	5,000	per day
Hall hire others	3,000	per day

LCD Hire	5,000	per day
PAS	5,000	per day
Per diems		
Per Diem for meetings		
Cities	14,000	Job group "P"
towns	10,500	Job Group "P"
Others	8,400	Job Group "P"
Per Diem for surveys/ implementation at sub counties		
Cities	11,200	Job group "N"
towns	8,400	Job Group "N"
Others	7,000	Job Group "N"
CHVs stipend	2,000	per month
Driver per diem (City)	6,300	H
Driver per diem (Town)	4,900	H
Driver per diem (Others)	4,200	H
Meal Allowance		
Breakfast	2,100	Job Group "P"
Lunch	2,800	each Job Group "P"
Dinner	2,800	each Job Group "P"
Driver Lunch (City)	1,260	Job Group H
Driver Dinner (City)	1,260	Job Group H
Driver Breakfast (City)	945	Job Group H
Lunch CHVs	500	per person per day
Communication		

Communication (fieldwork)	1,000	Per person per day (max 5 days)
Communication for coordination - Airtime, Internet data	5,000	For everything for planning and coordination per meeting
Consultancy		
National (in-country)	35,482	per day (WHO/PMI rates)
Regional Blocs	50,688	per day (WHO/PMI rates)
International	70,963	per day (WHO/PMI rates)
TV commercials production	5,000,000	per set (one off)
Radio spot production	350,000	per production
Airing of TVC (30 Seconds)	150,000	per spot
Airing Radio spots (30 seconds)	40,000	per spot
TVCs and Radio spot monitoring	250,000	Per month
Print message development	150,000	consultant
CD-Rom production	200	per CD

ICT INFRASTRUCTURE FOR END TO END DIGITAL HEALTH SOLUTION FOR LEVEL 2,3, 4 AND 5 FACILITIES					
Activity Detailed Description	**Budget Item**	**Unit/service points**	**Unit cost@**	**Total Cost KSH**	**Total Cost USD**
Procurement of Computers(Level 2 and 3	Desktop Monitors(for all service points)	49,753	15,000	746,295,000	7,316,618
	Think Client Technology	49,753	20,000	995,060,000	9,755,490
	Tablets for Incharges and Doctors (20 per Hospital)	5,559	12,000	66,708,000	654,000
				1,808,063,000	**17,726,108**

Procurement of Computers(Level 4 and 5)	Desktop Monitors(for all service points)	18,370	15,000	275,550,000	2,701,471
	Think Client Technology	18,370	20,000	367,400,000	3,601,961
	Tablets for In charges and Doctors (20 per Hospital)	3,510	12,000	42,120,000	412,941
Networking(Level of Level 4 and 5)	Cabling(Per/upto a Service point)	18,370	15,000	275,550,000	2,701,471
	Mini Server	351	50,000	17,550,000	172,059
	Power backup	351	20,000	7,020,000	68,824
	Mini Router	351	20,000	7,020,000	68,824
	Mini Switch	351	50,000	17,550,000	172,059
	AC	351	40,000	14,040,000	137,647
	rack	351	30,000	10,530,000	103,235
	Security(Grilling of server room)	351	30,000	10,530,000	103,235
Visualization of 47 County HUB's to support the solution(In line with Vision 2030 ICT flagship project)	Sever	47	900,000	42,300,000	414,706
	UPS	47	50,000	2,350,000	23,039
	Router	47	100,000	4,700,000	46,078
	Switch	47	150,000	7,050,000	69,118
	Laptops	47	80,000	3,760,000	36,863
	Firewall	47	350,000	16,450,000	161,275
	AC	47	100,000	4,700,000	46,078

	rack	47	80,000	3,760,000	36,863