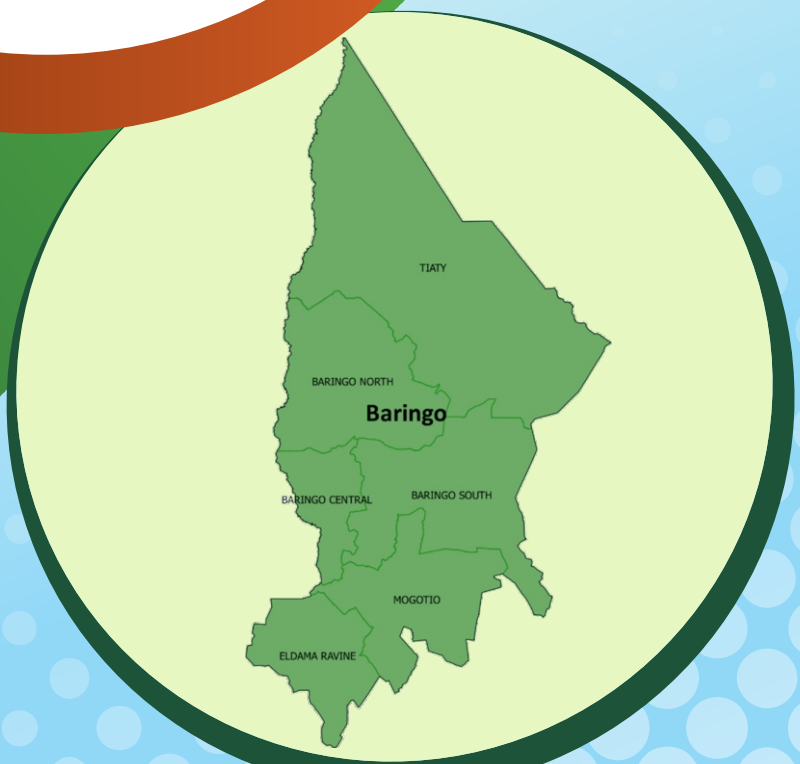
BARINGO COUNTY GOVERNMENT
DEPARTMENT OF HEALTH SERVICES

Monitoring and Evaluation Plan 2019 -2023



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ABBREVIATIONS/ACRONYMS

ANC	Antenatal Care
ART	Anti-Retroviral Treatment
AWP	Annual Work Plan
BEmONC	Basic Emergency Obstetrics and Newborn
CEmONC	Comprehensive Emergency Obstetrics and Newborn Care
CECM	County Executive Committee member
CASCO	County AIDS and STIs/STDs Coordinator
CCC	Comprehensive Care Centre
CDC	Centre for Disease Control and Prevention
CDSC	County Disease Surveillance Coordinator
CECM	County Executive Committee Member
CIDP	County Integrated Development Plan
CDOH	County Department of Health
CHEW	Community Health Extension Worker
CHMT	County Health Management Team
CHRIO	County Health Records Information officer
CHSSP	County Health Sector Strategic Plan
CHW	Community Health Worker
CHV	Community Health Volunteer
CMLAP	County Measurements Learning and Accountability
COH	Chief Officer of Health
CRHC	County Reproductive Health Coordinator
CTLC	County TB Lung and Leprosy Diseases Coordinator
CTLS	Community Led Total Sanitation
CWC	Child Welfare Clinic
CU	Community Units
DDIU	Data Demand and Information Use
DHIS	District Health Information System
DQA	Data Quality Assurance
EMMS	Essential Medicines and Medical Supplies
FANC	Focused Ante Natal Care
FBO	Faith Based Organizations
FY	Financial Year
GBV	Gender Based Violence
GOK	Government of Kenya
HCW	Health Care Worker
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HRH	Human Resources for Health
HRIS	Human Resources Information Systems
HTS	HIV Testing Services
ICD-10	International Classification of Diseases, 10th revision
ICU	Intensive care Unit
IDSR	Integrated Disease Surveillance and Response
IEBC	Independent Electoral and Boundaries Commission

IEC	Information, Education and Communication
IFMIS	Integrated Financial Management Information System
IMCI	Integrated management of childhood illness
IT	Information Technology
KDHS	Kenya Demographic Health Survey
KEMSA	Kenya Medical Supplies Authority
KNPHC	Kenya National Population and Household Census
KNBS	Kenya National Bureau of Statistics
LAN	Local Area Network
LLITN	Long Lasting Insecticide Treated Nets
LMIS	Logistical Management Information System
MDA	Mass Drug Administration
M&E	Monitoring and Evaluation
MEDS	Mission for Essential Drugs Supply
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NCDs	Non-Communicable Diseases
NHIF	National Hospital Insurance Fund
PHO	Public Health Officer
PMTCT	Prevention from Mother to Child Transmission
QI	Quality Improvement
RDQA	Rapid Data Quality Assurance
RMNCAH	Reproductive, Maternal Neonatal Child and Adolescent Health
SCHMT	Sub-County Health Management Team
SCHRIO	Sub-County Health Records and Information Officer
SCMOH	Sub-County Medical Officer of Health
SCPHO	Sub-County Public Health Officer
SDGs	Sustainable Development Goals
SOP	Standard Operating Procedure
SWOT	Strengths Weaknesses Opportunities and Threats
TB	Tuberculosis TWG Technical Working Group
UHC	Universal Health Coverage
USAID	United States Agency for International Development
WASH	Water Sanitation and Hygiene
WHO	World Health Organization

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FOREWORD

The County Government of Baringo aspires to have an attractive, competitive and resilient county health system. As such it is committed to improving the health status of the citizens through provision of quality, affordable, accessible healthcare services. It is therefore imperative that the county government's plans and interventions are monitored regularly and evaluated periodically to assess progress, identify shortcomings and most importantly make necessary adjustments for improvement. A sound Monitoring and Evaluation (M&E) framework is crucial for the success of county health service delivery.

This M&E plan has been developed to provide for an elaborate process of tracking progress of implementation of key health sector interventions. It links the outcomes sought with the inputs and processes that the county government and stakeholders are investing in towards improving health services in the county. It will also ensure that the indicators, their definitions, means of data collection and measurement are comparable over time. The plan also seeks to enhance coordination of stakeholders in monitoring and evaluation of the county health sector strategic plan for the period 2019-2023, by outlining structures and responsibilities for the various stakeholders.

The M&E plan has been informed by the situational analysis undertaken during the development of the County Health Sector Strategic plan as well as the assessment of County Health M&E system undertaken during the baseline assessment supported by the USAID's Tupime Kaunti Project. Capacity strengthening of the county health M&E system has been identified as a priority and M&E strengthening interventions are included this plan.

I wish to call upon the county health stakeholders to support the county government in implementing this plan to fruition.

Hon. Mary Panga
County Executive Committee Member for Health Services
Baringo County

EXECUTIVE SUMMARY

The County Health Monitoring and Evaluation (M&E) Plan is a significant step aimed at strengthening the M&E capacity among other series of interventions in the Baringo County Health Sector. The County Government of Baringo underscores the crucial role of a robust M&E system in generating useful information for decision making, measuring performance and fostering learning. The M&E plan will facilitate the application of a harmonized approach in tracking performance across all programs within the health sector in the county. This will ensure that the programs contribute to the overall desired results articulated in the Strategic Plan and the County Integrated Development Plan (CIDP). The County Government envisages that M&E will be integrated into the daily work of the county staff as well as other stakeholders. In this way, M&E systems will enable generation and sharing of data and information, thus promoting greater accountability and continuous learning.

The development of this M&E Plan for the County Health Sector Strategic Plan is to underscore the need to establish a robust monitoring and evaluation platform that provides information to all stakeholders for planning and evidence-based decision making. This is also in line with the requirements of the Constitution of Kenya 2010 in terms of advancing rights to health and information and accountability in service delivery. Legislations including the County Government Act 2012 and Public Financial Management Act 2012, the Health Act, 2017, Inter-Governmental Relations Act 2012 do also affirm the requirements for monitoring and evaluation in entrenching accountability through establishment of appropriate systems for data collection, reporting, information sharing, and feedback. Similarly, health sector policies including the Kenya Health Policy (2014 - 2030) and the (HIS) Health Information System Policy stipulates specific requirements and provide guidance on strengthening accountability mechanisms.

This plan is informed by the M&E situational assessment of situation in Baringo County Health Sector. The M&E plan is therefore designed to provide a common platform for the health sector performance monitoring and evaluation by guiding all actors at the county, sub-county, facility and community levels. It envisages that the County will build capacity of existing workforce in data management and information use at all levels for better planning and decision making. This is evident in the Department as it has shown increased commitment to a single unified HIS by developing or adopting key HIS/ M&E policies. Further, it will enhance the health sector coverage of outcomes and investments at all levels by applying impact indicators, outcome indicators, process indicators, and input indicators.

The plan lays out specific measures for data collection, analysis, and reporting. In addition, it

provides guidance on how the county health sector will carry out regular performance monitoring at the facility level, sub-county level and county level. The M&E plan provides a detailed analysis of the M&E audience information requirements to facilitate effective and responsive data collection and reporting procedures. These are anchored on a countywide health strategic M&E logical framework that illustrates the causal chain of inputs/processes, outputs and outcomes that ultimately lead to the achievement of overall goal in County Health Sector Strategic Plan. The indicators selected are elaborated in terms of definitions, data sources, frequency of collection and responsible persons for collection, in line with the guidance provided in the national health sector indicators and standards operating procedures manual. Further, a schedule of reporting considerations and requirements has been included to facilitate timely and accurate reporting. The M&E plan has an elaborate evaluation plan that provides for various evaluations to be undertaken during the implementation of the CHSSP.

To facilitate effective implementation of this M&E plan, institutional arrangements that support accountability at all levels of the county health system and embed alignment to the national M&E system and countywide M&E system will be enabled. Specifically, appropriate stakeholder coordination structures including a stakeholder coordination steering committee and M&E Technical Working Group need to be strengthened. Further, the need for formation of M&E unit at the health department and strengthening with a budget and human resources to support the effective delivery of M&E activities.

1.0 INTRODUCTION

1.1 County Health Sector

Baringo County is situated in the Rift Valley Region and shares borders with eight counties namely: West Pokot to the North West, Turkana to the North, Samburu to the North East, Laikipia to the East, Nakuru to the South, Kericho and Uasin-Gishu counties to the South West, and Elgeyo-Marakwet to the West. The county has a geographical area of 11,015 square kilometres and is administratively divided into seven (7) sub-counties, 30 wards and 116 locations.

The county has three lakes that account for 165 square kilometres of the surface area - Lake Baringo, Lake Bogoria and Lake Kapnarok. Other prominent geographical features in the county include: the Kerio Valley, Loboi Plain, Tugen Hills, several rivers and escarpments. The primary economic activity in the county is livestock keeping. There is also a considerable level of bee keeping, honey harvesting, crops farming, tourism and mining.

In terms of health sector performance, Baringo County has registered progress in health system investments since the establishment of the county department for health services. However, performance of key indicators in comparison to national averages is mixed. Life expectancy for Baringo citizens is equivalent to the national estimates. Infant mortality, under five mortality and maternal mortality rates for the county are slightly higher than the national averages. Similarly, the indicators for deliveries under skilled health workers, latrine coverage and contraceptive prevalence are slightly worse than national averages. The county scores better than national averages in terms of prevalence of communicable conditions - HIV, Malaria and TB. Table 1 summarises the estimates for key indicators for health.

Table 1 : Key Indicators in Health

Impact Level Indicators	National Estimates	County Estimates
Life Expectancy at birth (years)	59	58
Neonatal Mortality Rate (per 1,000 births)	22	31
Infant Mortality Rate (per 1,000 births)	39	62
Under 5 Mortality Rate (per 1,000 births)	52	60
Maternal Mortality Rate (per 100,000 births)	362	374
County latrine coverage	51%	43%
Open Defecation Rate	14%	70%
Immunization Coverage	68%	69%
% of deliveries by skilled attendants	61%	54%
Contraceptive Prevalence	40%	31%
HIV Prevalence	4.8%	1.3%
Malaria (as % of all 1st outpatient visits)	27.7%	11.8%
TB Prevalence (in every 10,000 persons)	39	6

1.2 County Monitoring and Evaluation for Health

Monitoring and Evaluation together with operational research, measures the overall performance of a programme or project and continuously evaluates achievements in targeted results. Monitoring refers to the routine tracking of key elements selected to determine programme performance through record keeping, regular reporting, supportive supervision, surveillance systems and periodic surveys. It also entails assessing whether the implementation of the planned activities is consistent with the programme design through generating data on inputs, processes and outputs of an on-going programme over time.

On the other hand, evaluation refers to the periodic assessment of the change in targeted results that can be attributed to an intervention. It links outcome or impact directly to an intervention over time. Evaluation entails systematic use of quantitative and qualitative research methods to investigate the programme's effectiveness, efficiency, relevance, sustainability and impact to determine the extent to which investments made yield expected results.

The need to have systems that support accountability to the citizens, is entrenched in the Constitution of Kenya, 2010 and various legislations such as the County Government Act, 2012; the Public Financial Management Act, 2012, Intergovernmental Relations Act, 2012 and sector specific legislation like the Health Act, 2017. As such the establishment of robust monitoring and evaluation system to support the county health sector is a critical ingredient for achievement of the desired level of accountability.

County governments are required to have elaborate plans laying out their agenda for the medium term and sectoral plans that articulate the sectoral agenda. Baringo County Government has put in place a County Integrated Development Plan for the period 2018-2022 and has a draft County Health Strategic Plan (CHSSP) 2018–2022. To ensure close monitoring of the progress of implementation of health sector strategic plan, and thus drive the path to attainment of overall health goal, the county government has put in place this M&E plan. The M&E plan outlines data needs, indicators, sources of data, data collection methods and data flow, analysis, use and reporting, feedback as well as the responsibilities of the various health stakeholders. This is in response to critical gaps identified in the County Health M&E systems that include: ineffective coordination, sub-optimal utilisation of data in decision making, inadequate physical infrastructure; inadequate personnel, inadequate supply of data collection and reporting tools and equipment, knowledge gaps in data management, research and evaluation; insufficient funding and limited use of information technology.

1.3 Purpose of the M&E Plan

This plan will also facilitate the institutionalisation of the M&E principles and practices in support of decision making and adaptive learning, planning and management across all the programs implemented by the County Health Sector. The overall purpose of this M&E plan is to facilitate the tracking of the progress of implementation of the County Health Sector Strategic Plan for the period 2018-2022.

The plan is expected to serve as a vital tool for timely and systematic data collection, analysis and reporting with the overall goal of improving performance and accountability to stakeholders.

Specifically, the Monitoring and Evaluation plan will support to:

a) Build coherence in the approach to systematically track performance across county health programs and ensuring that they contribute to the overall goal reflected in the County Health Sector Strategic Plan 2018-2022.
b) Define the data requirements (collection, sources, tools, collation, analysis) and assign responsibilities for effective tracking of interventions implemented at all levels.
c) Document progress and enhance performance through continuous learning, sharing and improvement.
d) Provide reporting requirements including reporting formats needed to promote timely reporting both within the county and externally to national government, partners and donors.
e) Define data feedback mechanisms and utilisation for decision making internally and among stakeholders.

1.4 Process of Development

This M&E plan was developed through a participatory and consultative process that enabled obtaining and synthesis of inputs from the county health department, county department of economic planning, implementation partners and other stakeholders.

Specifically, the approach applied included the following:

a) Desk review of relevant national and county documents.
b) Consultative meetings with senior management of the County Department of Health Services, program managers and M&E focal persons, sub-county teams, representatives of implementation partners. The process also relied on the baseline assessment of Measurements, Learning and Accountability systems undertaken in November and December 2018.
c) Consultations with the County Health M&E Technical Working Group and partners.
d) Technical workshop to review the status of county health M&E and formulate this plan.
e) Final draft review and validation meeting.

2. STRATEGIC M&E FRAMEWORK

2.1 Overall Objective

This section outlines the framework for coordinated, systematic and holistic tracking of progress in the county health sector. The framework is informed by the need to comprehensively monitor, and review programs within the county health sector. The framework for analysis is based on the M&E Logical Framework that depicts how inputs lead to outcomes and eventually desirable impact. It is intended to ensure that all indicator areas -inputs, processes, outputs, outcomes– are considered, and pathways of influence clarified in the analysis.

2.2 Strategic Framework for County Health Monitoring and Evaluation

The logical framework anchors the key objectives of the M&E plan in a snapshot. It describes briefly types of data and data sources, and how data will flow from the source to the central repository and to all relevant stakeholders; provides standard indicators, targets, frequency of reporting in a standard format for all county health implementers and stakeholders; provides guidance on the routine and periodic documentation of planned activities and measures expected outputs and outcomes when due; identifies implementation arrangements with clear responsibility centres; identifies and costs key actions that will enable smooth implementation of this plan.

Figure 1: M&E Logical Frame work

	Inputs and Processes			Outputs	Outcomes	Impact
Indicators domains	**Health Workforce** **Health Information** **Financing** **Leadership & governance**	**Health Infrastructure & Equipment**	**Essential Health Products & Technologies**	**Intervention access & services readiness** **Intervention quality, safety and efficiency**	**Coverage of interventions** **Prevalence risk behaviours and factors**	**Improved health outcomes and equity** **Social and financial risk protection** **Responsiveness**
Data Sources	**Administrative Sources** iHRIS, IPPD, IFMIS, budget Implementation reports, Infrastructure reports, supply chain reports, policy tracking reports			**Facility Assessments** Service Availability and Readiness	**Population-based surveys** Coverage, health status, equity, risk protection, responsiveness	
				Clinical Reporting Systems Service readiness, quality, coverage, health status		
						Vital registration
Analysis & Synthesis	**Data Quality Assessment Estimates and Projections, In depth studies and surveys, Assessments for progress and performance of health systems**					
Data dissemination & Information use	**Targeted and comprehensive reporting, regular county review processes, national reporting, county learning forum, stakeholders' forums for health**					

The county health sector will apply this framework to strategically focus on an integrated M&E approach that allows for continuous effective, efficient and economic use of resources; continuous learning through sharing of information for decision making in health.

2.3 Framework for County Health M&E

The following indicators will be applied in monitoring performance of the county health sector. Detailed table of indicators with definitions, data source, reporting frequency, level of measurement, responsibility, baseline year and values, and targets and specific comments is included in Appendix I

Table 2: Logical Framework for Baringo County Health Services

Strategic target	Inputs	Processes	Outputs	Outcome	Impact
Objective 1: To Reduce Non -Communicable Diseases					
Increase immunization coverage from 60% to 75% by 2022	• Vaccine doses acquired • Immunization equipment (cold chain) • Immunization information, education and communication (IEC) materials • Training and capacity building for health care providers • Outreach services	• Updating/training of health care workers on immunization policies and guidelines • Availing vaccines • Redistribution and Maintenance of cold chains • Opening of new immunization sites • Conducting outreaches on immunization (reach every child) • Sensitization of community units on immunization policies and guidelines • Conduct defaulters tracing • Conducting stakeholders' forums on immunization • Conducting quarterly data review meetings on immunization	• Number of children fully immunized • Number of facilities providing immunization • Number of community units sensitized • Number of HFs with functional cold chain • Number of health workers updated on immunization guidelines • Number of immunization defaulters traced	• Proportion of children below the age of one year who are fully immunized • % of health facilities offering immunization services	Reduction in morbidity and mortality due to vaccine preventable diseases

Strategic target	Inputs	Processes	Outputs	Outcome	Impact
Increase the percentage of TB patients completing treatment from 81% to 90% in 2022	• Finances • Provision of TB policies and guidelines • TB drugs • Gene Xpert machines •	• Updating/training of health care workers on current TB policies and guidelines • Sensitization of community units on TB policies and guidelines • Conducting quarterly data review meetings • Conducting TB stakeholders' forum • Defaulter tracing • Active case finding	• Number of health care workers and community health volunteers trained / updated on TB policies and guidelines • Number of community dialogue/action days conducted • Number of TB patients completing treatment • Number of newly diagnosed TB cases • Number TB sample s tested by Gene xpert	• TB treatment success rate • TB cure rate	Reduction in mortality
Increase the percentage of HIV+ pregnant mothers receiving preventive antiretroviral (ARVs) from 72% to 100%	• Finances • HAART availability • Skilled workforce • Infrastructure and equipment	• Conduct awareness on PMTCT • Conduct supervision, procure supplies and conduct training • Tracing of ART defaulters • Tracking of ART stocks availability	• Number of HIV outreaches conducted • Number of supplies procured and distributed • Number of HCWs reached with mentorship and OJT during supportive supervisions and training	• Proportion of health facilities without stock outs • Proportion of ART defaulters traced • Proportion of pregnant mothers receiving ART • % of reduction of MTCT	Reduction in mortality
Increase the percentage of HIV+ clients on ARVs from 76% to 100%	• Finances • Supplies and equipment • IEC materials on HIV/AIDS • HAART availability • Skilled workforce	• Tracing of ART defaulters • Tracking of stock outs • Updating/training of HIV testing services (HTS) providers on treatment guidelines • Sensitization of community units on HIV/AIDS policies and guidelines • Conducting quarterly HIV/AIDS meetings • Conducting HIV/AIDS stakeholder forum	• Number of HTS providers trained / updated on HIV management guidelines • Number of community units sensitized on HIV/AIDS policies and guidelines • Number of ART defaulters traced • Number of eligible HIV clients on ARVs	• Proportion of ARV defaulters traced • Proportion of HIV clients eligible initiated on ARVs •	Reduction in Mortality

Strategic target	Inputs	Processes	Outputs	Outcome	Impact
Increase testing for malaria suspected cases from 64.9% to 100%	• Finances • Availability of diagnostic kits	• Sensitization of health care workers and community health volunteers on malaria management • Availability of diagnostic reagents and kits	• Number of suspected malaria cases testing positive • Number of confirmed malaria cases treated	• Malaria Test Positivity Rate	Reduction in mortality due to malaria
Reduce the burden of diarrhea illnesses in under 5s from 21% to 11% in 2022	• Skilled human resources • IEC materials • Available funds • Availability of commodities (ORS & Zinc)	• Conduct outreaches • Conduct training, • Procure supplies, • Community sensitization and dialogues • Conduct supportive supervision. • Provision of Handwashing facilities	• Number of community outreaches conducted • Number of supervisions conducted • Number of health care workers (HCWs) and CHVs trained	• Proportion of under 5 children diarrhea cases treated	Reduction in under 5 mortality
Increase the proportion of school age children (6-14 years) de-wormed from 19% to 41% in 2022	• Skilled human resources • IEC materials • Available funds for school health program • Drugs availability	• Conduct school health outreaches • Conduct training, • Procure supplies, • Community sensitization • Conduct supportive supervision	• Number of outreaches conducted • Number of supervisions conducted • Number of health care workers (HCWs) trained • Number of schools implementing school health program	• Proportion of school going children dewormed	Reduction in morbidity and mortality from childhood illness
Objective 2:To Halt, and Reverse Burden of Non -Communicable Conditions					
Reduce the proportion of adult population with Body Mass Index (BMI) above 25 from baseline of 141 per population of 100000 to 191	• Human resources, equipment • Documentation tools, • Logistics	• Develop health promotion package on healthy lifestyle, • Conduct mass screening, • Regulate/ enact/enforce laws that govern food markets, • Establish recreation centers • Outreaches • Supportive supervision • Data review meetings focusing on NCDs	• Number of mass screenings conducted • Number of adult OPD clients with BMI of more than 25	• % reduction in adult population with BMI over 25	Reduction in mortality associated with lifestyle diseases

Strategic target	Inputs	Processes	Outputs	Outcome	Impact
Increase proportion of women of reproductive age screened for cervical cancers from baseline of 979 per 100,000 to 1,200	• Partners supporting the cervical cancer screening program • Updates on cervical cancer screening, management and referral policies and guidelines • Availability of health commodities	• Updating/training of health care workers on cervical cancer screening, management and referral • Updating community health volunteers on cervical cancer advocacy and referral • Procurement and distribution of cervical cancer diagnostic equipment and commodities • Conducting stakeholders' forum • Conducting quarterly cervical cancer data review meetings	• Number of health care workers (HCWs)trained / updated on cervical cancer screening, management and referral • Number of community health volunteers sensitized on cervical cancer screening and referral procedures • Number of women of reproductive age (WRA) screened for cervical cancer	• Reduced cancer prevalence • Percentage of women of reproductive age screened for cervical cancers	Reduction in mortality
Reduce proportion of new outpatients with mental health conditions by half	• Skilled human resources, • documentation tools • IEC materials • Mental health infrastructure	• Establish mental health units in high volume sub-county hospitals	• Number of mental health centers providing outpatient services • Number of new outpatients with mental health conditions	• Proportion of mental health conditions managed • Proportion of new outpatients with mental health conditions	Reduction in mortality
Reduce proportion of new outpatient cases with high blood pressure by half	• Skilled human resources, • Documentation tools, • Logistics (Blood Pressure kits availabilit)	• Create awareness of the risk of hypertension and the importance of regular checkups; • Conduct mass screening	• Number of outreaches • Number of new outpatients found with high blood pressure	• Proportion of new outpatients with high blood pressure • Proportion of hypertension cases managed	Reduced high blood pressure cases
Reduce proportion of patients admitted with cancer by half	• Skilled human resources, • Documentation tools, • Equipment for cancer screening	• Procure the medical equipment for screening • Supply of drugs • Outreaches	• Number of patients admitted with cancer • Number of eligible facilities offering cancer screening • Number of facilities reporting stock-out of cancer drugs	• Proportion of cancer cases managed • Percentage of patients admitted with cancer	Improvement of wellbeing and life expectancy Reduction in mortality

Strategic target	Inputs	Processes	Outputs	Outcome	Impact
Objective 3 : To Reduce the Burden of Violence and Injuries					
Reduce the proportion of outpatient cases attributed to gender-based violence by 50%	• Partnerships • Skilled workforce • Sensitization on sexual and gender- based violence management and referral policies and guidelines	• Updating/training of health care workers on the sexual and gender- based violence program • Updating community health volunteers on SGBV advocacy and referrals • Upgrading health facilities so offer SGBV related services • Data review and improvement	• Number of health care workers sensitised on SGBV management and referrals • Number of community health volunteers sensitised on SGBV advocacy and referrals • Number of health facilities offering services related to GBV • Number of new outpatient cases attributed to gender-based violence	• Reduced GBV related morbidity and mortality cases • Proportion of new outpatient cases attributed to gender-based violence	Reduction in mortality and morbidity associated with GBV
Reduce the proportion of outpatient cases attributed to road traffic injuries by 50%	• Skilled human resources, • Advocacy and enforcement of traffic rules, infrastructure and medical supplies • intersectoral collaboration/partnerships	• Engagement of road traffic partners through health stakeholder forum • Continuous advocacy through IEC/ BCC materials • Training of staff on accidents and emergencies care	• Number of staff trained on emergencies care • Number of facilities offering accident and emergency services • Number of new outpatient cases attributed to road traffic accidents	• Reduction in the number of deaths and disabilities due to road traffic accidents • Proportion of outpatient cases attributed to road traffic injuries	Reduce mortality and morbidity related to RTA
Reduce the proportion of new outpatient cases attributed to other injuries from 2.4% to 1.2% in 2022	• Skilled human resources • Advocacy • Enforcement of rules • Intersectoral collaboration	• Community sensitization • Law enforcement • Stakeholder forum • Peer learning forum • Data review meeting	• Number of community sensitization meetings held • Number of new outpatient cases attributed to other injuries	• Reduced morbidity and mortality from other injuries • Proportion of new outpatient cases attributed to other injuries	Reduce mortality and morbidity related to other injuries

Strategic target	Inputs	Processes	Outputs	Outcome	Impact
Reduce deaths due to injuries from 50% to 20% by 2022	• Ambulance services • Emergency Rescue Services • Skilled workforce • Equipment maintenance	• Upgrade county referral hospital to have ICU facilities • Equip county ambulances • Conduct training on emergency care	• Number of county health facilities with capacity to handle emergencies • Number of functional and fully equipped ambulances • Number of patients with injury related conditions dying in the county health facilities	Reduced mortality due to injuries	Reduce mortality and morbidity related to other injuries
Objective 4: To Provide Quality Essential Health Service					
Increase the proportion of deliveries conducted by skilled attendants from 41% to 66% by 2022	• Guidelines and standard operating procedures (SOPs) • Emergency obstetric and new-born care (EmONC) checklist • Comprehensive emergency obstetric and new-born care (CEmONC) checklist • IEC materials • Skilled workforce • Financing	• Training of health workers • Assessment of health facilities' EmONC readiness • Expansion of facilities infrastructure and equipment • Supportive supervision • Community mobilization • Distribution of IEC materials	• Number of health care workers trained on EmONC • Number of facilities offering EmONC • Number of facilities offering CEmONC • Number of community units that are sensitized • Number of deliveries conducted by skilled attendants in health facilities	• Proportion of deliveries conducted by skilled attendants • Reduced maternal and perinatal deaths	Reduce infant and maternal mortalities related to deliveries

Strategic target	Inputs	Processes	Outputs	Outcome	Impact
Increased the proportion of pregnant women attending at least four antenatal care visits from 33.6% to 51.6%	• Skilled human resource, • equipment • Infrastructure • IEC Materials	• Capacity building of health workers in focused antenatal care (FANC) • Community advocacy and mobilization on FANC • Procurement of health commodities • Strengthening referral system • Distribution of IEC materials	• Number of HCWs whose capacity in FANC has been built • Number of community units mobilized and sensitized on FANC • Number of pregnant women attending at least four ANC visits	• Increased uptake of ANC visits • proportion of pregnant women attending at least four antenatal care visits	Reduce maternal &child mortality,
Increase the Percentage of women of reproductive age receiving family planning from 36.3% to 51.3% by 2022	• Training curriculum • Family planning commodities and equipment • Guidelines and SOPs • IEC materials	• Training of health workers on current FP methods • Supportive supervision • Community awareness • Distribution of IEC materials	• Number of health care workers (HCWs) trained in current FP methods • Number of community units that are sensitized • Number of WRA receiving family planning commodity	• Increased uptake of family planning services • proportion of women of reproductive age receiving FP commodities	Reduce Maternal mortality,
Reduce Percentage of facility based maternal deaths from 0.028% to 0% by 2022	• Partnerships for reproductive health • Skilled workforce • Documentation • MPDSR Committees	• Capacity building of health workers • Maternal death audits at all levels • Community mobilization • Strengthen referral system • Distribution of IEC materials • Data reviews	• Number of HCWs whose capacity has been built • Number of maternal deaths • Number of maternal death audits conducted • Number of verbal autopsies conducted at the community level • Number of community units sensitized • % of maternal deaths reviewed and uploaded on DHIS	• Reduced facility based maternal mortality • Maternal case fatality rate	Reduce Maternal mortality

Strategic target	Inputs	Processes	Outputs	Outcome	Impact
Reduce the Percentage of new-borns with low birth weight from 5.2% to 4.9% by 2022	• IEC materials • Heath commodities supply	• Capacity building of health care workers in newborn health • Community advocacy and mobilization on newborn health • Procurement of health commodities • Strengthen referral system • Distribution of IEC materials	• Number of HCWs trained on new-born health • Number of community units mobilized and sensitized on new-born health • Number of health facilities with stock out of essential heath commodities	• Reduced newborns with low birth weight • Percentage of new-born with low birth weight	Reduce infant mortality
Reduce the Percentage of facility-based fresh still births from 1.16% to 0% by 2022	• IEC materials • Heath commodities supply	• Capacity building of health workers in management of labour and delivery • Community advocacy and mobilization on at least 4 antenatal care (ANC) visits • Procurement of health commodities • Strengthen referral system • Distribution of IEC materials	• Number of HCWs whose capacity in management of labour and delivery has been built • Number of community units mobilized and sensitized on 4 ANC visits • Number of health facilities supplied with commodities • Percentage of perinatal deaths reviewed and uploaded into DHIS	• Improved perinatal deaths reviews and reporting • Reduced fresh still births • Percentage of facility-based fresh still births	Reduced perinatal deaths
Objective 5: To Minimize Exposure to Health Risk Factors					
Reduce the Percentage population who smoke from 19% to 9% by 2022	• Regulatory framework • IEC materials	• Community sensitization on regulatory framework • Conduct sensitization through outreaches	• Number of community sensitizations • Number of households provided with health promotion messages	• Reduced population who smoke • Proportion of population who smoke	• Reduce cases / deaths related to smoking

Strategic target	Inputs	Processes	Outputs	Outcome	Impact
Increase the Percentage infants under six months on exclusive breastfeeding from 32% to 67%	IEC materials	• Training health care workers to promote exclusive breastfeeding • Community advocacy and mobilization on exclusive breastfeeding • Distribution of IEC materials	• Number of HCWs who have been trained to promote exclusive breastfeeding • Number of community units mobilized and sensitized on exclusive breastfeeding • Number of health facilities supplied with commodities • Number of households provided with health promotion messages	• Increased proportion of infants under the age of 6 months who are exclusively breastfed • Percentage infants under six months on exclusive breastfeeding	Reduce infant mortality
Increase the population aware of risk factors to health from 75% to 95%	IEC materials	• Training health care workers on health promotion • Community advocacy and mobilization • Distribution of IEC materials	• Number of households provided with health promotion messages	• Reduced health risk behaviors • Proportion of population aware of health risks	
Objective 6:To Strengthen Collaboration with Health -Related Sectors					
Reduce the Percentage of children under five stunted from 30% to 17%	• IEC materials • Partnerships • Commodities	• Capacity building of health workers in nutritional requirements of under-fives • Community advocacy and mobilization on nutrition in under-fives • Distribution of IEC materials	• Number of HCWs whose capacity in nutrition for under-fives has been built • Number of community units mobilized and sensitized on nutrition for under-fives • Number of health facilities supplied with nutrition commodities • Number of children under five years of age attending child welfare clinics who are under weight • Number of children under five years of age attending child welfare clinics who are stunted	• Reduce malnutrition in under-fives, • proportion of children under the age of 5 years who have stunted growth	Reduced under five mortality

Strategic target	Inputs	Processes	Outputs	Outcome	Impact
Reduce the Percentage of children under five underweight from 18% to 10%	• IEC materials • Partnerships • Commodities	• Capacity building of health workers in nutritional requirements of under-fives • Community advocacy and mobilization on nutrition in under-fives • Distribution of IEC materials	• Number of HCWs whose capacity in nutrition for under-fives has been built • Number of community units mobilized and sensitized on nutrition for under-fives • Number of children identified, referred and rehabilitated for malnutrition at community level • Number of children under five years of age attending child welfare clinics who are under weight • Number of children under five years of age attending child welfare clinics who are stunted	• Reduced proportion of children under the age of 5 years who are underweight • Proportion of under 5 who are underweight	Reduce under-fives mortality
Increase the Percentage of population with access to safe water from 37% to 52%	• Intersectoral collaboration/partnerships • IEC • Infrastructure • Commodities	• Training of HCWs and CHVs • Community sensitization • Outreaches	• Number of households reached with water treatment messages by the trained HCWs and CHVs	• Increased access to safe water • proportion of households with access to safe water	Reduced burden of diarrheal diseases
Increase the Percentage of households with latrines from 43% to 66%	• IEC materials • Guidelines • infrastructure	• Community advocacy and mobilization on latrine use • Capacity building of community health volunteers on community led total sanitation (CLTS) • Distribution of IEC materials	• Number of community units whose capacity in CTLS has been built • Number of open defecation free (ODF) villages • Number of villages triggered • Number of households with functional toilets	• Increased proportion of households with latrines	Reduced burden of diarrheal diseases

Strategic target	Inputs	Processes	Outputs	Outcome	Impact
Increase proportion of households with adequate ventilation from 40% to 75% by 2022	• IEC materials • Guidelines • infrastructure	• Community advocacy and mobilisation • Distribution of IEC materials	• Number of households inspected • Number of households with adequate ventilation based on inspection	• Increased houses with adequate ventilation • proportion of households with adequate ventilation	Reduced burden from respiratory illnesses
Increase the Percentage of schools providing complete school health package by 25%	• IEC materials • Partnerships	• School health program • Outreaches	• Number of schools providing complete school health package	• Proportion of schools providing complete school health package • Increased coverage of schools providing complete school health package	Reduced morbidity and mortality

2.4 County Health Sector Strategic Plan Targets

The County Government, guided by this logical framework, has developed targets for the five year period to track the progress of health outcomes and equity, social and financial risk protection and responsiveness at the impact level; coverage of interventions, prevalence of risk behaviour and factors at outcome level (mapped to the national health policy objectives) and various intervention access, service readiness, and quality at the output level ; and also inputs and processes guided by the health system investment areas. The baseline, mid-term and end-term targets for the County Health Sector Strategic Plan are presented in the table 4 that follows:

Table 3: County Health Sector Strategic Plan Targets

Policy Objective	Indicator	Targets		
		Baseline 2017/18	Mid Term 2020/2021	Target 2022/2023
IMPACT				
Improved health outcomes	Life Expectancy at birth	58	60	61
	Total annual number of deaths (per 100,000 population)			
	Maternal deaths per 100,000 live births	374	350	250
	Neonatal deaths per 1,000 live births	31	18	15
	Under five deaths per 1,000 births	60	45	30
	Infant mortality rate (per 1,000 births)	62	50	31
Distribution of health services	Percentage of range of health services outcome Index	No data	No data	No data
Service Responsiveness	Client Satisfaction Index	No data	No data	No data
HEALTH AND RELATED SERVICE OUTCOME TARGETS				
Eliminate Communicable Conditions	Percentage of Fully immunized children	60%	69%	75%
	Percentage of target population receiving MDA for trachoma	60%	80%	80%
	Percentage of TB patients completing treatment	81%	90%	90%
	Percentage of HIV + pregnant mothers receiving preventive ARV's(HAART)	72%	100%	100%
	Percentage of eligible pediatric HIV clients on ARV's	76%	91%	100%
	Percentage of targeted under 1's provided with LLITN's	66%	72%	76%
	Percentage of targeted pregnant women provided with LLITN's	50%	68%	80%
	Percentage of under 5's treated for diarrhea	21%	15%	11%
	Percentage of School age children dewormed	19%	34%	41%
Halt, and reverse the rising burden of non-communicable conditions	Percentage of adult population with BMI over 25	2.4%	1.8%	1.2%
	Percentage Women of Reproductive age screened for Cervical cancers	0.15%	15%	30%
	Percentage of new outpatients with mental health conditions	0.01%	0.075%	0.005%
	Percentage of new outpatient cases with high blood pressure	0.59%	0.35%	0.25%
	Percentage of patients admitted with cancer	No data	TBD	TBD
Reduce the burden of violence and injuries	Percentage of new outpatient cases attributed to sexual gender-based violence	0.1% (6)	0	0
	Percentage of new outpatient cases attributed to Road traffic Injuries	0.002% (2030)	0	0
	Percentage of new outpatient cases attributed to other injuries	2.4%	1.75%	1.2%
	Percentage of deaths due to injuries	-	0	0%

Policy Objective	Indicator	Targets		
		Baseline 2017/18	Mid Term 2020/2021	Target 2022/2023
Provide essential health services	Percentage of deliveries conducted by skilled attendant	41%	56%	66%
	Percentage of women of Reproductive age receiving family planning	36.3%	45.3%	51.3%
	Percentage of facility based maternal deaths	0.028% (8)	0	0
	Percentage of facility based under five deaths	-	0%	0%
	Percentage of newborns with low birth weight	5.2%	5.05%	4.95%
	Percentage of facility based fresh still births	1.16%	0.91%	0.81%
	Percentage of pregnant women attending 4 ANC visits	33.6%	44.4%	51.6%
Minimize exposure to health risk factors	Percentage of population who smoke	19%	13%	9%
	Percentage of population consuming alcohol regularly	-	-	-
	Percentage of infants under 6 months on exclusive breastfeeding	32%	53%	67%
	Percentage of Population aware of risk factors to health	70%	85%	95%
Strengthen collaboration with health-related sectors	Percentage of population with access to safe water	37%	46%	52%
Strengthen collaboration with health-related sectors	Percentage of population with access to safe water	37%	46%	52%
	Percentage of under 5's stunted	30%	22.16%	17.36%
	Percentage of under 5 underweight	18.7%	13.86%	10.23%
	Percentage of households with latrines	43.6%	58%	66%
	Percentage of houses with adequate ventilation	-	65.9	75.9
	Percentage of classified road network in good condition	-	-	-
	Percentage of Schools with adequate sanitation	30%	45%	55%
HEALTH INVESTMENT OUTPUTS				
Improving access to services	Outpatient utilization rate	1.2	2	2
	Percentage of population living within 5km of a facility	25%	40%	60%
	Percentage of facilities providing BEmONC	34% 76/222	49%	59%
	Percentage of facilities providing CEmONC	25% 2/8	62.5% 5/8	100% 8/8
	Bed Occupancy Rate	90%	85%	80%
	Percentage of facilities providing Immunization	58.6% 130/222	73.8%	83.8%
Improving quality of care	TB Cure rate	71%	82.4%	90%
	Percentage of confirmed malaria cases	64.9%	100%	100%
	Percentage of maternal deaths/deaths audits	100 8/8	100	100
	Malaria inpatient case fatality	No data	0	0
	Average length of stay (ALOS)	5	4	3
HEALTH INPUT AND PROCESS INVESTMENT				
Service Delivery Systems	Percentage of functional Community Units	40%	60%	75%
	Percentage of outbreaks investigated within 48 hours	100%	100%	100%
	Percentage of hospitals offering emergency trauma services	-	100	100
Health Workforce	Number of nurses per 10,000 population	7.1	8	10
	Percentage of eligible staff who have undertaken CPD	No data	80	100
	Staff attrition rate	1.5%	1%	0.5%
Health Infrastructure	Percentage of facilities equipped as per norms	18%	30%	45%
	Number of hospital beds per 10,000 population	-	-	-
Health Products	Percentage of health facilities reporting stock out of EMMS	No data	0	0

Policy Objective	Indicator	Targets		
		Baseline 2017/18	Mid Term 2020/2021	Target 2022/2023
Health Financing	Health expenditure as a percentage of total county expenditure	33%	35%	40%
	Total public health expenditure as percentage of Total Health Expenditure	48%	50%	52%
	Off budget expenditure as percentage of total county health expenditure	18%	16%	15%
	Out of pocket spending as percentage of county health expenditure	35.2%	30%	25%
Health Leadership	Percentage of health facilities inspected annually	No data	50	100
	Percentage of health facilities with functional committees	100	100	100
	Percentage county interagency forum meetings held	No data	100	100
	Percentage of facilities supervised	No data	100	100
	Percentage of CHSF Steering Committee Meetings held	No data	100	100
	Percentage of planning units submitting completed plans	No data	100	100
Health Information	Percentage of sector quarterly reports produced and disseminated	No data	4	4
	Percentage of planning units submitting timely, complete and accurate information	No data	100	100
	Percentage of facilities submitting timely, complete and accurate information	No data	100%	100

2.5 Key Responsibilities for Baringo Health Sector M&E

To be fully successful, M&E functions need to be carried out by the respective programmes and at all levels of health care delivery, from the national to the community level. Overall, the stewardship of the M&E agenda will be guided by three broad principles:

a) Supporting the establishment of a common data architecture.
b) Enhancing sharing of data and promoting information use for evidence-based decision making.
c) Strengthening performance monitoring and review processes.

The following section outlines the key responsibilities of various units under which M&E functions fall at the national and county level.

Table 4: Key Responsibilities and functions of the M&E unit

Stewardship Goal	National level	County Level: CHMT	Sub-County Level: SCHMT	County Level: Partners	Facility level
Establishment of a common data architecture	Define standards for data sharing between aggregate and patient-level data. Coordinate development of minimum data sets and data requirements of the health sector. Create and maintain a data repository of health and health related information. Carry out oversight functions to manage all health and health-related data from service providers at all levels to inform policy formulation.	Conduct oversight to manage all monitoring, evaluation and research data from all programmes within their area of jurisdiction. Create and maintain a monitoring system and data repository. Collaborate and work in partnership with other statistical constituencies at the county level to build one county-wide M&E system based on the principles outlined in this document. Compile all reports from the Sub counties into a single County Health report.	Conduct oversight to manage all monitoring, evaluation and research data from all programmes within their area of jurisdiction. Compile all reports from the Sub county health facilities into a single sub-County Health report.	Support the counties in establishing data collection structures. Work collaboratively with the MoH M&E Unit to provide data, as appropriate, on population-based statistics, and vital events (births and deaths), and health related research data for comparative analysis and warehousing.	Maintain and update the Health Information System, including records, filing system(s) and registry for primary data collection tools (such as registers, cards, file folders), and summary forms (such as reporting forms, CDs, electronic backups). Safeguard data and information system from any risks, e.g., fire, floods, access by unauthorized persons. Compile all reports from the Technical Officers into a single health facility report.

Stewardship Goal	National level	County Level: CHMT	Sub-County Level: SCHMT	County Level: Partners	Facility level
Improve performance and review processes	Aggregate, analyse, disseminate and use health and health-related data on the performance of the health sector priorities outlined in the KHSSP from all MoH departments, SAGAs, national hospitals, CHMTs and others, and provide feedback to all. Compile all reports at the national level on performance tracking of the strategic plan. Analyse the quality of all reports received and ensure follow-up in case of incompleteness, problems with validity, and delays. Provide technical support to all national-level operational units, SAGAs, and national referral hospitals in monitoring and evaluation.	Produce a health sector performance report that includes service delivery metrics. Analyse the quality of all reports received and ensure appropriate follow-up in case of incompleteness or problems with validity, as well as delays from the Sub county levels. Provide technical, material and financial support for M&E to all sub counties. Collate, analyse, disseminate and use health and health-related data from all Sub county offices and give feedback	Produce a health sector performance report that includes service delivery metrics. Analyse the quality of all reports received and ensure appropriate follow-up in case of incompleteness or problems with validity, as well as delays from the facilities Collate, analyse, disseminate and use health and health-related data from all Sub county facilities and give feedback	Work within the health sector M&E framework and guidelines and meet the reporting requirements as defined by minimum datasets.	Ensure compilation and processing of minutes, inventory, supervision and other activity reports. Analyse the quality of all reports received from various health facility units and ensure follow-up in case of incompleteness, problems with validity, or delays

Stewardship Goal	National level	County Level: CHMT	Sub-County Level: SCHMT	County Level: Partners	Facility level
Enhancing sharing of data and promoting use of information for decision-making	Develop M&E-related guidelines and policies. Prepare and disseminate national annual and quarterly performance review reports. Ensure proper information flow from various levels in accordance with national and international data and reporting obligations. (This includes, specifically, forwarding Country Health information as required to the Director for Health for forwarding to international actors.) Provide capacity-building in M&E. Prepare and share the Annual State of Health reports during the Health Congress.	Ensure proper information flow from various levels to inform policy formulation, guidelines, and development of protocols, and to address country's international obligations. (This specifically includes forwarding the County Health report to the National MoH.) Prepare data analyses for discussion during the CECM and directorate meetings and forum for decision-making. Develop County Health report and share with the CECM Develop quarterly feedback to the CECM and County Director for Health and share with them. Disseminate quarterly reports to Sub county health teams and Health Committee.	Ensure proper information flow from health facilities and community health units to inform policy formulation, guidelines, and development of protocols in the sub counties. Prepare data analyses for discussion during the directorate meetings, the County M&E congress and other forum for decision making forwarding the Sub-County Health report to the County Director for Health.	Provide support to strengthen the MoH M&E Unit in their areas of operation (e.g., through provision of technical support and capacity building).	Ensure that every health facility summarises health and health-related data from the community and health facility; analyses it; disseminates it and uses the information for decision-making; provides feedback; and transmits summaries to the next level. Prepare an analysis of the data for discussion during staff and board meetings for decision-making. Forward health and health-related reports to the Sub county level. Provide quarterly feedback to the health providers and the community unit committee. Disseminate quarterly reports to the health facility committee. Disseminate annual report to the health facility committee and Sub county forum

3. DATA MANAGEMENT - COLLECTION, COLLATION, ANALYSIS AND REPORTING

3.1 Towards a common data architecture

In support of the establishment of a common data architecture, the county government appreciates that the county health sector needs to apply a commonly understandable classification for services, medicines and medical supplies, and cadres for staff. Further, it also needs to apply a standard coding system for all databases. As such, the use of defined standards for exchange of patient and aggregate level data across the health information system is crucial. In the implementation of this plan, the county government will underline the importance of a common data architecture and will seek the necessary support from the national ministry of health and partners to build capacity in this regard.

3.2 Data Collection

Towards enhancing data sharing and information use for decision making, the county government appreciates the need to enhance the capacities for data sharing, statistical management through data sharing and information use to support evidence-based decisions.

Data collection for M&E indicators will utilize both qualitative and quantitative methods and, as much as possible, employ standardized data collection tools and analysis techniques. Most data will be collected routinely, and any survey-based indicators will be collected at baseline, midterm and at the end of implementation of the strategic plan. Data collection is appreciably carried out at all the levels of the county health system. The following activities are undertaken at all levels – collection of data on inputs, processes and outputs; processing or aggregation of data collected from the various service delivery points; and review of data for quality purposes. Data collection tools applied include the DHIS, LMIS, HRIS, Commodity Management Systems and Financial Systems. These tools as well as the reporting forms and responsible county personnel are listed in **Appendix 2.**

This plan anticipates that the relevant reporting tools will be made available at all levels of the county health system; and shared accordingly with the faith based and private for-profit facilities to ensure there is harmonised and complete reporting. The M&E unit will monitor the availability of the reporting tools in terms of stock levels and ensure that there are always safety stocks. The appropriate budget allocation for ensuring availability of the tools will be enabled and the CMHT and SCHMT will ensure proper utilisation of tools through regular supportive supervision.

3.3 Data sources

Baringo County Department of Health will rely on both routine and non-routine data sources.

3.3.1 Routine data sources

Routine data will be collected daily using MOH registers at the community and facility. At the community, data will be collected by the CHVs at the household level. At the facility, the healthcare worker providing the specific health service will input data into the daily service register. This data will be aggregated by the CHEW (community data) and facility-in-charge (facility-based data) at the end of every month using summary tools and entered into the

DHIS 2 by the SCHRIO. In addition, disease surveillance data; vital registration of births, deaths and marriages; and information on human resources will be updated regularly.

DHIS - The DHIS serves as the primary health services monitoring system for the health sector. The County government will work with national ministry of health to ensure that the existing system for DHIS is effectively utilised to support reporting on all the agreed indicators (outlined in the Annex 1). The county government will focus on improving timeliness and completeness in DHIS data reporting, strengthening regular data analysis and review at health facility, sub-county and county levels, supporting the mechanism for data collection and reporting from private sector health care facilities, supporting quarterly data review meetings of at sub county level and timely analysis and dissemination of data at all levels.

Integrated Disease Surveillance (IDSR) - The weekly epidemiological surveillance reporting system that reports on diseases of epidemic potential will be utilised to capture necessary data.

Logistic Management Information System (LMIS) -The web-based platform for ordering EMMS will be used to track quarterly orders made and orders filled and order fill rate.

Electronic Medical Records (EMR) - The county government currently has 13 facilities that are already using EMR for recording the daily activities at the facilities. Utilisation of this system will continue and challenges regarding inadequate budget for maintenance of system will be addressed.

TibuTB Care System- Tracking TB patients in support of DOT and follow ups

Electronic ART dispensing tool -At central ART sites the system is used for dispensing ARTs and provides data on the numbers of persons accessing ARTs.

Human Resources Information System (HRIS) - employees' information regarding gaps in staffing and employment, training / capacity needs, training database and development and attrition rate. Applies staff return forms.

Vital Registration - births registration (B1), deaths registration (D1), marriages and divorces.

Integrated Financial Management Information System (IFMIS) - Financial returns, ledgers, vote books
CLTS Database

3.3.2 Non – Routine Data sources

Non-routine data collection will be undertaken through surveys and census. Targeted surveys for the period include the following:

Health community surveys- Surveys undertaken by the Kenya National Bureau of Statistics (KNBS) with support from partners as well as by the county itself will be targeted to provide information on measures of household-based coverage indicators for

determining the impact of interventions. Community surveys for the period will include the following:

a) Kenya Population and Household Survey – popularly known as the National Census was last undertaken in 2009 and is scheduled to be undertaken in 2019. The county government will utilise the data from this census for its key decisions.
b) Kenya Demographic and Health Survey: The last Kenya Demographic and Health Survey (KDHS) was conducted in 2014 and included standardized questions on coverage of key health interventions. The next one is anticipated in 2019/2020.
c) Malaria Indicator Survey: The last Malaria Indicator Survey was undertaken in 2015 and will be undertaken again in 2019.
d) Kenya HIV/AIDS indicator Survey - The last Kenya HIV/AIDS indicator Survey was undertaken in 2012. The survey on HIV/AIDS indicators was carried out in 2018 but results are due in early 2019.
e) Kenya Mortality Trends (first one covered 2012 to 2016).
f) Small Scale Studies: Smaller scale household surveys are conducted periodically when there is a specific question requiring an answer. Such surveys have in the past included the following SMART survey – Annual Nutrition Survey - Conducted in July /August and targeting under 5 and Nutrition KAP – Knowledge Attitude and Practices Survey – targets Maternal Infants and Young Child Nutrition.

Health Facility Surveys

a) Service Provision Assessment: These assessments are normally nationwide, and designed to collect information on the availability and quality of specific services - such as RMNCAH, infectious disease (malaria, TB and HIV/AIDS) services provided in health facilities.
b) Service Readiness Assessments.
c) Commodities Availability Assessment.

3.3.3 Other complimentary methods

Other complimentary methods to be applied in data collection include the following:

a) Pharmacovigilance - The Pharmacy and Poisons Board (PPB) has designed a generic form to collect reporting of adverse drug reactions (ADR) as part of the pharmacovigilance system.
b) Health facility- based surveillance via sentinel sites and disease surveillance system
c) Activity monitoring systems/activity reports at both county and sub-county level. Sub-county level - routine implementation reports are compiled to understand progress of sub-county-level implementation of selected interventions. Examples of such reports include routine and activity-specific supervision and project implementation reports.
d) County level: At county level, compilation of activity reports by programs and the stakeholders will be coordinated by program managers and shared with M&E unit for further analysis and synthesis of level of achievement of relevant indicators and compilation of performance reports.
e) Periodically, several reports (sometimes with specified formats) are required from the county by the national ministry of health, and development partners.
f) Other studies - Periodically, specific studies will be undertaken to respond to significant questions in county health service delivery. These studies are intended to improve current interventions and provide opportunities for improvement.

3.4 Data Flow

The data communication for the county health sector shall follow the existing county health and national health ministerial coordination structures. The HMIS, IDSR, activity reports and services utilization data (including supervision/mentoring, logistics and supplies) are institutionalized mechanisms of data collection from the national level to the health facilities through the counties and sub-county health coordination structures. From the lowest level, reports flow to the higher levels and in return feedback is expected on the outputs of the reported data and any new information that could be available from other sources.

The county department for health services will use various communication channels to ensure public access to data and reports. Quantitative and qualitative data will be made publicly accessible through the relevant county government databases (The databases include but are not limited to DHIS, HRIS, IFMIS, LMIS). The Local Area Network (LAN) installed at the county health services department will facilitate inter-departmental communication. Email accounts will be created for all county and sub-county teams and hospitals and will be used for communication with the department of health services including the M&E unit. The public will also be able to access health information on the county government website, http://www.baringo.go.ke/.

In addition to the Information and Communication Technology facilities at the department of health services, the M&E Unit and the M&E TWG will collaborate with the persons responsible for Health Promotion at the department to translate data and information according to the target audience and utilize various communication channels including radio, television, teleconferencing, newsletters, booklets. Figure 3 shows the data flow hierarchy for the county health data

Figure 2: Baringo County Data Flow and Use map

Data Management Hierarchy

UPWARD DATA FLOW

	Data Collection	Compilation	Storage	Analysis	Reporting	Use
National Person(s) responsible	Indicator definition; Tools development	Data aggregation	Data warehousing	National level	National reports; Donor reports	Policy formulation; Resource management
	M&E TWG	HMIS department; Divisional heads	HMIS department; Divisional heads	HMIS department; Divisional heads; National TWGs	HMIS department; Divisional heads	Policy makers
County Person(s) responsible	Indicator definition; Customization; Tools development	Data aggregation	Data archiving	County level	County level	Policy formulation; Resource allocation
	CHMT, TWGs	CHRIO and M&E Coordinator	CHRIO and M&E Coordinator	CHRIO and M&E Coordinator	CHRIO and M&E Coordinator	County government
Sub County Person(s) responsible	Data verification and audit	Data entry and tabulation	Data archiving	Sub county and facility level	Sub county level	Indicator monitoring
	SCHRIO, SCHMT	SCHRIO, SCHMT	SCHRIO	SCHRIO	SCHRIO	SCHMT
Facility (public and non-public) Person(s) responsible	Data Capture	Collation and transmission	Data archiving	Facility + Community	Departmental and facility data	Resource Management; Health talks
	HRIO, facility managers	HRIO, facility managers	HRIO, facility managers	HRIO, facility managers	HRIO, facility managers	HRIO, facility managers
Community Person(s) responsible	Data Capture	Collation and transmission	Data archiving	Community Unit	CHEW	Community mobilization, planning
	CHW, CHV	CHEW	CHEW	CHEW	CHEW	CHEW

FEEDBACK FLOW

3.5 Data Quality

The county government will ensure that all levels of the county health system generate and disseminate quality data to support decision making. Data quality assurance processes will include periodic Data Quality Audits (DQA) of recorded data by supervisors from county health services department and (supported by implementation partners); regular training of staff, and provision of routine feedback to staff at all levels on completeness, reliability and validity of data; and data quality assessment and adjustment which will be carried out periodically. The objective of data validation is to ensure that the data used by the county health sector to make decisions is sound and accurate. Specific efforts will be made to undertake data validity including: application of the computed validation/data accuracy index into county, sub-county and facility annual reports; specific support for outliers; routine (quarterly) data reviews on a sample of facilities.

Regular data quality assurance for facility-based data including regular review and verification for accuracy and completeness will be carried out monthly by the health facility in-charges at all levels. All periodic reports will be reviewed and endorsed before submission to the relevant stakeholders.

DQA will be carried out at points of data collection, collation and analysis by the county health services department technical staff and by the HRIOs within the sub-county. The Standardized DQA tools developed by the national ministry of health and its programs will be applied at all levels.

DQA for county health evaluation studies will be carried out using agreed formats by the county health services department M&E unit which will have responsibility of coordinating the county health sector evaluation studies. County health facility (Hospitals Review Boards) will have the responsibility of data validation for health systems research carried out in the respective institutions as guided by the national MOH regulations.

In addition to the above data checks and validation, the county health services department M&E unit will carry out annual Rapid Data Quality Assessment (RDQA) in which a selected number of health facilities will be drawn from the master facility list for this assessment. RDQA will be undertaken together with other facility-based assessments where possible in the spirit of joint assessments. The RDQA will be carried out as a quality assessment of the entire process of data collection, analysis and synthesis for the county health sector.

The county health services department has an institutionalized mechanism for verification and validation of health data from both routine HMIS and activity reports. The department will also carry out verification of reported data for key county health indicators to check if service delivery and intermediate aggregation sites are collecting and reporting data to measure the county health outcome indicators accurately and on time and to cross-check the reported results with other data sources. This DQA will determine if a sample of Service Delivery Sites accurately record the activity related to the selected indicators on source documents. It will then trace that data to see if it has been correctly aggregated and/or otherwise manipulated as it is submitted from the initial Service Delivery Sites through intermediary levels to the county health services department. This data

verification exercise will take place in two stages:

- In-depth verifications at the Service Delivery Sites; and
- Follow-up verifications at the Intermediate Aggregation Levels and at County Health Services Department's M&E Unit.

The county health department will liaise with all stakeholders through the M&E TWG to standardize and harmonize county health sector DQA tools and instruments.

3.6 Data Analysis

The county government will undertake analysis and synthesis of data at county, sub-county and facility levels to make the data meaningful for planning and decision making. By applying various tools of analysis including content analysis, statistical analysis and GIS mapping, actual results will be compared against planned and agreed target; variations will be explained, and comparisons undertaken at different levels and across interventions. Analysed and synthesised data will be packaged and shared through various reporting mechanism including monthly, quarterly and Annual Progress Reports, mid- and end-term evaluations, thematic studies and surveys. The department of health services in collaboration with partners will strengthen the capacity of the county health sector to undertake data analysis and synthesis at all levels -CHMT, SCHMTs, health facilities and civil society organizations, to enhance bottom-up planning and decision-making.

3.7 Reporting, Data Dissemination and Data Sharing

Data need to be translated into information that is relevant for decision-making. Data will be packaged and disseminated in formats that are determined by management. The department of health services will ensure that service delivery data is packaged and displayed at the various health facilities using formats such as the DHIS dashboard reports, scorecards and service charter boards. The timing of information dissemination should fit in with the planning cycles and needs of the users. Further, the department will promote sharing of information across all the levels of care. Data and information generated at all levels of the sector and from different sources will be shared, translated and applied for decision-making during routine monitoring, periodic sector performance review, planning, resource mobilization and allocation, accountability, designing disease-specific interventions, policy dialogue, review and development.

3.8 Performance Reporting and Review process

The county health sector monitoring and review process is interlinked across the various planning levels. Service delivery information that is utilised for monitoring and review process will be obtained through a bottom-up approach based on the county platform that uses the decentralised structures (sub-counties, wards and county entities) as the units for design and analysis; based on continuous monitoring of different levels of indicators; gathering of additional data before, during and after review period for assessment applying a variety of methods and including interim and summative evaluation. Information at each level will be provided by the planning unit below it while management support (governance and partnership information) will be analysed at the level it is provided.

The M&E unit in collaboration with stakeholders will coordinate the gathering of performance data to enable tracking of progress made against the agreed targets and

objectives. Performance reports will be entrenched as a standing agenda in the meetings of the CHMT, M&E unit and even the M&E TWG. Performance monitoring and review will be carried out at all levels on a regular basis, the frequency being driven by the sector's need for information, as follows:

- At the community level, performance monitoring and review will be done on a monthly, quarterly and annual basis.
- At the facility level, it will be done on a daily, weekly, monthly, quarterly, biannual, annual and need-by-need basis.
- At the sub county level, it will be done on a weekly, monthly, quarterly, biannual, annual and need-by-need basis.
- At the county level, monitoring and review will be done on a weekly, monthly, quarterly, biannual, annual, midterm, end term and need-by-need basis.

Table 5 Performance Reviews Schedule

Methodology	Output	Frequency	Prepared by	Responsible person
Monthly progress report	Monthly progress reports	Monthly	CHEWs, Facility In charges, SCHMT	SCHRIO
Quarterly bulletin	Quarterly bulletin reports	Quarterly	County M&E Unit	M&E unit Coordinator
Quarterly report	Quarterly reports	Quarterly	County M&E Unit/SCHRIO	M & E unit Coordinator
Quarterly performance review	Quarterly performance review report	Quarterly	County M&E Unit/SCHRIO	M&E Unit Coordinator CHRIO
Bi-annual DQA reports	Bi-annual DQA report	Bi-annual	County M&E Unit/SCHRIO	M&E unit Coordinator
Annual performance report	Annual performance report	Annual	County M&E Unit/SCHRIO	M & E unit Coordinator CHRIO

The M&E Unit will ensure performance reports generated are distributed to the data generating points, and are also reviewed, amended and, if need be, new priorities for implementation for the subsequent years identified. In addition to the periodic performance report, there will be special surveys, such as patient exit surveys and data quality audits, that shall be coordinated by the M&E Unit.

This M&E plan will also inform the target setting and evaluations undertaken through the County Performance Contracting and Staff Performance Appraisal Process. Quarterly review of the performance contracts signed by the CECM, COH, Directors and Hospital Heads will be based on targets cascaded from the Annual Work Plan and aligned to this M&E Plan. The mid-year and end year review of staff performance will also be informed by this plan.

In terms of review of the strategic plan, this plan will inform the mid-term review to be conducted in the third year of the strategic plan's implementation, as well as at end term review to be carried out at the end of the strategic plan period to ascertain the county's performance in achieving health objectives.

4. IMPLEMENTATION

Under the County Health Sector Strategic Plan for 2018-2022, streamlining the organisation of collection and utilisation of data for evidence-based decision making at all levels of the county health care system is identified as a priority. The strategy appreciates that addressing the capacity issues across the health strengthening systems is critical to improving the county health M&E system. Various initiatives, including those supported by development and implementation partners, are currently under implementation towards this end.

This plan seeks to ensure that county M&E system for the health sector is linked to the County Integrated Monitoring and Evaluation (CIMES) spearheaded by the Department of Economic Planning; as well as the national government's health monitoring and evaluation system coordinated by the Monitoring and Evaluation unit of the national Ministry of Health and the National Integrated Monitoring and Evaluation Systems (NIMES) under the national Ministry responsible for Planning. In the sections that follow, the proposed coordination structures for monitoring and evaluation; proposed key activities and the attendant cost estimates are outlined.

4.1 Implementation Arrangements

The coordination arrangements proposed in this plan are geared towards ensuring that the key M&E functions that focus on information generation, validation, analysis, dissemination and use towards delivery of the sector priorities identified in the strategic plan and the CIDP, are effectively and efficiently delivered.

4.1.1 Coordination of County Health Monitoring and Evaluation

The county department of health services together with partners have agreed to work together in the spirit of three-ones (one implementation plan, one coordination mechanism and one M&E framework). The contribution of the partners to county health M&E will be effected by ensuring partners' efforts are in line with and coordinated by the county department of Health and, where appropriate, sharing and developing capacity for county health M&E. Data collected by partners has to be coordinated in order for the county health department to be able to monitor, evaluate and report holistically on progress of health interventions in Baringo County. This will enable the county department of health services to track progress made on national and international commitments too.

To enable the county government effectively co-ordinate M&E activities, the department of health services has identified and sensitised staff and stakeholders on the institutional and individual capacities required to support the M&E functions. At the institutional level, the county government has set up a directorate for health administration and planning that is responsible for amongst other functions, planning, monitoring and evaluation, under which the unit responsible for coordinating M&E functions for the health services department is anchored. The directorate is expected to accord the necessary linkages with the key programs for health services (curative and preventive and rehabilitative) as well as the economic planning department for the county government. The department of health services has also established Research Monitoring and Evaluation as a key subprogram under the Program on Health Administration and Planning in its Program Based Budget for purposes of ensuring that resource allocation for this agenda is elevated.

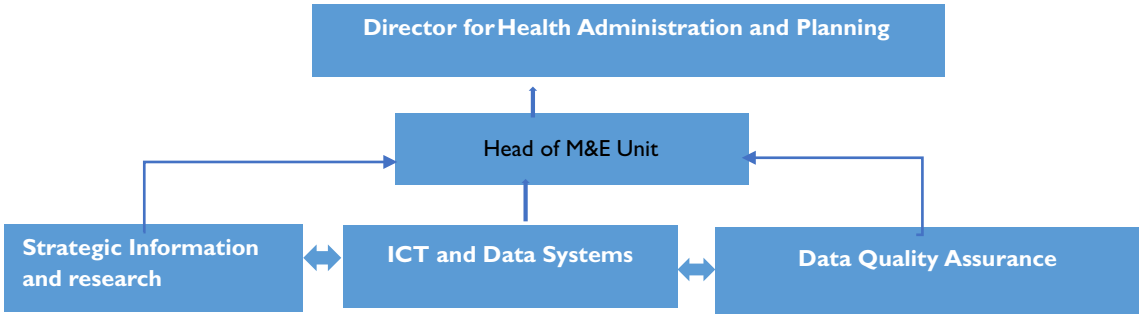
The roles and responsibilities for the M&E unit are summarised in Table 4.1

Roles and Responsibilities of Health Department's M&E Unit

- Coordinating the setting up the monitoring and evaluation system for health with focus on developing work plan and budget for monitoring and evaluation activities
- Collect, compile relevant M&E information
- Establish and maintain a database of health outcome measures
- Establish and maintain functional linkages with other relevant partners involved in county health M&E, including the national Ministry of Health , other County departments and sectors
- Analyze and interpret programmatic as well as outcome and impact data
- Prepare and regularly update the county health profile
- Provide feedback; prepare quarterly monitoring reports and annual health reports and reviews
- Develop capacity at the sub county level in M&E
- Serve as the Secretariat of the M&E Technical Working Group (TWG) that coordinates M&E within the County Health Sector.
- reviewing and providing feedback to programmes on the quality of methodologies established to collect monitoring data
- preparing consolidated progress reports for the County Health Stakeholders Forum

The County Department for Health Services will strengthen the current M&E unit within the department to enable it support coordination of the county health M&E functions. In proposing a suitable structure for the M&E unit, the county government has considered the need to ensure close linkages with the highest decision making organs, need to build a blend of skills necessary for delivery of the functions and build-up of a functional M&E system as well as providing opportunities for career development; and close collaboration with the County planning unit with a bid to feed appropriately into the County Integrated Monitoring and Evaluation System (CIMES). The structure is presented below:

Figure 3: Organisation structure for the County Health Services Department M&E Unit



4.1.2 Linkage with stakeholders

To accord effective participating of stakeholders and partners in the delivery of health M&E functions, the county health sector will strengthen and utilise the Monitoring and Evaluation TWG. The M&E TWG will be reconstituted and its capacity needs identified, and support sought to fill in gaps from the partners closely working with the county health services department. The M&E TWG shall share its reports with the County Health Stakeholder Forum through its Steering /Coordination Committee. Table 6 outlines the functions of the county M&E TWG for health services.

Table 4.2: Key functions of M&E TWG
• Supporting coordination/harmonization of M&E activities (data collection, analysis, dissemination) among the MOH and the partners. • Identifying and prioritizing critical action steps for county, Sub -County and Facility M&E work to assure that action is taken by the relevant group(s) to achieve quality M&E in a timely fashion. • Promote operational research to support evidence -based, efficient programme implementation and the use of M&E tools. • Identifying and recommending strategies for addressing the needs for capacity building in M&E at all levels. • Developing and maintaining consensus around M&E strategies across county department of health and partners. • Developing and providing technical guidance on selection and definition of indicators for county health reporting. • Providing technical guidance on appropriate data collection methods, analytic strategies, and dissemination of recommendations. • Monitoring changing needs in health M&E arena.

4.2 Operational Guidelines and Tools for County Health M&E

Implementation of this M&E Plan requires the county department of health to put in place various guidelines, standard operating procedures and protocols for data management, data quality assurance, data analysis and synthesis, and data dissemination. During the implementation of the CHSSP 2018-2022, the county government will formulate guidelines (or adopt the national ones where they are in existence) and follow up on implementation. This plan acknowledges the role of national government in setting policies, standards and regulation; and therefore, the existence of various standards. The county government will disseminate the standards and guidelines to the decentralized structures and support their implementation. These guidelines include amongst others: National M&E Framework, Monitoring and Evaluation Institutionalization Guidelines, Health Information System Policy, Indicators Manual and SOP, Data Quality Assurance Protocol and the Kenya Health Enterprise Architecture.

This plan envisages that the county health department will need to develop SOPs for data collection, data collation and reporting; data cleaning and validation, evaluations, survey and research, performance review, data review, and data dissemination. With regards to the tools supporting the implementation of the above SOPs, the county will continue support the application of both manual and electronic tools at the appropriate levels of the healthcare system.

4.3 Dissemination of Information and Information Products

Data need to be translated into information that is relevant for decision-making. Data will be packaged and disseminated in formats that are determined by management at the various levels. Service delivery data shall be packaged and displayed at the various health facilities using the HMIS formats and designed non-HMIS formats. The timing of information dissemination will be scheduled to fit in the planning cycles and needs of the users.

County health information will be disseminated through reports (electronic and print) to stakeholders, presentations and workshops, annual health review meetings, media briefs international health days, publications, websites and other documentation. Information products will be disseminated through:

- Quarterly and Annual Health Statistical Reports and Bulletins
- Quarterly Performance Review meetings and Reports

- Annual Performance Review
- Dissemination of Survey Findings: Feedback on survey findings will be in form of workshops and dissemination of reports which will be circulated to relevant stakeholders in hard copy as well as through the county website.

4.4 Evaluation Plan

The evaluation plan describes what will be evaluated, how and when. The evaluation endeavors to look at the overall project/interventions in terms of the operations, governance, deliverables, and hence assist the County Health Management Team and partners to learn and make improvements. The information obtained helps in planning, designing/redesigning and developing health sector interventions that are relevant, effective, efficient, sustainable and impactful.

The County Government will develop a detailed evaluation plan in the form of Outcomes Measurements Framework that will facilitate the evaluation of outcome indicators included in this M&E Plan. The outcomes measurement framework will elaborate amongst others – priority questions based on policy and strategic objectives, outcome indicators, linkage between outcome indicators, immediate outputs and the resources and processes applied, method of analysis, data sources and presentation. For purposes of tracking the outcomes, an outcomes measurements database will be established and made accessible to support community participation in monitoring and evaluation.

Table 7 : Evaluation Plan Guide

What to Measure	Evaluation Questions	Method to answer the Questions	Frequency	Responsible Person
Relevance	• How well was the health programme planned out, and how well was that plan put into practice? • To what extent are the objectives of the health programme still valid? • Are the activities and outputs of the health programme consistent with the overall goal and the attainment of its objectives? • Are the activities and outputs of the programme consistent with the intended impacts and effects?	• Monitoring system that tracks actions and accomplishments related to bringing about the mission of the initiative (activity) • Survey on satisfaction with goals (Client satisfaction survey) • Survey on satisfaction with outcomes (Provider satisfaction survey)	• Baseline (2018) • Annual • Midterm (2021) • End term (2023)	County M&E Coordinator
Effectiveness	• To what extent were the objectives achieved / are likely to be achieved? • What were the major factors influencing the achievement or non-achievement of the objectives?	• Monitoring system that tracks actions and accomplishments related to bringing about the mission of the interventions (activities)	• Baseline (2018) • Annual • Midterm (2021) • End term (2023)	County M&E Coordinator

What to Measure	Evaluation Questions	Method to answer the Questions	Frequency	Responsible Person
		• Behavioural surveys (primary and secondary data sources) • Interviews with key informants		
Efficiency	• Were activities cost-efficient? • Were objectives achieved on time? • Was the health programme implemented in the most efficient way compared to alternatives?	• Cost-effectiveness analysis	• Baseline (2018) • Annual • Midterm (2021) • End term (2023)	County M&E Coordinator
Impact	• What resulted from the health programme? • How has behaviour changed because of participation in the program? • Are participants satisfied with the experience? • Were there any negative results from participation in the program? • Were there any negative results from the program? • How many people have been affected? • Do the benefits of the program outweigh the costs?	• Behavioural surveys (primary and secondary data sources) • Interviews with key informants	• Baseline (2018) • End term (2023)	County M&E Coordinator
Sustainability	• To what extent did the benefits of the programme or project continue after donor funding ceased? • What were the major factors which influenced the achievement or non-achievement of sustainability of the programme or project?	• Monitoring system that tracks actions and accomplishments related to bringing about the mission of the initiative (activity) • Behavioural surveys (primary and secondary data sources) • Interviews with key informants	• Baseline (2018) • Midterm (2021) • End term (2023)	County M&E Coordinator

5. M&E SYSTEM STRENGTHENING IMPLEMENTATION MATRIX

5.1 Components of the County Health M&E system

In developing the M&E system strengthening implementation matrix, the County Department of Health Services has considered the 12 main components of an M&E system that are essential for effective and efficient delivery of M&E functions. These components will be strengthened progressively.

Table 8: Components of the M&E System

Component	Description
Organisation Structures for M&E functions	The county health services M&E Unit will coordinate health M&E functions in the county. Its roles are defined in section 4.1.
Human Capacity for M&E	The county will seek to hire or deploy where necessary, staff with necessary technical know-how and experience to support M&E functions in the department of health services. Further, the staff will be provided with continuous training and other capacity building initiatives to ensure that they keep abreast with current and emerging trends in the field.
Partnerships for planning, coordinating and managing the M&E system	The county government will partner with other organizations on M&E systems; to complement it's M&E efforts during the M&E process and act as a source of verification of whether M&E functions align with intended objectives. Such partnerships will extend to other government agencies, as well as private sector providers.
M&E framework/Logical Framework	The M&E framework outlined in Chapter 2 is crucial for the department of health services in that it outlines the objectives, inputs, outputs and outcomes of the intended programs and the indicators that will be used to measure them.
M&E work plan and costs	The costed M&E implementation work plan outlined in this chapter and which will be aligned to the Annual Work Plan shows how the resources that have been allocated for M&E functions will be used to achieve the goals of the M&E.
Communication, advocacy and Culture for M&E	The county government shall implement policies and strategies to promote communication and advocacy initiatives for M&E functions, without which it will be difficult to entrench an M&E culture within the county department of health services. Information products will be utilised towards this end.
Routine programme monitoring	The county department of health services will ensure that data is collected, collated, analyzed and reported and that performance reviews are carried out on a continuous basis to track the implementation of the County Health Sector Strategic Plan
Surveys and surveillance	The county will undertake surveys and surveillance frequently and use the information to evaluate progress of the health programs.

Component	Description
County and Sub-County databases	This plan has developed strategies of submitting relevant, reliable and valid data to national, county and sub-county databases
Supportive supervision and data auditing	The county health services department will ensure regular supportive supervision and data auditing for purposes of strengthening the M&E system. Data auditing is carried out for data reliability and validity while supportive supervision will be carried out to ensure the M&E process are operating efficiently.
Evaluation and research	The health services department will undertake baseline mid- and end-term evaluations of health programs at specific times to establish whether health programs have met the desired objectives. The evaluations will also provide further health information and learning experiences to be shared with county health stakeholders.
Data dissemination and use	The information dissemination plan in this plan will provide for effective sharing of information gathered during implementation. This will support decisions geared towards reinforce the implemented strategy or to change it. Further, it will also cement accountability to stakeholders and enable community participation in health M&E.

5.2 County Health M&E System Implementation Framework

The county will implement the following interventions towards strengthening the County Health M&E system. These activities will be factored in the Annual Work Plan for the department of health services under the sub-program of M&E in the planning and administration program, for the purposes of resource allocation.

Table 9: M&E System Strengthening Implementation Maritx

Intervention	Timeline (Years)					Responsibility	Budget	Source of funding	Expected outcome
	1	2	3	4	5		KES		
Present the M&E plan to County Health M&E TWG and CHSF	X					CDH		Baringo County /USAID	Consensus gained about the plan
Print and Disseminate the M&E plan	X					CDH	1,000,000	Baringo County /USAID	M&E plan disseminated
Recruit/ Deploy staff to the M&E Unit as per proposed structure	X	X				COH		Baringo County	Improved M&E planning and implementation
Conduct Quarterly M&E TWG Meetings	X	X	X	X	X	COH	4,000,000	Baringo County, USAID, CDC, World Bank	Improved M&E planning and implementation
Procurement of 10 Computers & accessories for M&E Unit and M&E focal persons	X	X				CDH	1,500,000	Baringo County	Computers & accessories procured
Establish LAN at county, sub -county and health facilities(hospitals and high volume health centres)	X	X	X	X	X	ICT Head	10,000,000	Baringo County, USAID, CDC, World Bank	Improved access to data and timely reporting
Print data collection and reporting tools	X	X	X	X	X	CHRIO	15,000,000	Baringo County, USAID, CDC, World Bank	Improved data collection & management
Tra ining the CHMT, S CHMT, M&E and HIS focal persons on M&E & Reporting	X	X				CHRIO	2,500,000	Baringo County, USAID, CDC, World Bank	Improved data collection, management (including missing data), quality improvement and dissemination
Training six M&E Staff of the County HIS/M&E unit in data analysis and reporting		X	X			CDH	700,000	Baringo County, USAID, CDC, World Bank	Improved data collection & management
Production/Compilation and dissemination of Quarterly & Annual reports	X	X	X	X	X	CDH	12,500,000	Baringo County, USAID, CDC, World Bank	Quarterly and annual M&E reports disseminated
Quarterly data review meetings with stakeholders	X	X	X	X	X	CDH	11,200,000	Baringo County, USAID, CDC, World Bank	Improved coordination
Disseminate HIS and M&E Policies and Standards(SOPs and guidelines) at all levels	X	X				M&E Coordinator/CHRIO	3,000,000	Baringo County, USAID, CDC, World Bank	Policies, SOPs and Guidelines disseminated and understood
Undertake quarterly supportive supervision	X	X	X	X	X	CDH	6,000,000	Baringo County, USAID, CDC, World Bank	Improved M&E planning and implementation

Intervention	Timeline (Years)					Responsibility	Budget	Source of funding	Expected outcome
	1	2	3	4	5		KES		
Monthly supervision to facilities by SCHMT	X	X	X	X	X	sub-County Health Coordinators /MoHs	6,000,000	Baringo County, USAID, CDC, World Bank	Improved M&E planning and implementation
Hold Quarterly Stakeholder Meetings/Forum	X	X	X	X	X	COH	25,000,000	Baringo County, USAID, CDC, World Bank	
Developing data collection tools for non-HMIS data	X	X				M&E Coordinator/CHRIO	3,500,000	Baringo County, USAID, CDC, World Bank	Non HMIS data collection tools utilized
Conducting mid-term evaluation of the County Health Sector Strategic Plan			X			CECM	2,500,000	Baringo County, USAID, CDC, World Bank	Improved implementation of M&E plan
Conducting end-term evaluation of the County Health Sector Strategic Plan					X	CECM	2,000,000	Baringo County, USAID, CDC, World Bank	Improved implementation of M&E plan
Develop a Data Quality Audits (DQA) Scheduling and tracking tool for DQIs	X					M&E Coordinator/CHRIO	300,000	Baringo County, USAID, CDC, World Bank, Global Fund	Improved Data quality
Conducting data quality audits (DQA) and verifications	X	X	X	X	X	M&E Coordinator/CHRIO	25,000,000	Baringo County, USAID, CDC, World Bank, Global Fund	Improved Data quality
Develop and implement a County Health Outcomes Measurement Framework	X					M&E Coordinator/CHRIO	1,000,000	Baringo County, USAID, CDC, World Bank, Global Fund	up to date County Health indicators status
Conduct evidence-based surveys and research	X	X	X	X	X	M&E Coordinator/CHRIO	5,000,000	Baringo County, USAID, CDC, World Bank, Global Fund	up to date County Health indicators status
Train county health staff at all levels on data management (ICD 10, Analytical data packages, iHRIS, DHIS)		X	X	X		COH	3,100,000	Baringo County, USAID, CDC, World Bank, Global Fund	Improved data collection & management
Develop a County Health Enterprise Architecture with linkages to existing subsystems	X					Head Health ICT	6,000,000	Baringo County, USAID, CDC, World Bank, Global Fund	Improved data collection & management
Compilation of County Health Bulletin on a Quarterly basis	X	X	X	X	X	M&E Coordinator	4,800,000	Baringo County, USAID, CDC, World Bank, Global Fund	Improved information dissemination and use of information for decisions
Produce Annual County health profile and fact sheet	X	X	X	X	X	M&E Coordinator	2,000,000	Baringo County, USAID, CDC, World Bank, Global Fund	Improved information dissemination and use of information for decisions
Monthly update of Health Portal in the County Website	X	X	X	X	X	M&E Coordinator	120,000	Baringo County Government	Improved information dissemination and use of information for decisions, Improved Public Participation

Intervention	Timeline (Years)					Responsibility	Budget	Source of funding	Expected outcome
	1	2	3	4	5		KES		
Produce quarterly profiles for programs performance (HIV, Malaria, TB, RMNCAH)	X	X	X	X	X	M&E Coordinator	4,800,000	Baringo County, USAID, CDC, World Bank, Global Fund	Improved information dissemination and use of information for decisions
Support quarterly communication dialogue meetings at Community level	X	X	X	X	X	Director Public Health	50,000,000	Baringo County, USAID, CDC, World Bank, Global Fund	Improved Community health system
							207,520,000		

APPENDIX 1:
PERFORMANCE MATRIX (INDICATOR DEFINITIONS, TARGETS, DATA SOURCES AND RESPONSIBILITY)

No	Indicator	Indicator Definition	Program Area	Numerator	Denominator	Indicator Type	Data collection Tools	Frequency of collection/ reporting	Data Collection Level (Community, HF, Other)	Data Source	Responsible entity	Baseline Year	Baseline Value	Target				
														Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
1	Maternal mortality ratio (Maternal deaths per 100,000 live births)	The maternal mortality ratio (MMR) is the annual number of female deaths from any cause related to or aggravated by pregnancy and its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42days of termination of pregnancy, irrespective of the duration and site of the pregnancy, per 100,000 live births, for a specified year.	Reproductive Health	Number of maternal deaths per 100 000 live births during a specified time period, usually one year.	Number of live births	Impact	Vital registration; KDHS; census; health service records	Five years	HF	DHIS	CDH, Medical superintendents, RH coordinator,	2018	374	0	0	0	0	0
2	% fully immunised children	Children under 1 year receiving measles1 vaccine	Immunization	N: Number of children under the age of 1 receiving measles 1 vaccine	D: Estimated number of children younger than one year	Outcome	DHIS:MOH 710 MOH 510; MOH 702; Surveys; KNBS	Monthly/ Quarterly/ Annually	HF	DHIS	CDH, EPI logistician	2018	68	73	78	83	88	93
3	% of TB patients completing treatment	Patients who have either completed treatment or got cured	TB	Number of patients who have completed treatment + cured	Total number of TB patients notified	Outcome	Facility TB Register; TIBU	Monthly, Quarterly, annual	HF	Facility register (TB4)	Sub county TB Coordinator	2017	81	85	88	90	90	92
4	% HIV+ pregnant, Breastfeeding women receiving preventive ARVs	Pregnant &Breastfeeding women who are confirmed positive and are receiving ARVs	HIV	Number of pregnant women enrolled on care and are receiving ARVs	Total number of pregnant &Breastfeeding women confirmed HIV positive	Outcome	ANC, Maternity, PNC Register	Monthly, Quarterly, annually	HF	ANC, maternity, PNC Register; ART Register	Sub county AIDS/STI Coordinator	2017	72	100	100	100	100	100
5	% of eligible HIV clients on ARVs	Clients tested positive for HIV and initiated on ARVs	HIV	Number of clients tested positive for HIV and started on ARVs	Total number of clients tested positive for HIV	Outcome	HTS Register	monthly, Quarterly annually	HF	ART Register; HTS Register	Sub county AIDS/STI Coordinator	2017	73	95	95	95	95	95
6	% of children under one provided with LLITNs	Children under one year provided with LLITNs at the facility	Malaria	Number of children under 1 year who received LLITNs at the facility	Estimated children under 1 at the facility	Output	CWC Register; Immunization Register	Monthly, Quarterly annually	HF	MOH 710; MOH 711	Sub county Malaria Coordinator	2017	66	68	70	72	74	76
7	% of targeted pregnant women provided with LLITNs	Pregnant women who received LLITNs at the facility	Malaria	Number of pregnant women who received LLITNs at the facility	Estimated number of pregnant women at the facility	Output	ANC Register	Monthly	HF	MOH 711	Sub county Malaria Coordinator	2017	50	56	62	68	74	80
8	% of children under five treated for diarrhoea	Children <5year treated for diarrhoea	Child Health	N: Number of under-5s treated for diarrhoea	D: Total number of children under five presenting at the facility	Output	MOH 204 A; DHIS:MOH 705 A	Monthly	HF, Community	DHIS	Facility in charge		266709 (5%)	253373	240704	228669	217236	206374
9	% of adult population with BMI over 25	Proportion of adults with >25 BMI Screened	Nutrition	Proportion of adults with >25 BMI screened	Total adult population screened	Outcome	MOH 711	Monthly, Quarterly, Annually	HF	Primary	Facility/C	2018	141 (per 100000)	151	161	171	181	191
10	% women of reproductive age screened for Cervical cancers	Proportion of women in reproductive age screened	RMNCAH	Number of women screened	Total number of women in reproductive age	Outcome	MOH 705 AB	Monthly, Quarterly, Annually		Primary	Facility/C	2018	979 (per 100000)	1000	1050	1100	1150	1200
11	% of new outpatients with mental health conditions	Proportion of out patients attended with mental illness	Medical services	Number of out patients attended with mental illness	Total number of out patients attended	Outcome	MOH 705 AB	Monthly, Quarterly, Annually		Primary	Facility/C	2018	1163	1200	1300	1400	1500	1600
12	% of new outpatients cases with high blood pressure	Proportion of out patients attended with high blood pressure	Medical services	Number of outpatient cases with high BP	Total Number of out patients attended to	Outcome	MOH 705 AB	Monthly, Quarterly Annually		Primary	Facility/C	2018	2961	4000	4500	5000	5500	6000
13	% of patients admitted with cancer	Proportion of patients admitted with cancer	Medical services	Number of patients admitted with cancer	Total number of admissions	Outcome	MOH 705 AB	Monthly, Quarterly Annually		Primary	Facility/C	2018	No data					
14	% new outpatient cases attributed to gender-based violence	Proportion of outpatient cases attributed to gender-based violence	Medical services	Number of new outpatient cases attributed to gender based violence	Total Number of out patients attended to	Outcome	MOH 705 AB	Monthly, Quarterly Annually		Primary	Facility/C	2018	0.03	0	0	0	0	0
15	% new outpatient cases attributed to road traffic Injuries	Proportion of outpatient cases attributed to road traffic injuries	Medical services	Number of new outpatient cases attributed to road traffic accidents	Total Number of out patients attended to	Outcome	MOH 705 AB	monthly, Quarterly Annually		Primary	facility/C	2018	2033					

No	Indicator	Indicator Definition	Program Area	Numerator	Denominator	Indicator Type	Data collection Tools	Frequency of collection/ reporting	Data Collection Level (Community, HF, Other)	Data Source	Responsible entity	Baseline Year	Baseline Value	Target				
														Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
16	% new outpatient cases attributed to other injuries	Proportion of outpatient cases attributed to other injuries	Medical services	Number of new outpatient cases attributed to other injuries	Total Number of out patients attended to	Outcome	MOH 705 AB	monthly, Quarterly, Annually		Primary	facility I/C	2018	24776					
17	% of deaths due to injuries	Proportion of deaths due to injuries	Medical services	Number of deaths due to injuries	Total number of deaths	Outcome	MOH 705 AB	Monthly, Quarterly, Annually		Primary	Facility I/C	2018	-					
18	% of new outpatient cases attributed to high blood sugar	Proportion of outpatient cases attributed to high blood sugar	Medical services	Number of outpatients with high blood sugar	Total number of new outpatient cases	Outcome	MOH 705 AB	Monthly, Quarterly, Annually		Primary	Facility I/C	2018	3610					
19	% of new outpatient cases attributedto visual defects	Proportion of outpatient cases attributed to visual defects	Medical services	Number of outpatient cases with visual defects	Total number of new outpatient cases	Outcome	MOH 705 AB	Monthly, Quarterly, Annually		Primary	Facility I/C	2018	15603					
20	% deliveries conducted by skilled attendant	Deliveries conducted by a skilled birth attendant	Reproductive Health	N: Number of deliveries conducted by skilled personnel	D:Total estimated population of deliveries of expected	Output	MOH 333;DHIS – MOH 711, MOH 717,	Monthly	HF	DHIS	Facility in charge		13869 (5%)	13869	14562	15290	16054	16857
21	% of women of reproductive age receiving family planning	Number of women aged 15-49 receiving family planning methods.	Reproductive Health	N: Numberof women receiving family planning services	D:Total number of women of reproductive age	Output	MOH 512; DHIS – MOH 711, MOH 717	Monthly	HF	DHIS	Facility in charge		43575 (2%)	44446	45335	46242	47166	48110
22	% of facility based maternal deaths	Death ofwoman resulting from pregnancy related conditions in a health facility	Reproductive Health	N: Number of maternal deaths occurring at the facility	D:Total number of expected deliveries	Outcome	MOH 333; DHIS – MOH 711;	Monthly	HF	DHIS	Facility in charge		8	0	0	0	0	0
23	% of facility based under five deaths	<5 deaths occurring at the health facilities	Child Health	N: Number of underfive deaths occurring at the facility	D:Total number of children under the age of 5	Outcome	MOH 511, MOH 301, MOH 204A; DHIS– Inpatient Morbidity and Mortality Report; KNBS projection	Monthly	HF	DHIS	Facility in charge		99	0	0	0	0	0
24	% of newborns with low birth weight	Newborns with low birth weight less than 2.5kg.	Nutrition	N: Number of newborns with less than 2.5kg body weight	D: Actual number of live births whose birth weights were measured	Outcome	MOH 333; DHIS – MOH 105	Monthly	HF	DHIS	Facility in charge		770 (15%)	693	623	530	450	383
25	% of facility based fresh stillbirths	Babies born death the facilities	Reproductive Health	N: Number of facility based fresh still births	D:Total number of deliveries conducted	Outcome	MOH 333; DHIS – MOH 717	Monthly	HF	DHIS	Facility in charge		111	105	100	95	90	85
26	% of pregnant women attending fourantenatal care visits	Pregnant women accessing ante natal care in facilities	Reproductive Health	N: Number of women making 4th ANC visit	D:Total number of pregnant women	Outcome	MOH 406; MOH 105; DHIS– MOH 711; KNBS projection	Monthly	HF	DHIS	Facility incharge		9437 (5%)	9909	10404	10924	11470	12043
27	% infants under six months on exclusive breastfeeding	Children less than 6 months old being exclusively breastfed	Nutrition	N: Number of infants who are exclusively breastfed up to the age of 6 months	D: Number of infants aged less than 6 months attending a child welfare clinic in a month	Outcome	MOH 704; MOH 713; MOH 511; MOH 216	Monthly	HF	DHIS	Facility in charge	2018	4145	4352	4569	4798	5037	5289
28	% population with access to safe water	Safe water istreated/piped water	WASH	Total homes with access to treated/piped water	Total county population	Outcome	MOH 515	Monthly	Community	DHIS	CHVs	2018	356073	356163	356273	356373	356473	356573
29	% children under five stunted	Children under 5 years attending CWC who fall below minus 2 SD from the median height for age of WHO child growth standards	Nutrition	Children under five with stunted growth	D:Total number of children under 5 years measured	Outcome	MOH 713	Monthly	HF	DHIS	Facility in charge	2019	6884	5851	5675	5505	4954	4806
30	% children under five underweight	Number of children under 5 years attending CWC who fall below minus 2 SD from the median weight	Nutrition	children under five who are underweight	Total number of <5children attending CWCchildren	Outcome	MOH 711	Monthly	HF	DHIS	Facility in charge	2019	25474	20379	15284	10189	5094	0
31	% of households with latrines	Households that use an improved sanitation facility	WASH	Number of households that use an improved sanitation facility, urban/rural	Estimated households in urban and rural areas	Outcome	MOH 515	Annually	Community	DHIS	CHVs, SCPHOs, CPHO	2018	119064 (5%)	125017	131267	137831	144722	151958

No	Indicator	Indicator Definition	Program Area	Numerator	Denominator	Indicator Type	Data collection Tools	Frequency of collection/ reporting	Data Collection Level (Community, HF, Other)	Data Source	Responsible entity	Baseline Year	Baseline Value	Target				
														Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
33	Per capita outpatient utilisation rate (M/F)	The rate at which specific outpatient patient is being utilized	All	Total number of patients attending outpatient seen at outpatient department	Expected number of outpatient clients	Output	Daily Activity Report/MOH 204AB,MOH 705	Quarterly, Semi Annual & Annual	County & Sub County	DHIS2	CHRIO/SCHRIOs	2018	2.2	2.3	2.4	2.5	2.6	2.7
34	Proportion of children 659 months supplemented with vitamin A	Children receiving Vit. A	Nutrition	N:number of children supplemented with vitamin A	Total Pop < 659 Months	Output	MOH 710	Monthly	HF	DHIS	Facility in charge	2018	73366	80702	81436	81509	81517	81518
35	% of children <15 yrs detected with AFP	No of children<15 yrs	VPD Surveillance	Total No. of cases detected	Total Pop < 15yrs	Outcome	MOH 502	monthly	HF	DHIS	SCDSC	2018						
36	Proportion of health facilities implementing IMAM	Integrated management of acute malnutrition	Nutrition	N: Number of facilities offering IMAM	Total number of facilities in the county	Output	MOH 713	Annually	Sub county	DHIS	SCN	2018	100	102	104	106	108	110
37	% of facilities providing BEOnNC	Facilities providing basic essential obstetric care services	reproductive health	N: Total number of level 2-6 facilities providing BEmONC	D: Total number of level 26 facilities in the area	Output	Rapid health facility surveys; Updated Master Facility List	Annually	Sub county		Head, planning and policy	2019	180	182	184	186	188	190
38	% of facilities providing CEOC	Facilities providing comprehensive essential obstetric care services	reproductive health	N: Number of level 4-6 health facilities providing CEmONC	D: Total number of level 46 health facilities in the catchment area surveyed	Output	Rapid health facility surveys; Updated Master Facility List (MFL)	Annually	Sub county		Head, planning and policy	2018	2	3	4	5	6	7
40	% of facilities providing immunisation	Facilities providing immunization services	Immunization	N: Number of health facilities providing immunization services	D: Total health facilities level in the county	Output	Rapid health facility surveys; Updated Master Facility List	Annually	county		Head, planning and policy	2018	180	190	200	210	220	240
41	TB cure rate	Sputum smear-positive patients accessing 6th month smear-negative microscopy result	TB	Number of sputum smear positive patients having negative 6th month result	Total number of bacteriologically confirmed TB cases	Outcome	Facility TB Register	monthly, Quarterly, annually	HF	TB4; TIBU	Sub county TB Coordinator	2017	71	74.8	78.6	82.4	86.2	90
42	Percentage confirmed malaria cases	Patients tested positive for malaria using RDT or microscopy	Malaria	Number of patients who have tested positive for malaria	Total number of cases suspected for malaria	Output	Morbidity Register	Monthly, Quarterly, annually	HF	OPD Register (MOH 705A/B)	Sub county Malaria Coordinator	2017	64.9	100	100	100	100	100
43	Proportion of maternal deaths reviewed	maternal death Review is an in-depth systematic analysis of maternal deaths to delineate their underlying health social and other contributory factors; the lessons learned from such a review are used in making recommendations to prevent similar future deaths.	Reproductive Health	Number of maternal deaths reviewed	Total number of maternal deaths reported	Output	Maternal review form	Daily, Monthly, Quarterly, annually	HF	MOH 711, MOH 333,	RH coordinator	2018	100	100	100	100	100	100
44	Malaria case fatality	Malaria confirmed cases who died while undergoing treatment	Malaria	Number of malaria confirmed who died while undergoing treatment	Total number of malaria confirmed	Outcome	outpatient &Inpatient Register	Monthly, Quarterly, annually	HF	OPD Register (MOH 705A/B)	Sub county Malaria Coordinator	2017						
45	Average length of stay	Length of Stay- The duration a patient spends in a health facility from admission to discharge	Medical services	Grand sum of Inpatient days	Total No. of Discharges	Output	Inpatient register	Daily, Monthly, Quarterly, annually	HF	Inpatient register	Facility in charge	2018	7	6	5	4	3	2
46	Percentage of functional community units	Functional community units	Community Health Services	N: Number of Community Units reporting to DHIS	D: Total number of Community Units established	Output	MOH 515	Monthly	Community	DHIS	CHVs, Community health focal persons	2018	23	28	33	38	43	46

No	Indicator	Indicator Definition	Program Area	Numerator	Denominator	Indicator Type	Data collection Tools	Frequency of collection/ reporting	Data Collection Level (Community, HF, Other)	Data Source	Responsible entity	Baseline Year	Baseline Value	Target				
														Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
47	HIV prevalence	Proportion of new HIV infections and already existing cases in the population	HIV	Estimated new infections + current infections	Total population	Outcome	HIV Surveillance; Program reports	Annual	HF, Surveys	HTS Register (MOH 362); ART Register (MOH 361A, MOH 361B); DAR (MOH 366)	Program Coordinator (County &Sub county); Service providers	2017	1.3	1.2	1.1	1	1	1
48	PercentageHIV new infections	New HIV incidences	HIV	New cases of HIV reported	Total population	Outcome	HIV Surveillance; Program reports	Annual	HF, Surveys	HTS Register (MOH 362); ART Register (MOH 361A, MOH 361B); DAR (MOH 366)	Program Coordinator (County &Sub county); Servie providers	2017	0.3	0.25	0.2	0.15	0.1	0.1
49	Percentage of pregnant women presenting with malaria	Pregnant women presenting with malaria at the facility	Malaria	Number of confirmed malaria cases among pregnant women	Total number of pregnant women	Outcome	Morbidity Register	Monthly	HF	OPD Register (MOH 705A/B)	Sub county Malaria Coordinator	2018	7.50	7.00	6.00	5.50	4.00	3.00
50	TB cases notified (per 100,000 population)	Newly diagnosed TB cases notified	TB	Number of TB patients reported	Total population	Outcome	TB4	Quarterly	HF	TIBU	Sub county TB Coordinator	2017	106	126	146	166	186	206
51	Proportion of facilities with functional quality improvement teams	A functional QI team should hold monthly meetings to discuss quality of services offered, areas of improvement ,develop, implement and monitor a joint action plan with respective health facilities	QI/QA	Number of facilities with a QI team	Total number of facilities with more than one staff	Outcome	Emonc Assessment tool	Biannual	HF		Facility in charges	2018	30	50	60	70	80	90
52	Number of community units with functional WITs	A functional Community WIT should hold monthly meetings to discuss quality of services offered by CHVs at community, identify areas of improvement, develop, implement and monitor a join action plan with respective CUs	QI/QA	Number of community units with a functional WIT	Total number of community units	Outcome	QI file	Biannual	Community	DHIS	CHEW	2018	20	30	40	50	60	70
53	Monthly reporting rates for essential medicines and program commodities	All facilities should submit a monthly report of essential medicines and program commodities	Supply chain	Number of facilities submitting monthly report	Total number of facilities expected to submit reports	Output	EMMS template ,FCDRR for FP ,Malaria and HIV	Monthly	HF	DHIS,EMMS tracker	pharmacists and facility incharges	2018	50	60	70	80	100	100
54	Percentage of facilities stocked according to plan	All facilities should be stocked according to plan	Supply chain	Number of facilities reporting to bestocked for all commodities	Total number of facilities expected to be stocked with essential tracer medicines and program commodities	Output	FCDRR reports, EMMS template	Monthly	HF	DHIS,EMMS tracker		2018	50	60	70	80	100	100
55	Percentage of facilities that submit accurate commodity report	All facilities should submit an accurate commodity report	Supply chain	Number of facilities whose beginning balance tallies with ending balance	Total number of facilities reports	Output	FCDRR reports,EMMS template	Monthly	HF	DHIS,EMMS tracker		2018	50	70	80	90	100	100
63	Percentage of HFs provided with quarterly Support supervision	A Health facility should receive support supervision from the Sub County team at least once in a quarter	All	Number of health facilities visited for purposes of support supervision	Total number of health facilities	Output	Supervision checklist	Quarterly	Sub County	Activity report	SCHMT		70	80	90	100	100	100
64	Per capita outpatient utilisation rate (M/F)	The rate at which specific outpatient patient is being utilized	All	Total number of patients attending outpatient seen at outpatient department	Expected number of outpatient clients	Output	Daily Activity Report/MOH 204AB, MOH 705	Quarterly,Semi Annual & Annual	County & Sub County	DHIS2	CHRIO&CHRIOs	2018	2.2	2.3	2.4	2.5	2.3	2.7

No	Indicator	Indicator Definition	Program Area	Numerator	Denominator	Indicator Type	Data collection Tools	Frequency of collection/ reporting	Data Collection Level (Community, HF, Other)	Data Source	Responsible entity	Baseline Year	Baseline Value	Target				
														Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
65	Percentage of population living within 5km of a facility	Eligible population are households living with 5km of a facility	All	Number of Households living within 5KM of a facility	Total catchment population of a facility	Outcome	GIS mapping devices	Annual	County & Sub County	Yearly GIS Mapping report	CDMS	2018						
66	Percentage of quarters for which analysed health information is shared with the sector	Health information can be shared on for a such as CMEs,Reviewmeetings,supportsupervisions,stakeholders forums etc	All	Number of health information sharing for a held	Expected number of health information sharing for a	Output	Activity report	Quarterly	County & Sub County	Activity report/DHIS2	CM&E Officer	2018	50	100	100	100	100	100
72	Number of medical health workers per 10,000 population	Medical Health workers here refers to nurses,clinical officers,medical doctors working in GOK Health facilities	HRH	Number of health workers	Total population	outcome	iHRIS Report	Quarterly	County & Sub County	iHRS	iHRIS focal persons	2018	10	20	30	40	50	60
73	Percentage staff who have undergone CPD	Eligible health workers from all the cadres who have completed CDP training	HRH	Number of staff trained	Number of eligible health workers	output	iHRIS Report	Quarterly	County & Sub County	Activity report	iHRIS focal persons	2018	57 (734/1285)	60	70	80	90	90
74	Percentage of health workers who have undergone leadership and management courses	Eligible health workers from all the cadres who have completed leadership management training	HRH	Number of staff undergone Leadership and management trainings	Total number of eligible staff	output	iHRIS Report	Quarterly	County & Sub County	Activity report	iHRIS focal persons	2018	3 (45/1285)	4	4	5	5	5
75	Staff attrition rate	Number of staff exiting the health workforce	HRH	Number of staff exiting the health workforce	Total number of staff	outcome	iHRIS Report	Quarterly	County & Sub County	iHRS	iHRIS focal persons	2018	2 (30/1285)	2	1	1	1	1
76	Percentage of health workers completing annual appraisal forms	Eligible health workers from all the cadres participating in annual staff appraisal	HRH	Number of health workers completing annual appraisal form	Total number of eligible health workers	output	iHRIS Report	Quarterly	County & Sub County	Appraisal report	iHRIS focal persons	2018	58 (750/1285)	70	80	90	95	95
77	Percentage of health workers with up to date data in IHRIS, staff returns and IPPD	Health workers with up to date data in IHRIS, staff returns and IPPD	HRH	Number of health workers with up to date data on iHRIS IPPD and staff returns	Total Number of Health workers	outcome	iHRIS Report	Quarterly	County & Sub County	iHRS	iHRIS focal persons	2018	70 (900/1285)	100	100	100	100	100

APPENDIX 2 : REPORTING TOOLS AND RESPONSIBLE PERSONS

#	Available Reporting Forms	Responsible Person	Overall responsibility at Sub-county	Hospitals	Primary Health Facility/ Community Unit.	Overall Responsibility at Health Facility	HF Reporting Channel (Where Applicable)
1	CHEW Summary (MOH 515)	Community Unit Focal person	SCHRIO/ SCMOH	CHEW	CHEW	Med Sup/ In-Charge	Hardcopy/DHIS
2	MoH 711 Integrated	Reproductive Coordinator/ District Public Health Nurse (DPHN)	SCHRIO/ SCMOH	Sectional In-charge/ HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
3	MoH 731-1 HIV CT	County AID and STI Coordinator	SCHRIO/ SCMOH	Sectional In-charge/ HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
	MoH 731-2 PMTCT	County AID and STI Coordinator	SCHRIO/ SCMOH	Sectional in-charge/ HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
	MoH 731-3 C&T	County AID and STI Coordinator	SCHRIO/ SCMOH	Sectional In-charge/ HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
	MoH 731-4 VMC	County AID and STI Coordinator	SCHRIO/ SCMOH	Sectional In-charge/ HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
	MoH 731-5 PEP	County AID and STI Coordinator	SCHRIO/ SCMOH	Sectional In-charge/ HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
	MoH 731-6 Blood Safety	County AID and STI Coordinator	SCHRIO/ SCMOH	Sectional In-charge/ HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
4	HCBC	County AID and STI Coordinator	SCHRIO/ SCMOH	Sectional In-charge/ HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
5	IDSR Weekly	District Disease Surveillance Coordinator(DDSC)	SCHRIO/ SCMOH	Facility surveillance focal person	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
6	Hospital Administrative Statistics (HAA).	County HRIO	SCHRIO/ SCMOH	HRIO		Med Sup/ In-Charge	Hardcopy/DHIS
7	MoH 705 A OPD <5 years	County HRIO	SCHRIO/ SCMOH	HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
8	MoH 705 B OPD >5 years	County HRIO	SCHRIO/ SCMOH	HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
9	MoH 717 Service Workload	County HRIO	SCHRIO/ SCMOH	HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
10	MoH 718 Inpatient M and M	County HRIO	SCHRIO/ SCMOH	HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
11	MoH 710 Immunization	CHMT Member responsible for Immunization	SCHRIO/ SCMOH	HRIO	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
12	MoH 706 Laboratory Report	County Laboratory Coordinator	SCHRIO/ SCMOH	Lab In-Charge	Lab In-Charge.	Med Sup/ In-Charge	Hardcopy/DHIS
13	Support Supervision	Chair CHMT	SCHRIO/ SCMOH	Sectional In-Charge/ HRIO			Hardcopy/DHIS
14	IMAM	County Nutrition Coordinator	SCHRIO/ SCMOH	Nutritionist	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
15	MoH 713 Nutrition Monthly Reporting.	County Nutritionist	SCHRIO/ SCMOH	Nutritionist	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
16	MoH 708 Environmental Health	County Public Health Officer.	SCHRIO/ SCMOH	PHT	Public Health Officer/Public Health Technician	Med Sup/ In-Charge	Hardcopy/DHIS

#	Available Reporting Forms	Responsible Person	Overall responsibility at Sub-county	Hospitals	Primary Health Facility/ Community Unit.	Overall Responsibility at Health Facility	HF Reporting Channel (Where Applicable)
17	Quarterly report on Tuberculosis and Multiple Drug Resistant TB case-finding	County TB and Leprosy Coordinator.	SCHRIO/ SCMOH	CO Tuberculosis and Lung	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
18	Cohort Report for TB	County TB and Leprosy Coordinator.	SCHRIO/ SCMOH	CO Tuberculosis and Lung	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
19	HSSF Monthly Expenditure	County Health Department Accountant	SCHRIO/ SCMOH	Facility accountant	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
20	HSSF summary	County Health Department Accountant	SCHRIO/ SCMOH	Facility accountant	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
21	Malaria Commodities Form	County Malaria Coordinator.	SCHRIO/ SCMOH	Pharmacist	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
22	Non-Pharmaceutical	County Pharmacist.	SCHRIO/ SCMOH	Nursing Officer Incharge	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
23	Division of Occupational therapy	County Occupational Therapist	SCHRIO/ SCMOH	Occupational Therapist	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
24	Logistic Management Information	Reproductive Health Coordinator/Sub county PHN	SCHRIO/ SCMOH	Pharmacist	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
25	FP Contraceptives	County Reproductive Health.	SCHRIO/ SCMOH	MCH In-Charge	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
26	Maternal Death Review Form	County HRIO	SCHRIO/ SCMOH	Maternity In-Charge – Maternal Death review team.	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
27	Ophthalmology Services	County Ophthalmologist	SCHRIO/ SCMOH	Ophthalmologist.	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS
28	Orthopedic Plaster	County Plaster technologist	SCHRIO/ SCMOH	Plaster Technologies.	Facility In-Charge	Med Sup/ In-Charge	Hardcopy/DHIS

APPENDIX 3

BARINGO COUNTY GOVERNMENT
DEPARTMENT OF HEALTH SERVICES

Document: Procedure for Data Collection	
Document Number:	I
Point of Use:	Health Facility and Community Unit
Frequency:	Daily

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

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

CHECKLIST FOR DATA COLLECTION

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

BARINGO COUNTY GOVERNMENT
DEPARTMENT OF HEALTH SERVICES

Document: Procedure for Data Collation and Validation	
Document Number:	2
Point of Use:	Health Facility and Community Unit
Frequency:	Daily, Weekly, and Monthly

Objective: To ensure accurate, complete and timely collation and validation of data.

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

CHECKLIST FOR DATA COLLATION AND VALIDATION BY DATA COLLECTOR

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

CHECKLIST FOR DATA VALIDATION BY SUPERVISOR

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

BARINGO COUNTY GOVERNMENT
DEPARTMENT OF HEALTH SERVICES

Document: Procedure for Reporting in DHIS2	
Document Number:	3
Point of Use:	County, Sub-County and Health Facility
Frequency:	Weekly, Monthly and Quarterly

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

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

CHECKLIST FOR REPORTING IN DHIS2

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

BARINGO COUNTY GOVERNMENT
DEPARTMENT OF HEALTH SERVICES

Document: Procedure for Data Analysis	
Document Number:	4
Point of Use:	County, Sub-County, Health Facility and Community Unit
Frequency:	Weekly, Monthly, Quarterly, and Yearly

Objective: To ensure accurate, valid, reliable and consistent analysis of data

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

CHECKLIST FOR DATA ANALYSIS

- Final approved data should be made available for data analysis
- Analyze data for priority indicators i.e. aligned to Annual Work Plans, programmatic strategic plans, County Health Sector Strategic and Investment Plan, County Integrated Development Plan, UHC and SDG
- Standard indicators should be used and the information verified and availed using information products e.g. dashboard, chal kboards, bulletins, county profiles amongst others
- Health information products should be developed, verified and circulated to relevant stakeholders including HMTs (County, Sub-County, and Facility) for discussions on data quality and performance improvement during data use meetings/ forums
- Document statistical methods used to ensure that the process can be replicated in future

BARINGO COUNTY GOVERNMENT
DEPARTMENT OF HEALTH SERVICES

Document: Procedure for Sharing and Use	
Document Number:	5
Point of Use:	County, Sub-County, Health Facility and Community Unit
Frequency:	Monthly, Quarterly and Yearly

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

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

CHECKLIST FOR DATA SHARING AND USE

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

APPENDIX 4: LIST OF CONTRIBUTORS

#	Name	Designation
1	Hon. Mary Panga	CEC - Health Services
2	Dr. Gideon Toromo	Chief Officer- Med. Services
3	Dr. Winnie Bore	Chief Officer Prev. Health
4	Dr. Abakalwa Gerishon	CDH - Admin / Planning
5	Dr. Robert Rono	CDH - Public Health
6	Dr. Mary Sang	M&E Officer
7	Mr. Gideon Yano	CHRIO
8	Mr. Zacharia Kimwetich	Special Programmes
9	Ms. Jane Sarich	SCHC - Tiaty
10	Mr. Patrick Terer	County H.A. O
11	Mr. Kiprono Kosgei	County Economist
12	Ms. Rhoda Tumo	AG. HRIO
13	Mr. Richard Tuitoek	SCHC - Mogotio
14	Dr. Mue Winnie	Med. Sup. Marigat
15	Dr. Philip Kamau	Med. Sup Kabartonjo
16	Mr. Ezekiel Kimetto	SCHC- E/Ravine
17	Mr. Isack K. Cheserek	C Wash/CLTSC
18	Christine Kiecha	Palladium CMLAP II - Ad. Gov
19	Dr. Samuel Nyingi	Palladium CMLAP II - Gov. Specialist
20	Ms. Maureene Ochieng	Palladium CMLAP II - CPLS
21	Mr. Erick Odipo	Afya Uzazi - SMERL
22	Mr. Benard Nyauchi	Afya Uzazi- LRM
23	Mr. Saul Atwa	Afya Uzazi - MERL
24	Ms. Mary Kamau	Afya Uzazi - HRH
25	Mr. Philip Koitalel	Afya Nyota - AD HSS
26	Ms. Sarah Olalo	Fred Hollows - P.O
27	Mr. Nick Oyugi	Palladium CMLAP - M&E Specialist

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