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County Institutional Capacity Assessment: Busia, Kakamega, Migori, Mombasa, Turkana

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DISCLAIMER

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ABBREVIATIONS

AIE	Authority to Incur Expenditure
ANC	Antenatal Care
ARV	Antiretroviral
AWP	Annual Work Plan
CAC	County Assessment Coordinators
CAF	County Assessment Facilitators
CEC	County Executive Committee Member for Health
CHA	Community Health Assistants
CHD	County Health Department
CHEW	Community Health Extension Workers
CHMT	County Health Management Team
CHS	County Health Strategy
CHSSIP	County Health Sector Strategic and Investment Plan
CHV	Community Health Volunteers
CIDP	County Integrated Development Plan
CICA	County Institutional Capacity Assessment
CICAT	County Institutional Capacity Assessment Tool
DANIDA	Danish International Development Agency
DHIS	District Health Information System
DQA	Data Quality Assessment
EHR	Electronic Health Record
EMMS	Essential Medicines and Medical Supplies
HIS	Health Information System
HPAK	Health Promotion Alliance of Kenya
HPP+	Health Policy Project Plus
HPT	Health Products and Technologies
HRD	Human Resources Development
HRH	Human Resources for Health
HRM	Human Resources Management
IBTCI	International Business and Technical Consultants Inc.
ICT	Information Communication Technology
IFMIS	Integrated Financial Management Information System
iHRIS	Integrated Human Resource Information System
IMCI	Integrated Management of Childhood Illness
ITN	Insecticide Treated Nets
IP	Implementing Partner
JICA	Japan International Cooperation Agency

KDHIS	Kenya District Health Information System
KEA	Kenya and East Africa
KEMSA	Kenya Medical Supplies Authority
KEPH	Kenya Essential Package for Health
KHSSP	Kenya Health Sector Strategic and Investment Plan
KMTC	Kenya Medical Training College
LMIS	Logistics Management Information Systems
M&E	Monitoring and Evaluation
MEDS	Missions for Essential Medicines
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSH	Management Sciences for Health
NHIF	National Hospital Insurance Fund
PBB	Performance-based Budgeting
PMF	Performance Management Framework
PPB	Kenya Pharmacy and Poisons Board
PPP	Public Private Partnerships
PQM	USAID Promoting Quality of Medicines program
PS Kenya	Population Services Kenya
RMNCH	Reproductive, Maternal, Neonatal and Child Health
SCHMT	Sub-County Health Management Team
SDG	Sustainable Development Goal
SOP	Standard Operating Procedure
TB	Tuberculosis
TWG	Technical Working Group
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USAID/KEA	USAID/Kenya East Africa
USG	U.S. Government
WHO	World Health Organization

EXECUTIVE SUMMARY

This report presents the results and recommendations from the County Institutional Capacity Assessment (CICA) assessment carried out between February and April 2018 in five United States Agency for International Development (USAID) Kenya and East Africa (KEA) priority counties, namely Busia, Kakamega, Migori, Mombasa, and Turkana. It includes a detailed analysis of key findings under each building block for all five focus counties and critical gaps in the health system identified through the CICA and which need to be addressed. This report also outlines the action plans proposed by county officials and implementing partners (IPs) that explain the operational strategies recommended to address each prioritized critical gap. Detailed action plans for each county are provided as in Annex C.

Through combined use of the institutional capacity assessment tool developed by USAID's Office of Health Population and Nutrition with desk reviews and focus groups, the Evaluation Team measured each county's capacity relative to the six World Health Organization (WHO) building blocks of the health system:

1. Governance and Leadership
2. Health Workforce
3. Health Information Systems
4. Access to Essential Medicines and Other Health Commodities
5. Health Systems Financing
6. Delivering Essential Health Services

The purpose of the CICA was to develop a shared understanding of the current capacity of institutions and organizations that the County Health Management Teams (CHMTs) represent in order to analyze gaps and develop a responsive capacity building strategy in the form of action plans. The assessment aimed to facilitate self-assessment for the evaluation of the county institutional capacity; provide a basis for joint prioritization of critical gaps by the county team; develop a joint action plan and responsibility assignment; provide a framework for collaboration and partnership; and provide the basis for contribution analysis, outcomes measurements, and accountability. The CICA technical approach made use of the institutional capacity assessment tool developed by USAID's Office of Health Population and Nutrition as the data collection tool. A purposive sampling strategy was used to identify and select participants who are most informed on county health programming. These representatives included CHMTs, Sub-CHMTs (SCHMTs), county officers from key health facilities, and USAID and non-USAID funded IPs. The assessment was implemented in a four-phased approach under the coordination of a Team Leader, two County Assessment Coordinators (CACs), and five County Assessment Facilitators (CAFs). Phase I – County Engagement, Desk Review and Team Planning; Phase II – County Institutional Capacity Assessment Tool (CICAT) Implementation Fieldwork; Phase III – Stakeholders Validation Workshop and Phase IV – Post Fieldwork and Report Writing.

All County Health Departments (CHDs) from the five counties were scored for capacity, with Kakamega showing the highest capacity at 57%, followed by Mombasa at 55%, Turkana at 54%, and Busia and Migori both at 53%. CHDs in all focus counties face largely similar challenges across the health systems building blocks. They are also similarly affected by the context in which they operate.

With respect to Governance and Leadership, Busia, Kakamega, and Turkana scored the highest capacity between the five counties. Each measured a capacity score of 44%, which is "average" capacity per the Likert scale and requires improvement. Mombasa scored the least capacity at 25%, followed by Migori at 38%. Both of these counties have limited capacity in Governance and Leadership, indicating significant support is required for improvement. Some critical gaps identified in this building block include lack of an M&E framework to track progress of the County Health Sector Strategic and Investment Plan (CHSSIP), inadequate capacity to develop work plans at all levels of the health system, lack of a communication plan, and inadequate protocols for

information flow from county and sub-county to other departments and partners. In addition, there is inadequate funding to implement annual work plans and lack of adequate financial accountability mechanisms. There is therefore a need to develop an M&E framework and communication plan, build capacity in annual work plan development, allocate and prioritize resources, and establish financial accountability mechanisms. The quality of annual work plans (AWPs) and strategies was also seen to be a challenge and therefore mentorship for the CHD, especially on the AWP development process, may be required. In addition, experience sharing and benchmarking with other counties, rather than stand-alone training, is important.

In management of Health Workforce, Mombasa and Turkana scored the highest capacity at 63% (significant functional capacity), followed by Migori at 44% (average capacity), Kakamega at 31% (limited capacity), and Busia with the least capacity at 19% (no capacity). Critical gaps identified in this area include lack of a structure and strategy for staff attraction, recruitment, and incentives for staff retention, lack of a performance appraisal system, and lack of harmonized data about trained staff at the CHD. These gaps, therefore, need to be addressed. Proposed actions to address them include developing a strategy for staff recruitment and retention, implementing and executing a performance appraisal system at all levels, and rolling out the County Performance Management Framework. Counties also need to build the capacity of more county officers on the Integrated Human Resource Information System (iHRIS) training module and conduct a Workload Indicator Staff Needs Survey to develop accurate norms and standards.

Regarding Health Information Systems, all CHDs in the five counties scored fairly high capacity. Turkana measured the highest capacity in this building block with 81%, which is very significant functional capacity, followed by Migori at 75% (significant functional capacity), Busia and Mombasa both at 69% (significant functional capacity), and Kakamega at 50% (average capacity). This area has received consistent partner support over the years. However, there are still some critical gaps that need to be addressed. Inadequate supply of data collection tools across all five counties was observed, especially at the facility and community level, and thus a need was seen for timely forecasting, procurement, and distribution of data tools—and ensuring an adequate supply of data collection tools in all service delivery points informed by demand. Capacity building of staff in management and use of data are also required, as the capacity here is low. In addition, county data management guidelines should be developed and disseminated. The DHIS2 is underutilized at the county level and capacity building of county officials on this is needed.

In ensuring Access to Essential Medicines and other Health Commodities, Kakamega and Migori CHDs measured the highest capacity,. Both these counties have a score of 63% (significant functional capacity), followed by Busia at 50% (average capacity), and then Mombasa and Turkana with the lowest in this area at 38% (limited capacity). Critical gaps identified include an inadequate ability to analyze supply chain data for forecasting and quantification; capacity building is required in this area. There is also need for an electronic system for Logistics Management Information Systems (LMIS) in Turkana and Mombasa and capacity building on LMIS for all commodity managers in the other three counties.

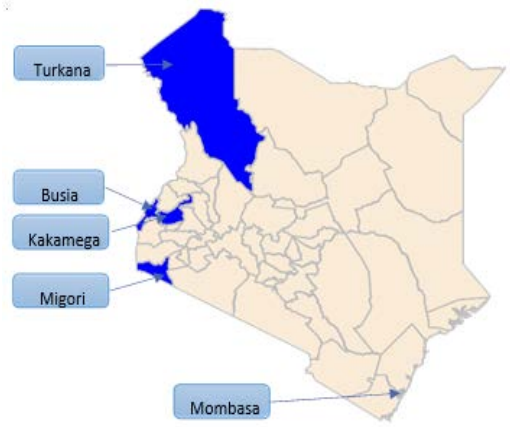
In Health Systems Financing, the CHDs capacity scored highest in Kakamega County at 75% (significant functional capacity), followed by Busia and Turkana at 50% (average capacity), Mombasa at 44% (average capacity), and Migori at 31% (limited capacity). In all five counties, the county health budget is developed annually with input from CHD. Estimated actual county health expenditures are systematically calculated on an annual basis as part of the budget formulation process. Trend analysis was used to analyze financial data (health expenditure) over the last four or five years for all five counties and this information is presented in this report. Challenges to health financing are diverse and may include long delays in disbursing funds, overreliance on partner support, low budget allocation for health services, and poor documentation. Some proposed actions to address gaps include monthly tracking of the expenditure at the departmental, sub-county, and facility level. There is a need for building the capacity of county officials respective to program-based budgeting, monitoring, execution, and reporting of budgets.

With respect to Delivering Essential Health Services, Mombasa scored the highest at 85% (very significant functional capacity) followed by Busia at 80% (very significant functional capacity), Kakamega at 75% (significant functional capacity), Migori at 65% (significant functional capacity), and Turkana at 50% (average capacity). Identified critical gaps included inadequate skills and funding in developing strategic policies and protocols on health service delivery. Also noted were inadequate involvement of community units in the annual work planning; structured and regular engagements with community units is essential to sustainable capacity. Some counties were also unable to meet some of the targets for their programs, (i.e. HIV/AIDS, tuberculosis (TB)/HIV, reproductive, maternal, newborn and child health (RMNCH), nutrition, water, sanitation and hygiene (WASH), and malaria programs). The counties need support to create community awareness, stimulating demand for health services, and also steady commodity supplies so as to achieve their targets.

1. INTRODUCTION

This section provides the purpose and objectives of the County Institutional Capacity Assessment (CICA), audience, and synopsis of the task. The purpose of the CICA was to develop a shared understanding of the current capacity of the institutions and organizations that County Health Management Teams (CHMTs) represent, in order to analyze gaps and develop a responsive capacity building strategy in the form of action plans. CICA was conducted in the five United States Agency for International Development (USAID) Kenya and East Africa (KEA) priority counties of Busia, Kakamega, Migori, Mombasa, and Turkana. The assessment aimed to facilitate self-assessment for the evaluation of the county institutional capacity; provide a basis for joint prioritization of critical gaps by county team; develop a joint action plan and responsibility assignment; provide a framework for collaboration and partnership; and provide the basis for contribution analysis, outcomes measurements, and accountability.

Figure 0.1 Five focus counties for the CICA



CICA was conducted in the five USAID KEA priority counties of Busia, Kakamega, Migori, Mombasa, and Turkana. The assessment was implemented in a four-phased approach under the coordination of a Team Leader, two County Assessment Coordinators (CACs), and five County Assessment Facilitators (CAFs).

Phase I. Phase I, which took place on February 6 and 8, 2018, involved gaining consensus on the field implementation approach and finalizing the assessment work plan and logistics. Prior to the start of the assessment, the Team Leader and the CACs visited the counties to sensitize and engage the County Health Department (CHD) representatives respecting the upcoming assessment and the indicative logistics for data collection. Turkana, Mombasa, and Migori Counties engagement happened on February 6 and engagement for Kakamega and Busia was conducted on February 8, 2018. Following the county-level engagement, the assessment team organized a five-day team planning meeting from February 12 to 19, 2018, which was an opportunity for the team to discuss the objectives of CICA, jointly review USAID's institutional assessment tool, agree on a plan for fieldwork logistics, conduct desk reviews, and plan for USAID debriefing. The outputs of Phase I included consensus on the field implementation approach and finalization of the assessment work plan and logistics.

Phase II. This was a two-step field data collection process, with county self-assessment and assessment through focused group discussions and panel discussions. This took place between February 19 and March 3, 2018 for all five counties. County self-assessment was necessary to familiarize the county stakeholders with the capacity assessment tool, as well as enable the CHMT to organize data sources in preparation for the

assessment team's visit. Whereas all the target counties were provided with the capacity assessment tool in advance, only Busia CHMT managed to undertake a thorough familiarization and scoring against each of the standards. Participants for the county assessments were drawn from three main target groups that included the CHMT/sub-county CHMT (SCHMT), key health facilities (county referral hospitals and sub county hospitals), U.S. Government implementing partners (IPs), and other stakeholders. The outputs of Phase II were five completed tools (one for each county), quantitative data, panel discussion notes, and initial action plans with responsibility assignments.

Phase III. This phase involved stakeholder validation, which took place between March 8 and April 5, 2018. Five validation workshops were conducted (one for each focus country) to validate findings from the assessment through panel discussions. This was a unique opportunity for all the development and implementing partners to engage with county leaderships in reviewing gaps, joint development of action plans, responsibility assignment, and the level of investments for every prioritized capacity gap. Information drawn from the desk reviews was also used to further enrich the panel discussion process and for data triangulation.

Phase IV, described as post fieldwork, involved consolidation of all findings, discussions, and suggestions from the validation workshops. This process culminated in the development of this CICA report. This report presents the findings of the CICA.

This report is organized to highlight the background, with a brief overview of each of the focal counties' contextual issues around the WHO's six building blocks, USAID project strategy, and activities implemented to address the purpose of the capacity assessment. The methodology provides a description of the analytical methods used followed by the key findings, critical gaps, and action plans identified within each building block, and organized by every focal county. Annexes show more detail.

2. BACKGROUND

Kenya has adopted universal health coverage (UHC) as one of four priority agendas—with the aspiration that by 2022 all persons in Kenya will be able to use the essential services they need for their health and well-being through a single unified benefit package, without the risk of financial catastrophe. An ambitious 100% target on UHC for all households in five years was undertaken, including enrolling all three million secondary school students into the National Hospital Insurance Fund (NHIF) by January 2018. This is part of a broader Government of Kenya agenda, with a road map for UHC aiming to reach 13 million principal members (from the current six million Kenyans). Support for UHC has been echoed at subnational level, with county governments taking the lead in rolling out UHC-related programs such as MakueniCare in Makueni County (Government of Makueni County. Makueni Universal Health Access Programme (Makueni Care): Realizing Universal Health Coverage: Department of Health Services; 2016).

At a global UHC forum in Tokyo, Japan in December 2017, Kenya was selected for the Tokyo Joint UHC initiative as one of 10 pilot countries. The initiative is in collaboration with the Government of Japan, Japan International Cooperation Agency (JICA), the World Bank, WHO, and United Nations Children's Fund (UNICEF).

The constitution of Kenya, under its Bill of Rights, gives citizens the right to the highest attainable standards of health in line with the WHO constitution (which declares health a fundamental human right), thereby committing to ensuring the highest attainable level of health for all. UHC has been adopted as Target 3.8 of the Sustainable Development Goals (SDGs), to ensure that individuals and communities receive the health services they need without suffering financial hardship. This includes provision of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care. Progress towards UHC will ensure progress towards other health-related targets and towards equity and social inclusion (2018. Refocusing on quality of care and increasing demand for services; Essential elements in attaining universal health coverage in Kenya. Policy Brief). A key for Kenya is the UHC policy window, created by the political leadership, which provides the heath sector an opportunity to reduce gaps between need and utilization, improve on quality of care, and improve on financial protection.

In addition, devolution continues to provide an opportunity for the health sector to expand services and become more accountable to citizens, providing a singular opportunity for transforming health care in the country. A rededicated effort is therefore needed to mobilize political will at all levels towards supporting devolution and strengthening leadership, management, and governance in the health sector for the realization of national health and development goals (Kenya Health Forum 2018 Communique).

A properly functioning health system has been deemed to be a critical component for accelerating progress in health and decreasing inequity in mortality and other health outcomes. WHO defines a health system to consist of all organizations, institutions, resources, and people whose primary function is to improve health. A health system therefore requires staff, funds, information, supplies, transport, communication, and overall guidance/direction in order to function. Strengthening the health system thus implies addressing key constraints and gaps in these areas (WHO, 2010. Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies. Geneva, Switzerland).

USAID has been implementing projects to address gaps and constraints around six WHO building blocks within in the five selected counties of Busia, Kakamega, Migori, Mombasa, and Turkana by with the goal of strengthening the capacity of Ministries of Health (MOH) to deliver public services in its sectors, with a key focus on supporting UHC and building institutional capacity. These projects work with county governments in order to build a strong health system responsive to the needs of individuals, families and communities (USAID/Kenya, 2014. Country Development Cooperation Strategy 2014–18).

USAID has also made significant progress in improving the supply chain management for malaria, HIV and family planning commodities. Projects in the various counties have also helped improve the collection, verification, and use of health data. In order to improve health financing, the programs strengthen planning and budgeting, with an emphasis on domestic resource mobilization for sustainability (USAID Kenya Global Health Factsheet, 2017). Health conditions in these different counties vary from county to county, with a number of common challenges and shortcomings experienced across the counties. The section below provides an overview of contextual issues around the six WHO building blocks in each of the focal counties.

WHO Health Systems Framework: Six Building Blocks

Building Block 1: Governance and Leadership

Health sector leadership addresses health stewardship and management functions, while health governance examines the function of institutions and health partnerships, including the relationships and coordination of different stakeholders (Kenya Health Sector Strategic and Investment Plan (KHSSP), June 2014–2018). The five focal counties have made significant progress in leadership and governance, but challenges are still common and cut across the five counties. Some of the constraints include lack of funds to support regular review meetings, training gaps in management, poor documentation, lack of a Public Private Partnerships (PPP) framework, and weak public participation. The KHSSP (2014–2018) identifies some of the areas that require improvement to strengthen health stewardship, including the use of annual work plan (AWP) guides to drive priority operations at all levels, consolidate health partnerships arrangements, and improve governance through monitoring and evaluation (M&E).

Building Block 2: Health Workforce

The Kenya Health Policy (KHP) 2014–2030 defines human resources for health (HRH) as the group of all people engaged in actions whose primary intent is to enhance health. For effective delivery of health services, the KHP puts emphasis on the need for an adequate, productive, equitably distributed and accessible pool of health workers. This, however, does not seem to be the case on the ground, with all focal counties reporting inadequate staff numbers across all cadres at both the county and sub-county levels. Some of the challenges that Busia faces in HRH, for instance, include lack of adequate funds for staff capacity building, poor mechanisms for attraction and retention of workers, acute staff shortages, and poor funding for supportive supervision among others. (Busia Health Sector Performance Review Report 2013/2014–2016/17). HRH is faced with similar constraints in Kakamega. The Kakamega County Health Sector Strategic and Investment Plan (CHSSIP) 2013–2017 provides an analysis of some of the constraints in HRH and points out staff shortages, weak partnerships, lack of specialized skills, and inadequate funding to support HRH activities as some of the leading challenges. In Turkana County, the CHSSIP points to an acute staff shortage with some specialized cadres reporting zero representation (MannionDaniels Ltd., 2017. Review and Tracking of Health Systems Performance in Turkana County. Institutional Review).

This is the same case with Migori County, which experiences shortage of staff to support the maternity section and other crucial departments in health facilities. Mombasa County is no different, with the doctor-to-patient ratio standing at 1:11,875 and nurse-to-population ratio at 1:18,678 (Mombasa County Government, 2017. First County Integrated Development Plan, 2013–2017). Overall, HRH is faced with similar challenges and constraints across five counties, with the leading difficulties reported as acute staff shortages and poor or little funding to support HRH activities.

Building Block 3: Health Information Systems

Health information systems (HIS) include five key areas: information generation, validation, analysis,

dissemination, and utilization. Counties receive information from facilities, vital events, regular surveys, disease surveillance, and research-based sources (KHSSP, 2014–2018). Overall, the health information sector has received support in the respective counties from both the county governments and partners, including USAID. Busia County has had major achievements in this area. The Busia Health Sector Performance Review Report 2013/2014 – 2016/17 indicated that the information department produced and disseminated 50% of its quarterly reports in 2016. The accuracy and completeness of the reports was at 95%—a key achievement. Other counties have also achieved milestones in HIS, with a few challenges in the areas of information generation and warehousing, validation, and dissemination (KHSSP 2014–2018). Health information was identified as a key area in the Kenya Health Sector Strategic and Investment Plan (2014–2018) for better investment, coordination, and alignment of health care resources. The Kenya Health Act, 2017 and Health Information Policy 2014–2030 provide for a National Health Information System that is responsive to the needs of the population.

Building Block 4: Access to Essential Medicines and Other Health Commodities

Essential medicines and other health commodities are a critical component of health care in any country's health care system. To contribute to optimal health care, these products should be available, affordable, safe, efficacious, and of good quality and use. The five focal counties where USAID is implementing its activities have reported gaps in accessing Health Products and Technologies (HPTs), which arise from multiple factors such as insufficient budget allocations for essential medicines and medical supplies (EMMS), weak institutional systems, weak regulatory structures, and inadequate personnel to handle the process (KHSSP 2014–2018). Some of the focus counties, however, have achieved some milestones in conducting quantification forecasts and lobbying for increased budget allocation to support EMMS. Nevertheless, a number of challenges are still being experienced, such as lack of supply and inadequate storage space. Other challenges include the utilization of the "push" system for commodities, lack of proper M&E to oversee the consumption of HPTs, and poor facilitation/distribution of HPTs. Counties such as Turkana have developed a procurement and supply plan, but a reported challenge in all counties remains in slow or no release of funds to support the timely purchase of products.

Building Block 5: Health Systems Financing

Health financing is fundamental to the ability of health systems to maintain and improve human welfare. This building block is concerned with the mobilization of funds, accumulation and allocation of resources to cover the health needs of the people individually and collectively in the health system (WHO, 2010. Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies. Geneva, Switzerland). Challenges to health financing are diverse and may include long delays in disbursing funds, overreliance on partner support, low budget allocation for health services, and poor documentation. Across the five counties, available direct financing allocations are inadequate to facilitate management functions and tracking expenditure for accountability is not regularly carried out. (KHSSP 2014–2018). All the focus counties report facing a number of challenges, including the lack of a resource mobilization strategy, or health financing framework, or a county health bill—all which contribute to coordinating finances and the accountability of resources.

Building Block 6: Delivering Essential Health Services

This building block looks into investments relating to the organization and management of health services (KHSSP 2014–2018). This covers the capacity of the county governments to engage sub-counties in delivering health services, its capacity to ensure appropriate use of standards and policies in the USAID thematic areas, and the capacity of the CHD to deliver proper health care in the priority areas.

USAID has been supporting the health sector in Kenya at both the county and at the national level. Projects are implemented by a consortium of IPs which include: HRH Kenya Programme, Health Policy Project Plus

(HPP+), Afya Ugavi, Afya Timiza, Afya Pwani, Health Communication Marketing (PS Kenya and others), PS Kenya, Tupime KauntiCounty, University of Maryland, Afya Halisi, Health Informatics Governance and Data Analytics, and PACT Timiza. These partners implement projects in the five focus counties in the areas of HIV/AIDs prevention, family planning, reproductive, maternal, newborn and child health (RMNCH), malaria prevention, nutrition, WASH, and TB control and prevention.

The support provided by these partners includes training of health care professionals, policy and strategy development, procurement and management of health commodities, health financing, and health information management. The projects work to build a stronger health system more responsive to the needs of individuals, families, and the community. In the prevention of malaria, for example, the support by USAID includes procurement of malaria treatment, provision of treated mosquito nets, and support for spraying of insecticides in homes. In RMNCH, activities focus on continuum of antenatal care (ANC), newborn care, postpartum care, skilled birth attendance, and support for voluntary family planning. The HIV epidemic has also seen USAID-implemented projects that enable HIV-positive persons to access treatment and care. These activities focus on HIV palliative care, nutrition, home based care, and TB services.

3. METHODOLOGY AND APPROACH

This section provides a brief description of the assessment methods used for the CICA and a detailed presentation on the analytical methods used, including data triangulation analytical processes and description on data limitations.

A cross-sectional assessment was carried out for this county institutional capacity assessment. This activity included an assessment of county core functions and expected outcomes using the six building blocks.

3.1. CICA Tool

The approach made use of the institutional capacity assessment tool developed by USAID's Office of Health Population and Nutrition as the data collection tool. This is a self-assessment tool; this means that during the assessment, CICA participants, including members of the CHMT/SCHMT, key health facilities (county referral hospitals and sub-county hospitals), U.S. Government (USG) and non-USG IPs, and other stakeholders worked through each component of the CICA tool together. Through discussion and validation, they came to a consensus on the appropriate score to assign for each standard and agreed on the findings. All county participants received the tool ahead of time in order to have a sense of the questions that were discussed and to locate any relevant documents that might be useful in answering the questions.

3.2. Assessment Sites and Sampling Strategy

This institutional capacity assessment focused on five focus counties, namely Busia, Kakamega, Migori, Mombasa, and Turkana. The selection of CICA participants was discussed during the initial county engagements. A purposive sampling strategy was used to identify and select participants who are most informed on county health programming. The county leadership selected fifteen representatives per county. These representatives included CHMT, SCHMT, and county officers from key health facilities. Five IPs including USG partners in the program areas of HIV/AIDS, TB/HIV, RMNCH, nutrition, WASH, and malaria were also selected.

3.3. The Approach

A phased implementation approach to this task order was carried out, as described in the section below.

3.3.1. Phase I – County Engagement, Desk Review and Team Planning

County Engagement: The Team Leader and the CACs engaged with the CHD leadership in all five counties. They visited the counties to sensitize them on the assessment, agree on the upcoming assessment, and plan for logistics of data collection. This was done in a period of two days: Turkana, Mombasa, Migori on February 6, 2018; and Kakamega and Busia on February 6, 2018. The CHD leadership expressed interest and commitment to the CICA process and appointed a lead person from the county to coordinate the process. The dates, venues, and participants for the CICA were discussed and agreed upon. The CICA tool was also shared with the county teams for joint self-assessment prior to the panel discussions with the assessment team.

Desk review: The desk review involved looking through national health-specific documents, county health-specific documents, USAID, and IBTCI documents. All review documents were made available to the assessment team prior to the planning meeting for review. Each member of the team conducted a thorough review of the documents.

Team planning meeting: This took place on February 12–19, 2018 at IBTCI's Evaluation Services and Program Support (ESPS) Nairobi Office. The Team Leader, two CACs and five CAFs attended this meeting. The

Assessment Team discussed the objectives of this institutional capacity assessment, jointly reviewed USAID's institutional capacity assessment tool and action plan template, planned for fieldwork logistics, and prepared for the USAID/ESPS in-brief meeting. The team also discussed the desk review material. Consensus was built on the field implementation approach and finalization of the assessment work plan and logistics. The agreed-upon dates of the CICA activity in the different counties were communicated. The final work plan was submitted to USAID for approval.

3.3.2. Phase II – County Institutional Capacity Assessment Tool (CICAT) Implementation Fieldwork

A two-step field data collection process for this assessment was carried out as described below:

County self-assessment: In preparation for the panel discussions, the Team Leader and CACs shared the capacity assessment tool with the county stakeholders in the five counties for self-assessment during the county engagement meeting. This was to ensure that the participants familiarized themselves with the capacity assessment tool and enabled them to prepare data sources that would be required to inform the process. However, the team found that due to competing county activities, only about 20% of county participants had reviewed the tool prior to panel discussions.

County Assessments - Panel Discussions: The Assessment Team facilitated discussions around the six building blocks as provided in the CICAT. The scoring process and the responses to the qualitative part of the tool were used to identify substantive critical gaps and to develop action plans. To assist the Team Leader, two CACs ensured the smooth operation of the assessments. One CAC coordinated activities in two focus counties, while the other coordinated activities in three focus counties. The CACs and CAFs facilitated the discussions both in the focus groups as well as in the plenary discussions to develop a shared understanding of the current capacity of the institutions and organizations that the CHMTs represent. In almost all the counties, the attendance of county/sub-county participants was at 100%. The assessments took place between February 19 and March 3, 2018.

Data Analysis: The WHO building blocks served as the analytical domains and provided a format for presenting the preliminary findings. An automated Excel spreadsheet was designed for data entry and analysis of each building block standard. A 4-point Likert scale was used to rank each standard, while a 5-point Likert scale was used to provide an overall rank per county, as shown in tables 3.1 and 3.2, respectively.

Table 3.1 Score Standards: 4-point Likert Scale

Score	Likert Scale
0-1	No Capacity
2	Low Capacity
3	Moderate Capacity
4	High Functional Capacity

Table 3.2 Overall Score (All Building Blocks): 5-point Likert Scale

Score	Likert Scale
20 & Below	No Capacity
21 – 39	Limited Capacity
40 -59	Average Capacity
60 -79	Significant Functional Capacity
80+	Very Significant Functional Capacity

Trend analysis was used to analyze financial data (mainly health expenditure over the last five years for the different counties). This was to determine the overall change since the start of devolution.

Content & Triangulation Analysis: Content analysis was used to identify key categories for triangulation, with evidence from the qualitative questions under each standard for every building block. The assessment team linked both quantitative scores and qualitative answers to the expected core functions of the county governments as stated in the Kenya Health Policy 2014–2030. A gap analysis for each building block was conducted to guide the development of action plans, as well as provide a guide for the facilitation of validation workshop.

The USAID and IBTCI In-brief Meeting was held on March 20, 2018 in Nairobi. The Team Leader gave a presentation on the CICA process and discussed the preliminary findings, lessons learned, limitations, and recommendations. The USAID team had an opportunity to ask questions and make suggestions.

3.3.3. Phase III – Stakeholders Validation Workshop

A workshop carried out by the Team Leader, CAC, and CAFs involved in the implementation of the CICAT was held in each of the five counties to validate findings of the capacity assessment. These workshops provided an opportunity for development and implementing partners that support health activities in the counties to engage with county leadership in joint prioritization of critical gaps, joint development of action plans, responsibility assignment, and discussions on investments for the prioritized capacity gaps. It also provided a platform for further consensus on the scores. An average of 30 stakeholders attended each validation workshop. The workshops were planned for 6–7 hours between March 8 and April 5, 2018 within the respective counties. The dates for the stakeholder validation workshops were determined by the availability of the county representatives.

3.3.4. Phase IV – Post Fieldwork

In preparation for report writing, the assessment team held a meeting to discuss updates from the validation meetings, findings, lessons learned, limitations and recommendations. The team analyzed the critical gaps identified under each building block by each focus county.

3.4. Limitations

Limitations of the tool: As the CICA tool was administered at the county level and not designed for specific sub-counties. It was therefore not able to capture key gaps at the sub-county level. The overall score for the county does not reflect the individual sub-county scores, which capacities may be at a different level from that of the overall county. Other specific tool-related limitations included:

- Some key focus areas, such as WASH, are missing from the tool.
- Some questions on non-pharmaceuticals are missing from the tool.
- The Health Workforce building block has some missing score guides, as well as some standards in the block that had no corresponding summary scores in the summary sheet.
- The Health Financing building block is missing questions on resource mobilization, revenue raising for UHC, strategic purchasing, financial protection at the county level, resource allocation, effective use of allocated resources, and resource accountability.

Limitations of the methodology: The time allocated to carry out the CICA was very short relative to the tool's length; the tool was detailed and took a long time to administer. In most cases, it took about four hours to cover one building block. It was also challenging to conduct the CICA with a larger team of 15–20 participants and therefore the CICA team divided the participants into focus groups of 5–6 people to ensure that each participant was able to contribute and provide input during the panel discussions.

Desired response bias: Due to the nature of the assessment (self-assessment), participants may give responses that they want the Assessment Team to hear. To mitigate this bias, panel discussions were held with all participants to get consensus on scores and findings. The assessment team also requested documentary evidence to validate the scores provided by the participants. In addition, the assessment team (Team Leader and CACs) engaged the county stakeholders prior to the start of the activity to ensure that they were sensitized on the assessment process.

4. ANALYSIS SECTION: KEY FINDINGS & CRITICAL GAPS

This section analyses the overall CICA results for all five focus counties as well as the key findings and critical gaps identified under each building block for each focus county.

4.1 Overall Capacity – Five Focal Counties

Table 4.1 shows a comparison of the overall scores per county, before and after the county validation workshops. With the exception of Migori, the overall scores for the counties remained relatively the same at average capacity before and after validation of scores by the CICA participants. Migori scores changed significantly after the validation workshop because the County Director of Health (who had not attended the assessment workshops but attended the validation workshop) was able to provide the CICA validation team with required documentary evidence needed to move the scores upwards. The County Director in Migori acknowledged that there was need to disseminate county information widely to the CHMT and other key personnel in the CHD to ensure that everyone was knowledgeable with the health initiates being undertaken in the county.

Table 4.1. Overall scores of five counties

County	Overall scores before validation	Overall scores after validation
Busia	53%	53%
Kakamega	56%	57%
Migori	37%	53%
Mombasa	55%	55%
Turkana	56%	54%

Figures 4.2 to 4.7 show the overall capacity of each CHD to perform its core functions in the five focus counties. The core functions of CHDs are organized in this report by the WHOs six building blocks. Overall, all CHDs from the five counties scored average overall capacity, with Kakamega having the highest capacity at 57%, followed by Mombasa at 55%, Turkana at 54%, and Busia and Migori both at 53%. This means that the overall capacity of the CHDs in all five focus counties needs improvement.

Figure 4.2. Overall Capacity for the five focal counties

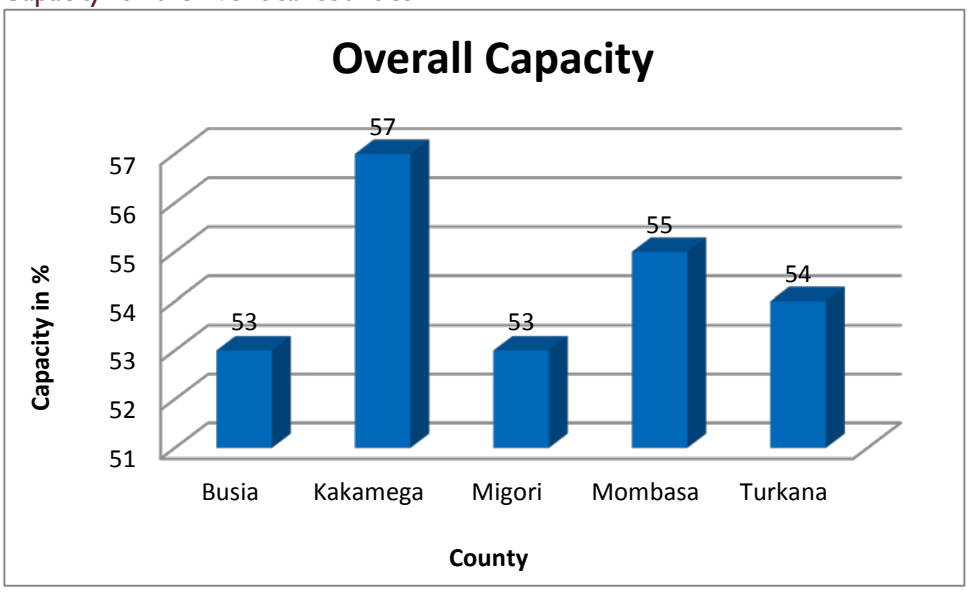


Figure 4.3. Busia County Overall capacity

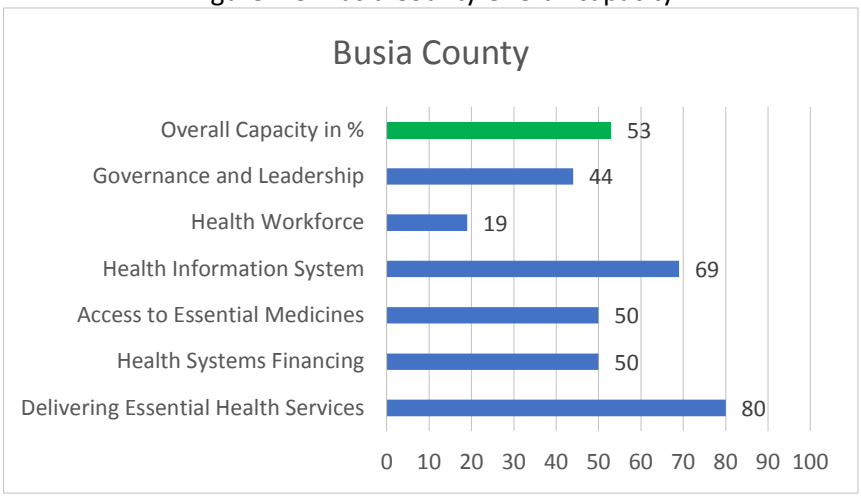


Figure 4.4. Kakamega County Overall Capacity

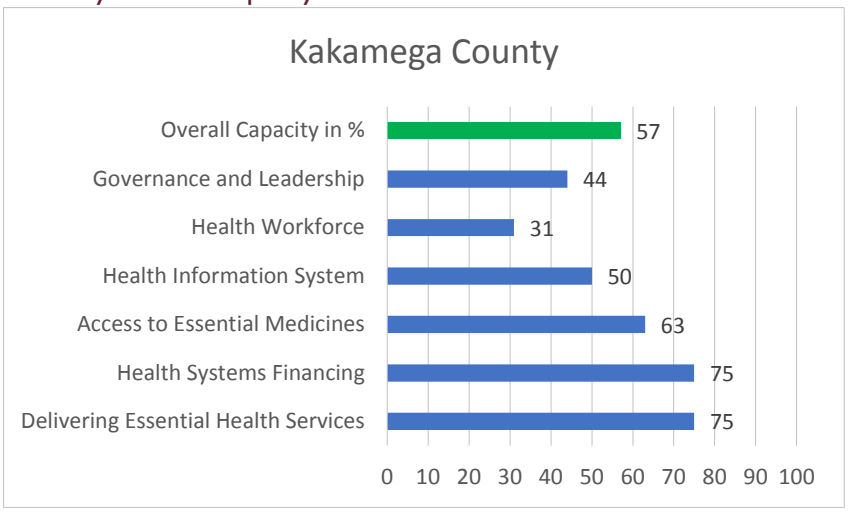


Figure 4.5. Migori County Overall Capacity

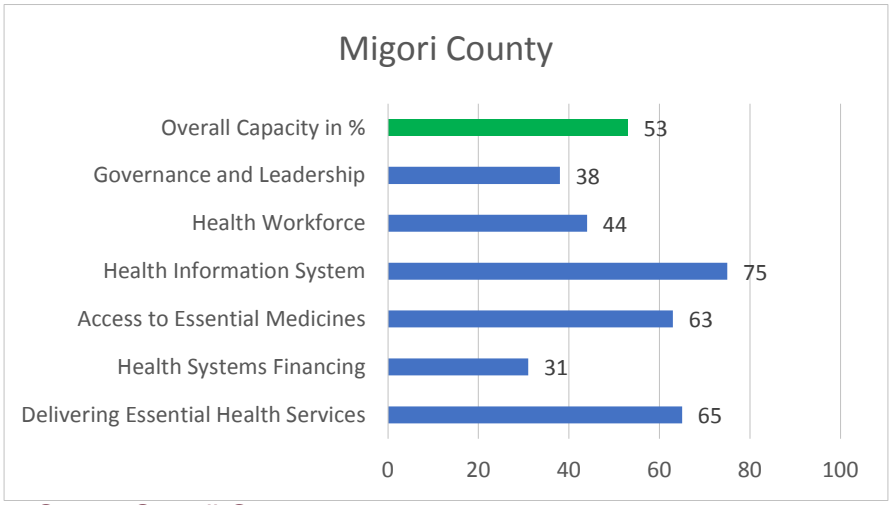


Figure 4.6. Mombasa County Overall Capacity

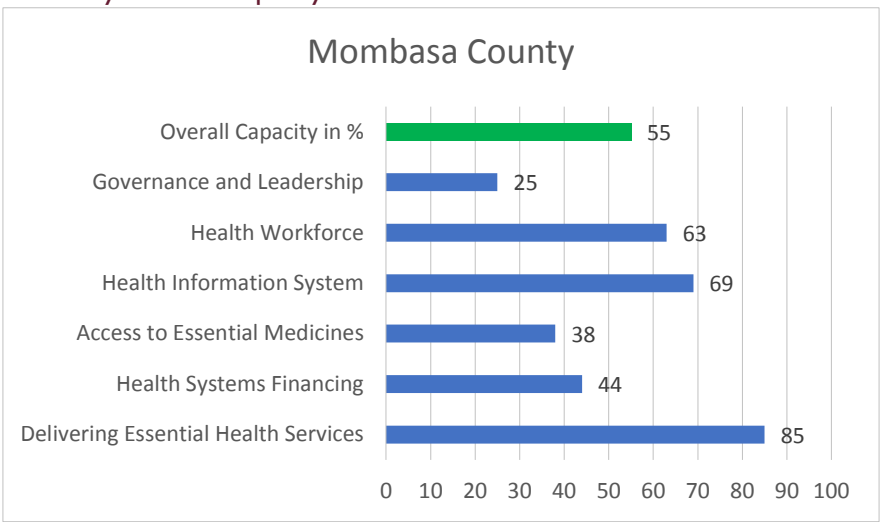
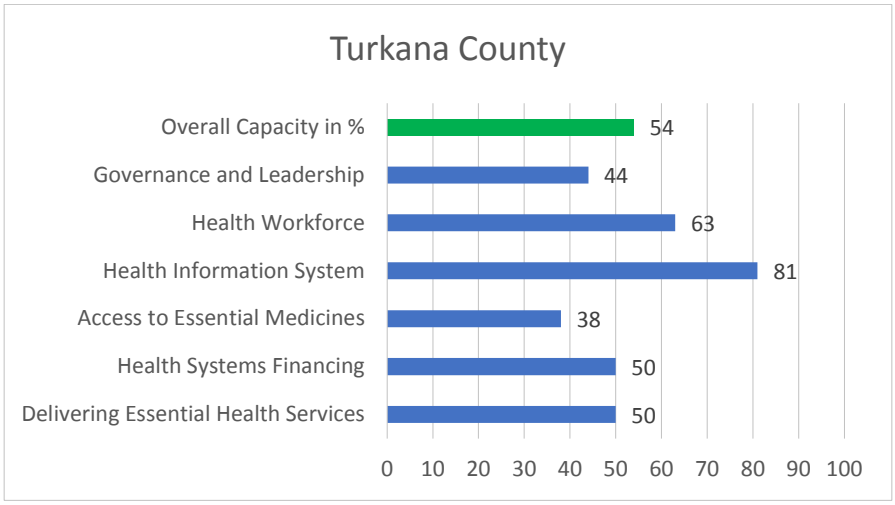


Figure 4.7. Turkana County Overall Capacity

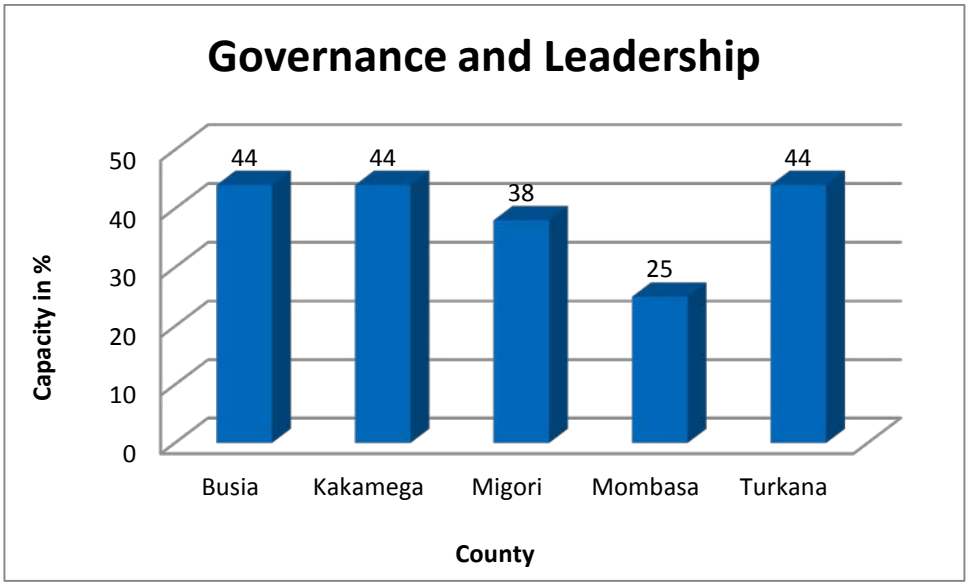


Sections 4.2 to 4.7 provide a detailed analysis of key findings under each building block for all five counties and identify critical gaps in the health system that should be addressed. These sections also outline the action plans proposed by the county officials that spell out the "what" and "how-to" strategies to address each prioritized critical gap. Detailed action plans for each county are provided in the annexes.

4.2 Governance and Leadership

The capacity of the CHD to perform its functions in Governance and Leadership is illustrated in Figure 4.8 below. Although the CHDs in Busia, Kakamega, and Turkana scored the highest capacity in Governance and Leadership between the five counties, their capacity is averaged at 44% and requires improvement. Mombasa scored the least capacity at 25%, followed by Migori at 38%. Both of these counties have limited capacity in Governance and Leadership, requiring significant support to improve.

Figure 4.8. Capacity in Governance and Leadership



Sections 4.2.1 to 4.2.4 provide a detailed analysis of the CHDs capacity to perform core functions under Governance and Leadership in the five focus counties. The core functions have been organized per the standards under the Governance and Leadership building block in the CICA tool.

4.2.1. Capacity of CHD to develop and implement a county health strategy

All the five focal counties have developed a County Health Sector Strategic and Investment Plan (CHSSIP) but have experienced successes and challenges in implementing the CHSSIP. In all the counties, except Turkana, there are mechanisms for overseeing and coordinating the implementation of each priority area in CHSSIP. Annual work plans are also developed for at least 50% of the CHSSIP priority areas. The CHSSIP was successfully adopted and disseminated to stakeholders in the five counties.

Implementing Partners were also involved in the development of the CHSSIP and some of them supported implementation of the plan and strategy reviews. For instance, in Kakamega the CHSSIP was developed with support from MSH through USAID funding. APHIAplus, also funded by USAID, provided technical support and assisted the county in printing and launching the strategy including supporting development of the annual work plan and reviews. PS Kenya provided training of county health workers on Logistics Management Information Systems (LMIS). Health Promotion Alliance of Kenya (HPAK) supported technical meetings and implementation

at the technical working group level. PATH Kenya, UNICEF and other partners played a key role in guiding the overarching strategy for the maternal bill, drafting core language, and securing critical buy-in from high-level leaders and civil society members. In Mombasa County, HPP Plus funded by USAID supported the restructuring of the health department and HRH Kenya also funded by USAID facilitated leadership training for senior managers in the County.

Despite these successes, there were a number of critical gaps identified by the county officials in the development and implementation of the CHSSIP in all five counties. Action plans that spell out the "how to" strategies to address each prioritized critical gap were also proposed. A summary of these critical gaps and proposed actions is in Table 4.1 below. Detailed action plans for each county can be found in the annexes.

Table 4.2. Critical gaps and proposed actions: Development and implementation of CHSSIP

Prioritized Critical Gaps Identified	Proposed Actions to Address Critical Gaps ("how-to" strategies)
Lack of M&E framework to track progress of the CHSSIP	Develop of an M&E framework to track progress of the CHSSIP
Lack of a functional county health department organogram	Review the current county health department organogram
Poor involvement and coordination of internal actors (lower levels of the health system) and external actors/stakeholders	Develop a Governance structure that properly spells out the roles and responsibilities of key stakeholders in achieving county health strategy goals
Inadequate capacity to develop work plans at all levels which affects quality of work plans at the county level	Continuous Capacity building on annual work plan development
Inadequate funding to implement annual work plans	Prioritization of funding from the counties for annual work plans and resource mobilization from partners

4.2.2. Capacity to communicate effectively within the county, sub-county, and other departments

None of the counties has a communication plan or protocols for information flow from within the county and sub-county to other departments within the county. The counties have been communicating through various media such as official letters, official circulars, emails, phone calls, memos, face-to-face meetings, WhatsApp groups, and SMS (short messaging service). However, there is no document or protocol in place to guide them in the process or mode of communication that is recommended for use.

Mechanisms/tools that exist to promote collaboration and for the coordination of health development partners and other stakeholders include Memorandum of Understanding (MOU) and terms of references for projects within the county. For instance, Busia County has an MOU with APHIAplus and AMPATH. Migori County has a partnership for resilience and economic growth for all USAID-funded partners to coordinate provision of certain services. Turkana County has MOUs with several partners and Mombasa County has an MOU with Mombasa Technical University. In Kakamega County, there are service-level agreements with the health partners, for instance, with Oparanya care (now called *Imarisha Afya ya Mama na mtoto*).

The county officials identified the critical communication gaps in the five counties and proposed actions to

address these gaps (Table 4.3).

Table 4.3. Critical gaps and proposed actions: Effective communication within CHD and with other stakeholders

Prioritized Critical Gaps Identified	Proposed Actions to Address Critical Gaps ("how-to" strategies)
Lack of a Communication Plan and protocols for information flow within the county and sub-county, to other departments within the county and to partners	Develop and disseminate a communication plan and protocols to guide and enable effective communication

4.2.3. Capacity of the CHD to coordinate different actors working towards the same goal

All five focal counties have a coordination framework that maps out the different stakeholders working in the health sector. In all five counties, mechanisms are in place to promote regular dialogue between CHD leadership and the different health actors such as health development partners, IPs, MCAs, religious/community leaders, and the private sector. These mechanisms include County Health Sector Forums, technical working meetings, Health Facility Management Committee meetings, quarterly program meetings, annual review meetings, data review meetings, inter-department forums, chief's *barazas*, stakeholder meetings, and community dialogue days. Sometimes, these meetings are irregularly held due to lack of financing for the meeting. Almost all counties lack a partnership coordination framework (for instance, private health sector, faith-based organization), which is key in coordinating the partners and other stakeholders in the health sector. PPP policies are not implemented at the county level, as there is no PPP unit or partnerships office to coordinate this. Service-level agreements and MOUs signed with various IPs for USAID are available; the counties, however, need a framework to hold accountable all partners in the health sector.

Budget formulation and performance reviews are done by CHMT, SCHMT, and partners who provide technical and financial assistance. All stakeholders are invited to quarterly performance reviews and there is also public participation in budget formulation as well as community engagements to identify population health needs and priorities. Partners who provide support include HPP Plus, funded by USAID, who have been training counties on Performance-based Budgeting (PBB) and budgeting cycles across all counties. Afya IPs, funded by USAID, also provided support during the AWP and budget development for Mombasa County. In Busia, the Tupime Kaunti project participated in some budget formulation processes (program-based budgets). The budget formulation process is complex and the health sector takes the largest share of the county budget. The budget committee is responsible for processing the budget approvals, budget consolidation, and presentation to the county executive team working with the county budget office. In some cases, county officials attend courses at Kenya School of Government to strengthen their capacity in budget formulation and leadership.

Table 4.4. Critical gaps and proposed actions: CHD coordination with different actors

Prioritized Critical Gaps Identified	Proposed Actions to Address Critical Gaps ("how-to" strategies)
Limited involvement of health actors in annual sector reviews, work plan development, and policy development	Development of a county health stakeholder's coordination mechanism to contribute to better programmatic coherence and enhance coordination
Irregular meetings between county and partners, which makes it difficult to effectively coordinate partners	Development of a county health stakeholder's coordination mechanism
Irregular performance update and reports from health sector actors to the CH leadership (CHMT, Governor, County Assembly, County Executive Committee)	Development of clear reporting schedules and reporting templates

4.2.4. Capacity of the CHD to hold responsibility and ownership for health care system at community level (accountability)

In Busia, Kakamega, and Turkana, the county primary health care system at community level is over 50% funded by county government, with input from the IPs. Busia County has also developed a community health strategy. In Migori and Mombasa, the primary health care system is funded by health IPs, with gaps existing where IPs are not implementing services. For instance, in Mombasa the county does not fund nor give the Community Health Volunteers (CHVs) any support. Leadership and ownership of the county primary health care system at community level in Busia, Kakamega and Turkana is held by the county Community Health Extension Workers (CHEWs)/Community Health Assistants (CHAs) with significant input from health IPs. In Busia, the county government has taken up the facilitation of CHEWs/CHAs. Functionality of community units is reported at 50%.

Table 4.5. Critical gaps and proposed actions: Responsibility and ownership for the health care system at community level (accountability)

Prioritized Critical Gaps Identified	Proposed Actions to Address Critical Gaps ("how-to" strategies)
Lack of an accountability platform for reviewing committed funding against results achieved at county, sub-county and facility levels	Partner engagement to facilitate annual accountability platform (Public Participation, Establish a Finance Committee with TORs)

GOVERNANCE AND LEADERSHIP: WHAT IS DRIVING THE SCORES

Busia, Kakamega, and Turkana Counties have the highest capacity in Governance and Leadership at 44%; Migori and Mombasa counties have relatively lower capacities at 38% and 25% respectively. For the counties with the highest capacity in governance and leadership, the defining characteristic is the level of ownership and goodwill from the county government. In Busia County, the community health strategy was well articulated with ownership clearly spelled out. The county government, through the governor, was reported to be keen on strengthening the primary health care system. Consequently, the county government had taken over the facilitation of CHAs.

In Kakamega, the county's top health leadership—including the County Executive Committee Member-for Health, Chief Officer of Health, and County Director of Health Services—launched the county health strategy. While partners were involved in planning and contributing towards the funding of development and implementation of these counties' health strategies, the counties were not entirely reliant on the partners for running of the health programs. Similarly, in Kakamega and Busia Counties, some mechanisms existed to promote regular dialogue. The mechanisms included a county health sector forum, community dialogues, action days, and community *barazas* coordinated by chiefs.

In Migori and Mombasa, there is heavy reliance on partners to support county health governance and leadership initiatives. Almost all key interventions on governance and leadership in these two counties were funded by IPs. The attitude is that there is no need for the county to allocate more funds for governance and leadership initiatives, as these are well funded by IPs. Due to this, when IPs complete their projects and leave the counties, the activities that they were funding tend to stagnate. The CHDs are also experiencing delayed disbursement of funds from the county governments to implement key initiatives. There is a correlation between governance and leadership and health financing. Counties that have better governance and leadership outcomes are the same ones that have better financial allocation. Migori and Mombasa are trailing in both cases.

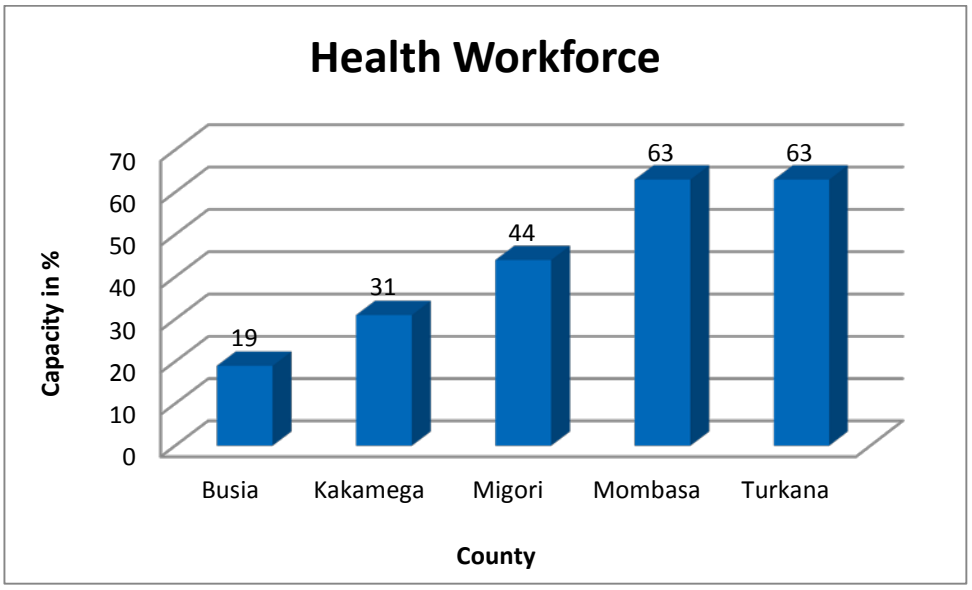
In summary, governance and leadership is pivotal to health service delivery at county, sub-county, facility, and community levels. The CHMT led by the County Director of Health played a vital role in showing commitment to ensure oversight and proper coordination of the county health system. If a performance-based health care system is implemented, this will drastically improve the situation in the counties. The mentoring and capacity building in leadership and governance is very critical to new CHMT and SCHMT members, both through trainings at Kenya School of Government and more application-based trainings at their work place. In order to have transformational leadership at the CHMT, more innovative and practical ways are needed to ensure governance and leadership principles are applied by making fundamental changes internally and externally. In addition, in order to improve the county health organizational performance, cultivating and strengthening relevant leadership competencies of health managers and junior staff at all levels in the county health system is required.

4.3. Health Workforce

The reported capacity of the CHD to perform its functions in the management of the Health Workforce is shown in Figure 4.9 below. Mombasa and Turkana reported the highest capacity at 63%, which is significant functional capacity per the Likert scale, followed by Migori at 44% (average capacity), Kakamega at 31% (limited capacity), and Busia with the least capacity at 19% (no capacity).

Sections 4.3.1 to 4.3.4 below provide a detailed analysis of the CHD's capacity to manage the Health Workforce in the five focus counties. The components of the Health Workforce system have been organized per standards under the Health Workforce building block in the CICA tool.

Figure 4.9. Health Workforce



4.3.1. Ability to attract, recruit, and retain Human Resources for Health worker positions

In four of five counties (except Busia), the CHD has developed standard job descriptions for health workers and a harmonized pay system/pay structure exists. HRH Kenya, funded by USAID, supported the development of job descriptions in Migori. In Busia County, job descriptions inherited from the national government are still used, most of which are generic to a cadre and not for specific staff. The pay system that exists is not harmonized. Staff employed by local authorities and those employed by devolved county system are paid different amounts, even though they do the same job.

In Turkana and Mombasa Counties, a structure for staff attraction, recruitment, and incentives for staff retention is in place, but the implementation of these strategies is very weak due to underfunding. In Busia, Kakamega, and Migori, there is no written strategy for attraction, recruitment, attrition, or retention. Staff are replaced when there are resignations. New staff recruitment to increase the numbers rarely happens. In some cases, such as Bunyala and Teso North in Busia, working conditions are not attractive nor safe, particularly in hard-to-reach areas, and staff do not get incentives to work in these hardship areas.

Some of the focus counties have reached agreements/contracts with pre-service institutions to train and recruit new staff. Turkana County had an agreement with Kenya Medical Training College (KMTC) to train and recruit new personnel and was remitting ksh 50 million per year to KMTC to ensure training of locals who could work in the county. This has stalled, however, due to lack of adequate financial resources and there is no agreement currently in existence. Mombasa County has an agreement with Afya Elimu Fund, funded by USAID (contract with Intrahealth-Funzo Elimu). The fund and the county have each contributed Ksh 5 million to a revolving fund. Students from Mombasa County who are interested in medical courses are loaned money from the fund and admitted to the KMTC for the different diploma and certificate medicine-related courses. They

are then posted to the areas most in need of those services in Mombasa County. This revolving fund was launched in 2016.

In Kakamega, the Afya Elimu fund, in collaboration with the Higher Education Loans Board, has established a link with training institutions for diploma courses. The county provides Ksh 6 million and the Afya Elimu fund provides Ksh 20 million for this program. At one point, Migori County had an agreement with KMTC to have 50% of students from Migori County to fill personnel gaps. This agreement later stalled. In Busia, KMTC has an informal policy of offering 30% of training slots to the local community in Busia, although no official agreement has been signed. This was agreed to by the county government due to the shortage of human resources—mainly for nurses and clinical officers. Save the Children sponsored some students to KMTC from areas such as Nambale. Intra Health has engaged in discussions with Busia County health team to support staffing and are currently supporting Busia with the development of an HRH strategic plan. Though these strategies to train and recruit new personnel are important and useful to the counties, they are not sustainable and when the partner supporting them exits, the counties are forced to release the staff due to lack of funding.

All five focus counties have conducted assessments on workforce needs and priorities. In July, 2017, HRH Kenya, funded by USAID, supported assessments in the five counties focusing on three core functions of HRH (i.e., human resource management (HRM), human resource development (HRD), and use of data including aspects of e-learning). In addition, during the development of HRH Strategic Plans for Kakamega, Migori, Mombasa, and Turkana, a capacity needs assessment was carried out to assess the status of the county HRH with respect to HRM Capacity; HRM Strategy; Personnel Policy and Practice; Staff Performance Management; HRM Data; Staff Training and Development. UNICEF supported this; the findings from these assessments are summarized in HRH Strategic Plans for the respective counties. Busia County has not conducted an assessment on workforce needs and priorities; there are plans to do so during the development of the County HRH Strategic Plan.

In Kakamega, the County General Hospital conducted a training needs assessment, which showed huge gaps in staffing for various cadres. However, in the 2015/2016 training report done by Price Waterhouse Coopers, there are claims of overstaffing. The Kakamega County team also carried out an internal self-assessment that captured staff training needs and staffing gaps. This report is not yet available. In Migori, a workload indicator staff needs survey, supported by HRH Kenya, will commence in the next quarter (from June 2018) to assess the staffing gaps, norms, and standards within the county. The national government also conducted a capacity needs assessment, but this report has not yet been issued.

Table 4.6. Critical gaps and proposed actions: Ability to attract, recruit, and retain human resources

Prioritized Critical Gaps Identified	Proposed Actions to Address Critical Gaps ("how-to" strategies)
Lack of a structure and strategy for staff attraction and recruitment and incentives for staff retention	Development and implementation of a strategy for staff attraction, recruitment, attrition and retention Development of staff job descriptions (Busia)
Weak induction system for newly posted/deployed staff	Development of an Induction Manual/guideline for county health staff Induction of new staff/Institutionalization as staff are brought on board
The HRH division is decentralized to sub county but no funding availed to facilitate its operations	The County HRH plan needs to be supported with funds for intervention /operation costs and not just

	salaries

4.3.2. Capacity of CHD to staff health facilities per staffing norms, standards, and guidelines

The 2014 National HRH norms, standards, and guidelines for conditions of employment, work standards, and development of the health work force for staffing of each level of the health system exist in all five counties. However, as the norms have been found to be unrealistic, they cannot be attained by any of the 47 counties and thus the MOH is planning to revise them. This revision will be guided by the workload information staff survey to assess staffing norms and standards that HRH Kenya plans to support in various counties, in collaboration with WHO.

In all five focus counties, an Integrated Human Resource Information System (iHRIS) system has been developed to track staffing levels and needs. However, in Busia and Kakamega, this system is not updated. The human resources team in Kakamega has not fully been trained on iHRIS and high turnover exists, requiring continuous refresher training. Though an iHRIS system exists in Migori, Mombasa, and Turkana, it is not frequently updated, as they do not have staff who are qualified or designated to update the iHRIS system. They also do not have a system to collect the training information from the people who are trained (iHRIS Train module). Mombasa County was awarded the best HRM unit in the country. According to the Mombasa After Devolution Report – 2013-2017, the department is able to handle human resources issues effectively. Annually, during the annual work planning process, Mombasa County is able to assess the number of staff available against the required number of staff and uses this information to mobilize and distribute health personnel based on each sub-county's and health facility's needs. However, in Busia, staff are distributed through speculation and no staffing gap assessment is conducted, due to budgetary constraints. In Kakamega, measuring of staffing gaps is done using monthly staff returns. In Turkana, staffing needs assessment is usually carried out and budgets are set aside for recruiting based on priority and urgency.

Although the counties budget for additional staffing during the AWP development, these budgets are hardly ever honored. The CHDs are therefore implementing a number of strategies to mobilize resources to meet staffing gaps in the counties. In Busia, the county is partnering with stakeholders (e.g., Save the Children, AMPATH, APHIAplus), employing casuals on contract basis, and engaging volunteers to support workload; in some rural areas the community pays allowances for some of the casuals to ensure continuity of service. In Kakamega, APHIAplus is paying nurses on a contract basis. Migori and Mombasa advocate for funds from partners to meet staffing gaps. In Turkana, the county is collaborating with development and implementing partners to address staffing gaps (e.g., EGPAF, Afya Timiza, International Red Cross). In addition, the county is making use of Industrial attachment, internship programs, and volunteer engagement.

Table 4.7. Critical gaps and proposed actions: Capacity of CHD to staff health facilities per staffing norms, standards, and guidelines

Prioritized Critical Gaps Identified	Proposed Actions to Address Critical Gaps ("how-to" strategies)
Lack of succinct staffing norms and standards for the county health staff	Conduct Workload Indicator Staff Needs survey and develop accurate norms and standards
iHRIS system not updated	Train staff to be able to update iHRIS monthly

Inadequate human resources officers at county and sub-county levels	Employ, train, and deploy human resources staff at county and sub-county levels

4.3.3. Capacity of CHD to conduct staff performance appraisals

In all focus counties, there are policies, guidelines, or a system at the county level, adopted from the National government, for staff performance appraisals. However, these appraisals are only conducted in Turkana and Kakamega. Busia, Migori, and Mombasa have yet to implement these. In Mombasa, the staff have been trained on performance contracting, but the tool has not been disseminated and distributed. This is due to competing tasks and the need to deliberately prioritize the dissemination with clear timelines. Reviews of guidelines have been done twice a year since 2015.

The counties are implementing various strategies for continuous performance improvement. Busia and Kakamega have institutional based mechanisms, such as continuous professional development, (e.g., Continuing Medical Education, trainings in-service on specific issues – HIV reproductive health, on-the-job training enabled by the county, clinical mentorship, sponsorship for post-graduate training). The county may not sponsor these, but it gives staff paid study leave and short- and long-term training supported by partners. In Busia, exchange visits are organized to see best practices to, for example, Kwale, Kitui, Nakuru, and Israel.

Mechanisms in place to promote accountability and transparency in the workforce include job descriptions. In Mombasa and Migori, HRH Kenya supported this development. In Kakamega, they are carrying out a client satisfaction survey supported by World Vision; in Migori, they have a code of regulations (COR) and public officers' ethics act, but these mechanisms are yet to be disseminated and and systems of enforcement do not exist. However, new staff members are being sensitized in these mechanisms. In Turkana, there are guidelines in the job descriptions about staff roles and responsibilities and since 2015, these are reviewed twice a year.

Mechanisms to address workforce absenteeism and poor productivity include duty rosters used in Busia County to check on staff availability and to register clock in and out. Since the removal of the performance management system, it has been a challenge to monitor staff productivity. Some partners, including AMPATH in Busia, use a dashboard to monitor staff seconded to the counties. In Kakamega, workload and revenue collection comparisons at health facilities and use of measurable outcomes at the program level (i.e., TB, HIV, malaria programs) are used to measure productivity.

Table 4.8. Critical gaps and proposed actions: Capacity of CHD to conduct staff performance appraisals

Prioritized Critical Gaps Identified	Proposed Actions to Address Critical Gaps ("how-to" strategies)
Lack of a performance appraisal system	Implement and execute a performance appraisal system at all levels Support roll-out of county performance management framework

4.3.4. Capacity of CHD to coordinate capacity development of Human Resources for Health

A system for coordinating in-service training for HRH exists in Turkana, Mombasa, and Migori, but not in

Kakamega and Busia. However, it is not adhered to in Turkana and Migori. In Mombasa, the county uses iHRIS Train software developed by HRH Kenya to track staff training. In the other counties, the iHRIS Train component exists, but its use is not optimal.

Mombasa County coordinates all trainings, including those conducted by vertical programs and IPs. All trainings—even those carried out by vertical programs and IPs—have to go through the advisory team in Mombasa County. They give study leave to all and sponsor some courses in cases where the county feels there is a need and when resources are available. In Migori, there is a lake-basin HRH TWG/Interagency Coordinating Committee cluster that focuses on technical exchange of HRH information. With regard to training needs assessment, HRH Kenya conducted a one in 2012, before devolution and focused on MOH and districts. Partners also identify in-service training needs through needs assessment.

Major pre-service training problems face the five focus counties. One is that pre-service training institutions send their students for attachment without supervisors. This over-loads the already stretched workforce. Another is affordability of the trainings; for locals, this is also a problem unless there is a scholarship provided. A third is public awareness within the county about the existence of these courses. In addition, people generally want courses that take a short time, and this affects their attitude. Major in-service training problems facing the county include a lack of coordination, shortage of health workers (thus managers are reluctant to release them for training as there will be a gap in the health facility), and people studying for courses that are not directly related to their job description.

It is the role of the national government to grant accreditation to pre-service training facilities. The county government has no capacity to do so. Assistance needed for the county to coordinate and document training includes training and mentorship for managers and Health Records Officers in iHRIS Train, equipment such as printers, scanners, computers for the team dealing with iHRS staff, and a work station for the Training Coordinator, and the establishment of a centralized training unit.

Priority performance areas most in need of strengthening within the CHDs that relate to HRH include performance appraisal, performance improvement, performance contracting, iHRIS management and updating, establishing a training unit, implementing, and annual tracking of the HRH Strategic Plan. There are a number of successes for strengthening health workforce. These are improved health outcomes, increased skilled birth deliveries, promotion for common cadres and competitive posts, and stronger supervision systems for the vertical staff by partners. Major challenges for strengthening the health workforce are industrial unrest, lack of succession plans, adverse shortage of staff, and sustainability of gains when partners pull out.

Table 4.9. Critical gaps and proposed actions: Capacity of CHD to coordinate capacity development of Human Resources for Health

Prioritized Critical Gaps Identified	Proposed Actions to Address Critical Gaps ("how-to" strategies)
Lack of system for coordinating in-service training for HRH in the county	Establish a functional training committee with TORs
Lack of operational plan to guide the retention of workforce	Evaluate and review of the current HRH Strategic Plan and develop a costed HRH Strategic Plan (current expires in June 2018) with an operational plan to support development of AWPs.

Lack of a succession plan	Develop and embed the succession plan at all levels into the new HRH Strategic Plan.
Lack of harmonized data on trained staff at the CHD (iHRIS Train is not utilized in most counties)	More capacity building on the iHRIS Train system

HEALTH WORKFORCE: WHAT IS DRIVING THE SCORES

Mombasa and Turkana scored the highest capacity in Health Workforce Management at 63%, followed by Migori at 44%, Kakamega at 31%, and Busia with the least capacity at 19%. The Health Workforce building block has encountered a number of challenges countrywide since 2017, due to continued industrial unrest (strikes) by doctors, nurses, and clinical workers. The health workers were protesting against low pay and delayed payment of salaries. This has somewhat affected progress towards achieving intended goals during the periods of unrest.

Among the many challenges facing the health system in Kenya is the acute shortage of competent health care providers. As a result of inadequate infrastructure and poor compensation packages, a sizeable number of physicians, nurses, environmental health officers, and other health professionals are lured away by development partners and NGOs in search of greener pastures and more lucrative positions. Related to brain drain is the problem of geographical distribution of health care professionals. There is a disproportionate concentration of medical professionals in urban areas. The main factors driving this problem have been identified as (HRH Policy Brief, 2018):

1. Insufficient resource and neglected health systems
2. Poor human resources planning and management practices and structures
3. Unsatisfactory working conditions

For instance, urban counties such as Mombasa seem to attract staff, due to the different facilities to which they have access, such as institutions of higher learning. However, staff members have no incentive to work in hard-to-reach areas such as Bunyala and Teso North, in Busia County, and therefore some of these areas remain underserved until this is addressed.

Human resources is a fundamental pillar of any health system. Availability of enough trained and well-motivated personnel can drive the difference between a functional and non-functional health system. Although counties allocate a budget for additional staffing during the AWP development, these budgets are hardly ever honored. The HRH budget is therefore inadequate to support several HRH functions, e.g., trainings and recruitment, leading to staff shortages in all the counties. A knowledgeable, skilled, and motivated health workforce is critical for reaching UHC.

In-service training for the health workforce is largely supported by partners in all five counties. These trainings, particularly for the vertical programs, are *ad hoc* and driven by the need for the partner to meet a deliverable. They are not typically driven by the county's needs. Although the iHRIS Train system is in place in all five counties, it is evident that it is not being optimally used. There is therefore no formal system for selecting the personnel to go for training. Those who attend trainings are sometimes the same people who may have attended similar trainings before, while their colleagues are not selected. Officers at the county level benefit more from these trainings, yet the greatest need is in the sub-counties.

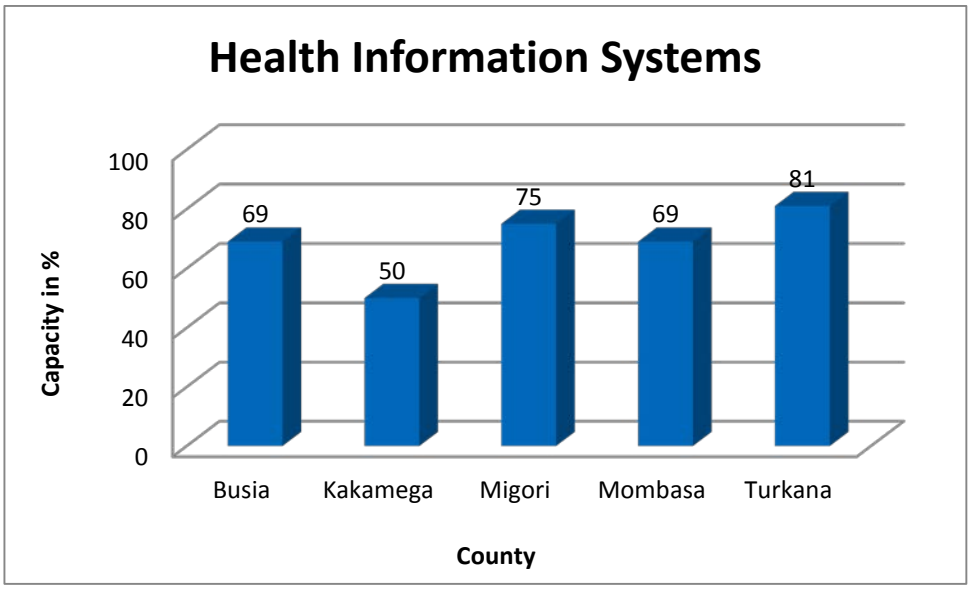
4.4. Health Information Systems

The capacity of the CHD in Health Information Systems is illustrated in Figure 4.10 below. Turkana scored the highest capacity in this building block with 81%, which is very significant functional capacity, followed by Migori at 75% (significant functional capacity), Busia and Mombasa both at 69% (significant functional capacity), and

Kakamega at 50% (average capacity).

Sections 4.4.1 to 4.4.4 provide a detailed analysis of the CHDs' capacity in Health Information Systems in the five focus counties. The components of the Health Information Systems building block have been organized per the standards under the Health Information Systems building block in the CICA tool.

Figure 4.10. Health Information Systems



4.4.1. Capacity of CHD to implement HIS policies, strategies, guidelines, protocols and use routine HIS forms

In all five counties, a national health information system policy and strategy exists. Data collection tools and systems for all key components are readily available at the county level (e.g., source registers, birth/death registration forms, reporting forms, data quality assessment protocol forms and disease surveillance forms). However, these tools are not in adequate supply at the sub-county level except in Turkana.

All five focus counties use DHIS, which is an integrated Health Information System that captures data and includes indicators, data elements, and sources. This system also captures data from the sub-county level. SOPs and Data Quality Assessment (DQA) protocols also exist in the counties. There are also indicator manuals that define specific indicators and are used for DQAs.

Table 4.10. Critical gaps and proposed actions: To implement HIS policies, strategies, guidelines, protocols and use routine HIS forms

Prioritized Critical Gaps Identified	Proposed Actions to Address Critical Gaps ("how-to" strategies)
Inadequate supply of data collections tools, especially at the facility and community level	Timely forecasting, procurement, and distribution of data tools, ensuring adequate supply of data collection tools in all service delivery points informed

	by demand
Inadequate staff capacity in data management knowledge and skills	Train all health workers on data analysis and management
Inadequate dissemination of M&E framework, plan, protocols, and guidelines to the sub-counties	Dissemination of M&E framework, plans, protocol and guidelines at sub county level

4.4.2. Capacity of CHD to collect quality health data

In all five counties, a county-wide single data collection and management systems (DHIS2) system exists, and data are routinely collected using standard data collection forms. CHD receives timely and complete reports from more than 75% of health facilities (public, private, and faith-based) (i.e., MOH 731 (HIV), MOH 515 (Community), MOH 710 (Immunization)).

The service delivery staff has the primary responsibility for collecting data for routine health information at the lower level facilities. At the higher-level facilities, it is the responsibility of caregivers as well as the responsibility of records staff. From the major health facilities, the Health Records Information Officers are responsible for collecting data on vital statistics.

Most of the DQAs the counties have done have been partner supported. e.g In Kakamega Quality Assessments are done with support from partners like TUPIME Kaunti and APHIAplus. DQAs are not regular—they are supposed to be quarterly, but that has not been possible due to lack of adequate funds. APHIAplus also supported provision of ICT and airtime provision to upload the reports. Kakamega County also has an M&E framework that indicates how all the indicators will be tracked. Turkana County has an M&E coordination department that presents plans on how data will be collected for monitoring, evaluating, disseminating, and analysis. Migori County has an M&E plan that tracks baseline values, indicators, frequency, and responsibility. Mombasa County conducts quarterly data reviews, performance meetings, data quality assessments, on-the-job trainings, and mentorship. Busia is currently establishing an M&E unit.

Table 4.11. Critical gaps and proposed actions: Capacity of CHD to collect quality health data

Prioritized Critical Gaps Identified	Proposed Actions to Address Critical Gaps ("how-to" strategies)
Health performance data are not reviewed regularly and regular feedback is not provided to all health facilities on data accuracy	Develop a plan for quarterly health performance reviews and feedback
DQAs are not regularly done	Enhance quarterly DQAs (schedule for DQAs)
The MOH's National Data Quality protocol and standards have not been institutionalized at the county health department	Customization of National quality data protocols and standards and dissemination

4.4.3. Capacity of CHD to manage data

In all counties, there is one single-county preferred electronic HIS platform (database), which exists at the county level for the various components of the health information system. Data are routinely extracted (at least annually) for use. However, integration of information from other health management systems (i.e., service statistics, financial, human resource, logistics information, and physical assets data systems) are not yet fully operational. In addition, county data management guidelines, including policy on health/research data sharing, do not yet exist.

At the sub-county level, data are stored in the facilities. The county store data in the DHIS2 that has a resource center module where survey data and annual plans can be stored. In Busia County, there are challenges with data storage; the space is inadequate and the filing system is poor.

Table 4.12. Critical gaps and proposed actions: Capacity of CHD to manage data

Prioritized Critical Gaps Identified	Proposed Actions to Address Critical Gaps ("how-to" strategies)
Inadequate storage space/cabinets (especially at sub-county level)	Procure adequate space for record keeping
Lack of county data management guidelines on health, research, and data sharing	Develop and disseminate County Data Management Guidelines on health research and data sharing
Underutilization of the DHIS2 at the county level e.g., resource center	Capacity building on use of DHIS various platforms
Lack of integration of information from other HIS systems e.g., logistics, physical assets, data	Digitize and integrate the health management information systems

4.4.4. Capacity of CHD to use collected data for planning and policy making

In all the focus counties except Kakamega, the counties analyze available HIS data quarterly and distribute reports containing these analysis to key members of the CHMT, SCHMT, health facilities, county assembly health committee, and other state and non-state actors. Presentations and discussions of data are part of the county health performance review meetings. The counties have been able to integrate data into the decision-making process, including rational budgeting, in the past year.

In Busia, Migori, Mombasa, and Turkana, routine health data analysis is presented to senior managers for discussion on a quarterly basis. However, there are still gaps in using data for decision-making and for policy formulation.

Performance data in Busia are presented to CHD leadership for discussion, problem-solving, and decision-making on an annual basis and in Migori and Turkana on a quarterly basis. In Kakamega, data from free maternity services is summarized on a monthly basis and reports for the Oparanya Care program are presented to senior management on an annual basis. Reports on HIV are presented monthly, reports for reproductive health monthly, reports for TB monthly, reports for malaria and nutrition quarterly. In Mombasa, the data are presented during quarterly performance reviews and on a monthly basis at sub-county level and health facilities.

Performance data has been used to identify opportunities to improve services; for example, in the recent allocation of Danish International Development Agency (DANIDA) funding in Busia, the county used workload data as the basis for mobilizing funding. In September, Mombasa County used Kenya District Health Information System (KDHIS) data to discover that a number of children were not immunized; afterward, they formed a taskforce to mobilize resources and followed up on it. They also intend to engage skilled midwives, informed by low deliveries data. Also in Mombasa, high teenage pregnancies enabled cooperation of the Ministry of Education (MOE) in starting a project for youth in and out of school. An induction for Members of County Assembly (MCAs) showcased data that led to a better understanding of health dynamics and helped encourage MCAs to advocate for health programs. One outcome was that MCAs agreed to follow up on national health insurance enrollment. There are 10 to 12 MCAs in the county level health committee.

On an annual basis, health data in Busia are used for reviewing/evaluating the success and/or failure of county health programs and strategies. In Migori, a score card is utilized in the CHD on an annual basis. For reproductive health programs in Kakmega, a review of data is supposed to be done on a quarterly basis but is rarely executed. HIV programs are reviewed quarterly with support from APHIAplus, TB program reviews are supported by CHD on a quarterly basis. In Turkana, this is also done on a quarterly basis.

In Busia and Migori, health data are used in the formulation of policy and/or incremental re-adaptation of existing programs and strategies during strategic planning. In Kakamega, this is contributing to the planning of HIV programs with support from KANCO, which provides data from key populations. Malaria data from high incidence areas are used to make decisions on procurement of commodities, supported by TUPIME Kaunti and Measure Evaluation.

Table 4.13. Critical gaps and proposed actions: Capacity of CHD to use collected data for planning and policy making

Prioritized Critical Gaps Identified	Proposed Actions to Address Critical Gaps ("how-to" strategies)
Inadequate regular data analysis and sharing with key actors like CHMTs, SCHMTs, and non-state actors for use as evidence in strategic planning and policy making, including rational budgeting and decision making.	Develop policies on regular data analysis and sharing for use.
Inadequate skills to develop policy briefs	Capacity building on development of policy briefs
Lack of a research policy	Develop a County health research policy Constitute a health research Internal Review Committee with a clear mandate

HEALTH INFORMATION SYSTEMS: WHAT IS DRIVING THE SCORES

Turkana scored the highest capacity in management of Health Information Systems with 81%, followed by Migori at 75%, Busia and Mombasa both at 69%, and Kakamega at 50%. Reasons for the high score in Turkana and other counties, which rank high under this block, can be attributed to the high level of support from IPs. Turkana County also has mentorship programs with actors that have technical capacity to provide mentorship. The mentorship program relies heavily on partners for resources. Most counties have the ability to monitor health data at their county level and report this under the DHIS. However, the evaluation function, knowledge sharing across county health teams, and strategic dissemination of the information/data analyses and generation is weak. Board and strategic technical support from M&E IPs is needed to develop this capacity for county health staff.

The HIS challenges at the county level are summarized as follows (HIS Policy Brief, MTR):

1. Inadequate county capacity for analytics and evidence use, and producing reports
2. Data ownership: Data issues are left to the health records and information officers and reports cannot be accessed in the absence of these officers
3. Donor-driven DQAs in some counties
4. Inadequate indicators and tools for reporting, especially at the community level
5. Inadequate information sharing and platforms for sharing
6. Inadequate priority investment in health information systems

DHIS2 system has presented unprecedented potential for the counties to move from the era of unreliable and fragmented HIS systems to the more ideal situation of availability and use of quality health information for informed decision-making. However, there are still challenges reported with respect to data quality and the capacity of various health workers to analyze and use DHIS2 information. In addition, there is still a very low level of data demand and use. DHIS2 is suffering from an overload of data elements and indicators and contains indicators that may have limited use for counties. The demand for further disaggregation risks increasing the burden of recording and reporting for health workers. Embracing Electronic Health Record (EHR) in data entry at the service provider level is an important strategy to reduce the burden of recording and especially reporting, but still requires a rational approach to avoid an overload of data collection at the cost of service provision. The range of data and information available in the DHIS system should be explored so that health managers, researchers, and other stakeholders can be challenged to take a more proactive role in use of this data for more informed health decision making and operational research.

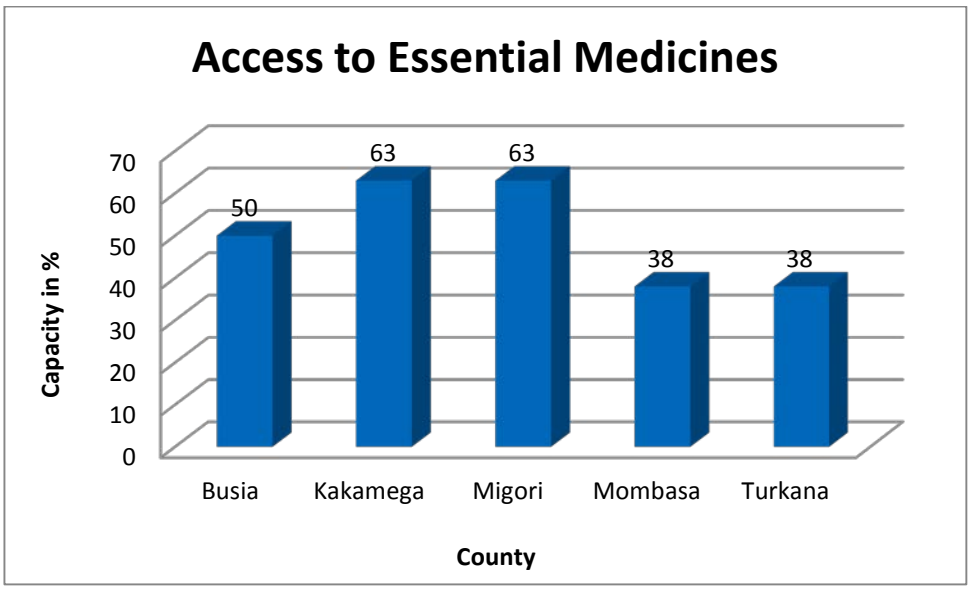
Lack of integration of information from other health management systems (i.e., service statistics, financial, human resources, logistics information, and physical assets data systems) is another challenge. This is due to different installed software programs; these software programs are frequently incompatible, due to different platforms and/or data format or types. This leads to poor electronic information interchange; users get frustrated as they spend time manually entering data into different sub-systems.

4.5. Access to Essential Medicines & Other Health Commodities

Figure 4.11 illustrates the capacity of the five focus counties to ensure access to essential medicines and other health commodities for the population. Kakamega and Migori have the highest capacity, in this building block, of 63% (significant/ functional capacity), followed by Busia at 50% (average capacity) and then Mombasa and Turkana with the least capacity in this area at 38% (limited capacity).

A detailed analysis of the CHDs capacity to ensure access to essential medicines and other health commodities in all five focus counties is provided in sections 4.5.1 to 4.5.4. The analysis has been organized as per the standards under the Access to Essential Medicines building block in the CICA tool.

Figure 4.11. Access to Essential Medicines & Other Health Commodities



4.5.1. Capacity of CHD to ensure access to essential medicines and other health commodities

All five counties have a commodity security unit/team within the CHD representing key service areas. In Kakamega and Migori, the County Commodity Security Committee structure has been adopted, operationalized, and implemented at the sub-county level.

The Kenya National Pharmaceutical Policy of 2012 provides guidance for county pharmaceutical operations on governance and regulation of pharmaceutical commodities. The public sector is primarily supplied through the Kenya Medical Supplies Authority (KEMSA), and secondarily by Missions for Essential Medicines (MEDS). MEDS supplies mainly faith-based organizations or clinics. Lastly, there is the private commercial supply chain. The procedures for implementing and supervising supply chain services are highlighted in the commodity management manual. A procurement plan is devised where selection, forecasting, and quantification requirements are developed. Quantities ordered from KEMSA and MEDS are based on estimated requirements of health products and commodities; commodities are then delivered directly to health facilities based on the consumption-based commodity data. Challenges exist in delayed payments from county to KEMSA due to delays in disbursements. Also, different programs employ different commodity reporting cycles regarding essential medicines, vaccines, TB, antiretrovirals (ARVs), lab reagents, and consumables. The reordering cycle is first integrated into a logistic management information system, then into the DHIS2 system. Commodity dashboards are available on the status of commodities at county, sub-county, and even facility level. The

commodity security technical working group conducts regular joint supervision with other health cadres to ensure adequate supply chain services at the lower levels and redistribution is done. There is no clear supply chain system for nutrition commodities.

Commodity management guidelines provide the basic standards for selection, quantification, and commodity reporting. The counties use the national Kenya Essential Medicines List and Kenya Essential Medicines Supply List for product selection. For quantification, they have a tool for ordering, called the Commodity Reporting National Tool. Health commodities are to be ordered and distributed every quarter, based on consumption data, and there is a ten-day lead-time for KEMSA/MEDS to supply to health facilities. Delays do occur due to funding. Last mile distribution of commodities is encouraged and practiced, but for vaccines and commodities needing cold-chain storage, distribution is to the county warehouse. The health facility in/charges employs social accountability mechanisms to ensure commodities are available at facilities and that patients are not charged for free commodities. The inspection and acceptance committee at the county level is responsible to ensure deliveries are as required and of good quality.

Supply chain data are used to help decision making at county, sub-county, and facility levels. The commodity security working group at the county level plays a vital role in reviewing data from DHIS and LMIS and presenting status reports on stock levels to maintain adequate buffer stocks at acceptable levels within the quarters. This is communicated to national level programs and KEMSA.

County pharmacists and pharmaceutical personnel are involved in supervision at county and sub-county levels and the supervision checklist has tracer commodities to gauge availability and stock outs. Programs with specific needs such as TB, HIV, and RMNCH have direct supervision support at the national level, using their county coordinators, and ensure maintenance of adequate commodity supplies.

The counties take a whole-market approach to strengthening commodity management systems for the county. They also supply commodities also to faith-based hospitals and clinics, especially for those serving needs for TB, HIV, malaria, and essential medicines. Some organizations offer subsidized commodities. There have been incidents (with anti-malarials, family planning services, or rapid diagnostic tests) where some commodity is supposed to be provided for free with consultation services, yet private facilities sell the product. Capacity building in supply chain management impacts all clinic staff and supervision, including faith-based clinics. In general, the LMIS and DHIS ensure that commodity indicators and trend graphs are maintained and these supply chain statistics are presented to the commodity security committee. However, industrial action (strikes) by nurses and doctors affected consumption patterns of commodities in 2017. Correct disposal mechanisms are largely utilized for disposal of medicines.

Procedures are used to make sure that essential medicines and health commodities are distributed according to need. Poverty indices are used to guide equitable distribution. Medicines are also subsidized and are free in health centers and dispensaries; when in sub-county and county referral hospitals, a small fee is charged and is reimbursed by the NHIF. To ensure affordability, counties purchase medicines from KEMSA and MEDS and this pooled procurement mechanism ensures lower prices and direct supplies to the health facility.

Quality assurance of essential medicines is critical to ensure no sub-standard or counterfeit medicines are available in the public-sector supply chain. To ensure quality and safety of medical products, various systems are in place including policies and standards, laboratories which monitor quality, post-market surveillance, manufacturing surveillance, and local and global pharmacovigilance to monitor adverse drug events. Some of these are funded by USAID through the Promoting Quality of Medicines global health program (PQM) and implemented by United States Pharmacopeia and in Kenya with Pharmacy and Poisons Board (PPB).

Table 4.14. Critical gaps and proposed actions: Capacity of CHD to ensure access to essential medicines and other health commodities

Prioritized Critical Gaps Identified	Proposed Actions to Address Critical Gaps ("how-to" strategies)
Lack of essential commodities data set in the District Health Information System (DHIS2)	Liaise with the MOH to finalize essential commodities data set within DHIS
Inadequate quality assurance of essential commodities	Developing a QA plan: Build capacity on pharmacovigilance by PPB, county Minilab™ testing and provision of pharmacovigilance tools. Identify risks based on post-market surveillance in the counties mentored by the Pharmacy and Poisons Board
Inconsistent supportive supervision	Allocate funds to conduct integrated supportive supervision and ensure commodity managers are represented

4.5.2. Capacity of CHD in forecasting, quantification, and procurement of commodities

All five focus counties have the capacity to estimate commodity needs and develop a supply plan. However, the counties have only partial capability to fully procure or source (i.e., buy or secure donations of) essential commodities. The five focus counties require some external technical assistance to estimate commodity needs. The commodity security technical working group at county level plays a vital role in reviewing data from DHIS and LMIS and presenting status reports on stock levels to maintain adequate buffer stocks within the quarters at acceptable levels.

Commodity needs are identified through guidance offered from the Government—Kenya Essential Package for Health levels and the Kenya Essential Medicines List 2016. County, sub-county, and health facility needs are identified through needs assessment. National government agencies and institutions play a role in assessing county commodity needs. KEMSA utilizes the consumption data and guides counties in ordering stock and restocking levels. Some commodities are also still supplied from the national level, including vaccines, anti-TB, ARVs, and malaria medications, as well as family planning.

Once commodities are identified, orders are consolidated, reviewed, and included in LMIS, DHIS. Orders are made through standard ordering forms on a quarterly basis. Challenges exist in the delay of disbursement from the treasury to health facilities; this in turn delays the purchase of commodities. Also staff sometimes struggles to get commodities and supplies to facilities in areas where boats are needed for access. Thus, the role of development partners for health and/or IPs in procuring essential medicines is pivotal for access to some commodities. For instance, PS Kenya supports the private sector with family planning commodities, training, and LMIS data. APHIAplus supported Busia to buy a boat to enable transportation of commodities to hard-to-reach areas with water access only.

In Kakamega County, the proportion of county spending on commodities as a percentage of total county health spending is almost 10% (FY 2017–2018: Ksh 360 million commitment for commodities out of the total health budget of Ksh 3.7 billion). In Busia, it is 5.42% of the total health budget (approximately 350 million allocated for FY2016–2017). In Migori, it is 14% (approximately Ksh 252 million of a Ksh 1.8 billion county health budget FY2017–2018). In Turkana, it is 16.7% (350 million of a 2.1 billion [900 million to salaries] FY2017–2018).

Table 4.15. Critical gaps and proposed actions: Capacity of CHD on forecasting, quantification, and procurement of commodities

Prioritized Critical Gaps Identified	Proposed Actions to Address Critical Gaps ("how-to" strategies)
Inadequate capacity to analyze supply chain data for forecasting and quantification	Build capacity of pharmaceutical staff Allocate funds for forecasting and quantification exercise, F&Q reporting, and procurement of commodities per plan

4.5.3. Capacity of CHD to develop or adopt LMIS

Prioritized Critical Gaps Identified	Proposed Actions to Address Critical Gaps ("how-to" strategies)
Lack of electronic system for LMIS in some counties (Turkana and Mombasa)	Develop an electronic LMIS (Mombasa and Turkana)
Lack of data quality improvement plan for all LMIS elements	Development of data quality improvement plan for all LMIS elements
Not all commodity managers have been trained on LMIS	Train all the commodity managers on commodity LMIS
Inadequate reporting tools and for commodities	Procure commodity reporting tools and job aids and various commodity functions (inventory management,

	storage, distribution, etc.)

The counties generally have either an EMMS or KEMSA LMIS for broader measurement, and separate programs for specific commodities (RMNCH, HIV/AIDS, malaria, TB, and vaccines), at times linked to national DHIS reporting. EMMS orders to KEMSA are placed when instructions are received from the Chief Officer on the amount available for procurement. This amount is allocated to sub-counties and facilities based on workload and disease burden; for some counties, it is based on consumption. Once facilities obtain their ceilings, they prepare orders using a standard order form and forward to the sub-county pharmacist or supply chain officer for review, consolidation, and forwarding to the county pharmacist. The county pharmacist reviews orders and prepares a requisition, which is in turn sent to KEMSA or MEDS through the Chief Officer to prepare a pro forma invoice. Supply is determined based on quarterly or half-year orders and based on county health budget availability.

Kakamega, Busia, and Migori counties use a Health Commodities LMIS that includes at least two of the three following components: stock-keeping record, consumption/usage register, or transaction record. There is a system for distributing/resupplying these records. Most staff in these counties have also been trained in the use of the LMIS. Reporting of LMIS data, however, is below 50% for all facilities annually. Turkana and Mombasa counties do not use LMIS; they have a manual system. Mombasa County held a meeting with KEMSA and a team from IBM/Watson and the Bill and Melinda Gates Foundation recently concerning software development for LMIS.

Table 4.16. Critical gaps and proposed actions: Capacity of CHD to adopt LMIS

4.5.4. Capacity of health facilities to effectively store and account for health commodities through appropriate records and reports.

In all focus counties, warehouses or facilities for commodity storage exist at the county, sub-county, or facility level, with some accommodation for items requiring special storage. However, in most counties, the county/sub-county warehouse and health facility store is inadequate and does not meet all four criteria (large enough, regularly cleaned, dry, and well organized).

In all five counties, procedures for the proper storage of essential medicines and other health commodities at county, sub-county, and health facility level are described in job aids for proper inventory management and storage management and displayed in most health facilities (Management Sciences for Health supported this activity). FEFO (first expiry first out) and FIFO (first in first-out) standards are utilized. Proper shelving, lighting, and temperature for commodity storage areas is required.

The community-based groups and networks have played a role in the distribution of some commodities (e.g., condoms, family planning supplies, dewormers, malaria drugs). The private sector also has a role to play in commodity procurement, storage, and distribution. Some commodities are supplied to faith-based organizations. Data from private facilities is also used for procurement. However, supervision in private facilities is often inadequate.

Regarding the quality of medicines and other health commodities at the county level, county capacity is limited and most support is from KEMSA and PPB; inspection and acceptance committees exist to ensure quality once products are delivered. The counties rely on KEMSA and MEDS quality assurance laboratories, which are WHO-qualified and have ISO and ISO 17025 accreditation (maintained over years). These laboratories have batch quality checking on all products. Bigger health facilities and sub-county MOH levels prequalify suppliers. PPB, with other regulatory bodies from medical, nursing, and laboratory groups, also conducts routine joint

surveillance with a harmonized checklist in both public and private facilities. Portable minilabs are present to ensure quality supported by PPB and the USAID PQM program, but expertise is lacking. PQM collaborated with key stakeholders to scale up the monitoring of quality of medicines. It was expanded to include additional counties and ports of entry and support was given in sampling strategies, refresher training on Minilab™ basic tests, and data reporting. However, this requires continued sustainable support from USAID and local partners such as PPB, due to high staff turnover at the county level of pharmaceutical personnel; some counties may not have benefited from this support (USAID/Promoting Quality of Medicines Annual Performance Report, 2016–2017).

Pharmacovigilance systems and reporting on adverse drug reactions exist. Minilabs are available at county referral hospitals for spot check on the quality of medicines, including post-market surveillance as prescribed by PPB. For medical waste management, all sub-county and major health facilities have incinerators and involve National Environment Management Authority in waste disposal. Within the counties, there are no elaborate quality assurance mechanisms for medicines; however, some counties have elements of quality and pharmacovigilance systems in place through the support of the MOH and procuring entities such as KEMSA.

Table 4.17. Critical gaps and proposed actions: Capacity of health facilities to store and account for health commodities

Prioritized Critical Gaps Identified	Proposed Actions to Address Critical Gaps ("how-to" strategies)
Lack of adequate storage for health commodities, including special storage needs at all levels (county, sub county, health facility)	Improve health commodity stores at all health facilities as per the good storage guidelines
Inadequate mechanisms at the county to ensure efficient distribution of commodities	Re-evaluate/redesign distribution system to be more efficient SCM assessment to inform a better supply chain system for the county
Unreliable pharmacovigilance systems in the county (for monitoring and reporting on adverse drug effects and poor quality reporting)	Strengthen pharmacovigilance reporting system
Lack of clear mechanisms for waste disposal of government stocks	Initiate processes for establishing a waste disposal system

ACCESS TO ESSENTIAL MEDICINES & OTHER HEALTH COMMODITIES: WHAT IS DRIVING THE SCORES

Kakamega and Migori scored the highest capacity in this building block, at 63%, followed by Busia at 50%, and then Mombasa and Turkana with the least capacity at 38%. This was mainly at CHMT level and not at sub-county or health facility level, as this capacity was not assessed at the lower levels. There are underlying reasons for the gaps in access to essential medicines and commodities in specific counties. These gaps have implications for service delivery in the counties since essential commodities availability is critical to public health care delivery.

Kakamega and Migori have functional and active county and sub-county commodity security and inspection and acceptance committees which ensure essential medicines are delivered as required and supply chain performance statistics are maintained at county, sub-county, and facility levels, reflecting improving trends over time. County pharmacist leadership in both counties is the main driver to ensuring proper coordination and functioning of the supply chain function. In addition, development partners' support through USAID and through programmatic support from HIV, TB, and malaria has assisted from a health system perspective to strengthen commodity management at county and sub-county levels. However, the challenge of storage of health commodities and inadequate storage conditions still persists at the health facility level, since infrastructure is wanting with lack of proper shelving, pallets, refrigeration, and thermometers to monitor storage conditions. There is also limited involvement of the for-profit private sector in supply chain management at the county and sub-county levels, despite commercial supply chains being more efficient, reliable, and technology-focused. There may be opportunities in fostering this collaboration for wider gains in both public and private health facilities.

Turkana County presents a low score in delivery of essential medicines and other products, especially in the sub-counties, due to difficult terrain. Few partners support this function. Another major gap is lack of a LMIS for health commodities and dependence on the national LMIS at a county level. There is also the challenge of different information systems for various commodities, such as laboratory consumables, nutrition, and others. There are no commodity security technical working groups at the sub-county level and this contributes to low scores for ensuring governance and oversight at lower levels. The situation in Mombasa County is similar, with governance committees at county and sub-county, but no supply chain statistics are monitored and there is the lack of an electronic supply chain system or LMIS. In addition, the county has storage challenges for essential medicines, with no warehouse at the county or sub-county level. Currently, the health facility stores do not meet standards of good storage and the redistribution to sub-counties is not done, or has poor record-keeping. Records are not updated or maintained.

In summary, all the counties assessed above still have gaps, despite some doing better than others, and this important building block needs to be strengthened across the board. It is important to note that other counties in Kenya can share their best practices and establish of a center of excellence within a regional block. For instance, through Afya Ugavi, Isiolo is setting up a center of learning on commodity management, ensuring a well-functioning supply chain at all levels, and looking at a regularly updated dashboard to undertake monitoring of commodities at all levels.

4.6. Health Systems Financing

Figure 4.12 and 4.13 illustrate the capacity of the five focus counties to ensure Health Systems Financing. Kakamega County scored the highest capacity in this building block at 75% (significant functional capacity), followed by Busia and Turkana at 50% (average capacity), Mombasa at 44% (average capacity), and Migori at 31% (limited capacity).

A detailed analysis in all five focus counties is provided in sections 4.6.1 to 4.6.5. The analysis has been organized per the standards of the Health Systems Financing building block in the CICA tool.

Figure 4.12. Health Systems Financing

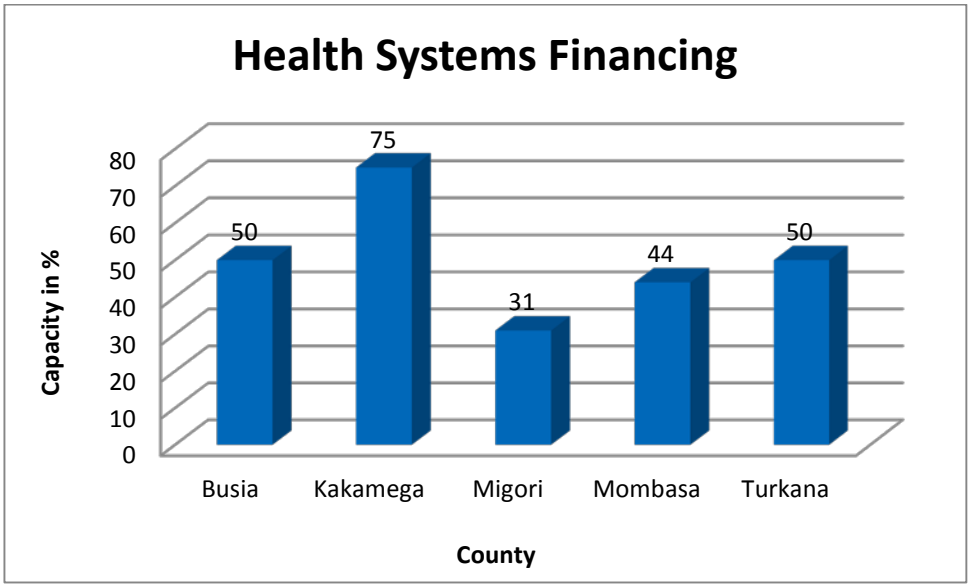
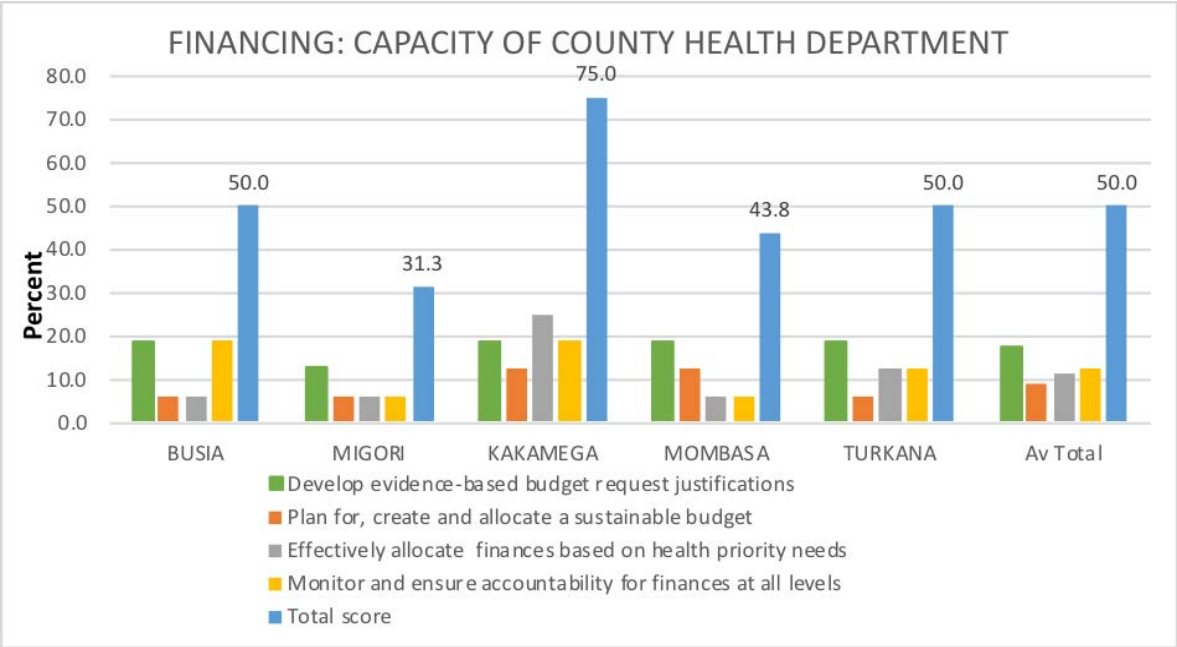


Figure 4.13. Trend analysis of CHD capacity



4.6.1. Capacity of the CHD to ensure that adequate public funds from the total county government budget are allocated to public health and population activities

In all five counties, the county health budget is developed annually with input from the county health department. Estimated actual county health expenditures are systematically calculated on an annual basis as part of budget formulation process. The health budget is between 25% and 30% of the overall county government budget, except in Migori and Turkana where it is less than 25% (Figure 4.13).

Funding comes from mainly national and county government through the exchequer and county revenue collection. Additional funding is provided by development partners such as USAID, Global Fund Against AIDS, TB and Malaria (GFATM), DFID, UNICEF, DANIDA, HSS, and GAVI (immunization). Mechanisms to determine county health budget needs of individual sub-counties are prescribed under the Public Finance Management Act of 2012 (PMF) and guidance through the budget cycle process is provided by CIDP, the Medium Term Expenditure Framework (MTEF), Sector plans, annual development plan, and AWPs.

4.6.2. Capacity of CHD to plan for, create, and allocate a sustainable budget

Busia County is not doing well in three out of the four criteria necessary in a sustainable budget; the county is not doing well in input, allocation and initiative criteria, but is very good at planning. To address this, the county feels that they need to develop a resource mobilization strategy to tap into funding sources other than the mainstream of funding (e.g., from the philanthropists in the county, religious groups, factories etc.). The CHD mentioned that Busia has celebrity sportsmen from Busia County that could be approached to support the building of a hospital ward. In Kakamega, the county does not prioritize primary health care services and there are weak budget collection processes. County primary health care is funded mainly by partners focused on HIV, TB, malaria, and MNCH. Three of the budget's sustainability criteria need improvement in Turkana and Migori (planning, input, allocation).

In Mombasa, an Integrated Financial Management Information System (IFMIS) system exists but is a challenge to use at the lower level, as staff are not trained. There is need for a simpler tracking system for the lower levels to use. There were challenges with cash flow due to delays in disbursement of funds. The PMF is in place and

this is a legal requirement; however, it needs political goodwill to implement. The County Executive Committee Member for Health needs to take it up to ensure it works. The county reported plans to learn from other counties that have made this act work, such as Kilifi. Mombasa County also plans to develop a County Health Sector Fund Bill to regulate department funds. This will enable money to be used for its appropriate designation. The centralization of finance processes at the county level is a challenge. The MOH should be given some powers to manage funds at the sub-county level. Finance powers should be devolved to the sub-county level.

4.6.3. Capacity of CHD to effectively distribute finances

In Busia and Migori, there is a financial system is in place which is sometimes inefficient. Policies exist but may not be adequately distributed and are inconsistently used. Three factors out of four necessary to effectively distribute and or allocate finances need improvement (tracking, responsibility, and dissemination of policies). Policies need to be disseminated and monthly financial reviews carried out. Kakamega County also lacks finance management manuals for banking and collection. Tracking is done with IFMIS, vote books, cash books, expenditures, and Authorities to Incur Expenditure (AIEs) In Mombasa, each sub-county does their own budget (raise AIEs) and sends it to the county for consultation. There are mechanisms in place to ensure transparency in revenue collection and distribution. When an AIE is raised, it has to be accounted for before another AIE can be raised. *Lipa na mpesa* (paying using mobile money platforms) has minimized siphoning of money in selected facilities. In Turkana, there are no mechanisms in place to ensure fair and adequate distribution of funds to the sub-county health teams, but sub-counties with more functional health facilities get more money. There is inadequate transparency, except in donor-driven programs; local taxes and fee levies are not transparently utilized. Financial policies required by the counties include the Public Financial Act 2012, Treasury circulars procurement and disposal policies, recurrent and development expenditures -40:60 (country best practices).

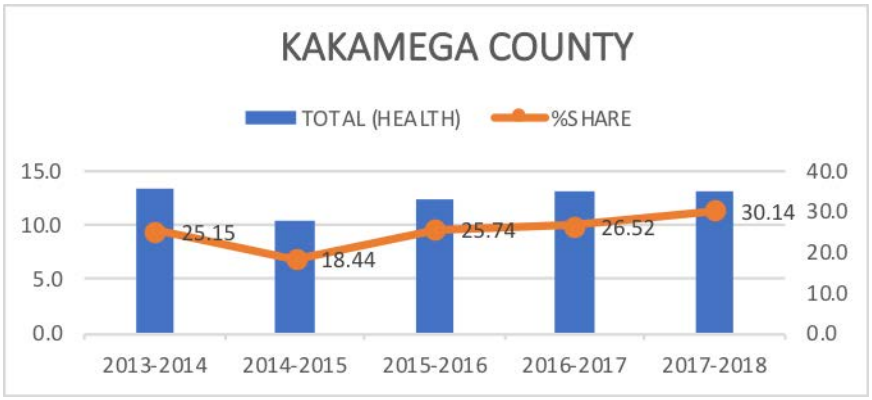
4.6.4. Capacity of CHD to monitor and ensure accountability for finances at the county and sub-county levels

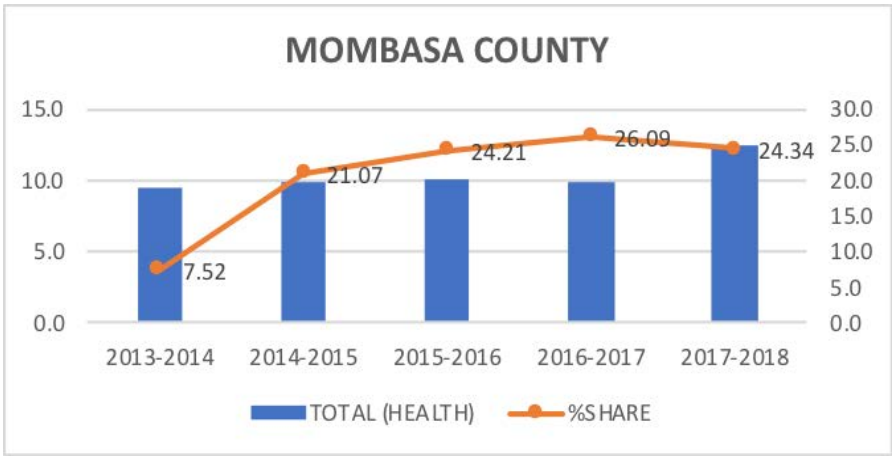
Of the four factors necessary to effectively monitor finances (documentation, review, reporting, audit), Busia needs improvement in reviewing expenses on a monthly basis to ensure applicability and allowability according to the budget and internal policies. In Kakamega, Migori, and Mombasa, in order to monitor and ensure accountability for finances the Department of Finance disburses funds, conducts internal audits and revenue collection. The Department of Public Service and Administration (under the sub-county administrator) chairs the project implementation committee; county assembly approves budget and oversight. In Turkana, accountants monitor funds using a vote-book control system (how much is released, spent, surrendered). There is limited capacity in all five counties to undertake performance-based contracting and there is need for capacity building for technical and procurement staff.

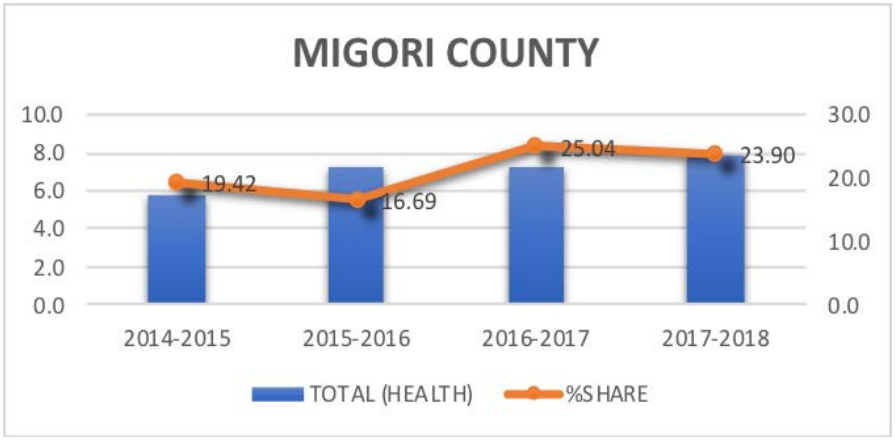
4.6.5. Trend Analysis: Health Expenditure over the last five years for all the five counties

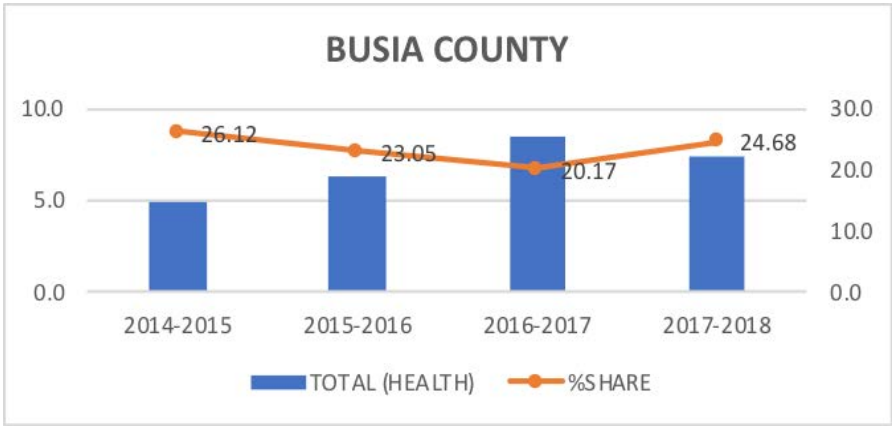
Trend analysis was used to analyze financial data (health expenditure) over the last four or five years for all the five counties. A time plot of health expenditure (KES) with year (2013/4–2017) as time index is presented in Figure 4.14. The trend analysis showed that Kakamega and Mombasa have prioritized the health sector in their expenditures more than the other counties; however, there was noted decline in health spending in Mombasa County in FY2017–2018. Migori and Busia counties have somewhat inconsistent funding for the health sector, which might make it difficult for policymakers to plan their expenditures. Steady increases in funding the health sector is noted in Turkana from FY2015–16.

Figure 4.14. Health Financing Allocation – Five Focus Counties


KAKAMEGA COUNTY
TOTAL (HEALTH)
%SHARE
15.0
10.0
5.0
0.0
40.0
30.0
20.0
10.0
0.0
25.15
18.44
25.74
26.52
30.14
2013-2014
2014-2015
2015-2016
2016-2017
2017-2018


MOMBASA COUNTY
15.0
10.0
5.0
0.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
7.52
21.07
24.21
26.09
24.34
2013-2014
2014-2015
2015-2016
2016-2017
2017-2018
TOTAL (HEALTH)
%SHARE


MIGORI COUNTY
10.0
8.0
6.0
4.0
2.0
0.0
30.0
20.0
10.0
0.0
19.42
16.69
25.04
23.90
2014-2015
2015-2016
2016-2017
2017-2018
TOTAL (HEALTH)
%SHARE


BUSIA COUNTY
10.0
5.0
0.0
30.0
20.0
10.0
0.0
26.12
23.05
20.17
24.68
2014-2015
2015-2016
2016-2017
2017-2018
TOTAL (HEALTH)
%SHARE

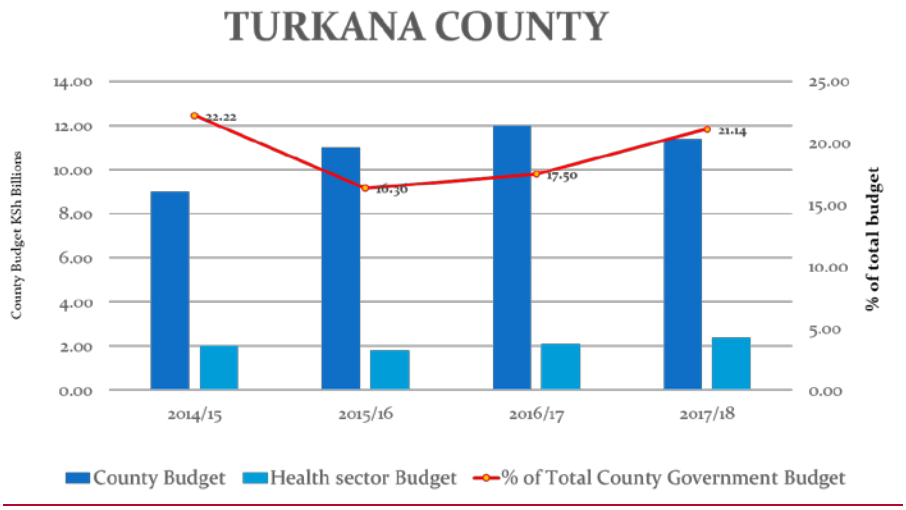

TURKANA COUNTY
14.00
12.00
10.00
8.00
6.00
4.00
2.00
0.00
25.00
20.00
15.00
10.00
5.00
0.00
County Budget KSh Billions
% of total budget
22.22
16.36
17.50
21.14
2014/15
2015/16
2016/17
2017/18
County Budget
Health sector Budget
% of Total County Government Budget

Table 4.18. Critical gaps and proposed actions: Health Systems Financing

Prioritized Critical Gaps Identified	Proposed Actions to Address Critical Gaps ("how-to" strategies)
Lack of departmental expenditure tracking and quarterly review framework	Strengthen capacity of the Executive Expenditure Committee Monthly tracking of the expenditure at the departmental, sub-county, and facility level
No County Health Account reports	Liaise with the relevant departments to conduct County Health Accounts analysis
Inadequate funding for the county health sector	Capacity building in expenditure tracking, priority setting, and linking funding to outputs County to improve local revenue collection CHD to develop resource mobilization strategy
Inadequate use of evidence-based data to inform budget prioritization allocation at county level	AWP and annual report to inform budget process
Delayed disbursement of funds	Advocacy for the timely disbursement of funds from county treasury to CHD
Lack of skills in program-based budgeting	Need to train county and sub-county managers and health facility in-charges on program-based budgeting
No proper systems for tracking distribution and utilization of funds	Develop a financial tracking tool (electronic vote book) at county health department and lower levels
PMF Policy in place but not effectively implemented	Implementation of PMF Policy
Inefficient use of existing resources (corruption, poor accountability structures and allocation mechanisms)	Strengthen accountability and transparency mechanisms from the county to the sub-counties

HEALTH SYSTEMS FINANCING: WHAT IS DRIVING THE SCORES

Kakamega County has the highest capacity in this building block at 75% followed by Busia and Turkana at 50%, Mombasa at 44% and Migori at 31%. Kakamega County performs best overall in health care financing largely because the sector is highly prioritized supported by demand-side financing targeting maternal and child health. However, there is general weakness in the capacity of all the five counties to plan for, create and allocate sustainable budgets. The most affected counties are Busia, Migori and Turkana. The other key areas of weakness is the capacity of the counties to effectively allocate finances based on priority needs. Migori and Mombasa counties also show significant weakness in monitoring and ensuring accountability at all levels (county and sub-county).

The counties however, have significant capacity developing evidence-based budget request justifications. Busia and Kakamega counties are also very strong on monitoring and ensuring accountability for finances at all levels. A key issue emerging from the discussions with Migori County officials was the politics and the lack of transparency surrounding disbursement of funds from the county treasury to the sub-counties and facilities. There is a general feeling that the leadership at the county health department headquarters were not speaking the same language with some of the CHMT and also with sub-county health managers.

In summary, the lack of adequate financial protection in the counties is attributed to low funding, fragmentation of resources and low insurance coverage. Direct Out of Pocket Expenditures (OOPs) places the burden of bearing the costs of illness to the sick person and their families and is therefore a major contributor to inequities. (Health Financing Policy Brief, 2018)

To address these barriers, the Health Financing Policy Brief, 2018 calls for the Kenyan government to:

- Prioritize investments in health, particularly among neglected areas such as maternal health and family planning
- Reduce the burden on poor households of out-of-pocket spending on health by expanding alternative financing sources such as health insurance and vouchers for key services and by partnering with the private health sector
- Address missed opportunities in implementing high impact preventive interventions

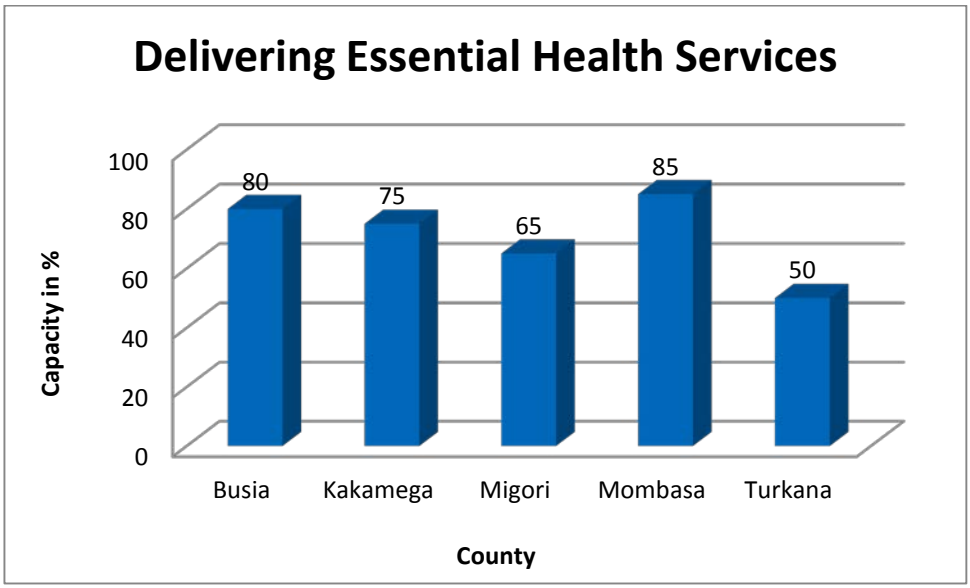
4.7. Delivering Essential Health Services

Figure 4.15 illustrates the capacity of the five focus counties to deliver essential health services. Mombasa has the highest capacity in this building block at 85% (very significant functional capacity), followed by Busia at 80% (very significant functional capacity), Kakamega at 75% (significant functional capacity), Migori at 65% (significant functional capacity), and Turkana at 50% (average capacity).

Sections 4.7.1 to 4.7.5 present a detailed analysis of the CHDs capacity in the five focus counties. The components of this building block have been organized per the standards of the Delivering Essential Health

Services building block in the CICA tool.

Figure 4.15. Delivering Essential Health Services



4.7.1. Extent of interaction between the CHD and sub-counties

In all the five counties except Turkana, there is structured interaction with sub-counties. The CHD interacts at least once a year with sub-county health administrators on budget-related issues, health service planning activities, maintenance, and coordination of facilities. The CHDs hold regular quarterly meetings with sub-county health administrators and also interact with the sub-county during supportive supervision (twice per year) and annual work planning and budgeting (once per year). On maintenance and coordination of facilities, the health facility manager at the county level and the administrator engage with sub-county health administrators. However, this interaction is still inadequate and inconsistent in some counties.

Community stakeholders are involved in quarterly dialogue and action days that allow these community units to discuss issues affecting health in the community. These stakeholders are also involved in public participation county forums at the health planning stage and during allocation of funds (through the health facility management committee). Sub-county health officers are involved in the bottom-up planning process for service delivery at county, facility, and sub-county levels. The officers consolidate health needs and priorities and participate in joint annual work planning sessions held in the county. IPs are actively involved and work very closely with the CHD. Key IP roles include provision of technical support, creation of consensus on priorities and targets at target-setting stage, and support for other planning mechanisms such as development of the County Health Strategic Plan and CIDP (every 5 years). All the focus counties develop an AWP (health sector plan), which documents the previous achievements, challenges, and sector priority interventions and actions for department of health for next period. This is a consultative and participatory process involving a series of meetings with internal stakeholders from the CHMT, SCHMT, health facilities, and other stakeholders at various levels. The AWP follows the government planning cycle and service delivery is prioritized.

Table 4.19. Critical gaps and proposed actions: Extent of interaction between the CHD and sub-counties

Prioritized Critical Gaps Identified	Proposed Actions to Address Critical Gaps ("how-to" strategies)
Inadequate interaction between the CHD and sub-county health administrators (budgeting, planning, maintenance, coordination & assessment)	Hold quarterly consultative meetings between CHD and sub-county health managers
Inadequate involvement of community units in the annual work planning	Structured and regular engagements with community units
Irregular supportive supervision	Strengthen supportive supervision by the CHMT

4.7.2. Capacity of CHD to develop and distribute (to the sub-counties) policies, plans, and standards for key health care delivery areas

All the five focus counties have a county health strategy aligned to national health strategy (2014–2018). However, Kakamega, Busia, and Mombasa have also distributed specific clinical standards and guidelines to sub-counties and health facilities, and these are being used in at least 50% of sub-counties.

The counties provide guidance to the sub-county administrators regarding service delivery; they also provide HIV, TB, and malaria protocols on management by the vertical programs and MNCH protocols for labor and maternity wards. These guidelines and policies are adopted from the national health services guidelines. Dissemination of the policies and guidelines, including the strategic plans, is a challenge and most of the guidelines are in soft rather than hard copies as recommended by the MOH. Services that need to be provided at the sub-county level are stipulated in the norms under the Kenya Essential Package for Health (KEPH) (level 1 to 6).

Table 4.20. Critical gaps and proposed actions: Capacity of CHD to develop and distribute policies, plans, and standards

Prioritized Critical Gaps Identified	Proposed Actions to Address Critical Gaps ("how-to" strategies)
Poor dissemination of the standards and guidelines at sub-county and facility level	Create a repository for health standards and guidelines
Inadequate capacity (skills and funds) to develop strategic policies and protocols on health service delivery	Build capacity of the county to develop service-delivery procedures and policies

4.7.3. Capacity of CHD to supervise sub-counties in the use of health service delivery standards, guidelines, and protocols

In all five counties, a system for monitoring adherence to standards, guidelines, and protocols exists. The counties have guidelines for lines of responsibility, supervision schedules, and supervision guidelines/checklists

for health facilities. In addition, the counties provide some support to sub-counties to monitor adherence at the facility level, but not consistently.

Integrated supportive supervision and monitoring of the use of health service delivery standards, guidelines, and protocols is done by the sub-counties monthly. Counties perform supportive supervision of the sub-counties on a quarterly basis, but they do not adequately engage the sub-county MOHs. Program-based supervision is carried out quarterly (sometimes monthly), or as new programs start (e.g., monthly supervision for TB and quarterly for malaria). Funding is a driver for most supervision.

Monthly monitoring by sub-counties has been a challenge, as most of the sub-counties do not have resources to visit facilities for supervision. In addition, supportive supervision was affected last year (2017) due to the industrial action (nurses, doctors, and clinical staff on strike). Sometimes partners support supervision visits, but only specific to their focus areas. After supportive supervision, feedback is not consistently relayed to the health facilities and sub-county team.

Indicators used to measure service quality include periodic reporting; use of quality of care proxies such as waiting time; average duration of stay; outcomes of certain services; service charters and exit surveys; and quarterly meetings for vertical programs to assess data and quality of care.

Some of the successes in quality of care in the system include improved documentation (in some of the facilities, data reporting rose from 30% to 100%); improved skills; quality improvement; systems have been improved (e.g., in maternal care); neonatal deaths are now reduced. In some cases, this may be because they are captured in the DHIS and discussed promptly and addressed. For vertical programs, sitting together as multidisciplinary teams has improved service delivery, capacity has developed in CHVs to attend to mothers for malaria, pneumonia, malnutrition, and all laboratories are going through accreditation (one in Busia has been accredited and given 2 stars).

There are also some of gaps in the quality of care system. Client satisfaction surveys have not been institutionalized in some counties, Quality Improvement Teams are not active in some counties, there are personnel shortages, inadequate funding for services or supervision, lack of adequate logistical support to conduct supportive supervision, and a persistent lack of transport.

Table 4.21. Critical gaps and proposed actions: Capacity of CHD to supervise sub-counties in the use of health service delivery standards, guidelines, and protocols

Prioritized Critical Gaps Identified	Proposed Actions to Address Critical Gaps ("how-to" strategies)
Irregular monitoring of compliance in the use of standards and guidelines at sub-county and health facility level	Adequate financing for M&E unit to monitor compliance
Lack of joint planning for monitoring compliance in the use of standards and guidelines	Development of joint plans for monitoring
Inadequate technical and financial support to sub-counties to monitor adherence at facility level	Provide technical and financial support to the sub-counties to monitor adherence at facility level
Inadequate supportive supervision skills at county and sub county levels	Provide technical and financial support to the sub-counties to monitor adherence at facility level

4.7.4. Number of operational public, private, and faith-based health facilities compared to the total that routinely report complete and accurate data

All counties have a list of all the public, private, and faith-based health facilities. The counties also have a tracking system for all operational public, private, and faith-based health facilities. Of these, at least 75% of are operational and routinely report monthly. Of these, about 75% of the facilities report complete and accurate data.

Table 4.22. Critical gaps and proposed actions: Number of operational public, private, and faith-based health facilities that routinely report complete and accurate data

Prioritized Critical Gaps Identified	Proposed Actions to Address Critical Gaps ("how-to" strategies)
Lack of a system of quarterly review of complete and accurate data	Enhance data quality reviews for accuracy and completeness
Inadequate data quality audits	Conduct quarterly focused data quality assurance

4.7.5. Capacity of CHDs to implement health programs (HIV/AIDS, TB/HIV, RMNCH, nutrition, WASH, malaria, and sub-programs)

The CHDs in all the five counties have the capacity to implement programs in HIV/AIDS, TB/HIV, RMNCH, nutrition, WASH, and malaria. They also have the capacity to identify priority health areas, develop standards for health programs, develop an implementation plan for priority health programs, and conduct periodic M&E reporting of priority health programs.

In Busia, the county is doing well in implementation of HIV/AIDS programs because of IP support. The strongest services are HIV/AIDS,m and WASH. However, services that present the most challenges in Busia are RMNCH and TB. Skilled birth deliveries stand at only 43%, infant exclusive breastfeeding at 38%. Other statistics are PMTCT—96% mothers, 105% for infants—82% HIV care and treatment, full immunization at 80%, and utilization of ITNs at 80%. These do not anticipate reaching all their targets due to challenges of skilled birth delivery—mothers are still delivering at home. In addition, ANC4 targets may not be achieved due to poor health-seeking behaviour in the community, low education of the community, lack of adequate resources to implement some programs, and commodities stock-out. However, with the anticipated World Bank program on transforming Health Systems for Universal Care, implementation of programs may improve with the uptick of planned activities and resources to support them. In order to reach their targets, Busia will need resources, commodities, support to reach hard to reach areas (transport), continuous support on community sensitization, support on data quality, and cold chain (gases and equipment).

In Kakamega, the county is able to deliver at all levels, but the system is imperfect and programs are heavily reliant on IPs. At the primary care level, 140 facilities are functioning and 11 sub-county hospitals. HIV, TB, malaria, and community health services are the strongest. The services that present the most challenges are mortuary services (with only 1 pathologist), delays in referrals despite ambulances, lack of some services such intensive care unit (not working to capacity), renal unit (no specialist), no burns unit, no neurology clinic, a

psychiatric unit without a psychiatrist, no dermatologist (thus no proper diagnosis) and some surgery specialties. Some of the statistics in Kakamega include 58% fully immunized (against 90% target), ANC coverage at 60%. County HIV prevalence is at 4%, the number of tested = 406,375 (21% of all population – 1.9m). The most assistance is required for trainings on the community component in integrated community case management (diarrhea, etc.), integrated management of childhood illness (IMCI) clinician training, triage training, and staffing gaps at the sub-county level and commodities supply.

The strongest programs in Migori are for HIV, TB, and RMNCH and the services that present the most challenges are nutrition and WASH. Some of the targets include 90% of TB patients completing treatment: 100% HIV-positive pregnant mothers receiving preventive ARVs, 95 % of HIV clients on ARVs whose viral load is suppressed, 90% of targeted children under one year provided with ITNs. Assistance needed to reach these targets includes supportive supervision, capacity building for new staff on RMNCH issues, cold chain equipment, outreaches and defaulter tracing, and collection of commodities from the depot. The strongest programs in Mombasa are for HIV (PMTCT), TB, malaria, community health services, and skills delivery. Services that present the most challenges are emerging diseases (*chikungunya*, *ong'ong'o*, and Dengue fever); non-communicable diseases and HIV/AIDS new infections.

The Mombasa health delivery system is organized into four tiers of care per the norms and standards—community, primary care, primary referral, and secondary referral. Community services focus on demand creation for these services, while primary care and referral services focuses on responding to that demand. The CHD has developed and implemented a HIV/AIDs strategic plan, combo plan, and a technical working group for the key population and adolescents. For TB interventions, there is active case finding, contact tracing, and increased GeneXpert utilization. Malaria control has been enhanced through household spraying, mass net distribution, and improved case management. The county has developed a county nutrition plan, micronutrients supplementation through screening for non-communicable diseases. Some of the specifics for Mombasa County include; 80% of the under one children were reported to be fully immunized (against target of 90%), under-five mortality ratio of 32.3/1,000, infant mortality ratio of 57/1,000, PMTCT at 65% (treatment at 82% but uptake is 90%). Assistance needed to reach targets includes increased awareness-creation programs to stimulate demand, support for defaulter tracing, rapid response initiatives to cover for the effect of doctors/nurses strikes, and training on case management.

In Turkana, there is skilled and trained leadership at the CHMT to manage delivery of KEPH, but the actual delivery is hampered by poor state of roads, sub-optimal health workforce, and inadequate and often erratic supply of commodities. The other major barrier is low levels of financing, especially from the county government. The strongest services are RMNCH and community health services because they are heavily financed by donors who have a very well-trained and motivated workforce. Services that present the most challenges include the county response to HIV/AIDS (weak and without partners). Current donors are pulling out and gains could be reversed. The same is the case with WASH and nutrition. Others, such as the family planning program, is challenged by culture, illiteracy, and poverty, which makes up-take very low. There are also challenges of addressing neglected tropical diseases such as *kalaazar*, *trachoma* and *hydatie*.

Some of the specifics include, as of 2017: % deliveries conducted with skilled attendant (target 65%; achieved 74.9%); % of newborns with low birth weight (target= 5%; achieved 4.8%); % of facility based fresh stillbirths (target= 5%; achieved 2.1%); % of pregnant women attending ANC4 (target= 80%; achieved 60.1%); % infants under six months on exclusive breastfeeding (target= 100%; achieved 68.1%); % facilities providing Basic Emergency Obstetric Care (target=90%; achieved 9%). The county does not anticipate reaching their targets. The key issue is financing, as they do not receive budgetary allocations anywhere close to estimates. Assistance required includes financing, capacity building in data management and reporting, and additional HRH. The county is doing its best to ensure that care is delivered in a respectful environment to the patient; however, the communication skills of some health workers need to improve so that mothers at the point of delivery do

not feel harassed.

Table 4.23. Critical gaps and proposed actions: Capacity of CHD to implement health programs

Prioritized Critical Gaps Identified	Proposed Actions to Address Critical Gaps ("how-to" strategies)
Inadequate staffing for health programs	Employment of more staff by the health department
Inadequate funding for health programs	Increased partner engagement and resources
Inadequate knowledge for technical modules for CHVs	Training of CHV's on technical modules
Inability to meet some of the targets for the programs: HIV/AIDS, TB/HIV, RMNCH, nutrition, WASH, malaria, and sub-programs	Increased community awareness creation to stimulate demand; increased commodities supply

DELIVERING ESSENTIAL HEALTH SERVICES: WHAT IS DRIVING THE SCORES

Mombasa County scored the highest capacity in this building block at 85%, followed by Busia at 80%, Kakamega at 75%, Migori at 65%, and Turkana at 50%. Overall performance in terms of delivery of essential services is very encouraging, largely because the key services evaluated are heavily donor-supported. However, Turkana County performs the worst in service delivery, mainly because of the terrain which does not allow quick movement of health commodities.

Key areas of weakness that may require immediate attention include coordinated efforts between the county health department headquarters and the sub-county offices, as well as development and distribution of policies, strategic plans, guidelines, and protocols. Migori County also needs attention on the latter area. Other than Migori County, which scored lowest in their capacity to supervise sub-counties in the use of health service delivery policies and strategies, the scores are almost standardized across the counties for all the other indicators.

Overall, the worst performing areas for all the counties is their capacity to develop and distribute policies, strategic plans, guideline and protocols; and their capacity to supervise sub-counties in the use of health service delivery policies and strategies.

5. LESSONS LEARNED

- **Engagement with county senior management at the beginning of the CICA process** to discuss the technical approach, CICA tool, and process was very important, as it enhanced ownership, commitment, and ensured time was set aside for their own and staff's full participation.
- **Involvement of the sub-county officers (SCHMT & sub-county officers from key health facilities) was also very important and useful,** as they are directly in charge of service delivery at the sub-county level and were able to assess the health system capacity to deliver essential health services. However, due to competing county activities, only about 20% of county/sub-county participants had gone through the tool prior to panel discussions. They stated that it was difficult for them to come together and carry out the capacity self-assessment prior to panel discussions
- **Involvement of IPs was also very important**, as they collaborated seamlessly with the county and provided essential input on areas they are supporting/plan to support.
- **Using a mix of both focus group discussions and panel discussions to collect data worked very well** as it enabled joint discussion and active participation from all participants and enhanced objectivity and consensus-building on the CICA scores. Consensus building during panel discussions reduced response bias. However, data collection during the CICA takes time, and therefore more time is needed to conduct the focus group and panel discussions so as not to rush the discussions.
- **The validation exercise was a useful process in ensuring all CHMTs and other members of the county health department build consensus and validate the assessment results.** The validation exercise was also a means to reflect on the outcome of the assessment, as CHD personnel were able to discuss the health system together.
- **Sourcing, collection, and evaluating appropriate evidence during CICA is essential** as it supports the verification of the scores and findings and limits response bias.

6. RECOMMENDATIONS

1. **The CICA should not be carried out too often,** in order to allow time for capacity to increase. Proposed frequency for conducting the CICA is annually, supported by quarterly reviews of the action plans, to ensure health investments are targeted and are being provided to the areas of the health system that need support.
2. **The CICA should be carried out at both county and sub-county levels** to get a holistic assessment of the entire county health system, as the two levels have different roles and responsibilities and perform different functions. Their health systems are also at different levels of capacity.
3. **Carrying out the CICA jointly with the CHMT and SCHMT should not be rushed,** otherwise the value of joint learning will be lost and the quality of the CICA reports adversely affected. There needs to be adequate time for the CICA to be carried out well and ensure its role as a learning exercise.
4. **If possible, the CHMT and SCHMT should be involved in the development of the CICA tool,** as they are able to look critically at the health system in which they are operating and identify the key areas that need to be assessed.
5. **The CICA team proposes three days instead of two for focus group discussions/panel discussions,** as the CICA tool is very lengthy and it takes a long time to administer it. It takes approximately 4 hours to discuss each building block.

ANNEXES

Annex 1: Statement of Work
Annex 2: CICA Tools – Five Counties
Annex 3: CICA Action Plans – Five Counties
Annex 4: Data Analysis – Five Counties
Annex 5: Additional input from National Mechanisms

USAID | KENYA AND EAST AFRICA
FROM THE AMERICAN PEOPLE

RFTOP Issuance Date: **July 27, 2017, 2017**
RFTOP Closing date: **August 10, 2017 3:00pm Nairobi local time**

SUBJECT: Request for Task Order Proposals (RFTOP) No. SOL-615-17-000021. County Institutional Capacity Assessment under AID-623-I-13-00001.

Dear Potential Offeror:

The United States Government, represented by the U.S Agency for International Development in Kenya (USAID/Kenya), is seeking proposals from qualified companies and organizations to conduct County Institutional Capacity Assessment as stipulated in the attached solicitation.

Subject to availability of funds, the Government plans to award a firm fixed fee contract. The anticipated period of performance is about 45 days.

Any questions regarding the RFTOP's requirements must be submitted via e-mail to Esther Ndungu, A&A Specialist, at ENdungu@usaid.gov and Nya Kwai Boayue, Contracting Officer, at NBoayue@usaid.gov no later than the date and time listed at the top of this letter.

Proposals must be received electronically on or before the closing date and time stipulated above. Proposals must be sent via e-mail to, A&A Specialist, at ENdungu@usaid.gov and Nya Kwai Boayue, Contracting Officer, at NBoayue@usaid.gov and must conform to all requirements outlined herein. Receipt time is when the proposal is received by the USAID internet server.

This RFTOP does not obligate the United States Government to award a contract, nor does it commit USAID to pay for any costs incurred in the preparation or submission of proposals. USAID reserves the right to award this contract without discussions and any resultant contract is subject to the availability of funds.

Sincerely,

/S/

Nya Kwai Boayue
Contracting Officer
USAID/KEA

SECTION B – SUPPLIES OR SERVICES AND PRICE/COSTS

B.1 PURPOSE

This Task Order must provide all evaluation services as described in detail in Section C.

B.2 CONTRACT TYPE

This will be a Firm-Fixed-Price Task Order.

B.3 PRICE

The total price of this Task Order is TBD.

B.4 APPLICABILITY OF IDIQ

All Sections from the Indefinite Delivery Indefinite Quantity (IDIQ) are hereby incorporated. If there are any discrepancies between IDIQ and the Task Order, then the Task Order shall take precedence.

[End of Section B]

SECTION C – STATEMENT OF WORK

I. Purpose:

The purpose of this Statement of Work (SOW) is to seek services from qualified contractors to conduct county institutional capacity assessment in 5 (**Mombasa, Turkana, Kakamega, Migori, and Busia)** priority counties in Kenya. USAID Kenya and East Africa (USAID KEA), Health Population and Nutrition (HPN) Office, has selected these priority counties based on its current health portfolio investments (HIV/AIDS, RMNCAH, Nutrition, Malaria and Health Systems Strengthening) and other development partners' presence for effective leveraging of resources for greater impact.

Evaluation Focus and Geographical Scope

Despite HIV/AIDS and FP/RMNCAH/Nutrition and WASH geographic targeting that have resulted into less focus in North Eastern region with an exception of Turkana county, it's critical that USAID KEA documents key factors that have worked for and/or against the achievement of intended results, key lessons learnt and key challenges. More importantly, the documentation of the well triangulated and grounded "how to" strategies from a broad-based stakeholders working in the region will provide learning platform for future programming for USAID KEA, other development partners and their respective projects. This evaluation is therefore expected to spend considerable level of efforts in the analysis of the "what" and "how to" implementation strategies that AMREF and its sub-partners used; facilitate subject matter experts' panels discussions individually and through validation workshops, and document workshop outputs into well synthesized strategic directions for future programming. Discussions on the future "what" and "the how" program implementation strategies and their cost feasibilities will form part of this panel analysis. The geographical scope for this evaluation will be limited to **Turkana and Samburu counties**.

A. BACKGROUND INFORMATION

HPN's Program Approval Document was designed to support the achievement of the Country Development and Cooperation Strategy (CDCS) Goal by contributing to DO2, *Health and Human Capacity Strengthened*, and more specifically by contributing to increased use of quality health services (DO2 IR 2.2) and increased Kenyan ownership of health (DO2 IR2.1). HPN's Health PAD is contributing to

CDCS's intermediate results through strengthened county health systems and strengthened county health service delivery. The primary focus for the Kenya Health PAD will be at the county level with activities encompassing family planning and reproductive health (FP/RH); maternal, newborn and child health (MNCH); nutrition; malaria; tuberculosis (TB); water, hygiene and sanitation (WASH); HIV/AIDS prevention, care and treatment; and health systems strengthening (HSS).

HPN plans to develop strong partnerships with focal counties that are more strategic, mature and mutually accountable. The overall goal of these partnerships as part of its contribution to the achievement of CDCS goals is to ensure effective functioning of county health departments in strategic planning, budgeting and accounting, outreach and communication, transparency and accountability, procurement, coordination and collaboration with both state and non-state actors. HPN plans to use assessment results to develop leadership, knowledge and skills of county health department officials; and strengthen their planning, performance, oversight and public financial management and revenue generation systems.

County Capacity Assessment Objectives

The following are some of the illustrative objectives organized in a chronological manner, with a lot of interdependency and must as much as possible be answered with total well triangulated evidence. The Contractor is encouraged to use its technical expertise to suggest additional objectives that could enrich the evidence from the assessment.

- Facilitate self-assessment for the evaluation of the county institutional capacity
- Provide basis for joint prioritization of critical gaps by county team
- Joint action plan development, joint responsibility assignment
- Provide a framework for collaboration /partnerships
- Provide basis for contribution analysis, outcomes measurements and accountability

County Core Functions and Expected Outcomes:

The core functions of county health department are organized in this SOW by WHO's Six Building Blocks, and for every building block illustrative outcome measures are proposed.

<u>Illustrative Measures by WHO Building Block:</u>

Building Block	**Illustrative Outcomes**	**Measurement Method/Annually**
Leadership & Governance	i) Equity in the distribution of health services and interventions ii) Collaboration with private and other sectors iii) Management systems and functions iv) Partnership and coordination of healthcare delivery v) Governance systems and functions vi) Engaging of public and private services providers vii) Planning and monitoring systems and services viii) Health regulatory framework and services	Post intervention CICAT Documents Reviews Key Informant Interviews
HRH:	i) equitable distribution health workers by cadre a. rural vs. urban distribution ii) ratio of health providers to population served by cadre a. doctors: population b. nurses: population iii) health providers deployment norms and standards in use iv) standardized job grading and salary structure in use	Post intervention CICAT Documents Reviews Key Informant Interviews
Health Information System:	i) Health research and information policies, regulations, and standards in use ii) Accurate, timely and complete public health information generation iii) Functional health information dissemination mechanisms for state and non-state actors iv) Existence of plan for strengthening information systems v) Existence of county health research agenda that supports evidence-based policy making	Post intervention CICAT Documents Reviews Key Informant Interviews
Essential Medicines & Other Health Commodities:	i) Existence of a framework for establishing strategic county health products and technologies (HPT) reserve a. harmonized county regulatory framework for health products and technologies exists b. effective and reliable procurement and supply systems	Post intervention CICAT Documents Reviews Key Informant Interviews
Health Systems Financing:	i. Transparency and accountability in resource mobilization, allocation, and use. ii. Cost-effectiveness and cost efficiency of resource allocation and use iii. Sustainable financing system for strategic health commodities iv. Health budget utilization/execution rate, a. health budget balance of primary and tertiary health care services, b. health budget balance of recurrent and development activities v. Private sector participation in financing of healthcare vi. Functional social health protection mechanism (attainment of universal coverage)	Post intervention CICAT Documents Reviews Key Informant Interviews

Building Block	**Illustrative Outcomes**	**Measurement Method/Annually**
Essential Health Services:	i) Effective supervision on implementation of health policies, & adherence to regulations and standards in place ii) Mentorship program for improvement of HCWs knowledge, skills, and competencies in place iii) Existence of functional management and oversight teams for every Health Service Delivery System with an approved organizational structure	Post intervention CICAT Documents Reviews Key Informant Interviews

Data Collection Method:

The assessment team must use HPN's County Institutional Capacity Assessment Tool as the only approved data collection tool.

Sampling Strategy:

All 5 focal counties will participate in the capacity assessment. Within every focal county, a purposive sampling strategy is recommended to allow for the identification and selection of participants with greater probability of making meaningful and constructive contributions. USAID KEA expects that whatever sampling designs that the Contractor proposes would ensure good representation

Data Analysis Approaches:

The proposed ***data analysis methods are illustrative and the Contractor is required to use its technical niche to propose any other appropriate data analysis technique***.

The proposed and illustrative data analysis approaches in this evaluation include:

Trend analysis – determine the overall change in key quantitative indicators over the last 4 years since the start of devolution, comparing/plotting year by year to assess the level of the quantitative indicators using basic statistical analysis methods. This is likely to be applied under health care financing.

Grounded theory analysis – this technique will help build well-grounded body of evidence from the insights, perceptions and observation from the diverse county stakeholders participating in the capacity assessment sessions. Summarize observations and insights, especially from the qualitative questions and grouping them into thematic issues/categories and test theories from the start to the end and where possible make follow ups to support the refinement of the identified capacity gaps. This analytical

technique is expected to help the assessment team develop very substantive and evidence based capacity gaps.

Content & Triangulation Analysis: Using content analysis as an analysis tool to identify key thematic and categories for triangulation with evidence from the qualitative questions answered as part of the assessment for every building block. Assessment team is expected to link as much as possible both quantitative scores and qualitative answers to the expected core functions of the county governments as stated in the Kenya Health Policy 2014 – 2030. This technique will help the assessment team to better understand the technical support that if provided and effectively implemented could result in sustainable county capacity institutional improvement outcomes.

Limitations to the Proposed Evaluation Design and Methodology

The known data limitations are two fold 1) data quality largely related to **data reliability** and 2) subjectivity especially from the selected participants largely due to ***conflict of interest***. The Contractor is expected to propose ways through which such limitations will be addressed and/or minimized to the extent possible.

County Institutional Capacity Assessment Management and Participation:

The Contractor will provide overall technical direction to the Assessment Team; avail all the key project documents, provide all the logistical support required to perform this assessment; USAID KEA will be responsible for the overall management and oversight of the assessment as its primary responsibility and will provide oversight and direction jointly with Contractor management. The Contractor/assessment team shall be responsible for arranging all forms of data collection as part of the institutional capacity assessment. **An Assessment team of 3 (Team leader, and 2 Capacity Assessment Facilitators) upon finalization and approval of assessment work plan, will move to the five focal counties (Mombasa, Turkana, Kakamega, Migori, and Busia).** The Contractor is responsible for quality control (***especially by ensuring that the personnel recruited for this work have relevant experience conducting similar activities in the public sector***) and delivery of the required report as agreed to by USAID KEA. The Contractor shall be responsible for arranging all domestic travel and hotel arrangements.

County Institutional Capacity Assessment Implementation Plan:

The Contractor is expected to conduct institutional capacity assessments in two phases. In phase I, in every focal county two facilitators will work with county leadership to develop an outline for the assessment where participants will use CICAT tool to evaluate the current status of issues for each building block. In this phase, participants upon completion of the scoring exercise will be facilitated to develop objective responses for every qualitative question. The whole exercise of scoring and developing responses for all qualitative questions is estimated to take a maximum of two working days. In phase two, the Contractor is expected to consult with the focal county leadership on the best way of organizing a county validation workshop where, for every county all key stakeholders, state and non-state actors will be facilitated through validation of identified institutional capacity issues, issues' prioritization and action plan development process. The stakeholders' validation workshop is expected to take one day for every focal county.

Estimated performance period:

A total of 45 working days including Saturdays is estimated for this activity.

Tasks	**Estimated time at most (days)**
Planning	5 days
Phase I (Implementation of CICAT)	20 days
Phase II (Stakeholders Validation Workshops)	10 days
Report Writing	10 days

USAID Evaluation Policy standards must be met by the offeror throughout the contract.

[End of Section C]

SECTION D – PACKAGING AND MARKING

D.1. INCORPOARATION OF IDIQ CLAUSES

The clauses included in the IDIQ are hereby incorporated by reference.

[End of Section D]

SECTION E – INSPECTION AND ACCEPTANCE

E.1. INCORPORATION OF IDIQ CLAUSES

The clauses included in the IDIQ are hereby incorporated by reference.

[End of Section E]

SECTION F – DELIVERIES OR PERFORMANCE

F.1. INCORPORATION OF IDIQ CLAUSES

The clauses included in the IDIQ are hereby incorporated by reference.

F.2 PERIOD OF PERFORMANCE

The period of performance will be 45 days including Saturdays from the signing of the Task Order.

F.3 PLACE OF PERFORMANCE

The place of performance is **Kenya** (**Turkana and Samburu counties**.)

F.4 DELIVERABLES

All reports are subject to approval by the Contracting Officer's Representative (COR). Updates shall be provided to the COR on all Task Order deliverables, and discussions will be held upon USAID request, between the Chief of Party and COR on progress and implementation issues.

All reports shall be submitted electronically using Microsoft Word, Excel, PowerPoint software or any other USG SIMS reporting system. All reports shall comply with the standards at Section C.3.2 of the IDIQ AID-623-I-13-00001. All products produced by the Contractor and submitted to USAID shall:

- Be written in proper American English with correct spelling and grammar
- Be written in Plain English, as defined at http://www.plainlanguage.gov/
- Be submitted on time
- Be accurate, with all data substantiated

TASKS AND DELIVEABLES:

A. **In Briefing/Team Planning Meeting**: In-briefing/team planning meeting involving USAID staff, The Contractor, the assessment team to review and discuss the County Institutional Capacity Assessment SOW and make sure everyone is on the same page regarding assessment expectations. The Contractor is required to propose the most appropriate time that this initial meeting would be held and communicate the same to USAID KEA for planning.

B. **Proposal/Work plan**: The assessment team will provide a detailed work plan to USAID KEA before commencing the assessment. The work plan will outline how the assessment will be undertaken, the facilitation, data triangulation processes, analysis and prioritization methods to be used considering the proposed capacity assessment tool proposed in this SOW. The work plan must be approved by USAID KEA before commencing field work.

C. **Briefings**: The assessment team will provide regular in-country briefs to USAID/Kenya and East Africa on progress and discuss problems and issues on a bi-weekly basis via email communications and/or meeting with the Contractor leadership to brief USAID KEA on the fieldwork progress, any implementation challenges and how they are being addressed, A mid-term briefing will be held at the mid-point of the assessment process and Team leader will make a presentation on the progress made by mid-point and include any challenges that would require USAID KEA's attention. Additional debriefings will be convened as required and upon agreement by the two parties.

D. **County Stakeholders' Validation Workshop**: The assessment team will organize 5 validation workshops where key county stakeholders will be invited to validate some of the proposed "how to" strategies for focal county. These workshops will provide unique opportunity for all the development and implementing partners that support institutional capacity building related activities in the focal counties to engage with county leaderships in discussing action plans, responsibility assignment and level of investments for every prioritized capacity gap.

E. **Final Presentation**: The assessment team will make a PowerPoint presentation with handouts to USAID Kenya and East Africa on the main preliminary findings, highlighting priority areas under each building block (not necessarily by county at the end of the assessment.

F. **Organization of Assessment Report**: USAID KEA anticipates as a deliverable for this assessment that details the outputs of the analytical work that formed part of the prioritization of critical capacity gaps. The analytical work should present the "what, in this case the critical gaps" and the "how to, in this case some of the possible strategies that could be used by development partners, other stakeholders and the county leadership to address the capacity gaps" implementation strategies with high likelihood of achieving sustainable results in the focal counties. The "what" and the "how to" strategies are expected to inform the work planning processes at the focal counties by multiple development partners and other civil society organization that program county institutional capacity interventions in the 5 focal counties.

G. **Draft Report**: Acceptance of the draft report by USAID/Kenya and East Africa will be contingent upon the report adequately fulfilling the scope of work and addressing major important areas of inquiry outlined in the SOW. The format of the draft report will follow the required format for the final assessment report as outlined in the section under **"Format of Final Assessment Report"**.

H. **Final Assessment Report:** Upon final approval of the content by USAID/Kenya and East Africa, the Contractor will have the assessment report edited and formatted. The final report will be

submitted both electronically and in hard copy. Four hard copies of the report will be provided to USAID/Kenya and East Africa. In addition, all the raw data will be submitted to USAID on CD labeled "County Institutional Capacity Assessment Data" for future reference. Once USAID approves the final report, the Contractor will submit the report and all the final capacity assessment-related information products to the Development Experience Clearinghouse (DEC) as provided for in the activity contract.

I. **Format of Final Evaluation Report**

The Contractor is responsible for ensuring that the final evaluation report meets all quality criteria listed in **Appendix 1** of USAID's Evaluation Policy. The final evaluation report shall have a maximum of 45 pages:

1. Executive Summary—concisely states the most salient findings and recommendations (2pg);
2. Table of Contents (1pg);
3. Introduction—purpose, audience, and synopsis of task (1pg);
4. Background—brief overview of each of the focal counties' contextual issues around the WHO Six Building Blocks, USAID project strategy and activities implemented to address the problem, and purpose of the capacity assessment (3pg);
5. Methodology—brief description of the assessment methods, detailed presentation on the analytical methods used including data triangulation analytical processes, description on data limitations, impact of any on priority critical gaps identified and the "what" and "how to" strategies recommended (3pg);
6. Analytical Section: Key Findings/Critical gaps identified by every building block/action planning—organized by every focal county (11 – 45pg);
7. Annexes —including the full assessment SOW, a summary of the d the assessment, analysis and prioritization processes used, data collection schedules and a list of any additional qualitative question(s) asked originally not thought of. Annexes will also include lists of participants for every county.

Quality of Deliverables:

The Contractor must ensure that all indictors and their respective performance standards are correctly rated and that all the qualitative questions are comprehensively and objectively answered by the participants. Additionally, all the reporting requirements must be delivered within the time frame of the contract. Finally, the Scope of Work must be carried out by assessment team members who meet the

key personnel requirements. The Contractor is expected to review USAID's requirements and expectations on the draft and final reports as detailed on the "Checklist for Assessing Evaluation Reports". It is important to note that USAID will subject the structure and content of the report to the parameters outlined on the checklist and will use this as a basis for accepting and/or rejecting the reports.

Evaluation Management and Participation:

The Contractor will provide overall technical direction to the Assessment Team; avail all the key project documents, provide all the logistical support required to perform this assessment; USAID KEA will be responsible for the overall management and oversight of the assessment as its primary responsibility and will provide oversight and direction jointly with the Contractor management. Contractor/assessment team shall be responsible for arranging all forms of data collection as part of the institutional capacity assessment. **An Assessment team of 3 (Team leader, and 2 Capacity Assessment Facilitators) upon finalization and approval of assessment work plan, will move to the five focal counties (Mombasa, Turkana, Kakamega, Migori, and Busia).** The Contractor is responsible for quality control (***especially by ensuring that the personnel recruited for this work have relevant experience conducting similar activities in the public sector***) and delivery of the required report as agreed to by USAID KEA. The Contractor shall be responsible for arranging all domestic travel and hotel arrangements.

F.5 KEY PERSONNEL

It is anticipated that the county institutional capacity assessment will be carried out by a three person team ("Assessment Team") consisting of the following persons with specific expertise and experience:

Team Leader (TL): The TL will be a local senior organizational development subject matter expert (Senior Social Scientist) with strong program public sector management and leadership experience, especially in the expertise understanding of core functions of county governments related to the implementation of priority areas reflected in the county integrated development plans. S/he will have overall responsibility for fulfilling the requirements of this SOW. S/he will have a master's degree and significant experience in public sector management, experience in managing diverse stakeholders' interests and developing joint consensus in difficult contexts is required. Ten years and above of extensive experience related to organizational development and/or public sector institutional capacity building is required. S/he will have experience in drafting high quality assessment reports. The Contractor will present to USAID for review a copy of the last three similar reports that he/she wrote

and a reference for each. S/he will ensure that each County Institutional Capacity Assessment session is well guided and managed to generate substantive critical gaps, that action plans are developed that detail out responsibility for each key stakeholder that spells out illustrative the "what" and the "how to" strategies to address each prioritized critical gap and jointly with the county stakeholders agree on the measures of success.

County Cluster Coordinator (**2**):

This person will be a local senior level social scientist with very communication and negotiation skills, and experienced in senior level engagements with senior public officials in the public sector, preferably at the county level governments. S/he will be experienced in facilitating stakeholders in developing joint consensus building involving priority in an environment of scarce budgetary resources. Organizational development specialists with past experience in facilitating the process of developing strategic plans are highly desirable for this work. S/he will have a master's degree and significant experience in public sector management, experience in managing diverse stakeholders' interests and developing joint consensus in difficult contexts is required. Ten years and above of extensive experience related to organizational development and/or public sector institutional capacity building is required. This position will solely be responsible for coordinating assessment works in a cluster of up to 4 neighboring counties, with ultimate goal of ensuring that both phases I and II run smoothly to effective conclusions with acceptable quality products.

Assessment Facilitator (6): This person will be a local mid to senior level social scientist with very good facilitation, communication and negotiation skills, with experience in conducting similar activities in the past. S/he will have a master's degree and significant experience in public sector management, experience in managing diverse stakeholders' interests and developing joint consensus in difficult contexts is required. Work experience of 3 – 5 years is suggested, with experience facilitating public sector meetings involving such as activities as strategic planning, sector work plan development involving many stakeholders among others. S/he will be experienced in facilitating stakeholders in developing joint consensus building involving priority in an environment of scarce budgetary resources. Organizational development specialists with past experience in facilitating the process of developing strategic plans are highly desirable for this work.

[End of Section F]

SECTION G – TASK ORDER ADMINISTRATION DATA

G.1. INCORPORATION OF IDIQ CLAUSES

The clauses included in the IDIQ are hereby incorporated by reference

G.2 PAYMENT SCHEDULE

The Contractor must submit a proper invoice for full payment after submission and acceptance of all deliverables stated in F.4 Deliverables. The contractor should allow 30 days receipt of payment after acceptance of the invoice.

G.3. CONTRACTING OFFICER'S AUTHORITY

The Contracting Officer is the only person authorized to make or approve any changes in the requirements of this Task Order and notwithstanding any provisions contained elsewhere in this task order, the said authority remains solely in the Contracting Officer. In the event the Contractor makes any changes at the direction of any person other than the Contracting Officer, the change shall be considered to have been made without authority, an unauthorized commitment, and costs may be disallowed and no adjustment shall be made in the contract terms and conditions, including price.

G.4 TECHNICAL DIRECTION AND DESIGNATION OF RESPONSIBLE USAID OFFICIALS

The Contractor will be supervised by and all the deliverables reviewed for acceptance by HPN Deputy Director or her designate and by the HPN's county team leaders. The Contractor will work collaboratively with USAID KEA staff and County Health Executive Committee members, county health chief and county health directors, though the Contractor is fully responsible for meeting the objectives in this Statement of Work.

Task Order Contracting Officer Address:

Nya Kwai Boayue,
Contracting Officer
Telephone: 254-20-8622000
NBoayue@usaid.gov

Task Order Contracting Officer Technical Representative (COR) Address:

Padmaja Shetty
Deputy Director
Health, Population and Nutrition
USAID/Kenya and East Africa
PShetty@usaid.gov

The alternate COR is:

Washington Omwomo
Strategic Information Team Leader
Health, Population and Nutrition
USAID/Kenya and East Africa
WOmwomo@usaid.gov

Any amends to the COR or alternate COR will be made via designation letter.

[End of Section G]

SECTION H – SPECIAL TASK ORDER REQUIREMENTS

H.1. INCORPORATION OF IDIQ CLAUSES

The clauses included in the basic IDIQ are hereby incorporated by reference.

Additionally the following clauses have been updated:

H.2 752.7005 Submission Requirements for Development Experience Documents (Sept 2013)

(a) Contract Reports and Information/Intellectual Products.

(1) Within thirty (30) calendar days of obtaining the contracting officer representative's approval, the contractor must submit to USAID's Development Experience Clearinghouse (DEC) one copy each of reports and information products which describe, communicate or organize program/project development assistance activities, methods, technologies, management, research, results and experience. These reports include: Assessments, evaluations, studies, technical and periodic reports, annual and final reports, and development experience documents (defined as documents that:

(i) Describe the planning, design, implementation, evaluation, and results of development assistance; and

(ii) Are generated during the life cycle of development assistance programs, or activities. The contractor must also submit copies of information products including training materials, publications, videos and other intellectual deliverable materials required under the Contract Schedule. The following information is not to be submitted:

(A) Time-sensitive materials such as newsletters, brochures or bulletins.

(B) The contractor's information that is incidental to award administration, such as financial, administrative, cost or pricing, or management information.

(2) Within thirty (30) calendar days after completion of the contract, the contractor must submit to the DEC any reports that have not been previously submitted and an index of all reports and information/intellectual products referenced in paragraph (a)(1) of this clause.

(b) Submission requirements. The contractor must review the DEC Web site for the most up-to-date submission instructions, including the DEC address for paper submissions, the document formatting and the types of documents to be submitted. The submission instructions can be found at: https://dec.usaid.gov.

(1) Standards:
(i) Material must not include financially sensitive information or personally identifiable information (PII) such as social security numbers, home addresses and dates of birth. Such information must be removed prior to submission.
(ii) All submissions must conform to current USAID branding requirements.

(iii) Contract reports and information/intellectual products can be submitted in either electronic (preferred) or paper form. Electronic documentation must comply with Section 508 of the Rehabilitation Act of 1973.
(iv) The electronic submissions must consist of only one electronic file, which comprises the complete and final equivalent of the paper copy.
(v) Electronic documents must be in one of the National Archives and Records Administration (NARA)-approved formats as described in NARA guidelines related to the transfer of permanent E-records. (See http://www.archives.gov/recordsmgmt/initiatives/transfer-to-nara.html).

(2) Essential bibliographic information. Descriptive information is required for all contractor products submitted. The title page of all reports and information products must include the contract number(s), contractor name(s), name of the USAID contracting officer's representative, the publication or issuance date of the document, document title, (if non-English, provide an English translation of the title), author name(s), and development objective or activity title (if non-English, provide a translation) and associated number, and language of the document (if non-English). In addition, all hard copy materials submitted in accordance with this clause must have, attached as a separate cover sheet, the name, organization, address, telephone number, fax number, and internet address of the submitting party.

H.3 52.228-3 Workers' Compensation Insurance (Defense Base Act) (Jul 2014)

(a) The Contractor shall

(1) Before commencing performance under this contract, establish provisions to provide for the payment of disability compensation and medical benefits to covered employees and death benefits to their eligible survivors, by purchasing workers' compensation insurance or qualifying as a self-insurer under the Longshore and Harbor Workers' Compensation Act (33 U.S.C. 932) as extended by the Defense Base Act (42 U.S.C. 1651, et seq.), and continue to maintain provisions to provide such Defense Base Act benefits until contract performance is completed;

(2) Within ten days of an employee's injury or death or from the date the Contractor has knowledge of the injury or death, submit Form LS-202 (Employee's First Report of Injury or Occupational Illness) to the Department of Labor in accordance with the Longshore and Harbor Workers' Compensation Act (33 U.S.C. 930(a), 20 CFR 702.201 to 702.203);

(3) Pay all compensation due for disability or death within the time frames required by the Longshore and Harbor Workers' Compensation Act (33 U.S.C. 914, 20 CFR 702.231 and 703.232);

(4) Provide for medical care as required by the Longshore and Harbor Workers' Compensation Act (33 U.S.C. 907, 20 CFR 702.402 and 702.419);

(5) If controverting the right to compensation, submit Form LS-207 (Notice of Controversion of Right to Compensation) to the Department of Labor in accordance with the Longshore and Harbor Workers' Compensation Act (33 U.S.C. 914(d), 20 CFR 702.251);

(6) Immediately upon making the first payment of compensation in any case, submit Form LS-206 (Payment Of Compensation Without Award) to the Department of Labor in accordance with the Longshore and Harbor Workers' Compensation Act (33 U.S.C. 914(c), 20 CFR 702.234);

(7) When payments are suspended or when making the final payment, submit Form LS-208 (Notice of Final Payment or Suspension of Compensation Payments) to the Department of Labor in accordance with the Longshore and Harbor Workers' Compensation Act (33 U.S.C. 914(c) and (g), 20 CFR 702.234 and 702.235); and

(8) Adhere to all other provisions of the Longshore and Harbor Workers' Compensation Act as extended by the Defense Base Act, and Department of Labor regulations at 20 CFR Parts 701 to 704.

(b) For additional information on the Longshore and Harbor Workers' Compensation Act requirements see http://www.dol.gov/owcp/dlhwc/lsdba.htm.

(c) The Contractor shall insert the substance of this clause, including this paragraph (c), in all subcontracts to which the Defense Base Act applies.

H.4 752.7032 International travel approval and notification requirements (APR 2014)

International Travel Approval and Notification Requirements (APR 2014) Prior written approval by the contracting officer, or the contracting officer's representative (COR) if delegated in the Contracting Officer's Representative Designation Letter, is required for all international travel directly and identifiably funded by USAID under this contract. The Contractor must therefore present to the contracting officer or the contracting officer's representative, an itinerary for each planned international trip, showing the name of the traveler, purpose of the trip, origin/destination (and intervening stops), and dates of travel, as far in advanced of the proposed travel as possible, but in no event less than three weeks before travel is planned to commence. The contracting officer's or contracting officer's representative's (if delegated by the contracting officer) prior written approval may be in the form of a letter or telegram or similar device or may be specifically incorporated into the schedule of the contract. At least one week prior to commencement of approved international travel, the Contractor must notify the cognizant Mission, with a copy to the contracting officer or contracting officer's representative, of planned travel, identifying the travelers and the dates and times of arrival.

[End of Section H]

SECTION I – CONTRACT CLAUSES

I.1 INCORPORATION OF IDIQ CLAUSES

The clauses included in the basic IDIQ are hereby incorporated by reference.

Additionally the following clauses have been updated:

I.2 INCORPORATED BY REFERENCE

52.202-1	Definitions	(Nov 2013)
52.203-5	Covenant against Contingent Fees	(May 2014)
52.203-7	Anti-Kickback Procedures	(May 2014)
52.203-10	Price or Fee Adjustment for Illegal or Improper Activity	(May 2014)
52.203-13	Contractor Code of Business Ethics and Conduct	(Oct 2015)
52.204-10	Reporting Executive Compensation and First-Tier Subcontract Awards	(Oct 2015)
52.209-6	Protecting the Government's Interest When Subcontracting with Contractors Debarred, Suspended, or Proposed for Debarment	(Oct 2015)
52.222-21	Prohibition of Segregated Facilities	(Apr 2015)
52.222-26	Equal Opportunity	(Apr 2015)
52.222-29	Notification of Visa Denial	(Apr 2015)
52.222-35	Equal Opportunity for Veterans	(Oct 2015)
52.222-36	Equal Opportunity for Workers with Disabilities	(Jul 2014)
52.222-37	Employment Reports on Veterans	(Oct 2015)
52.222-50	Combating Trafficking in Persons	(Mar 2015)
52.222-54	Employment Eligibility Verification	(Oct 2015)
52.226-6	Promoting Excess Food Donation to Nonprofit Organizations	(May 2014)
52.227-14	Rights in Data—General	(May 2014)
52.226-6	Promoting Excess Food Donation to Nonprofit Organizations	(May 2014)
52.227-14	Rights in Data—General	(May 2014)
52.232-17	Interest	(May 2014)
52.232-23	Assignment of Claims	(May 2014)
52.232-25	Prompt Payment	(Jul 2013)
52.232-33	Payment by Electronic Funds Transfer-System for Award Management	(Jul 2013)
52.233-1	Disputes	(May 2014)
52.244-6	Subcontracts for Commercial Items	(Dec 2015)

I.3 52.209-9 Updates of Publicly Available Information Regarding Responsibility Matters (JUL 2013)

(a) The Contractor shall update the information in the Federal Awardee Performance and Integrity Information System (FAPIIS) on a semi-annual basis, throughout the life of the contract, by posting the required information in the System for Award Management database via https://www.acquisition.gov.

(b) As required by section 3010 of the Supplemental Appropriations Act, 2010 (Pub. L. 111-212), all information posted in FAPIIS on or after April 15, 2011, except past performance reviews, will be publicly available. FAPIIS consists of two segments—

(1) The non-public segment, into which Government officials and the Contractor post information, which can only be viewed by—

(i) Government personnel and authorized users performing business on behalf of the Government; or

(ii) The Contractor, when viewing data on itself; and

(2) The publicly-available segment, to which all data in the non-public segment of FAPIIS is automatically transferred after a waiting period of 14 calendar days, except for—

(i) Past performance reviews required by subpart 42.15;

(ii) Information that was entered prior to April 15, 2011; or

(iii) Information that is withdrawn during the 14-calendar-day waiting period by the Government official who posted it in accordance with paragraph (c)(1) of this clause.

(c) The Contractor will receive notification when the Government posts new information to the Contractor's record.

(1) If the Contractor asserts in writing within 7 calendar days, to the Government official who posted the information, that some of the information posted to the non-public segment of FAPIIS is covered by a disclosure exemption under the Freedom of Information Act, the Government official who posted the information must within 7 calendar days remove the posting from FAPIIS and resolve the issue in accordance with agency Freedom of Information procedures, prior to reposting the releasable information. The contractor must cite 52.209-9 and request removal within 7 calendar days of the posting to FAPIIS.

(2) The Contractor will also have an opportunity to post comments regarding information that has been posted by the Government. The comments will be retained as long as the associated information is retained, i.e., for a total period of 6 years. Contractor comments will remain a part of the record unless the Contractor revises them.

(3) As required by section 3010 of Pub. L. 111-212, all information posted in FAPIIS on or after April 15, 2011, except past performance reviews, will be publicly available.

(d) Public requests for system information posted prior to April 15, 2011, will be handled under Freedom of Information Act procedures, including, where appropriate, procedures promulgated under E.O. 12600.

[End of Section I]

SECTION J – ATTACHMENTS

USAID evaluation policy

https://www.usaid.gov/sites/default/files/documents/1868/USAIDEvaluationPolicy.pdf

[End of Section J]

SECTION L – INSTRUCTIONS TO OFFEROR

L.1. GENERAL INSTRUCTIONS TO OFFEROR

Single Award. The U. S. Government anticipates awarding one (1) contract as a result of this Solicitation.

RFTOP Instructions.

This RFTOP describes **ALL** known specifics associated with this Solicitation's requirements. If a prospective Offeror notes inconsistencies or conflicting information in the body of this Solicitation document or discovers substantive error(s) which may require explanation or correction, these should communicated by email to NBoayue@usaid.gov and ENdungu@usaid.gov **not later** than (10) calendar days from the RFTOP issuance date. Please identify RFP section/sub-section and page number where error/inconsistency is detected. USAID reserves the right not to respond to communications received after this date. If the nature of communication (must be received within 10-day window stated above) necessitates posting additional information or clarifications, an Amendment will be issued.

L.2. DELIVERY INSTRUCTIONS

The Offeror must submit the proposal:

(1) Electronically – Internet e-mail with attachments (20MB limit) per e-mail compatible with MS Word, Excel and/or Adobe Acrobat (as specified in this Task Order) in an MS Windows environment.
(2) The internet e-mail addresses for submission of the proposals are: NBoayue@usaid.gov, and ENdungu@usaid.gov.

L.3. INSTRUCTIONS FOR PREPARATION OF THE TECHNICAL PROPOSAL

The Contractor must submit the following information for evaluation of the technical proposal:

1. A technical proposal not exceeding 15 pages that describes the proposed evaluation methodology, evaluation team composition, and tentative evaluation schedule.
2. Resumes/CVS for the proposed key personnel. Each individual resume must not exceed two pages.

L.4. INSTRUCTIONS FOR PREPARATION OF THE COST PROPOSAL

The Offeror must provide the budgets in an Excel worksheet. The Offeror may present their budget as they see fit, but the Excel worksheet must be easy to understand. Please follow all of the provisions for the submission of the Cost Proposal as provided in the base IDIQ. There is no page limit on the cost proposal. The cost proposal shall be submitted in a separate volume from the technical proposal and include a budget narrative.

[End of Section L]

SECTION M – EVALUATION CRITERIA

M.1. GENERAL INFORMATION

The Government will evaluate the technical and cost proposal for acceptability. This may include a review of the strength of the proposed staffing and technical approach. The cost proposal will be reviewed for reasonableness, allocability and allowabilty.

[End of Section M]

[End of RFTOP]

County Institutional Capacity Strengthening Strategy: A Capacity Assessment Tool

Introduction and Instructions

This tool was adapted and harmonized with numerous OCAT tools with an overall goal of facilitating the identification and prioritization of core functional areas that USAID Kenya and East Africa, Health Population and Nutrition aspires to partner with national and county governments; and jointly develop action plans to help achieve increased use of quality county-led health services. The tool is based on the World Health Organization (WHO) Health Systems Framework that focuses on six building blocks of a health system.

Use of the tool is meant to be collaborative in nature. It is first and foremost a self-assessment tool, meaning that members of the assessment team and members of the County Health Management Team (CHMT), other key county health institutions including where possible members of county health committee and selected implementing partners work through each component of the tool together. All participants in the assessment receive the tool ahead of time, to have a sense of what questions will be discussed and to locate any relevant documents that will be useful in answering the questions. During the assessment process, participants from the CHMT, selected partners and the assessment team should read through the response options under each standard (component) together, and through discussion, and validations come to a consensus on the appropriate score to assign for each standard. The goal of the exercise is to develop a shared understanding of the current capacity of the institutions and organizations that CHMT represent in order to analyze gaps and develop a responsive capacity building strategy in the form of action plans.

The tool includes a summary scoring sheet organized by Building Block, with space to record scores for each indicator per Building Block. The summary scoring sheet is followed by a description of the scoring for each indicator and related qualitative questions.

County Institutional Capacity Assessment – Quantitative Summary

Summary Scoring

County Institutional Capacity Quantitative Assessment		Score
Building Block 1: Governance and Leadership		**7/16**
Indicator 1.1: Capacity of County Health Department to lead efforts aimed at improving the health of all residents of the county		
	Standard 1.1.1: Capacity of County Health Department to develop and implement a County Health Strategy	3/4
Indicator 1.2: Capacity of County Health Department towards intra and inter agency communication and coordination		
	Standard 1.2.1: Capacity of County Health Department to communicate and coordinate within the County and Sub-County Health Department and other Departments in the county.	0/4
	Standard 1.2.2: Capacity of the County Health Department to lead and engage (coordination) with different health actors working towards the same county goals	1/4
	Standard 1.2.3: Capacity of County Health Department to hold responsibility and ownership for the health system	3/4
Building Block 2: Health Workforce		**3/16**
Indicator 2.1: County Health Department capacity in management of the existing health workforce by putting in place attraction, retention and motivational mechanisms		
	Standard 2.1.1: Ability to recruit and retain human resources for health worker positions, staff health facilities as per staffing guidelines, make working conditions and rural and hard to reach areas more attractive and safe,	0/4
	Standard 2.1.2: Capacity of County Standards and Guidelines	2/4
Indicator 2.2: Capacity of County Health Department to improve institutional frameworks that support workforce performance development and management		
	Standard 2.2.1: Capacity of County Health Department to institutionalize systems for measuring performance and competence of health workforce; strengthen HRH development systems and practice including continuous professional development, communication, ethics and values systems.	1/4
	Standard 2.2.2: Capacity of County Health Department to coordinate capacity development of Human Resources for Health	0/4
Indicator 2.3: County Health department capacity in the development of an adequate, appropriate and equitably distributed health workforce		
	Standard 2.3.1: Capacity of County Health Department to strengthen HRH planning function covering the entire health system	/4
	Standard 2-3.2: Capacity of County Health Department to encourage and support various institutions to adhere to the established norms and standards for HRH in delivery of KEPH	/4

Building Block 3: Health Information Systems	**11/16**

Indicator 3.1: Capacity of County Health Department to plan for and systematically collect health information		
	Standard 3.1.1: Capacity of County Health Department to develop and implement HMIS policies, strategies, guidelines, and protocols appropriate to the data needs of the county	2/4
	Standard 3.1.2: Capacity of County Health Department to collect quality health data	3/4
	Standard 3.1.3: Capacity of County Health Department to manage data	3/4
Indicator 3.2: Capacity of County Health Department to promote evidence-based decisions and policy making		
	Standard 3.2.1: Capacity of County Health Department to use routine performance, surveys and surveillance data for planning including performance management, rational budgeting and policy making	3/4
	Building Block 4: Access to Essential Medicines & Other Health	**8/16**
Indicator 4.1: Capacity of County Health Department to ensure access to essential medicines for the population		
	Standard 4.1.1: Capacity of the County Health Department to provide oversight to commodity management to downstream facilities (ref: - existence of a functional commodity security committee).	2/4
	Standard 4.1.2: County Health Department's capacity to estimate commodity needs, develop a supply plan and procure/source these commodities	3/4
	Standard 4.1.3: County Health Department's capacity to develop and/or adopt and use a National/County-owned Logistics Management Information System (I-MIS)	2/4
	Standard 4.1.4: Health facility's capacity to effectively store and account for health commodities through appropriate records and reports.	1/4
	Building Block 5: Health Systems Financing	**8/16**
Indicator 5.1: Capacity of the County Health Department to ensure that adequate funds are allocated to health expenditures within the overall county budgets		
	Standard 5.1.1: Capacity of the County Health Department to develop evidence-based budget request justifications that ensures adequate funds from the total county government budget are allocated to key areas such as HRH, health commodities and programs.	3/4
Indicator 5.2 Capacity of County Health Department to formulate, distribute, and monitor financing for the health sector		
	Standard 5.2.1: Capacity of County Health Department to plan for, create and allocate a sustainable budget	1/4
	Standard 5.2.2: Capacity of County Health Department to effectively allocate finances based on county health priority needs	1/4
	Standard 5.2.3: Capacity of County Health Department to monitor and ensure accountability for finances at the county and sub-county levels	3/4
	Building Block 6:Delivering Essential Health Services	**16/20**
Indicator 6.1: Capacity of County Health Department to engage sub-counties in delivering health services		

	Standard 6.1.1: Extent of interaction between the County Health Department and /4 Sub-County Health Administration Offices	3/4
	Standard 6.1.2: Capacity of the County Health Department to develop and distribute (to the sub-counties and health facilities) policies, strategic plans, guidelines, protocols and standards for key health service areas	3/4
Indicator 6.2: Capacity of County Health Department to ensure appropriate use of policies and standards related to health service delivery for HIV/AIDS, TB/HIV, RMNCH, Nutrition, Water & Sanitation, Malaria program areas		
	Standard 6.2.1: Capacity of County Health Department to supervise sub-counties in 114 the use of health service delivery policies, strategies, guidelines and standards	3/4
	Standard 6.2.2: Number of operational public, private and faith based health facilities /4 as compared to the total that routinely report complete and accurate data	3/4
Indicator 6.3: Capacity of County Health Department to deliver health care in priority areas		
	Standard 6.3.1: Capacity of County Health Department to develop and implement /4 priority health programs per county health strategy	4/4
	TOTAL SCORE	**53/104**

Scoring Guide by Building Block[1]

Block 1: Governance and Leadership

Indicator 1.1: Capacity of County Health Department to lead efforts aimed at improving the health of all county residents

Standard 1.1.1: Capacity of County Health Department to develop and implement a County Health Strategy	
0	• No current county health strategy • aligned with Kenya Health Sector Strategic Plan (KHSSP) 2014 – 2018
1	• The current county health sector strategy is aligned with KHSSP 2014 – 2018. • Adopted by the county health management team/county health department.
2	• The county health strategy adopted; • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area.
3	• The county health strategy adopted • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area. • Evidence of at least one annual work plan/operational/action plan developed for at least 50% of the county health strategy priority areas
4	• The county health strategy adopted • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area.; • Evidence of annual work plan/operational/action plan developed for at least 80% of the county health strategy priority areas; • Monitoring and evaluation framework developed to track progress. • A Governance structure that properly sorts out the roles and responsibilities of key stakeholders in achieving county health strategy goals exists.
Comments: ▪ The Busia County Health Sector Strategic and Implementation Plan (BCHSSIP) 2013 – 2018 is in place and aligned to the KHSSP. ▪ The County develops annual work plans that addresses all the different building blocks. (provided in the evidence folder)	

[1] The building blocks included in this tool are taken from the World Health Organization's six Building Blocks of a Health System (see http://www.who.int/healthinfo/systems/monitoring/en/index.html for details).

- The county CHMT and SCHMT provide leadership. Meetings however should be monthly, but various committees have not been able to have frequent meetings, even for the designed quarterly meetings due to competing priorities.
- For proper operationalization, there must be dissemination of the work plans as soon as they are developed.

Qualitative Questions Standard 1.1.1

1. What successes and challenges have you experienced in implementing the county health strategic plan? 2013/14 – 2017/18

Successes	Challenges
• A strategy in place – Busia County Health Sector Strategic Plan 2013/4-2017/8 (BCHSSIP) • HRH 484 above the 400 that had been planned for • Infrastructural plans done in the first year were many – every sub-county had a project. Although most have not been completed, there is something going on. • Essential medicines – the office was able to work out a quantification plan that was used to secure funds a secure amount for essential medicines • Bought 7 ambulances to improve health services • 2013/4 – Community strategy was supported and there has been over 50% improvement. Many partners on board to support the community strategy, As a result, there are increased no. of community units, number of CHEWs and no. of partners. • Busia was declared open defecation free (ODF) free zone by a national M&E team that assessed it. This is certified; latrine coverage is over 95%. • Department of health is the heaviest funded in the county • End-term review of the strategic plan has been done	• Funding for the planned activities • Throughout the period there was no M&E plan in place to use to measure • As much as work plans are developed they are not fully operational. • Low political goodwill; bureaucracies hinder the implementation/utilization especially for commodities. • There are some indicators that were tracked over the 5 years, especially those that are not tracked by DHIS. • Adoption of national strategic plan without being cognizant of the county priorities. There is need to look at the country priorities but domesticate based on the county's context. • Question that was asked by the evaluation team – was this just a copy paste from the national (Lessons learnt – the county will make indicators that are relevant to the county and not directly from the national – Tailor it when doing the next County health Plan) • The health care workers did not quite identify with the health strategy – need to involve the smallest units in the development – down up approach) • The ownership of strategy. The health care workers seem not to identify with it. Involvement of the lower units is minimal. This affected the implementation of the strategy. • Linking the annual plans with the public budget cycle. Usually by the time the county completes the work plan, the funding has been allocated • Funding agencies stop funding abruptly and that affects services e.g. RH services

	• Coordination of partners and leveraging of funds.

2. What is the role of partners in developing the plan and contributing to its achievement?
    - Partners were involved in the development of the plan (BCHSSIP). Some facilitated the meetings. They participated to ensure most of their interventions were included.
    - At the validation stage the partners ensure that their interest areas were included. They support specifically within their priority areas; anything outside is not supported.
    - Partner support sometimes is limited – sometimes limited to sub-counties or project areas. This brings a discrepancy in the supported sub-counties against those that are not.

3. What additional capacity would strengthen implementation across the county (capacity in individual knowledge, skills, behaviors and attitudes as well as the structures, policies, systems and procedures of the organization and system as a whole)?
    - Alignment of the different policies in the county so that they speak to each other
    - Development of the strategic plan should be all-inclusive, to enhance ownership, and to enable inclusion of activities supported by the partners in the plan. The presentation from stakeholders is usually very weak and this poses challenges at the implementation stage (bring partners on board early)
    - Dissemination of the strategic plan to the sub-counties. There is lack of ownership of the plan due to lack of dissemination
    - Implementation of a performance appraisal system
    - A well-coordinated partnership framework such that they engage at all levels from the development of the strategic plan.
    - M&E capacity to drive the health strategy development. The county is already working on establishing an M&E unit.

Indicator 1.2: Capacity of County Health Department towards intra and inter agency communication

Standard 1.2.1: Capacity to communicate effectively within the County and Sub-County Health Department and other Departments within the County	
0	• No evidence of communication plan and protocols for information flow within the county and sub-county and to other departments within the county.
1	• There is a communication plan, and protocols are clearly established to guide the plan.
2	• There is a communication plan, and protocols are clearly established to guide the plan. • At least 50% of CHMT are aware of the internal communication plan and protocols but no evidence of use of the plan and protocols
3	• There is a communication plan, and protocols are clearly established to guide the plan. • More than 50% of CHMT are aware of the internal communication plan and protocols but no evidence of use of the plan and protocols .

4	• There is a communication plan, and protocols are clearly established to guide the plan. • More than 50% of key county staff are aware of the internal communication plan and protocols AND evidence exists of use the plan and protocols more than once a year.
Comments: ▪ There is no document or protocols in place to guide the county. People use their personal experience as career civil servant, gained over the years of working in the public sector, to communicate. Protocols are not written or known. ▪ The staff use their own personal emails, not official. ▪ With no job descriptions, it is not clear who communicates/reports to who or how. ▪ As much as the county has been communicating through various media, there is no document or protocol in place to guide themselves and any other to guide how they communicate.	

Qualitative Questions Standard 1.2.1

a) 1. Briefly describe the communication strategy of the county. What mechanisms/tools exist for communication within each department? Between departments? With County Assembly Health Committees?

Communication within the health department:

- Communication is not very clear – a nurse could write a letter to the Chief Officer, and will not copy the supervisor or any other people in between. A real example was given, where an Officer from Health Officer in a Dispensary wrote to the Chief Officer asking for a title deed. The Chief Officer wrote on it, "Use the correct communication channels," and sent it back.
- The health workers need to communicate through the direct supervisor
- Communication was clearer before devolution. Sometimes the communication is actioned, and yet the direct supervisor is not aware. Some of the channels for communication include use of verbal communication, text messaging. whatApp and email communication, which are not official and often times does not provide paper trail. They therefore need to be followed with an official letter.
- Writing of official letters is rare. *The response to an official letter to a senior officer, will not be responded to using another official letter, but instead, the response is hand written in the same letter and sent back to the sender.*
- There are generally no standards as to what forms of communication should be used when and with who.

Communication with other departments and County Assembly Health Committees?

- Through letters, emails, phone calls.

b) What mechanisms/tools exist for communication between county and health development partners and/or implementing partners?

c) Through letters, emails, phone calls depending on the strength of the communication.

Mechanisms/tools between county and implementing partners:

- Through letters, emails, phone calls

d) What are some of the successes/evidence of effectiveness and challenges with the strategy and mechanisms/tools?

2. Briefly describe the policies and procedures in place written to promote collaboration between County Health Department and implementing partners and/or health development partners?
   a) What mechanisms/tools exist for the coordination of health development partners and other stakeholders?
   -
   - Development of MOUs (sample in the evidence folder) and proposals. Example: There was an MOU with Aphia Plus on HRH – engagement and exit of staff that addressed the issue of the employees employed by the partner being absorbed by the County.)
   - Most of the time the specific partners develops the MOU
   - Engagement with the CECM
   - No clear protocols or strategies that guides the development of MOUs but most will meet with the Governor or the CEC Health

(Evidence: County stake holder coordination draft document)

   b) Do we have any form of agreements between county and health development partners and/or implementing partners that support delivery of health services? Yes but they are not standard. They are normally developed by the partners and the county looks and edits and adapts
   - There is one with APHIAplus (it was about engagement of their staff when APHIA plus exits
   - Link between partners is done at the county level
   - AMPATH apart from signing MOUs with county was also to do the same with some sub-counties
   - Broadly the partners usually outlines mainly their areas of interventions and how they would want to relate with the count

3. Is there a policy to guide collaborations? Please describe.
   - County stakeholders' coordination mechanism is in draft form

Standard 1.2.2: Capacity of the County Health Department to lead and engage (coordination) with different actors working towards the same goal	
0	• No evidence of coordination framework that maps out different stakeholders working in the health sector.
1	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Occasional meetings are held between the county and different health actors, but these are irregular, and do not involve all of them. Implementing partners and other key stakeholders have no opportunity to present and review health priorities and their contributions towards health goals.
2	• Evidence of coordination framework that maps out different stakeholders working in the health sector

	• Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals.
3	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals. • The county health leadership receives regular performance updates in the form of reports from at least 50% - 75% of different health actors working in the county.
4	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals. • County health leadership receives regular performance updates in the form of reports from all different health actors. • All different health actors are fully involved in annual sector performance reviews, county health annual work plan development and in policy development affecting the county population and health services (Partnership Code of Conduct exists).
Comments: • The meetings are not regular or not structured. The reports are forthcoming but not regular. Different partners are not involved in the performance meetings • During Annual Planning Session, The CHMT with support from Partners bring together key Sub County Managers who come with their specific Sub County Drafts and consolidate the County plan. These Key members include: SCMOH, SCHRIO, SCPHO, SCPHN and SCHAO.	

Qualitative Questions Standard 1.2.2.

What mechanisms are in place to promote regular dialogue between County Health Department leadership and the different health actors such as health development partners, implementing partners, MCAs, religious/community leaders, private sector and sub-county health administrators?

Mechanisms to promote regular dialogue

- Ad hoc depending on the needs of the partners: There are stakeholder review meetings; data review meetings (these are scheduled to take place quarterly but most of the time happen haphazardly.
- There are also TWG (along interventions; have over 10 TWGs) meetings. Tupime has tried to help structure along investment areas e.g. service delivery, infrastructure, commodities, workforce, M&E to ensure integration meetings). Ideally they should be quarterly but this does not happen because of funding. Though TWGs have been structured around investment areas,

they are yet to be operationalised. Investment areas: Service delivery, infrastructure, commodities, HIS, work force). The idea was to make sure there is integration. The gap has been the operationalization of the new structure

- A structure does not exist; however, Tupime County is trying to support the establishment of a health sector coordination structure

Engagement with MCAs

- Among the MCA there is a health committee and an assembly committee – the initial induction meeting, and the others as need arises.
- Periodic meetings as need arises (give report on areas of implementation, challenge areas; most of the discussions are budgetary in nature; share where not doing well and seeking support.)
- Given their oversight role, sometimes the MCAs summon the CHMT (There was a recent summon wanting to understand how far the CHMT had implemented the health financing act of 2016; the summons have been very specific to the investment areas e.g. equipment and supply, revenue collection, supplies, human resources, infrastructure) – story of faulty service delivery where children got faulty vaccination etc.
- Program meetings – the MCAs have been invited so that they understand the health sector better.

Engagement with religious and community leaders

- During community dialogue days, meet them; also involved as special interest groups during the preparation of strategic plans

Engagement with the private sector

- Has been informal. In case of celebrations, the county engages private sector for support. It is not structured in anyway.
- To some extent they have been involved in planning
- Also brought on board during data review meetings
- Players in public health interventions
- Implement county and health policies as far as county and national health is concerned.

Engagement with Sub-county Health Administrators

- At the sub-county, the engagement is not one on one. They are ad hoc meetings. Meet through partners e.g. through the TWGs.
- They are basically through partners supported activities. But this FY, the director is trying to improve on this so that the administrators are involved
- There is a team among Sub-county MOHs who would regularly participate, but also those that don't participate. E.g. if there is a data review meeting, there are usually faces that you would always see and others seem to be missing. This goes back to the lack of strategy.
- Lack of financial support killed the sub-county health management boards.
- Participation at ward level is very minimal in the health service delivery discussions.
- Most of the time sub-county leadership are called for programmes, but not for focal meetings.
- During support supervision, there is interaction between the county and sub-county teams. However, there is little interaction with sub-county teams as an organ.

How are different health actors engaged in county health sector performance reviews, county health budget formulations, and policy development, programs review and/or/evaluation?

Who is involved in budget formulation and their role?

Many engagements of the MOH is done when there are partner supported activities at Sub-county level

- Circulars are sent; and deadlines are set; given the short span, it does not give room for the budget to come from down upwards
- The process usually starts late, hence the lack of involvement of the lower cadre
- Every stage of development of the budget, there is always a direction from treasury on what to do.
- Sub-county administrators: Have not played any role
- Partners: Some partners e.g. Tupime participated in some budget formulation processes (program based budgets); some partners supported in coming up with sector working groups (Tupime). This was done sometimes last year.

Health sector performance reviews

- Broadly at the county level, there are usually data review meetings which happen quarterly where the sub-counties meet with facilities discussing how they performed as well as the elements of the quality of data. This culminate into county meetings;
- At sub-county: Sub county deputy chiefs, as well as partners
- County level: CHMT, Sub-county MOHs
- Coming up with the review templates;
- The meetings are regular and mostly program based.
- Program reviews are more active than sector reviews, because they have support from the national government; and partners support
- Sector reviews: the issue of budget is inhibitive (it is not being done effectively)

What are the strategies for building leadership capacity of health care managers and practitioners at the county and sub-county level?

- Health management boards should be revived – Participate at the ward levels to address those grass root issues
- Support supervision – there is need to engage with the sub-county supervision meeting – this is done normally at the hospital level.
- Boards need to be functioning
- Budget formulation - who is involved? The circulars are sent to the county to develop with clear deadlines. Due to short span/turnover, the budget process is not as participatory. This should begin early enough so that there is more involvement.
- Partner-involvement in budgets – have been involved in program-based budget 6.7B. Done in Kitale
- Sector-working group report was done in 2018.
- County Data review meetings – meant to be quarterly meetings – sub-county level (SC committees, SC MOH, Hospitals & partners);

- Annual performance review templates – these are used to get information for the annual performance report

- Self-development, exposure/mentorship (problems arise when MOHs are given this senior leadership positions directly from medical school. No management training offered). There was a training offered in Kisumu to train all the snr, health managers, but it got interrupted and was supported by a partners. This training was done haphazardly. Management courses were according to job groups.

- Out of the 4 who were present, only 1 has been given capacity building on leadership and senior management course from the Kenya School of Government. Some have been slotted for a training in March.
- The county has not conducted a TNA; so there is no projection. For now it is just being done haphazardly.
- All the management courses are carried out depending on specific job groups; so there is need to marry the training for progression and those for capacity on relevant competency areas.

Standard 1.2.3: Capacity of County Health Department to hold responsibility and ownership for the health care system at community level (Accountability)	
0	• The county primary health care system at community level is over 50% funded by health implementing partners, with gaps existing where implementing partners are not implementing services.
1	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners
2	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) below 50%, with significant input from development partners for health and implementing partners.
3	• The county primary health care system at community level is over 50% funded by county government, with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) over 50%, with significant input from development partners for health and implementing partners. • Functionality of community units is at 50% per the reporting rates (MOH515)
4	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) over 50%, with significant input from development partners for health and implementing partners. • Functionality of community units is over 50% per the reporting rates (MOH515) • Annual accountability platform for reviewing committed funding against results achieved at community level in place.
Comments: • The Governor has promised to strengthen the primary health care system.	

- Busia has articulated a community health strategy so there is clear ownership
- Reporting rate on MOH 515 is over 50% (specifically an average 77%)
- The county government is more focused on the curative part, but little on the primary health care level. The partners seem to be doing more on primary.
- CHEWs now Community Health Assistants (CHAs)
- The county government has taken the facilitation of CHAs
- Leadership and ownership of the county primary health care system is going to be the focus of the county government as was communicated by the governor.
- Community are functional and reporting;
- The county has articulated community strategy
- They CHAs report through the county systems
- The scoring was upgraded to 3 (subject to the confirmation of the reporting rate)
- CHEWs are now referred to as CHAs

Gap: Lack of an accountability framework – ring fencing secured budget; Expenditure analysis done quarterly tied to quarterly AWP monitoring reviews

Qualitative Questions Standard 1.2.3

1. What are the strategies to build leadership capacity of health care managers and practitioners at the county and sub county levels (Repeated question. Same as last question in 1.2.2)

Building Block 2: Health Workforce

Indicator 2.1: County Health Department capacity in management of the existing health workforce by putting in place attraction, retention and motivational mechanisms

Standard 2.1.1: Ability to attract, recruit and retain human resources for health worker positions	
0	• Job descriptions do not exist,
1	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure)
2	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure)

	• Structure for staff attraction and recruitment in place.
3	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place. • Incentives for staff retention are in place but not effectively.
4	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place. • Incentives for staff retention are in place but not effectively. • Working conditions attractive and safe, financial and non-financial incentives for rural and hard to reach places are made more attractive and HRH wellness and welfare improved

Comments:

- No JDs exist. They use the job descriptions inherited from the national government, most of which are generic to a cadre and not for the specific staff
- No training needs assessment (TNAs) conducted in the county
- The pay system that exists is not harmonized. The staff employed by the local authorities and those employed by the devolved county system get paid different amounts even though they do the same job.
- No written strategy for attraction, recruitment, attrition, retention. Staff are replaced when there are resignations or when they have left for some reason. New staff recruitment, to increase the numbers rarely happens.
- There are no incentives provided for staff retention, such as bonuses. The only thing that motivates staff are promotions, which however are not guaranteed. Before devolution, there were staff parties, and staff were rewarded for good work. Tea was provided for staff. That is no longer the case and even the tea for staff is not there in most county health offices and facilities.
- Normal staff claims are hardly responded to. When staff are sent out for an activity without funds, they are hardly reimbursed for the expenses they incur, and so get discouraged and refuse to go out on any other activity unless facilitated for the same in advance.
- Working conditions are not attractive and safe in some areas, particularly the hard to reach areas such as Bunyala and Teso North. The staff struggle to get commodities and supplies to the health facilities, and the staff do not have houses in some of these areas. They sleep in a small dilapidated rooms within the hospital.
- Challenges of access exist in some of these areas, where they have to use a boat. A partner (APHIA Plus) supported the buying of a boat, but fuelling it (roughly Kshs. 8,000/-) is a challenge. Staff do not get any incentives to work in these hardship areas.

Qualitative Questions Standard 2.1.1

1. Briefly describe County Health Department's strategy for health work force attraction, recruitment and retention at all levels?

a) Do you have an operation plan to attract and recruit new workforce? Please describe. No operation plan in place

b) Has the county reached any agreements/ contracts with pre-service institutions to train and recruit new workforce? Please describe

- There are no written agreements, just a gentleman's agreement in most cases.
- Kenya Medical Training College (KMTC) has a policy where they offer 30% of the training slots to locals of any County that they work in. 30% of the students in KMTC Busia have to be Busia locals though no official agreement has been signed. This was however negotiated by the county government due to the shortage of human resource, mainly for Nurses & Clinical Officers).
- Save the Children sponsor some students to KMTC from areas such as Nambale A partner
- Intra health has engaged in discussions with Busia County Health team to support staffing. They however require a HRH strategic plan in place before they can begin offering that support. They are currently supporting the development of HRH strategic plan.
- The challenge however exists when the partners exit. The sub-county is left struggling, as staff have to be released due to lack of funding.

c) Has county conducted periodic assessments of workforce needs and priorities? Please describe. No. However there is hope that the HRH strategy being developed will address this.

Key gaps include:

- Completion HRH strategic plan and implementation (including the assessing of the HRH situation).
- The team would like to see the following in place:
    - Job descriptions in place
    - Training needs assessments done every 3 years
    - A clear plan for recruitment, retention and attraction (A special plan for the hardship areas as they do not have accommodation and so live in the hospital. A hardship allowance and transport allowance to motivate staff in areas such as Bulwani.
    - A clear exit plan (There are partners that have supported staffing such as AMPATH who currently have 284 staff. There is no plan in place to explain what will happen to this staff when the partner exits the county later this year.
    - Succession plan to replace senior staff that retire or move out of the county.
- Agreements with pre-service providers such as KMTC and all the other Pre-service providers that use the Busia facilities for attachment or practicum.

Standard 2.1.2: Capacity of County Health Department to staff health facilities as per Staffing Norms, Standards and Guidelines	
0	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards, and development of the health work force for staffing of each level of the health system do not exist.
1	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists.
2	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists.

	• A iHRIS has been developed to track staffing levels and needs,
3	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists. • A system has been developed to track staffing levels and needs, • iHRIS monthly updated (upon exit and recruitment).
4	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists. • A system has been developed to track staffing levels and needs, • iHRIS monthly updated (upon exit and recruitment). • Staffing data on needs by staffing cadre is being used to advocate for resources to meet staffing gaps.
Comments: • As much as the iHRIS was developed, no one updates it. There is need to update the iHRIS monthly. • There needs to be a mechanism where training reports are sent to the HR, at least on a quarterly basis for the updating of the iHRIS. • The transfers of staff also need to be keyed in by those with HR & HRIOs in the iHRIS. • Disseminate the 2014 HRH norms to staff in the sub-counties • HR needs to do a staff needs assessment, and use that to develop a recruitment plan and subsequently a resource mobilization plan for recruitment and retention of these staff.	

Qualitative Questions Standard 2.1.2

1. Briefly describe the County Health Department's strategy to mobilize and distribute health workforce based on each sub-county's and health facilities' needs.
   a) How are the needs assessed? Not done. Staff are distributed through speculation.
   b) Who is involved in the needs assessment? Not applicable since it is not officially done
   c) How often is a workforce needs assessment conducted? Not done

2. Briefly describe the County Health Department's health work force planning.
   a) How has the county adopted staffing based on norms, standards and guidelines? There was a system of staffing that existed before devolution that was based on the previous staffing based on norms, standards and guidelines. This is what the County has inherited and uses. There are currently some attempts (e.g. by the County Nursing Officer) to use the 2014 National HRH norms, standards and guidelines to justify the staffing needs in different parts of the County, but the process has been slow and is ongoing. As a department, there has been budgetary constraints, limiting the process.

   b) What strategies are being used in the mobilization of resources to meet staffing gaps?
      - Partnering with stakeholders (e.g. Save the Children, AMPATH, Aphia plus),
      - Casuals are employed on contract basis
      - Volunteers are engaged.

- Community staff in rural areas. The community meet and agree to pay for some of the services, so as to ensure their provision or in other cases, the staff are budgeted for as contracted staff.

c) How does the country measure on regular basis the staffing gaps at all levels of health care delivery? It does not happen because there is no plan

Indicator 2.2: Capacity of County Health Department to strengthen performance management and supervision of the existing health workforce

Standard 2.2.1: Capacity of County Health Department to conduct staff performance appraisals	
0	• There are no policies or guidelines at the county on staff performance appraisals at all levels of health care management and delivery.
1	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists.
2	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted.
3	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted as scheduled in the guidelines. • Supervisor performance monitoring is ad hoc.
4	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted as scheduled in the guidelines. • Supervisor performance monitoring is ad hoc. • System exists for rewards and sanctions based on performance.
Comments: • Policies, guidelines or system at the county on staff performance appraisals have been adopted from the National government • The key gap is the dissemination of these National guidelines and policies	

Qualitative Questions Standard 2.2.1

1. Briefly describe mechanisms in place to review staff competencies and performance. No performance reviews done.
   a) What is the course of action after a performance review? N/A
   b) Do you have any strategies for continuous performance improvement? Please explain
      - Institutional based such as continuous professional development e.g. CMEs
      - Trainings in-service on specific issues – HIV RH, OJT enabled by the County.
      - Clinical mentorship

- Sponsorship for post-graduate training. The County many not sponsor these but it gives staff paid study leave.
- Short term training supported by partners.
- Exchange visits to see best practices such as to Kwale, Kitui, Nakuru and Israel.

(Evidence Training summary reports)

2. Briefly describe the mechanisms in place to promote accountability and transparency in the workforce.
   a) Are there clear guidelines in the job descriptions about staff roles and responsibilities? Please describe one or more? No job descriptions.

   b) How often are these guidelines reviewed and implemented? N/A because guidelines are not there.

3. What mechanisms are in place to address workforce absenteeism and poor productivity.
   - Absenteeism – Duty roosters check on staff availability, clock in and out register (challenge is that some people check in and then leave).

   - Poor productivity – In the past, County staff were able to review performance against set indicators. This no longer happens. Since the removal of the performance management system, this has been a challenge.

   Partners - AMPATH uses a dashboard to monitor staff. Every staff has a table where they record number of clients/patients they attended to. At the end of the day that shows who was productive. The time taken by a patient in the facility is also monitored, and staff have to answer as to why a patient took so long in the facility. This speaks to staff performance.

To address absenteeism or poor performance the following is done:

- Firstly, a verbal warning is given. If this gets out of hand, it is escalated to the advisory committees to address the issues. If they do not deal with this then it is taken up at county HR office level.

Note: This rarely happens due to various reasons such as:

- Management with a human face: The Managers sympathize with non-performers e.g. staff that have a drinking problem and report to work drunk. Sometimes managers reason that the family may suffer, or they consider that the person is about to retire, so they wait for that time instead of pushing for dismissal.
- Fear that the staff may use other ways to hit back at the managers due to the fact that they are in the same locality

Standard 2.2.2: Capacity of County Health Department to coordinate capacity development of Human Resources for Health	
0	• No system for coordinating in-service training for HRH exists,
I	• System for coordinating in-service training for HRH exists, no adhered to.

2	• System for coordinating in-service training for HRH exists, • The county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments not coordinated by the county,
3	• System for coordinating in-service training for HRH exists, • The county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments conducted and coordinated by the county. • Training schedules are not fully coordinated/ communicated to all relevant stakeholders.
4	• System for coordinating in-service training for HRH exists, county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments conducted and coordinated by the county. • Training schedules are fully coordinated/ communicated to all relevant stakeholders. • Assessments of the impact of trainings to improved service delivery is conducted annually and feedback used during performance appraisals.

Comments:

There is no system in place for coordinating in-service training for HRH – they are completely ad hoc.

- People request for trainings they want to do. It is not based on the needs of the County.
- Many staff pursue academic papers, and so go for diploma or degree programs that are not motivated by the need to improve service delivery. They may even pursue academic papers that are not related to their job definition.
- Many are motivated by their desire for promotion or their desire to change stations or office.
- Assessments of the impact of trainings is only done by the partners to track training they have carried out or sponsored.

What team feels should happen:

- The County Department needs to take a lead
- The County should see the gaps and identify available courses. They should then advise staff to apply for those.
- County should do Gap analysis, a training needs assessment to deal with service delivery gaps.

Qualitative Questions Standard 2.2.2

1. Describe any agreements made with institutions of higher learning to provide <u>in-service training</u> for staff? No formal agreements made
   a) How are training needs identified? Not done as there are no agreements.
   b) How are curricula developed and approved? Not done with the County.
   c) How often is a training needs assessment conducted? Not done
   d) Is there a formal mechanism to engage institutions of higher learning to provide training? No.

e) What institutions have been engaged so far? None besides KMTC, which is not a written agreement. The agreement with KMTC is similar in all the other Counties that they work in and so is not unique to Busia County,

2. What types of trainings have been provided by the county in the past year? EXCLUDING vertical programs and implementing partners.
    a) Who were trained?
    b) Who determines the staff to be trained?
    c) How were the training needs identified?
    d) Who initiated/ requested the training?
    e) Who conducted the training?
    f) How was the training funded?

(a-f addressed by table below)

Trainings carried out	Renal	Radiology (Use)	Radiology (equipment)	Medical engineering	Theatre (Anesthesia)
a. Who were trained	Medical consultants (1) Nurses (4)	Radiographers (4)	Medical engineers (2)	Medical engineers (2)	Nurses (2), Anesthetists(2)
b. Who determines the staff to be trained	Medical Superintendent Nursing Officer (depended on individual. nurse interest)	Medical Superintendent	Medical Superintendent	Medical Superintendent	Medical Superintendent
c. How training needs were identified	Requested for by National government	Requested for by National government	Requested for by National government	Requested for by National government	Requested for by National government
d. Who initiated/requested trainings	National Government	National Government	National Government	National Government	National Government
e. Who conducted trainings	KNH, Nakuru District Hospital, Moi Referral Hospital				
f. How was it funded	National Government	National Government	National Government	National Government	National Government

Note: National government provided equipment and training to use and maintain and the equipment through the renal training offered.

3. Please describe the county health department's policy to strengthen existing workforce through vertical programs. No policy or guidelines exist
    a) Is there an operational plan for in-service training? No

b) How are in-service training needs identified? Through performance gaps. When new initiatives come up, staff are capacity built on the same. Individual interests.
c) How often are in-service trainings delivered? Continuous – as need arises.
d) Is there an operation plan to retain existing workforce? No
e) Do county health staff that complete requisite in-service trainings get incentives? No

4. Does the county health department have a centralized Training Unit to address training needs for the county health staff? How is training currently coordinated and documented? No. However there is a training committee that meets occasionally.
   a) How are training needs and training programs or opportunities matched? No training needs assessment done and so these are ad hoc requests.
   b) What records are kept on in-service training for individual health workers? this is not done, but ideally should be done by in the iHRIS.
   c) What do you think are the major pre-service training problems facing the county?
      - Getting qualified candidates from the County
      - Poverty – affordability of the trainings for the locals, unless there is a scholarship provided.
      - Public awareness within the County on the existence of these courses
      - Means of advertising used are not very familiar to many i.e. online applications
      - Attitude – people generally want courses that take a short time so that they can start earning faster
      - Employment opportunities – people often go for the Clinical Officers and nursing courses due to their greater employment opportunities, and not because they have the interest.

   d) What do you think are the major in-service training problems facing the county?
      - Shortage of health workers and so the managers are reluctant to release them for training as there will be a gap in the facility
      - People studying courses that are not directly related to their job description. the promotion criteria does not recognize these.
      - Concern of managers that the staff will not benefit the facility
      - Interest of staff is studying for promotion purposes and not to make a difference in service delivery

      Comment: there is need to have a training needs assessment and implementation plan.

   e) What kind of assistance does the county need to coordinate and document training?

- The establishing of a centralized training unit
- Bonding of the trained Officers to get them to commit to serving the County for an agreed period of time after training
- Strengthening of the iHRIS system updating mechanisms
- Quarterly posting of the training staff returns
- Infrastructure and facilitation of the training unit
- Capacity building of the HR staff on their role in training, and that of other staff that have training as a deliverable in their job descriptions.
- A HR Officer in each Sub-county to support the one at the County level. Currently there is only one HR Officer in the County that take care of 1172 staff.

- Proper training of HR staff. Currently the HR staff in the County are staff deployed to do HR duties.

5. What is the capacity of county health department towards granting accreditation to pre-service training facilities?
   a) What is the role of the national government in accreditation of pre-service training facilities? It is the mandate of the National government.
   b) How often is accreditation conducted? Once, and when need arises
   c) Are accreditation standards comprehensive and up to date? Very comprehensive
   d) Who conducts accreditation? Professional bodies
      How is this team formed? There is a panel of professionals from the accrediting body and the respective CHMT bodies
   e) What kind of assistance does the county need towards implementing accreditation?
- Technical assistance from the National government

6. What are three priority performance areas most in need of strengthening within the county health department that relate to HRH?

   i. Performance management
      - Performance appraisal
      - Performance improvement
      - Performance contracting
   ii. iHRIS management i.e. updating
   iii. Establishing a training Unit

7. What are the successes and major challenges for strengthening health workforce? (ask for each vertical program (HIV/AIDS, TB/HIV, RMCH, Malaria, Nutrition) and the county as a whole)?

Performance area	Successes	Challenges
HIV/AIDS, TB/HIV, Nutrition, Malaria	Heavy partner support (AMPATH 284)	When partners exit or funding reduces – no clear exit strategy
	Focused staff	Commodities reduce
	Trainings for performance improvement and service delivery	Services in those clinics where partners exit is affected
	Infrastructure development improving the work environment	
	Continuity of services during industrial unrest	
	Stronger supervision systems for the vertical staff by partners	
	Improved data review meetings	
	Improved diagnosis (Radiology, gene expert machines)	
RMCH	Trainings for performance improvement and service delivery	To sustain the gains when partners pull out
	Focused staff	Commodities reduce
	Provision of incentives for birth companions and CHVs	High dependence on vertical programmes
	Outreaches	
	Transport facilitation for expectant mothers using the local motorbikes	
	Infrastructure improvements	

	Improved data review meetings & M&E	
	Income generating activities for CHV for incentives and health insurance (NHIF)	
	Support supervision	
	Innovation on Kangaroo mother care (pre-term babies)	
Other County Initiatives		
Ophthalmology services	Infrastructure improvement	Inadequate space
	Staff training	Donor dependency – lack of exit strategy
	Support supervision	
	Eye surgical camp	

Building Block 3: Health Information Systems

Indicator 3.1: Capacity of Health Department to plan for and systematically collect health information

Standard 3.1.1: Capacity of County Health Department to implement HIS policies, strategies, guidelines, protocols and use routine HIS forms	
0	• The county does not have national health information system policy and strategy.
1	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are not readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms.
2	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms • Sub-counties, facilities and community units do not have adequate supply
3	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms • Sub-counties, facilities and community units have adequate supply • Mentorship program on correct use of HIS forms institutionalized in less than 75%of sub-counties and/or facilities.

4	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms • Sub-counties, facilities and community units have adequate supply • Mentorship program on correct use of HIS forms institutionalized in at least 75% of sub-counties and/or facilities.
Comments: Have the data collection tools	

Adapted from the WHO's *Monitoring the Building Blocks of Health Systems,* key components of a HIS include: routine health information, vital statistics, disease surveillance and health surveys

1. Does the county have an integrated Health Information System that includes indicators, data elements and sources, frequency of collection, data flow, data validation rules and quality assessment guidance/protocol?
   - Using DHIS which captures all these elements.
   - The system will reject certain elements
   - Have the indicator manuals that define specific indicators; using the manuals for data quality assessments
   - There are also programs supported data quality audits
2. How has this system been rolled out to sub-counties and facilities?
   - At sub-county level is the center of all data issues
   - Reports from the sub-counties and sub-county facilities.
   - The managers were taken through the trainings. Among the documents that they were given were the soft copies; the last training was done last year.
3. Does the county have a system for monitoring and evaluation of county programs that details priority health impact and outcome level indicators at a minimum that presents plans on how data will be collected for monitoring, evaluating, disseminating and using analyzed data, that clearly spells out roles and responsibilities, capacity building and county stakeholders' data review forums?
   - Just establishing the M&E unit
   - Can log into the DHIS, and establish the status of indicators
   - The systems exist to the extent of what data its collect, the periodicity, data sources
   - In the process of establishing the M&E unit and one of the deliverables is to have an M&E plan; this is for monitoring all that we do in the health sector
   - Have the national plan, which the county is following; and the DHIS itself is the plan itself and it's self-monitoring; can be able to determine the completion rates and the basic analytics can also be done;

- Would want to do some form of quarterly data review process;

4. How has this plan been rolled out to sub-counties and facilities?
   - At the sub-county level have the program coordinators to ensure that the indicators ae tracked. The program coordinators are able to identify if there are any gaps in the indicators.

Standard 3.1.2: Capacity of County Health Department to collect quality health data	
0	• There are no county-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) in place.
1	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data are not routinely collected using standard data collection forms.
2	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data routinely collected using standard data collection forms. • County department of health receives timely and complete reports from less than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization)
3	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data routinely collected using standard data collection forms. • County department of health receives timely and complete reports from more than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization) • County department of health receives accurate reports from less than 75% of health facilities (public, private and faith based)
4	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist; data are routinely collected using standard data collection forms. • County department of health receives timely and complete reports from less than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization) • County department of health receives accurate reports from more than 75% of health facilities (public, private and faith based) • Health performance data reviewed regularly and regular feedback provided to all health facilities on data accuracy.
Comments: ▪ Usually hold performance reviews, but not regular ▪ Lack of feedback ▪ More than 75% in all the indicators	

Qualitative Questions Standard 3.1.2

1. Who has the primary responsibility for collecting data for routine health information, vital statistics, disease surveillance and health surveys systems?

- The service delivery staff have the primary responsibility at the lower facilities
- At the higher facilities it is a combination of care givers as well as the responsible record staff.
- From the major health facilities it is the HIRO responsible for the vital statistics
- Service providers are the ones who generates the data; the disease surveilance collects the data
- Vital statistics is critical and is one of the areas which the county needs to address. There are serious gaps in terms of quality and quantity. The numbers that are reported are lower than those received at civil registrars. Some of the challenges are systemic; need to work together because that is one of the important for the department.
- DHIS has it's on internal errors; especially when you run pivot tables; many people rush to this.

2. Who has the primary responsibility for submitting/entering data and validating it from these data systems?

- Sub-county HIROs, and facility HROs for major facilities
- A few program related reports have been given to
- Service providers are responsible for submission.
- Validation: It supposed to be done all the way from the facility level, before submitting to the higher level; the sub-county HRIMO should also do the validation

3. To what extent has the county health department institutionalized Ministry of Health's National Data Quality Protocol and Standards?

- Had a training
- Most of the DQAs the county has done has been partner driven.
- The DQAs are not regular; they are supposed to be quarterly , but that has not been possible
- Also do program DQAs, and it is usually the MOH protocol; the issue is the irregularity

4. What is the process for data quality assessment and how often is it conducted by county health department? By Sub-county health administrators' offices?

- repeated

Qualitative Question Standard 3.1.3

1. Where is health data stored at the county and sub-county levels?

- DHIS

Standard 3.1.3: Capacity of Health Department to manage data	
0	• No one single county-wide preferred electronic or paper based exists.
1	• Separate information management systems (paper or electronic) exist for the various components of the HIS. • It's difficult or impossible to manipulate or extract data from the system.
2	• One Single County preferred Electronic Health Information Systems platforms (databases) exist for the various components of HIS • Data are not routinely extracted for reports and other use.

3	• One Single County preferred Electronic Health Information System platforms (databases) exist at the county for the various components of the HIS, • Data are routinely extracted (at least annually) for use. • Integration of information from other health management systems (i.e., service statistics, financial, human resource, logistics information, and physical assets data systems) not yet fully operational.
4	• One Single County preferred Electronic Health Information System platforms (databases) exist at the county for the various components of the HIS, • Data are routinely extracted (at least annually) for use. • Integration of information from other health management systems (i.e., service statistics, financial, human resource, logistics information, and physical assets data systems) is evident. • County Data Management Guidelines exist including policy on health/research data sharing policy.
Comments: ▪ Not yet integrated the health management systems ▪ Extract data especially during the review meetings ▪ For the hard copies, the data are stored where they are generated; at sub-county level we have the documents from the facilities (summaries) ▪ A copy of the reports is usually with the facilities. ▪ There are challenges with the same data storage; the space is not adequate, and the filing system is wanting; **POOR FILING SYSTEM**	

Indicator 3.2: Capacity of County Health Department to promote evidence-based decisions and policy making

Standard 3.2.1: Capacity of County Health Department to use collected data for planning and policy making	
0	• No evidence of data use for strategic planning including rational budgeting and decision making.
1	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county health committee and other state and non-state actors. • No evidence of data use for strategic planning including rational budgeting and decision making.
2	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings.

3	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county assembly health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings. • The county can identify at least two examples of how data have been integrated into a decision-making process including rational budgeting in the past year.
4	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county assembly health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings. • The county can identify at least two examples of how data have been integrated into a decision-making process including rational budgeting in the past year. • Policy and planning framework (that details national development goals, national health sector priority goals, county health priority goals, county budgetary and donor allocations, and county health development outcomes) exists.
Comments: ▪ Have been able to do some data analyses and share information among themselves. Example given, RHMCH score card shared through; ▪ Hold quarterly data review meeting; analyzed data on how the county is performance ▪ The lack of regularity may remove us from 3 (However, agreed to retain 3, subject to evidence provided) ▪ It is need-based;	

Qualitative Questions Standard 3.2.1

1. How often is routine health data analysis presented to senior managers for discussion, field monitoring/supportive supervision, problem solving and decisions?
   - This is done quarterly,
   - Used in the strategic planning and CIDP;
2. How often is performance information presented to County Health Department leadership for discussion, problem solving and decision making? Provide examples of how reviewed performance data have been used to identify opportunities to improve services.
   - This is done annually during the annual progress review (APR)
   - There is always a preplanned APR that runs all the way up to the national level.
   - Sometimes happens on quarterly; but the gap is the issue of regularity and the completeness.
   - Performance data are usual useful in commodities; infrastructure development (facilities performing better in terms of work load)
   - In the recent allocation of DANIDA funding, the county used the workload as the basis for funding.
3. How often is health data used in reviewing/evaluating the success and/or failure of county health programs and strategies?

- For most programmes it annually.
- Much not have opportunities to review their strategies, until recently when the county was helped through Tupime to review the strategy.

4. How often is health data used in the formulation of policy and/or incremental re-adaptation of existing programs and strategies?

- During strategic planning use a lot of data to inform what next to do.
- In terms of establishing the current M&E Unit as part of information gathering structure.
- Policy related to family health care
- More of political will than data influence policy formulation.
- Implemented Kangaroo strategy; child-survival (improving the care of neonates)

5. What role does the CHMT play in promoting and/or facilitating the use of health data for management decision making at county level?

- **There is still a lot of gaps in using data for decision making and for policy formulation;**

Building Block 4: Access to Essential Medicines & Other Health Commodities

Indicator 4.1: Capacity of County Health Department to ensure access to essential medicines for the population

Standard 4.1.1: Capacity of the County Health Department to provide oversight to commodity management to downstream levels of service delivery	
0	• The county does not have an organized unit (of more than three persons) to oversee and coordinate commodity security in the entire county.
1	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership.
2	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate.
3	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate. • The County Commodity Security Committee structure has been adopted, operationalized and implemented at the sub-county level for all the sub-counties in the county.

4	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate. • The County Commodity Security Committee structure has been adopted, operationalized and implemented at the sub-county level for all the sub-counties in the county. • Supply chain performance statistics are maintained at county, sub-county and facility levels and reflect improving trends overtime.
Comments: ▪ The system has not been cascaded to sub-counties and facility level	

Qualitative Questions Standard 4.1.1

1. Describe the procedures for implementing and supervising supply chain services in the county?

Procedures

- Have commodity focal persons at the sub-county and county levels. Are mandated to ensure the flow of commodities is protected.
- They do support supervision at their various facilities in their sub-counties.
- The county comes in when doing inter-sub-county distributions

a) Describe the way through which the county ensures availability and use of required guidelines, protocols and tools for product selection, quantification, commodity reporting, use, support supervision and M&E at all levels of service delivery in the county?

- Have Kenya Essential Medical list, which guides the various levels on what to request. These documents are available in soft and are with the sub-county pharmacists and a few facilities can also access
- Have IC materials available which guides on how to quantify what to order;
- Reporting guidelines on how to report are clear; there are standard documents for reporting
- Have a standard checklist and guidelines how to commodity support supervision.
- Have drug lists in terms of protocols, which guides the drugs that should be supplied

b) Briefly describe how supply chain data is used to help decision making at county/sub-county and facility level; and how the county ensures that systems for collecting data from lower levels and feedback loop from higher levels is in existence, adequate and continuously being improved.

- County: When and how to request for more supplies to support the sub-counties; help to understand the usage of the commodities (if the usage is not commensurate, then alert on how the usage is like); budgeting, re-distribution plan, planning and budgeting, to ensure proper; avoid stock outs; reporting rate for a particular tool.
- Sub-county: Ordering and redistribution
- Facilities level (the same)

- Most of the officers are trained on commodities management; these are captured in the monthly reports;
- Have a partners supporting issues of commodities management (AFYA Ugavi
- FP commodities there is a dashboard, so the health facilities give their reports on quarterly basis, and the system feeds back.

c) How does the process of supportive supervision for service delivery incorporate supervision for supply chain service/commodity management at health facility level?

- The checklist on integrated support supervision has a whole section on commodities management. However, sometimes time does not allow for looking at the nitty-gritties

2. Describe the procedures for monitoring and reporting supply chain performance at all levels in the county?

- FP commodities, report completeness and timeliness. Facilities are rated on these dimensions.
- On immunization commodities, started a system on monthly basis, data regarding vaccines are uploaded into DHIS, and the county level able to monitor, but this did not pick very.
- Programme supported commodities: report on supply chain performance. Partners support to do supply chain audits to look at various gaps affecting supply chain.
- Some programmes have gone ahead to establish feedback mechanisms.
- Trying to establish

a) In which specific ways does the county take a whole-market approach in strengthening commodity management systems for the county? (ie inclusion of non-government health sub-sector (eg faith-based)that offer services within the county)

- Some of the FBOs supported facilities also receive commodities from the programmes. The county is not limited to supervision the GOK supported facilities
- Training commodity CMEs incorporate people managing other facilities.
- Rarely engages private hospitals.

b) How does the county ensure trend graphs on key supply chain performance indicators are maintained as a measure of quality of supply chain services rendered in the county? eg stock-out rates, stocking according to plan, reporting rates, and commodity disposal due to expiration.

- AFYA Ugavi has a system for tracking malaria commodities
- Have similar for FP commodities (FP commodities); limited to programmes supported commodities; lack this system in the county supported commodities
- The county is able to monitor the reporting rate, but for programmes supported commodities

c) How is equity ensured in commodity distribution and dispensing? In other words, what procedures are used to make sure that essential medicines and health commodities are distributed/ issued out according to need?

- Allow facilities to request what they need based on their consumption; this ensure they get what their needs
- Sometimes do redistributions, incase a particular county has excess and another requires that particular facility;

- FP commodities, the county give a quarterly report, which is a requisite before supplies, but sometimes some facilities don't submit and hence the commodities may be pushed.
- At level 4 the drugs are charged but not at level 2.

d) How does the county ensure improved access to quality and affordable essential medicines and other health commodities? (Consider systems for commodity quantification and supply planning, inventory management tools, commodity information management, commodity financing and procurement, and financing for continuous improvement of supply chain systems)

- Had an exercise where commodity managers were trained on commodity quantification;
- The assembly is providing the budget that is near the requirement.
- Been using KEMSA in the supplies, have a well-established laboratory to ensure right quality; the prices are affordable; Because of the current centralized system it's hard to avail affordable system.

Standard 4.1.2: County Health Department's capacity to estimate commodity needs, develop a supply plan and procure/source these commodities (Forecasting, Quantification and Procurement)	
0	• No capacity (external or internal to the county) available to conduct a forecasting and quantification exercise (estimate commodity needs, develop a supply plan, and procure essential commodities).
1	• The county is reliant on external technical assistance to estimate commodity needs, and develop a supply plan, no mechanism exists to fully procure or source (i.e. buy or secure donations of) essential commodities.
2	• The county is reliant on external technical assistance to estimate commodity needs, and develop a supply plan, • County partially has capability to fully procure or source (i.e. buy or secure donations of) essential commodities.
3	• The county has capacity to estimate commodity needs, and develop a supply plan, • County partially has capability to fully procure or source (i.e. buy or secure donations of) essential commodities, • County requires minimal external technical assistance to estimate commodity needs.
4	• The county has capacity to estimate commodity needs, and develop a supply plan, • County has capacity to fully procure or source (i.e. buy or secure donations of) essential commodities, • County requires no external technical assistance to estimate commodity needs, • Health commodity procurement done at least once annually.
Comments:	

- The county does not have the capacity to operate without external technical assistance to estimate commodity needs.
- Have no capacity to procure program commodities

Qualitative Questions Standard 4.1.2

1. How are commodity needs identified?
   - At facility levels, have their monitoring system
   - Based on consumption data, facilities are able to quantify what they need and even forecast and order for buffers

   a) How are the county, sub-county and health facility needs identified?
   - Service delivery data to know what is required at various levels;

   b) What role does National Government agencies/institutions play in assessing county commodity needs?
   - From program commodities e.g. malaria, the national government decide on how much they should provide to a county depending on the service delivery
   - The national government has a role in generating the essential medical list.

   c) What happens after commodity needs are identified? How are requests made?
   - County: Once the needs have been identified; liaise with the procurement, who then engages the suppliers
   - Program supported commodities: During reporting, you also report your requests; the national program after rationalizing, communicates to KEMSA
   - Sub-county: Central procurement system, they only forward their requests to the county.
   - Have a template at the facility level; this is submitted to the sub-county; the sub-county aggregates and forwards to the county. This is usually done in soft. The county aggregates and forward to procurement; Here there are challenges: The process takes time, thus delaying the supplies (orders requested in October are being supplied in February)
2. What is the role of development partners and CHMT for health and/or implementing partners in procuring essential medicines?
   - Tupime Kaunti: Interaction with data on commodities; guiding projections in terms of commodities; informing processes that might lead to procurement. This can be done during performance data review meetings.
   - Development partners are the ones who provide funds for procurement of essential medicine
   - Implementing partners support the distribution of essential medicines. IPAS sometimes procure FP commodities.
3. What is the proportion of county spending on commodities as % of total county health spending?
   - 5.42% (Approximately 350 million allocated in the budget for FY2016-2017.

Standard 4.1.3: County Health Department's Capacity to Develop and/or adopt and Use a National/County-owned Health Commodities' Logistics Management Information System (LMIS)	
0	• County currently uses no Health Commodities' LMIS system.

1	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records.
2	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, reporting of LMIS data is below 50% for all facilities annually.
3	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, county has access to limited logistics data including: stock on hand within the system and consumption/usage for the past reporting period and demonstrates reporting rates of least 50% from the sub-counties. • County has a plan for routine DQA exits, DQA of LMIS data conducted at least once annually
4	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, county has access to logistics data including: stock on hand within the system and consumption/usage for the past reporting period and demonstrates reporting rates of least 75% from the sub-counties. • County has a plan for routine DQA exits, DQA of LMIS data conducted semi annually • Data Quality Improvement Plan for LMIS data developed for every DQA and implemented
Comments: ▪ Need to move from paper-based system to electronic ▪ Not all commodity managers have been trained	

Standard 4.1.4: Health facility's capacity to effectively store and account for health commodities through appropriate records and reports.	
0	• No system exists for proper storage and distribution of commodities, including essential medicines. (***special storage requirements of medicines and other commodities are not followed, poor records keeping and consumption reporting***)
1	• Warehouse/stores(s) for commodity storage exists at either county, sub-county or facility level, with some accommodation for items requiring special storage.

2	• The county/sub-county warehouse and health facility store meets at **least two** of the following four criteria: warehouse/store size is adequate, storage spaces are is well maintained and clean (including pest, lighting, temperature and humidity control), • County warehouse has designated storage equipment for special storage needs, and re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance.
3	• The county/sub-county warehouse and health facility store meets at **least three** of the following four criteria: warehouse/store size is adequate, storage spaces are well maintained and clean (including pest, lighting, temperature and humidity control) • County warehouse has designated storage equipment for special storage needs, • Re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance.
4	• The county/sub-county warehouse and health facility store is adequate – meets all four criteria (i.e. large enough, regularly cleaned, dry, well organized) with all special needs storage areas clearly designated with correct signage, • County warehouse has an established re-order and stocking plan, including the use of protocols (such as first expiry, first out), job aides (such as SOP for emergency procurements) • Re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance. • Stock-control records such as stock cards and bin cards are well maintained
Comments: ▪ As much have a county store it lacks some equipment supporting commodities management ▪ Using manual system in monitoring commodities	

Qualitative Questions Standard 4.1.4

1. Describe the procedures adopted for proper storage of essential medicines and other health commodities(county, sub-county and health facilities)
   - The county has tried to have some of the required equipment e.g. pallets and shelves.
   - Most of the commodities are stored in pallets and shelves to ensure that they maintain their quality?
   - Have standards and guidelines regarding the storage of various commodities.
2. What is the role of community-based groups and networks in community commodity distribution?
   - They do for limited items e.g. condoms, FP, dewormers, malaria; more in distribution.
3. What is the role of private sector in commodity procurement, storage and distribution?
4. What mechanisms does the county use to assure quality for medicines and other health commodities within the county level?

- There are pharmaceutical and non-pharmaceutical; liaise with the regulatory boards (Pharmacy and Poisons Board)
- Whenever procure samples are sent to the Pharmacy and Poisons Board;
- Have a mini-lab, but have not put them to use.
- There is a system for reporting drug reaction

5. Does the county have in place a pharmacovigilance system? If so, since when? If not, is there a plan to develop/put in place such a system? Please describe.

- The county have incinerators in most facilities
- Waste that require incineration are usually collected by CPHO to level 4
- Have composed pits and some have burning chambers
- Have IPC protocols that address waste management
- Have the protocols be revised? One of the participants requested to know.
- For the expired commodities there are gaps; for you to destroy commodities, the procedure is long; requires authority. Don't have facilities to burn some of the toxic molecules/drugs are being procured in the county.

6. What systems does the county have in place for medical waste management?

Building Block 5: Health Systems Financing

Indicator 5.1: Capacity of the County Health Department to ensure that adequate funds are allocated to the health sector within the overall county budget.

Standard 5.1.1: Capacity of the County Health Department to ensure that adequate public funds from the total county government budget are allocated to public health and population activities.	
0	• The county health department has no input into the development of the county budget estimates.
1	• The county health department has input into the county budget estimates development, • But public health expenditures are not systematically calculated on an annual basis and total at least 20% of the overall county government budget.
2	• The county health budget is developed annually, with input from county health department • County health expenditures are not systematically calculated on an annual basis as part of budget formulation process • It's less than 25% of the overall county government budget.
3	• The county health budget is developed annually, with input from county health department • Estimated actual county health expenditures are systematically calculated on an annual basis as part of budget formulation process. • Health budget is between 25% and 30% of the overall county government budget.
4	• The county health budget is developed annually, with input from county health department. • Estimated actual county health expenditures are systematically calculated on an annual basis as part of budget formulation process • Program, surveys and surveillance data used as justification for budget requests • County health budget is at least between 30% - 40% of the overall county government budget.
Comments: The Approved Budget Estimates FY 2017-2018 for The County Government of Busia (June 2017) shows the health Budget to be 27.5% of the overall budget	

Qualitative Questions Standard 5.1.1

1. Briefly characterize funding sources for health services in the county.
   a) Where does funding for health care services come from?
   - County Government of Busia

- Local implementing Partners
- Development partners in Health (DANIDA, Fred Hallows, Save the children, AMREF, World Bank.)
- The National Ministry of Health
- Private Institutions, normally in kind not cash – Supermarkets e.g. Tesia supermarket provided fridges for the newborn unit and toys. They also painted the nursery. KCB Bank bought mattresses for the hospital
- Beyond zero initiation provides support for RMCH e.g. provision of a mobile clinic
- Amani trust – Provided shoes for those in the jigger control program and an ambulance
- Out of pocket – payment by patients for primary care
- Insurance – NHIF reimbursements
- Busia blood donor service - Supa Loaf provides sodas and bread to blood donors
- Individual donors – (leasing of land to use for health services)

b) What percentage of funding comes from national treasury equitable share, conditional grants, county revenue collection, private sector, household out of pocket, health insurance and external development partners for health? To confirm from County Accountant
Key gap identified is in the dissemination of the expenditure review reports for Health Department

2. Briefly describe the mechanisms in place to determine county health budget needs of individual sub-counties?
- The no set mechanism for determining the sub-county needs. The facilities do their budgets, and send to the sub-county team. This teams consolidate and send to the county level.

a) Who is responsible for determining county and sub-county budgetary needs?
- Sub-county MOH leads a team - the Sub-county Health Management Team (SCHMT)
- County level lead is the Chief Officer, who leads County Health Management Team (CHMT) in the process

b) How often is a county health budget review conducted?
- A least once a year during the AWP process

3. How is the process organized? To what extent are stakeholders involved in this process? (Program Based Budgeting).
   a) Who is involved in the budget making process in the county and why?
      - The implementing partners – support the process; budget for the vertical programs (approx. 3.7 B is partner supported)
      - Sub- counties - they know the needs in the grassroots so present the pressing needs to the county.
      - County Assembly Health Committee – Advocacy for funds
      - Finance Committee – Looks at the funding and resource mobilization of funds as a whole
      - Budget and Appropriation Committee – Looks at the county budget as a whole and adds or takes away.
      - County Budget and Economic Forum - This is an oversight forum that is supposed to harmonize the budget. It is not aligned to any group. It however is not effective as it always meets after the budget has been passed by the assembly, which should not be the case.

- The Public, through public participation. Besides understanding the desires of the public, this is a requirement of the law.
- County Executive Committee – This is where the budget leaves before going to the assembly
- Controller of Budgets, who is in charge of the budget making process at the county level.

b) How are county priorities set in the health sector during the budget process?

- The three main programs are considered (administration, curative and preventive) – There are essential services (curative), that must run, salaries (35%), budgets for commodities, operations and maintenance, development,
- Ongoing projects are reviewed using the annual performance report
- Try to align to priorities in the CIDP, CHSSIP – partners handle many vertical programs (Malaria – county government only does commodities)
- Partners have their areas of interest in the county e.g. DANIDA uses the workload per facility to the distribute the funds
- Use of strategy paper

c) How are county health programs/subprograms determined in the budget?

The department of Health and Sanitation determines its budget through three programs that is; General administration and support services, Curative health services, Preventive and health promotion services. These have also been sub programmed to four with a view of fair financial distribution and function, while encouraging balanced service delivery. The sub programs, Referral services, Referral (Hospital) services, Public health systems and Primary health care.

d) How does county improve efficiency in resource allocation and use (value for money)?

This should ideally be done using an efficient tracking system. An example was given of how last year, the department expended only 6% of the allocated funds for non-pharmaceutical products, which logically meant to cost more than the medical products. This happened because there was no monthly tracking system.

e) How does county ensure value for money for resources allocated to the health sector?

- Conducting market surveys
- Ensure timely use of resources
- A good absorption rate
- Ensure the commodities purchased are of good quality.
- Ensure that offices put in place to oversee utilization do their work (there is a centralized procurement system in the county)
- Audit to follow up on the utilization

f) What challenges does the county have in formulating program based budgeting that factors in efficiency, effectiveness and equity?

Challenges:

- When it comes to procurement issues within the department, for example the building of a theatre, the procurement process is carried out by another department. As the Finance and procurement department source for a contractor, they may select one who ends up costing more than the department had budgeted for. If there was a Finance Office within the Health Department, this would probably not happen.

- There is a wish that the finance and procurement office could be decentralized, such that the CDOH could handle their own procurement. After lengthy discussion it was deemed an impossible request.

g) How does the county ensure equitable allocation of resources for improving the social welfare of the most needy in the society? The needy were identified as, Senior citizens, Youth, PWDs, widows and widowers, orphans, children under five and pregnant women.
   - There is no social protection fund, but there is the 30:70 ratio that is maintained
   - The County Government has come up with a bursary to support needy youth for pre-service training – (HELB, save the children). This could support those going into health related trainings to boost the health workforce in the county.
   - Primary health care facilities serve the needy because they are free in the dispensaries and health centers
   - Use of health insurance such as NHIF
   - Maternity support through the *Linda mama insurance*
   - Youth friendly services provided
   - Having reserved tenders in the process of procurement for special groups such as youth, women PWD for equity

Indicator 5.2 Capacity of County Health department to formulate, distribute and monitor financing for the health sector.

The four criteria necessary in a *sustainable budget* are as follows

Planning: County Health Department has a realistic and sustainable budget informed by sound revenue forecasting methods including use of past experience/expenses, development partners for health contributions and projections
Input: All key stakeholders are involved (including county health department, sub-county health administrators, civil society including religious groups, public participation, and as necessary development partners for health and implementing partners)
Allocation: County Health Department compiles an adequate budget that prioritizes primary health care services, with specific line items for key areas outlined in the County Health Strategy.
Initiative: Process for collection of budget information is led collectively by the County Health Department and sub-county health administrators' offices and the system is standardized across all sub-counties.

Standard 5.2.1: Capacity of County Health Department to plan for, create and allocate a sustainable budget	
0	• No sustainable budget exists (see four criteria necessary for sustainable budget above).
1	• Three of the budget sustainability criteria need improvement (see four criteria necessary for sustainable budget above).
2	• Two of the budget sustainability criteria need improvement (see four criteria necessary for sustainable budget above).
3	• One of the budget sustainability criteria needs improvement (see four criteria necessary for sustainable budget above).

4	• All of the budget sustainability criteria are completed and sustainable, with the county and sub-county health administrators' offices taking the lead on developing the county health budget (see four criteria necessary for sustainable budget above).
Comments: The county is not doing so well in input, allocation and initiative but the county is very good at planning. -To address this, the county feel they need to develop a resource mobilization strategy, to tap into other funding sources other than the mainstream sources of funding e.g. from the philanthropists in the county, religious groups, factories etc. It was mentioned that celebrity sportsmen such as the footballers *Wanyama* and *Mariga* are from Busia county. They could be approached to support the building of a hospital ward.	

The four factors necessary to *effectively distribute and or allocate finances* are as follows:

Financial System: A system exists within the County Health Department to distribute funds among its activities. This includes differentiating by funding source (e.g., development partners for health, national and county revenue, etc.) and by funding recipient (e.g., by line item, and by district).
Tracking: County Health Department has a system to track its distributed funds against its total budget, the sub-counties distributions against total budgets, manage cash flow and segregate expenses
Policies: Policies for allowable expenses exist and are distributed among County Health Department staff and sub-counties. These policies are implemented on a regular basis.
Responsibility: Monthly review of internal expenses versus revenue (both for the county health budget and each sub-county's budget) is designated to an employee(s) as a responsibility

Standard 5.2.2: Capacity of County Health Department to effectively distribute finances	
0	• No system to distribute funds exists (see four factors necessary for effective distribution and/or allocation of finances above).
1	• Three of the budget distribution factors need improvement (see four factors necessary for effective distribution and/or allocation of finances above)
2	• Two of the budget distribution factors need improvement (see four factors necessary for effective distribution and/or allocation of finances above).
3	• One of the budget distribution factors needs improvement (see four factors necessary for effective distribution and/or allocation of finances above).
4	• All of the four (4) budget distribution factors are completed and sustainable (see four factors necessary for effective distribution and/or allocation of finances above).
Comments: There is a financial system is in place. It may be inefficient, but it exists. Policies exist but may not be adequately distributed, and so are inconsistently used. The team then settled for a one because three	

areas need improvement i.e. the tracking, responsibility and dissemination of policies are the main gap in this point.

Policies need to be disseminated and there needs to be monthly financial reviews carried out. The department accountant needs to track and share the financial reports with the Executive Expenditure Committee, chaired by the Chief Officer. This committee does not exist.

Qualitative Questions Standard 5.2.2

1. Briefly describe the mechanisms in place to ensure fair and adequate distribution of funds to the sub-county health teams. There is no adequate distribution of funds to any level. Apart for the donor funded activities, the staff depend on imprests. Funds are irregular. There is no fixed figure. needs determined according to the size of facility
   a) How is the process set up? The process is not a regular process, but it is dependent on availability of funds. Funds are irregular, so when available, they are distributed based on the needs.

   b) How are needs determined? According to funds availability and the size of facility.

2. Briefly describe the mechanisms in place to ensure transparency in revenue collection and distribution. (Note that revenue is not distributed)
   a) What policies and procedures are in place? We rely on the Annual County Revenue Bill. It sets the timeline and charges of collection. Use of the digital point of sales (POS). All revenue collected must be banked 100%, but this is affected by the inadequate funding of hospitals who sometimes use the money for essential services and emergencies. Personal integrity is important. The Governor directed that all collection be automated, and this is being worked on.

   b) What is the course of action when a discrepancy is identified?
   Many of these loopholes are not known. When there is a discrepancy in what is collected and what is banked, which is normally the case, this is raised in internal audit. The team attempts to explain and provides relevant documentation. If there are pilfered funds, there are guidelines that are used to handle that. Appropriate action is taken including taking to court, recovery processes from the salary and even job loss.

The four factors necessary to *effectively monitor finances* are as follows:

Documentation: County keeps financial documentation in a secure place, has a policy for keeping receipts and requirements for documentation kept with each type of payment. These policies flow down to sub-counties and adherence is monitored.
Review: County reviews expenses monthly to ensure applicability and allowability according to the budget and internal policies. Exceptions are documented. (These are periodic – will be sorted out by tracking)
Reporting: A reporting system exists both for the county to report to the County Government Treasury and for the sub-counties to report to the county. Reports are completed and submitted according to applicable deadlines.

Audit: County either has an internal review of its and the sub-counties' accounting systems or hires external auditors on an annual basis.

Standard 5.2.3: Capacity of County Health Department to monitor finances at the National and Provincial levels	
0	• No tracking/monitoring system exists.
1	• Three of the factors necessary to effectively monitor finances need improvement (see four factors necessary for effective distribution and/or allocation of finances above)
2	• Two of the factors necessary to effectively monitor finances need improvement (see four factors necessary for effective distribution and/or allocation of finances above).
3	• One of the factors necessary to effectively monitor finances need improvement (see four factors necessary for effective distribution and/or allocation of finances above).
4	• All of the four (4) factors necessary to effectively monitor finances are completed and sustainable (see four factors necessary for effective distribution and/or allocation of finances above).
Comments: The review is the issue. This can be addressed by the tracking mechanism discussed earlier. (Evidence: Financial reports) *The team noted that the question in the standard differed from that in the scoring sheet and needed to be addressed.*	

Qualitative Questions Standard 5.2.3

1. How is the overall county budget monitored?
   a) Who monitors/ manages the county health department budget at the county treasury level?
   - Health Departmental Accountant
   b) What input do individual departments other than health department provide towards managing the overall county health department budget?
   - Director budget, Chief Officer Finance, Head of Procurement, Director of Accounting Services

2. Briefly describe your procurement policies and procedures? The county relies on the Procurement ACT.
   a) Do you have different thresholds for procurement? Yes, Two levels: 1. Letter from the facilities requesting items. This comes to the Departmental County Procurement office, which raises the requisition to the main procurement in the Finance department

   b) What do you keep as documentation in your files? Orders, vouchers, payment receipts, procurement plans S11, S13, letters of request from facilities – requests from the facilities.

c) How do you ensure transparency in procurement? Following the Procurement Act, There are several people involved, advertising of tenders etc. The process involves many people and that ensures transparency.

3. What is the county's capacity towards developing and implementing Performance-based contracts (PBC)? None. It is a new concept
   a) How are performance indicators identified? What is the county's process for identifying the indicators? N/A
   b) How are contractors identified? What is the county's process for identifying the contractors? Float quotations, direct procurement, open tendering, reserved tenders for special groups such as youth, women PWD for equity
   c) Is there a policy/ operational plan to guide the PBC process? No.
   d) How is performance evaluated and recognized? Timeliness, quality of work, value of money. An Inspection and Acceptance Committee ((IAC), is constituted by County Procurement Office, to inspect the work or goods. This also ensures transparency.
   e) What kind of assistance does the county provide to sub-counties health administrators' offices in implementing PBC? None because PBC is yet to be operationalized in the county.
4. What resources and support does County Health Department need to implement PBCs across all sub-counties?
   a) Financial needs – there is money that can be used for this
   b) Procurement and logistic needs – Capacity rights – The County Health Dept. cannot do this as an island. It needs to happen in all the departments. There is also a possibility that the PBC is happening but the Health Department does not know because procurement is not its mandate.
   c) Training needs – the capacity building on the policy, plan and operationalization. The CHMT, and the County Administration need capacity building

5. What is the county health department's budget allocation utilization rate (% of expenditure in total allocated health budget)? 2016/17 is 79%
   a) Recurrent expenditure – 98.8%
   b) Development expenditure – 79%
   (Evidence: Budget 2016/17)

Building Block 6: Delivering Essential Health Services

Indicator 6.1: Capacity of County Health Department to engage sub-counties in delivering public health services

Standard 6.1.1: Extent of interaction between the county health department and sub-counties	
0	• No structured interaction with sub-counties.
1	• The health department interacts at least once a year with sub-county health administrators on: o Budget-related issues only.
2	• The health department interacts at least once a year with sub-county health administrators on: o Budget related issues o Health service planning activities.
3	• The health department interacts at least once a year with sub-county health administrators on: o Budget related issues o Health service planning activities, o Maintenance and coordination of facilities.
4	• The health department interacts at least four times a year with sub-county health administrators on: o Budget related issues o Health service planning activities, o Maintenance and coordination of facilities, o Assessments and planning for community health needs.
Comments: ▪ In terms of maintenance of facilities, the interaction is when they are doing support supervision; ensuring that the standards are being adhered to across the board. ▪ The sub-counties are involved in the budget making process, but there is a gap in their involvement. ▪ They didn't attain because the engagements with the sub-county health administrators rarely happens quarterly. ▪ The team agreed with the score.	

Qualitative Questions Standard 6.1.1

1. What mechanisms are in place to involve community stakeholders, sub-county health officers and partners in planning for service delivery?

- Planning usually starts from the facility levels where there are the boards. The same is cascaded to the level 4 hospitals.
- Partners are involved from facility level upwards (planning and budgeting for the facilities)
- The health management committee involves special populations including the youth, PWDs, in planning for health services
- Partners involve community stakeholders in planning for the programmes through the mainstream MOH system.
- Partners use the mainstream health management system in engaging the public and other stakeholders
- There are community action/dialogue days. The dialogue days are supposed to be held on quarterly basis. Data is shared on how the community unit is performing. In the meeting, they plan for an action day to address the gaps. That mechanism is there and is happening, but the happening is irregular.
- Use the CIDP stipulate mechanism: ward level to get their needs. Save the children did a baseline survey to get the needs and understand how to engage with the county
- The MCAs brought in some projects without involving the health department, and that has caused some issues.
- There is an elaborate process around the Annual appraisal review (APR), that generates the report that leads to the annual work plans for the entire department of health that even has the vertical programs. (Evidence: Templates)
- Community dialogue days are held on quarterly basis by the CHEWS and CHVs. Data is shared on performance and gaps are discussed. Actions are discussed. The mechanism is in place, but sometimes it does not flow smoothly and some units do not meet regularly.

2. Has the county conducted a formal exercise to plan for health services?
   a) How often is planning conducted?
   b) Is there a general Annual Work Plan?
   c) Do you have unit-specific and or Vertical Programs specific Annual Work Plans? How were they developed and shared?
- The existing work plan is for the entire health department. It is integrated but still captures the different programmes.

   d) Who is involved in the planning process?
   e) How is the planning process organized?

3. How are priority service areas identified?
   a) Is service delivery reflective of priority health needs per county health strategic plan? Yes.
- The health interventions are aligned primarily with the national health policy and KHSSP, from which the CHSSP is developed.
- Have been relying on the national level indicators for planning, but there should be efforts to formulate other indicators, which could be specific to the context of the county.
  - The gap was the development of comprehensive data tools.

   b) What policies do you have in place to ensure service delivery targets priority health needs? Please describe.

Policies to ensure service delivery targets priority needs

- So long as it is captured in the strategic plan, it is considered a priority.

- Have appraisal system, if well implemented it can lead to the county achieving some of the specific targets in the strategic plans; The appraisal system is not fully implemented.
- There are specific Acts that are currently in the pipeline (County Health Services Act, to improve the health services; the County Public Health Act; the County Health Financing Bill; Maternal and Reproductive Health Bill.) (Get highlights of the Bills and Acts)

Standard 6.1.2: Capacity of County Health Department to develop and distribute (to the sub-counties) policies, plans and standards for key health care delivery areas	
0	• No County Health Department's Health Strategy exists.
1	• The county has a health strategy aligned to national health strategy (2014 – 2018)
2	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities.
3	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities. • The county clinical standards and guidelines are currently used by least 50% of sub-counties within the last two years.
4	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities. • The county clinical standards and guidelines are currently used by least 80% of sub-counties within the last two years. • The county health department conducts regular sub-county and health facility visits to monitor compliance in the use of standards and guidelines.

Comments:

- Indicated that while the county clinical standards and guidelines are currently being used, the use may not be at the 80%.
- Whatever, is available my need revision.
- The sub-counties have the standards and guidelines in soft copies. The recommended that the standards and guidelines should be displayed.
- Health work is so specific to guidelines; so had a feeling that the figure could be at least 50%.
- County clinical standards and guidelines are currently used by less than 80% but more than 50%. Not sure the exact number because there is no survey, but this is an estimate.
- The sub-county officers have soft copies and not hard copies, as required by the Ministry.

Qualitative Questions Standard 6.1.2

1. What guidance does the county provide the sub-county health administrators regarding service delivery?
   a) Are there policies and procedures? The dissemination is the challenge

Policies and procedures

- The guidelines and policies that exist are adopted from the national health services
- There may not be county-level guidelines and policies
- Dissemination of the policy and guidelines including the strategy plans has a gap. Most of the guidelines are not in hard copies (not doing well in this area)

   b) Does the county annual work plan provide guidance to sub-counties? The process is up down and down up so all the different levels are involved

Work plan provide guidance

- The county work plan provide guidance
- The AWP contains planned activities that would be carried out throughout the year. It is already guidance to the particular services to be given to specific sub-counties

2. Who decides what services need to be provided at the sub-county level? CDH with support of the CHMT and Stakeholders
   - There is a policy document defining the specific interventions for each level.
   - Political support and goodwill
   - Technical experts
   - Sometimes the services are demand driven.
   - Some of the hospitals in the sub-counties such as Nambale have the title of Sub-county hospitals, but they do not have the infrastructure and the HRH to offer all the services they should at their level.

Indicator 6.2: Capacity of County Health Department to ensure appropriate use of policies, plans and standards related to Health Service Delivery for HIV/AIDS, TB/HIV, RMNCH, Nutrition, Water & Sanitation, and Malaria

Standard 6.2.1: Capacity of County Health Department to supervise sub-counties in the use of Health Service Delivery Standards, Guidelines, Protocols	
0	• No system exists at the county to monitor adherence of sub-counties to standards, guidelines, protocols.
1	• Some elements of a basic system exist for monitoring adherence to standards, guidelines and protocols.
2	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (***lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities),*** but use of these guidelines is not consistent by the county health department or sub-counties.
3	• A system of monitoring of adherence to standards, guidelines and protocols

	• County has guidelines for one or two of the following areas (***lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities)*** • County provides support to sub-counties to monitor adherence at the facility level, but not consistently.
4	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (***lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities)*** • County provides support to sub-counties to monitor adherence at the facility level. • The county jointly with sub-counties has joint plans for conducting adherence monitoring at the health facility level.
Comments: Gap is • The county lacks joint plans for conducting adherence monitoring at the health facility level.	

Qualitative Questions Standard 6.2.1

1. What mechanisms exist in place for supervision of sub-county health facilities? Monthly supervisions are carried out and it is integrated, It sometimes does not happen regularly. Program based supervision is carried out quarterly or as new programs start. (Evidence: Reports)
   a) Is supervision focused on medical audits or coaching and performance improvement or both?
      - Integrated monitoring is done by the sub-county on monthly basis. And the county does its monitoring of the sub-counties on quarterly basis. Last year (2017) due to the industrial action (nurses, doctors and clinical staff strikes), supervision was affected.
      - Monthly monitoring by sub-counties has been a challenge. Most of the sub-counties do not have resources to move around. It is only the partners, which once in a while supports, but specific to their focus areas.
      - Supervision from the county does occur; but the Sub-County MOHs are not involved.
      - One of the challenges is that the county carries out the supervision but does not adequately engage the sub-county. They often do not provide the feedback after supervision to the sub-county team

   b) How often is supervision conducted? Monthly by the SC and Quarterly by County and also as need arises. Not all facilities are visited all the time however.

   c) How are supervision needs determined? (needs-based or regularly scheduled?)

   Determination of supervision needs

      - Prepare the schedule at the CHMT.
      - Sample facilities, prepare the teams and go for support monitoring
      - Depending on the issues established, that inform the next supervision

- It is needs-based.
- Have not supervised the Sub-County Health Management Teams

d) Who conducts the supervision visits?
- The ideal should be that the county supervises the sub-county and the sub-county supervises the facilities. But this is usually not the case; there are gaps that the county will commit to address.
- CHMT supervises the sub-counties; they also do randomly sampling of some of the facilities within a sub-county.

e) Is there clarity about levels of supervision (who supervises who) and reporting?
- The membership of CHMT is replicated at the sub-county

f) What tools are used to conduct supervision?

g) How is supervision findings used?

Use of findings

- Share the report with the view of looking at how to address the areas of weaknesses identified.
- At the specific facilities, there is usually a book, where the findings are recorded and the action plan prepared and counter-signed by the monitoring team.
- While the county does not share the facility level monitoring report, the same is available in the facility books and should be accessible to the sub-county teams during their monitoring of the facilities.
- It will be better practice to have the reports consolidated and filed within the facilities.
- These reports are shared in the CHMT meetings to determine how to address the gaps. At the facility level, there is a book that the team signs and writes the gaps and what they are to address. This acts as a basis for continuum support supervision. The sub-county teams are expected to do a follow up.
- The sub-counties do not get the final reports sent after the discussion at the CHMT level, and they would want that to get back to them and be filed in the facility with definite action points.

h) Are supervision results linked to any type of reward/recognition/incentives system?
- Ideally that should be the case. To some extent there is reward system, supported by some of the partners e.g. PS Kenya and Save the Children. At the county level there is a gap.
- The tool commonly used for support supervision was adopted from the national government. The starting point should be to modify the tool to capture the details of reward and sanctions in a way that responds to the county needs.
- Have been moving staff/or even demotions based on the support supervision reports.
- One key disciplinary action has been transfers.

i) What are the challenges to conducting supervision?
- Inadequate funding
- Transport to accommodate the big group that needs to go for supervision
- Some areas have no vehicle (e.g. Teso North, Samia)

- Taking action of the challenges – probably due to the resources available (inadequate funding of operations, inability of the managers on the ground – the money is in the centre – county treasury)
- Distribution of the little resources; biggest priority is maintenance, but usually there is no money allocated and even when it comes priority changes
- The advice the CHMT gives sometimes contradicts advise from the Sub-counties; the linkage between the sub-county and CHMT is lack; this was attributed to the lack of adherence to the standards
- No proper dissemination of the checklist used in supervision

2. What mechanisms exist for improving quality of care through the health system? Quality of care – (Infrastructure, Equipment, adequate resources, adequate staff and client awareness), OJT, Trainings, Quality improvement teams for vertical programs and sections in the hospital. Clinical mentorship that is on the job, Malaria care - outreach training support supervision. Continuous medical education (CMEs)
   What are the gaps in quality of care in the system? What are some of the successes in improving quality of care?

Successes	**Gaps**
• Improved documentation in some of the facilities – data management rose from 30% - 100% • Improved skills • Quality improvement • Systems have been improved e.g. in maternal care as they discuss. Neonatal deaths are now reduced because they are captured in the DHIS and discussed promptly and addressed • Vertical programs – sitting together as multidisciplinary teams has improved service delivery • Capacity development CHVs to attend to mothers for malaria, pneumonia, malnutrition • One lab has been accredited and given 2 stars. All the labs are going through accreditation • Exit interviews - Busia County Referral Hospital has done two and all those ear marked for accreditation are carrying out exit interviews. This gives the view of the client (Evidence: Reports)	• No institutionalized client exit surveys to measure what the client satisfaction surveys • Quality improvement teams and work improvement teams – are they active? This initiative was partner driven and was focusing on CCC in HIV programs • Save the children did a focus-group discussion with the community, bringing out a lot of issues

a) What indicators are used to measure service quality?
   - There are indicators on specific service delivery areas e.g. Kenya HIV Quality Improvement Framework for HIV; Lab – ISO certification, internal and external quality controls (this has a gap because there needs to be a control and sometimes this is not possible)

b) What kind of mechanism exists to assess quality of care regularly and who is in charge to monitor this?

c) Are there QI teams in place at the community, facility and/or sub-county levels? This exists at Facility level. They usually form a team that is multi-disciplinary, they identify the indicators they want to track. They set plans to address these gaps and report. (Evidence: QI reports from Aphia plus)
   - In the lab, there is a person in-charge of malaria control and this person goes even to the private facilities for that
   - Have QI teams in specific facilities (SEO PORT, Nambale, Samkura etc); a multi-disciplinary team is identified to steer quality;
   - This needs to be strengthened at both sub-county and county levels (quality improvement scale up has been wanting)
   - Standardization and scale up is however critical

d) How is county supporting QA/QI in the private sector?
   - For laboratory, have somebody in charge of malaria diagnostic; have network with the private sector

Standard 6.2.2: Number of operational public, private and faith based health facilities as compared to the total that routinely report complete and accurate data	
0	• The county does not have a list of the number of public, private and faith based health facilities.
1	• The county has a list of the number of public, private and faith based health facilities, but there is no system to determine and report which of the facilities by type report complete and accurate data
2	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities, but less than 50% of the total report complete and accurate data
3	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities (at least 75% of operational public, private and faith based health facilities of the total number are operational routinely report monthly) • About 75% of the reporting health facilities report complete and accurate data.
4	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities (at least 80% of operational public, private and faith based health facilities of the total number are operational routinely report monthly) • About 85% of the reporting health facilities report complete and accurate data.

	• County has a system for quarterly review of complete and accurate data.
Comments: • 124 facilities - Get the complete breakdown from county	

Indicator 6.3: Capacity of County Health Department to deliver health care in identified priority areas (HIV/AIDS, TB/HIV, RMNCH, Nutrition, Water & Sanitation, and Malaria)

Standard 6.3.1: Capacity of County Health Department to implement health programs. ***NOTE: This question can be asked of HIV/AIDS, TB/HIV, RMNCH, Nutrition, Water & Sanitation, and Malaria and sub programs as appropriate (Assessment of CHMT Capacity)***	
0	• Program does not have capacity to identify priority areas for implementation
1	• Program has capacity to identify priority health areas and develop standards for health programs.
2	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs.
3	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs. • The program has capacity to conduct periodic monitoring and evaluation (M&E) of priority health programs.
4	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs. • The program has capacity to conduct periodic monitoring and evaluation (M&E) of priority health programs. • The program has capacity to promote data sharing, communication, and collaboration within individual priority health programs.
Comments:	

Scoring of Standard 6.3.1

a) Scores from each individual program for standard 1.3.1 above:

Program	HIV/AIDS	TB/Leprosy	RMNCH	Nutrition	Water and sanitation	Malaria
Score /4	4	4	4	4	4	4

b) Total score from above table (a) = _____24_____

c) Total number of programs included = ___6_____

d) Average score (b/c) = _____4____ Please enter this score for Standard 6.3.1 above.

Qualitative Questions Standard 6.3.1

1) What is the county's capacity towards delivering Essential Health Services Package (EHSP)?

Capacity - Doing very well in the area of HIV/AIDS because of partners support

2) Which services are the strongest? (HIV/AIDS, Malaria, WASH,)
3) Which services present the most challenges? RMNC, TB/L)

Maternal and newborn services

1) How do you identify targets? Target-setting at different levels that is then captured in the AWP. There is a clear process. National indexes are cascaded to the County level. These indexes offer guidelines. The County them looks at the sub-county, and down to the facility levels
    a. Please list some of your targets.
        i. PMTCT At 90%
        ii. Maternal 3.6% of the total population =33056 out of 860978 population
        iii. Under 5 = _____
        iv. Under 25 – surveillance 47.8% - 414980
        v. WRA – 22.8% = 198274
        vi. Infants 6-11months – half of the under one = 16,528
        (Evidence: Indicators and reports)
2) Where are you with your targets for maternal and newborn services (Evidence: reports)

- Deliveries 43%
- Pregnant women attending 1st ANC visits
- Infant (exclusive breast feeding) 37% female, 38%male

3) Do you anticipate reaching all your targets for the year? If no, please explain why – Challenge of Skilled birth delivery - mothers still delivering at home so those may not be achieved, plus the 4 ANC visits. This is due to attitudes, systems etc. With anticipated World Bank program, this may improve significantly because there is a lot of planned activities and resources to support the same. Poor health seeking behavior.
4) What assistance do you need to reach your targets? Resources, Antigens (for immunizations – waiting for them from the National govt.). Support to reach hard to reach areas (transport, commodities).

- Shortages of antigens
- Require support in terms of improving access e.g. carrying out outreaches
- Commodity stock outs
- Health seeking behavior at community level: Continuous support on community sensitization

Child health services

1) How do you identify targets? Please list some of your targets.

- Fully immunized - At 80%. Some sub-counties are doing very well (Nambale, Matayos) (Evidence: scorecard)
- Samia, Teso North and Teso South, not performing well. Teso North has very poor access. The facilities are very far apart.

- There are also issues with data quality
- Some of the targets were affected by the industrial action.

2) Where are you with your targets for child health services?
    a. Samia , Teso North(52%) and Teso South(63%) are not doing well because of access – facilities are far apart. Education at community level is low, Community units and CHVs have improved. Frequent breakdown of cold chain systems, so they are not able to keep vaccines, affecting availability. Data quality presents a problem – under or over reporting. Industrial action also affected this last quarter

3) Do you anticipate reaching all your targets for the year? If no, please explain why
4) What assistance do you need to reach your targets?
    a. Cold chain – gases and equipment
    b. Data quality audits
    c. Consistent outreaches

Family Planning and Reproductive health (FP/RH)

1) How do you identify targets? Please list some of your targets.
    - WRA accessing FP are at 30%. Most counties are in the red (only one in yellow).
2) Where are you with your targets for reproductive health services?
3) Do you anticipate reaching all your targets for the year? If no, please explain why

- No. These services were adversely affected by the industrial action
- Commodities – Dependent on partner support. Some of the products have not been available for a year e.g. COC. POC. Erratic supply of these commodities affects the choices of the women.
- Donor bias – leads to availability of long-term methods, which is not the preference of the client. FP is very donor reliant.
- Culture - Men do not support FP
- May not reach the targets
- Commodities stock out (these are supported by partners); for the past one year have not had the oral. This is coordinated by the national government.
- Erratic supply of the commodities make the clients to make wrong choices.
- Donor biasness; preferring a particular commodity over another, which could be preferred by the clients.
- FP is donor reliant

4) What assistance do you need to reach your targets?

HIV/AIDS:

1) How do you identify targets? Please list some of your targets (90-90-90).
    a. PMTCT – 96% mothers; 105% for infants

Challenges:

- Still have clients defaulting – they prefer to use traditional medicine; some do not want to disclose too their partners and so do not adhere as they should; hide drugs in places that are not conducive affecting the drugs.
- Great suppression among children and adolescence – Going to school and do not disclose, adolescents go through other things that affect their adherence
- High targets provided by the donors

(Evidence: scorecard)

2) Where are you with your targets for patients on treatment and mother to child transmission?

- 96% utilizing PMTCT
- 82% HIV care and treatment

3) Do you anticipate reaching all your targets for the year? If no, please explain why

- Clients are still defaulting: Many still do not want to disclose to partners; storage; trying differentiated model of care; now forming some groups called community ARV.....Groups
- Targets set by the donor agencies are usually higher than those set by the counties (there was however, a counter argument that these are not exactly donor targets, but country targets).

4) What assistance do you need to reach your targets?

- Adherence support for clients on ARVs - Viral suppression target is 90%.

Malaria:

1) How do you identify targets? Please list some of your targets.
county at 70% - varies at different sub-county levels e.g Nambale at 57%
2) Where are you with your targets for ITN use among pregnant women and children under 1 year?

- All CHVs in county have been trained
- Issue of ITN gone up to 100%
- A lot of support from partners
- Adequate tools

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3) Do you anticipate reaching all your targets for the year? If no, please explain why

- Community strategy (community case malaria management)
- Utilization of ITNs, currently at 80%
- Have a lot of support from partners

4) What assistance do you need to reach your targets?

- The mosquitos have changed their behavious and feed during the day. The nets are therefore no longer useful
-

Note:
For Maternal/Newborn, Child Health, FP/RH, HIV, and Malaria, the CICAT assessment team will also probe the issue of "respectful care" during the MNCH questions, particularly for maternal health services offered at facility level during prenatal, labor, and postnatal care.

Metrics: Illustrative outcomes

Building Block	Illustrative Outcomes	Measurement Method/Annually
Leadership & Governance	i) Equity in the distribution of health services and interventions ii) collaboration with private and other sectors iii) Management systems and functions iv) Partnership and coordination of healthcare delivery v) Governance systems and functions vi) Engaging of public and private services providers vii) Planning and monitoring systems and services viii) Health regulatory framework and services	Post intervention CICAT Documents Reviews Key Informant Interviews
HRH:	i) equitable distribution health workers by cadre a. rural vs. urban distribution ii) ratio of health providers to population served by cadre a. doctors: population b. nurses: population iii) health providers deployment norms and standards in use iv) standardized job grading and salary structure in use	Post intervention CICAT Documents Reviews Key Informant Interviews
Health Information System:	i) Health research and information policies, regulations, and standards in use ii) Accurate, timely and complete public health information generation iii) Functional health information dissemination mechanisms for state and non-state actors iv) Existence of plan for strengthening information systems v) Existence of county health research agenda that supports evidence-based policy making	Post intervention CICAT Documents Reviews Key Informant Interviews
Essential Medicines & Other Health Commodities:	i) Existence of a framework for establishing strategic county health products and technologies (HPT) reserve a. harmonized county regulatory framework for health products and technologies exists	Post intervention CICAT Documents Reviews Key Informant Interviews

Building Block	Illustrative Outcomes	Measurement Method/Annually
	b. effective and reliable procurement and supply systems	
Health Systems Financing:	i. Transparency and accountability in resource mobilization, allocation, and use. ii. Cost-effectiveness and cost efficiency of resource allocation and use iii. Sustainable financing system for strategic health commodities iv. Health budget utilization/execution rate, a. health budget balance of primary and tertiary health care services, b. health budget balance of recurrent and development activities v. Private sector participation in financing of healthcare vi. Functional social health protection mechanism (attainment of universal coverage)	Post intervention CICAT Documents Reviews Key Informant Interviews
Essential Health Services:	i) Effective supervision on implementation of health policies, & adherence to regulations and standards in place ii) Mentorship program for improvement of HCWs knowledge, skills, and competencies in place iii) Existence of functional management and oversight teams for every Health Service Delivery System with an approved organizational structure	Post intervention CICAT Documents Reviews Key Informant Interviews

Introduction and Instructions

This tool was adapted and harmonized with numerous OCAT tools with an overall goal of facilitating the identification and prioritization of core functional areas that USAID Kenya and East Africa, Health Population and Nutrition aspires to partner with national and county governments; and jointly develop action plans to help achieve increased use of quality county-led health services. The tool is based on the World Health Organization (WHO) Health Systems Framework that focuses on six building blocks of a health system.

Use of the tool is meant to be collaborative in nature. It is first and foremost a self-assessment tool, meaning that members of the assessment team and members of the County Health Management Team (CHMT), other key county health institutions including where possible members of county health committee and selected implementing partners work through each component of the tool together. All participants in the assessment receive the tool ahead of time, to have a sense of what questions will be discussed and to locate any relevant documents that will be useful in answering the questions. During the assessment process, participants from the CHMT, selected partners and the assessment team should read through the response options under each standard (component) together, and through discussion, and validations come to a consensus on the appropriate score to assign for each standard. The goal of the exercise is to develop a shared understanding of the current capacity of the institutions and organizations that CHMT represent in order to analyze gaps and develop a responsive capacity building strategy in the form of action plans.

The tool includes a summary scoring sheet organized by Building Block, with space to record scores for each indicator per Building Block. The summary scoring sheet is followed by a description of the scoring for each indicator and related qualitative questions.

County Institutional Capacity Assessment – Quantitative Summary

Summary Scoring

County Institutional Capacity Quantitative Assessment		Score
Building Block 1: Governance and Leadership		**7/16**
Indicator 1.1: Capacity of County Health Department to lead efforts aimed at improving the health of all residents of the county		
	Standard 1.1.1: Capacity of County Health Department to develop and implement a County Health Strategy	**3/4**
Indicator 1.2: Capacity of County Health Department towards intra and inter agency communication and coordination		
	Standard 1.2.1: Capacity of County Health Department to communicate and coordinate within the County and Sub-County Health Department and other Departments in the county .	**0/4**
	Standard 1.2.2: Capacity of the County Health Department to lead and engage (coordination) with different health actors working towards the same county goals	**1/4**
	Standard 1.2.3: Capacity of County Health Department to hold responsibility and ownership for the health system	**3/4**
Building Block 2: Health Workforce		**5/16**
Indicator 2.1: County Health Department capacity in management of the existing health workforce by putting in place attraction, retention and motivational mechanisms		
	Standard 2.1.1: Ability to recruit and retain human resources for health worker positions, staff health facilities as per staffing guidelines, make working conditions and rural and hard to reach areas more attractive and safe,	**1/4**
Indicator 2.2: Capacity of County Health Department to improve institutional frameworks that support workforce performance development and management		
	Standard 2.2.1: Capacity of County Health Department to institutionalize systems for measuring performance and competence of health workforce; strengthen HRH development systems and practice including continuous professional development, communication, ethics and values systems.	**2/4**
Indicator 2.3: County Health department capacity in the development of an adequate, appropriate and equitably distributed health workforce		
	Standard 2.3.1: Capacity of County Health Department to strengthen HRH planning function covering the entire health system	**2/4**

	Standard 2.3.2: Capacity of County Health Department to encourage and support various institutions to adhere to the established norms and standards for HRH in delivery of KEPH	0/4
Building Block 3: Health Information Systems		8/16
Indicator 3.1: Capacity of County Health Department to plan for and systematically collect health information		
	Standard 3.1.1: Capacity of County Health Department to develop and implement HMIS policies, strategies, guidelines, and protocols appropriate to the data needs of the county	2/4
	Standard 3.1.2: Capacity of County Health Department to collect quality health data	3/4
	Standard 3.1.3: Capacity of County Health Department to manage data	3/4
Indicator 3.2: Capacity of County Health Department to promote evidence-based decisions and policy making		
	Standard 3.2.1: Capacity of County Health Department to use routine performance, surveys and surveillance data for planning including performance management, rational budgeting and policy making	0/4
Building Block 4: Access to Essential Medicines & Other Health Commodities		10/16
Indicator 4.1: Capacity of County Health Department to ensure access to essential medicines for the population		
	Standard 4.1.1: Capacity of the County Health Department to provide oversight to commodity management to downstream facilities (ref: - existence of a functional commodity security committee).	3/4
	Standard 4.1.2: County Health Department's capacity to estimate commodity needs, develop a supply plan and procure/source these commodities	3/4
	Standard 4.1.3: County Health Department's capacity to develop and/or adopt and use a National/County-owned Logistics Management Information System (LMIS)	3/4
	Standard 4.1.4: Health facility's capacity to effectively store and account for health commodities through appropriate records and reports.	1/4
Building Block 5: Health Systems Financing		12/16
Indicator 5.1: Capacity of the County Health Department to ensure that adequate funds are allocated to health expenditures within the overall county budgets		
	Standard 5.1.1: Capacity of the County Health Department to develop evidence-based budget request justifications that ensures adequate funds from the total county government budget are allocated to key areas such as HRH, health commodities and programs.	3/4
Indicator 5.2 Capacity of County Health Department to formulate, distribute, and monitor financing for the health sector		
	Standard 5.2.1: Capacity of County Health Department to plan for, create and allocate a sustainable budget	2/4
	Standard 5.2.2: Capacity of County Health Department to effectively allocate finances based on county health priority needs	4/4

	Standard 5.2.3: Capacity of County Health Department to monitor and ensure accountability for finances at the county and sub-county levels	3/4
Building Block 6: Delivering Essential Health Services		15/20
Indicator 6.1: Capacity of County Health Department to engage sub-counties in delivering health services		
	Standard 6.1.1: Extent of interaction between the County Health Department and Sub-County Health Administration Offices	3/4
	Standard 6.1.2: Capacity of the County Health Department to develop and distribute (to the sub-counties and health facilities) policies, strategic plans, guidelines, protocols and standards for key health service areas	3/4
Indicator 6.2: Capacity of County Health Department to ensure appropriate use of policies and standards related to health service delivery for HIV/AIDS, TB/HIV, RMNCH, Nutrition, Water & Sanitation, Malaria program areas		
	Standard 6.2.1: Capacity of County Health Department to supervise sub-counties in the use of health service delivery policies, strategies, guidelines and standards	3/4
	Standard 6.2.2: Number of operational public, private and faith-based health facilities as compared to the total that routinely report complete and accurate data	3/4
Indicator 6.3: Capacity of County Health Department to deliver health care in priority areas		
	Standard 6.3.1: Capacity of County Health Department to develop and implement priority health programs per county health strategy	3/4
TOTAL SCORE		57/100

Scoring Guide by Building Block[2]

Block 1: Governance and Leadership

Indicator 1.1: Capacity of County Health Department to lead efforts aimed at improving the health of all county residents

Standard 1.1.1: Capacity of County Health Department to develop and implement a County Health Strategy	
0	• No current county health strategy • aligned with Kenya Health Sector Strategic Plan (KHSSP) 2014 – 2018
1	• The current county health sector strategy is aligned with KHSSP 2014 – 2018. Adopted by the county health management team/county health department.
2	• The county health strategy adopted; • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area.
3	• The county health strategy adopted • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area. • Evidence of at least one annual work plan/operational/action plan developed for at least 50% of the county health strategy priority areas
4	• The county health strategy adopted • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area.; • Evidence of annual work plan/operational/action plan developed for at least 80% of the county health strategy priority areas; • Monitoring and evaluation framework developed to track progress. • A Governance structure that properly sorts out the roles and responsibilities of key stakeholders in achieving county health strategy goals exists.
Comments: • Though an M& E framework exists, it needs improvement to enable to tracking of progress • The governance structure exists on paper but not functional in practice with senior positions acting for a substantive period for instance the county director as well there is an immediate plan for appointment of two (2) chief officers and more restructuring underway and will state roles and responsibilities of key stakeholders • The county health strategy was launched and signed off by the CEC-Health, Chief Officer of Health and County Director of Health Services • Evidence of implementation framework and M&E available	

[2] The building blocks included in this tool are taken from the World Health Organization's six Building Blocks of a Health System (see http://www.who.int/healthinfo/systems/monitoring/en/index.html for details).

- Evidence for AWP for FY 2016/2017 – Yes in existence

Qualitative Questions Standard 1.1.1

1. What successes and challenges have you experienced in implementing the county health strategic plan?

The successes experienced include:

a. An implementation plan was done for the county health strategy and annual work plan for each sub county and overall county including performance and quarterly reviews of the annual plan.
b. There has been an end term evaluation of the county health strategy but a mid-term evaluation was not conducted due to lack of financial support.
c. Existence county health strategy has rallied development and implementing partners to support implementation and strategy reviews supported by Aphia Plus (USAID supported), PSKenya.
d. The strategy was successful adopted and disseminated to stakeholders in the county.

The challenges include:

a. Irregular monitoring and evaluation of the strategy however individual programmatic reviews are conducted and not for the entire strategy due to lack of financing.
b. Lack of funding to implement components of the county health strategy

** The Kakamega County Health Sector Strategic and Investment Plan 2013 – 2017 is in existence and anchored to the Kenya Health Policy 2012-2030 and aligned to KHSSP II (a soft copy is in the CICAT drop box)

"The vision of my ministry is to make Kakamega "an efficient and high quality county

health care system that is accessible, equitable and affordable for every citizen" thus,

free from preventable diseases and ill health through primary health care interventions at

individual, household, community, primary health facility and at the hospital levels. "(Excerpt from foreword from County Executive Committee Member for Health Services on the county health strategy)

2. What is the role of partners in developing the plan and contributing to its achievement?

The partners in the county have participated in planning, financial contribution towards development of the county health strategy and support in implementation. Examples of partners and their support:

- The Strategy was developed with support from Management Sciences for Health (MSH) through USAID funding which ends in 2017 and the end term evaluation has been conducted and report is available. The process has commenced to develop a new county health strategy for the next five years however support maybe required.
- Aphia Plus provided technical support plus assisted the county in printing and launching the strategy including supporting development of the annual work plan and reviews.
- PSKenya (Population Services Kenya) provided training of county health workers on logistics management information systems (LMIS) on malaria insecticide treated nets (ITN's), health promotion under HPAK on quarterly basis, in addition supported technical meetings and implementation at technical working group (TWG) level.

- PATH Kenya advocates, UNICEF, and other partners played a key role in guiding the overarching strategy for the maternal bill, drafting core language, and securing critical buy-in from high-level leaders and civil society members. Kakamega County Governor H.E. Wycliffe Oparanya signed the Kakamega County Maternal Child Health and Family Planning Bill 2017 into law, guaranteeing pregnant women living on less than one US dollar a day additional support to access essential antenatal and postnatal care for themselves and their babies. (http://www.path.org/news/press-room/831/?_ga=2.185410537.1562914617.1519703829-363105420.1519703829)

3. What additional capacity would strengthen implementation across the county? (capacity in individual knowledge, skills, behaviors and attitudes as well as the structures, policies, systems and procedures of the organization and system as a whole).

a. The county requires support in dissemination of the next county health strategy to the lower levels since the current strategy dissemination reached the sub county level, primary health care level and community level.
b. Support on monitoring and evaluation especially on performance reviews of the annual work plans, having an integrated evaluation matrix for the annual work plan due to numerous health indicators and additional capacity on monitoring and evaluation personnel since currently there is an Acting head of M&E at county level, however the M&E governance structure was envisioned in the strategy but has no established structure.
c. The county health strategy has had inadequate public participation due to lack of funding therefore the county gets few representatives from the county's public and with limited stakeholders'.

Indicator 1.2: Capacity of County Health Department towards intra and inter agency communication

Standard 1.2.1: Capacity to communicate effectively within the County and Sub-County Health Department and other Departments within the County	
0	• No evidence of communication plan and protocols for information flow within the county and sub-county and to other departments within the county. -
1	• There is a communication plan, and protocols are clearly established to guide the plan.
2	• There is a communication plan, and protocols are clearly established to guide the plan. • At least 50% of CHMT are aware of the internal communication plan and protocols but no evidence of use of the plan and protocols
3	• There is a communication plan, and protocols are clearly established to guide the plan. • More than 50% of CHMT are aware of the internal communication plan and protocols but no evidence of use of the plan and protocols .
4	• There is a communication plan, and protocols are clearly established to guide the plan. • More than 50% of key county staff are aware of the internal communication plan and protocols AND evidence exists of use the plan and protocols more than once a year.

Comments:

Defining what a communication plan is is critical in understanding this question:

- Ideally; Communication is required to build understanding and support as the county requires goodwill from internally and its stakeholders to achieve the desired outcomes. A communication plan/strategy that focuses on issues needed to be addressed to ensure enhanced awareness among the county stakeholders will need to be developed. This should include use of digital media channels like project website, official letters email and phones in addition who is responsible for official communication etc. Besides, focus should also be on how the education and knowledge of stakeholders, including communities, can be built to ensure increased capacity to engage in order to achieve outcomes of the county health strategic plan
- The score was zero due to no communication plan within the county health department.

Qualitative Questions Standard 1.2.1

e) 1. Briefly describe the communication strategy of the county. What mechanisms/tools exist for communication within each department? Between departments? With County Assembly Health Committees?

The county health department does not have a communication plan however an informal communication plan exists which is not documented but was described by the county leadership during the consensus meeting.

The tools for communication include official circulars, official letters (CEC's – responsible for intergovernmental communications, Chief Officer – on financial and administration matters and County Director on all technical communications), memos, face to face meetings, phone calls, emails, what's app groups and short messaging services (SMS) are other communications mechanisms.

Between departments; the official communication channel is through officially stamped letters and/or emails with a scanned county official letter attached followed up by SMS reminders and phone call on basis of the official letter. The inter-department communication has not been perfect for instance one partner mentioned their existed a project between the Ministry of Health and Ministry of Energy and this did not work perfectly.

Under the county assembly health committees' communication mechanisms, the CEC is responsible and submits to the clerk of county assembly and sometimes a phone call for informal communication.

What mechanisms/tools exist for communication between county and health development partners and/or implementing partners?

i. Official letters

ii. Email communication
iii. Phone calls for follow ups

f) What are some of the successes/evidence of effectiveness and challenges with the strategy and mechanisms/tools:

The county lacks a communication strategy however, the communication mechanisms described above have been effective as follows:

i. Emails and what's app group have proved to be fast, efficient, effective and information is relayed on a timely fashion.
ii. Phone reminders and what's app group for pharmacists in the county for instance have been effective in follow ups and advance communication and planning.
iii. The official stamped letters with county logo provides authenticity/validity and acceptance from lower levels for implementing partners during planning for forums.

4. Briefly describe the policies and procedures in place to promote collaboration between County Health Department and implementing partners and/or health development partners?

Policies and procedures for collaboration between county and implementing/development partners include:

i. Memorandum of Understanding and terms of references for projects within the county but there is no partnerships coordination framework.
ii. Service level agreements for instance with Oparanya care (now called *Imarisha Afya ya Mama na mtoto programme* and now officially Kakamega County MNCH and Family Planning Bill *passed by the county assembly)* *https://blog.path.org/2017/11/how-kakamega-county-kenya-is-protecting-resources-for-healthy-moms-and-kids/*
iii. Some selected policies are passed at County cabinet level.
iv. Generally, no public private partnership agreement exist as per the National PPP act since there is no capacity to implement Public Private Partnerships at the county health department.

c) What mechanisms/tools exist for the coordination of health development partners and other stakeholders?

The county has programmatic technical working groups for example in Malaria, HIV, health promotion, RMNCAH, Family Planning, M&E and commodity and this feeds into the county health stakeholders' forum (which has not been meeting regularly due funding)

d) Do we have any form of agreements between county and health development partners and/or implementing partners that support delivery of health services?

- Service level agreements exists and Memorandum of Understanding.

5. Is there a policy to guide collaborations? Please describe
   - No, however there is an adhoc official policy for selected projects for instance partnerships with Kenya Red Cross ambulances (leasing services)

Standard 1.2.2: Capacity of the County Health Department to lead and engage (coordination) with different actors working towards the same goal

0	• No evidence of coordination framework that maps out different stakeholders working in the health sector.
1	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Occasional meetings are held between the county and different health actors, but these are irregular, and do not involve all of them. Implementing partners and other key stakeholders have no opportunity to present and review health priorities and their contributions towards health goals. -
2	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals.
3	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals. • The county health leadership receives regular performance updates in the form of reports from at least 50% - 75% of different health actors working in the county.
4	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals. • County health leadership receives regular performance updates in the form of reports from all different health actors. • All different health actors are fully involved in annual sector performance reviews, county health annual work plan development and in policy development affecting the county population and health services (Partnership Code of Conduct exists).
Comments: - The score is 1 because of irregular coordination meetings at county stakeholder forums due to financing issues. - Stakeholder's forum not happening regularly but TWG's meet quarterly and regular basis but not all the pillars. - Coordination systems at county and sub county level especially technical working groups are functioning well on Malaria, HIV however the county needs to harness potential from partners - Developing work plans involves partners and inputs within the annual work plan	

Qualitative Questions Standard 1.2.2.

What mechanisms are in place to promote regular dialogue between County Health Department leadership and the different health actors such as health development partners, implementing partners, MCAs, religious/community leaders, private sector and sub-county health administrators?

Regular dialogue mechanisms include:

i. County Health Sector Forum; where all implementing and development partners, private sector, community leaders are members and the chairman is the CEC for Health services.
ii. Programmatic technical working groups and this feeds into the county health sector forum
iii. For MCA's, dialogue is between the Chair of the Health Committee at county assembly who communicates with CEC, County Director and clerk of assembly for CHMT meetings with the MCA's. In addition, the county health department has a leadership development group which assist to coordinate regular briefs to the MCA's however a proper mechanism needs to be established between MCA's and the health department.
iv. Within the county health facilities the Health Facility Management Committees (HFMC) are heavily involved and the members consists of the leadership of the health facility, religious faith leaders and community representatives.
v. Private sector is involved in public health days like World Health days and brought on board as corporate social responsibility sponsors for instance in blood donation. However there no exists no formal engagement process with the private health sector and commercial players in the county.
vi. Community dialogue, action days exists and barazas coordinated by the chiefs and community leaders including religious leaders who are required at times to demystify use of bed nets, immunization.

There exists a gap in coordination with other diverse stakeholders from county health department, a liaison person for partner linkages and resource mobilization.

How are different health actors engaged in county health sector performance reviews, county health budget formulations, and policy development, programs review and/or/evaluation?

Performance reviews are done by CHMT, sub county HMT and partners who provide the technical and financial assistance.

The performance contracting (appraisal process) is started at the highest level with the Governor, then CEC and cascaded downwards to the heads of department. Performance is assessed at mid- term and end term and involves external evaluators including verification of the appraisal system.

The Budget formulation process is complex and the health sector takes the largest share of the county budget. The budget committee is responsible for processing the budget approvals and budget consolidation and presentation to the county executive team working with the county budget office. The Budget committee is composed of chief officers, the sector working group is also key in budget formulation with a report published based on the following documents – Treasury Circulars, County Budget Review and Outlook Paper (CBROP), Quarterly implementation reports, Audit reports, County Fiscal Strategy Paper and program based budgeting process.

What are the strategies for building leadership capacity of health care managers and practitioners at the county and sub-county level?

The county has a Human Resources for Health (HRH) strategy which is aligned to the national HRH strategy and identifies and provides capacity needs for the county health workers. The training projection is conducted at county level and the HR department leads this process based on annual basis.

The Kenya School of Government (Baringo) has been providing the senior management and strategic leadership courses based on the training plan for the county.

NB: The Kakamega county HRH plan needs to be made available.

Standard 1.2.3: Capacity of County Health Department to hold responsibility and ownership for the health care system at community level (Accountability)	
0	• The county primary health care system at community level is over 50% funded by health implementing partners, with gaps existing where implementing partners are not implementing services.
1	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners
2	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) below 50%, with significant input from development partners for health and implementing partners.
3	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) over 50%, with significant input from development partners for health and implementing partners. • Functionality of community units is at 50% per the reporting rates (MOH515)
4	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) over 50%, with significant input from development partners for health and implementing partners. • Functionality of community units is over 50% per the reporting rates (MOH515) • Annual accountability platform for reviewing committed funding against results achieved at community level in place.
Comments:	

- The score is 3 as there is no annual accountability platform however functionality of community unit as per DHIS2 – MOH 515 is over 50%.
- Under Responsibility, there is good will from the county but due to limited resources.

- Under ownership a gap exists on implementation of projects and decision making e.g. Kakamega teaching and referral hospital upgrading this was not driven by count health government but by politically driven
- Many projects are in control of the county health department especially health infrastructure e.g. random health facilities coming up and politicians play a big role in making the decisions and the county health department staff expected to manage them despite shortfalls.

- No functional organogram at Kakamega county level but a structure exists in the county health strategy (page 44)

- The Governor is responsible/oversight for healthcare delivery of all the citizens of the County; the CEC and leadership oversees this function on his behalf.

Qualitative Questions Standard 1.2.3

2. What are the strategies to build the leadership capacity of health care managers and practitioners at the county and sub-county levels? (repeated question as above)

Building Block 2: Health Workforce

Indicator 2.1: County Health Department capacity in management of the existing health workforce by putting in place attraction, retention and motivational mechanisms

Standard 2.1.1: Ability to attract, recruit and retain human resources for health worker positions	
0	• Job descriptions do not exist,
1	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure)
2	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place
3	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place. • Incentives for staff retention are in place but not effectively.
4	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place. • Incentives for staff retention are in place but not effectively. • Working conditions attractive and safe, financial and non-financial incentives for rural and hard to reach places are made more attractive and HRH wellness and welfare improved
Comments: - Structure for staff attraction and recruitment in place, this doesn't exist	

Qualitative Questions Standard 2.1.1

2. Briefly describe County Health Department's strategy for health work force attraction, recruitment and retention at all levels?
   -
   a. Do you have an operation plan to attract and recruit new workforce? Please describe.
   None in existence
   b. Has the county reached any agreements/ contracts with pre-service institutions to train and recruit new workforce? Please describe.

No agreements reached despite a plan with the Kenya Medical Training College (KMTC). MOU with Masinde Muliro University of Science and Technology (MMUST) is work in progress, in order to attract doctors and start a medical school.

- Intrahealth (FUNZO Kenya – Afya Elimu fund in collaboration with HELB has established a link with training institutions and train on diploma courses. The county provides Ksh 6m (county) and Elimu fund provides (Ksh 20m).

c. Has county conducted periodic assessments of workforce needs and priorities? Please describe

Kakamega County General Hospital did a training needs assessment and developed a tool and there are huge gaps in various cadres. In the 2015/2016 training report done by PWC there are claims of overstaffing

In addition an Internal self-assessment by county team was done and captures staff training needs, facility gaps (draft report available by this quarter)

A county HRH strategy was developed and supported by UNICEF supported in 2016

Standard 2.1.2: Capacity of County Health Department to staff health facilities as per Staffing Norms, Standards and Guidelines	
0	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards, and development of the health work force for staffing of each level of the health system do not exist.
1	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists.
2	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists. • A iHRIS has been developed to track staffing levels and needs,
3	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists. • A system has been developed to track staffing levels and needs, • iHRIS monthly updated (upon exit and recruitment).
4	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists. • A system has been developed to track staffing levels and needs, • iHRIS monthly updated (upon exit and recruitment). • Staffing data on needs by staffing cadre is being used to advocate for resources to meet staffing gaps.
Comments: HR team at the county is not fully been trained on iHRIS and high turnover exists requiring continuous refresher training.	

Qualitative Questions Standard 2.1.2

3. Briefly describe the County Health Department's strategy to mobilize and distribute health workforce based on each sub-county's and health facilities' needs
    a) How are the needs assessed?

The staffing needs do not meet the2014 HRH norms and standards.

The HRH needs are determined by the gaps created by resignation of staff, retiring staff and new facilities constructed subject to availability of funds. iHRIS can be used also for needs assessment but has not been updated to be reliable for this. The annual work plan has a component on HRH gaps identified.

    b) Who is involved in the needs assessment?

The Health Facility In-charges (AWP), County Director of Health, heads of department at county health office and Sub county MOH's, medical superintendents'' and health in-charges.

    c) How often is a workforce needs assessment conducted?

During the Annual (AWP) and Circulars done sporadically.

4. Briefly describe the County Health Department's health work force planning
    a) How has the county adopted staffing based on norms, standards and guidelines?

Due to challenges in finances the county is unable to recruit as per norms and standards for HRH, and only about 30-40% has adopted the norms and standards of HRH.

There exist huge gaps in staffing of specialist doctors at Kakamega County General Hospital e.g. anesthesiologist, gastroenterologist, Neonatologist, nephrologist are lacking.

    b) What strategies are being used in the mobilization of resources to meet staffing gaps?

Within the last two years the county has employed over 750 county health staff of the 2,500 entire health work force (HRH strategy had envisioned 16,000 staff based on ideal HRH norms). The county is also sponsoring doctors for specialization however they ae yet to come back to county from 2013 as they are on their studies. Aphia plus pays nurses on contract basis.

County is also hiring cadres for instance nurses, Clinical Officer's – anesthetists on temporary basis.

    c) How does the country measure on regular basis the staffing gaps at all levels of health care delivery?

This is done based on monthly staff returns data at sub county from facilities data and aggregated by the County HR office and assesses levels of attrition but has not been utilized to the best of their knowledge to improve or rationalize county health staffing. There are 7 new county hospitals being set up and require staffing needs.

Indicator 2.2: Capacity of County Health Department to strengthen performance management and supervision of the existing health workforce

Standard 2.2.1: Capacity of County Health Department to conduct staff performance appraisals	
0	• There are no policies or guidelines at the county on staff performance appraisals at all levels of health care management and delivery.
1	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists.
2	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted.
3	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted as scheduled in the guidelines. • Supervisor performance monitoring is ad hoc.
4	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted as scheduled in the guidelines. • Supervisor performance monitoring is ad hoc. • System exists for rewards and sanctions based on performance.
Comments: The Staff appraisal is signing of contract at the highest level, individual senior county employees then sign performance appraisals quarterly with mid-year review. Negotiation happens at commencement; targets setting is also conducted.	

Qualitative Questions Standard2.2.1

4. Briefly describe mechanisms in place to review staff competencies and performance
    a) What is the course of action after a performance review?
    They are several courses of actions including:
    i. Congratulation though non-monetary incentives and recognition of best individual or team
    ii. Promotion due to high performance
    iii. 13th bonus salary in some cases
    iv. Development of an Improvement plan and transfers
    v. Rehabilitation (professional support) and counselling (marital/social)
    b) Do you have any strategies for continuous performance improvement? Please explain
    Continuous medical education (CME's) and on the job training (OJT), conferences/seminars, short courses, long term studies are used as strategies for continuous performance improvement.
5. Briefly describe the mechanisms in place to promote accountability and transparency in the workforce
    a) Are there clear guidelines in the job descriptions about staff roles and responsibilities?
    There are inadequate job descriptions (since appointment letters are used as inference to position and available as per schemes of service however a Job Description manual is being developed by the county.
    b) Please describe one or more

c) How often are these guidelines reviewed and implemented? They are not reviewed

6. What mechanisms are in place to address workforce absenteeism and poor productivity?
   Work force Absenteeism can be addressed

i. Use of biometric clocking systems for detecting abseentism, suggestion boxes, Health facility management committees involving communities, client satisfaction surveys (partners like World Vision are supporting)
ii. Show cause letter and disciplinary letter, interdiction
iii. Transfer with close monitoring and supervision
   For Poor productivity this can be addressed
iv. Suggestion boxes at health facilities or offices where client complaints share their complaints
v. Work load and revenue collection comparisons at health facility
vi. Measurable outcomes at programme level i.e. TB, HIV, malaria programmes

Standard 2.2.2: Capacity of County Health Department to coordinate capacity development of Human Resources for Health	
0	• No system for coordinating in-service training for HRH exists, (HRH trainings are completely ad hoc).
1	• System for coordinating in-service training for HRH exists, no adhered to.
2	• System for coordinating in-service training for HRH exists, • The county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments not coordinated by the county,
3	• System for coordinating in-service training for HRH exists, • The county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments conducted and coordinated by the county. • Training schedules are not fully coordinated/ communicated to all relevant stakeholders.
4	• System for coordinating in-service training for HRH exists, county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments conducted and coordinated by the county. • Training schedules are fully coordinated/ communicated to all relevant stakeholders. • Assessments of the impact of trainings to improved service delivery is conducted annually and feedback used during performance appraisals.
Comments:	

Qualitative Questions Standard 2.2.2

8. Describe any agreements made with institutions of higher learning to provide in-service training for staff?, no functional agreement does exist but they have been discussions with the Kenya Medical Training College and Masinde Muliro University of Science and Technology (MMUST)
   a) How are training needs identified?
   b) How are curricula developed and approved?

c) How often is a training needs assessment conducted?
d) Is there a formal mechanism to engage institutions of higher learning to provide training?
e) What institutions have been engaged so far?

9. What types of trainings have been provided by the county in the past year? EXCLUDING vertical programs and implementing partners
    a) Who were trained? Senior county managers or middle level managers were trained on senior management course (JG L and above) and supervisory management (JG K and above) sponsored by the County Government and at the Kenya School of Government
    b) Who determines the staff to be trained? This is determined the County Health Huma Resources Committee (comprises of chief officers from various departments) based on Interest, application and elaborate selection process.
    c) How were the training needs identified? At health facility level based on existing gaps and this is forwarded by Medical Superintendent or health in/charge to the sub county MOH.
    d) Who initiated/ requested the training? This is done by the Department of Public Service and Administration for promotion requirements and requirement to equip the staff with requisite skills
    e) Who conducted the training? Kenya School of Government (Baringo
    f) How was the training funded? Through County Government and some National Government under the Ministry of Health and Education.

10. Please describe the county health department's policy to strengthen existing workforce through vertical programs. (Policy in the training manual – minimum of five days)
    a) Is there an operational plan for in-service training? None
    b) How are in-service training needs identified?
    c) How often are in-service trainings delivered?
    d) Is there an operation plan to retain existing workforce? No
    e) Do county health staff that complete requisite in-service trainings get incentives?

11. Does the county health department have a centralized Training Unit to address training needs for the county health staff? None is in existence and needs to be instituted. How is training currently coordinated and documented?

    a) How are training needs and training programs or opportunities matched?
    b) What records are kept on in-service training for individual health workers?
    c) What do you think are the major pre-service training problems facing the county?
    d) What do you think are the major in-service training problems facing the county?
    e) What kind of assistance does the county need to coordinate and document training?

12. What is the capacity of county health department towards granting accreditation to pre-service training facilities? There exists no capacity
    a) What is the role of the national government in accreditation of pre-service training facilities? Training is a function of National Government and they set training standards, assess training facilities, assess skill levels and curriculum development review under the county educational institutions.

b) How often is accreditation conducted? On need basis
c) Are accreditation standards comprehensive and up to date? Dependent on faculty
d) Who conducts accreditation? How is this team formed? The regulatory bodies for instance Kenya Medical Practitioners and Dentists Board and Pharmacy Poisons Board etc. The role of the County Health Management Team is to guide them in the county but county does not play a huge role.
e) What kind of assistance does the county need towards implementing accreditation? The county needs capacity to have their own accreditors or accreditation agencies to be from county for local ownership.

13. What are three priority performance areas most in need of strengthening within the county health department that relate to HRH?
    i. HRH training policy & plan required
    ii. iHRIS which is the integrated health resource information system on (Train & Manage) modules needs to be linked to needs assessment to training institutions offering courses
    iii. Human resource development plan
    iv. HRH training

14. What are the successes and major challenges for strengthening health workforce? (ask for each vertical program (HIV/AIDS, TB/HIV, RMCH, Malaria, Nutrition) and the county as a whole)

Programme	Successes	Challenges
HIV	- ¾ of HIV county workforce are supported by partners - NASCOP sponsored training - NASCOP procured data tools and trained all sub counties (12) on revised tools - County HIV strategy existence	-High staff turnover leading to losing skills on use of tools and reporting affected -Risk of scaled down funding and lack of sustainability plan -Stigma on some MOH health workforce
TB	- TB partners supporting workforce - National TB programme supports training - Team work with other cadres has led to an increase in TB	- Transport of sputum - Staff shortage on lab technicians, nurses – depends on community to employ - With devolution no full support example is World TB Day –

	cases – increase of 35% - Strengthening of the Public Private Mix	screening support by the county - Vertical programmes like TB, HIV and Malaria are still nationally supported – not less than Ksh 20m
Malaria	- Training of health care workers on treatment guidelines, case management - Reporting improved from 53.7 to 100% for reporting (No. 1 in the country for malaria reporting) - Testing the suspected and positivity rate is low - Assured antimalarial commodities and availability heavily reduced stock out at health facilities - Reduced malaria prevalence from 38% to 27% -Formation of work improvement teams through the Kenya Quality Model of Health	- No adequate lab technologists as not recruited and reliance on Rapid Diagnostic Test's but this were meant for community level. - Inadequate training
Nutrition	- Staff employed by Nutrition - Adequate food support for PLHWA and TB	
County	- Recruitment, promotions done - Staff being trained - Salaries paid on time	-Frequent strikes by doctors, nurses, clinical officers -Lack of equipment

Building Block 3: Health Information Systems

Indicator 3.1: Capacity of Health Department to plan for and systematically collect health information

Adapted from the WHO's *Monitoring the Building Blocks of Health Systems,* key components of a HIS include: routine health information, vital statistics, disease surveillance and health surveys

1. Does the county have an integrated Health Information System that includes indicators, data elements and sources, frequency of collection, data flow, data validation rules and quality

Standard 3.1.1: Capacity of County Health Department to implement HIS policies, strategies, guidelines, protocols and use routine HIS forms	
0	• The county does not have national health information system policy and strategy.
1	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are not readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms.
2	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms • Sub-counties, facilities and community units do not have adequate supply
3	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms • Sub-counties, facilities and community units have adequate supply • Mentorship program on correct use of HIS forms institutionalized in less than 75%of sub-counties and/or facilities.

assessment guidance/protocol? Yes

4	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms • Sub-counties, facilities and community units have adequate supply • Mentorship program on correct use of HIS forms institutionalized in at least 75% of sub-counties and/or facilities.
Comments:	

2. How has this system been rolled out to sub-counties and facilities?
   Roll out done via training sub county HRIOs, only those below sub counties were never trained. Quality assessments done with support from partners like TUPIME County, APHIA Plus. APHIA + also supported in provision of ICTs and air time provision to upload the reports.
3. Does the county have a system for monitoring and evaluation of county programs that details priority health impact and outcome level indicators at a minimum that presents plans on how data will be collected for monitoring, evaluating, disseminating and using analyzed data, that clearly spells out roles and responsibilities, capacity building and county stakeholders' data review forums?
   The County has a monitoring and evaluation framework that indicates how all the implementation of tracking all HMIS indicators will be tracked.
4. How has this plan been rolled out to sub-counties and facilities?
   Yes, was launched and disseminated to sub county teams in 2016 up to Sub-County Health Management Teams.

Standard 3.1.2: Capacity of County Health Department to collect quality health data	
0	• There are no county-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) in place.
1	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data are not routinely collected using standard data collection forms.
2	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data routinely collected using standard data collection forms. • County department of health receives timely and complete reports from less than 75% of health facilities (public, private and faith based) o MOH 731 (HIV)

	o MOH 515 (Community) o MOH 710 (Immunization)
3	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data routinely collected using standard data collection forms. • County department of health receives timely and complete reports from more than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization) • County department of health receives accurate reports from less than 75% of health facilities (public, private and faith based)
4	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist; data are routinely collected using standard data collection forms. • County department of health receives timely and complete reports from less than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization) • County department of health receives accurate reports from more than 75% of health facilities (public, private and faith based) • Health performance data reviewed regularly and regular feedback provided to all health facilities on data accuracy.
Comments:	

Qualitative Questions Standard 3.1.2

1. Who has the primary responsibility for collecting data for routine health information, vital statistics, disease surveillance and health surveys systems?
   Service providers at different levels of service delivery
2. Who has the primary responsibility for submitting/entering data and validating it from these data systems?
   The Sub-County HRIO uploads in the system. Other service providers at sub county e.g. pharmacists, laboratory technologists, malaria coordinators, these all enter their data, validate and upload.
3. To what extent has the county health department institutionalized Ministry of Health's National Data Quality Protocol and Standards?
   This is ongoing at County level and yet to be done at Sub-County and health facility levels.
4. What is the process for data quality assessment and how often is it conducted by county health department? By Sub-county health administrators' offices?

   This is done by checking data in the DHIS and getting back to health facility to compare the summaries at the register. The data quality assessment is conducted annually. At other times

DQA is done quarterly supported by NASCOP, Palladium and ITECH (implementing partners). TB DQA is done annually.

Qualitative Question Standard 3.1.3: Where is health data stored at the county and sub-county levels? At DHIS , data is stored at County Levels and hard copy reports at Sub-County and facilities data stored at registrars. At community level data this is recorded with Chalk Boards.

Standard 3.1.3: Capacity of Health Department to manage data	
0	• No one single county-wide preferred electronic or paper based exists.
1	• Separate information management systems (paper or electronic) exist for the various components of the HIS. • It's difficult or impossible to manipulate or extract data from the system.
2	• One Single County preferred Electronic Health Information Systems platforms (databases) exist for the various components of HIS • Data are not routinely extracted for reports and other use.
3	• One Single County preferred Electronic Health Information System platforms (databases) exist at the county for the various components of the HIS, • Data are routinely extracted (at least annually) for use. • Integration of information from other health management systems (i.e., service statistics, financial, human resource, logistics information, and physical assets data systems) not yet fully operational.
4	• One Single County preferred Electronic Health Information System platforms (databases) exist at the county for the various components of the HIS, • Data are routinely extracted (at least annually) for use. • Integration of information from other health management systems (i.e., service statistics, financial, human resource, logistics information, and physical assets data systems) is evident. • County Data Management Guidelines exist including policy on health/research data sharing policy.
Comments:	

Indicator 3.2: Capacity of County Health Department to promote evidence-based decisions and policy making

Qualitative Questions Standard 3.2.1

1. How often is routine data analysis presented to senior managers for discussion, field monitoring/supportive supervision, problem solving and decisions?
   This is never done at all; the county needs a lot of support in this area to facilitate this process.
2. How often is performance information presented to County Health Department leadership for discussion, problem solving and decision making? Provide examples of how reviewed performance data have been used to identify opportunities to improve services.
   Maternity free services presented monthly, Oparanya Care report presented annually. HIV done monthly, RH Monthly, TB Monthly, Malaria Quarterly except in (Likuyani and Lugari Monthly), and Nutrition Quarterly.
3. How often is data used in reviewing/evaluating the success and/or failure of county health programs and strategies?

Standard 3.2.1: Capacity of County Health Department to use collected data for planning and policy making	
0	• No evidence of data use for strategic planning including rational budgeting and decision making.
1	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county health committee and other state and non-state actors. • No evidence of data use for strategic planning including rational budgeting and decision making.
2	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings.
3	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county assembly health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings. • The county can identify at least two examples of how data have been integrated into a decision-making process including rational budgeting in the past year.
4	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county assembly health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings. • The county can identify at least two examples of how data have been integrated into a decision-making process including rational budgeting in the past year. • Policy and planning framework (that details national development goals, national health sector priority goals, county health priority goals, county budgetary and donor allocations, and county health development outcomes) exists.
Comments:	

For reproductive health this is supposed to be done quarterly but it's never done due to lack of funds. HIV Programs done quarterly with the support from APHIA + , TB programs quarterly supported by CHS

4. How often is data used in the formulation of policy and/or incremental re-adaptation of existing programs and strategies?

This is happening in HIV programs, HTS data, with support from KANCO which provides data from Key Population. Malaria data from high incidence areas used to make decision in procurement of commodities. Supported by TUPIME Kaunti, Measure Evaluation ICDT.

Building Block 4: Access to Essential Medicines & Other Health Commodities

Indicator 4.1: Capacity of County Health Department to ensure access to essential medicines for the population

Standard 4.1.1: Capacity of the County Health Department to provide oversight to commodity management to downstream levels of service delivery	
0	• The county does not have an organized unit (of more than three persons) to oversee and coordinate commodity security in the entire county.
1	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership.
2	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate.
3	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate. • The County Commodity Security Committee structure has been adopted, operationalized and implemented at the sub-county level for all the sub-counties in the county.
4	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate. • The County Commodity Security Committee structure has been adopted, operationalized and implemented at the sub-county level for all the sub-counties in the county. • Supply chain performance statistics are maintained at county, sub-county and facility levels and reflect improving trends overtime.
Comments: The score is three since the supply chain statistics are not maintained at county, sub counties and facility level to reflect improving trends overtime.	

Qualitative Questions Standard 4.1.1

3. Describe the procedures for implementing and supervising supply chain services in the county?
   This is highlighted in the commodity management manual and using best practices at national level. Supply chain services originate from procurement plan where selection, forecasting and quantification requirements are developed, and quantities ordered from KEMSA and MEDS based on estimate requirements of health products and commodities. Commodities are then delivered directly to health facilities based on the consumption based commodity data, though challenges exist in delayed payments from county to KEMSA due to delay in disbursements.

- Different programmes employ different commodity reporting cycles from the essential medicines, vaccines, TB, ART, lab reagents & consumables etc..
- The reordering cycle is integrated into a logistic management information management system and integrated into DHIS 2 system and commodity dashboards available on status of commodities at county, sub county and even facility level.
- The commodity security technical working group conducts regular joint supervision with other health cadres to ensure adequate supply chain services at lower level and correction done.
- No clear supply chain system for nutrition commodities system is in existence.

a) Describe the way through which the county ensures availability and use of required guidelines, protocols and tools for product selection, quantification, commodity reporting, use, support supervision and M&E at all levels of service delivery in the county?

The commodity management guidelines provide the basic standards for selection, quantification and commodity reporting. Health commodities are to be ordered and distributed every quarter based on consumption data and there is a lead time of 10 days for KEMSA/MEDS to supply to health facilities however delays do happen due to funding.

Last mile distribution of commodities is encouraged/practiced and but to county ware house this is used for vaccines commodities needing cold chain.

The health facility in/charges employ social accountability mechanisms to ensure commodities are available at facilities and patients not charged for the free commodities.

The Inspection and acceptance committee at county level as the procurement act is responsible to ensure deliveries as per requirements and of good quality.

-

b) Briefly describe how supply chain data is used to help decision making at county/sub-county and facility level; and how the county ensures that systems for collecting data from lower levels and feedback loop from higher levels is in existence, adequate and continuously being improved.

The commodity security technical working group at county level plays a vital role in reviewing data from DHIS and LMIS and presenting status reports on stock levels to maintain adequate buffer stocks within the quarters at acceptable levels. This is communicated to national level programmes and KEMSA.

c) How does the process of supportive supervision for service delivery incorporate supervision for supply chain service/commodity management at health facility level?

County Pharmacists and pharmaceutical personnel are involved in supervision at county and sub county levels and the supervision checklist has indicator tracer commodities to gauge availability and stock outs. Programmes like TB, HIV and RMNCH has direct support supervision support from national level using their county coordinators and ensure maintenance of adequate commodity supply.

4. Describe the procedures for monitoring and reporting supply chain performance at all levels in the county?

a) In which specific ways does the county take a whole-market approach in strengthening commodity management systems for the county? (ie inclusion of non-government health sub-sector (e.g. faith-based)that offer services within the county)

The county commodities are also procured from MEDS which is faith based organization and supply also may happen to faith based hospitals or clinics especially for commodities like TB, HIV, malaria and some essential medicines.

Some private sector offer subsidized commodities for instance PSKenya TUNZA clinics.

There is a challenge of free commodities for instance Anti-malarials or RDT's where some private facilities sell yet it is to be free and but supposed to charge only consultation services. Same applies for family planning services.

Capacity building on supply chain management also involves faith based clinics staff and supervision encompasses all the clinics including FBO's.

b) How does the county ensure trend graphs on key supply chain performance indicators are maintained as a measure of quality of supply chain services rendered in the county? e.g. stock-out rates, stocking according to plan, reporting rates, and commodity disposal due to expiration.

In general the LMIS and DHIS ensures the commodity indicators and commodity security committee this supply chain statistics are presented. However the industrial action on nurses and doctors affected consumption patterns of commodities in 2017

The correct disposal mechanisms are utilized for disposal of medicines

c) How is equity ensured in commodity distribution and dispensing? In other words, what procedures are used to make sure that essential medicines and health commodities are distributed/ issued out according to need?

The use of drawing rights and poverty indices guides the equity distribution and through the disease workload and test. Medicines are also subsidized and are free in lower health facilities like health centres and dispensaries apart from the sub county and county referral hospitals where a small fee is charged and NHIF reimburses them.

d) How does the county ensure improved access to quality and affordable essential medicines and other health commodities? (Consider systems for commodity quantification and supply planning, inventory management tools, commodity information management, commodity financing and procurement, and financing for continuous improvement of supply chain systems)

On affordability:

The county purchases medicines from KEMSA and MEDS and this pooled procurement mechanisms ensures prices are lower and supply is directly to the health facility.

On quality assurance, the county relies on KEMSA and MEDS who have WHO approved quality assurance laboratories which have batch quality checking on all products in addition the bigger health facilities prequalify suppliers and also at sub county MOH level. Pharmacy and Poisons Board with other regulatory bodies like medical and laboratory board also conduct routine surveillance in both public and private facilities. Portable minilabs are present to ensure quality.

There exists a procurement plan for all health commodities and proper forecasting and quantification is undertaken. Few donations exists the one was from Living Goods.

Standard 4.1.2: County Health Department's capacity to estimate commodity needs, develop a supply plan and procure/source these comm odities (Forecasting, Quantification and Procurement)	
0	• No capacity (external or internal to the county) available to conduct a forecasting and quantification exercise (estimate commodity needs, develop a supply plan, and procure essential commodities).
1	• The county is reliant on external technical assistance to estimate commodity needs, and develop a supply plan, no mechanism exists to fully procure or source (i.e. buy or secure donations of) essential commodities.
2	• The county is reliant on external technical assistance to estimate commodity needs, and develop a supply plan, • County partially has capability to fully procure or source (i.e. buy or secure donations of) essential commodities.
3	• The county has capacity to estimate commodity needs, and develop a supply plan, • County partially has capability to fully procure or source (i.e. buy or secure donations of) essential commodities, • County requires minimal external technical assistance to estimate commodity needs.
4	• The county has capacity to estimate commodity needs, and develop a supply plan, • County has capacity to fully procure or source (i.e. buy or secure donations of) essential commodities, • County requires no external technical assistance to estimate commodity needs, • Health commodity procurement done at least once annually.
Comments: The score is three since the county requires external technical assistance to estimate commodity needs for vaccines and other health commodities	

Qualitative Questions Standard 4.1.2

4. How are commodity needs identified?
   Guidance is offered from national Government, KEPH levels and the Kenya Essential medicines list 2016 plus needs assessment
   a) How are the county, sub-county and health facility needs identified? Needs assessment
   b) What role does National Government agencies/institutions play in assessing county commodity needs? KEMSA utilizes the consumption needs guides counties stock ordering and restocking levels, some commodities are still supplied from national level like vaccines, Anti-TB's, ART and malaria plus family planning
   c) What happens after commodity needs are identified? How are requests made?
   Once commodities are identified, orders are consolidated and reviewed and included in LMIS and DHIS and orders made through standard ordering forms on a quarterly basis. Challenges exists in capacity of health facilities to order commodities and delay of disbursement from treasury therefore delays purchase of commodities
5. What is the role of development partners for health and/or implementing partners in procuring essential medicines? Provision of some commodities, PSKenya supports the private sector with family planning commodities, training and LMIS data.
6. What is the proportion of county spending on commodities as % of total county health spending? Almost 10% like this FY 2017/2018: Ksh 360 m commitment out of Ksh 3.7b health budget

Standard 4.1.3: County Health Department's Capacity to Develop and/or adopt and Use a National/County-owned Health Commodities' Logistics Management Information System (LMIS)	
0	• County currently uses no Health Commodities' LMIS system.
1	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records.
2	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, reporting of LMIS data is below 50% for all facilities annually.
3	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, county has access to limited logistics data including: stock on hand within the system and consumption/usage for the past reporting period and demonstrates reporting rates of least 50% from the sub-counties. • County has a plan for routine DQA exits, DQA of LMIS data conducted at least once annually
4	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, county has access to logistics data including: stock on hand within the system and consumption/usage for the past reporting period and demonstrates reporting rates of least 75% from the sub-counties. • County has a plan for routine DQA exits, DQA of LMIS data conducted semi annually • Data Quality Improvement Plan for LMIS data developed for every DQA and implemented
Comments: The score is three since data quality improvement plan for LMIS data is not present.	

Standard 4.1.4: Health facility's capacity to effectively store and account for health commodities through appropriate records and reports.	
0	• No system exists for proper storage and distribution of commodities, including essential medicines. (***special storage requirements of medicines and other commodities are not followed, poor records keeping and consumption reporting***)
1	• Warehouse/stores(s) for commodity storage exists at either county, sub-county or facility level, with some accommodation for items requiring special storage.
2	• The county/sub-county warehouse and health facility store meets at **least two** of the following four criteria: warehouse/store size is adequate, storage spaces are being well maintained and clean (including pest, lighting, temperature and humidity control),

	• County warehouse has designated storage equipment for special storage needs, and re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance.
3	• The county/sub-county warehouse and health facility store meets at **least three** of the following four criteria: warehouse/store size is adequate, storage spaces are well maintained and clean (including pest, lighting, temperature and humidity control) • County warehouse has designated storage equipment for special storage needs, • Re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance.
4	• The county/sub-county warehouse and health facility store is adequate – meets all four criteria (i.e. large enough, regularly cleaned, dry, well organized) with all special needs storage areas clearly designated with correct signage, • County warehouse has an established re-order and stocking plan, including the use of protocols (such as first expiry, first out), job aides (such as SOP for emergency procurements) • Re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance. • Stock-control records such as stock cards and bin cards are well maintained
Comments:	

Qualitative Questions Standard 4.1.4

7. Describe the procedures adopted for proper storage of essential medicines and other health commodities(county, sub-county and health facilities)
   The procedures are described in job aids for proper inventory management and storage management and displayed in most health facilities this was supported by MSH. FEFO (first expiry first out) and FIFO (first in first out) standards are utilized, shelving and lighting and temperatures for commodity storage areas
8. What is the role of community-based groups and networks in community commodity distribution? Supervision and distribution of commodities for instance Global fund recipients like CBDA
9. What is the role of private sector in commodity procurement, storage and distribution? More of business partners and Government supervises their premises to ensuring good quality standards for health products being sold.
10. What mechanisms does the county use to assure quality for medicines and other health commodities within the county level? County capacity is limited and most support is from KEMSA and PPB. Inspection and acceptance committee's exists to ensure quality assurance once products are delivered. Pharmacovigilance systems exists and reporting on adverse drug reactions and poor quality medicines. Minilabs available at county referral hospital for spot check on quality of medicines including post market surveillance as prescribed by PPB.
11. What systems does the county have in place for medical waste management? All sub county and major health facilities have incinerators and involve NEMA in waste disposal.

Block 5: Health Systems Financing

Indicator 5.1: Capacity of the County Health Department to ensure that adequate funds are allocated to the health sector within the overall county budget.

Standard 5.1.1: Capacity of the County Health Department to ensure that adequate public funds from the total county government budget are allocated to public health and population activities.	
0	• The county health department has no input into the development of the county budget estimates.
1	• The county health department has input into the county budget estimates development, • But public health expenditures are not systematically calculated on an annual basis and total at least 20% of the overall county government budget.
2	• The county health budget is developed annually, with input from county health department • County health expenditures are not systematically calculated on an annual basis as part of budget formulation process • It's less than 25% of the overall county government budget.
3	• The county health budget is developed annually, with input from county health department • Estimated actual county health expenditures are systematically calculated on an annual basis as part of budget formulation process. • Health budget is between 25% and 30% of the overall county government budget.
4	• The county health budget is developed annually, with input from county health department. • Estimated actual county health expenditures are systematically calculated on an annual basis as part of budget formulation process • Program, surveys and surveillance data used as justification for budget requests • County health budget is at least between 30% - 40% of the overall county government budget.
Comments: The score is three (3) because the county does not routinely use program, surveys and surveillance data as justification for budget requests and county budget is slightly less than 30% of the overall county government budget. In terms of county health budget Ksh 3.7 billion is allocated for health out of an estimated Ksh 10 billion allocation (almost 30% of county budget and this available on the Kakamega county website FY 2017/2018 allocations)	

Qualitative Questions:

1. Briefly characterize funding sources for health services in the county.

h) Where does funding for health care services come from?

The funding comes from mainly National and County Government through the exchequer and county revenue collection, in addition from development partners like USAID, Global Fund Against Aids, TB and Malaria (GFATM), DFID, UNICEF, DANIDA – HSS, GAVI (immunization). The private sector and foundations don't provide any funding unless on corporate social responsibility to celebrate world health days at county or lower levels.

i) What percentage of funding comes from national treasury equitable share, conditional grants, county revenue collection, private sector, household out of pocket, health insurance and external development partners for health?

For the FY17/18 budget estimates (this will be confirmed with accurate figures):

i. National treasury equitable share (need to confirm)

ii. Conditional grants – Ksh 700m from conditional grants

iv. County revenue collection – 135m/365m (FY 2017)

v. NHIF – 30% out of total population – capitation

v. Out of pocket not known

vi. Development partners i.e. World Bank – Ksh 50m on MNCH (directly), DANIDA (HSS) – Ksh 25m (directly), GAVI – EPI, DFID – supporting renovations and community unit establishment and USAID utilizes implementing partners.

4. Briefly describe the mechanisms in place to determine county health budget needs of individual sub-counties? This is prescribed under the PFM act of 2012 and guided through the budget cycle process and is guided by CIDP, Medium Term Expenditure Framework (MTEF), Sector plans, Annual Development Plan, Annual work plan

a) Who is responsible for determining county and sub-county budgetary needs?
The Chief Officer of Health is responsible at county level, at sub county level, the sub county MOH and at health facility/hospital this is the Medical Superitendant or health in charges.

b) How often is a county health budget review conducted?
When need arises for this financial year a supplementary budget is in existent.

5. How is the process organized? To what extent are stakeholders involved in this process? (Program Based Budgeting).
Stakeholders are involved in the budget making process however the limitation is in the public participation phase.

a) Who is involved in the budget making process in the county and why?
The County Health Management Team (CHMT) led by the Chief officer of Health

b) How are county priorities set in the health sector during the budget process?
County priorities are established during the budget planning process and is based on previous year activities, reference to baseline, data reviews done at quarterly level – supported by sub counties and programmes and national priorities as per national documents aligned to vision 2030.

c) How are county health programs/subprograms determined in the budget?
Based on programme priorities and reviewing contributions from implementing partners and disease work load including mortality indicators and where the most need is required.

d) How does county improve efficiency in resource allocation and use (value for money)?
Through Internal auditing system and external audit office and engaging procurement agencies which do pooled procurement i.e. KEMSA and MEDS

e) How does county ensure value for money for resources allocated to the health sector?

Through a tendering process – strict procurement committee at all levels as per the new guidelines and strictly adhering to the procurement procedures and new procurement act 2015.

f) What challenges does the county have in formulating program based budgeting that factors in efficiency, effectiveness and equity?
-Challenges include lack of funding due to scarcity of resources, the focus at times is allocating budgeting for operations and maintenance and not on development issues and lack of capacity building at sub county and facility level on programme based budgeting process

g) How does the county ensure equitable allocation of resources for improving the social welfare of the most needy in the society?
Some examples of how the county ensures equitable allocation of resources includes: Kakamega has in place a maternal health programme and bill (Imarisha Afya ya Mama na Mtoto) and this targets poor mothers where 1/3 of the budget is ring-fenced for this commitment – for this financial year almost Ksh 90m.
As per the procurement regulation on securing 30% of the tenders to women, youth and physically challenged this is being implemented by county and sub counties like Malava sub county.

Indicator 5.2 Capacity of County Health department to formulate, distribute and monitor financing for the health sector.

The four criteria necessary in a *sustainable budget* are as follows

***Planning**:* County Health Department has a realistic and sustainable budget informed by sound revenue forecasting methods including use of past experience/expenses, development partners for health contributions and projections (covers and based on ceilings)

***Input**:* All key stakeholders are involved (including county health department, sub-county health administrators, civil society including religious groups, public participation, and as necessary development partners for health and implementing partners)

***Allocation**:* County Health Department compiles an adequate budget that prioritizes primary health care services, with specific line items for key areas outlined in the County Health Strategy.

***Initiative**:* Process for collection of budget information is led collectively by the County Health Department and sub-county health administrators' offices and the system is standardized across all sub-counties.

Standard 5.2.1: Capacity of County Health Department to plan for, create and allocate a sustainable budget	
0	• No sustainable budget exists (see four criteria necessary for sustainable budget above).
1	• Three of the budget sustainability criteria need improvement (see four criteria necessary for sustainable budget above).
2	• Two of the budget sustainability criteria need improvement (see four criteria necessary for sustainable budget above).

3	• One of the budget sustainability criteria needs improvement (see four criteria necessary for sustainable budget above).
4	• All of the budget sustainability criteria are completed and sustainable, with the county and sub-county health administrators' offices taking the lead on developing the county health budget (see four criteria necessary for sustainable budget above).
Comments: Ksh 3.7 billion health allocation of which (1.7b – salaries, 1b – County teaching, 200m – two sub county hospitals, 360m- drugs, 10m (110m) – hospital) Primary health care is funded mainly by partners focused on HIV, TB, Malaria and MNCH. The scoring is 2 due to as the county does not prioritize primary healthcare services and weak budget collection processes.	

The four factors necessary to *effectively distribute and or allocate finances* are as follows:

***Financial System**:* A system exists within the County Health Department to distribute funds among its activities. This includes differentiating by funding source (e.g., development partners for health, national and county revenue, etc.) and by funding recipient (e.g., by line item, and by district).

***Tracking**:* County Health Department has a system to track its distributed funds against its total budget, the sub-counties distributions against total budgets, manage cash flow and segregate expenses

***Policies**:* Policies for allowable expenses exist and are distributed among County Health Department staff and sub-counties. These policies are implemented on a regular basis. –

***Responsibility**:* Monthly review of internal expenses versus revenue (both for the county health budget and each sub-county's budget) is designated to an employee(s) as a responsibility

Standard 5.2.2: Capacity of County Health Department to effectively distribute finances	
0	• No system to distribute funds exists (see four factors necessary for effective distribution and/or allocation of finances above).
1	• Three of the budget distribution factors need improvement (see four factors necessary for effective distribution and/or allocation of finances above)
2	• Two of the budget distribution factors need improvement (see four factors necessary for effective distribution and/or allocation of finances above).
3	• One of the budget distribution factors needs improvement (see four factors necessary for effective distribution and/or allocation of finances above).
4	• All of the four (4) budget distribution factors are completed and sustainable (see four factors necessary for effective distribution and/or allocation of finances above).
Comments: The score is 4 however based on the qualitative questions the county lacks in finance management manuals for banking and collection and comprehensive procedures for Examples of policies are Treasury circulars, PFM act 2012, procurement act, recurrent and development expenditures -40:60 (country best practice), based on core function, Tracking is done with IFMIS, vote books, cash book, expenditures and Authority to Incur Expenditure (AIE's).	

Qualitative Questions Standard 5.2.2

1. Briefly describe the mechanisms in place to ensure fair and adequate distribution of funds to the sub-county health teams.

Fair and adequate distribution of funds to sub county health teams is based on work load but this may not be sufficient and needs to be reviewed to include other factors

a. How is the process set up?

Not documented since 2014 and needs to be reviewed

b. How are needs determined?

Not documented and needs to be documented and updated.

2. Briefly describe the mechanisms in place to ensure transparency in revenue collection and distribution

a. What policies and procedures are in place?

i. Public Finance Management Act
ii. Revenue collection agency
iii. Lack of county specific manual for banking and collections

b. What is the course of action when a discrepancy is identified?

i. Paying back /refunds directed by county management
ii. Investigation on the cause of discrepancy and action taken
iii. If found as an offense this is reported to the police authorities to take criminal action

The four factors necessary to *effectively monitor finances* are as follows:

Documentation*:* County keeps financial documentation in a secure place, has a policy for keeping receipts and requirements for documentation kept with each type of payment. These policies flow down to sub-counties and adherence is monitored.

Review*:* County reviews expenses monthly to ensure applicability and allowability according to the budget and internal policies. Exceptions are documented

Reporting: A reporting system exists both for the county to report to the County Government Treasury and for the sub-counties to report to the county. Reports are completed and submitted according to applicable deadlines

Audit*:* County either has an internal review of its and the sub-counties' accounting systems or hires external auditors on an annual basis. –

Standard 5.2.3: Capacity of County Health Department to monitor finances at the National and Provincial levels	
0	• No tracking/monitoring system exists.
1	• Three of the factors necessary to effectively monitor finances need improvement (see four factors necessary for effective distribution and/or allocation of finances above)
2	• Two of the factors necessary to effectively monitor finances need improvement (see four factors necessary for effective distribution and/or allocation of finances above) .
3	• One of the factors necessary to effectively monitor finances need improvement (see four factors necessary for effective distribution and/or allocation of finances above) .
4	• All of the four (4) factors necessary to effectively monitor finances are completed and sustainable (see four factors necessary for effective distribution and/or allocation of finances above) .
Comments: - Internal audit at county and sub counties; and external audit by Kenya National Audit office (KENAO)	

Qualitative Questions Standard 5.2.3

6. How is the overall county budget monitored?
    a) Who monitors/ manages the county health department budget at the county treasury level? Chief Officer of Health
    b) What input do individual departments other than health department provide towards managing the overall county health department budget?
    i. Department of finance does disbursement of funds, internal audit and revenue collection
    ii. Department of public service and administration under the sub county administrator chairs the project implementation committee
    iii. County assembly does approval of budget and oversight
7. Briefly describe your procurement policies and procedures?
    This is Conducted as per National procurement act 2015 and as per the procurement manual and regulations adopted by the county from the national level.
    a) Do you have different thresholds for procurement?
    i. Stated in the procurement act
    ii. Procurement Circular for the thresholds

    b) What do you keep as documentation in your files?
    i. Contract awards – requisition forms, evaluation forms, inspection forms, counterreceipt forms (S13), LP), delivery notes, invoices
    ii. For Big contracts (more than Ksh 2/4m) – needs approval from cabinet, advert, bills of quantities, opening report, evaluation report, professional opinion,

    c) How do you ensure transparency in procurement?

By adhering to procurement act (adhoc) committees regulations including opening and closing of bids when all bidders are present in addition all citizens have access to the advert and procurement procedures.
The County Public Procurement and Oversight Authority, complaints can be reported plus regular audits undertaken

8. What is the county's capacity towards developing and implementing Performance-based contracts (PBC)? There is no performance based contracting in Kakamega county.
    a) How are performance indicators identified? What is the county's process for identifying the indicators?
    b) How are contractors identified? What is the county's process for identifying the contractors?
    c) Is there a policy/ operational plan to guide the PBC process?
    d) How is performance evaluated and recognized?
    e) What kind of assistance does the county provide to sub-counties health administrators' offices in implementing PBC?

9. What resources and support does County Health Department need to implement PBCs across all sub-counties?
   Not there and sensitization is required.
    a) Financial needs
    b) Procurement and logistic needs
    c) Training needs
10. What is the county health department's budget allocation utilization rate (% of expenditure in total allocated health budget)?
    99.5% against total (FY 16/17)
    a) Recurrent expenditure (mostly over 80%)
    b) Development expenditure (less than 20% and is dependent on partners)

Building Block 6: Delivering Essential Health Services

Indicator 6.1: Capacity of County Health Department to engage sub-counties in delivering public health services

Standard 6.1.1: Extent of interaction between the county health department and sub-counties	
0	• No structured interaction with sub-counties.
1	• The health department interacts at least once a year with sub-county health administrators on: o Budget-related issues only.
2	• The health department interacts at least once a year with sub-county health administrators on: o Budget related issues o Health service planning activities.
3	• The health department interacts at least once a year with sub-county health administrators on:

	o Budget related issues o Health service planning activities, o Maintenance and coordination of facilities.
4	• The health department interacts at least four times a year with sub-county health administrators on: o Budget related issues o Health service planning activities, o Maintenance and coordination of facilities, o Assessments and planning for community health needs.
Comments: There is lack of regular quarterly meetings with county health department and sub county health administrators, support supervision (twice in a year), annual work planning (once in a year) Sub-counties are not involved in budget negotiations	

Qualitative Questions Standard 6.1.1

4. What mechanisms are in place to involve community stakeholders, sub-county health officers and partners in planning for service delivery?

   Community stakeholders are involved during dialogue and action days (community unit discuss issues affecting their health headed by CHEW), involved in health planning for service delivery (health facility management committee)) in approval of budgets, public participation is done through the county forum where the chief officers and Governor participate

   Sub county health officers provide relevant information on the needs, prioritization by health facility and channel to county and during annual work planning they involved in the joint consultations (annual work plan templates available)

   Implementing Partners support in the consolidation process –through supporting meeting venue , printing and publishing, support TWG plans and M&E support to feed into the stakeholders forum

   -

5. Has the county conducted a formal exercise to plan for health services? Yes
   a) How often is planning conducted? Annually for the annual work plans and five year strategic plan under CIDP and county health strategic plan.
   b) Is there a general Annual Work Plan? Yes for 2017/2018 (needs to be shared)
   c) Do you have unit-specific and or Vertical Programs specific Annual Work Plans? Yes but not stand alone integrated in the county health work plans How were they developed and shared? Disseminated occurs at county level to stakeholders
   d) Who is involved in the planning process? All stakeholders
   e) How is the planning process organized?

6. How are priority service areas identified? During the planning this refers previous year activities and reference to baseline, data reviews done at quarterly level supported by sub counties and programmes, national priorities as per national documents like vision 2030.
   a) Is service delivery reflective of priority health needs per county health strategic plan? Yes
   b) What policies do you have in place to ensure service delivery targets priority health needs? Please describe. Examples include:

Imarisha Afya ya Mama na Mtoto bill (Oparanya care) – fixed a certain percentage within the budget (safeguards) https://blog.path.org/2017/11/how-kakamega-county-kenya-is-protecting-resources-for-healthy-moms-and-kids/

Challenges from previous year and lessons learn't

- Free maternity programme implemented at national level by NHIF

Standard 6.1.2: Capacity of County Health Department to develop and distribute (to the sub-counties) policies, plans and standards for key health care delivery areas	
0	• No County Health Department's Health Strategy exists.
1	• The county has a health strategy aligned to national health strategy (2014 – 2018)
2	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities.
3	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities. • The county clinical standards and guidelines are currently used by least 50% of sub-counties within the last two years.
4	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities. • The county clinical standards and guidelines are currently used by least 80% of sub-counties within the last two years. • The county health department conducts regular sub-county and health facility visits to monitor compliance in the use of standards and guidelines.
Comments:	

Qualitative Questions Standard 6.1.2

3. What guidance does the county provide the sub-county health administrators regarding service delivery?
    a) Are there policies and procedures?

Protocols on HIV, TB and Malaria management by the vertical programmes
MNCH protocols in labor and maternity wards,

    b) Does the county annual work plan provide guidance to sub-counties? Yes
4. Who decides what services need to be provided at the sub-county level?

This is stipulated in the norms under the Kenya Essential Package of Healthcare (KEPH) levels (level 1 to 6)

Indicator 6.2: Capacity of County Health Department to ensure appropriate use of policies, plans and standards related to Health Service Delivery for HIV/AIDS, TB/HIV, RMNCH, Nutrition, Water & Sanitation, and Malaria

Standard 6.2.1: Capacity of County Health Department to supervise sub-counties in the use of Health Service Delivery Standards, Guidelines, Protocols	
0	• No system exists at the county to monitor adherence of sub-counties to standards, guidelines, protocols.
1	• Some elements of a basic system exist for monitoring adherence to standards, guidelines and protocols.
2	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (***lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities),*** but use of these guidelines is not consistent by the county health department or sub-counties.
3	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (***lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities)*** • County provides support to sub-counties to monitor adherence at the facility level, but not consistently.
4	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (***lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities)*** • County provides support to sub-counties to monitor adherence at the facility level. • The county jointly with sub-counties has joint plans for conducting adherence monitoring at the health facility level.
Comments:	

Qualitative Questions Standard 6.2.1

3. What mechanisms exist in place for supervision of sub-county health facilities?
    j) Is supervision focused on medical audits or coaching and performance improvement or both? Support supervision is done
    k) How often is supervision conducted? Monthly for the TB, Malaria – quarterly, funding is a driver for most supervisions
    l) How are supervision needs determined? (needs-based or regularly scheduled?) This is needs based and integrated and at the end of year all health facilities have to been supervised.
    m) Who conducts the supervision visits? CHMT and sub county MOH and teams
    n) Is there clarity about levels of supervision (who supervises who) and reporting? Available in the county supervision guidelines
    o) What tools are used to conduct supervision? Programme and integrated checklist and schedules are available.
    p) How is supervision findings used? Immediate correction, report and follow up
    q) Are supervision results linked to any type of reward/recognition/incentives system? Performance based incentive – Aphia Plus supported

r) What are the challenges to conducting supervision? Lack of adequate funding to supervise all facilities.

4. What mechanisms exist for improving quality of care through the health system?
   Trainings on Kenya Quality Management in Health (KQMH) and champions in sub counties are available to monitor this.
   Centres of excellence in the 25 health facilities (2 in every sub county)

   What are the gaps in quality of care in the system?
   i. HR shortage
   ii. Funding
   iii. Logistical support
   -

   What are some of the successes in improving quality of care?

   e) What indicators are used to measure service quality? Reporting, waiting time, average duration of stay, outcomes of certain service, service charters, exit surveys and client satisfaction surveys,
   f) What kind of mechanism exists to assess quality of care regularly and who is in charge to monitor this? From sub county level
   g) Are there QI teams in place at the community, facility and/or sub-county levels? Yes at facility level
   h) How is county supporting QA/QI in the private sector? Yes county does that, through support supervision, DQA , inspection and trainings.

Standard 6.2.2: Number of operational public, private and faith based health facilities as compared to the total that routinely report complete and accurate data	
0	• The county does not have a list of the number of public, private and faith based health facilities.
1	• The county has a list of the number of public, private and faith based health facilities, but there is no system to determine and report which of the facilities by type report complete and accurate data
2	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities, but less than 50% of the total report complete and accurate data
3	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities (at least 75% of operational public, private and faith based health facilities of the total number are operational routinely report monthly) • About 75% of the reporting health facilities report complete and accurate data. (above 80%)
4	• The county has a list of the number of public, private and faith based health facilities

	• The county has a tracking system for all operational public, private and faith based health facilities (at least 80% of operational public, private and faith based health facilities of the total number are operational routinely report monthly) • About 85% of the reporting health facilities report complete and accurate data. • County has a system for quarterly review of complete and accurate data.
Comments: County has no system for quarterly review of complete and accurate data.	

Indicator 6.3: Capacity of County Health Department to deliver health care in identified priority areas (HIV/AIDS, TB/HIV, RMNCH, Nutrition, Water & Sanitation, and Malaria)

Standard 6.3.1: Capacity of County Health Department to implement health programs. ***NOTE: This question can be asked of HIV/AIDS, TB/HIV(need to add Leprosy), RMNCH, Nutrition, Water & Sanitation, and Malaria and sub programs as appropriate (Assessment of CHMT Capacity)***	
0	• Program does not have capacity to identify priority areas for implementation
1	• Program has capacity to identify priority health areas and develop standards for health programs.
2	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs.
3	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs. • The program has capacity to conduct periodic monitoring and evaluation (M&E) of priority health programs.
4	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs. • The program has capacity to conduct periodic monitoring and evaluation (M&E) of priority health programs. • The program has capacity to promote data sharing, communication, and collaboration within individual priority health programs.
Comments:	

Scoring of Standard 6.3.1

e) Scores from each individual program for standard 1.3.1 above:

Program	HIV	TB (leprosy)	Malaria	RMNCH	Nutrition	WASH	NCD		
Score /4	4	4	2	4	4	2	2		

f) Total score from above table (a) = ____22_____

g) Total number of programs included = __7_____

h) Average score (b/c) = ____3_____ Please enter this score for Standard 1.3.1 above.

Qualitative Questions Standard 6.3.1

What is the county's capacity towards delivering Essential Health Services Package (EHSP)?

i. The county is able to deliver at all levels but not a perfect system but at community system this is 100% working; at primary care level – 140 facilities are functioning and 11 sub counties hospitals.
ii. This is aligned to Kenya health policy 2014-2030
iii. The county is able to treat and transfer refer patients with adequate ambulances services coverage.
iv. PPH – 100% CHS coverage; functionality is at 30%
v. Other services are provided optimally

Which services are the strongest? HIV, TB, Malaria and Community health services,
Which services present the most challenges? Mortuary services present most challenge with only 1 pathologist, in addition delays in referrals despite the ambulances, lack of some services like ICU (not working to capacity), renal unit (no specialist), no burns unit, neurology clinic, psychiatric unit without a psychiatrist, no dermatologist (no proper diagnosis) and some surgery specialties. 50% able to deliver at curative, but promotive is high.

Maternal and newborn services

How do you identify targets? Please list some of your targets – ANC visits 94), deliver at health facilities, Accessing FP methods, All neonates and mothers examines after 48 hrs. (post-natal care), Iron and folic acid supplement, IPT, (2016-2017)

Where are you with your targets for maternal and newborn services?

- 58% fully immunized against 90%
- ANC coverage – 60%

Do you anticipate reaching all your targets for the year? No If no, please explain why

What assistance do you need to reach your targets?

i. Lack of proper advocacy communication skills and tools.
ii. Most facilities lack lab reagents and staffing of lab techs.

DHIS Summary

Data	2016	2017
1st ANC	56	18.3
2nd ANC	34	18.3
Skilled delivery	59.6	27.6
Family Planning	42.3	19.6

Child health services

How do you identify targets? Please list some of your targets.

After devolution, this service has not been adequately supported. However there is EPI immunization coverage of 58% , service delivery is less than 10% trained in IMCI and not able to treat Malaria and HIV quite well , Less than 10% of staff are trained on ICCM, there is need to train all community units on ICCM.

Where are you with your targets for child health services?

Do you anticipate reaching all your targets for the year? If no, please explain why

What assistance do you need to reach your targets? Lack of neonatologist and specialized care has led to a high rate of neonatal deaths. Doctors qualify without neonatal care knowledge due to lack of specialists to train them. More assistance is required for:

i. Trainings on community component – ICCM (diarrhea, etc.)
ii. IMCI clinicians training
iii. Triage training
iv. Compliance to first Rx of pneumonia and ORS/Zn compliance
v. Diagnosis for mRDT in the private sector is weak

Family Planning and Reproductive health (FP/RH)

How do you identify targets? Please list some of your targets.

i. All women within reproductive age and within 15 yrs.
ii. FP methods
iii. Contraceptive prevalence rate
iv. After delivery using a FP method (post-natal FP)

Where are you with your targets for reproductive health services?

Do you anticipate reaching all your targets for the year? If no, please explain why

What assistance do you need to reach your targets?

i. Staffing gaps at level 2
ii. Lack of commodities like Oral contraceptives pills
iii. Inadequate ASRH policy implementation
iv. Inadequate Youth friendly services support

-

HIV/AIDS:

How do you identify targets? Please list some of your targets.

County HIV prevalence – 4%

Number of tested = 406,375 (21% of all population – 1.9m) – far from 90-90-90 targets

Where are you with your targets for patients on treatment and mother to child transmission?

Do you anticipate reaching all your targets for the year? If no, please explain why

What assistance do you need to reach your targets?

Heavily reliant on implementing partners a lot to sustain the CCC staff and HIV clinic. HTS is not at 90%; partner supported

HIV stigma is some sub counties like Navakholo sub county,

Malaria:

How do you identify targets? Please list some of your targets.

Kenya Malaria Strategy (KMIS) has documented all this.

Where are you with your targets for ITN use among pregnant women and children under 1 year?

Do you anticipate reaching all your targets for the year? If no, please explain why

What assistance do you need to reach your targets?

Metrics: Illustrative outcomes

Building Block	Illustrative Outcomes	Measurement Method/Annually
Leadership & Governance	i) Equity in the distribution of health services and interventions ii) collaboration with private and other sectors iii) Management systems and functions iv) Partnership and coordination of healthcare delivery v) Governance systems and functions vi) Engaging of public and private services providers vii) Planning and monitoring systems and services viii) Health regulatory framework and services	Post intervention CICAT Documents Reviews Key Informant Interviews
HRH:	i) equitable distribution health workers by cadre a. rural vs. urban distribution ii) ratio of health providers to population served by cadre a. doctors: population b. nurses: population iii) health providers deployment norms and standards in use iv) standardized job grading and salary structure in use	Post intervention CICAT Documents Reviews Key Informant Interviews
Health Information System:	i) Health research and information policies, regulations, and standards in use ii) Accurate, timely and complete public health information generation iii) Functional health information dissemination mechanisms for state and non-state actors iv) Existence of plan for strengthening information systems v) Existence of county health research agenda that supports evidence-based policy making	Post intervention CICAT Documents Reviews Key Informant Interviews
Essential Medicines & Other Health Commodities:	ii) Existence of a framework for establishing strategic county health products and technologies (HPT) reserve a. harmonized county regulatory framework	Post intervention CICAT Documents Reviews Key Informant Interviews

Building Block	Illustrative Outcomes	Measurement Method/Annually
	for health products and technologies exists b. effective and reliable procurement and supply systems	
Health Systems Financing:	vii. Transparency and accountability in resource mobilization, allocation, and use. viii. Cost-effectiveness and cost efficiency of resource allocation and use ix. Sustainable financing system for strategic health commodities x. Health budget utilization/execution rate, a. health budget balance of primary and tertiary health care services, b. health budget balance of recurrent and development activities xi. Private sector participation in financing of healthcare xii. Functional social health protection mechanism (attainment of universal coverage)	Post intervention CICAT Documents Reviews Key Informant Interviews
Essential Health Services:	iv) Effective supervision on implementation of health policies, & adherence to regulations and standards in place v) Mentorship program for improvement of HCWs knowledge, skills, and competencies in place vi) Existence of functional management and oversight teams for every Health Service Delivery System with an approved organizational structure	Post intervention CICAT Documents Reviews Key Informant Interviews

ANNEX 02: COUNTY INSTITUTIONAL CAPACITY ASSESSMENT TOOL

County Institutional Capacity Strengthening Strategy: A Capacity Assessment Tool

Introduction and Instructions

This tool was adapted and harmonized with numerous OCAT tools with an overall goal of facilitating the identification and prioritization of core functional areas that USAID Kenya and East Africa, Health Population and Nutrition aspires to partner with national and county governments; and jointly develop action plans to help achieve increased use of quality county-led health services. The tool is based on the World Health Organization (WHO) Health Systems Framework that focuses on six building blocks of a health system.

Use of the tool is meant to be collaborative in nature. It is first and foremost a self-assessment tool, meaning that members of the assessment team and members of the County Health Management Team (CHMT), other key county health institutions including where possible members of county health committee and selected implementing partners work through each component of the tool together. All participants in the assessment receive the tool ahead of time, to have a sense of what questions will be discussed and to locate any relevant documents that will be useful in answering the questions. During the assessment process, participants from the CHMT, selected partners and the assessment team should read through the response options under each standard (component) together, and through discussion, and validations come to a consensus on the appropriate score to assign for each standard. The goal of the exercise is to develop a shared understanding of the current capacity of the institutions and organizations that CHMT represent in order to analyze gaps and develop a responsive capacity building strategy in the form of action plans.

The tool includes a summary scoring sheet organized by Building Block, with space to record scores for each indicator per Building Block. The summary scoring sheet is followed by a description of the scoring for each indicator and related qualitative questions.

County Institutional Capacity Assessment – Quantitative Summary

Summary Scoring

County Institutional Capacity Quantitative Assessment		Score
Building Block 1: Governance and Leadership		**6/16**
Indicator 1.1: Capacity of County Health Department to lead efforts aimed at improving the health of all residents of the county		
	Standard 1.1.1: Capacity of County Health Department to develop and implement a County Health Strategy	**3/4**
Indicator 1.2: Capacity of County Health Department towards intra and inter agency communication and coordination		
	Standard 1.2.1: Capacity of County Health Department to communicate and coordinate within the County and Sub-County Health Department and other Departments in the county .	**0/4**
	Standard 1.2.2: Capacity of the County Health Department to lead and engage (coordination) with different health actors working towards the same county goals	**3/4**
	Standard 1.2.3: Capacity of County Health Department to hold responsibility and ownership for the health system	**0/4**
Building Block 2: Health Workforce		**7/16**
Indicator 2.1: County Health Department capacity in management of the existing health workforce by putting in place attraction, retention and motivational mechanisms		
	Standard 2.1.1: Ability to recruit and retain human resources for health worker positions, staff health facilities as per staffing guidelines, make working conditions and rural and hard to reach areas more attractive and safe,	**1/4**
Indicator 2.2: Capacity of County Health Department to improve institutional frameworks that support workforce performance development and management		
	Standard 2.2.1: Capacity of County Health Department to institutionalize systems for measuring performance and competence of health workforce; strengthen HRH development systems and practice including continuous professional development, communication, ethics and values systems.	**4/4**
Indicator 2.3: County Health department capacity in the development of an adequate, appropriate and equitably distributed health workforce		
	Standard 2.3.1: Capacity of County Health Department to strengthen HRH planning function covering the entire health system	

		0/4
	Standard 2.3.2: Capacity of County Health Department to encourage and support various institutions to adhere to the established norms and standards for HRH in delivery of KEPH	**0/4**
Building Block 3: Health Information Systems		**10/16**
Indicator 3.1: Capacity of County Health Department to plan for and systematically collect health information		
	Standard 3.1.1: Capacity of County Health Department to develop and implement HMIS policies, strategies, guidelines, and protocols appropriate to the data needs of the county	**2/4**
	Standard 3.1.2: Capacity of County Health Department to collect quality health data	**3/4**
	Standard 3.1.3: Capacity of County Health Department to manage data	**1/4**
Indicator 3.2: Capacity of County Health Department to promote evidence-based decisions and policy making		
	Standard 3.2.1: Capacity of County Health Department to use routine performance, surveys and surveillance data for planning including performance management, rational budgeting and policy making	**4/4**
Building Block 4: Access to Essential Medicines & Other Health Commodities		**10/16**
Indicator 4.1: Capacity of County Health Department to ensure access to essential medicines for the population		
	Standard 4.1.1: Capacity of the County Health Department to provide oversight to commodity management to downstream facilities (ref: - existence of a functional commodity security committee).	**4/4**
	Standard 4.1.2: County Health Department's capacity to estimate commodity needs, develop a supply plan and procure/source these commodities	**3/4**
	Standard 4.1.3: County Health Department's capacity to develop and/or adopt and use a National/County-owned Logistics Management Information System (LMIS)	**2/4**
	Standard 4.1.4: Health facility's capacity to effectively store and account for health commodities through appropriate records and reports.	**1/4**

Building Block 5: Health Systems Financing		**5/16**
Indicator 5.1: Capacity of the County Health Department to ensure that adequate funds are allocated to health expenditures within the overall county budgets		
	Standard 5.1.1: Capacity of the County Health Department to develop evidence-based budget request justifications that ensures adequate funds from the total county government budget are allocated to key areas such as HRH, health commodities and programs.	**2/4**
Indicator 5.2 Capacity of County Health Department to formulate, distribute, and monitor financing for the health sector		
	Standard 5.2.1: Capacity of County Health Department to plan for, create and allocate a sustainable budget	**1/4**
	Standard 5.2.2: Capacity of County Health Department to effectively allocate finances based on county health priority needs	**1/4**
	Standard 5.2.3: Capacity of County Health Department to monitor and ensure accountability for finances at the county and sub-county levels	**1/4**
Building Block 6: Delivering Essential Health Services		**13/20**
Indicator 6.1: Capacity of County Health Department to engage sub-counties in delivering health services		
	Standard 6.1.1: Extent of interaction between the County Health Department and Sub-County Health Administration Offices	**3/4**
	Standard 6.1.2: Capacity of the County Health Department to develop and distribute (to the sub-counties and health facilities) policies, strategic plans, guidelines, protocols and standards for key health service areas	**2/4**
Indicator 6.2: Capacity of County Health Department to ensure appropriate use of policies and standards related to health service delivery for HIV/AIDS, TB/HIV, RMNCH, Nutrition, Water & Sanitation, Malaria program areas		
	Standard 6.2.1: Capacity of County Health Department to supervise sub-counties in the use of health service delivery policies, strategies, guidelines and standards	**2/4**
	Standard 6.2.2: Number of operational public, private and faith based health facilities as compared to the total that routinely report complete and accurate data	**3/4**
Indicator 6.3: Capacity of County Health Department to deliver health care in priority areas		
	Standard 6.3.1: Capacity of County Health Department to develop and implement priority health programs per county health strategy	**3/4**

TOTAL SCORE	35/100

Scoring Guide by Building Block[3]

Block 1: Governance and Leadership

Indicator 1.1: Capacity of County Health Department to lead efforts aimed at improving the health of all county residents

Standard 1.1.1: Capacity of County Health Department to develop and implement a County Health Strategy	
0	• No current county health strategy • aligned with Kenya Health Sector Strategic Plan (KHSSP) 2014 – 2018
1	• The current county health sector strategy is aligned with KHSSP 2014 – 2018. • Adopted by the county health management team/county health department.
2	• The county health strategy adopted; • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area.
3	• The county health strategy adopted • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area. • Evidence of at least one annual work plan/operational/action plan developed for at least 50% of the county health strategy priority areas
4	• The county health strategy adopted • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area.; • Evidence of annual work plan/operational/action plan developed for at least 80% of the county health strategy priority areas; • Monitoring and evaluation framework developed to track progress. • A Governance structure that properly sorts out the roles and responsibilities of key stakeholders in achieving county health strategy goals exists.
Comments:	

[3] The building blocks included in this tool are taken from the World Health Organization's six Building Blocks of a Health System (see http://www.who.int/healthinfo/systems/monitoring/en/index.html for details).

Qualitative Questions Standard 1.1.1

1. What successes and challenges have you experienced in implementing the county health strategic plan? To begin with, programs and projects are mostly guided by the annual work plans; we also have a committed workforce that keeps planning even though there is a general weakness in implementation of the work plan. We also have personnel with technical capacity to plan;

   There are financial challenges when it comes to implementing work plans; e.g. almost all key interventions are funded by partners and to come up with strategic plans, etc, we have to resort to donors for funding. There is also the inability to absorb budgetary allocations because funds come so late in the day to fund planned activities.

   [Funds supposed to come from the county treasury to the health department but the funds are micromanaged at treasury; budget estimates not funded and approved budget is further informally cut at the treasury. The little that is allocated is not fully utilized because the channels of flow from the treasury are not clear; money does not come on time, does not meet the budgetary requirements; funds for one programme used for another, e.g. donor funds for HIV used to pay salaries because county funds delayed
2. What is the role of partners in developing the plan and contributing to its achievement? Partners have played critical roles in increasing CHVs networks to realize the plan, improving data analytics and ICT infrastructure, HIV care and treatment, HR development, MNCH (renovation of facilities), equipment, et.
3. What additional capacity would strengthen implementation across the county (capacity in individual knowledge, skills, behaviors and attitudes as well as the structures, policies, systems and procedures of the organization and system as a whole)? Strengthening community health services to reduce burden of disease, capacity building for sub-county programme leaders and facilities managers to develop annual work plans; lack of policies to guide leadership- there is need for a county health policy and other thematic area policies; need for advocacy skills to change the attitude that health sector already has a lot of money from donors

Indicator 1.2: Capacity of County Health Department towards intra and inter agency communication

Standard 1.2.1: Capacity to communicate effectively within the County and Sub-County Health Department and other Departments within the County	
0	• No evidence of communication plan and protocols for information flow within the county and sub-county and to other departments within the county.
1	• There is a communication plan, and protocols are clearly established to guide the plan.
2	• There is a communication plan, and protocols are clearly established to guide the plan. • At least 50% of CHMT are aware of the internal communication plan and protocols but no evidence of use of the plan and protocols
3	• There is a communication plan, and protocols are clearly established to guide the plan. • More than 50% of CHMT are aware of the internal communication plan and protocols but no evidence of use of the plan and protocols .

4	• There is a communication plan, and protocols are clearly established to guide the plan. • More than 50% of key county staff are aware of the internal communication plan and protocols AND evidence exists of use the plan and protocols more than once a year.
Comments:	

Qualitative Questions Standard 1.2.1

1. Briefly describe the communication strategy of the county. What mechanisms/tools exist for communication within each department? Between departments? With County Assembly Health Committees? The county has no communication strategy; communication between departments is not guided by any written protocols but seems more a top-down strategy where senior managers issue instructions to be followed. An organizational culture seems to guide communication; engagement of assembly committee: through CEC member for health; Unstructured way of communication; informal channels including *Whatsapp*; email; physical correspondence letters; regular meetings; ad hoc committees e.g. for advocacy; Monday morning google briefs in calendars; sub-counties briefed through official email for weekly briefs from the director; memos
   g) What mechanisms/tools exist for communication between county and health development partners and/or implementing partners? MOUs; TWGs; mandatory introductory meetings with new partners
   h) What are some of the successes/evidence of effectiveness and challenges with the strategy and mechanisms/tools? Gatekeeping for structured communication, e.g. who attends meetings and who doesn't; effective documentation for partners; mass communication e.g. reminders, raising alerts; updates real time for what is happening between counties/// letters are slow; communication strategy slows down bureaucracy, e.g. deciding on who to channel request; long term calendar planning helps
6. Briefly describe the policies and procedures in place to promote collaboration between County Health Department and implementing partners and/or health development partners?
   e) What mechanisms/tools exist for the coordination of health development partners and other stakeholders? Priority setting of activities which donors adhere to; joint quarterly work plan; M&E coordinator for govt & partner activities; M&E TWG has calendar of activities so identify which to do per quarter; activities are supported by different partners; partnership for resilience & econ growth (PREG) for all USAID funded partners to coordinate provision of certain services, i.e. linkages between projects/programs; regular CHMT meetings to decide projects to support; TOR on details of TWG operations;
   f) Do we have any form of agreements between county and health development partners and/or implementing partners that support delivery of health services? Integrated work plans; e.g. partners must share work plans with health dept; MOUs
7. Is there a policy to guide collaborations? Please describe.

Standard 1.2.2: Capacity of the County Health Department to lead and engage (coordination) with different actors working towards the same goal

0	• No evidence of coordination framework that maps out different stakeholders working in the health sector.
1	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Occasional meetings are held between the county and different health actors, but these are irregular, and do not involve all of them. Implementing partners and other key stakeholders have no opportunity to present and review health priorities and their contributions towards health goals.
2	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals.
3	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals. • The county health leadership receives regular performance updates in the form of reports from at least 50% - 75% of different health actors working in the county.
4	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals. • County health leadership receives regular performance updates in the form of reports from all different health actors. • All different health actors are fully involved in annual sector performance reviews, county health annual work plan development and in policy development affecting the county population and health services (Partnership Code of Conduct exists).
Comments:	

Qualitative Questions Standard 1.2.2.

1. What mechanisms are in place to promote regular dialogue between County Health Department leadership and the different health actors such as health development partners, implementing partners, MCAs, religious/community leaders, private sector and sub-county health administrators? Mechanisms for dialogue: quarterly performance reviews; engagement for prioritizations; accountability on expenditure over e.g. 5 years for planning; development partners meet quarterly with top level managers, e.g. CEC, CO

2. How are different health actors engaged in county health sector performance reviews, county health budget formulations, and policy development, programs review and/or/evaluation?
3. What are the strategies for building leadership capacity of health care managers and practitioners at the county and sub-county level?

Standard 1.2.3: Capacity of County Health Department to hold responsibility and ownership for the health care system at community level (Accountability)	
0	• The county primary health care system at community level is over 50% funded by health implementing partners, with gaps existing where implementing partners are not implementing services.
1	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners
2	• The county primary health care system at community level is over 50% funded by county government, with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) below 50%, with significant input from development partners for health and implementing partners.
3	• The county primary health care system at community level is over 50% funded by county government, with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) over 50%, with significant input from development partners for health and implementing partners. • Functionality of community units is at 50% per the reporting rates (MOH515)
4	• The county primary health care system at community level is over 50% funded by county government, with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) over 50%, with significant input from development partners for health and implementing partners. • Functionality of community units is over 50% per the reporting rates (MOH515) • Annual accountability platform for reviewing committed funding against results achieved at community level in place.
Comments:	

Qualitative Questions Standard 1.2.3

3. What are the strategies to build the leadership capacity of healthcare managers and practitioners at the county and sub-county levels?

Sub-county capacity building is poor; Palladium Huge capacity gaps; capacity building is minimal

Building Block 2: Health Workforce

Indicator 2.1: County Health Department capacity in management of the existing health workforce by putting in place attraction, retention and motivational mechanisms

Standard 2.1.1: Ability to attract, recruit and retain human resources for health worker positions	
0	• Job descriptions do not exist,
1	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure)
2	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place.
3	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place. • Incentives for staff retention are in place but not effectively.
4	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place. • Incentives for staff retention are in place but not effectively. • Working conditions attractive and safe, financial and non-financial incentives for rural and hard to reach places are made more attractive and HRH wellness and welfare improved
Comments: There is an harmonized pay structure with itemized pay slip Under Staff attraction, the promotion aspects is only done for selected cadres like nurses and doctors. The Human Resource Advisory Committee guides this moving forward	

Qualitative Questions Standard 2.1.1

3. Briefly describe County Health Department's strategy for health work force attraction, recruitment and retention at all levels? Staff projections up to 5 years; HR policy of national government not implemented; no promotions for all others except doctors, nurses & COs. No concrete strategy to attract, recruit and retain.
   The job description have been developed and validated by the county with support from HRH Kenya under USAID mechanism and remains the process of approval and printing of the JD's.

A similar county assessment was done in July 2017 supported by HRH Kenya and focused on the three core functions of HRH i.e. Human Resource Management (HRM), Human Resource Development (HRD) and use of data including aspects of e-learning. The key areas assessed included and the HRH Kenya report will be annexed in the main report

i. HRH maturation-HRM & D capacity, HRM strategy, policy and practice, performance management, HRM data, staff training & development and gender mainstreaming in HRM. For each indicator, the counties were classified as being at either starting, developing, consolidating or sustaining stage-a 1-4 hierarchy score from lowest to highest.
ii. iHRIS data demand and use-were technical aspects of HRH data and analytics, individual aspects of HRH data and analytics, organizational aspects of HRH data and analytics and the iHRIS sustainability index. For the sustainability index, the counties were also classified as being at either starting, developing, consolidating or sustaining stage.
iii. Institutionalization of in-service training for health workers-HRD coordination, training needs assessment, budgeting, implementing and managing trainings.

An HRH maturation index provided by HRH Kenya provided for this counties and also other couties

d) Do you have an operation plan to attract and recruit new workforce? Please describe. No operation plan; recruitment depends on urgent need…recruitment is haphazard; staff attrition not being addressed; too much red-tape in recruitment; recruitment based on extreme cases, e.g. radiographers. Frozen employment for all cadres except radiology. People go 10 – 15 years without promotion; no promotions- budget for promotions are not disbursed. …HRH requirements are documented by the commitment to recruit is not in place. Promotions driven by industrial action.
e) Has the county reached any agreements/ contracts with pre-service institutions to train and recruit new workforce? Please describe. Agreement at one point with KMTC to have 50% of students from Migori County to fill personnel gaps. Agreement later reneged.
f) Has county conducted periodic assessments of workforce needs and priorities? Please describe. Yes, first in 2013/14 to guide development of strategic plan. All cadre needs were assessed. Capacity assessment needs conducted by the national government; report not yet implemented. Budget estimates for recruitment never respected. Workers are highly demotivated
A work load indicator staff needs survey will commence in the next quarter to assess the staff gaps, norms and standards within the county supported by HRH Kenya.

Standard 2.1.2: Capacity of County Health Department to staff health facilities as per Staffing Norms, Standards and Guidelines	
0	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards, and development of the health work force for staffing of each level of the health system do not exist.
I	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists.

2	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists. • A iHRIS has been developed to track staffing levels and needs,
3	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists. • A system has been developed to track staffing levels and needs, • iHRIS monthly updated (upon exit and recruitment).
4	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists. • A system has been developed to track staffing levels and needs, • iHRIS monthly updated (upon exit and recruitment). • Staffing data on needs by staffing cadre is being used to advocate for resources to meet staffing gaps.

Comments:

There is a WHO study - workload information staff survey to asses staffing norms and standards will be done by HRH Kenya undertake in Migori and Nakuru counties and then develop the staffing norms and standards

2014 norms and standards cannot be attained/unrealistic and revision of the documentel at MOH lev will be guided by the workload survey.

Formed county TWG for IHRIS and meeting every month/changes in the sub county and address attrition issues (minutes can be made available) updated on weekly basis the iHRIS system.

Staff establishment available at the county level included within CIDP/annual work plans/budgets projects and documents number of staff forms basis of recruitment.

Qualitative Questions Standard 2.1.2

5. Briefly describe the County Health Department's strategy to mobilize and distribute health workforce based on each sub-county's and health facilities' needs. Depends on requests from sub-county heads; send staff on disciplinary grounds; transfers on political affiliations; no enough staff so distribution is skewed; distribution does not account for density
   a) How are the needs assessed? Never been done
   b) Who is involved in the needs assessment? No one
   c) How often is a workforce needs assessment conducted? Never been conducted
6. Briefly describe the County Health Department's health work force planning.
   a) How has the county adopted staffing based on norms, standards and guidelines? Norms are not followed. If partner staff could be withdrawn Migori health system would collapse
   b) What strategies are being used in the mobilization of resources to meet staffing gaps? Budget estimates for staffing never respected

c) How does the country measure on regular basis the staffing gaps at all levels of health care delivery? Never assessed; e.g. county suddenly realized had no radiographers. These are gaps that can be identified during support supervision; HR is not included in the supervision

Indicator 2.2: Capacity of County Health Department to strengthen performance management and supervision of the existing health workforce

Standard 2.2.1: Capacity of County Health Department to conduct staff performance appraisals	
0	• There are no policies or guidelines at the county on staff performance appraisals at all levels of health care management and delivery.
1	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists.
2	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted.
3	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted as scheduled in the guidelines. • Supervisor performance monitoring is ad hoc.
4	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted as scheduled in the guidelines. • Supervisor performance monitoring is ad hoc. • System exists for rewards and sanctions based on performance.
Comments:	

Qualitative Questions Standard2.2.1

7. Briefly describe mechanisms in place to review staff competencies and performance. Only done for staff for development partners; i.e. no personal appraisal
   University of Maryland supported county staff is done, however the county has customized the national performance appraisal at all levels but is yet to implement and disseminate to lower levels (need to provide the evidence)
   a) What is the course of action after a performance review? No reviews
   b) Do you have any strategies for continuous performance improvement? Please explain. None
8. Briefly describe the mechanisms in place to promote accountability and transparency in the workforce. Code of regulations (COR); leadership and governance under chapter 6 of the

constitution; public officers' ethics act; problem is dissemination; however, new staff are being sensitized. Systems of enforcement do not exist

a) Are there clear guidelines in the job descriptions about staff roles and responsibilities? Please describe one or more? No job descriptions approved but the draft JD's have been developed and validated.
b) How often are these guidelines reviewed and implemented? No reviews, very weak implementation

9. What mechanisms are in place to address workforce absenteeism and poor productivity? Duty rosters, support supervision===in some places; existing mechanisms need to be strengthened

Standard 2.2.2: Capacity of County Health Department to coordinate capacity development of Human Resources for Health	
0	• No system for coordinating in-service training for HRH exists, (HRH trainings are completely ad hoc).
1	• System for coordinating in-service training for HRH exists, no adhered to.
2	• System for coordinating in-service training for HRH exists, • The county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments not coordinated by the county,
3	• System for coordinating in-service training for HRH exists, • The county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments conducted and coordinated by the county. • Training schedules are not fully coordinated/ communicated to all relevant stakeholders.
4	• System for coordinating in-service training for HRH exists, county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments conducted and coordinated by the county. • Training schedules are fully coordinated/ communicated to all relevant stakeholders. • Assessments of the impact of trainings to improved service delivery is conducted annually and feedback used during performance appraisals.
Comments: Sensitization of HRH TNA by HRH Kenya has been done but TNA is being planned. HRH Kenya or FUNZO Kenya did a TNA in 2012 before devolution and focused on MOH and districts (report is attached for reference IHRIS in two parts i.e. TRAIN and Management and the level of maturation for Migori is being strengthened with ongoing support.	

An IHRIS TWG exists and capacity being built with an IHRIS focal person nominated. Support available for the next four years by HRH Kenya on this

IHRIS train component is included but not updated/adhered to the training needs as the use is not optimal

They are gaps in awareness and dissemination issues for HRH aspects

There is a Lake basin HRH TWG/ICC cluster which focuses on technical exchange of information through the CLA – Kisumu and Nyamira etc..

The county health department has recently deployed an HRH officer and established an HRAC (advisory committee) at the County Health Department to assist with linkages with sub counties and coordination

Qualitative Questions Standard 2.2.2

15. Describe any agreements made with institutions of higher learning to provide in-service training for staff? Discussions on internship with two universities (UON & Rongo); MOU with UON to cooperate on health information research and clinical capacity building; Maseno Uni trains staff on HIV care; collaboration based on mutual interests [these are planned]; training senior managers by KSG
    a) How are training needs identified? No structured capacity needs assessment
    b) How are curricula developed and approved? No curriculum development
    c) How often is a training needs assessment conducted? Not done
    d) Is there a formal mechanism to engage institutions of higher learning to provide training? No agreements signed yet
    e) What institutions have been engaged so far? Plan to engage UON, Rongo, Maseno universities; KMTC (HACKATHON);
16. What types of trainings have been provided by the county in the past year? EXCLUDING vertical programs and implementing partners. Senior management course; minute writing
    a) Who were trained? Senior managers at county hqs; secretary
    b) Who determines the staff to be trained? Self-determined
    c) How were the training needs identified? N/A
    d) Who initiated/ requested the training? Trainee
    e) Who conducted the training? KSG
    f) How was the training funded? County government
17. Please describe the county health department's policy to strengthen existing workforce through vertical programs.
    a) Is there an operational plan for in-service training? No
    b) How are in-service training needs identified? Self-driven mainly for promotion; individuas make applications which are assessed at department and county level
    c) How often are in-service trainings delivered? No pattern; ad hoc
    d) Is there an operation plan to retain existing workforce? No
    e) Do county health staff that complete requisite in-service trainings get incentives? No
18. Does the county health department have a centralized Training Unit to address training needs for the county health staff? Yes, at department and county level. How is training currently coordinated and documented? Applications are received by training committee who gives course approval and allowed to proceed; rarely is funding available
    a) How are training needs and training programs or opportunities matched? Not always because there is no training coordination; unless it is doctors going for special courses. Lack of coordination= no financial investment

b) What records are kept on in-service training for individual health workers? Records are kept but not all; e.g. for partners not kept
c) What do you think are the major pre-service training problems facing the county? No plans for pre-service training; unemployment; skills not matched with training;
d) What do you think are the major in-service training problems facing the county? No incentives for those trained; lack of coordination; opportunities not matched skill needs
e) What kind of assistance does the county need to coordinate and document training? CHMT and sub-county HMT capacity building; empower HR; develop HR strategic plan; conduct training needs analysis; support for conducting staff appraisal, qualified HR recruitment; train health admin officers on HR roles; iHRIS strengthened; need for internet connectivity

19. What is the capacity of county health department towards granting accreditation to pre-service training facilities? Not CHD role
    a) What is the role of the national government in accreditation of pre-service training facilities? Bodies in national government through education policies and stds
    b) How often is accreditation conducted? Cannot say
    c) Are accreditation standards comprehensive and up to date? Not sure
    d) Who conducts accreditation? How is this team formed? Done at national level
    e) What kind of assistance does the county need towards implementing accreditation?
20. What are three priority performance areas most in need of strengthening within the county health department that relate to HRH? (1)HR strategic plan; HR needs assessment; HR support supervision; TNA; (2) performance appraisals; (3) staff promotions mechanisms
21. What are the successes and major challenges for strengthening health workforce? (ask for each vertical program (HIV/AIDS, TB/HIV, RMCH, Malaria, Nutrition) and the county as a whole)?

HIV/AIDS: performance monitoring, AWP, support supervision; implementation of planned activities; strategic plans for all vertical programs; strengthened HRH (supported by many partners); new infection rates up in some areas, Integration of services

=few are trained on HIV (Newly employed staff have not been trained); e.g. clinicians not competent to handle CCC (comprehensive care centres e.g. EID Website); capacity to reach 90/90/90; targets, lack of funds to conduct training follow ups

TB services: robust real time system in tracking patient; new diagnostic tests (gene expert: turnaround time is 2 days; able to pick resistance patterns/// challenge: data in Tibu system does not communicate with DHIS (interoperability); low case search (capacity to suspect TB); lose to follow up

RMCH: results are negative progression (Apga Score) increased skilled birth attendant big gap still remains; high MMR; FP below 45%; child mortality still high; teenage pregnancies up (access to condoms, lack of empowerment for young poor girls=men older – tend not to use condoms); young girls taken back to school; access to FP and HIV testing and connected to the system for management

Malaria: reduction malaria rates; inferred reduced mortality rates; no outbreaks for a long time now (5 years)

Nutrition: facilities not equipped to handle all nutrition services; inadequate skilled nutrition staff; Knowledge gap among health care providers and leadership on nutrition intervention; Inadequate avenues for task shifting ; low funding for nutrition: high malnutrition burden among children below five years and adults with chronic illness; inadequate and poor quality in patient nutrition services ; Knowledge gap and low demand for nutrition services among population; Inadequate partnership and

inter sectoral prioritization for nutrition; no county specific food and nutrition policy; weak nutrition monitoring and evaluation and research system; inadequate policy and guide line dissemination to health facilities; inadequate nutrition equipment maintenance.

General: Challenges: inadequate funding for support superviosn, ICT infrastructure to HRH (need for data); inadequate capacity to manage HRH

Building Block 3: Health Information Systems

Indicator 3.1: Capacity of Health Department to plan for and systematically collect health information

Adapted from the WHO's *Monitoring the Building Blocks of Health Systems,* key components of a HIS include: routine health information, vital statistics, disease surveillance and health surveys

Standard 3.1.1: Capacity of County Health Department to implement HIS policies, strategies, guidelines, protocols and use routine HIS forms	
0	• The county does not have national health information system policy and strategy.
1	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are not readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms.
2	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms • Sub-counties, facilities and community units do not have adequate supply
3	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms • Sub-counties, facilities and community units have adequate supply • Mentorship program on correct use of HIS forms institutionalized in less than 75%of sub-counties and/or facilities.
4	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are readily available:

	o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms • Sub-counties, facilities and community units have adequate supply • Mentorship program on correct use of HIS forms institutionalized in at least 75% of sub-counties and/or facilities.
Comments: DHIS2 has a repository for all the reports and data collection tools	

5. Does the county have an integrated Health Information System that includes indicators, data elements and sources, frequency of collection, data flow, data validation rules and quality assessment guidance/protocol?
   Yes, this is available on DHIS2 (both in soft and hard versions since depends on both as from facility it is paper based and from sub county is now electronic) and also on manual basis, at sub county level the DHIS 2 is used to gather data from health facilities however for instance some indicators are not present in DHIS like TB using TIBU, neglected diseases indicators though there is a plan for integration with DHIS with this other health information systems.
   The DHIS is a national system and probably some county health information systems needs to be developed to capture other indicators not in DHIS.
   DHIS selected indicators are important, implementing partners use DATIM (software) for monitoring the key indicators.
   DHIS has a repository for including data tools and resource centre.
   NB: The National Health information systems is not devolved to counties though county expressed interest in developing a county health information system for monitoring other indicators.
6. How has this system been rolled out to sub-counties and facilities?
   DHIS is upto sub county level and big hospitals (level 4 and above) where their officer who has knowledge on DHIS and is not restricted to any facility. All the sub county HRIO use the DHIS and key in information from facilities and most programme officers have been trained on DHIS.
   Sub county HRIO's key data from community level.

7. Does the county have a system for monitoring and evaluation of county programs that details priority health impact and outcome level indicators at a minimum that presents plans on how data will be collected for monitoring, evaluating, disseminating and using analyzed data, that clearly spells out roles and responsibilities, capacity building and county stakeholders' data review forums?
   The county has an M&E plan which tracks baselines values, indicators, frequency, responsibility (to be shared) and DHIS is used to track and monitor. The DHIS system indicates responsibility, conducting analysis and user rights.

8. How has this plan been rolled out to sub-counties and facilities?

The M&E plan has not been rolled out to sub county teams however during technical working group meetings they are involved. There exists a gap here in terms of usage of DHIS at sub counties and health facilities.

Standard 3.1.2: Capacity of County Health Department to collect quality health data	
0	• There are no county-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) in place.
1	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data are not routinely collected using standard data collection forms.
2	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data routinely collected using standard data collection forms. • County department of health receives timely and complete reports from less than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization)
3	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data routinely collected using standard data collection forms. • County department of health receives timely and complete reports from more than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization) • County department of health receives accurate reports from less than 75% of health facilities (public, private and faith based)
4	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist; data are routinely collected using standard data collection forms. • County department of health receives timely and complete reports from less than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization) • County department of health receives accurate reports from more than 75% of health facilities (public, private and faith based) • Health performance data reviewed regularly and regular feedback provided to all health facilities on data accuracy.
Comments:	

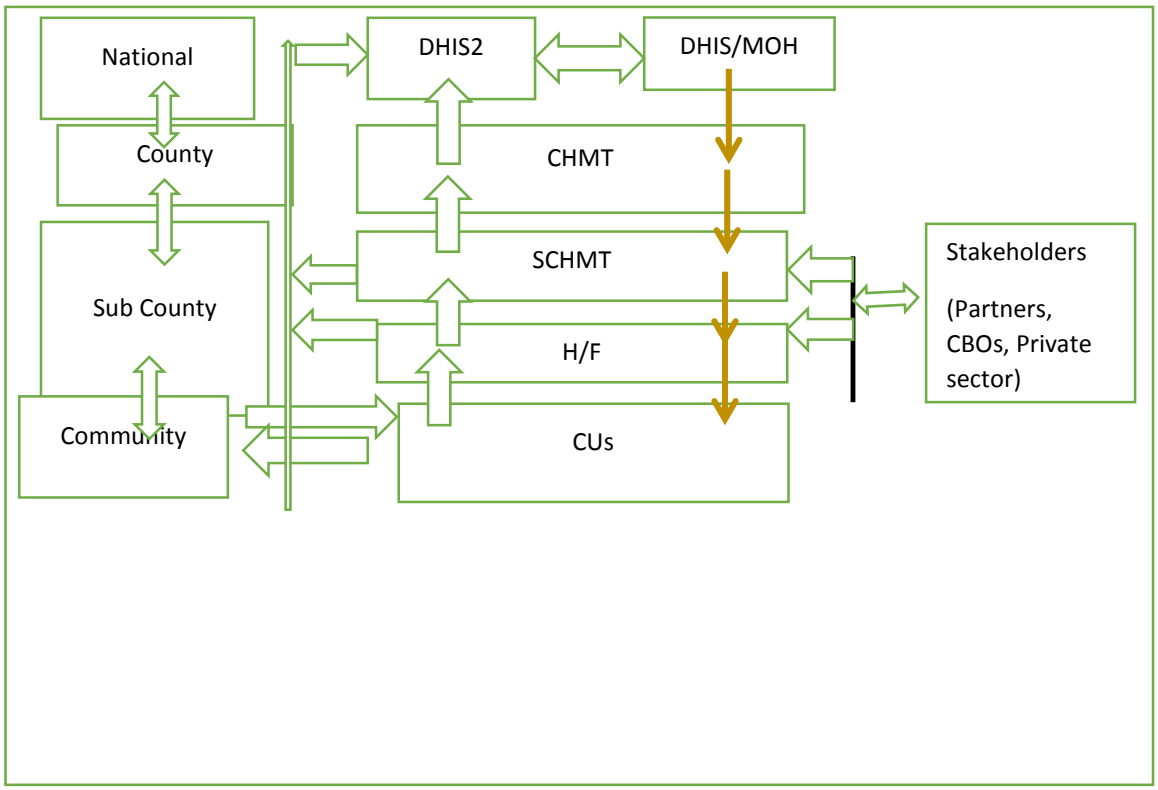
Qualitative Questions Standard 3.1.2

5. Who has the primary responsibility for collecting data for routine health information, vital statistics, disease surveillance and health surveys systems?
   The health service providers, record officers, data clerks, and community health volunteers, CHA and sub county HRIO's have responsibility for data collection in various information gathering systems.

6. Who has the primary responsibility for submitting/entering data and validating it from these data systems?
   The sub county and big health facility HRIO's and submissions. The health care provider submits this .

Information Flow Chart

Figure 3



7. To what extent has the county health department institutionalized Ministry of Health's National Data Quality Protocol and Standards?
   The county is not aware of the MOH's National Data Quality Protocol and Standards, but CHRIO noted basic elements/requirements for data quality i.e. timeliness (by 5th the reports should have come to sub county and by 15th every month should be entered in DHIS). The county needs to institutionalize the data quality protocols and standards.
8. What is the process for data quality assessment and how often is it conducted by county health department? By Sub-county health administrators' offices?
   Data quality assessment is done quarterly at the county level and a tool exists (excel based), what happens is reviewing of reporting tools and DHIS. This DQA process is irregular and more focused on programme data. No DQA's are done at sub county level from the county integrated but programme based

Standard 3.1.3: Capacity of Health Department to manage data	
0	• No one single county-wide preferred electronic or paper based exists.
1	• Separate information management systems (paper or electronic) exist for the various components of the HIS. • It's difficult or impossible to manipulate or extract data from the system.
2	• One Single County preferred Electronic Health Information Systems platforms (databases) exist for the various components of HIS • Data are not routinely extracted for reports and other use.
3	• One Single County preferred Electronic Health Information System platforms (databases) exist at the county for the various components of the HIS, • Data are routinely extracted (at least annually) for use. • Integration of information from other health management systems (i.e., service statistics, financial, human resource, logistics information, and physical assets data systems) not yet fully operational.
4	• One Single County preferred Electronic Health Information System platforms (databases) exist at the county for the various components of the HIS, • Data are routinely extracted (at least annually) for use. • Integration of information from other health management systems (i.e., service statistics, financial, human resource, logistics information, and physical assets data systems) is evident. • County Data Management Guidelines exist including policy on health/research data sharing policy.
Comments: DHIS has a repository Other health information - systems Kenya EMR, TIBU, Icare,	

Qualitative Question Standard 3.1.3: Where is health data stored at the county and sub-county levels?

At the county level data is stored at the DHIS2, and they don't receive manual records and can be received from DHIS. At sub county they have both DHIS and manual data.

DHIS has a resource centre module where the survey data, annual plans has not been updated and stored and the county needs to explore this functionality.

Sub county HRIO's and programme data is available on DHIS2. County might have a gap on space for keying other data for indicators.

Indicator 3.2: Capacity of County Health Department to promote evidence-based decisions and policy making

Qualitative Questions Standard 3.2.1

6. How often is routine data analysis presented to senior managers for discussion, field monitoring/supportive supervision, problem solving and decisions? This is done at quarterly level and is irregular.
   How often is performance information presented to County Health Department leadership for discussion, problem solving and decision making? Provide examples of how reviewed performance data have been used to identify opportunities to improve services.
   This is done quarterly but not regular examples include the score card and monitoring the immunization rates, etc.

Standard 3.2.1: Capacity of County Health Department to use collected data for planning and policy making	
0	• No evidence of data use for strategic planning including rational budgeting and decision making.
1	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county health committee and other state and non-state actors. • No evidence of data use for strategic planning including rational budgeting and decision making.
2	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings.
3	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county assembly health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings. • The county can identify at least two examples of how data have been integrated into a decision-making process including rational budgeting in the past year.
4	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county assembly health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings. • The county can identify at least two examples of how data have been integrated into a decision-making process including rational budgeting in the past year. • Policy and planning framework (that details national development goals, national health sector priority goals, county health priority goals, county budgetary and donor allocations, and county health development outcomes) exists.
Comments:	

7. How often is data used in reviewing/evaluating the success and/or failure of county health programs and strategies?
   Example is the score card is utilized in the county health department.
8. How often is data used in the formulation of policy and/or incremental re-adaptation of existing programs and strategies?
   Yes, during the strategic plan, M&E framework and data is used to inform the work plans. This is done when need arises
   Examples include:

i. The county noticed the adolescent/teenage pregnancies are on the rise in the county and the county is currently developing adolescent plans to address this issues.
ii. The county health department has meetings with the county assembly members on the Migori county health bill (heath care financing key issues)
iii. Nutrition programme used evidence data for advocacy to meet with county assembly members

The county requires skills on making policy briefs to boost the advocacy and getting evidence into policy and practice for senior managers at the county.

Building Block 4: Access to Essential Medicines & Other Health Commodities

Indicator 4.1: Capacity of County Health Department to ensure access to essential medicines for the population

Standard 4.1.1: Capacity of the County Health Department to provide oversight to commodity management to downstream levels of service delivery	
0	• The county does not have an organized unit (of more than three persons) to oversee and coordinate commodity security in the entire county.
1	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership.
2	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate.
3	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate. • The County Commodity Security Committee structure has been adopted, operationalized and implemented at the sub-county level for all the sub-counties in the county.
4	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate. • The County Commodity Security Committee structure has been adopted, operationalized and implemented at the sub-county level for all the sub-counties in the county. • Supply chain performance statistics are maintained at county, sub-county and facility levels and reflect improving trends overtime.
Comments:	

Qualitative Questions Standard 4.1.1

5. Describe the procedures for implementing and supervising supply chain services in the county?

The procedures include:

i. Quantification where job aids are available
ii. Dispensing includes job aids and issuing drugs procedures
iii. Storage and expiries procedures available
iv. Supervision with a targeted supply chain supervision check list

a) Describe the way through which the county ensures availability and use of required guidelines, protocols and tools for product selection, quantification, commodity reporting, use, support supervision and M&E at all levels of service delivery in the county?

During the last five year period, the county has received support from partners for printing and distribute the commodity guidelines however dissemination is still an issue.

b) Briefly describe how supply chain data is used to help decision making at county/sub-county and facility level; and how the county ensures that systems for collecting data from lower levels and feedback loop from higher levels is in existence, adequate and continuously being improved.

Currently supply chain data for decision making this is done only for the programme commodities i.e. Malaria – DHIS used for quantification based on consumption data, ART, TB , Family planning– national level how to resupply based on monthly reports.
For the Other commodities i.e. essential medicines and supplies there is a weak system for quantification, no consumption data available but bin cards are available though no monthly system)
There are No LMIS tools or system and gap for bed nets in county and fully managed by PSKenya

c) How does the process of supportive supervision for service delivery incorporate supervision for supply chain service/commodity management at health facility level?

The integrated supervision checklist and programme based supply chain contains a commodity management section. Redistribution of commodities happens during the support supervision

6. Describe the procedures for monitoring and reporting supply chain performance at all levels in the county?

Monitoring is done through commodity review meetings (monthly)– reporting, stock outs for programme commodities especially Aphia Ugavi – Commodity support plus use at pharmacy and other service areas is monitored.

a) In which specific ways does the county take a whole-market approach in strengthening commodity management systems for the county? (ie inclusion of non-government health sub-sector (e.g. faith-based)that offer services within the county)

Both programme commodities and others – have incorporated FBO's and some private (hard to reach areas) and they report at DHIS and involved in supervision

b) How does the county ensure trend graphs on key supply chain performance indicators are maintained as a measure of quality of supply chain services

rendered in the county? e.g. stock-out rates, stocking according to plan, reporting rates, and commodity disposal due to expiration.

This is done through regular TWG meetings (monthly) and data is discussed and each sub county projects the data and with a monitoring dash board developed by Malaria programme and FP programme– has quality indicators. For the other commodities the county procures currently there exists no capacity for checking supply chain indicators.

The county pharmacist has been developing a system for tracking commodities out of own initiative – tracer list , though there is no support for printing and dissemination of the tool.

c) How is equity ensured in commodity distribution and dispensing? In other words, what procedures are used to make sure that essential medicines and health commodities are distributed/ issued out according to need?

When planning for procurement the county uses drawing rights, based on work load and allocation of amount but there exists challenges and happens when ordering from KEMSA. When procuring from KEMSA for facilities it is needs based but central procurement buying at county level is not.

d) How does the county ensure improved access to quality and affordable essential medicines and other health commodities? (Consider systems for commodity quantification and supply planning, inventory management tools, commodity information management, commodity financing and procurement, and financing for continuous improvement of supply chain systems)

For Quality assurance the county only procures from suppliers licensed by Pharmacy and Poisons Board (PPB) and procurement through KEMSA as they have quality laboratory.

The county received some quality lab equipment to do basic quality checks of commodities i.e. Minilab equipment placed at Isebania however the person who understood usage of equipment left and there is no personnel to assist.
Other quality assurance mechanisms are an Inspection and acceptance committee, pharmacovigilance system but more for programmatic medicines – ART, TB and malaria programs.

Other System are:

- Bin cards available (70-75% are adequate for commodity inventory management
- LMIS – nutrition, HIV, malaria
- Other commodities no LMIS

Standard 4.1.2: County Health Department's capacity to estimate commodity needs, develop a supply plan and procure/source these commodities (Forecasting, Quantification and Procurement)	
0	• No capacity (external or internal to the county) available to conduct a forecasting and quantification exercise (estimate commodity needs, develop a supply plan, and procure essential commodities).
1	• The county is reliant on external technical assistance to estimate commodity needs, and develop a supply plan, no mechanism exists to fully procure or source (i.e. buy or secure donations of) essential commodities.

2	• The county is reliant on external technical assistance to estimate commodity needs, and develop a supply plan, • County partially has capability to fully procure or source (i.e. buy or secure donations of) essential commodities.
3	• The county has capacity to estimate commodity needs, and develop a supply plan, • County partially has capability to fully procure or source (i.e. buy or secure donations of) essential commodities, • County requires minimal external technical assistance to estimate commodity needs.
4	• The county has capacity to estimate commodity needs, and develop a supply plan, • County has capacity to fully procure or source (i.e. buy or secure donations of) essential commodities, • County requires no external technical assistance to estimate commodity needs, • Health commodity procurement done at least once annually.
Comments:	

Qualitative Questions Standard 4.1.2

7. How are commodity needs identified?
    i. Facilities request based on their gaps and sub county and county level aggregates the commodity requests.
    ii. Annual quantification was being done supported by a partner i.e. MSH though the project completed and the county has not been able to do it.

    a) How are the county, sub-county and health facility needs identified?

    b) What role does National Government agencies/institutions play in assessing county commodity needs?

The national government role is provision of programme commodities i.e. HIV tests kits,TB malaria, family planning and training for commodity management and DHIS training.

    c) What happens after commodity needs are identified? How are requests made?

The health facility prepares an order through a standard ordering form, at sub county level, the pharmacist aggregates orders using the KEMSA LMIS system with an excel sheet and county level aggregates with 8 sub counties and do a county order and a local purchase order for requisition and proforma invoice – three times a year

Bednets programme from PSKenya – facilities place order to sub county malaria programme on quarterly basis on two weeks but not through the county pharmacist

8. What is the role of development partners for health and/or implementing partners in procuring essential medicines? They are key in provision of essential medicines and examples include:
    i. Nutrition international procured nutritional and MNCH commodities
    ii. AMREF and Kenya Red cross provided chlorhexidine, ZINC COPAC
    iii. During cholera outbreak – UNICEF provides assistance

9. What is the proportion of county spending on commodities as % of total county health spending?

- Ksh 252m out of Ksh 1.8m (county health budget) – allocation budget - check percentage
- Expenditure data for commodities challenge to get for Migori county.

Standard 4.1.3: County Health Department's Capacity to Develop and/or adopt and Use a National/County-owned Health Commodities' Logistics Management Information System (LMIS)	
0	• County currently uses no Health Commodities' LMIS system.
1	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records.
2	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, reporting of LMIS data is below 50% for all facilities annually.
3	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, county has access to limited logistics data including: stock on hand within the system and consumption/usage for the past reporting period and demonstrates reporting rates of least 50% from the sub-counties. • County has a plan for routine DQA exits, DQA of LMIS data conducted at least once annually
4	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, county has access to logistics data including: stock on hand within the system and consumption/usage for the past reporting period and demonstrates reporting rates of least 75% from the sub-counties. • County has a plan for routine DQA exits, DQA of LMIS data conducted semi annually • Data Quality Improvement Plan for LMIS data developed for every DQA and implemented
Comments:	

Standard 4.1.4: Health facility's capacity to effectively store and account for health commodities through appropriate records and reports.	
0	• No system exists for proper storage and distribution of commodities, including essential medicines. (***special storage requirements of medicines and other commodities are not followed, poor records keeping and consumption reporting***)

1	• Warehouse/stores(s) for commodity storage exists at either county, sub-county or facility level, with some accommodation for items requiring special storage.
2	• The county/sub-county warehouse and health facility store meets at **least two** of the following four criteria: warehouse/store size is adequate, storage spaces are being well maintained and clean (including pest, lighting, temperature and humidity control), • County warehouse has designated storage equipment for special storage needs, and re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance.
3	• The county/sub-county warehouse and health facility store meets at **least three** of the following four criteria: warehouse/store size is adequate, storage spaces are well maintained and clean (including pest, lighting, temperature and humidity control) • County warehouse has designated storage equipment for special storage needs, • Re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance.
4	• The county/sub-county warehouse and health facility store is adequate – meets all four criteria (i.e. large enough, regularly cleaned, dry, well organized) with all special needs storage areas clearly designated with correct signage, • County warehouse has an established re-order and stocking plan, including the use of protocols (such as first expiry, first out), job aides (such as SOP for emergency procurements) • Re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance. • Stock-control records such as stock cards and bin cards are well maintained
Comments:	

Qualitative Questions Standard 4.1.4

12. Describe the procedures adopted for proper storage of essential medicines and other health commodities(county, sub-county and health facilities)

Within the health facilities, storage is an issue and at sub county level – commodities are stored and facilities can get them from the sub county stores.

There exists a big gap on storage facilities at health facilities (lack of adequate storage for commodities) make shift facilities have been created and sometimes essential commodities are put on stones (since there are no pallets, shelves).

At Sub county there is very limited space for storage for essential and other commodities and security for commodities (make shift stores). In addition there is limited space and challenge of expired drugs collection at facility level and space to store at sub county before they are expired.

Some HIV drugs require special storage – Kaletra and however they are being stored at KEPI fridges and require separate storage.

The county does bulk procurement and delivers directly to health facilities and there is no storage problem.

There is also inadequate dissemination of job aids for proper storage and the existing stores lack cleanliness, security, lighting and temperature control systems.

13. What is the role of community-based groups and networks in community commodity distribution?

The ensure ownership and pharmacovigilance/surveillance or medicines safety at facility level – they check. For malaria community case management the CHV's are given commodities for distribution and even diagnosis.

14. What is the role of private sector in commodity procurement, storage and distribution?
    Some commodities are supplied to FBO and private sector facilities for procurement
    Supervision in private facilities does not happen. The private sector has minor role apart from supplying.
15. What mechanisms does the county use to assure quality for medicines and other health commodities within the county level?
    - Check above
16. What systems does the county have in place for medical waste management?
    The medical waste management component is performing poorly and a big gap exists due to lack of functional incinerators and even the referral hospitals are not effective, only burning chambers are available
    Coded bins available in health facilities but disposal is a big challenge

Building Block 5: Health Systems Financing

Indicator 5.1: Capacity of the County Health Department to ensure that adequate funds are allocated to the health sector within the overall county budget.

Standard 5.1.1: Capacity of the County Health Department to ensure that adequate public funds from the total county government budget are allocated to public health and population activities.	
0	• The county health department has no input into the development of the county budget estimates.
1	• The county health department has input into the county budget estimates development, • But public health expenditures are not systematically calculated on an annual basis and total at least 20% of the overall county government budget.
2	• The county health budget is developed annually, with input from county health department • County health expenditures are not systematically calculated on an annual basis as part of budget formulation process • It's less than 25% of the overall county government budget.
3	• The county health budget is developed annually, with input from county health department • Estimated actual county health expenditures are systematically calculated on an annual basis as part of budget formulation process. • Health budget is between 25% and 30% of the overall county government budget.
4	• The county health budget is developed annually, with input from county health department.

	• Estimated actual county health expenditures are systematically calculated on an annual basis as part of budget formulation process • Program, surveys and surveillance data used as justification for budget requests • County health budget is at least between 30% - 40% of the overall county government budget.
Comments:	

Qualitative Questions Standard 5.1.1

1. Briefly characterize funding sources for health services in the county.
   h) Where does funding for health care services come from?
   i) What percentage of funding comes from national treasury equitable share, conditional grants, county revenue collection, private sector, household out of pocket, health insurance and external development partners for health?
6. Briefly describe the mechanisms in place to determine county health budget needs of individual sub-counties?
   a) Who is responsible for determining county and sub-county budgetary needs?
   b) How often is a county health budget review conducted? Annually….
   MOH sub-county disempowered; financially deprived (amendment of acts will help health financing)
   Latest disconnect; facilities collected money in past and streamed back but these days money collected is not received back to support facilities
7. How is the process organized? To what extent are stakeholders involved in this process? (Program Based Budgeting).
   a) Who is involved in the budget making process in the county and why? Communication to prog officer and hospitals to prepare budget requirements; program heads and hspitals and MOHs; development/implementing partners
   b) How are county priorities set in the health sector during the budget process? Priorities guided by strategic plan and AWP; priorities picked by MOHs
   c) How are county health programs/subprograms determined in the budget? Service delivery blocks; disease burden; priorities; training by USAID
   d) How does county improve efficiency in resource allocation and use (value for money)? Forums to assess performance; challenges; more focused on outcomes; not much attention paid to efficiency….no assessment in terms of value for money;- same problem dicussed 3-4 years running meaning no efficiency monitoring;
   e) How does county ensure value for money for resources allocated to the health sector? We don't know actal amunts allocated; e.g. request for X and receive Y so many activities not carried out; e.g. maternal health is an indiactor of overall quality of health system- dysfunctional ambulances, blood transfusion services down, ….overall system is not improving; 8 ambulances bought and now broken down; bulk buying from KEMSA lowers costs but these days buying less and less….debts not paid in time so instead of KEMSA (owed money) so buy locally expensivey
   f) What challenges does the county have in formulating program based budgeting that factors in efficiency, effectiveness and equity? Major problems, e.g. TB/HIV allocated 1m but from budget showed 152m; the 1.1m was never delivered)could not be accessed; CHMT trained well on PBB but sub-county lack capacity so affects budget estimates; efficiency, effectiveness; equity

g) How does the county ensure equitable allocation of resources for improving the social welfare of the most needy in the society? Campaign to have NHIF membership; effective waiver system- assessed by nurses and social workers (no social workers who ideally should do assessment); exemptions: elders, u5, prisoners; outreaches are free and target the poor and hard to reach; enrolment in Linda Mama funded by Govt (free maternity care centralized to get rid of corruption at counties to ensure the contract between facility and NHIF not national treasury and county treasury). NIHF contracted AMREF to conduct nationwide registration for informal sector which Migori has boiught into;includes reg of very poor and vulnerable and to enrol

Indicator 5.2 Capacity of County Health department to formulate, distribute and monitor financing for the health sector.

The four criteria necessary in a *sustainable budget* are as follows

Planning: County Health Department has a realistic and sustainable budget informed by sound revenue forecasting methods including use of past experience/expenses, development partners for health contributions and projections
Input: All key stakeholders are involved (including county health department, sub-county health administrators, civil society including religious groups, public participation, and as necessary development partners for health and implementing partners)
Allocation: County Health Department compiles an adequate budget that prioritizes primary health care services, with specific line items for key areas outlined in the County Health Strategy.
Initiative: Process for collection of budget information is led collectively by the County Health Department and sub-county health administrators' offices and the system is standardized across all sub-counties.

Standard 5.2.1: Capacity of County Health Department to plan for, create and allocate a sustainable budget	
0	• No sustainable budget exists (see four criteria necessary for sustainable budget above).
1	• Three of the budget sustainability criteria need improvement (see four criteria necessary for sustainable budget above).
2	• Two of the budget sustainability criteria need improvement (see four criteria necessary for sustainable budget above).
3	• One of the budget sustainability criteria needs improvement (see four criteria necessary for sustainable budget above).
4	• All of the budget sustainability criteria are completed and sustainable, with the county and sub-county health administrators' offices taking the lead on developing the county health budget (see four criteria necessary for sustainable budget above).
Comments: Allocation is not transparent; fungibility and impunity; lack of fiscal discipline; approved budgets are not actual expenditure because there is another unofficial budget cut at the treasury County lost free maternity revenue because treasury could not channel money to the MNCH programme; 315m KSh could not be accounted for Migori leading in maternal and child deaths	

The four factors necessary to *effectively distribute and or allocate finances* are as follows:

Financial System: A system exists within the County Health Department to distribute funds among its activities. This includes differentiating by funding source (e.g., development partners for health, national and county revenue, etc.) and by funding recipient (e.g., by line item, and by district).
Tracking: County Health Department has a system to track its distributed funds against its total budget, the sub-counties distributions against total budgets, manage cash flow and segregate expenses
Policies: Policies for allowable expenses exist and are distributed among County Health Department staff and sub-counties. These policies are implemented on a regular basis.
Responsibility: Monthly review of internal expenses versus revenue (both for the county health budget and each sub-county's budget) is designated to an employee(s) as a responsibility

Standard 5.2.2: Capacity of County Health Department to effectively distribute finances	
0	• No system to distribute funds exists (see four factors necessary for effective distribution and/or allocation of finances above).
1	• Three of the budget distribution factors need improvement (see four factors necessary for effective distribution and/or allocation of finances above)
2	• Two of the budget distribution factors need improvement (see four factors necessary for effective distribution and/or allocation of finances above).
3	• One of the budget distribution factors needs improvement (see four factors necessary for effective distribution and/or allocation of finances above).
4	• All of the four (4) budget distribution factors are completed and sustainable (see four factors necessary for effective distribution and/or allocation of finances above).
Comments:	

Qualitative Questions Standard 5.2.2

1. Briefly describe the mechanisms in place to ensure fair and adequate distribution of funds to the sub-county health teams. No systematic way of distribution; it is not fair, not adequate; MOHs not allocated money
   a) How is the process set up? Unsigned agreement CHD and county treasury that CDH would get 15m monthly for operations; not happened last several months; started at 15m then 10m then 5m with sevral months missing; used to pay for maintenance and fuel, elec., power disconnectetions, less food in hospitals, ambulances broken down or no fuel; the act blocks MOHs from getting money into sub-county accounts

   CDH has not vote-book; commits, controls budget; tracks hw much miney is allocated, spent, balance in each item/program. So budgets used in haphazard manner

   CHD does NOT control its won budget= not able to prioritise own expe; initially sub-C would issue AIE in previous system complemented by FIF and keep 75% of facility funds// MOHs reduced to beggars/// peripheries disempowered. In boks the CO controls budget but in reality budget controlled from county treasury/// cost of revenue ollection higher than revenie collcted

b) How are needs determined? By CDH through MOHs and community

2. Briefly describe the mechanisms in place to ensure transparency in revenue collection and distribution. Health staff used to be involved in revenue; nowadays treasuiry posted revenue clerks to collect reveue from facilities; more was collected then than now cos lack of control of clerks by health facilities so controlling revenue is hard /// previously money collcted were displayed publicly on monthly basis with targets; nowadays no; no spot check these days; internal audits at treasury not at CDH
   a) What policies and procedures are in place? Revenue collection take over by treasury
   b) What is the course of action when a discrepancy is identified? Ask the treasury

The four factors necessary to *effectively monitor finances* are as follows:

Documentation: County keeps financial documentation in a secure place, has a policy for keeping receipts and requirements for documentation kept with each type of payment. These policies flow down to sub-counties and adherence is monitored.
Review: County reviews expenses monthly to ensure applicability and allowability according to the budget and internal policies. Exceptions are documented.
Reporting: A reporting system exists both for the county to report to the County Government Treasury and for the sub-counties to report to the county. Reports are completed and submitted according to applicable deadlines.
Audit: County either has an internal review of its and the sub-counties' accounting systems or hires external auditors on an annual basis.

Standard 5.2.3: Capacity of County Health Department to monitor finances at the National and Provincial levels	
0	• No tracking/monitoring system exists.
1	• Three of the factors necessary to effectively monitor finances need improvement (see four factors necessary for effective distribution and/or allocation of finances above)
2	• Two of the factors necessary to effectively monitor finances need improvement (see four factors necessary for effective distribution and/or allocation of finances above) .
3	• One of the factors necessary to effectively monitor finances need improvement (see four factors necessary for effective distribution and/or allocation of finances above) .
4	• All of the four (4) factors necessary to effectively monitor finances are completed and sustainable (see four factors necessary for effective distribution and/or allocation of finances above) .
Comments:	

Qualitative Questions Standard 5.2.3

11. How is the overall county budget monitored? Finance committee at the county assembly (oversight role)
    a) Who monitors/ manages the county health department budget at the county treasury level? Not specifically for health but budget controller monitors all budgets for depts.; several layers for monitoring budget
    b) What input do individual departments other than health department provide towards managing the overall county health department budget? Treasury (finance and planning) distributes and monitors finances
12. Briefly describe your procurement policies and procedures? In line wtit national government procurement requirements (
    a) Do you have different thresholds for procurement? Procumrement unit at county then various departmensts have procurements units (e.g. CDH has 2 proc officers); individual facilities are no longer procurement entities/// thresholds for proc: follow schedule in proc act (low value items <50 do direct proc; more advertise for tenders
    b) What do you keep as documentation in your files? approved requisition from user dept, agreement; copy of LPO; delivery notes, copy of 13; invoices, payment voucher;
    c) How do you ensure transparency in procurement? Difficult to monitor; ad hoc committees sometimes are not representative: evaluation committee for tech and financial aspects= so sometimes supplies do not meet required specifications ("that is where we are cooked")/// user dept shd be involved//// proc unit does not function cos powers taken by actes that need tp be amended///
13. What is the county's capacity towards developing and implementing Performance-based contracts (PBC)? Public service management has devpd template for PBC but implementation is a problem
        a) How are performance indicators identified? What is the county's process for identifying the indicators? …. PBC not signed; have not been there for some time now; at level of CEC, CO level; has not been cascaded to sub-counties
    b) How are contractors identified? What is the county's process for identifying the contractors? Prequalified contractors for various supplies/services// document is reviewed annually/// areas of expertise through quotations
    c) Is there a policy/ operational plan to guide the PBC process? No policy; guided by national proocuremtn act
    d) How is performance evaluated and recognized? Hrough iidnictprs
    e) What kind of assistance does the county provide to sub-counties health administrators' offices in implementing PBC? None so far. PBC is not at sub-counties
14. What resources and support does County Health Department need to implement PBCs across all sub-counties?
    a) Financial needs: not quantified
    b) Procurement and logistic needs: create proc units at sub-county and facility level, empower CO to control budget and proc funtions
    c) Training needs: for managers (accouting oficrs and proc officers at sub-C level)
15. What is the county health department's budget allocation utilization rate (% of expenditure in total allocated health budget)?
    a) Recurrent expenditure (
    b) Development expenditure
    CO

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Building Block 6: Delivering Essential Health Services

Building Block 6: Delivering Essential Health Services

Indicator 6.1: Capacity of County Health Department to engage sub-counties in delivering public health services

Standard 6.1.1: Extent of interaction between the county health department and sub-counties	
0	• No structured interaction with sub-counties.
1	• The health department interacts at least once a year with sub-county health administrators on: o Budget-related issues only.
2	• The health department interacts at least once a year with sub-county health administrators on: o Budget related issues o Health service planning activities.
3	• The health department interacts at least once a year with sub-county health administrators on: o Budget related issues o Health service planning activities, o Maintenance and coordination of facilities.
4	• The health department interacts at least four times a year with sub-county health administrators on: o Budget related issues o Health service planning activities, o Maintenance and coordination of facilities, o Assessments and planning for community health needs.
Comments: The score is three due to assessment and planning of community needs not regularly done	

Qualitative Questions Standard 6.1.1

7. What mechanisms are in place to involve community stakeholders, sub-county health officers and partners in planning for service delivery?

Partners – A lot of interaction with counties during AWP, TWG, Health stakeholders forum
On service delivery, the sub county health officer join support supervision with the county health facilities.
Community dialogue – community health services, done quarterly at each community unit – over 60% is done
Sub counties health officers – Happens for instance in the annual work plan development happens upto to community level, programme based performance review meetings – all sub counties involved in the process

8. Has the county conducted a formal exercise to plan for health services?

Yes, the county has during the preparation of the strategic plan and county is doing another county health strategy, annual work plan and annual review of the annual work plan

a) How often is planning conducted?

Sub counties present: Nyatike and Kuria West
Partners – Aphia Halisi, University of Maryland, PSKenya present

The table shows some of the key partners in Migori (from the draft annual strategic plan)

Name of Organization	Mandate
Aphia Hails	Maternal, child health, Nutrition, reproductive health, WASH
PATH	HIV/AIDs
University of Maryland	HIV/AIDS/TB
Kenya Red Cross Society	Nutrition, emergencies
World vision	Child and adolescent protection
UNICEF	WASH, Nutrition and commodity
UNFPA	RMNCAH
Palladium(Tupime Kaunti)	Measurement, leaning & accountability (Health systems strengthening)
AMREF	Sanitation
KIWASH	Water & sanitation, Nutrition
IMPACT RDO	Voluntary Male Medical Circumcision
RAPPADO	
Nyarami VCT	HIV/Aids
Lwala community	Community Health Services
AIRS	Indoor Residual Spray
CHEMONIcs	Commodity Logistics Management Information System
European Union(We World)	Nutrition
AIHA – DREAMS	HIV/Aids and Adolescent 9Most at risk populations
Nutrition International	Nutrition, Maternal, neonatal and child health services
LVCT – HEALTH	HIV/Aids – testing and care and treatment
Ministry of Health	Policy, training, Malaria, HIV/Aids/TB, KEMSA,
NHP plus	HIV/Aids commodity

During the annual work planning, the county and sub counties meet together to plan and then quarterly reviews of annual work plan done with counties. operational plan

- Partners ae met at the sub county level
- Sub county health management team meet weekly to plan for services – regular engagement
- All reviews end up with an action plan
-

b) Is there a general Annual Work Plan? Yes
c) Do you have unit-specific and or Vertical Programs specific Annual Work Plans? How were they developed and shared?

Programmatic plans, unit plans are consolidated to make AWP through program based planning

Some programmes have strategic plans – RH, Malaria, HIV program based strategic plans

Every health facility has an annual work plan broken to quarterly and monthly

Development and dissemination:

- CIDP informs Health sector strategic plans informed by various unit and programme plans

- The normal planning cycle – the process starts at county, sub counties and bring in partners and health facilities.
- Sensitization meetings and consolidation at facility then sub counties then county
- Partner involvement at annual work planning has not been regular – only engaged at county level but at community and sub counties are involved
- Partner coordination framework is done.

d) Who is involved in the planning process? Community, sub county managers, county, management board, facility committees, CU's, service providers,

e) How is the planning process organized?

Sensitization at community, facility, sub county, county using the national guiding documents.

9. How are priority service areas identified?

Top priority is preventive services – based on priority focus or gaps focus

- E.g. FP – teenage pregnancies are on the rise and emphasis was on that, Data/Statistic like stunting, HIV and DHIS- health seeking behavior, health expenditure,

a) Is service delivery reflective of priority health needs per county health strategic plan?

Yes reflective but has challenges and depends on the level
Most partners ask for priorities before proposal e.g. Nutrition – EU and USAID for nutrition – partners include in the prioritization
Sharing of costs by partners and county
Lack of financial support

b) What policies do you have in place to ensure service delivery targets priority health needs? Please describe.

Strategic plan, County health services bill – linked to the health act 2017, Sanitation bill (county to share even a nutrition strategy being developed)

Standard 6.1.2: Capacity of County Health Department to develop and distribute (to the sub-counties) policies, plans and standards for key health care delivery areas	
0	• No County Health Department's Health Strategy exists.
1	• The county has a health strategy aligned to national health strategy (2014 – 2018)
2	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities.
3	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities. • The county clinical standards and guidelines are currently used by least 50% of sub-counties within the last two years.
4	• The county has a health strategy aligned to national health strategy (2014 – 2018)

	• The county has clinical standards, guidelines already distributed to sub-counties and health facilities. • The county clinical standards and guidelines are currently used by least 80% of sub-counties within the last two years. • The county health department conducts regular sub-county and health facility visits to monitor compliance in the use of standards and guidelines.
Comments: The score is 2 because of usage of the standards and guidelines is less than 50%	

Qualitative Questions Standard 6.1.2

5. What guidance does the county provide the sub-county health administrators regarding service delivery?
   From sub county always seek guidance from county through communications, email, what's app,
   Policies made at county level - sub county ensures implementation
   If sub county finds difficult any challenges they consult with county
   a) Are there policies and procedures?
      County strategies and policies
   b) Does the county annual work plan provide guidance to sub-counties? Yes
6. Who decides what services need to be provided at the sub-county level?
   Depends on the level :
   – community – community decides during community dialogue with help CU – community CU decides
   - Sub county health management team in conjunction with partners at sub county level who perform different activities
   - County -
   - Set criteria by KEPH the county uses this

Indicator 6.2: Capacity of County Health Department to ensure appropriate use of policies, plans and standards related to Health Service Delivery for HIV/AIDS, TB/HIV, RMNCH, Nutrition, Water & Sanitation, and Malaria

Standard 6.2.1: Capacity of County Health Department to supervise sub-counties in the use of Health Service Delivery Standards, Guidelines, Protocols	
0	• No system exists at the county to monitor adherence of sub-counties to standards, guidelines, protocols.
1	• Some elements of a basic system exist for monitoring adherence to standards, guidelines and protocols.
2	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (***lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities),*** but use of these guidelines is not consistent by the county health department or sub-counties.
3	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (***lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities)*** • County provides support to sub-counties to monitor adherence at the facility level, but not consistently.
4	• A system of monitoring of adherence to standards, guidelines and protocols

	• County has guidelines for one or two of the following areas (***lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities)*** • County provides support to sub-counties to monitor adherence at the facility level. • The county jointly with sub-counties has joint plans for conducting adherence monitoring at the health facility level.
Comments: The score is 2	

Qualitative Questions Standard 6.2.1

5. What mechanisms exist in place for supervision of sub-county health facilities?
   Yes, programmatic based supervision – different programmes have their own check list, integrated supervision – four sub county health team members supposed to be funded by county but due to financial constraints not done. Ride on other programme funded support supervisions
   - Ideally quarterly support supervisions (integrated or programme related) not consistent (funds for fuel and lunches missing)
   - Supervision report compiled and target a meeting with facilities and share the findings – regularity depends on availability of funds
     s) Is supervision focused on medical audits or coaching and performance improvement or both?
   - Supervision check list has thematic areas – staffing levels, capacity of staff, commodities and supplies, referral system, gaps/needs assessment, programme areas
   - Not regular supervision
   - Once gaps identified who do mentorship on documentation and other areas
   - Assess performance of health facility feedback is give on performance to the in-charges

     t) How often is supervision conducted? Not regular but ideally quarterly at sub county and facilities also.
     Community level – irregular supervision

     u) How are supervision needs determined? (needs-based or regularly scheduled?)
     The driver is data and performance is reviewed before to decide which facilities
     It is needs based and schedule on this basis

     v) Who conducts the supervision visits? Sub county health management team – MOH, nursing officer, data, programme officer.
     County Health Management Team does supervision also

     w) Is there clarity about levels of supervision (who supervises who) and reporting?
     Yes there is clarity, County health management team supervises by sub county HMT and they supervise facility.
     At community level – CU – CHA supervising CHV; tool and check list present

     x) What tools are used to conduct supervision? Standard Supervision check lists/tool (county has an integrated check list and cuts across all service delivery points – HIV, child survival, MNH etc..,
     No guideline for supervisory checklist

Supervisory book in the health facility – leave with findings and gaps which includes an action plan – timelines, responsible person
Visitors book
If supervision is partner driven – partner specific supervision checklist might be developed jointly with county

y) How is supervision findings used? Abit of challenge, feedback provided by team to facility, book to record key issues and recommendations
Follow up on action plan and recommendations not followed

- Used for decision making for instance in commodity redistribution, staffing issues and improve on management issues but if regular supervision is done things would change.
- Financial constraints by county also for issues raised not being covered for instance lack of reagents at facility due to county not being procured – County Director mentioned at one supervision

z) Are supervision results linked to any type of reward/recognition/incentives system?
-Kuria west sub county wanted to introduce e.g. celebration of ODF zones assisted by a partner with a trophy but not actualized due to lack of finances – partners yet to support
- Rongo sub county – able to reward the best performing facility
- Partner recommends to include in the joint annual work plan like APhia Halisi they can support a reward
- Incentives can be trainings for individual and health facility
- PSKenya – Malaria programme – award and recognition ceremony working with county and PSkenya – cash vouchers etc. based on performance on management of commodities and reporting
- Other ways of recognition – support for conferences, abstracts, leadership within area of working, recognition during meeting forums for individuals.

aa) What are the challenges to conducting supervision? These include:

i. Financial support is lacking i.e. fuel,
ii. Attitude
iii. Inadequate support supervision skills at county and sub county level – not policing and do more of mentorship
iv. In supervision – person needs to understand all service areas
v. Competing tasks with other priorities – staff attending to patients etc..

6. What mechanisms exist for improving quality of care through the health system? What are the gaps in quality of care in the system? What are some of the successes in improving quality of care?
   - Yes, Quality Improvement (QI) teams present at county, sub county and facility level
   - QIT TWG and focal person at health facility level and disseminates to facility – assess challenges
   - Each facility has a quality improvement team
   - Data quality audits are done though inconsistent– e.g. HIV was done
   - CME's provided to focus on quality gaps, specific training to focus on service delivery issues, mentorship

Gaps of quality of care:

i. Staffing
ii. Commodities and supplies
iii. Infrastructure
iv. Not all facilities have quality improvement teams –
v. Skills of QIT and trainings
vi. Focused on only HIV the quality improvement – county led quality improvement (CQI) – UMB – Maryland
vii. PTBI – preterm birth issues – QI partner support this
viii. Need to Strengthen the QI team at all levels and facility in-charges needs to spearheaded

*Benchmarking was done in Kericho QI team which is doing well and the Migori team visited which was a holistic QIT and combined with work improvement teams

Successes in improving quality of care

i. Migori has done well on coordination structures for QI
ii. County coordinator for QI is present
iii. Training on KQMH
iv. Committees present
v. Facility level
vi. Community QI undertaken in 9 community units started last month

i) What indicators are used to measure service quality?

Some examples include:

i. MNCH – pregnant mothers undergo anthropometric, child undergoing physical examination,
ii. HIV – Did all eligible patients for viral load get tested
iii. Reporting – timely
iv. KQMH principles are used and AWP indicators
v. No guidelines on service quality
vi. Guidelines for infection prevention and control can provide guidance
vii. Standards Based Management and Recognition tool (SBMI) is available to guide also

j) What kind of mechanism exists to assess quality of care regularly and who is in charge to monitor this?

The county has quality improvement teams or QI focal persons present at county level and sub county level who monitor quality of care.

k) Are there QI teams in place at the community, facility and/or sub-county levels? Some community units have QI teams i.e. 9 out of 177 community units –which include: Suna west (3), Nyatike (3) and Kuria west (3) supported by SCALE/ LVCT and this commenced last month.

T Facility and sub county level QI teams exist but are not very functional

How is county supporting QA/QI in the private sector

There is no support for private sector on QA and QI and the support is mainly targeted for FBO's and PSKenya TUNZA facilities conduct their own quality assurance.

Standard 6.2.2: Number of operational public, private and faith based health facilities as compared to the total that routinely report complete and accurate data	
0	• The county does not have a list of the number of public, private and faith based health facilities.

1	• The county has a list of the number of public, private and faith based health facilities, but there is no system to determine and report which of the facilities by type report complete and accurate data
2	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities, but less than 50% of the total report complete and accurate data
3	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities (at least 75% of operational public, private and faith based health facilities of the total number are operational routinely report monthly) • About 75% of the reporting health facilities report complete and accurate data.
4	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities (at least 80% of operational public, private and faith based health facilities of the total number are operational routinely report monthly) • About 85% of the reporting health facilities report complete and accurate data. • County has a system for quarterly review of complete and accurate data.
Comments: Struggling with disease surveillance data	

Indicator 6.3: Capacity of County Health Department to deliver health care in identified priority areas (HIV/AIDS, TB/HIV, RMNCH, Nutrition, Water & Sanitation, and Malaria)

Standard 6.3.1: Capacity of County Health Department to implement health programs. ***NOTE: This question can be asked of HIV/AIDS, TB/HIV, RMNCH, Nutrition, Water & Sanitation, and Malaria and sub programs as appropriate (Assessment of CHMT Capacity)***	
0	• Program does not have capacity to identify priority areas for implementation
1	• Program has capacity to identify priority health areas and develop standards for health programs.
2	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs.
3	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs. • The program has capacity to conduct periodic monitoring and evaluation (M&E) of priority health programs.

4	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs. • The program has capacity to conduct periodic monitoring and evaluation (M&E) of priority health programs. • The program has capacity to promote data sharing, communication, and collaboration within individual priority health programs.
Comments:	

Scoring of Standard 6.3.1

i) Scores from each individual program for standard 1.3.1 above:

Program	HIV/AIDS	TB/HIV	RMNCAH	NUTRITION	WASH	MALARIA			
Score /4	4	3	2	2	2	3			

j) Total score from above table (a) = ____16_____

k) Total number of programs included = _____6____

l) Average score (b/c) = _____2.6= 3_____ Please enter this score for Standard 1.3.1 above.

Qualitative Questions Standard 6.3.1

What is the county's capacity towards delivering Essential Health Services Package (EHSP)?
Structure is there, but implementation is a challenge
Which services are the strongest?
HIV, TB and RMNCAH
Which services present the most challenges?
Nutrition and
WASH (WASH has most challenges – total sanitation- safe drinking water, latrine, behavior change,

Objective	**Indicator**		**Targets (where applicable)**				
		Baseline (2017)	**Yr 1**	**Yr 2**	**Yr 3**	**Yr 4**	**Yr 5**
Eliminate Communicable Conditions	% Fully immunized children	74	78	81	84	87	90
	% of target population receiving treatment for schistosomiasis	0.08	1.0	2.0	3.0	4.0	5.0
	% of TB patients completing treatment (Treatment success rates)	86	90	90	90	90	90
	% HIV + pregnant mothers receiving preventive ARV's	94	100	100	100	100	100
	% of HIV clients on ARV's	99	100	100	100	100	100
	% of HIV Patients clients on ARVs whose viral load is suppressed	86.9	95	95	95	95	95
	% of targeted under 1's provided with LLITN's	64	90	90	90	90	90

	% of targeted pregnant women provided with LLITN's	75	100	100	100	100	100
	% of under 5's treated for diarrhea	1.9	1	1	1	0.75	0.5
	% of households with latrine	72	78	84	90	95	100
	% number of households to access to safe water	33	38	43	48	53	58
	% number of households managing wastes using refuse pit						
	% School age children dewormed	84	87	89	91	93	95
	Proportion of ODF village	0	40	60	85	95	100
	% of suspected malaria cases tested	75%	80	85	90	95	100
	% of IpTP2 uptake	54%	60	65	70	75	80
	% of male eligible clients clientsacccesingvmmc services	59	65	70	75	78	80

The above table is derived from the Draft Migori County strategic and investment plan 2018-2022.

Maternal and newborn services

How do you identify targets? Please list some of your targets.

Indicator manual and from strategic plan and use proportions from the county and guided by national. Calculate from previous year.

HIV pregnant receiving – 100% (target) 94% (progress)
48.7%
IPT 2 uptake – 54% - 60%(target) – can achieve
Maternal death audit – at county at 87% and need to be at 89%
4th ANC – 35% - 40% (target)
% skilled care
Mothers attending 4th ANC
Under 1 year given measles
Immunization – 74% (2017) 86% (2017)…
Hospital deliveries
Pregnancy accessing women services and

Where are you with your targets for maternal and newborn services?

Deliveries by skilled attendants – 59% - 62% (target)

Do you anticipate reaching all your targets for the year? If no, please explain why

What assistance do you need to reach your targets?

- Issues with HR – employment frozen by the county
- Support supervision
- Capacity building for new staff on RMNCAH issues
-

Child health services

How do you identify targets? Please list some of your targets.

Where are you with your targets for child health services?

Fully immunized child – 74% - 78%

Children under 1 yr. provided with long lasting ITN – 64% and need to be at 90%

Under five treated for diarrhea – 1.9% to reduce to 1%

IMCI

Deworming

Do you anticipate reaching all your targets for the year? If no, please explain why

Fully immunized is challenge due to inadequate cold chain equipment, staff not trained and lack of capacity among the staff

What assistance do you need to reach your targets?

They need cold chain equipment

Support for outreaches and defaulter tracing

Collection of commodities from the depot

Support for beyond zero

Family Planning and Reproductive health (FP/RH)

How do you identify targets? Please list some of your targets.

Where are you with your targets for reproductive health services?

Screening for cervical cancer – 14% - 22% (target)

mCPR – 43% - against target (KDHIS 2014)

Couples years of protection (CYP)

Maternal deaths per 100, 000 live births

Do you anticipate reaching all your targets for the year? If no, please explain why

What assistance do you need to reach your targets?

- For FP need support for implementing the plan – more trainings and follow up, commodities security support

HIV/AIDS:

How do you identify targets? Please list some of your targets.

- Based on the 90-90-90 targets
- Each sub county set their own targets

First 90 for positive – currently at 82 (will meet the target

Next 90 to be put on treatment – at 98% (abit of underestimated and discussing with NASCOP

Last 90 – general scale for children and adults – at 96%

Where are you with your targets for patients on treatment and mother to child transmission?

By Jan 6.1% for mother to child transmission at 18 months – plans to reduce

Do you anticipate reaching all your targets for the year? If no, please explain why

What assistance do you need to reach your targets?

Elimination of mother to child transmission – challenge – each county has its own EMCTC strategic plan migori does not have one - Partner to support is lacking (UNICEF has accepted to support)

Aphia Halisi yet to support – Early infant diagnosis and integration

PATH and UMB

Malaria:

How do you identify targets? Please list some of your targets.

Where are you with your targets for ITN use among
pregnant women and children under 1 year?-

Do you anticipate reaching all your targets for the year? If no, please explain why
What assistance do you need to reach your targets?

TB

Prevalence surveys and national targets
Targets – cure rates 85%, TSR (90%), Under five initiated on IPT, health workers screened for TB, number of care on IPT and screened using gene pert on TB.
- As county at 90% TSR based on 2016 performance – need to manage transfer outs to other counties
- Challenge to achieve all TB targets – level of screening of paediatric is low, contact tracing is a challenge, case search – rely on self-referral cases
WASH and nutrition is missing
- WASH – ODF – 20% - attain by 2020 (support for community led total sanitation is required – this 1,2000 to ODF
-Nutrition – growth monitoring inadequate equipment, due to high malnutrition rate (acute – 4%, underweight – 8.6%, chronic stunting – 26.4%); focus on stunting requires multi-sectoral intervention
- Iron and folic acid, exclusive breastfeeding to address malnutrition
- Managing acute nutrition – behavior change – community oriented focus to institute behavior change
Community Health services since it is a cross cutting
Gaps - low coverage of CU's, skills gaps at CHS services
- 100% coverage of CU's but at 81%
-functional – 62% (out of 177 only 61 % - reporting, CHV's, dialogue
Technical modules for CHV's -capacity on nutrition, HIV
Gap on tools -CHIS – and chalk boards

Note**:**
For Maternal/Newborn, Child Health, FP/RH, HIV, and Malaria, the CICAT assessment team will also probe the issue of "respectful care" during the MNCH questions, particularly for maternal health services offered at facility level during prenatal, labor, and postnatal care.

Metrics: Illustrative outcomes

Building Block	Illustrative Outcomes	Measurement Method/Annually
Leadership & Governance	i) Equity in the distribution of health services and interventions ii) collaboration with private and other sectors iii) Management systems and functions iv) Partnership and coordination of healthcare delivery v) Governance systems and functions vi) Engaging of public and private services providers vii) Planning and monitoring systems and services viii) Health regulatory framework and services	Post intervention CICAT Documents Reviews Key Informant Interviews
HRH:	i) equitable distribution health workers by cadre a. rural vs. urban distribution ii) ratio of health providers to population served by cadre a. doctors: population b. nurses: population iii) health providers deployment norms and standards in use iv) standardized job grading and salary structure in use	Post intervention CICAT Documents Reviews Key Informant Interviews
Health Information System:	i) Health research and information policies, regulations, and standards in use ii) Accurate, timely and complete public health information generation iii) Functional health information dissemination mechanisms for state and non-state actors iv) Existence of plan for strengthening information systems v) Existence of county health research agenda that supports evidence-based policy making	Post intervention CICAT Documents Reviews Key Informant Interviews
Essential Medicines & Other Health Commodities:	iii) Existence of a framework for establishing strategic county health products and technologies (HPT) reserve a. harmonized county regulatory framework for health products and technologies exists	Post intervention CICAT Documents Reviews Key Informant Interviews

Building Block	Illustrative Outcomes	Measurement Method/Annually
	b. effective and reliable procurement and supply systems	
Health Systems Financing:	xiii. Transparency and accountability in resource mobilization, allocation, and use. xiv. Cost-effectiveness and cost efficiency of resource allocation and use xv. Sustainable financing system for strategic health commodities xvi. Health budget utilization/execution rate, a. health budget balance of primary and tertiary health care services, b. health budget balance of recurrent and development activities xvii. Private sector participation in financing of healthcare xviii. Functional social health protection mechanism (attainment of universal coverage)	Post intervention CICAT Documents Reviews Key Informant Interviews
Essential Health Services:	vii) Effective supervision on implementation of health policies, & adherence to regulations and standards in place viii) Mentorship program for improvement of HCWs knowledge, skills, and competencies in place ix) Existence of functional management and oversight teams for every Health Service Delivery System with an approved organizational structure	Post intervention CICAT Documents Reviews Key Informant Interviews

ANNEX 02: COUNTY INSTITUTIONAL CAPACITY ASSESSMENT TOOL

County Institutional Capacity Strengthening Strategy: A Capacity Assessment Tool

Introduction and Instructions

This tool was adapted and harmonized with numerous OCAT tools with an overall goal of facilitating the identification and prioritization of core functional areas that USAID Kenya and East Africa, Health Population and Nutrition aspires to partner with national and county governments; and jointly develop action plans to help achieve increased use of quality county-led health services. The tool is based on the World Health Organization (WHO) Health Systems Framework that focuses on six building blocks of a health system.

Use of the tool is meant to be collaborative in nature. It is first and foremost a self-assessment tool, meaning that members of the assessment team and members of the County Health Management Team (CHMT), other key county health institutions including where possible members of county health committee and selected implementing partners work through each component of the tool together. All participants in the assessment receive the tool ahead of time, to have a sense of what questions will be discussed and to locate any relevant documents that will be useful in answering the questions. During the assessment process, participants from the CHMT, selected partners and the assessment team should read through the response options under each standard (component) together, and through discussion, and validations come to a consensus on the appropriate score to assign for each standard. The goal of the exercise is to develop a shared understanding of the current capacity of the institutions and organizations that CHMT represent in order to analyze gaps and develop a responsive capacity building strategy in the form of action plans.

The tool includes a summary scoring sheet organized by Building Block, with space to record scores for each indicator per Building Block. The summary scoring sheet is followed by a description of the scoring for each indicator and related qualitative questions.

County Institutional Capacity Assessment – Quantitative Summary

Summary Scoring

County Institutional Capacity Quantitative Assessment		Score
Building Block 1: Governance and Leadership		**4 /16**
Indicator 1.1: Capacity of County Health Department to lead efforts aimed at improving the health of all residents of the county		
	Standard 1.1.1: Capacity of County Health Department to develop and implement a County Health Strategy	**3/4**
Indicator 1.2: Capacity of County Health Department towards intra and inter agency communication and coordination		
	Standard 1.2.1: Capacity of County Health Department to communicate and coordinate within the County and Sub-County Health Department and other Departments in the county .	**0/4**
	Standard 1.2.2: Capacity of the County Health Department to lead and engage (coordination) with different health actors working towards the same county goals	**1/4**
	Standard 1.2.3: Capacity of County Health Department to hold responsibility and ownership for the health system	**0/4**
Building Block 2: Health Workforce		**10/16**
Indicator 2.1: County Health Department capacity in management of the existing health workforce by putting in place attraction, retention and motivational mechanisms		
	Standard 2.1.1: Ability to recruit and retain human resources for health worker positions, staff health facilities as per staffing guidelines, make working conditions and rural and hard to reach areas more attractive and safe,	**3/4**
	Standard 2.1.2: Capacity of County Health Department to staff health facilities as per Staffing Norms, Standards and Guidelines	**4/4**
Indicator 2.2: Capacity of County Health Department to improve institutional frameworks that support workforce performance development and management		
	Standard 2.2.1: Capacity of County Health Department to institutionalize systems for measuring performance and competence of health workforce; strengthen HRH development systems and practice including continuous professional development, communication, ethics and values systems.	**1/4**
	Standard 2.2.2: Capacity of County Health Department to coordinate capacity development of Human Resources for Health	**2/4**

Indicator 2.3: County Health department capacity in the development of an adequate, appropriate and equitably distributed health workforce		
	Standard 2.3.1: Capacity of County Health Department to strengthen HRH planning function covering the entire health system	**/4**
	Standard 2.3.2: Capacity of County Health Department to encourage and support various institutions to adhere to the established norms and standards for HRH in delivery of KEPH	**/4**
Building Block 3: Health Information Systems		**11 /16**
Indicator 3.1: Capacity of County Health Department to plan for and systematically collect health information		
	Standard 3.1.1: Capacity of County Health Department to develop and implement HMIS policies, strategies, guidelines, and protocols appropriate to the data needs of the county	**2/4**
	Standard 3.1.2: Capacity of County Health Department to collect quality health data	**3/4**
	Standard 3.1.3: Capacity of County Health Department to manage data	**3/4**
Indicator 3.2: Capacity of County Health Department to promote evidence-based decisions and policy making		
	Standard 3.2.1: Capacity of County Health Department to use routine performance, surveys and surveillance data for planning including performance management, rational budgeting and policy making	**3/4**
Building Block 4: Access to Essential Medicines & Other Health Commodities		**6/16**
Indicator 4.1: Capacity of County Health Department to ensure access to essential medicines for the population		
	Standard 4.1.1: Capacity of the County Health Department to provide oversight to commodity management to downstream facilities (ref: - existence of a functional commodity security committee).	**2/4**
	Standard 4.1.2: County Health Department's capacity to estimate commodity needs, develop a supply plan and procure/source these commodities	**3/4**
	Standard 4.1.3: County Health Department's capacity to develop and/or adopt and use a National/County-owned Logistics Management Information System (LMIS)	**0/4**
	Standard 4.1.4: Health facility's capacity to effectively store and account for health commodities through appropriate records and reports.	**1/4**
Building Block 5: Health Systems Financing		**7/16**
Indicator 5.1: Capacity of the County Health Department to ensure that adequate funds are allocated to health expenditures within the overall county budgets		

	Standard 5.1.1: Capacity of the County Health Department to develop evidence-based budget request justifications that ensures adequate funds from the total county government budget are allocated to key areas such as HRH, health commodities and programs.	**3/4**
Indicator 5.2 Capacity of County Health Department to formulate, distribute, and monitor financing for the health sector		
	Standard 5.2.1: Capacity of County Health Department to plan for, create and allocate a sustainable budget	**2/4**
	Standard 5.2.2: Capacity of County Health Department to effectively allocate finances based on county health priority needs	**1/4**
	Standard 5.2.3: Capacity of County Health Department to monitor and ensure accountability for finances at the county and sub-county levels	**1/4**
Building Block 6: Delivering Essential Health Services		**17 /20**
Indicator 6.1: Capacity of County Health Department to engage sub-counties in delivering health services		
	Standard 6.1.1: Extent of interaction between the County Health Department and Sub-County Health Administration Offices	**4/4**
	Standard 6.1.2: Capacity of the County Health Department to develop and distribute (to the sub-counties and health facilities) policies, strategic plans, guidelines, protocols and standards for key health service areas	**3/4**
Indicator 6.2: Capacity of County Health Department to ensure appropriate use of policies and standards related to health service delivery for HIV/AIDS, TB/HIV, RMNCH, Nutrition, Water & Sanitation, Malaria program areas		
	Standard 6.2.1: Capacity of County Health Department to supervise sub-counties in the use of health service delivery policies, strategies, guidelines and standards	**3/4**
	Standard 6.2.2: Number of operational public, private and faith based health facilities as compared to the total that routinely report complete and accurate data	**3/4**
Indicator 6.3: Capacity of County Health Department to deliver health care in priority areas		
	Standard 6.3.1: Capacity of County Health Department to develop and implement priority health programs per county health strategy	**4/4**
TOTAL SCORE		**55/104**

Scoring Guide by Building Block[4]

Block 1: Governance and Leadership

Indicator 1.1: Capacity of County Health Department to lead efforts aimed at improving the health of all county residents

Standard 1.1.1: Capacity of County Health Department to develop and implement a County Health Strategy	
0	• No current county health strategy • aligned with Kenya Health Sector Strategic Plan (KHSSP) 2014 – 2018
1	• The current county health sector strategy is aligned with KHSSP 2014 – 2018. • Adopted by the county health management team/county health department.
2	• The county health strategy adopted; • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area.
3	• The county health strategy adopted • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area. • Evidence of at least one annual work plan/operational/action plan developed for at least 50% of the county health strategy priority areas
4	• The county health strategy adopted • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area.; • Evidence of annual work plan/operational/action plan developed for at least 80% of the county health strategy priority areas; • Monitoring and evaluation framework developed to track progress. • A Governance structure that properly sorts out the roles and responsibilities of key stakeholders in achieving county health strategy goals exists.
Comments: The County Health Strategic and Investment Plan (CHSIP) provides a roadmap that outlines the priority interventions that the County will undertake and monitor to overcome its challenges and attain its health goals. A copy is available and was shared. There is an internal structure for overseeing and coordinating the implementation but not specified for the external stakeholders.	

Qualitative Questions Standard 1.1.1

1. What successes and challenges have you experienced in implementing the county health strategic plan? The County Health Department has been able to achieve some indicators e.g. fully immunized children target was overachieved. However, they have to carry forward some

[4] The building blocks included in this tool are taken from the World Health Organization's six Building Blocks of a Health System (see http://www.who.int/healthinfo/systems/monitoring/en/index.html for details).

of their targets such as infrastructure targets, which they did not meet. For referral – some ambulances were procured. For health workers they have a HRH strategic plan and they have been able to recruit some cadres such as nurses and also have had capacity building for leadership. Have developed a county nutrition strategic plan.

Challenges: They were over ambitious when coming up with the plan only to realize it is not possible to do all that they had indicated. They had not thought through the finance ceilings that come with it. With devolution, they were new to the implementation and that resulted in delays and challenges in disbursement of funds, hence they did not implement activities right on time since there were new structures in the county treasury.

2. What is the role of partners in developing the plan and contributing to its achievement? They play a crucial role and are fully involved. They are able to tell us the areas they can support and the estimated costs. Support in service delivery and in leadership. Helped to come up with an Organogram following the merge that came with devolution (see in CHSIP document). A partner, HP Plus, helped in restructuring of the health department and Intra Health facilitated a leadership training for Senior Managers in the County.

3. What additional capacity would strengthen implementation across the county (capacity in individual knowledge, skills, behaviors and attitudes as well as the structures, policies, systems and procedures of the organization and system as a whole)? In the AWP there is a listing of what partners do. There is no official document that says what our partners do and their roles and their areas of support such as providing Continuous Medical Education (CME)

Indicator 1.2: Capacity of County Health Department towards intra and inter agency communication

Standard 1.2.1: Capacity to communicate effectively within the County and Sub-County Health Department and other Departments within the County	
0	• No evidence of communication plan and protocols for information flow within the county and sub-county and to other departments within the county.
1	• There is a communication plan, and protocols are clearly established to guide the plan.
2	• There is a communication plan, and protocols are clearly established to guide the plan. • At least 50% of CHMT are aware of the internal communication plan and protocols but no evidence of use of the plan and protocols
3	• There is a communication plan, and protocols are clearly established to guide the plan. • More than 50% of CHMT are aware of the internal communication plan and protocols but no evidence of use of the plan and protocols .
4	• There is a communication plan, and protocols are clearly established to guide the plan. • More than 50% of key county staff are aware of the internal communication plan and protocols AND evidence exists of use the plan and protocols more than once a year.
Comments:	

Qualitative Questions Standard 1.2.1

1. Briefly describe the communication strategy of the county. What mechanisms/tools exist for communication within each department? Between departments? With County Assembly Health Committees? Emails, WhatsApp - E.g. - Have a senior management group and another for the CHMT- used it to convene us for this meeting. .Between departments the communication is letters scanned and attached to the email. For County Assembly Health Committee we send a hard copy and a soft copy. Telephone is commonly used. Airtime is provided for the mobile hence can be categorized as official. The same happens for interaction with the partners.
   a) What mechanisms/tools exist for communication between county and health development partners and/or implementing partners? Emails, What app - E.g.- Have a senior management group and another for the CHMT- used it to convene us for this meeting. .Between departments the communication is letters scanned and attached to the email. For County Assembly Health Committee we send a hard copy and a soft copy. Telephone is commonly used. Airtime is provided for the mobile hence can be categorized as official. The same happens for interaction with the partners.
   b) What are some of the successes/evidence of effectiveness and challenges with the strategy and mechanisms/tools? Quick response to phone calls. Emails may take longer to be accessed
   a) Briefly describe the policies and procedures in place to promote collaboration between County Health Department and implementing partners and/or health development partners? Have no written policy but is there in our strategic plan option 3 which is through stakeholder forums. We started having them quarterly but have been adhoc this days due to competing priorities , have MOUs with universities-eg have MOU with Mombasa Technical university and university of… Have MOUs with implementing partners some cases.
   b) What mechanisms/tools exist for the coordination of health development partners and other stakeholders? Emails, What app - Eg- Have a Senior management group and another for the CHMT- used it to convene us for this meeting. .Between departments the communication is letters scanned and attached to the email. For County Assembly Health Committee we send a hard copy and a soft copy. Telephone is commonly used. Airtime is provided for the mobile hence can be categorized as official. The same happens for interaction with the partners.
   c) Do we have any form of agreements between county and health development partners and/or implementing partners that support delivery of health services? Have MOUs with implementing partners some cases.
2. Is there a policy to guide collaborations? Please describe. There are no collaboration Policy.

Standard 1.2.2: Capacity of the County Health Department to lead and engage (coordination) with different actors working towards the same goal	
0	• No evidence of coordination framework that maps out different stakeholders working in the health sector.
1	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Occasional meetings are held between the county and different health actors, but these are irregular, and do not involve all of them. Implementing partners and other key stakeholders have no opportunity to present and review health priorities and their contributions towards health goals.
2	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals.

3	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals. • The county health leadership receives regular performance updates in the form of reports from at least 50% - 75% of different health actors working in the county.
4	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals. • County health leadership receives regular performance updates in the form of reports from all different health actors. • All different health actors are fully involved in annual sector performance reviews, county health annual work plan development and in policy development affecting the county population and health services (Partnership Code of Conduct exists).
Comments: It is not a framework as such but a list of the partners and what they do. We have a documented stakeholder analysis report. The meetings are not regular and are ad hoc. They have quarterly performance reviews of the county. The partners do not have parallel reporting tools hence it is actually the partners that ask for reports from the county.	

Qualitative Questions Standard 1.2.2.

1. What mechanisms are in place to promote regular dialogue between County Health Department leadership and the different health actors such as health development partners, implementing partners, MCAs, religious/community leaders, private sector and sub-county health administrators? Whenever there is an activity the county involves the sub county administrators and ward administrators are in the picture community leaders and development partners are also involved.. E.g. last year we had meeting to thrash out who does what. We have focal persons in county and Sub County. The Community Health Volunteers (CHVs) have quarterly dialogue meetings that give input from community upwards to the top. There is public participation during budget preparation. MCAs are represented in the CHMT for example, we invited all the new MCAs for induction to what the DOH does. For private sector, met with private providers to discuss how they will report. There is a PPP framework that is currently being worked on. We invited the chamber of commerce, Civil Society Alliance and CEOs forum from 21 companies and sensitized them on TB.

2. How are different health actors engaged in county health sector performance reviews, county health budget formulations, and policy development, programs review and/or/evaluation?
   AWP prepares reports with support from the Afya implementing Partners. The CHMT and SCHMT and other partners go through the performance of various indicators in the AWP chart the gaps and then make action plans on follow up. Partners join us in our Program Based Budgeting as we try to follow the cycle. The budget formulation involves sub county and major facilities. It starts from facility to sub county to county. at the community level we have a community focal person.
3. What are the strategies for building leadership capacity of healthcare managers and practitioners at the county and sub-county level? Training for management has been conducted following a needs

assessment. They go to KSG for training. Partners have helped the counties understand program based budgeting management and have cap`acitated them to conduct TNAs.

Standard 1.2.3: Capacity of County Health Department to hold responsibility and ownership for the health care system at community level (Accountability)	
0	• The county primary health care system at community level is over 50% funded by health implementing partners, with gaps existing where implementing partners are not implementing services.
1	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners
2	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) below 50%, with significant input from development partners for health and implementing partners.
3	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) over 50%, with significant input from development partners for health and implementing partners. • Functionality of community units is at 50% per the reporting rates (MOH515)
4	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) over 50%, with significant input from development partners for health and implementing partners. • Functionality of community units is over 50% per the reporting rates (MOH515) • Annual accountability platform for reviewing committed funding against results achieved at community level in place.
Comments: County does not fund nor give the CHVs any support.	

Qualitative Questions Standard 1.2.3

1. What strategies are in place to strengthen the primary health care system at community level? Have community Units and CHVs at community level and hold *barasas* (community meetings)
2. What mechanisms are in place to capture the community feedback in relation to the performance and quality of the primary health care system? We have focal persons in county and sub county. The Community Health Volunteers (CHVs) have quarterly dialogue meetings that give input from community upwards to the top .
3. Are there any processes in place community members to hold CHMT, health managers and health workers accountable for the provision of primary health care services? Please describe. Engagement at community level is through public participation. First we make them aware of what we have then they let us know what they want. At the community level, all are invited through a *Barasa* to give both positive and negative feedback, we then incorporate this into the budget. There are also some CSOs in community who educate the communities on budgeting hence ensure they are aware of the allocation of resources.

Building Block 2: Health Workforce

Indicator 2.1: County Health Department capacity in management of the existing health workforce by putting in place attraction, retention and motivational mechanisms

Standard 2.1.1: Ability to attract, recruit and retain human resources for health worker positions	
0	• Job descriptions do not exist,
1	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure)
2	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place.
3	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place. • Incentives for staff retention are in place but not effectively.
4	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place. • Incentives for staff retention are in place but not effectively. • Working conditions attractive and safe, financial and non-financial incentives for rural and hard to reach places are made more attractive and HRH wellness and welfare improved
Comments: Working conditions need improvement and there needs to be a clear guide on incentives for staff in place.	

Qualitative Questions Standard 2.1.1

4. Briefly describe County Health Department's strategy for health work force attraction, recruitment and retention at all levels?
   g) Do you have an operation plan to attract and recruit new workforce? Please describe. The HRH strategic plan 2015 – 2018 talks about staff recruitment and retention, but there is no clear plan that spells out how that is done.

   h) Has the county reached any agreements/ contracts with pre-service institutions to train and recruit new workforce? Please describe. Afya Elimu Fund – Contract with Intrahealth (Funzo Elimu). Intrahealth have paid 5M and the County has put in 5M into a revolving fund, similar to Higher Education Loans Board (HELB). Students from Mombasa interested in medical courses are loaned the money and admitted to Kenya Medical Training College (KMTC) for all the different Diploma and certificate medical related courses. They are then posted to the areas

most in need of those services. Launched in 2016, began in 2017. Details of this fund including numbers are in the presentation quoted.

(Documents: Afya Elimu Fund Presentation in evidence folder)

i) Has county conducted periodic assessments of workforce needs and priorities? Please describe. The team felt that the last major assessment in the County was done was before devolution. Literature review however revealed that there was one done in 2015 at the HRH strategic planning workshop. The HRH strategic planning workshop carried out a systematic assessment of these needs using a suitably adapted MOST approach which assesses and scores the current status of the County HRH with respect to HRM Capacity; HRM Strategy; Personnel Policy and Practice; Staff Performance Management; HRM Data; Staff Training and Development. The findings from this assessment are summarized in HRH Strategic Plan 2015-2018, p.4-7.

The team felt that the county should carry out needs assessments annually concurrently with the AWP. Clear guidelines on staff induction also need to be put in place.

Standard 2.1.2: Capacity of County Health Department to staff health facilities as per Staffing Norms, Standards and Guidelines	
0	● The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards, and development of the health workforce for staffing of each level of the health system do not exist.
1	● The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health workforce for staffing of each level of the health system exists.
2	● The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health workforce for staffing of each level of the health system exists. ● A iHRIS has been developed to track staffing levels and needs,
3	● The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health workforce for staffing of each level of the health system exists. ● A system has been developed to track staffing levels and needs, ● iHRIS monthly updated (upon exit and recruitment).
4	● The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health workforce for staffing of each level of the health system exists. ● A system has been developed to track staffing levels and needs, ● iHRIS monthly updated (upon exit and recruitment). ● Staffing data on needs by staffing cadre is being used to advocate for resources to meet staffing gaps.
Comments: Mombasa County was awarded the best HRM unit in the Country. The department has operational county HRMAC and facilities (4) and sub-county HRMAC. This has enabled the department to handle HR issues effectively. (Mombasa After Devolution Report – 2013-2017, p.37)	

Qualitative Questions Standard 2.1.2

7. Briefly describe the County Health Department's strategy to mobilize and distribute health workforce based on each sub-county's and health facilities' needs.
   a) How are the needs assessed? Annually during the annual work planning process. The CHSIP also assessed the number of staff available against the required number of staff. It stated that in 2014, the county had a total of 1,632 or 36.4 % staff in place against an ideal requirement of 4,483 staff and 992 or 49.5% community health workers CHVs (volunteers) against a requirement of 2,003 CHWs (volunteers). This means that, overall; the county department for health is understaffed by about 60%. (CHSIP 2013/4-2017/8, p. 25).
   b) Who is involved in the needs assessment? The CHMT and the SCHMT
   c) How often is a workforce needs assessment conducted? Annually during AWP, and as need arises
8. Briefly describe the County Health Department's health work force planning.
   a) How has the county adopted staffing based on norms, standards and guidelines? Through the development of the HRH Strategic Plan 2015-2018.
   b) What strategies are being used in the mobilization of resources to meet staffing gaps? Advocacy
   c) How does the country measure on regular basis the staffing gaps at all levels of health care delivery? Through the CHSIP and through the MTEF 2018 – 2021 see page 11- 15 (in evidence Folder)

Indicator 2.2: Capacity of County Health Department to strengthen performance management and supervision of the existing health workforce

Standard 2.2.1: Capacity of County Health Department to conduct staff performance appraisals	
0	• There are no policies or guidelines at the county on staff performance appraisals at all levels of health care management and delivery.
1	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists.
2	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted.
3	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted as scheduled in the guidelines. • Supervisor performance monitoring is ad hoc.
4	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted as scheduled in the guidelines. • Supervisor performance monitoring is ad hoc. • System exists for rewards and sanctions based on performance.
Comments: Staff appraisals have not been done since the onset of devolution.	

Qualitative Questions Standard 2.2.1

10. Briefly describe mechanisms in place to review staff competencies and performance.
    a) What is the course of action after a performance review? The county realized that this is a gap. They have been trained on performance contracting. The challenge with this is the

dissemination and distribution of the tool. This has been due to competing tasks and so there is need to deliberately prioritize the dissemination and set clear timelines.

b) Do you have any strategies for continuous performance improvement? Implement performance management. Please explain

11. Briefly describe the mechanisms in place to promote accountability and transparency in the workforce.
    a) Are there clear guidelines in the job descriptions about staff roles and responsibilities? Please describe one or more? Yes they are there. The county was supported to develop these by Intra health and they also used the Scheme of Service. Partners in the County of Mombasa work very closely with the County Departments The job groups and pay scales are reported in the *Mombasa County After Development Report 2013-2017 p.3 - 22*. .
    b) How often are these guidelines reviewed and implemented?

12. What mechanisms are in place to address workforce absenteeism and poor productivity? Human Resource Advisory Committees at the facility level, the sub-county level and one at the County level. The processes start at the facility level, and are escalated to the Sub-county and eventually to the County level.

Standard 2.2.2: Capacity of County Health Department to coordinate capacity development of Human Resources for Health	
0	• No system for coordinating in-service training for HRH exists, (HRH trainings are completely ad hoc).
1	• System for coordinating in-service training for HRH exists, no adhered to.
2	• System for coordinating in-service training for HRH exists, • The county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments not coordinated by the county,
3	• System for coordinating in-service training for HRH exists, • The county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments conducted and coordinated by the county. • Training schedules are not fully coordinated/ communicated to all relevant stakeholders.
4	• System for coordinating in-service training for HRH exists, county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments conducted and coordinated by the county. • Training schedules are fully coordinated/ communicated to all relevant stakeholders. • Assessments of the impact of trainings to improved service delivery is conducted annually and feedback used during performance appraisals.
Comments: All trainings even those carried out by vertical programs and implementing partners have to go through the advisory team. For staff to go for the pre-service, they have to fill a form that goes to the advisory for approval, and that keeps the county advisory informed of on who is going for what training.	

Qualitative Questions Standard 2.2.2

22. Describe any agreements made with institutions of higher learning to provide in-service training for staff? The county does not have agreements with the Higher Institutions of learning
    a) How are training needs identified? Individual staff have to take the initiative to request for training. It is up to individuals to apply for those trainings and attend.
    b) How are curricula developed and approved?
    c) How often is a training needs assessment conducted?
    d) Is there a formal mechanism to engage institutions of higher learning to provide training? No
    e) What institutions have been engaged so far?

The County gives study leave to all, and they sponsor some in cases where the county feels there is a need and also when resources are available.

2. What types of trainings have been provided by the county in the past year? EXCLUDING vertical programs and implementing partners. (See table below for a-f)
    a) Who were trained?
    b) Who determines the staff to be trained?
    c) How were the training needs identified?
    d) Who initiated/ requested the training?
    e) Who conducted the training?
    f) How was the training funded?

Training	Leadership & Management (6 Months-part-time)	Leadership & Management (6 weeks)	iHRIS (5 days but refreshers have also been done)	In-service Courses (Various)
a. Who were trained?	Senior Management	Senior Management; Strategic Leadership Development Program (SLDP)	Human Resource Officers; ICT Officers, Records Officers	Masters programs for Medical Doctors (15); Special Nurses courses – ICU (2), Theatre (1), Renal (2), Anesthesia (2); sign language (1); Cardiac; Clinical Officer (1); - Oncology; Dermatovenerology (1); Prosecution PHO (6); Records Management (1)
b. Who determines the staff to be trained?	HR Advisory Committee	The Managers themselves	Intra health/National Govt.	Supervisors/Individuals
c. How were the training needs identified?	Intra Health– through an assessment	The Managers themselves		Through supervisors

d. Who initiated/ requested the training?	Intra Health	The Managers themselves	County Govt.	The County/Individuals
e. Who conducted the training?	Strathmore University	Kenya School of Government	Intra health	Various Regional Universities/Institutions/Medical Colleges
f. How was the training funded?	Intra Health	The County/Intra health	Intra health	

Gap: There is no report that captures this information which is a gap. There are minutes however by the advisory that can verify this. There is need for a Training Coordinator to coordinate and capture these and ensure it gets to the iHRIS train software.

Intra Health has a software that they use, however it only has information of the trainings that they have carried out. They however confirm that it was meant for the County, not just for intra health.

3. Please describe the county health department's policy to strengthen existing workforce through vertical programs.

f) Is there an operational plan for in-service training? No. It is ad hoc and most of these trainings are done by partners in response to needs
g) How are in-service training needs identified?
   - Innovations/existing policies e.g. test and treat for HIV; Gene expert for TB.
   - Identified by partners through needs assessment.
   - Change of guidelines
h) How often are in-service trainings delivered? Ad hoc. They are continuous. Depend on priorities of the resource holder
i) Is there an operation plan to retain existing workforce? No operation plan. There is are good retention plans in the HRH Strategic Plan, but it lacked an operation plan and that was the hindrance in implementation. There is need to evaluate the existing HRH strategic plan which expires in June 2018, and develop a costed plan which has an operation plan from which annual work plans can be drawn.
j) Do county health staff that complete requisite in-service trainings get incentives?
No, other than the opportunity to go for the training. There is need for incentive guidelines to be developed. This needs to be very innovative, taking into consideration that Mombasa is in an urban set up. The incentives need to be creative, and not necessarily money related.

23. Does the county health department have a centralized Training Unit to address training needs for the county health staff? How is training currently coordinated and documented?
a) How are training needs and training programs or opportunities matched? Yes, but not in an organized way. Gaps are normally identified when the team goes for supervision. When a problem seems to occur in several facilities, then there is need for a training. The team then looks for a partner that can support that training. Some of the gaps just need sensitization to sort it out, so the team could ride on an existing training. It helps that the County Department knows their partners well and so they are able to approach partners in their areas of interest.

b) What records are kept on in-service training for individual health workers? The partners keep their own records. The Program Coordinators keep their own records and training report. The danger identified with this is that the Program Coordinators will leave the county with his records and not leave them with any one. Hence the need for a Training Coordinator. Long term Certificates are put in the staff's file. Short term ones are however not put in the staff member's HR file. The Training Coordinator can support HR to upload the certificates, including the short-term ones into the iHRIS.

c) What do you think are the major pre-service training problems facing the county?
   - The Students who come for attachment use a lot of consumables, and what they pay cannot cover that.
   - The pre-service training institutions send their students for attachment without supervisors. This overloads the already stretched workforce.

d) What do you think are the major in-service training problems facing the county?
   - Lack of coordination – other staff do not know when colleagues are out.

e) What kind of assistance does the county need to coordinate and document training?
   - Training and mentorship for Mangers and health Records Officers on iHRIS Train
   - Equipment such as Printers, Scanners, Computers for the team dealing with iHRS staff and a work station for the Training Coordinator
   - Facilitation for the iHRIS Coordinator in terms of transport and communication to support staff at the sub-county level

24. What is the capacity of county health department towards granting accreditation to pre-service training facilities? This the team felt is the role of the National Government function and the County has no role.
    a) What is the role of the national government in accreditation of pre-service training facilities? Regulation and standards
    b) How often is accreditation conducted? Various professional bodies/councils do this.
    c) Are accreditation standards comprehensive and up to date?
    d) Who conducts accreditation? How is this team formed?
    e) What kind of assistance does the county need towards implementing accreditation?

25. What are three priority performance areas most in need of strengthening within the county health department that relate to HRH?
    i. Strengthening of the HRM Unit
    ii. Evaluate, review and disseminate the HRH Strategic Plan
    iii. Implementation and annual tracking of the new HRH Strategic Plan

26. What are the successes and major challenges for strengthening health workforce? (ask for each vertical program (HIV/AIDS, TB/HIV, RMCH, Malaria, Nutrition) and the county as a whole)?

Trainings	Successes	Challenges
General to all (HIV/AIDS, TB/HIV, RMCH, Malaria, Nutrition)	Improved health outcomes	Industrial unrest
	Promotions motivated staff	Lack of a wellness centre for staff
	Promotion for common cadres and competitive posts	Lack of a succession plan
		Inadequate health workforce
		Aging workforce – in the next 3 years there will only be one

		Radiologist if this is not addressed.
HIV/AIDS; TB	Re-designation of 9 support staff as HTS counselors	
RMCH	Skilled birth deliveries have gone up	
	Improved competence of midwives hence reduced maternal complications and fewer still births	
Malaria	Cases for Malaria have gone down in the last one year	
	Rational use for treatment of malaria	
Nutrition		Adverse shortage of nutritionists leading to task shifting

Building Block 3: Health Information Systems

Indicator 3.1: Capacity of Health Department to plan for and systematically collect health information

Standard 3.1.1: Capacity of County Health Department to implement HIS policies, strategies, guidelines, protocols and use routine HIS forms	
0	● The county does not have national health information system policy and strategy.
1	● County health department has the national health information system policy and strategy ● Data collection tools systems for all key components are not readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms.
2	● County health department has the national health information system policy and strategy ● Data collection tools systems for all key components are readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms ● Sub-counties, facilities and community units do not have adequate supply
3	● County health department has the national health information system policy and strategy ● Data collection tools systems for all key components are readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms ● Sub-counties, facilities and community units have adequate supply ● Mentorship program on correct use of HIS forms institutionalized in less than 75%of sub-counties and/or facilities.
4	● County health department has the national health information system policy and strategy ● Data collection tools systems for all key components are readily available: o source registers

	○ birth/death registration, ○ reporting forms, ○ data quality assessment protocol forms, ○ disease surveillance forms ● Sub-counties, facilities and community units have adequate supply ● Mentorship program on correct use of HIS forms institutionalized in at least 75% of sub-counties and/or facilities.
Comments: HIS tools are inadequate . Would ranked 3 but 2 due to the inadequate tools. Mentorship program is ok as they have HRIO visit facilities and train the staff. GAP: Country feels that they need to have a County specific HIS M&E framework where the output and outcome can be monitored which is not captured in the national HIS M&E plan. One of the issues that can be included includes the need for private Health facilities to report.	

Adapted from the WHO's *Monitoring the Building Blocks of Health Systems*, key components of a HIS include: routine health information, vital statistics, disease surveillance and health surveys

1. Does the county have an integrated Health Information System that includes indicators, data elements and sources, frequency of collection, data flow, data validation rules and quality assessment guidance/protocol? YES. DHIS includes all the elements

2. How has this system been rolled out to sub-counties and facilities? We have had cascaded training the counties. When there is an update and we do refreshers, data review, DQA, also we do on the job training and mentorship.

3. Does the county have a system for monitoring and evaluation of county programs that details priority health impact and outcome level indicators at a minimum that presents plans on how data will be collected for monitoring, evaluating, disseminating and using analyzed data, that clearly spells out roles and responsibilities, capacity building and county stakeholders' data review forums? Through quarterly data review/ performance meetings.

4. How has this plan been rolled out to sub-counties and facilities? When needed the county does refreshers, Data reviews, Data Quality Assessments, On Job Trainings and Mentorship

Standard 3.1.2: Capacity of County Health Department to collect quality health data	
0	● There are no county-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) in place.
1	● County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data are not routinely collected using standard data collection forms.
2	● County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data routinely collected using standard data collection forms.

	• County department of health receives timely and complete reports from less than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization)
3	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data routinely collected using standard data collection forms. • County department of health receives timely and complete reports from more than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization) • County department of health receives accurate reports from less than 75% of health facilities (public, private and faith based)
4	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist; data are routinely collected using standard data collection forms. • County department of health receives timely and complete reports from less than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization) • County department of health receives accurate reports from more than 75% of health facilities (public, private and faith based) • Health performance data reviewed regularly and regular feedback provided to all health facilities on data accuracy.
Comments:	

Qualitative Questions Standard 3.1.2

1. Who has the primary responsibility for collecting data for routine health information, vital statistics, disease surveillance and health surveys systems? Health records and information personnel at the 3 levels Facility, Sub County and County.
2. Who has the primary responsibility for submitting/entering data and validating it from these data systems? Health Records Information Officer (HRIO)
3. To what extent has the county health department institutionalized Ministry of Health's National Data Quality Protocol and Standards? We use the DQA protocol. We have adopted but yet to institutionalize.
4. What is the process for data quality assessment and how often is it conducted by county health department? By Sub-county health administrators' offices? We use the 7 dimensions. Standardized tool from excel go to the facility and check selected indicators. We generate data from the primary sources in facility then compare that with the facility summary and the DHIS. It is conducted quarterly depending on the indicator or where there is need. At least 1 DQA is conducted per program. The CHMT coverage is county wide while the SCHMT do it at sub level.

Qualitative Question Standard 3.1.3

1. Where is health data stored at the county and sub-county levels? Data is stored at Sub County. They store the summaries in facilities and the sub county. The county has the DHIS as the store.

Standard 3.1.3: Capacity of Health Department to manage data	
0	• No one single county-wide preferred electronic or paper based exists.
1	• Separate information management systems (paper or electronic) exist for the various components of the HIS. • It's difficult or impossible to manipulate or extract data from the system.
2	• One Single County preferred Electronic Health Information Systems platforms (databases) exist for the various components of HIS • Data are not routinely extracted for reports and other use.
3	• One Single County preferred Electronic Health Information System platforms (databases) exist at the county for the various components of the HIS, • Data are routinely extracted (at least annually) for use. • Integration of information from other health management systems (i.e., service statistics, financial, human resource, logistics information, and physical assets data systems) not yet fully operational.
4	• One Single County preferred Electronic Health Information System platforms (databases) exist at the county for the various components of the HIS, • Data are routinely extracted (at least annually) for use. • Integration of information from other health management systems (i.e., service statistics, financial, human resource, logistics information, and physical assets data systems) is evident. • County Data Management Guidelines exist including policy on health/research data sharing policy.
Comments: : No policy for data sharing . They use the DHIS for data sharing. No integration of information from other health management systems. They have IHRIS and service statistics. None for financial is yet to be fully rolled out. They have an inventory but it is manual. Mombasa county has a system referred to as 'Situation Room'. There is a HIV system that picks data from NACC, DHIS and informs KEMSA in terms of commodities supply.	

Indicator 3.2: Capacity of County Health Department to promote evidence-based decisions and policy making

Standard 3.2.1: Capacity of County Health Department to use collected data for planning and policy making	
0	• No evidence of data use for strategic planning including rational budgeting and decision making.
1	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county health committee and other state and non-state actors. • No evidence of data use for strategic planning including rational budgeting and decision making.

2	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings.
3	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county assembly health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings. • The county can identify at least two examples of how data have been integrated into a decision-making process including rational budgeting in the past year.
4	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county assembly health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings. • The county can identify at least two examples of how data have been integrated into a decision-making process including rational budgeting in the past year. • Policy and planning framework (that details national development goals, national health sector priority goals, county health priority goals, county budgetary and donor allocations, and county health development outcomes) exists.
Comments: Do not have a framework that shows the donor allocation. The budgets are based on previous year performance. The Challenge Initiative is the only donor program that is sharing its allocation.	

Qualitative Questions Standard 3.2.1

1. How often is routine health data analysis presented to senior managers for discussion, field monitoring/supportive supervision, problem solving and decisions? As we do the quarterly performances review. Monthly at sub county and facilities.

2. How often is performance information presented to County Health Department leadership for discussion, problem solving and decision making? Quarterly performances review and Monthly at sub-county and facilities.
   Provide examples of how reviewed performance data have been used to identify opportunities to improve services. . 1. In September we identified from KDHIS data that we have a number of children that are not immunized hence formed a taskforce to mobilize resources and followed up on it. 2. Traditional Birth Attendants (TBAs)- wanted to engage the TBA midwives as informed by the low deliveries data. 3. High teenage pregnancies enabled cooperation of Ministry of Education (MOE) to start a project for youth in and out of school. Member of County Assembly (MCAs) Induction showcased data that led to understanding health dynamics and hence MCAs are sensitized to advocate for health programs. The outcome from this is that MCAs agreed to follow up on NHIF recruitment 5. Nutrition data indicates the Base Mass Index is not good for our population and are working closely with MCAs and training them on health. We have 10 to 12 MCAs in the Health committee at county level.

3. How often is health data used in reviewing/evaluating the success and/or failure of county health programs and strategies? Quarterly at county and monthly at sub county

4. How often is health data used in the formulation of policy and/or incremental re-adaptation of existing programs and strategies? As need arises
5. What role does the CHMT play in promoting and/or facilitating the use of health data for management decision making at county level? Advocacy, Encourage opportunities of integration

Building Block 4: Access to Essential Medicines & Other Health Commodities

Indicator 4.1: Capacity of County Health Department to ensure access to essential medicines for the population

Standard 4.1.1: Capacity of the County Health Department to provide oversight to commodity management to downstream levels of service delivery	
0	• The county does not have an organized unit (of more than three persons) to oversee and coordinate commodity security in the entire county.
1	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership.
2	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate.
3	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate. • The County Commodity Security Committee structure has been adopted, operationalized and implemented at the sub-county level for all the sub-counties in the county.
4	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate. • The County Commodity Security Committee structure has been adopted, operationalized and implemented at the sub-county level for all the sub-counties in the county. • Supply chain performance statistics are maintained at county, sub-county and facility levels and reflect improving trends overtime.
Comments: The county Technical Working Group also incorporated the 4 sub county pharmacies team. Have never thought about having a replica at county level. We don't have supply chain statistics but have reporting rates for program commodities but trying to develop one for essential medicals tracking.	

Qualitative Questions Standard 4.1.1

1. Describe the procedures for implementing and supervising supply chain services in the county?
   Essential medicines orders are generated from the facilities based on consumption and current stocks then are send to sub county level then forwarded to county to HPDT (Health Product …) then we place the order on KEMSA LMIS. Once we have proforma then is LPOs then order is authorized and supplies done mostly within 2 to 3 weeks. Then they are delivered directly to the facilities order are verified and entered into the stock card and then stored.
   a) Describe the way through which the county ensures availability and use of required guidelines, protocols and tools for product selection, quantification, commodity reporting, use, support supervision and M&E at all levels of service delivery in the county?
      County team supervises with Sub County and samples. For program commodities (Immunization, HIV, RH, TB, FP). We have satellite and central site facilities for storage. There are commodity guidelines. -we use the national Kenya Essential Medicines List and Kenya Essential Medicines Supply List for product selection. For quantification we have a tool that we use for ordering and is referred to as the Commodity reporting national tool and DHIS. For m&e we have quarterly data review meetings.

   b) Briefly describe how supply chain data is used to help decision making at county/sub-county and facility level; and how the county ensures that systems for collecting data from lower levels and feedback loop from higher levels is in existence, adequate and continuously being improved. We do supply chain- planning forecasting and quantification helps us in determining. E.g. Lishabora Implementing partner used data from county for forecasting data to supply county with IFAS(Iron, Folic Acid supplement). The feedback loop from high level to lower levels is a challenge. It is in existence but not structured and sometimes inadequate.
   c) How does the process of supportive supervision for service delivery incorporate supervision for supply chain service/commodity management at health facility level?
   At county level for support supervision we have structured it into 4 teams that look in all areas. However the supervision is not regular and consistent due to lack of resources
2. Describe the procedures for monitoring and reporting supply chain performance at all levels in the county? We have the DHIS and a county formed system in excel called TRACER commodity tool
   a) In which specific ways does the county take a whole-market approach in strengthening commodity management systems for the county? (ie inclusion of non-government health sub-sector (eg faith-based)that offer services within the county)
      We involve all in commodity management training. We have included only one facility in our tool and provide them with commodities as well. About 84% are private based and faith based so we give commodities for which they charge and hence they send the clinical data to us.

   b) How does the county ensure trend graphs on key supply chain performance indicators are maintained as a measure of quality of supply chain services rendered in the county? eg stock-out rates, stocking according to plan, reporting rates, and commodity disposal due to expiration.
      There are no trend graphs yet but are trying to adapt using the tracer tool. It is not yet done. We are populating the tool we have done a baseline. AFYA PWANI is helping us. There is a directive for disposal committee establishment. We have good partnership with the association. We recently had a disposal event with the Pharmaceutical Association of Kenya about 11 to 13 tons of drugs were disposed.
   c) How is equity ensured in commodity distribution and dispensing? In other words, what procedures are used to make sure that essential medicines and health commodities are distributed/ issued out according to need?

We supply based on the consumption. We look at the workloads it's a pool system based on the needs and demand. We have clinical guidelines that are not fully adhered to. For the community they believe in food supplements. Need to sensitive the community on medicine use.

d) How does the county ensure improved access to quality and affordable essential medicines and other health commodities? (Consider systems for commodity quantification and supply planning, inventory management tools, commodity information management, commodity financing and procurement, and financing for continuous improvement of supply chain systems) We do the forecasting and quantification although there is no standardized electronic inventory management tool. We have the DHIS for information management and manual tools as well. Procurement is from KEMSA as they have subsidized rates and ensure the quality. We use F&Q data to lobby for resources. We have been procuring using the user fees foregone from 4 funds from national government but it hasn't been consistent. Partners assist us in reporting , reviews and commodity capacity building,

Standard 4.1.2: County Health Department's capacity to estimate commodity needs, develop a supply plan and procure/source these commodities (Forecasting, Quantification and Procurement)	
0	• No capacity (external or internal to the county) available to conduct a forecasting and quantification exercise (estimate commodity needs, develop a supply plan, and procure essential commodities).
1	• The county is reliant on external technical assistance to estimate commodity needs, and develop a supply plan, no mechanism exists to fully procure or source (i.e. buy or secure donations of) essential commodities.
2	• The county is reliant on external technical assistance to estimate commodity needs, and develop a supply plan, • County partially has capability to fully procure or source (i.e. buy or secure donations of) essential commodities.
3	• The county has capacity to estimate commodity needs, and develop a supply plan, • County partially has capability to fully procure or source (i.e. buy or secure donations of) essential commodities, • County requires minimal external technical assistance to estimate commodity needs.
4	• The county has capacity to estimate commodity needs, and develop a supply plan, • County has capacity to fully procure or source (i.e. buy or secure donations of) essential commodities, • County requires no external technical assistance to estimate commodity needs, • Health commodity procurement done at least once annually.
Comments: County not capable of fully procuring essential commodities . We require technical assistance from partners to consolidate the data and report writing mostly for lack of resources for conferencing as many players are required for the activity of F & Q. F & Q process involves- Sampling of facilities then do data collection for the workload and selected medicines looking for physical stocks then, quantity is calculated and data is aggregated. Then do projection and derive the costs. NB: The tool does not seem to focus on the equipment aspect enough	

Qualitative Questions Standard 4.1.2

1. How are commodity needs identified? From the facility needs based on consumption based on past 3 month consumption. The KEML check for standardized prescription and restricts clinicians on medicine use.
   a) How are the county, sub-county and health facility needs identified? Past consumptions and using KEML Checklists
   b) What role does National Government agencies/institutions play in assessing county commodity needs? The supplies are from the national government KEMSA, TB,NASCOP they look at the reports supplied by the counties
   c) What happens after commodity needs are identified? How are requests made? Place to county then to KEMSA through LMIS. Sometimes facilities can do direct request to KEMSA. There is a monthly CDRR(Commodity Report to national level through DHIS and LMIS to determine supply
2. What is the role of development partners and CHMT for health and/or implementing partners in procuring essential medicines? Technical assistance in quantification. Support in procurement in program they are supporting. Also in Capacity building in commodity management and distribution. The global funds and UNFPA procure commodities at national level.
3. What is the proportion of county spending on commodities as % of total county health spending?

Standard 4.1.3: County Health Department's Capacity to Develop and/or adopt and Use a National/County-owned Health Commodities' Logistics Management Information System (LMIS)	
0	• County currently uses no Health Commodities' LMIS system.
1	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records.
2	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, reporting of LMIS data is below 50% for all facilities annually.
3	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, county has access to limited logistics data including: stock on hand within the system and consumption/usage for the past reporting period and demonstrates reporting rates of least 50% from the sub-counties. • County has a plan for routine DQA exits, DQA of LMIS data conducted at least once annually
4	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, county has access to logistics data including: stock on hand within the system and consumption/usage for the past reporting period and demonstrates reporting rates of least 75% from the sub-counties. • County has a plan for routine DQA exits, DQA of LMIS data conducted semi annually

	• Data Quality Improvement Plan for LMIS data developed for every DQA and implemented
Comments: Manually it is in place but it is not there in electronic form. KEMSA had a meeting with MSA county recently with a team from IBM/Watson and Bill & Melinda gates with regards to software development. – too soon to tell if it will materialize.	

Standard 4.1.4: Health facility's capacity to effectively store and account for health commodities through appropriate records and reports.	
0	• No system exists for proper storage and distribution of commodities, including essential medicines. (***special storage requirements of medicines and other commodities are not followed, poor records keeping and consumption reporting***)
1	• Warehouse/stores(s) for commodity storage exists at either county, sub-county or facility level, with some accommodation for items requiring special storage.
2	• The county/sub-county warehouse and health facility store meets at **least two** of the following four criteria: warehouse/store size is adequate, storage spaces are is well maintained and clean (including pest, lighting, temperature and humidity control), • County warehouse has designated storage equipment for special storage needs, and re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance.
3	• The county/sub-county warehouse and health facility store meets at **least three** of the following four criteria: warehouse/store size is adequate, storage spaces are well maintained and clean (including pest, lighting, temperature and humidity control) • County warehouse has designated storage equipment for special storage needs, • Re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance.
4	• The county/sub-county warehouse and health facility store is adequate – meets all four criteria (i.e. large enough, regularly cleaned, dry, well organized) with all special needs storage areas clearly designated with correct signage, • County warehouse has an established re-order and stocking plan, including the use of protocols (such as first expiry, first out), job aides (such as SOP for emergency procurements) • Re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance. • Stock-control records such as stock cards and bin cards are well maintained
Comments: No warehouse at county or sub level. currently use a facility store that does not meet all the standards. • Re-distribution/dispatching/dispensing to sub-counties is not schedule and stock cards and bin cards are not well maintained	

Qualitative Questions Standard 4.1.4

1. Describe the procedures adopted for proper storage of essential medicines and other health commodities (county, sub-county and health facilities) Facilitates receive, segregate then alphabetical arrangement. First Expiry First Out (FEFO) arrangement, stock control cards are in place but are not up to date Adapt good storage practices air circulation, dry. There are no SOPs

in the facilities but we teach them during training what to do. Security is in most of the facilities but some need to be secured

2. What is the role of community-based groups and networks in community commodity distribution? We have CHVs that distribute ORS, Zinc, Vitamin A, FP pills and condoms. Some CHVs have formed CBOs from such interactions. There are no CUs

3. What is the role of private sector in commodity procurement, storage and distribution? Private facilities are our private sector players. We give them commodities. We use their data to procure. We have not involved them in other activities
4. What mechanisms does the county use to assure quality for medicines and other health commodities within the county level? Procurement is from reliable suppliers e.g. KEMSA. There is the Pharma co vigilance which is a national system in place to which reports of drug reaction and poor quality this are submitted. which are then forwarded to the Pharmacy and Medicines Board. Especially for immunization.
5. Does the county have in place a pharmacovigilance system? If so, since when? If not, is there a plan to develop/put in place such a system? Please describe. No. Use the national system

6. What systems does the county have in place for medical waste management? None. Last year supported the transport over 10 tons of expired medicines to Nairobi for incineration.

Building Block 5: Health Systems Financing

Indicator 5.1: Capacity of the County Health Department to ensure that adequate funds are allocated to the health sector within the overall county budget.

Standard 5.1.1: Capacity of the County Health Department to ensure that adequate public funds from the total county government budget are allocated to public health and population activities.	
0	• The county health department has no input into the development of the county budget estimates.
1	• The county health department has input into the county budget estimates development, • But public health expenditures are not systematically calculated on an annual basis and total at least 20% of the overall county government budget.
2	• The county health budget is developed annually, with input from county health department • County health expenditures are not systematically calculated on an annual basis as part of budget formulation process • It's less than 25% of the overall county government budget.
3	• The county health budget is developed annually, with input from county health department • Estimated actual county health expenditures are systematically calculated on an annual basis as part of budget formulation process. • Health budget is between 25% and 30% of the overall county government budget.
4	• The county health budget is developed annually, with input from county health department. • Estimated actual county health expenditures are systematically calculated on an annual basis as part of budget formulation process • Program, surveys and surveillance data used as justification for budget requests • County health budget is at least between 30% - 40% of the overall county government budget.
Comments: The team debated and said that their budget is around 26%. Looking at the draft county health budget in the Budget for 2017/18, it was 24.7%. A Fiscal Paper 2018 (in evidence folder) was presented on the 28th Feb 2018. In this paper, the health budget had been reviewed to slightly over 29%.after lobbying with the MCAs. Program, data, National surveys e.g. the KDHS are used as justification for budget requests.	

Qualitative Questions Standard 5.1.1

1. Briefly characterize funding sources for health services in the county.
   a) Where does funding for health care services come from?
      - Out of pocket
      - National Government

- County Government
- Implementing Partners
- Development Partners
- Private sector – under corporate
- Social Insurance e.g. NHIF
- Other insurance
- Philanthropists – e.g. Friends of Joho

(Evidence: County Health Accounts – Provided in Folder)

b) What percentage of funding comes from national treasury equitable share, conditional grants, county revenue collection, private sector, household out of pocket, health insurance and external development partners for health?

Detailed in the County Health Accounts. An analysis was done by Afya Pwani and HP plus as shown below

Table 4-2: Absolute value of THE by financing sources

Financing Sources	2013/14	2014/15	2016/17	% Change
Private Firms	1,471,444,147	1,783,324,567	1,375,878,668	-6.5%
Government	1,247,765,332	1,747,288,343	4,411,808,935	253.6%
Households	3,466,677,322	3,589,839,073	4,572,187,918	31.9%
Donors	1,830,633,052	1,668,076,958	2,412,203,782	31.8%
Grand Total	**8,016,519,853**	**8,788,528,941**	**12,772,079,304**	**59.3%**

(Evidence: County Health Accounts – Provided in Folder)

2. Briefly describe the mechanisms in place to determine county health budget needs of individual sub-counties? Each Sub-county does their own budget and they send that over to the County for consultation. Disease-burden is considered mainly for HIV, but the others are not really done in detail. However, using the DHIS, the information on the high morbidity and high mortality diseases is also taken into consideration in budgeting at the Sub-county level. An example was given with the recent outbreak of cholera. That is what informed the county to budget for the chlorine that was used for chlorinating the pools of water

a) Who is responsible for determining county and sub-county budgetary needs?
   - Sub-county MOH leads a team - the Sub-county Health Management Team (SCHMT)
   - County level lead is the Chief Officer, who leads County Health Management Team (CHMT) in the process

b) How often is a county health budget review conducted?
   - Review is done quarterly at the treasury level for the overall county budget. This happens
   - Review at the Department level e.g. the Health Department is supposed to be done quarterly. However, the common practice is that it happens only when a supplementary budget is given, so as to distribute the money.

Before devolution, performance monitoring used to happen quarterly and the system worked better. With devolution, there are too many other control points.
The gap is in the budget implementation committee. If this was there, this process would be easier, and would allow for inter-sectoral engagement

3. How is the process organized? To what extent are stakeholders involved in this process? (Program Based Budgeting).

- We look at what we want to do at the facility, sub-county and county levels
- A performance budget review is done to determine what should be dome
- There are three different major programs and 15 sub-programs.

Program	Sub-programmes
Preventive and promotive health services	SP 1: Administration, School Health and Health promotions SP 2: Communicable disease control (Malaria, TB, HIV) SP 3: Maternal and child health care SP 4: Non-communicable diseases control and Nutrition SP 5: Public health and Alcohol and Drug Abuse(ADA)
Curative and Rehabilitative services	SP 1 County referral services (CGH) SP 2: Mental Health SP 3 Secondary services SP 4: Primary Services
General Administration, Planning and Support Services	SP1 Human Resource Management and Financing SP 2.Health standards and Quality Assurance SP 3 Health Policy Planning SP 4. Health products and Technology SP 5. Infrastructure SP 6 Health Research

Source: MTEF 2018-2021 (in evidence folder)

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h) Who is involved in the budget making process in the county and why?
CHMT – They are responsible; also guide in terms of prioritizing
SCHMT – They are implementers at the sub-county level
Facilities – Implementers
Partners – Technical assistance
Public participation – Through a stakeholder consultation through which they identify priorities – This is what led to the development of the CIDP
County Assembly – They give approvals for the budget
County Treasury – They provide the ceilings and disburse the funds

i) How are county priorities set in the health sector during the budget process?

- The County Investment Development Plan (CIPD) SWOT analysis – Gives the County Priority
- County Health Sector Strategic and Investment Plan (CHSSIP 2013-2018). The Fiscal Paper that was shared is aligned to the CIDP *(See Draft Fiscal Strategy Paper 2018)*
- Annual work Plans
- Quarterly reviews

Note: These are live documents and so the document can be modified and crisis factored in as required.

j) How are county health programs/subprograms determined in the budget?

- Guided by the disease trends
- Guided by the National priorities e.g. HIV, TB, Malaria RHMC. Cancer and neglected tropical diseases are coming up
- These are County specific like in the case of *Chikungunya (a disease that hit the Coast region)*

F. Summary of Expenditure by Economic Classification (Kshs.)

PROGRAMME		ESTIMATES 2017/18	PROJECTIONS	
			2018/19	2019/20
P1	**General Administration, Planning and Support**	**2,319,136,460**	**2,227,651,591**	**2,339,034,171**
	Recurrent Expenditure	2,063,433,886	1,941,092,236	2,038,146,847
	Development Expenditure	255,702,574	286,559,356	300,887,323
P2	**Promotive and Preventive**	**193,685,886**	**187,778,269**	**129,167,182**
	Recurrent Expenditure	141,724,686	126,071,651	97,375,234
	Development Expenditure	51,961,200	61,706,618	31,791,948
P3	**Curative**	**389,788,087**	**403,774,856**	**386,963,599**
	Recurrent Expenditure	315,870,087	384,462,056	303,685,159
	Development Expenditure	73,918,000	79,312,800	83,278,440
	Total vote:	**2,902,610,433**	**2,719,204,716**	**2,855,164,952**

Source PBB Health Department - Finalized by Finance Department (in evidence folder)

k) How does county improve efficiency in resource allocation and use (value for money)?

- Through the use of the county health accounts. The county had previously located more money to curative services, but they realized that there is more value for money when it is put in preventive services – shift in 2018-19
- Priority programs
- Through budget analysis
- Looking at the health outcomes, which goes back to the disease burden

l) How does county ensure value for money for resources allocated to the health sector?

- Similar to the above answer

m) What challenges does the county have in formulating program based budgeting that factors in efficiency, effectiveness and equity?

- PBB is still very new and most people are still trying to understand it. Factoring in efficiency, effectiveness and equity is therefore a challenge.
- PBB shifts the focus to resources being allocated to results, and previously resources were allocated to process. It requires a mind shift, and that is a process. "We are still stuck on process issues yet we are budgeting for results."
- As a department, the team may develop a program based budget, but when the resources come, they are still line-item budgets.

Equity:

- Allocation does not depend much on evidence. It depends on who is able to articulate their case better. "The power of negotiation."
- Sometimes it is more reactive than proactive.

n) How does the county ensure equitable allocation of resources for improving the social welfare of the most needy in the society? The needy were named as OVC, slum dwellers, women, children, elderly, People with disability, Key population, and adolescents.

- The question of to what extent does the county do an analysis of the disease burden arose. The team responded that this is done mainly in different programs like the HIV, RMCH
- Lobbying for more funds to go to the preventive and promotive interventions
- Representatives of the different programs need to highlight their areas e.g. the medically assisted therapy (MAT) for drug users or screening for TB and cancers, then this will reduce the disease burden
- Cross-sector linkages with Ministry of Education, gender and youth
- Plan of recruiting the over 60 year olds to NHIF to cushion them from out of pocket expenditure for health. This has not quite taken off. It has stalled but it is in the pipeline.
- Universal coverage.

Indicator 5.2 Capacity of County Health department to formulate, distribute and monitor financing for the health sector.

The four criteria necessary in a *sustainable budget* are as follows

Planning: County Health Department has a realistic and sustainable budget informed by sound revenue forecasting methods including use of past experience/expenses, development partners for health contributions and projections
Input: All key stakeholders are involved (including county health department, sub-county health administrators, civil society including religious groups, public participation, and as necessary development partners for health and implementing partners)
Allocation: County Health Department compiles an adequate budget that prioritizes primary health care services, with specific line items for key areas outlined in the County Health Strategy.
Initiative: Process for collection of budget information is led collectively by the County Health Department and sub-county health administrators' offices and the system is standardized across all sub-counties.

Standard 5.2.1: Capacity of County Health Department to plan for, create and allocate a sustainable budget	
0	• No sustainable budget exists (see four criteria necessary for sustainable budget above).
1	• Three of the budget sustainability criteria need improvement (see four criteria necessary for sustainable budget above).
2	• Two of the budget sustainability criteria need improvement (see four criteria necessary for sustainable budget above).
3	• One of the budget sustainability criteria needs improvement (see four criteria necessary for sustainable budget above).
4	• All of the budget sustainability criteria are completed and sustainable, with the county and sub-county health administrators' offices taking the lead on developing the county health budget (see four criteria necessary for sustainable budget above).
Comments: There was a debate on whether the funding can be considered sustainable if most of the budget is partner dependent. The conclusion was that budgets are made according to what is available, and so the county	

would adjust accordingly if the situation changed. It was also said that the National Health budget also depends on donors, and so the Mombasa situation is not unusual. The DANIDA support was said to be very stable.

Tracking was said to be a challenge. The IFMIS system exists but it is a challenge to use at the lower level because the staff are not trained. There is need for a simpler tracking system or the lower levels to use. It was argued by some that the Authority to Incur Expenditure (AIE) system used is a method of tracking in itself.

There were challenges with cash flow due to delays in disbursement of funds.

There is the PFM Act in place. This is a legal requirement. It however needs political goodwill to implement. The CEC needs to take it up to ensure it works. There was a suggestion to have a benchmarking with counties that have managed to make this Act work to learn from them. Kilifi was said to have succeeded.

Develop a County Health Sector Fund Bill to ring fence the department funds. This will enable money to be used for what it is designated for.

The centralization of finance processes at the County level is a challenge. The MOH should be given some powers to manage funds at the sub-county level. Devolve finance powers to the Sub-counties.

The four factors necessary to *effectively distribute and or allocate finances* are as follows:

Financial System*:* A system exists within the County Health Department to distribute funds among its activities. This includes differentiating by funding source (e.g., development partners for health, national and county revenue, etc.) and by funding recipient (e.g., by line item, and by district).
Tracking*:* County Health Department has a system to track its distributed funds against its total budget, the sub-counties distributions against total budgets, manage cash flow and segregate expenses
Policies*:* Policies for allowable expenses exist and are distributed among County Health Department staff and sub-counties. These policies are implemented on a regular basis.
Responsibility*:* Monthly review of internal expenses versus revenue (both for the county health budget and each sub-county's budget) is designated to an employee(s) as a responsibility

Standard 5.2.2: Capacity of County Health Department to effectively distribute finances	
0	• No system to distribute funds exists (see four factors necessary for effective distribution and/or allocation of finances above).
1	• Three of the budget distribution factors need improvement (see four factors necessary for effective distribution and/or allocation of finances above)
2	• Two of the budget distribution factors need improvement (see four factors necessary for effective distribution and/or allocation of finances above).
3	• One of the budget distribution factors needs improvement (see four factors necessary for effective distribution and/or allocation of finances above).
4	• All of the four (4) budget distribution factors are completed and sustainable (see four factors necessary for effective distribution and/or allocation of finances above).
Comments:	

Qualitative Questions Standard 5.2.2

1. Briefly describe the mechanisms in place to ensure fair and adequate distribution of funds to the sub-county health teams.
   a) How is the process set up?

Each Sub-county does their own budget and they send that over to the County for consultation. They raise *Authority to incur expenditure* (AIE). There was a concern that there are some facilities that do not get the user fees.

b) How are needs determined?

- Guided by the disease trends
- Guided by the National priorities e.g. HIV, TB, Malaria RHMC.

2. Briefly describe the mechanisms in place to ensure transparency in revenue collection and distribution.
   - When an AIE is raised, this has to be accounted for before another AIE can be raised.
   - Automation at collection points
   - *Lipa na mpesa* (paying using mobile money platforms) has minimized siphoning of money in selected facilities. There is need to document best practices on this.

a) What policies and procedures are in place?

- Supervision
- Sensitization on where to pay
- Pricing policy that is facility specific
- Finance Bill by the counties

b) What is the course of action when a discrepancy is identified?

- Follow up is done to find out if something has been done
- It is recovered from the staff's salary
- Reshuffling of staff
- Dismissal in serious cases, but the team said they need to confirm this

The four factors necessary to *effectively monitor finances* are as follows:

Documentation*:* County keeps financial documentation in a secure place, has a policy for keeping receipts and requirements for documentation kept with each type of payment. These policies flow down to sub-counties and adherence is monitored.
Review: County reviews expenses monthly to ensure applicability and allowability according to the budget and internal policies. Exceptions are documented.
Reporting: A reporting system exists both for the county to report to the County Government Treasury and for the sub-counties to report to the county. Reports are completed and submitted according to applicable deadlines.
Audit*:* County either has an internal review of its and the sub-counties' accounting systems or hires external auditors on an annual basis.

Standard 5.2.3: Capacity of County Health Department to monitor finances at the National and Provincial levels	
0	• No tracking/monitoring system exists.
1	• Three of the factors necessary to effectively monitor finances need improvement (see four factors necessary for effective distribution and/or allocation of finances above)
2	• Two of the factors necessary to effectively monitor finances need improvement (see four factors necessary for effective distribution and/or allocation of finances above) .
3	• One of the factors necessary to effectively monitor finances need improvement (see four factors necessary for effective distribution and/or allocation of finances above) .
4	• All of the four (4) factors necessary to effectively monitor finances are completed and sustainable (see four factors necessary for effective distribution and/or allocation of finances above) .

Comments:

- Documentation was not there.
- Reviews are ad hoc and unstructured.
- The internal audit – An auditor is sent from the County. The Health Department is supposed to have its own auditor, but there is none.

There is need for an internal auditor in the Health Department. In all 4 sub-counties there is need for an accountant. A budget committee is required as discussed earlier. Policies exist but the manpower to implement is the key gap.

Qualitative Questions Standard 5.2.3

c) Who monitors/ manages the county health department budget at the county treasury level?
   - Chief Officer Finance. The Controller of Budgets at a higher level.

d) What input do individual departments other than health department provide towards managing the overall county health department budget?
   - Finance Department – Provide ceilings, allocation of funds, disbursement of funds, Expenditure reviews
   - County Assembly – They give approvals for the budget
   - County Treasury – They provide the ceilings and disburse the funds

16. Briefly describe your procurement policies and procedures?

The process begins with an invitation of the procurement. It is followed by the preparation of the bid documents. The advertisement or invitation to bid is then sent out. The bids are then received, opened and evaluated. The contract is then awarded to the winning bidder. After communication the contractor signs a contract. The goods are supplied, or service provided. Inspection and acceptance follows. Goods are then stored, managed and distributed. (*Detailed in Procurement Procedures in the evidence folder)*

a) Do you have different thresholds for procurement?
   - Yes. It is clearly understood

b) What do you keep as documentation in your files?
   - Tender documents, LPOs, LSOs, Quotations, Bill of Quantities (BQs), Contracts, Tender evaluations.

c) How do you ensure transparency in procurement?
   - Open tender process
   - Procuring from KEMSA as the first point of call – according to the Act. This has no kickback

17. What is the county's capacity towards developing and implementing Performance-based contracts (PBC)? The team was unsure of this question and they had different views. This was largely because none of the members was involved directly in procurement. The Head of Management however provided clarity the following day.

    This he said is mainly done for the contracting of renovations or building and there is a set process for doing this through the procurement team. The county has capacity as there is a team and a procurement procedures document in place to guide the process and the process is supported by the Ministry of transport and infrastructure through very clear guidelines.

    a) How are performance indicators identified? What is the county's process for identifying the indicators?
    This is done by the facility requiring the work to be done. The request is passed on to the County level for approval. The County Health team them passes this on to the Ministry of transport and infrastructure, who then begin the process of identifying a contractor.

    b) How are contractors identified? What is the county's process for identifying the contractors?
       - This is similar to 5.2.3 (2) above. This is mainly done by the project Manager in the Ministry of Transport and Infrastructure.

    c) Is there a policy/ operational plan to guide the PBC process?
    Yes. Procurement Manual for Works by the Public Procurement Oversight Authority (in evidence folder)

    d) How is performance evaluated and recognized?
       - The specification is provided by the team raising the need
       - The Ministry of transport and infrastructure assesses the work and gets a contractor using the approved tendering systems
       - The contractor prepares a progress of work document with a gantt chart. This is ratified by the Project Manager. This is what is assessed at the different stages to determine if the contractor is paid at the different stages.

    e) What kind of assistance does the county provide to sub-counties health administrators' offices in implementing PBC?
       - Identifying, supervising and paying of a contractor

18. What resources and support does County Health Department need to implement PBCs across all sub-counties?
    a) Financial needs
    b) Procurement and logistic needs – Technical assistance to develop a database of pre-qualified contractors comprising of contractors that have done a good job in the past, with all the right

credentials, based on qualification and having the mandatory documents. This will help save time during the tendering process.

c) Training needs

19. What is the county health department's budget allocation utilization rate (% of expenditure in total allocated health budget)?
    a) Recurrent expenditure – 82.6%
    b) Development expenditure 17.4%

    (Evidence: Draft Fiscal Strategy Paper 2018)

The plan according to the CHSIP, P. 78, was that overall, recurrent and developmental expenditure will constitute 45% and 55% of the overall budget. The bulk of the developmental expenditure will go towards upgrading and expansion health infrastructure. This as we see from the Fiscal Paper 2018 is not what has happened.

Building Block 6: Delivering Essential Health Services

Indicator 6.1: Capacity of County Health Department to engage sub-counties in delivering public health services

Standard 6.1.1: Extent of interaction between the county health department and sub-counties	
0	• No structured interaction with sub-counties.
1	• The health department interacts at least once a year with sub-county health administrators on: o Budget-related issues only.
2	• The health department interacts at least once a year with sub-county health administrators on: o Budget related issues o Health service planning activities.
3	• The health department interacts at least once a year with sub-county health administrators on: o Budget related issues o Health service planning activities, o Maintenance and coordination of facilities.
4	• The health department interacts at least four times a year with sub-county health administrators on: o Budget related issues o Health service planning activities, o Maintenance and coordination of facilities, o Assessments and planning for community health needs.
Comments: The County holds regular quarterly meetings with sub county health administrators, support supervision (twice in a year), annual work planning (once in a year) Sub-counties are involved in budget related issues, quarterly review meetings. On maintenance and coordination of facilities, the health facility manager at County level and the administrator engages with sub-county health administrators	

Qualitative Questions Standard 6.1.1

10. What mechanisms are in place to involve community stakeholders, sub-county health officers and partners in planning for service delivery?

    Several mechanisms exist through which to involve community stakeholders, sub-county health officers and partners in planning for service delivery:

a) Community stakeholders: are involved in the implementation of the community health strategy

- Quarterly dialogues and action days that allows the community unit to discuss issues affecting health in the community

- Public participation county forums at health planning stage and during allocation of funds (through the health facility management committee

b) Sub county health officers: are involved in the bottom-up planning process (they participate in planning for service delivery at county, facility and sub-county levels). The officers consolidate health needs and priorities and participate in joint annual work planning sessions held in the county.

c) Implementing Partners: Are actively involved and work very closely with the county health department. Their key roles include provision of technical support, creation of consensus on priorities and targets at target setting stage and support for other planning mechanisms such as development of the County Health Strategic Plan and CIDP).

11. Has the county conducted a formal exercise to plan for health services? Yes
    a) How often is planning conducted? Annual work plans and every five year for CIDP and county health strategic planning.
    b) Is there a general Annual Work Plan? Yes, APR/AWP (Health Sector plan) 2017/2018. It documents the previous achievements, challenges and sector priority interventions and actions for department of health for period 2017/ 2018.
    c) Do you have unit-specific and or Vertical Programs specific Annual Work Plans? Yes ; integrated in APR/AWP (Health Sector plan)
    d) How were they developed and shared? It is a product of a consultative process of stake holders at various levels.
        - Planning process started with the Orientation of the Planning teams at the County, Sub County, Facility and Community level,
        - Followed by the actual development of the various levels plans whose focus was on priority outputs from levels 1, 2&3, 4 and 5.
        - Plans at these levels were then consolidated into Sub County Health Sector plan.
        - The Sub County Consolidated plans were then appraised at the County level before the sub County were allowed to produce their final copies.
        - The Sub County Health plans were then consolidated into this County health sector plan
    e) Who is involved in the planning process? All stakeholders: A consultative and participatory process involving series of meetings and with internal stakeholders from the county health management team, sub-county management teams. stakeholders at various levels

    f) How is the planning process organized?
        The process was initially started by a working group with stewardship from the HMIS/Planning and Monitoring department. The County health management team, sub-county health management teams participated and consulted
        - Planning follows the planning cycle
        - Template shared from the national level is adopted for planning
        - Sensitization of lower levels is an initial step
        - Situational analysis is done based on the baseline targets

12. How are priority service areas identified? It is standard and follows the national guidelines. As a requirement of the County Governments Act 2012, APR/AWP outlines

previous achievement and provides the annual planning and budgeting process for the coming financial year

a) Is service delivery reflective of priority health needs per county health strategic plan? Yes; seven investment areas including; Service delivery, Health Infrastructure , Health Workforce, Health information, Health Products, Health Financing and Leadership and Governance

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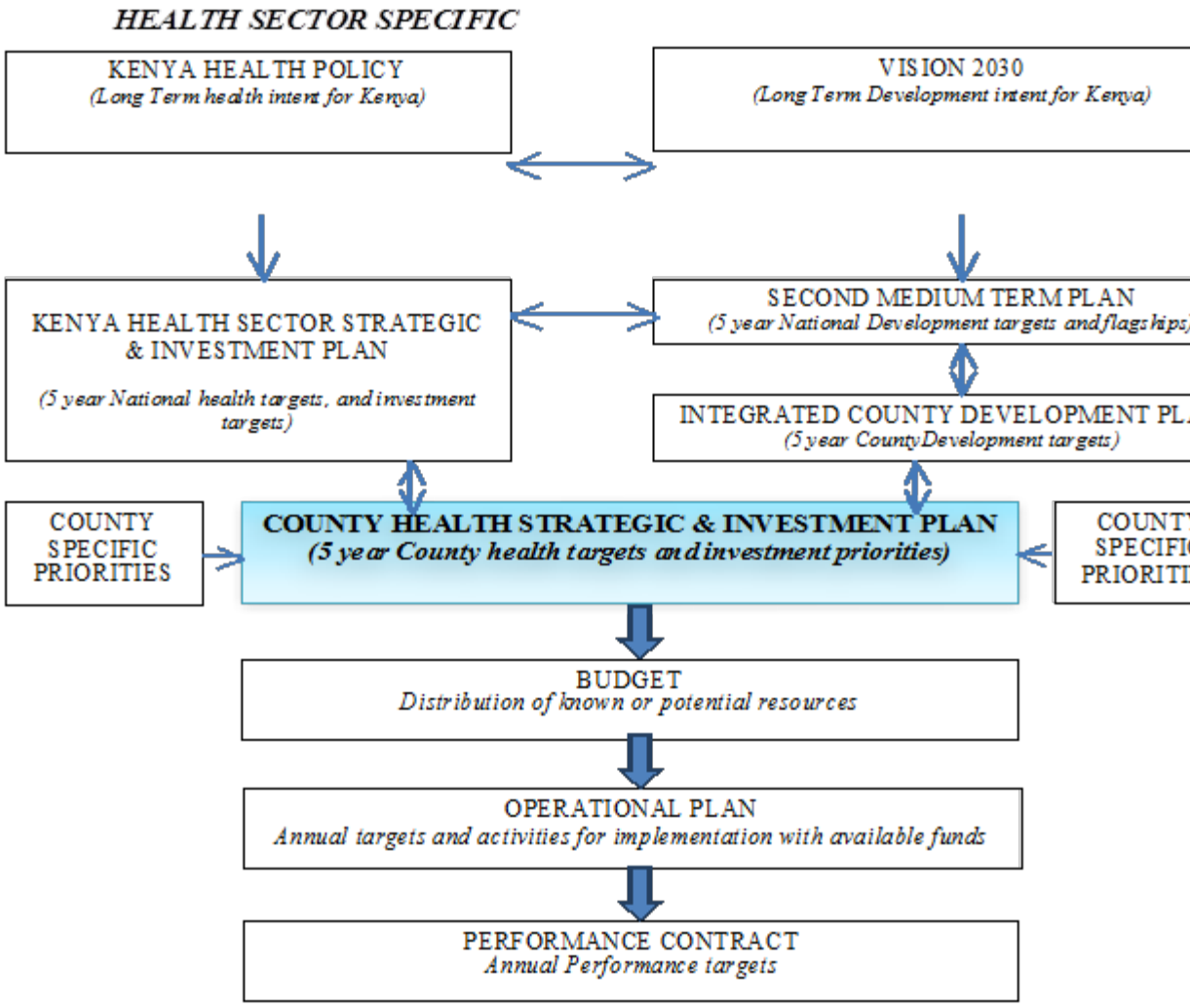
b) What policies do you have in place to ensure service delivery targets priority health needs? Please describe. The County health results framework captures the policy frameworks



Standard 6.1.2: Capacity of County Health Department to develop and distribute (to the sub-counties) policies, plans and standards for key health care delivery areas	
0	• No County Health Department's Health Strategy exists.
1	• The county has a health strategy aligned to national health strategy (2014 – 2018)

2	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities.
3	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities. • The county clinical standards and guidelines are currently used by least 50% of sub-counties within the last two years.
4	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities. • The county clinical standards and guidelines are currently used by least 80% of sub-counties within the last two years. • The county health department conducts regular sub-county and health facility visits to monitor compliance in the use of standards and guidelines.
Comments: There was i) Inconsistent sub-county and health facility visits to monitor compliance in the use of standards and guidelines and ii) Irregular support supervision	

Qualitative Questions Standard 6.1.2

7. What guidance does the county provide the sub-county health administrators regarding service delivery?
    a) Are there policies and procedures?

- Provides guidance to national Protocols such
- Training on policies and procedures
- Support supervision

    b) Does the county annual work plan provide guidance to sub-counties? Yes, the county strategy and AWP targets are disaggregated to sub-county levels and guide operations at sub-county level

8. Who decides what services need to be provided at the sub-county level?
   National policies, protocols and guidelines such as Kenya Essential Package of Healthcare (KEPH) stipulate and guide what services are provided in the level 1-5 facilities in the county levels (level 1 to 6)

Indicator 6.2: Capacity of County Health Department to ensure appropriate use of policies, plans and standards related to Health Service Delivery for HIV/AIDS, TB/HIV, RMNCH, Nutrition, Water & Sanitation, and Malaria

Standard 6.2.1: Capacity of County Health Department to supervise sub-counties in the use of Health Service Delivery Standards, Guidelines, Protocols

0	• No system exists at the county to monitor adherence of sub-counties to standards, guidelines, protocols.
1	• Some elements of a basic system exist for monitoring adherence to standards, guidelines and protocols.
2	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (*lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities),* but use of these guidelines is not consistent by the county health department or sub-counties.
3	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (*lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities)* • County provides support to sub-counties to monitor adherence at the facility level, but not consistently.
4	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (*lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities)* • County provides support to sub-counties to monitor adherence at the facility level. • The county jointly with sub-counties has joint plans for conducting adherence monitoring at the health facility level.
Comments: • Inconsistent support to sub-counties for adherence monitoring at the facility level. • High Workload/ turn-over in quality of care • Limited customer and health workforce satisfaction surveys	

Qualitative Questions Standard 6.2.1

7. What mechanisms exist in place for supervision of sub-county health facilities?
    - Program officers for various programs monitor/mentor sub-counties
    - JD s exist and organizational structure is well stipulated
    - There is a supervision schedule in existence
    - The county has customized the national supervision checklist

    bb) Is supervision focused on medical audits or coaching and performance improvement or both? Both

    cc) How often is supervision conducted? Three supervision teams (Administration, EPI and Surveillance and Programs exist)
        - Program specific supervision is done 'depending on availability of resources/activities but is done at least quarterly'

- Integrated supervision is 'supposed to be done quarterly but does not happen'

dd) How are supervision needs determined? (needs-based or regularly scheduled?)

- Program specific supervision is decided on by program officers ; Data availability informs the issues e.g T.B sub-county coordinators visit facilities monthly and sub-counties quarterly
- Integrated supervision: CHMT decides; issues are picked from sub-county/facility levels; quarterly support supervision is conducted ('*We go to service point, administer supervision checklist. Support the health facility to use the checklist. It is a learning/sharing of best practices, interactive and peer mentorship'*- Participant, CICA Mombasa)

ee) Who conducts the supervision visits? CHMT and sub county MOH and teams

ff) Is there clarity about levels of supervision (who supervises who) and reporting? Available in the county supervision guidelines

gg) What tools are used to conduct supervision? Programme and integrated checklist and schedules are available.

hh) How is supervision findings used? Findings are used to give instant feedback at facility level; propose action points; recommend training/capacity building; to provide mentorship and follow-up

ii) Are supervision results linked to any type of reward/recognition/incentives system? There is a well-developed reward/recognition/incentives system at (County-led and also Sub-county led). Facility awards criteria and Sub-county awards criteria has been developed and is used to offer rewards/recognition/incentives.

jj) What are the challenges to conducting supervision?

- Lack of means of transport
- Inadequate funding to supervise all facilities.
- Shortage of staff makes it difficult to conduct regular support supervision as patients are left unattended to during such visits
- Some members of the supervisory team have not been trained on support supervision

8. What mechanisms exist for improving quality of care through the health system?
    - Monitoring adherence to guidelines/standards
    - Conducting exit interviews
    - Reports by Quality teams
    - Trainings on Quality Management

What are the gaps in quality of care in the system?

iv. Workload: patients do not get adequate time for diagnosis, advice on adherence etc due to the heavy workload on health staff in the County

v. Drugs dispensed by non-professionals such as nurses or CHVs
vi. High Staff turnover

-

What are some of the successes in improving quality of care?

Successes in improving quality of care in Mombasa County;

- Adoption of quality improvement approaches and putting in place Quality improvement teams at county, sub-county and facility levels
- Institutionalizing routine monitoring/feedback system
- Dissemination of updates
- Conducting refresher courses
- Improved quality of reporting and capturing of new indicators
- Revision of tools
-

l) What indicators are used to measure service quality? Periodic reporting; Use of Quality of care proxies such as waiting time, average duration of stay, outcomes of certain service, service charters, and exit surveys ; Quarterly meeting for TB Program to assess data and quality of care; General Quality Assessment conducted by Quality and Standards team at County level.

m) What kind of mechanism exists to assess quality of care regularly and who is in charge to monitor this? Quality and Standards team at County level

n) Are there QI teams in place at the community, facility and/or sub-county levels? Yes at facility level; QI and TWG s exist at sub-county level

o) How is county supporting QA/QI in the private sector? Yes. All facilities in the county whether public or private are supported e.g HIV program integrates all private and public health facilities

- Consultants'/private clinics had QA/QI compliance issues however

Standard 6.2.2: Number of operational public, private and faith based health facilities as compared to the total that routinely report complete and accurate data	
0	• The county does not have a list of the number of public, private and faith based health facilities.
1	• The county has a list of the number of public, private and faith based health facilities, but there is no system to determine and report which of the facilities by type report complete and accurate data
2	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities, but less than 50% of the total report complete and accurate data
3	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities (at least 75% of operational public, private and faith based health facilities of the total number are operational routinely report monthly)

	• About 75% of the reporting health facilities report complete and accurate data. (above 80%)
4	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities (at least 80% of operational public, private and faith based health facilities of the total number are operational routinely report monthly) • About 85% of the reporting health facilities report complete and accurate data. • County has a system for quarterly review of complete and accurate data.
Comments: • About 20 percent of facilities (private) do not report complete and accurate data to the county • Limited Inclusion of consultant clinics/ Mapping and sensitization of private facilities on reporting not done • Immunization is a challenge	

Indicator 6.3: Capacity of County Health Department to deliver health care in identified priority areas (HIV/AIDS, TB/HIV, RMNCH, Nutrition, Water & Sanitation, and Malaria)

Standard 6.3.1: Capacity of County Health Department to implement health programs. *NOTE: This question can be asked of HIV/AIDS, TB/HIV(need to add Leprosy), RMNCH, Nutrition, Water & Sanitation, and Malaria and sub programs as appropriate (Assessment of CHMT Capacity)*	
0	• Program does not have capacity to identify priority areas for implementation
1	• Program has capacity to identify priority health areas and develop standards for health programs.
2	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs.
3	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs. • The program has capacity to conduct periodic monitoring and evaluation (M&E) of priority health programs.
4	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs. • The program has capacity to conduct periodic monitoring and evaluation (M&E) of priority health programs.

	• The program has capacity to promote data sharing, communication, and collaboration within individual priority health programs.
Comments: • Challenge in attaining the 90 percent coverage targets • New/emerging diseases/NCD-chikungunya, ong'ong'o, Dengue Fever	

Scoring of Standard 6.3.1

m) Scores from each individual program for standard 1.3.1 above:

Program	HIV	TB (leprosy)	Malaria	RMNCH	Nutrition	WASH	NCD/Emerging Diseases
Score /4	4	4	4	3	4	3	3

n) Total score from above table (a) = ____25_____

o) Total number of programs included = __7_____

p) Average score (b/c) = ____4_____ Please enter this score for Standard 1.3.1 above.

Qualitative Questions Standard 6.3.1

What is the county's capacity towards delivering Essential Health Services Package (EHSP)?

vi. The county indicated that it is able to deliver EHSP 'apart from when new policy or team which requires training. Continuous training lacks'

vii. The Mombasa health delivery system is organized into 4 tiers of care as per the norms and standards- community, primary care, primary referral, and secondary referral. The community services focuses on demand creation for the services, while the primary care and referral services focuses on responding to the demand

viii. The department has developed and implemented HIV/AIDs strategic plan, combo plan and technical working group for the key population and adolescents. For the TB intervention, there is active case finding, contact trailing and increased Gene Expert utilization. Malaria control has been enhanced through household spraying, mass net distribution and improved case management. On nutrition, the county has developed county nutrition plan, micronutrients supplementation through ECD and screening for NCD

ix. County had 92 facilities offering immunization services. 80% of the under one children were reported to be fully immunized against the eligible population while against target it was 90%.10, 628 per 100,000 adult population reported to have BMI over 25.

x. Average distance to a health facility: 0.55 Km(except hard to reach area at > 5 kms)

xi. Doctor: population ratio: 1: 11, 875

xii. Nurse : population ratio: 1: 18, 678

Which services are the strongest? HIV (PMTCT), TB, Malaria, Community health services, and skills delivery

Which services present the most challenges? Emerging diseases (chikungunya, ong'ong'o, and Dengue Fever; NCDs and HIV/AIDS new infections

Maternal and newborn services

How do you identify targets? County targets are based on set national targets. Target setting is done when developing Annual Work plans.

Please list some of your targets? Where are you with your targets for maternal and newborn services?

- In 2015/16 the county hospital deliveries increased from 28,321 to 30,584(70% coverage) with increased maternal deaths from 50 to 60(202 per 100,000LB) while under five deaths reduced from 1,087 to 898
- As at 2015-2016 the maternal mortality rate stood at 195/100,000 live births,
- Neonatal Mortality Rate : 11/ 1,000 births

Child health services

How do you identify targets? Please list some of your targets.

- 80% (against target of 90%). of the under one children were reported to be fully immunized.
- under five mortality 32.3/1,000
- infant mortality rate 57/1,000

Where are you with your targets for child health services?

Do you anticipate reaching all your targets for the year? If no, please explain why. Industrial action in 2017 greatly impeded delivery of services

What assistance do you need to reach your targets

- Increased awareness creation to stimulate demand
- Support for Defaulter tracing
- Rapid Response Initiatives to cover for the effect of doctors/nurses strikes

Family Planning and Reproductive health (FP/RH)

How do you identify targets? Please list some of your targets.

Where are you with your targets for reproductive health services? There are generally delayed ANC visits with most clients visiting in the 4th quarter

Do you anticipate reaching all your targets for the year? If no, please explain why

What assistance do you need to reach your targets?

v. Capacity building (Basic Bmock targeting private facilities)
vi. Increased outreaches

-

HIV/AIDS:

How do you identify targets? Please list some of your targets.

Where are you with your targets for patients on treatment and mother to child transmission?

- Prevalence in Mombasa County stands at 7.5% for HIV; the Mombasa County HIV/AIDs prevalence 7.4 %(UNAID 2012) is among the highest in the country
- During the 2016/17 reporting period, the number of clients tested for HIV increased from 69,196 to 127,791, while HIV+ pregnant mothers receiving preventive ARV's to reduce risk of mother to child reduced from 2002 to 1830 (71.2% coverage against need)
- Mother to child transmission rate of HIV (9.1%)

Do you anticipate reaching all your targets for the year? If no, please explain why. Fairly good delivery, PMTCT 65%; Treatment 82% but uptake is 90%
What assistance do you need to reach your targets?

- Increased funding for more outreaches
- De-stigmatization through awareness/consistent communication

TB:
How do you identify targets? Please list some of your targets.

Tuberculosis incidence (per 100,000 people) in Mombasa County is 700/100,000 for TB (Above national at 515/100,000)
What assistance do you need to reach your targets?
.Community awareness: 'there are many undiagnosed cases in the communities'
Support logistics
Diagnosis equipment (the county has only 7 machines)

Malaria:
How do you identify targets? Please list some of your targets.

- Based on Kenya Malaria Strategy (KMIS).
- Prevalence rates for malaria are 8%.
- In terms of providing quality and safety care, out of 102,884 reported suspected with malaria cases were tested using microscopy with 13,290 being positive and for RDTCs reported a total of 124,480 with 14,701 positive cases.
- The county positivity rate for reported cases is 11.8%.

Where are you with your targets for ITN use among pregnant women and children under 1 year?

- Net distribution is over 80% but utilization is 60%

Do you anticipate reaching all your targets for the year? If no, please explain why
What assistance do you need to reach your targets?

- Training on case management
- Work with private facilities to 'test before treating and to use policy'
- Target Pharmacists on 'over the counter drug dispensation'

ANNEX 02: COUNTY INSTITUTIONAL CAPACITY ASSESSMENT TOOL

County Institutional Capacity Strengthening Strategy: A Capacity Assessment Tool

Introduction and Instructions

This tool was adapted and harmonized with numerous OCAT tools with an overall goal of facilitating the identification and prioritization of core functional areas that USAID Kenya and East Africa, Health Population and Nutrition aspires to partner with national and county governments; and jointly develop action plans to help achieve increased use of quality county-led health services. The tool is based on the World Health Organization (WHO) Health Systems Framework that focuses on six building blocks of a health system.

Use of the tool is meant to be collaborative in nature. It is first and foremost a self-assessment tool, meaning that members of the assessment team and members of the County Health Management Team (CHMT), other key county health institutions including where possible members of county health committee and selected implementing partners work through each component of the tool together. All participants in the assessment receive the tool ahead of time, to have a sense of what questions will be discussed and to locate any relevant documents that will be useful in answering the questions. During the assessment process, participants from the CHMT, selected partners and the assessment team should read through the response options under each standard (component) together, and through discussion, and validations come to a consensus on the appropriate score to assign for each standard. The goal of the exercise is to develop a shared understanding of the current capacity of the institutions and organizations that CHMT represent in order to analyze gaps and develop a responsive capacity building strategy in the form of action plans.

The tool includes a summary scoring sheet organized by Building Block, with space to record scores for each indicator per Building Block. The summary scoring sheet is followed by a description of the scoring for each indicator and related qualitative questions.

County Institutional Capacity Assessment – Quantitative Summary

Summary Scoring

County Institutional Capacity Quantitative Assessment		Score
Building Block 1: Governance and Leadership		**7/16**
Indicator 1.1: Capacity of County Health Department to lead efforts aimed at improving the health of all residents of the county		
	Standard 1.1.1: Capacity of County Health Department to develop and implement a County Health Strategy	**1/4**
Indicator 1.2: Capacity of County Health Department towards intra and inter agency communication and coordination		
	Standard 1.2.1: Capacity of County Health Department to communicate and coordinate within the County and Sub-County Health Department and other Departments in the county .	**0/4**
	Standard 1.2.2: Capacity of the County Health Department to lead and engage (coordination) with different health actors working towards the same county goals	**3/4**
	Standard 1.2.3: Capacity of County Health Department to hold responsibility and ownership for the health system	**3/4**
Building Block 2: Health Workforce		**10/16**
Indicator 2.1: County Health Department capacity in management of the existing health workforce by putting in place attraction, retention and motivational mechanisms		
	Standard 2.1.1: Ability to recruit and retain human resources for health worker positions, staff health facilities as per staffing guidelines, make working conditions and rural and hard to reach areas more attractive and safe,	**3/4**
Indicator 2.2: Capacity of County Health Department to improve institutional frameworks that support workforce performance development and management		
	Standard 2.2.1: Capacity of County Health Department to institutionalize systems for measuring performance and competence of health workforce; strengthen HRH development systems and practice including continuous professional development, communication, ethics and values systems.	**3/4**
Indicator 2.3: County Health department capacity in the development of an adequate, appropriate and equitably distributed health workforce		
	Standard 2.3.1: Capacity of County Health Department to strengthen HRH planning function covering the entire health system	**3/4**
	Standard 2.3.2: Capacity of County Health Department to encourage and support various institutions to adhere to the established norms and standards for HRH in delivery of KEPH	**3/4**
Building Block 3: Health Information Systems		**13/16**
Indicator 3.1: Capacity of County Health Department to plan for and systematically collect health information		

	Standard 3.1.1: Capacity of County Health Department to develop and implement HMIS policies, strategies, guidelines, and protocols appropriate to the data needs of the county	**4/4**
	Standard 3.1.2: Capacity of County Health Department to collect quality health data	**3/4**
	Standard 3.1.3: Capacity of County Health Department to manage data	**3/4**
Indicator 3.2: Capacity of County Health Department to promote evidence-based decisions and policy making		
	Standard 3.2.1: Capacity of County Health Department to use routine performance, surveys and surveillance data for planning including performance management, rational budgeting and policy making	**3/4**
Building Block 4: Access to Essential Medicines & Other Health Commodities		**6/16**
Indicator 4.1: Capacity of County Health Department to ensure access to essential medicines for the population		
	Standard 4.1.1: Capacity of the County Health Department to provide oversight to commodity management to downstream facilities (ref: - existence of a functional commodity security committee).	**2/4**
	Standard 4.1.2: County Health Department's capacity to estimate commodity needs, develop a supply plan and procure/source these commodities	**3/4**
	Standard 4.1.3: County Health Department's capacity to develop and/or adopt and use a National/County-owned Logistics Management Information System (LMIS)	**0/4**
	Standard 4.1.4: Health facility's capacity to effectively store and account for health commodities through appropriate records and reports.	**1/4**
Building Block 5: Health Systems Financing		**8/16**
Indicator 5.1: Capacity of the County Health Department to ensure that adequate funds are allocated to health expenditures within the overall county budgets		
	Standard 5.1.1: Capacity of the County Health Department to develop evidence-based budget request justifications that ensures adequate funds from the total county government budget are allocated to key areas such as HRH, health commodities and programs.	**3/4**
Indicator 5.2 Capacity of County Health Department to formulate, distribute, and monitor financing for the health sector		
	Standard 5.2.1: Capacity of County Health Department to plan for, create and allocate a sustainable budget	**1/4**
	Standard 5.2.2: Capacity of County Health Department to effectively allocate finances based on county health priority needs	**2/4**
	Standard 5.2.3: Capacity of County Health Department to monitor and ensure accountability for finances at the county and sub-county levels	**2/4**
Building Block 6: Delivering Essential Health Services		**13/20**
Indicator 6.1: Capacity of County Health Department to engage sub-counties in delivering health services		
	Standard 6.1.1: Extent of interaction between the County Health Department and Sub-County Health Administration Offices	**0/4**

	Standard 6.1.2: Capacity of the County Health Department to develop and distribute (to the sub-counties and health facilities) policies, strategic plans, guidelines, protocols and standards for key health service areas	**1/4**
Indicator 6.2: Capacity of County Health Department to ensure appropriate use of policies and standards related to health service delivery for HIV/AIDS, TB/HIV, RMNCH, Nutrition, Water & Sanitation, Malaria program areas		
	Standard 6.2.1: Capacity of County Health Department to supervise sub-counties in the use of health service delivery policies, strategies, guidelines and standards	**3/4**
	Standard 6.2.2: Number of operational public, private and faith based health facilities as compared to the total that routinely report complete and accurate data	**3/4**
Indicator 6.3: Capacity of County Health Department to deliver health care in priority areas		
	Standard 6.3.1: Capacity of County Health Department to develop and implement priority health programs per county health strategy	**3/4**
TOTAL SCORE		**54/100**

Scoring Guide by Building Block[5]

Block 1: Governance and Leadership

Indicator 1.1: Capacity of County Health Department to lead efforts aimed at improving the health of all county residents

Standard 1.1.1: Capacity of County Health Department to develop and implement a County Health Strategy	
0	• No current county health strategy • aligned with Kenya Health Sector Strategic Plan (KHSSP) 2014 – 2018
1	• The current county health sector strategy is aligned with KHSSP 2014 – 2018. • Adopted by the county health management team/county health department.
2	• The county health strategy adopted; • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area.
3	• The county health strategy adopted • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area. • Evidence of at least one annual work plan/operational/action plan developed for at least 50% of the county health strategy priority areas
4	• The county health strategy adopted • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area.; • Evidence of annual work plan/operational/action plan developed for at least 80% of the county health strategy priority areas; • Monitoring and evaluation framework developed to track progress. • A Governance structure that properly sorts out the roles and responsibilities of key stakeholders in achieving county health strategy goals exists.
Comments: Some of the CHMT/SCHMT members did not know that a County Health Strategy existed. Those who had seen it said that the content of the County Health Strategy kept varying and there could be more than one version of the Strategy	

Qualitative Questions Standard 1.1.1

4. What successes and challenges have you experienced in implementing the county health strategic plan? Budgeting and priority listing; no clear strategic plan; too ambitious plans not backed by resources (wishful thinking); departments not fully funded by County Government; department of health policy & planning has no funds at all- no goodwill and commitment from the county to run the department - usually very poor attendance for meetings to discuss strategic plan; poor dissemination of policy documents; lack of engagement of all stakeholders

[5] The building blocks included in this tool are taken from the World Health Organization's six Building Blocks of a Health System (see http://www.who.int/healthinfo/systems/monitoring/en/index.html for details).

5. What is the role of partners in developing the plan and contributing to its achievement?
   Engaged in development of strategic plans of priority areas e.g. stakeholders invited; inter-agency meetings by health department including NGOs, FBOs,
6. What additional capacity would strengthen implementation across the county (capacity in individual knowledge, skills, behaviors and attitudes as well as the structures, policies, systems and procedures of the organization and system as a whole)?
   Disseminate the plan so that all individuals are acquainted with it; fund sub-counties to disseminate the plan and build their capacity for work-planning. Facility in-charges should be briefed on county health priorities which should be adequately funded. Overall, there is need for advocacy to mobilize political will to ensure that priorities that are identified are implemented.

Indicator 1.2: Capacity of County Health Department towards intra and inter agency communication

Standard 1.2.1: Capacity to communicate effectively within the County and Sub-County Health Department and other Departments within the County	
0	• No evidence of communication plan and protocols for information flow within the county and sub-county and to other departments within the county. [no communication strategy]
1	• There is a communication plan, and protocols are clearly established to guide the plan.
2	• There is a communication plan, and protocols are clearly established to guide the plan. • At least 50% of CHMT are aware of the internal communication plan and protocols but no evidence of use of the plan and protocols
3	• There is a communication plan, and protocols are clearly established to guide the plan. • More than 50% of CHMT are aware of the internal communication plan and protocols but no evidence of use of the plan and protocols .
4	• There is a communication plan, and protocols are clearly established to guide the plan. • More than 50% of key county staff are aware of the internal communication plan and protocols AND evidence exists of use the plan and protocols more than once a year.
Comments:	

Qualitative Questions Standard 1.2.1

1. Briefly describe the communication strategy of the county. What mechanisms/tools exist for communication within each department? Between departments? With County Assembly Health Committees? Turkana County does not have a formal communication strategy. However, certain mechanisms exist for communication within the county health department and between departments.
   i) What mechanisms/tools exist for communication between county and health development partners and/or implementing partners? Mechanisms and tools for Communication with implementing partners are defined in the MOUs that the County Department of Health develops with Implementing Partners before implementation of specific programmes. Informal channels of communication, such as telephone calls, emails and WhatsApp Groups are used to communicate within the department and between departments.

j) What are some of the successes/evidence of effectiveness and challenges with the strategy and mechanisms/tools? The informal channels enable rapid feedback mechanisms and management of routine/daily activities including sending out alerts on disease outbreaks and other emergencies. The challenge is that some of the issues discussed, e.g. over the phone are not documented for future references and this can sometimes lead to conflict over what was discussed and agreed and who discussed it.

8. Briefly, describe the policies and procedures in place to promote collaboration between County Health Department and implementing partners and/or health development partners?
   g) What mechanisms/tools exist for the coordination of health development partners and other stakeholders? The County Health Department develops MOUs with health development partners to guide coordination and interactions
   h) Do we have any form of agreements between county and health development partners and/or implementing partners that support delivery of health services? The County Health Department has developed MOUs with health development partners in key services such as HIV/AIDS and MNCH
9. Is there a policy to guide collaborations? Please describe. To ensure sustainability of initiatives and smooth transition when partners leave at one point, the county has drafted contracting guidelines with a focus on staffing for partners, remuneration guidelines, exit plans and absorption of staff when partners leave. Apart from that, there are MOUs which guide day-to-day activities of partners.

Standard 1.2.2: Capacity of the County Health Department to lead and engage (coordination) with different actors working towards the same goal	
0	• No evidence of coordination framework that maps out different stakeholders working in the health sector.
1	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Occasional meetings are held between the county and different health actors, but these are irregular, and do not involve all of them. Implementing partners and other key stakeholders have no opportunity to present and review health priorities and their contributions towards health goals.
2	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals.
3	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals. • The county health leadership receives regular performance updates in the form of reports from at least 50% - 75% of different health actors working in the county.
4	• Evidence of coordination framework that maps out different stakeholders working in the health sector

	• Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals. • County health leadership receives regular performance updates in the form of reports from all different health actors. • All different health actors are fully involved in annual sector performance reviews, county health annual work plan development and in policy development affecting the county population and health services (Partnership Code of Conduct exists).
Comments:	

Qualitative Questions Standard 1.2.2.

1. What mechanisms are in place to promote regular dialogue between County Health Department leadership and the different health actors such as health development partners, implementing partners, MCAs, religious/community leaders, private sector and sub-county health administrators? There are quarterly meetings, annual review meetings, inter-department forums; chief's barazas; stakeholder meetings. These provide updates on county health sector priorities
2. How are different health actors engaged in county health sector performance reviews, county health budget formulations, and policy development, programs review and/or/evaluation? All stakeholders are invited to quarterly performance reviews and there is also public participation in budget formulation as well as community engagements to identify population health needs and priorities
3. What are the strategies for building leadership capacity of health care managers and practitioners at the county and sub-county level? Most CHMT members have undergone strategic leadership training at the Kenya School of Government (KSG); there are also those who have undergone senior management course (KSG). A training plan exists for sub-counties but due to lack of resources not much has been done to build the leadership capacity for sub-county managers

Standard 1.2.3: Capacity of County Health Department to hold responsibility and ownership for the health care system at community level (Accountability)	
0	• The county primary health care system at community level is over 50% funded by health implementing partners, with gaps existing where implementing partners are not implementing services.
1	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners
2	• The county primary health care system at community level is over 50% funded by county government, with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) below 50%, with significant input from development partners for health and implementing partners.
3	• The county primary health care system at community level is over 50% funded by county government, with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) over 50%, with significant input from development partners for health and implementing partners. • Functionality of community units is at 50% per the reporting rates (MOH515)
4	• The county primary health care system at community level is over 50% funded by county government, with input from the implementing partners

	• Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) over 50%, with significant input from development partners for health and implementing partners. • Functionality of community units is over 50% per the reporting rates (MOH515) • Annual accountability platform for reviewing committed funding against results achieved at community level in place.
Comments:	

Qualitative Questions Standard 1.2.3

4. What strategies are in place to strengthen the primary health care system at community level? The county works hand-in-hand with partners to support key interventions such as nutrition and WASH. The county also relies on a network of CHWs/CHVs to ensure that primary health interventions such as nutrition, HIV/AIDS and malaria are effective in disease prevention.
5. What mechanisms are in place to capture the community feedback in relation to the performance and quality of the primary health care system? There are regular meetings with CHW to feedback on progress of interventions and community needs. Facility committees are another platform through which quality of care and community needs are assessed and acted upon.
6. Are there any processes in place community members to hold CHMT, health managers and health workers accountable for the provision of primary health care services? Please describe. The facility health committees are a good avenue to hold the health sector management accountable but these require to be empowered to demand for better quality services when the need arises.

Building Block 2: Health Workforce

Indicator 2.1: County Health Department capacity in management of the existing health workforce by putting in place attraction, retention and motivational mechanisms

Standard 2.1.1: Ability to attract, recruit and retain human resources for health worker positions	
0	• Job descriptions do not exist,
1	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure)
2	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place.
3	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place. • Incentives for staff retention are in place but not effectively.
4	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place. • Incentives for staff retention are in place but not effectively. • Working conditions attractive and safe, financial and non-financial incentives for rural and hard to reach places are made more attractive and HRH wellness and welfare improved
Comments:	

Qualitative Questions Standard 2.1.1

5. Briefly describe County Health Department's strategy for health work force attraction, recruitment and retention at all levels? The structure for staff attraction and recruitment is in place but implementation of the strategy is very weak due to underfunding.

a) Do you have an operation plan to attract and recruit new workforce? Please describe. There is an operation plan in place but challenges exist in housing of health staff and training of staff.

b) Has the county reached any agreements/ contracts with pre-service institutions to train and recruit new workforce? Please describe. The county was remitting 50 million per year to KMTC to ensure training of locals who could work in the County. This has however stalled for financial reasons, and currently no current agreement is in existence.

c) Has county conducted periodic assessments of workforce needs and priorities? Please describe. The assessment on work force needs and priorities was conducted before the development of the HRH strategy.

Standard 2.1.2: Capacity of County Health Department to staff health facilities as per Staffing Norms, Standards and Guidelines	
0	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards, and development of the health work force for staffing of each level of the health system do not exist.
1	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists.
2	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists. • A iHRIS has been developed to track staffing levels and needs,
3	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists. • A system has been developed to track staffing levels and needs, • iHRIS monthly updated (upon exit and recruitment).
4	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists. • A system has been developed to track staffing levels and needs, • iHRIS monthly updated (upon exit and recruitment). • Staffing data on needs by staffing cadre is being used to advocate for resources to meet staffing gaps.
Comments:	

Qualitative Questions Standard 2.1.2

1. Briefly describe the County Health Department's strategy to mobilize and distribute health workforce based on each sub-county's and health facilities' needs

   a. How are the needs assessed? The HR office has tool that informs the staffing gaps and they also use the IHRIS

b. Who is involved in the needs assessment? The sub county Health Management Teams (HMTs)

c. How often is a workforce needs assessment conducted? This is usually done on annual basis.

2. Briefly describe the County Health Department's health work force planning

a. How has the county adopted staffing based on norms, standards and guidelines? The County has HRH Recruitment plan based on the national and WHO recommended norms and standards of health facility staffing and population-to-health worker ratio. The county is continually working to fulfill these staffing norms.

b. What strategies are being used in the mobilization of resources to meet staffing gaps? The county is collaborating with development and implementing partners to address staffing gaps. E.g. EGPAF, AFYA TIMIZA, IRC. In addition, the county is making use of Industrial attachment, internship programs, and volunteer engagement.

c. How does the country measure on regular basis the staffing gaps at all levels of health care delivery? The staffing needs assessment is usually carried out and budgets set aside to recruit based on priority and urgency.

Indicator 2.2: Capacity of County Health Department to strengthen performance management and supervision of the existing health workforce

Standard 2.2.1: Capacity of County Health Department to conduct staff performance appraisals	
0	• There are no policies or guidelines at the county on staff performance appraisals at all levels of health care management and delivery.
1	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists.
2	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted.
3	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted as scheduled in the guidelines. • Supervisor performance monitoring is ad hoc.
4	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted as scheduled in the guidelines. • Supervisor performance monitoring is ad hoc. • System exists for rewards and sanctions based on performance.
Comments:	

Qualitative Questions Standard2.2.1

1. Briefly describe mechanisms in place to review staff competencies and performance

a. What is the course of action after a performance review? If the staff scores 50% and above after the performance appraisal, the staff can be promoted. If less, than 50% a person can be demoted and transferred.

b. Do you have any strategies for continuous performance improvement? Please explain. Performance appraisal and performance improvement plan.

2. Briefly describe the mechanisms in place to promote accountability and transparency in the workforce

a. Are there clear guidelines in the job descriptions about staff roles and responsibilities? Yes, these exist especially for staff directly employed by County Service Board.

Please describe one or more

b. How often are these guidelines reviewed and implemented? Reviews of guidelines are done twice a year from 2015.The line manager is critical in the implementation of these guidelines and is often at hand to clarify and monitor performance of the roles and responsibilities.

3. What mechanisms are in place to address workforce absenteeism and poor productivity? Spot checks for mid-level managers, client satisfaction surveys, clocking time sheets, daily attendance registers, leave of absence form.

Standard 2.2.2: Capacity of County Health Department to coordinate capacity development of Human Resources for Health	
0	• No system for coordinating in-service training for HRH exists, (HRH trainings are completely ad hoc).
I	• System for coordinating in-service training for HRH exists, no adhered to.
2	• System for coordinating in-service training for HRH exists, • The county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments not coordinated by the county,
3	• System for coordinating in-service training for HRH exists, • The county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments conducted and coordinated by the county. • Training schedules are not fully coordinated/ communicated to all relevant stakeholders.
4	• System for coordinating in-service training for HRH exists, county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments conducted and coordinated by the county. • Training schedules are fully coordinated/ communicated to all relevant stakeholders. • Assessments of the impact of trainings to improved service delivery is conducted annually and feedback used during performance appraisals.
Comments:	

Qualitative Questions Standard 2.2.2

1. Describe any agreements made with institutions of higher learning to provide in-service training for staff?
    a. How are training needs identified? Training needs are identified by programme Officers
    b. How are curricula developed and approved? This is a national Government function
    c. How often is a training needs assessment conducted? This is not in place in the County
    d. Is there a formal mechanism to engage institutions of higher learning to provide training? No.
    e. What institutions have been engaged so far? Staff are usually trained at the Kenya School of Government KSG

2. What types of trainings have been provided by the county in the past year? EXCLUDING vertical programs and implementing partners
    a. Who were trained? No training was done in the past one year. Training inventory does not exist in the County and staff usually are trained at times without involvement of County HRH office.
    b. Who determines the staff to be trained? The Programme Officers (Coordinators) and in some cases the sub county Health Management Team, requests their staff to apply for training opportunities, and the teams decide who will be trained.
    c. How were the training needs identified? There is seldom a formal process so individuals are left to identify their own training needs.
    d. Who initiated/ requested the training? Training needs are in most cases initiated by individual employees. In other cases, a development partner could do a training needs assessment and initiate training.
    e. Who conducted the training? N/A
    f. How was the training funded? N/A

3. Please describe the county health department's policy to strengthen existing workforce through vertical programs.
    a. Is there an operational plan for in-service training? Yes
    b. How are in-service training needs identified? Through training gap /training needs assessment, and also performance appraisal
    c. How often are in-service trainings delivered? Annually
    d. Is there an operation plan to retain existing workforce? Yes, through bonding the trained staff to work for the County for 3 years after training.
    e. Do county health staff that complete requisite in-service trainings get incentives? Yes, promotion

4. Does the county health department have a centralized Training Unit to address training needs for the county health staff? Yes, County Health Training Committee.
How is training currently coordinated and documented? The County health training committee holds meetings to assess training request.

    a. How are training needs and training programs or opportunities matched? The County health training committee holds meetings to assess training request.
    b. What records are kept on in-service training for individual health workers? Training bio-data form, Course approval forms, study leave forms.
    c. What do you think are the major pre-service training problems facing the county? Coordination of training institutions and the County Government. The County lacks enough resources for training.
    d. What do you think are the major in-service training problems facing the county? County staff go directly to development partners to request for support for training without involvement and knowledge of the County Health Department. Training is therefore conducted in a haphazard manner
    e. What kind of assistance does the county need to coordinate and document training? Need to have proper database of trainings done, and training needs of staff. Need to have County HRH office fully supported by budgetary allocation and have the Unit harmonized with County HR unit so that the staff selected for training by HRH are not changed at the whim of any other office in the County. Ensure training is not just for Doctors, but also for nurses, and all other cadres.

5. What is the capacity of county health department towards granting accreditation to pre-service training facilities? This a national government function.
    a. What is the role of the national government in accreditation of pre-service training facilities? It is at the discretion of the national government to grant or deny accreditation based on laid down procedures as well as terms and conditions that the institution applying for accreditation must abide by.
    b. How often is accreditation conducted? This is based on demand.
    c. Are accreditation standards comprehensive and up to date? We do not have this information but since it is a national role that has been there for many years, we believe that the standards are comprehensive and up to date to guide training needs in the country.
    d. Who conducts accreditation? How is this team formed? As a county we have no information on how the national government performs this function.
    e. What kind of assistance does the county need towards implementing accreditation? This is not our role. The national government does the accreditation.

6. What are three priority performance areas most in need of strengthening within the county health department that relate to HRH? Funding the HRH unit. Training inventory development. Training needs assessment to be conducted. Staff establishment of all cadres to be developed

7. What are the successes and major challenges for strengthening health workforce? (ask for each vertical program (HIV/AIDS, TB/HIV, RMCH, Malaria, Nutrition) and the county as a whole) The vertical programs are largely run by partners and usually have their own staff for whom they support in skills development; e.g. in HIV/AIDS, trained staff are given support to work in HIV programs. There is a transition policy for the trained staff in each of these programs to be retained by County Government, an arrangement which has resulted in retention of some highly skilled staff at the county health department. One major challenge with Turkana County, e.g. in Turkana East and Turkana West sub-counties is that donors are leaving hence key services such as HIV/AIDS will suffer until another partner comes in to support HIV work in these two areas.

Building Block 3: Health Information Systems

Indicator 3.1: Capacity of Health Department to plan for and systematically collect health information

Adapted from the WHO's *Monitoring the Building Blocks of Health Systems,* key components of a HIS include: routine health information, vital statistics, disease surveillance and health surveys

9. Does the county have an integrated Health Information System that includes indicators, data elements and sources, frequency of collection, data flow, data validation rules and quality

Standard 3.1.1: Capacity of County Health Department to implement HIS policies, strategies, guidelines, protocols and use routine HIS forms	
0	• The county does not have national health information system policy and strategy.
I	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are not readily available: o source registers

	○ birth/death registration, ○ reporting forms, ○ data quality assessment protocol forms, ○ disease surveillance forms.
2	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are readily available: ○ source registers ○ birth/death registration, ○ reporting forms, ○ data quality assessment protocol forms, ○ disease surveillance forms • Sub-counties, facilities and community units do not have adequate supply
3	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are readily available: ○ source registers ○ birth/death registration, ○ reporting forms, ○ data quality assessment protocol forms, ○ disease surveillance forms • Sub-counties, facilities and community units have adequate supply • Mentorship program on correct use of HIS forms institutionalized in less than 75%of sub-counties and/or facilities.
4	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are readily available: ○ source registers ○ birth/death registration, ○ reporting forms, ○ data quality assessment protocol forms, ○ disease surveillance forms • Sub-counties, facilities and community units have adequate supply • Mentorship program on correct use of HIS forms institutionalized in at least 75% of sub-counties and/or facilities.
Comments: County refers to the national HIS policy and strategy. Counties have mentorship programs with teams that have technical capacity to provide the mentorship. However, there is not enough resources to facilitate the mentorship teams to access the facilities for capacity building. The County relies heavily on partners for resources to facilitate the mentorship.	

assessment guidance/protocol? Yes, the DHIS including guidelines on health system strengthening and SOPs and there is also a DQA Protocol.

10. How has this system been rolled out to sub-counties and facilities? Yes, there is a chart that guides information flow from facilities to CHRIO (available). To share information flow chart from facilities to CHRIO.

11. Does the county have a system for monitoring and evaluation of county programs that details priority health impact and outcome level indicators at a minimum that presents plan on how data will be collected for monitoring, evaluating, disseminating and using analyzed data, that clearly spells out roles and responsibilities, capacity building and county stakeholders' data review forums? Yes, there is an M&E coordination department. An organogram is available to share
12. How has this plan been rolled out to sub-counties and facilities? At sub county, SCHRIO acts as an M&E Coordinator at sub county level. He coordinates with program officers so as to report for M&E. At facility level the facility in charge takes responsibility for M&E. It is challenging for staff to do data collection at facility level. The department of M&E under the directorate of M&E research, policy and planning is least funded. Reliance on partners is very high. The budget allocated is very little. It has been proposed that every program should allocate 1% of their budget to M&E

Standard 3.1.2: Capacity of County Health Department to collect quality health data	
0	• There are no county-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) in place.
1	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data are not routinely collected using standard data collection forms.
2	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data routinely collected using standard data collection forms. • County department of health receives timely and complete reports from less than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization)
3	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data routinely collected using standard data collection forms. • County department of health receives timely and complete reports from more than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization) • County department of health receives accurate reports from less than 75% of health facilities (public, private and faith based)
4	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist; data are routinely collected using standard data collection forms. • County department of health receives timely and complete reports from less than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization) • County department of health receives accurate reports from more than 75% of health facilities (public, private and faith based) • Health performance data reviewed regularly and regular feedback provided to all health facilities on data accuracy.

Comments:

Qualitative Questions Standard 3.1.2

9. Who has the primary responsibility for collecting data for routine health information, vital statistics, disease surveillance and health surveys systems? SC Health Records and Information officers at Sub County Hospitals have the primary responsibility for data collection but clinicians do the data collection in some facilities that do not have SCHRIOs. Faith based reports are accurate and timely as compared to public facilities.
10. Who has the primary responsibility for submitting/entering data and validating it from these data systems? SCHRIOs receive data from facility in-charges
11. To what extent has the county health department institutionalized Ministry of Health's National Data Quality Protocol and Standards? 75% of the facilities have Data Quality Protocol and Standards. DQAs are conducted. A Countywide malaria DQA and support supervision was conducted in March 2017 – (DQA report). Target DQA for HIV/AIDS to facilities with data issues.
12. What is the process for data quality assessment and how often is it conducted by county health department? These are done by sub-county health administrators. The DQAs are regular and not scheduled and have been supported by partners.
13. Where is health data stored at the county and sub-county levels? Data is filed and stored on a monthly basis in the M&E offices at the County and Sub-County level. DHIS is also used. Turkana West store theirs at Kakuma due to lack of power and furnishing in office; the facility remains with a copy and submits the original to the SCHRIO which enters the data into the DHIS. The HRIO access the data from the DHIS

Qualitative Question Standard 3.1.3

1. Where is health data stored at the county and sub-county levels?

Standard 3.1.3: Capacity of Health Department to manage data	
0	• No one single county-wide preferred electronic or paper based exists.
1	• Separate information management systems (paper or electronic) exist for the various components of the HIS. • It's difficult or impossible to manipulate or extract data from the system.
2	• One Single County preferred Electronic Health Information Systems platforms (databases) exist for the various components of HIS • Data are not routinely extracted for reports and other use.
3	• One Single County preferred Electronic Health Information System platforms (databases) exist at the county for the various components of the HIS, • Data are routinely extracted (at least annually) for use. • Integration of information from other health management systems (i.e., service statistics, financial, human resource, logistics information, and physical assets data systems) not yet fully operational.
4	• One Single County preferred Electronic Health Information System platforms (databases) exist at the county for the various components of the HIS, • Data are routinely extracted (at least annually) for use.

	• Integration of information from other health management systems (i.e., service statistics, financial, human resource, logistics information, and physical assets data systems) is evident. • County Data Management Guidelines exist including policy on health/research data sharing policy.
Comments: Have electronic for HIV, currently in the process of setting IHRIS, for example APHIA EHMS- has the billing, laboratory, logistics, inpatient and outpatient services and is installed in 12 sub county health facilities. The facilities use the data for reporting extracted data from the system	

Indicator 3.2: Capacity of County Health Department to promote evidence-based decisions and policy making

Qualitative Questions Standard 3.2.1

Standard 3.2.1: Capacity of County Health Department to use collected data for planning and policy making	
0	• No evidence of data use for strategic planning including rational budgeting and decision making.
1	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county health committee and other state and non-state actors. • No evidence of data use for strategic planning including rational budgeting and decision making.
2	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings.
3	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county assembly health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings. • The county can identify at least two examples of how data have been integrated into a decision-making process including rational budgeting in the past year.
4	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county assembly health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings. • The county can identify at least two examples of how data have been integrated into a decision-making process including rational budgeting in the past year. • Policy and planning framework (that details national development goals, national health sector priority goals, county health priority goals, county budgetary and donor allocations, and county health development outcomes) exists.
Comments: County health strategic plan is developed based on the evidence. CHRIO conducts analysis on a monthly basis. For the nutrition department the County extracts data from the HIS to place an order to WFP or KEMSA (Screen shot from system available). The CHRIO consolidates the number of active community units and CHVs reports which enable the county to know the partner supported CUs and CHVs	

9. How often is routine data analysis presented to senior managers for discussion, field monitoring/supportive supervision, problem solving and decisions?
   This is done quarterly for all program indicators. Reporting rates (timeliness and completeness) is done monthly for the sub counties. Analysis is also done on a need basis depending on the situation. There are some program specific data analysis forums such as nutrition, HIV/AIDs where managers meet with partners to analysis the programs. For example, data analysis was conducted during the recent Malaria upsurge.
   Data is also used to help decision makers when they need to prioritize resources especially when targeting resources to prioritize appropriate interventions.

10. How often is performance information presented to County Health Department leadership for discussion, problem solving and decision making? Quarterly for county leadership and monthly for programs.
    Provide examples of how reviewed performance data have been used to identify opportunities to improve services. Actions are identified then partners assigned roles to play. (See county performance report)
11. How often is data used in reviewing/evaluating the success and/or failure of county health programs and strategies? Monthly and quarterly. For the nutrition department through a forum CNTF- County Nutrition Technical Forum, Programs can decide to use it as needed. HIV programme does quarterly reviews. All programs have their forums RMNCH have a scorecard system that shows how they are performing
12. How often is data used in the formulation of policy and/or incremental re-adaptation of existing programs and strategies? It is a continuous process depending on the program. There is no time line attached to this. Formulation is based on identified needs.
13. What role does the CHMT play in promoting and/or facilitating the use of health data for management decision making at county level? The CHMT are provided with data by sub-county management teams so they use the data to make county intervention and expenditure priorities. However, there are cases when decisions are not data/evidence based especially where expenditure is driven by political priorities rather than health priorities.

Building Block 4: Access to Essential Medicines & Other Health Commodities

Indicator 4.1: Capacity of County Health Department to ensure access to essential medicines for the population

Standard 4.1.1: Capacity of the County Health Department to provide oversight to commodity management to downstream levels of service delivery	
0	• The county does not have an organized unit (of more than three persons) to oversee and coordinate commodity security in the entire county.
1	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership.
2	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate.

3	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate. • The County Commodity Security Committee structure has been adopted, operationalized and implemented at the sub-county level for all the sub-counties in the county.
4	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate. • The County Commodity Security Committee structure has been adopted, operationalized and implemented at the sub-county level for all the sub-counties in the county. • Supply chain performance statistics are maintained at county, sub-county and facility levels and reflect improving trends overtime.
Comments: There is a plan to form a Technical Working Group for Commodity Security at the sub-counties but this has not been formed yet	

Qualitative Questions Standard 4.1.1

7. Describe the procedures for implementing and supervising supply chain services in the county?
   a) Describe the way through which the county ensures availability and use of required guidelines, protocols and tools for product selection, quantification, commodity reporting, use, support supervision and M&E at all levels of service delivery in the county? Procurement protocols are disseminated to sub-counties and we have TWGs to develop supply chain and oversee the ordering schedules; any other ordering tool are taken to SC committees. The quantification committee TWG provides oversight to pharmacist & SC committee). Needs identified through bottom-up process involving the community and estimation is done bi-annually. Reporting tools and guidelines exists from the facility, sub-county and the county.
   b) Briefly describe how supply chain data is used to help decision making at county/sub-county and facility level; and how the county ensures that systems for collecting data from lower levels and feedback loop from higher levels is in existence, adequate and continuously being improved. Consumption data at every point of use including work-load/service data help in assessing epidemiological patterns. These are amalgamated at county level at the quantification committee for validation of needs; managing specific orders are given back to counties
   c) How does the process of supportive supervision for service delivery incorporate supervision for supply chain service/commodity management at health facility level? All supportive supervision incorporates supervision for supply chain service/commodity management and commodity management usually takes center stage; e.g. reporting, stock, storage, partners. However, sometimes supportive supervision targeting commodities only is carried out
8. Describe the procedures for monitoring and reporting supply chain performance at all levels in the county?
   a) In which specific ways does the county take a whole-market approach in strengthening commodity management systems for the county? (i.e. inclusion of non-government health sub-sector (e.g. faith-based) that offer services within the county). Partners are a part of the TWG

and also help in data collection, management, reporting and quantification. Also there is an MOU with FBOs to get supplies from counties e.g. of medical equipment. There is limited involvement of for-profit private sector, which is only active in supplying lab commodities to the county facilities.

b) How does the county ensure trend graphs on key supply chain performance indicators are maintained as a measure of quality of supply chain services rendered in the county? eg stock-out rates, stocking according to plan, reporting rates, and commodity disposal due to expiration. The health facilities report stock-outs of essential commodities; There is no other indicator used. Annual reviews for commodities is carried out; Stocking is based on need

c) How is equity ensured in commodity distribution and dispensing? In other words, what procedures are used to make sure that essential medicines and health commodities are distributed/ issued out according to need? Quantification of needs is based on evidence from utilization patterns at health facilities. The utilization reflects need and the amounts required. To ensure that these needs are addressed, a code of ethics exists for workers to ensure proper utilization of the supplies and this is complemented by support supervision

d) How does the county ensure improved access to quality and affordable essential medicines and other health commodities? (Consider systems for commodity quantification and supply planning, inventory management tools, commodity information management, commodity financing and procurement, and financing for continuous improvement of supply chain systems): The county continues to invest the supply chain including ordering/procurement, reception, distribution, transport and dispensing, to ensure that the chain is not broken. This also involves strengthened communication between suppliers, the procurement team and health facilities as well as capacity building for commodity management. However, some conditions don't have medicines at lower level and patients with such conditions, mostly chronic, have to travel to referral facilities.

Standard 4.1.2: County Health Department's capacity to estimate commodity needs, develop a supply plan and procure/source these commodities (Forecasting, Quantification and Procurement)	
0	• No capacity (external or internal to the county) available to conduct a forecasting and quantification exercise (estimate commodity needs, develop a supply plan, and procure essential commodities).
1	• The county is reliant on external technical assistance to estimate commodity needs, and develop a supply plan, no mechanism exists to fully procure or source (i.e. buy or secure donations of) essential commodities.
2	• The county is reliant on external technical assistance to estimate commodity needs, and develop a supply plan, • County partially has capability to fully procure or source (i.e. buy or secure donations of) essential commodities.
3	• The county has capacity to estimate commodity needs, and develop a supply plan, • County partially has capability to fully procure or source (i.e. buy or secure donations of) essential commodities, • County requires minimal external technical assistance to estimate commodity needs.
4	• The county has capacity to estimate commodity needs, and develop a supply plan, • County has capacity to fully procure or source (i.e. buy or secure donations of) essential commodities, • County requires no external technical assistance to estimate commodity needs, • Health commodity procurement done at least once annually.

Comments: • Capacity to estimate commodity needs, develop a supply plan, and procure essential commodities requires strengthening at dispensary and health centre levels but it is considerably stronger at higher levels (Sub-county and County levels). • Estimation not based on evidence and there is need for training on estimation/quantification; 85 – 95% of facilities are dispensaries which require training on commodity quantification;	

Qualitative Questions Standard 4.1.2

10. How are commodity needs identified?
    a) How are the county, sub-county and health facility needs identified? This is a bottom-up process that starts at the community and cascades to the county level. There are various community groups, facility committees and technical working groups that help in identifying community, facility, sub-county and county needs.
    b) What role does National Government agencies/institutions play in assessing county commodity needs? Verification of orders to account for resource vs. need
    c) What happens after commodity needs are identified? How are requests made? The usual procurement procedure is followed as described in 4.1.1
11. What is the role of development partners and CHMT for health and/or implementing partners in procuring essential medicines? Partners are in a part of committee to strengthen supply chain e.g. helping in quantification;
12. What is the proportion of county spending on commodities as % of total county health spending? =16.7% (350m out of 2.1billion [900m to salaries) FY2017/18

Standard 4.1.3: County Health Department's Capacity to Develop and/or adopt and Use a National/County-owned Health Commodities' Logistics Management Information System (LMIS)	
0	• County currently uses no Health Commodities' LMIS system
1	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records.
2	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, reporting of LMIS data is below 50% for all facilities annually.
3	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, county has access to limited logistics data including: stock on hand within the system and consumption/usage for the past reporting period and demonstrates reporting rates of least 50% from the sub-counties. • County has a plan for routine DQA exits, DQA of LMIS data conducted at least once annually

4	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, county has access to logistics data including: stock on hand within the system and consumption/usage for the past reporting period and demonstrates reporting rates of least 75% from the sub-counties. • County has a plan for routine DQA exits, DQA of LMIS data conducted semi annually • Data Quality Improvement Plan for LMIS data developed for every DQA and implemented
Comments: National LMIS exists but not but have not been adapted at sub-county level which leaves the county with no single platform but every other department, e.g. lab, nutrition, supply, HR, etc., has its own LMIS platform.	

Standard 4.1.4: Health facility's capacity to effectively store and account for health commodities through appropriate records and reports.	
0	• No system exists for proper storage and distribution of commodities, including essential medicines. (***special storage requirements of medicines and other commodities are not followed, poor records keeping and consumption reporting***)
1	• Warehouse/stores(s) for commodity storage exists at either county, sub-county or facility level, with some accommodation for items requiring special storage.
2	• The county/sub-county warehouse and health facility store meets at **least two** of the following four criteria: warehouse/store size is adequate, storage spaces are is well maintained and clean (including pest, lighting, temperature and humidity control), • County warehouse has designated storage equipment for special storage needs, and re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance.
3	• The county/sub-county warehouse and health facility store meets at **least three** of the following four criteria: warehouse/store size is adequate, storage spaces are well maintained and clean (including pest, lighting, temperature and humidity control) • County warehouse has designated storage equipment for special storage needs, • Re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance.
4	• The county/sub-county warehouse and health facility store is adequate – meets all four criteria (i.e. large enough, regularly cleaned, dry, well organized) with all special needs storage areas clearly designated with correct signage, • County warehouse has an established re-order and stocking plan, including the use of protocols (such as first expiry, first out), job aides (such as SOP for emergency procurements)

	• Re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance. • Stock-control records such as stock cards and bin cards are well maintained

Comments:

- Afya EHMS (Electronic Health Management System) is used at sub-county hospitals and health centers but not at County hospital level due to lack of funds to expand this system to the county hospital.
- The storage space for health commodities is limited. General infrastructure is weak including lack of shelving, pelleting, fridges and thermometers
- Record keeping and consumption reporting tools exist but they are not effectively used

Qualitative Questions Standard 4.1.4

17. Describe the procedures adopted for proper storage of essential medicines and other health commodities (county, sub-county and health facilities): The county needs a lot of help in this regard. The issue has been discussed at different levels without progress. Before devolution, district hospitals were handling everything to do with procurements and stored supplies for all the other facilities. After devolution, these facilities have not been expanded and therefore the spaces available are too limited to house supplies for all county facilities. There is a plan to have a centralized storage for facility but the building is unfinished…maybe in the next financial year it will be finished. There are plans to have a warehouse at each sub-county (7 warehouses in total)- only two so far have been constructed but are not functional (they remain white elephants). Storage is now at individual facilities but these are very crowded; i.e. they are not the desired storage. To make some improvement, we have had a budget approved for shelving for 80 facilities but still we need pallets; all facilities need at least 2 – 3 pallets. Out of 200 facilities, 30 have the required number of pallets.
18. What is the role of community-based groups and networks in community commodity distribution? They are active in distributing FP commodities, ORS, nutrition products (CHW are involved but this kind of arrangement is limited in the county
19. What is the role of private sector in commodity procurement, storage and distribution? The role of the private sector is very limited, e.g. is involved in the supply of a few products such as supply of lab commodities.
20. What mechanisms does the county use to assure quality for medicines and other health commodities within the county level? KEMSA quality assurance model; one major government approved supplier; MEDS- county visit to MEDS quality control lab. No quality assurance at county general store; no equipment to analyze quality; proper storage remains a big problem, no special storage conditions, e.g. vaccines; poor distribution and transportation mechanism
21. Does the county have in place a pharmacovigilance system? Yes. If so, since when? Since 2013; If not, is there a plan to develop/put in place such a system? Please describe.
22. What systems does the county have in place for medical waste management? Segregated based on toxicity; waste management protocol is followed

Building Block 5: Health Systems Financing

Indicator 5.1: Capacity of the County Health Department to ensure that adequate funds are allocated to the health sector within the overall county budget.

Standard 5.1.1: Capacity of the County Health Department to ensure that adequate public funds from the total county government budget are allocated to public health and population activities.	
0	• The county health department has no input into the development of the county budget estimates.
1	• The county health department has input into the county budget estimates development, • But public health expenditures are not systematically calculated on an annual basis and total at least 20% of the overall county government budget.
2	• The county health budget is developed annually, with input from county health department • County health expenditures are not systematically calculated on an annual basis as part of budget formulation process • It's less than 25% of the overall county government budget.
3	• The county health budget is developed annually, with input from county health department • Estimated actual county health expenditures are systematically calculated on an annual basis as part of budget formulation process. • Health budget is between 25% and 30% of the overall county government budget.
4	• The county health budget is developed annually, with input from county health department. • Estimated actual county health expenditures are systematically calculated on an annual basis as part of budget formulation process • Program, surveys and surveillance data used as justification for budget requests • County health budget is at least between 30% - 40% of the overall county government budget.
Comments:	

Qualitative Questions Standard 5.1.1

1. Briefly characterize funding sources for health services in the county.
   o) Where does funding for health care services come from? County government, national government for vertical programs, development partners, facility improvement fund (FIF) (user fees); health insurance; households
   p) What percentage of funding comes from national treasury equitable share, conditional grants, county revenue collection, private sector, household out of pocket, health insurance and external development partners for health. –The County Department of Health does not have this information because they do not have a health expenditure tracking system.
8. Briefly describe the mechanisms in place to determine county health budget needs of individual sub-counties? Sub-counties do not have budget estimates; budgets passed down for implementation and they work with the allocations which have serious limits
   a) Who is responsible for determining county and sub-county budgetary needs? The CHMT with facilities and SCCHMT draw budget estimates based on county needs but the treasury micromanages all budget allocations
   b) How often is a county health budget review conducted? Not often; done once a year

9. How is the process organized? To what extent are stakeholders involved in this process? (Program Based Budgeting).
   a) Who is involved in the budget making process in the county and why? Deputy directors, accountants, directors, CO & CEC; office for controller of budget…because they are the key policy decision makers in the budget process.
   b) How are county priorities set in the health sector during the budget process? Mostly political priorities; sometimes based on needs of communities as evidenced from health facility data
   c) How are county health programs/subprograms determined in the budget? Based on key service delivery units and roles; alignment with national programs; based on goals of the health system
   d) How does county improve efficiency in resource allocation and use (value for money)? Based on programs and priority; activities identified and funded (spending is broken down to activity level)
   e) How does county ensure value for money for resources allocated to the health sector? Through identification of priority areas and funding them but there is formal process to link spending with health outcomes or outputs
   f) What challenges does the county have in formulating program based budgeting that factors in efficiency, effectiveness and equity? No work-planning right from the grassroots; same work plans are used year in year out…. only dates change; lack of capacity for work-planning especially at sub-county
   g) How does the county ensure equitable allocation of resources for improving the social welfare of the neediest in the society? Most facilities do not charge for primary services; services are ward-based…. services are decentralized to ward level. There are also policies on waivers and exemptions

Indicator 5.2 Capacity of County Health department to formulate, distribute and monitor financing for the health sector.
The four criteria necessary in a *sustainable budget* are as follows
Planning: County Health Department has a realistic and sustainable budget informed by sound revenue forecasting methods including use of past experience/expenses, development partners for health contributions and projections
Input: All key stakeholders are involved (including county health department, sub-county health administrators, civil society including religious groups, public participation, and as necessary development partners for health and implementing partners)
Allocation: County Health Department compiles an adequate budget that prioritizes primary health care services, with specific line items for key areas outlined in the County Health Strategy.
Initiative: Process for collection of budget information is led collectively by the County Health Department and sub-county health administrators' offices and the system is standardized across all sub-counties.

Standard 5.2.1: Capacity of County Health Department to plan for, create and allocate a sustainable budget	
0	• No sustainable budget exists (see four criteria necessary for sustainable budget above).
1	• Three of the budget sustainability criteria need improvement (see four criteria necessary for sustainable budget above).
2	• Two of the budget sustainability criteria need improvement (see four criteria necessary for sustainable budget above).
3	• One of the budget sustainability criteria needs improvement (see four criteria necessary for sustainable budget above).

4	• All of the budget sustainability criteria are completed and sustainable, with the county and sub-county health administrators' offices taking the lead on developing the county health budget (see four criteria necessary for sustainable budget above).
Comments:	

The four factors necessary to *effectively distribute and or allocate finances* are as follows:

Financial System: A system exists within the County Health Department to distribute funds among its activities. This includes differentiating by funding source (e.g., development partners for health, national and county revenue, etc.) and by funding recipient (e.g., by line item, and by district).
Tracking: County Health Department has a system to track its distributed funds against its total budget, the sub-counties distributions against total budgets, manage cash flow and segregate expenses
Policies: Policies for allowable expenses exist and are distributed among County Health Department staff and sub-counties. These policies are implemented on a regular basis.
Responsibility: Monthly review of internal expenses versus revenue (both for the county health budget and each sub-county's budget) is designated to an employee(s) as a responsibility

Standard 5.2.2: Capacity of County Health Department to effectively distribute finances	
0	• No system to distribute funds exists (see four factors necessary for effective distribution and/or allocation of finances above).
1	• Three of the budget distribution factors need improvement (see four factors necessary for effective distribution and/or allocation of finances above)
2	• Two of the budget distribution factors need improvement (see four factors necessary for effective distribution and/or allocation of finances above).
3	• One of the budget distribution factors needs improvement (see four factors necessary for effective distribution and/or allocation of finances above).
4	• All of the four (4) budget distribution factors are completed and sustainable (see four factors necessary for effective distribution and/or allocation of finances above).
Comments:	

Qualitative Questions Standard 5.2.2

1. Briefly describe the mechanisms in place to ensure fair and adequate distribution of funds to the sub-county health teams. No clear mechanisms but sub-counties with more functional health facilities get more money. Generally, money is sent to implement budget plans
   a) How is the process set up? There is no clear mechanism
   b) How are needs determined? Based on disease burden as reported by facilities
2. Briefly describe the mechanisms in place to ensure transparency in revenue collection and distribution. The treasury collects revenue
   a) What policies and procedures are in place? No adequate transparency except in donor-driven programs; local taxes and fees levies are not transparently utilized
   b) What is the course of action when a discrepancy is identified? Recovering money from salary, relieving of duties (not implemented)

5.2.3 The four factors necessary to *effectively monitor finances* are as follows:

Documentation: County keeps financial documentation in a secure place, has a policy for keeping receipts and requirements for documentation kept with each type of payment. These policies flow down to sub-counties and adherence is monitored.
Review: County reviews expenses monthly to ensure applicability and allowability according to the budget and internal policies. Exceptions are documented.
Reporting: A reporting system exists both for the county to report to the County Government Treasury and for the sub-counties to report to the county. Reports are completed and submitted according to applicable deadlines.
Audit: County either has an internal review of its and the sub-counties' accounting systems or hires external auditors on an annual basis.

Standard 5.2.3: Capacity of County Health Department to monitor finances at the National and Provincial levels	
0	• No tracking/monitoring system exists.
1	• Three of the factors necessary to effectively monitor finances need improvement (see four factors necessary for effective distribution and/or allocation of finances above)
2	• Two of the factors necessary to effectively monitor finances need improvement (see four factors necessary for effective distribution and/or allocation of finances above) .
3	• One of the factors necessary to effectively monitor finances need improvement (see four factors necessary for effective distribution and/or allocation of finances above) .
4	• All of the four (4) factors necessary to effectively monitor finances are completed and sustainable (see four factors necessary for effective distribution and/or allocation of finances above) .
Comments:	

Qualitative Questions Standard 5.2.3

20. How is the overall county budget monitored? Accountants monitor funds using vote-book control system; i.e. how much is released, spent, surrendered. CEC finance, Chief officer (finance), accountant; Finance controller is the overall boss in budget matters
    a) Who monitors/ manages the county health department budget at the county treasury level? The CHMT do not know the exact person but they suspect the finance controller does that
    b) What input do individual departments other than health department provide towards managing the overall county health department budget? Finance department is involved in monitoring and audit
21. Briefly describe your procurement policies and procedures? Requisition by user dept.; goes to dept. Head then to the chief officer for approval; procurement dept. for procurement process; float quotation based on cost implication (full procedure or float to a few suppliers); documentation team looks at quote and award tenders
    a) Do you have different thresholds for procurement? Cost beyond a certain amount (e.g. KSh 50,000.00) is advertised for bidding
    b) What do you keep as documentation in your files? All the communication (e-mails, receipts, contract agreement forms, etc)
    c) How do you ensure transparency in procurement? Competitive bidding

22. What is the county's capacity towards developing and implementing Performance-based contracts (PBC)? Signed by chief officer and CECs; prequalification process; when adverts come out, prequalified contractors apply; vetting committee; and tender is awarded
    a) How are performance indicators identified? What is the county's process for identifying the indicators? MOU specifying quality; stages of contract delivery; guarantees (years/months)
    b) How are contractors identified? What is the county's process for identifying the contractors?
    c) Is there a policy/ operational plan to guide the PBC process? SOP on conditions to be met by a contractor; e.g. no black-listed contractors, record of previous work, Evaluation report, certificates of previous work
    d) How is performance evaluated and recognized? County engineers, physical planners, public health officer, etc.
    e) What kind of assistance does the county provide to sub-counties health administrators' offices in implementing PBC? Problem area: procurement is centralized at county level; sometimes the contractor does not work with the sub-counties---often no knowledge of contractor; sometimes work is shoddy and no one to ask
23. What resources and support does County Health Department need to implement PBCs across all sub-counties?
    a) Financial needs financial resources to implement PBC and establish procurement units to the sub-counties and facilities
    b) Procurement and logistic needs: establish sub-county procurement dept.
    c) Training needs: procurement and logistics training for the county, sub-county and facilities
24. What is the county health department's budget allocation utilization rate (% of expenditure in total allocated health budget)?
    a) Recurrent expenditure about 80%
    b) Development expenditure <50%

Building Block 6: Delivering Essential Health Services

Indicator 6.1: Capacity of County Health Department to engage sub-counties in delivering public health services

Standard 6.1.1: Extent of interaction between the county health department and sub-counties	
0	• No structured interaction with sub-counties.
1	• The health department interacts at least once a year with sub-county health administrators on: o Budget-related issues only.
2	• The health department interacts at least once a year with sub-county health administrators on: o Budget related issues o Health service planning activities.
3	• The health department interacts at least once a year with sub-county health administrators on: o Budget related issues o Health service planning activities, o Maintenance and coordination of facilities.
4	• The health department interacts at least four times a year with sub-county health administrators on: o Budget related issues o Health service planning activities, o Maintenance and coordination of facilities, o Assessments and planning for community health needs.
Comments: Sub-counties have no capacity in PBB so budget estimates are passed down to them without their involvement; Assumption is that planning is the preserve of Counties not sub-counties; ideally sub-counties should be involved	

Qualitative Questions Standard 6.1.1

13. What mechanisms are in place to involve community stakeholders, sub-county health officers and partners in planning for service delivery? Template of planning from community, sub-county and county but these are never followed. No formal annual work-planning at sub-county. Weak follow-up and financial implications in terms of printing tools; poor coordination
14. Has the county conducted a formal exercise to plan for health services?
    a) How often is planning conducted? Plans are developed annually but not implemented effectively for lack of funds. Plan are not consultative for lack of funds
    b) Is there a general Annual Work Plan? Yes
    c) Do you have unit-specific and or Vertical Programs specific Annual Work Plans? How were they developed and shared? Yes; developed by counties and sub-counties in consultation with respective partners
    d) Who is involved in the planning process? MOH at sub-county, facilities in-charges, program officers, level 4 facilities
    e) How is the planning process organized? Each level from the headquarters to sub-counties and health facilities at various levels of care are usually expected to develop own plans. The plans should start from the community which informs various health facilities; the health facility plans

inform plans by sub-counties which are merged at the county level. This is how it is supposed to work. In reality, the plans at various stages never speak to each other. In most cases, only dates change but content of plans from previous years remain the same.

15. How are priority service areas identified? Based on disease burden; pressing need to address access issues; government agenda
    a) Is service delivery reflective of priority health needs per county health strategic plan? Yes
    b) What policies do you have in place to ensure service delivery targets priority health needs? Please describe. No policies but there are strategic plans and acts; usually guided by national policy. No county health policy. Policies customized are community health and environmental services

Standard 6.1.2: Capacity of County Health Department to develop and distribute (to the sub-counties) policies, plans and standards for key health care delivery areas	
0	• No County Health Department's Health Strategy exists.
1	• The county has a health strategy aligned to national health strategy (2014 – 2018)
2	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities.
3	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities. • The county clinical standards and guidelines are currently used by least 50% of sub-counties within the last two years.
4	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities. • The county clinical standards and guidelines are currently used by least 80% of sub-counties within the last two years. • The county health department conducts regular sub-county and health facility visits to monitor compliance in the use of standards and guidelines.
Comments: the guidelines need to be 100% at facilities	

Qualitative Questions Standard 6.1.2

9. What guidance does the county provide the sub-county health administrators regarding service delivery?
    a) Are there policies and procedures? The county uses national policies but not domesticated for the county; guidelines exist at county level; not disseminated to the SC because of lack funds. Health Officers not taken through content of guidelines, policies and procedures
    b) Does the county annual work plan provide guidance to sub-counties? SC work plans do not derive from county work plan
10. Who decides what services need to be provided at the sub-county level? Need-driven based on epidemiological patterns at the community; facility management committee drives community needs; occasional interactions in public barazas to identify needs; needs also based on evidence from CHVs

Indicator 6.2: Capacity of County Health Department to ensure appropriate use of policies, plans and standards related to Health Service Delivery for HIV/AIDS, TB/HIV, RMNCH, Nutrition, Water & Sanitation, and Malaria

Standard 6.2.1: Capacity of County Health Department to supervise sub-counties in the use of Health Service Delivery Standards, Guidelines, Protocols	
0	• No system exists at the county to monitor adherence of sub-counties to standards, guidelines, protocols.
1	• Some elements of a basic system exist for monitoring adherence to standards, guidelines and protocols.
2	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (***lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities),*** but use of these guidelines is not consistent by the county health department or sub-counties.
3	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (***lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities)*** • County provides support to sub-counties to monitor adherence at the facility level, but not consistently.
4	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (***lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities)*** • County provides support to sub-counties to monitor adherence at the facility level. • The county jointly with sub-counties has joint plans for conducting adherence monitoring at the health facility level.
Comments:	

Qualitative Questions Standard 6.2.1

9. What mechanisms exist in place for supervision of sub-county health facilities? Quarterly supervision; scheduled supervision with partners and county program supervision; program-specific supervision- depends on available resources

kk) Is supervision focused on medical audits or coaching and performance improvement or both? Health indicators guide supervision; support supervision based on medical audits, performance (indicators), gap analysis e.g. in equipment, for follow up on previous findings; feedback sessions e.g. after training (own-job and mentorship)

ll) How often is supervision conducted? Quarterly supervision, ad hoc.

mm) How are supervision needs determined? (needs-based or regularly scheduled?) Both

nn) Who conducts the supervision visits? Sub-CHMT, CHMT

oo) Is there clarity about levels of supervision (who supervises who) and reporting? CHMT supervises sub-CHMT; Sub-CHMT supervises facility managers; CHAs supervise CHVs

pp) What tools are used to conduct supervision? Standardized checklists

qq) How are supervision findings used? Capacity building; stocking; performance feedback;

rr) Are supervision results linked to any type of reward/recognition/incentives system? Gifts, money, promotion, recognition as center of learning; staff motivation

ss) What are the challenges to conducting supervision? Heavy reliance on partners; e.g. when AMREF pulled out supervision collapsed; financial problems; terrain problems, availability of vehicles; security; problem disseminating supervision findings.

10. What mechanisms exist for improving quality of care through the health system? Clinical guidelines, SOPs, procedure manuals, regular ward-rounds; quality improvement teams; capacity training (continuous med education); towards optimal health worker staffing; QA dept; customer satisfaction survey; med therapeutic committee; procurement from reputed suppliers; service charters; respectful maternity care. What are the gaps in quality of care in the system? Human resource gaps; medical equipment; physical facilities; What are some of the successes in improving quality of care? Reduction in malnutrition rates; (no documented successes); improved access i.e. improved utilization
    p) What indicators are used to measure service quality? Includes existence of a functional QA system; existence of a functional QI team; service utilization; population health outcomes
    q) What kind of mechanism exists to assess quality of care regularly and who is in charge to monitor this? There is quality audits led by the QA team
    r) Are there QI teams in place at the community, facility and/or sub-county levels? Not at community but at facility and SC….most are functional
    s) How is county supporting QA/QI in the private sector? SOPs adhered to through QA teams; QA/QI not enforced in private sector because of weaknesses in supervision

Standard 6.2.2: Number of operational public, private and faith based health facilities as compared to the total that routinely report complete and accurate data	
0	• The county does not have a list of the number of public, private and faith based health facilities.
1	• The county has a list of the number of public, private and faith based health facilities, but there is no system to determine and report which of the facilities by type report complete and accurate data
2	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities, but less than 50% of the total report complete and accurate data
3	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities (at least 75% of operational public, private and faith based health facilities of the total number are operational routinely report monthly) • About 75% of the reporting health facilities report complete and accurate data.
4	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities (at least 80% of operational public, private and faith based health facilities of the total number are operational routinely report monthly) • About 85% of the reporting health facilities report complete and accurate data. • County has a system for quarterly review of complete and accurate data.
Comments: Communication is hampered by telephone connectivity	

Indicator 6.3: Capacity of County Health Department to deliver health care in identified priority areas (HIV/AIDS, TB/HIV, RMNCH, Nutrition, Water & Sanitation, and Malaria)

Standard 6.3.1: Capacity of County Health Department to implement health programs. ***NOTE: This question can be asked of HIV/AIDS, TB/HIV, RMNCH, Nutrition, Water & Sanitation, and Malaria and sub programs as appropriate (Assessment of CHMT Capacity)***	
0	• Program does not have capacity to identify priority areas for implementation
1	• Program has capacity to identify priority health areas and develop standards for health programs.

2	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs.
3	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs. • The program has capacity to conduct periodic monitoring and evaluation (M&E) of priority health programs.
4	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs. • The program has capacity to conduct periodic monitoring and evaluation (M&E) of priority health programs. • The program has capacity to promote data sharing, communication, and collaboration within individual priority health programs.
Comments: County officials indicated that project or programme funding and financial allocations to the health sector is based more on political priorities than the health needs of the population	

Scoring of Standard 6.3.1

q) Scores from each individual program for standard 1.3.1 above:

Program	HIV/AIDS	TB/HIV	RMNCAH	NUTRITION	WASH	MALARIA
Score /4	3	4	3	2	3	4

r) Total score from above table (a) = _____19_____

s) Total number of programs included = __6_____

t) Average score (b/c) = ___3.2_____ Please enter this score for Standard 1.3.1 above.

Qualitative Questions Standard 6.3.1

4) What is the county's capacity towards delivering Essential Health Services Package (EHSP)? There is skilled & trained leadership at CHMT to manage delivery of EHSP but the actual delivery is hampered by poor state of roads, sub-optimal health workforce and inadequate and often erratic supply of commodities supplies. The other major barrier is low levels of financing especially from the county government
5) Which services are the strongest? RMNCH and community health services (CHS) are very strong because they are finance heavily by donors and the donors have very well trained and motivated workforce.
6) Which services present the most challenges? County response to HIV/AIDS is weak and without partners (donors pulling out) all the gains could be reversed. The same case with WASH/nutrition. Others such as family planning program is challenged by culture, illiteracy, and poverty, which makes up take very low. There are also challenges of addressing neglected tropical diseases such as kalaazar, trachoma and hydatie

Maternal and newborn services

5) How do you identify targets? We use international and national government targets. We also tend to look at where we are, i.e. the resources available and situation at the baseline that we

use to set targets. Please list some of your targets. E.g. 90 -90 -90 targets; % of fully immunized children;

6) Where are you with your targets for maternal and newborn services? As of 2017: % deliveries conducted with skilled attendant (target 65%; achieved 74.9%); % of newborns with low birth weight (target= 5%; achieved 4.8%); % of facility based fresh still births (target= 5%; achieved 2.1%); % of pregnant women attending four antenatal care visits (target= 80%; achieved 60.1%); % Infants under six months on exclusive breastfeeding (target= 100%; achieved 68.1%); % of facilities providing Basic Emergency Obstetric Care (BEOC) (target=90%; achieved 9%)
7) Do you anticipate reaching all your targets for the year? If no, please explain why. No, given the past trends and the resources at our disposal. Besides, things such as culture do not change overnight
8) What assistance do you need to reach your targets? The key issue is financing. We never get budgetary allocations anywhere close to our estimates.

5) **Child health services:** Demand and utilization of services hampered by cultural beliefs, distance, and low literacy. Low ANC uptake (40% first ANC and 10% fourth ANC visits. Demand generation is not well coordinated and sometimes because of many actors, activities are duplicated. How do you identify targets? Please list some of your targets. We use international and national government targets. We also tend to look at where we are, i.e. the resources available and situation at the baseline that we use to set targets.
6) Where are you with your targets for child health services? % children under five stunted (target 15%; achieved 2.4%); % children under five underweight target 5%; achieved 10.1%); % schools providing complete school health package (target 50%; achieved= not reported); % facilities providing immunization (target= 100%; achieved 85%)
7) Do you anticipate reaching all your targets for the year? If no, please explain why: No, reporting is weak in some areas and the resources at their disposal cannot allow them to meet all their targets.
8) What assistance do you need to reach your targets? Assistance in financing, capacity building in data management and reporting, additional HRH. The county is doing its best to ensure that care is delivered in a respectful environment to the patient, however, communication skills of some health workers would need to improve so that mothers at the point of delivery do not feel harassed.

Family Planning and Reproductive health (FP/RH)

5) How do you identify targets? Please list some of your targets. We use international and national government targets. We also tend to look at where we are, i.e. the resources available and situation at the baseline that we use to set targets.
6) Where are you with your targets for reproductive health services? % women of reproductive age receiving family planning (target = 80%; achieved 16.9%); Information the FP/RH focus area scanty due to cultural barriers
7) Do you anticipate reaching all your targets for the year? If no, please explain why. No, there are cultural barriers to adopting and scaling up FP planning services.
8) What assistance do you need to reach your targets? Capacity building on data management and reporting; community advocacy to promote use FH/RH services

HIV/AIDS:

5) How do you identify targets? Please list some of your targets. We use international and national government targets. We also tend to look at where we are, i.e. the resources available and situation at the baseline that we use to set targets.
6) Where are you with your targets for patients on treatment and mother to child transmission? % HIV+ Pregnant mothers receiving preventive antiretroviral (ARVS) (target= 90%; achieved 90%); % of eligible clients on ARVs (target= 90%; achieved 64.5%)

7) Do you anticipate reaching all your targets for the year? If no, please explain why. No, resources to reach all eligible cases; few come for voluntary tests; lose to follow up
8) What assistance do you need to reach your targets? Donors are slowing pulling out and we need to find domestic resources to channel into HIV/AIDS programs

Malaria:

5) How do you identify targets? Please list some of your targets. We use international and national government targets. We also tend to look at where we are, i.e. the resources available and situation at the baseline that we use to set targets.
6) Where are you with your targets for ITN use among pregnant women and children under 1 year? % of targeted children under one-year-old provided with Long-lasting insecticide-treated nets (LLITNs) (target= 85%, achieved = no reports); % of targeted pregnant women provided with LLITNs (target 85%; achieved 12.3%).
7) Do you anticipate reaching all your targets for the year? If no, please explain why. No, poor reporting hampers planning for targets; culture is a barrier to ITN use.
8) What assistance do you need to reach your targets? Capacity building on data management and reporting; community advocacy promote use of ITNs

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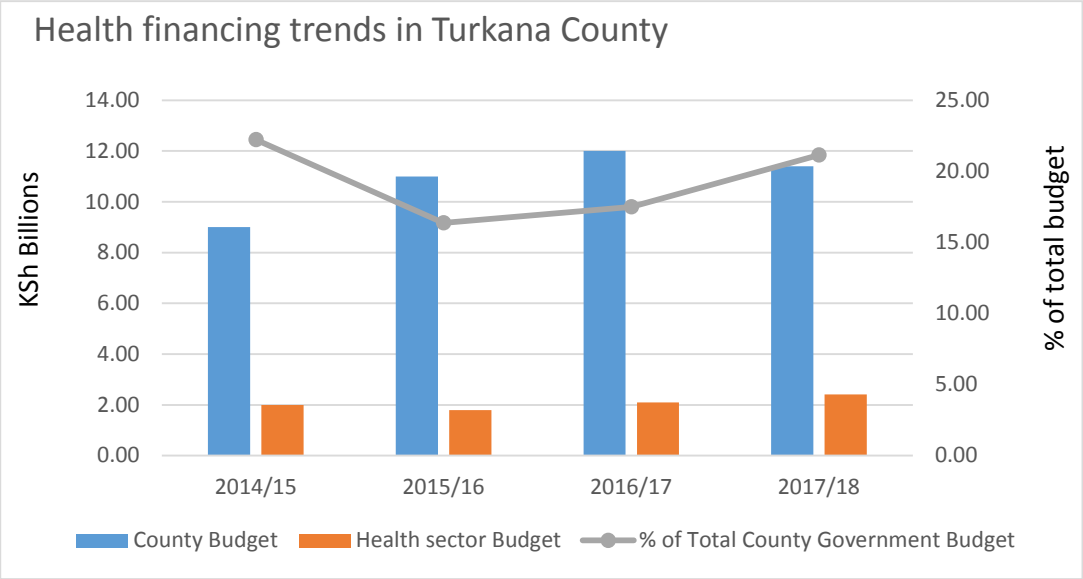
Note**:**
For Maternal/Newborn, Child Health, FP/RH, HIV, and Malaria, the CICAT assessment team will also probe the issue of "respectful care" during the MNCH questions, particularly for maternal health services offered at facility level during prenatal, labor, and postnatal care.

Metrics: Illustrative outcomes

Building Block	Illustrative Outcomes	Measurement Method/Annually
Leadership & Governance	i) Equity in the distribution of health services and interventions ii) collaboration with private and other sectors iii) Management systems and functions iv) Partnership and coordination of healthcare delivery v) Governance systems and functions vi) Engaging of public and private services providers vii) Planning and monitoring systems and services viii) Health regulatory framework and services	Post intervention CICAT Documents Reviews Key Informant Interviews
HRH:	i) equitable distribution health workers by cadre a. rural vs. urban distribution ii) ratio of health providers to population served by cadre a. doctors: population b. nurses: population iii) health providers deployment norms and standards in use iv) standardized job grading and salary structure in use	Post intervention CICAT Documents Reviews Key Informant Interviews
Health Information System:	i) Health research and information policies, regulations, and standards in use ii) Accurate, timely and complete public health information generation iii) Functional health information dissemination mechanisms for state and non-state actors iv) Existence of plan for strengthening information systems v) Existence of county health research agenda that	Post intervention CICAT Documents Reviews Key Informant Interviews

Building Block	**Illustrative Outcomes**	**Measurement Method/Annually**
	supports evidence-based policy making	
Essential Medicines & Other Health Commodities:	iv) Existence of a framework for establishing strategic county health products and technologies (HPT) reserve a. harmonized county regulatory framework for health products and technologies exists b. effective and reliable procurement and supply systems	Post intervention CICAT Documents Reviews Key Informant Interviews
Health Systems Financing:	xix. Transparency and accountability in resource mobilization, allocation, and use. xx. Cost-effectiveness and cost efficiency of resource allocation and use xxi. Sustainable financing system for strategic health commodities xxii. Health budget utilization/execution rate, a. health budget balance of primary and tertiary health care services, b. health budget balance of recurrent and development activities xxiii. Private sector participation in financing of healthcare xxiv. Functional social health protection mechanism (attainment of universal coverage)	Post intervention CICAT Documents Reviews Key Informant Interviews
Essential Health Services:	x) Effective supervision on implementation of health	Post intervention CICAT Documents Reviews

Building Block	Illustrative Outcomes	Measurement Method/Annually
	policies, & adherence to regulations and standards in place xi) Mentorship program for improvement of HCWs knowledge, skills, and competencies in place xii) Existence of functional management and oversight teams for every Health Service Delivery System with an approved organizational structure	Key Informant Interviews


Health financing trends in Turkana County
KSh Billions
% of total budget
14.00
12.00
10.00
8.00
6.00
4.00
2.00
0.00
25.00
20.00
15.00
10.00
5.00
0.00
2014/15
2015/16
2016/17
2017/18
County Budget
Health sector Budget
% of Total County Government Budget

BUSIA COUNTY INSTITUTIONAL CAPACITY ASSESSMENT (CICA)
ACTION PLAN
AS AT FEBRUARY 2018

ntified from Capacity Assessment		Proposed Actions to Address Gaps	Person Responsible (County Official)	Year 1 (Govt Cycle)				Year 2 (Govt Cycle)				Organisations Providing Support
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Building Block 1: Governance and Leadership												
Capacity of County Health Department to develop and implement a County Health Strategy												
Lack of M&E framework to track progress of the County Health Sector Strategic and Investment Plan (CHSSIP)		Develop M&E framework for the second CHSSIP (2018-2022)	CHRIMO									County government, Tupime, IPAS
Weak M&E unit		Strengthening the M&E Unit	CHRIMO									
Capacity of County Health Department to communicate and coordinate within the County and Sub-County Health Department and other Departments in the county												
Lack of communication plan and protocols		Develop and disseminate a communication plan and protocol	CDH									County Government, FRED Hollows, APHIAplus, PS
		Develop an overall organization structure (organogram) with clear reporting levels, and staff orientation	CDH, HRMO									
Irregular coordination of meetings		Create a partner liaison office with clear terms of reference	CDH									
Capacity of the County Health Department to lead and engage (coordination) with different health actors working towards the same county goals												
Irregular coordination of meetings		Implementation of the county health stakeholders coordination mechanism (periodicity is enshrined in the document)	CDH									AMPATH, Tupime (All strategic partners)
		Resource mobilization to support the implementation of the county health stakeholders coordination mechanism										
Limited involvement of health actors in annual sector reviews, work plan development and policy development		Implementation of the county health stakeholders coordination mechanism (periodicity is enshrined in the document)	CDH									
Irregular performance update and reports from health sector actors to the CH leadership (CHMT, Governor, County Assembly, CEC County Executive Committee)		Develop clear reporting schedule and reporting templates	CDH and M&E Unit									
		Consolidate reports as per the agreed schedules	CDH and M&E Unit									
No clear exit strategy for partners in the county		Clear exit strategy developed for partners	CDH									APHIAplus, AMPATHplus, Save the Children,
Capacity of County Health Department to hold responsibility and ownership for the health system												

Lack of oversight role		Track county health activities on a quarterly/monthly basis	Chief Officer (Chief Officers, Internal auditors,									
Lack of annual accountability platform for reviewing funding against commitments		Conducting quarterly annual work planning/expenditure analysis (performance and expenditure tracking) [Quarterly]	Chief Officer. CDH and CHAO									County Treasury, County Assembly, Tupime Kaunti
		Involvement of the county health directors and SCMOHs in the issuance and approval of AIEs	Chief Officer									County Treasury, Health Policy Plus

BUSIA COUNTY INSTITUTIONAL CAPACITY ASSESSMENT (CICA)
ACTION PLAN
AS AT FEBRUARY 2018

ps Identified from Capacity Assessment		Proposed Actions to Address Gaps	Person Responsible (County Official)	Year 1 (Govt Cycle)				Year 2 (Govt Cycle)				Organisations Providing Support
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Building Block 2: Health Workforce												
Ability to recruit and retain human resources for health worker positions, staff health facilities as per staffing guidelines, make working conditions and rural and hard to reach areas more attractive and safe.												
Lack of HRH job descriptions		Develop HRH JDs comparing them with SRC JDs and schemes of service to customise Busia County Job descriptions	CDH									APHIAplus, AMPATHplus, Save the Children, Intrahealth, HP+, Tupime Kaunti
No county HRH strategy		Develop, disseminate and implement a county HRH strategy	CDH, M&E Unit									HRH Kenya
		Strengthen the HR unit in the different levels.	CDH									
No written strategy for attraction, recruitment, attrition and retention of staff		Develop a plan for attraction, recruitment, attrition and retention	CDH									APHIAplus, AMPATHplus, Save the Children, Intrahealth, HP+, Tupime Kaunti
No written agreement for pre-service and in-service training with institutions		Develop and enforce standard agreements with training institutions	CDH									Intrahealth, HP+
Training needs assessment not carried out		Carry out training needs assessment every 3 years	CDH									Intrahealth, HP+
Capacity of County Health Department to staff health facilities as per Staffing Norms, Standards and Guidelines												
Lack of updating of iHRIS		Capacity building of staff to be able to update iHRIS monthly	CDH									APHIAplus, AMPATHplus, Save the Children, Intrahealth, HP+, Tupime Kaunti
		Develop a mechanism for reporting trainings in place	CDH									APHIAplus, AMPATHplus, Save the Children, Intrahealth, HP+, Tupime
Capacity of County Health Department to institutionalize systems for measuring performance and competence of health workforce; strengthen HRH development systems and practice including continuous professional development, communication, ethics and values systems.												
Weak dissemination of guidelines and policies		Strengthen dissemination processes for policies and guidelines such as staff, attraction and appraisals and performance management	CDH									APHIAplus, AMPATHplus, Save the Children, Intrahealth, HP+, Tupime Kaunti

Absenteeism and poor productivity of county health staff		Strengthen the mechanisms for sanctions and rewards	CDH										APHIAplus, AMPATHplus, Save the Children, Intrahealth, HP+, Tupime Kaunti
		Conduct annual staff satisfaction surveys	County HR										Intrahealth
Inadequate pharmaceutical personnel.		Recruit and make appropriate deployment of pharmaceutical personnel considering the workload	Chief Officer of Health										County Government
Capacity of County Health Department to coordinate capacity development of Human Resources for Health													
High dependency on vertical programmes		County to mobilize resources for vertical health programmes	CDH										APHIAplus, AMPATHplus, Save the Children, Intrahealth, HP+, Tupime Kaunti

BUSIA COUNTY INSTITUTIONAL CAPACITY ASSESSMENT (CICA)
ACTION PLAN
AS AT FEBRUARY 2018

Identified from Capacity Assessment		Proposed Actions to Address Gaps	Person Responsible (County Official)	Year 1 (Govt Cycle)				Year 2 (Govt Cycle)				Organisations Providing Support
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
		Building Block 3: Health Information Systems										
Capacity of County Health Department to develop and implement HMIS policies, strategies, guidelines, and protocols appropriate to the data needs of the county												
Inadequacy of the data reporting tools		Procure quality reporting tools	CDH									County Government, APHIAplus, AMPATHplus
Inadequate staff capacity on data management (knowledge and skills)		Train all health workers on data management tools	CHRIMO									County Government, Tupime Kaunti, HP+, Health IT and HIGDA
Capacity of County Health Department to collect quality health data												
Data Quality Assessments (DQA) are not regularly done		Enhance quarterly DQAs (schedule for DQAs)	CHRIMO									County Government, Tupime
Limited support for data bundles for internet connectivity		Procure data bundles for each Sub County	CDH									County Government, Tupime

BUSIA COUNTY INSTITUTIONAL CAPACITY ASSESSMENT (CICA)
ACTION PLAN
AS AT FEBRUARY 2018

s Identified from Capacity Assessment		Proposed Actions to Address Gaps	Person Responsible (County Official)	Year 1 (Govt Cycle)				Year 2 (Govt Cycle)				Organisations Providing Support
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Building Block 4: Access to Essential Medicines & Other Health Commodities												
Capacity of the County Health Department to provide oversight to commodity management to downstream facilities (ref: - existence of a functional commodity security committee).												
Inadequate mechanisms to ensure the right usage of health commodities in general		Establish and strengthen the functionality of the medicine and therapeutic commitees in all level hospital levels (or at ward levels)	CDH									County Government, AFYA Ugavi
Lack of a system for reporting commodity supplies chain other than programmes supported commodities		Establish a robust system for reporting and monitoring commodity supplies chain	County Pharmacist									County Government, AFYA Ugavi
Inadequate capacity in terms of forecasting and quantification amongst the lower facility in-charges		Capacity building on health incharges on lower level facilities on commodities forecasting and quantification	County Pharmacist									County Government, AFYA Ugavi
Minimal collaboration between the user departments and the procurement department to ensure availability of quality and affordable essential commodities		Establish a mechanism to enable close consultation between procurement and users of essential commodities. (MEDS, KEMSA and other accredited GOK suppliers)	Chief Officer									County Government
		Adhere to the specifications provided by the user department	County Pharmacist									
County Health Department's capacity to estimate commodity needs, develop a supply plan and procure/source these commodities												
Inadequate number of health workers trained on commodities quantification		Scale up the commodity quantification training to other non-trained health care workers	County Pharmacist									County Government, AFYA Ugavi
County Health Department capacity to develop and/or adopt and use a National or County owned Health Commodities Logistics Management Information System (LMIS)												
Not all commodity managers have been trained on LMIS		Train all the commodity managers on commodity LMIS	County Pharmacist									County Government, AFYA Ugavi
Inadequate transactional tools on commodity management		Procure transactional tools , specifically LSO,LPO, L11, S12, S13, S3.	Chief Officer									County Government
Lack of routine DQA plans on commodities management		Establish and implement routine DQA on commodities management	County Pharmacist									County Government, Tupime Kaunti
Lack of data quality improvement plan for LMIS		Develop data quality improvement plan for LMIS	CHRIMO									County Government, Tupime Kaunti
Health facility's capacity to effectively store and account for health commodities through appropriate records and reports.												

Inadequate mechanisms at the county store to ensure efficient distribution and issuing of commodities		Establish an electronic commodities management system	Chief Officer								County Government, AFYA Ugavi
Sub-county stores do not meet the required operational standards		Construction and maintenance of standard stores in sub-counties and facilities as per good storage practices	Chief Officer								County Government, AFYA Ugavi, Save the Children
Inadequated distribution of the guidelines on commodity management to newly opened facilities		Disseminate and distribute the guidelines on commodity management to newly opened facilities	County Pharmacist								County Government, AFYA Ugavi

BUSIA COUNTY INSTITUTIONAL CAPACITY ASSESSMENT (CICA)
ACTION PLAN
AS AT FEBRUARY 2018

lentified from Capacity Assessment		Proposed Actions to Address Gaps	Person Responsible (County Official)	Year 1 (Govt Cycle)				Year 2 (Govt Cycle)				Organisations Providing Support
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Building Block 5: Health Systems Financing												
Capacity of the County Health Department to develop evidence-based budget request justifications that ensures adequate funds from the total county government budget are allocated to key areas such as HRH, health commodities and programs.												
No departmental expenditure tracking and review framework		a.)Strengthen the Executive Expenditure Committee	Chief Officer									Tupime Kaunti, HP+
		b.)Monthy tracking of the expenditure at the departmental, sub-county and facility level	Chief Officer, CDH, SCMOH, Med Sups, Facility in-changes									
No County Health Account Reports		a.) Capacity Building of CHMT and Sub-county administrators to carry out CHA analysis	CDH									Tupime Kaunti, HP+
		b.) Liaise with the relevant departments to conduct County Health Accounts analysis	CDH									
Capacity of County Health Department to plan for, create and allocate a sustainable budget												
Untapped county resources		Develop a resource mobilization strategy to include comprehensive sources of funds	Chief Officer/County Chief Nurse, SCMOH,									Tupime Kaunti, HP+
Capacity of County Health Department to effectively allocate finances based on county health priority needs												
No mechanism for distribution of financial policies to the sub-county and facility level		Develop a plan to distribute and disseminate policies and resources (funds) equitably	Chief Officer, CDH, CHAO									Tupime Kaunti, HP+
		Equitable distribution of health resources	Chief Officer of Health									
Misaligned work planning linked budget cycle.		Harmonize budgeting and work planning processes for the department and all partners	Chief Officer of Health									All partners
Capacity of County Health Department to monitor and ensure accountability for finances at the county and sub-county levels												
Reviews of expenses not done on a monthly basis		Addressed by the tracking system in 5.1.1										
Performance based contracting (PBC) does not exist		Develop a PBC Policy	Chief Officer of health									Tupime Kaunti, HP+, Save the children

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fied from Capacity Assessment		Proposed Actions to Address Gaps	Person Responsible (County Official)	Year 1 (Govt Cycle)				Year 2 (Govt Cycle)				Organisations Providing Support
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
		Building Block 6: Delivering Essential Health Services										
Extent of interaction between the county health department and sub-counties												
Inadequate interaction between CHD and sub-county Health managers		Hold quarterly consultative meetings between CHD and sub-county health managers	CDH									County Government, AMPATHplus, APHIAplus, Save the Children, Fred
Lack of structured planning engagement between the community stakeholders, the CHD and sub-county HMT		Support structured planning engagement between the community stakeholders, the CHD and sub-county HMT	CDH									
		Hold joint CHMT and SCHMT meetings to track progress	CDH									
Capacity of the County Health Department to develop and distribute (to the sub-counties and health facilities) policies, strategic plans, guidelines, protocols and standards for key health service areas												
Lack of county adapted clinical standards and guidelines		Adapt, disseminate, distribute and use National and County clinical standards and guidelines	CDH , SCMOHs and Facility In-charges									
Irregular sub-county and facility visits to monitor adherence in use of standards and guidelines		Support sub-county and facility visits to monitor adherence in use of standards and guidelines	CDH									
Inadequate implementation QA/QI system		Fully Implement the QA/QI system	CDH									
Inadequate capacity (skills and funds) to develop strategic policies and protocols on health service delivery.		Build capacity of the county to develop service delivery procedures and policies	CDH									
Capacity of County Health Department to supervise sub-counties in the use of Health Service Delivery Standards, Guidelines, protocols.												
Lack of joint plans for conducting adherence monitoring at facility level		Develop joint plans for conducting adherence monitoring at facility level	CDH									
Inadequate technical and financial support to sub-counties to monitor adherence at facility level		Provide technical and financial support to the sub-counties to monitor adherence at facility level	CDH									
Number of operational public, private and faith based health facilities as compared to the total that routinely report complete and accurate data												
Poor quality and completeness of data		Enhance data quality reviews for accuracy and completeness	CDH									
Capacity of County Health Department to develop and implement priority health programs per county health strategy												

Inadequate support for outreach services		Resource mobilization for support of outreach services	CDH									
Inadequate cold-chain equipment		Procure and maintain cold-chain equipment	CDH									

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Identified from Capacity Assessment		Proposed Actions to Address Gaps	Person Responsible (County Official)	Year 1 (Govt Cycle)				Year 2 (Govt Cycle)				Organisations Providing Support
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Building Block 1: Governance and Leadership												
Capacity of County Health Department to develop and implement a County Health Strategy												
Lack of a functional county health department organogram		Review the current county health department organogram	CEC Health/CDH/COH									County Government, Palladium (TUPIME Kaunti), Intra Health
Capacity of County Health Department to communicate and coordinate within the County and Sub-County Health Department and other Departments in the county												
a. Lack of a communication plan for County Health Department		Development of a communication plan	CDH									County Government, Palladium (TUPIME Kaunti)
b. Inadequate engagement with County Assemby		Quarterly engagement with County Health Assembly Committee	CEC Health									Palladium (TUPIME Kaunti), Ipas, PSK
Capacity of the County Health Department to lead and engage (coordination) with different health actors working towards the same county goals												
a. Lack of a partnership coordination framework		Finalization and dissemination of a partnership coordination framework	CDH									
b. Irregular stakeholder coordination meetings		A focal point for stakeholder/partner engagement on coordinations meeting support	CDH									All county health partners
c. Weak Human Resources for Health (HRH) office to facilitate leadership capacity building for county and sub county staff		Strengthen HRH office by harmonizing function of County HR Advisory Committee and finance the office to fully carry out the leadership capacity building (Establish a functional County HRH Advisory Committee conducting regular meetings)	CDH									County Government/Intra Health

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				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Building Block 2: Health Workforce												
Ability to recruit and retain human resources for health worker positions, staff health facilities as per staffing guidelines, make working conditions and rural and hard to reach areas more attractive and safe.												
Lack of structure for staff attraction and recruitment		Develop a structure for staff attraction, recruitment, development and retention for standard service delivery i.e. equity in cadre management and staff ratios to clients/patients.	CDH/HR/CEC									County Govt, Intrahealth, Aphia Plus
Lack of effective incentives for staff retention		Establish county committee to address staff retention incentives	CEC, Health									County Govt, Intrahealth
Capacity of County Health Department to staff health facilities as per Staffing Norms, Standards and Guidelines												
a) Weak functional IHRIS system		Operationalize the iHRIS to generate staffing data to advocate for resources to meet staffing gaps through cleaning, updating, and periodic data generation for county health dashboards. Employ and deploy HRs in sub counties)	COH									County Govt,Intrahealth, MMUST
Indequate HR officers at county and sub county levels		Employ, capacity build and deploy HR staff at county and sub county levels										County Government
Capacity of County Health Department to coordinate capacity development of Human Resources for Health												
Lack of system for coordinating in-service training for HRH in the county		Establish a functional training committee with TORs	HR									Couty Govt, HR, Intrahealth

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				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Building Block 3: Health Information Systems												
Capacity of County Health Department to develop and implement HMIS policies, strategies, guidelines, and protocols appropriate to the data needs of the county												
Inadequte supply of data collections tools,especially at the facility and community level		Timely forecasting, procurement and distribution of data tools, Ensuring adequate supply of data collection tools in all service delivery points informed by demanded indicators.	County Health Records Information Officer (CHRIO)									NASCOP, COUNTY GOVERNMENT APHIA Plus, PSKenya, CABDA,
Capacity of County Health Department to collect quality health data												
Irregular health performance reviews and feedback		Draw a plan for quarterly health performance reviews and feedback	CHRIO									County Government and partners
Capacity of Health Department to manage data												
a) Lack of integration of information from other health management systems , especially finacial, Human resource		Plan for interoperability with other health management systems , especially financial & human resource modules	CHRIO									County Government and partners,HIGDA
b) Lack of County Data Management Guideline on health, research and data sharing.		Develop and disseminate County Data Management Guidelines on health research and data sharing	M&E									County Government, TUPIME COUNTY,HIGDA
Capacity of County Health Department to use routine performance, surveys and surveillance data for planning including performance management, rational budgeting and policy making												
Inadequate regular data analysis and sharing , with Key actors like CHMTs ,Sub County HMTs and non State actors for use as evidence in strategic planning and policy making including rational budgeting and decision making.		Develop policies on regular data analysis and sharing for use.	M&E									County Government, TUPIME COUNTY, APHIA + ,HIGDA

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Identified from Capacity Assessment		Proposed Actions to Address Gaps	Person Responsible (County Official)	Year 1 (Govt Cycle)				Year 2 (Govt Cycle)				Organisations Providing Support
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
		Building Block 4: Access to Essential Medicines & Other Health Commodities										
Capacity of the County Health Department to provide oversight to commodity management to downstream facilities (ref: - existence of a functional commodity security committee).												
Lack of essential commodities data set in the District Health Information System (DHIS 2)		Liaise with the Ministry of Health to finalize on essential commodities data set within DHIS	County Pharmacist									KCG
Commodity security committee is not operational in 4 sub counties		Cascade the commodity security committee in the 4 sub counties	County Pharmacist									KCG
County Health Department's capacity to estimate commodity needs, develop a supply plan and procure/source these commodities												
Inadequate capacity at county and lower levels to estimate commodity needs for vaccines (GAVI support is winding up		Capacity building in estimation of commomodity requirements especially for vaccines	EPI focal person									KCG/Aphia Ugavi (Chemonics)
County Health Department capacity to develop and/or adopt and use a National or County owned Health Commodities Logistics Management Information System (LMIS)												
Lack of data quality improvement plan for all Logistics Management Information System (LMIS) elements		Development of data quality improvement plan for all LMIS elements	M&E focal person/County									KCG/TUPIME county (M&E), Aphia Ugavi (commodity),
Health facility's capacity to effectively store and account for health commodities through appropriate records and reports.												
Lack of storage for health commodities including special storage needs at all levels (county, sub county, health		Improve health commodity stores at all health facilities as per the good storage practices	CEC Health									County Govt, UNICEF, Aphia Ugavi (thermometers, Job

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				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Building Block 5: Health Systems Financing												
Capacity of the County Health Department to develop evidence-based budget request justifications that ensures adequate funds from the total county government budget are allocated to key areas such as HRH, health commodities and programs.												
Lack of Program, surveys and surveillance data usage as justification for budget requests		Implementation of programme based budgeting at the sub counties (Annual review of facility imprest allocation)	CDH/COH/Sector working									HPPlus (Palladium), County Govt
Inadequate funding support for the county health budget		Resource mobilization	CEC/COH/CDH									County Govt, Partners..
Capacity of County Health Department to plan for, create and allocate a sustainable budget												
Inadequate budget for primary health care services		Advocacy for increased allocation of primary health care services	CEC/COH/CDH									County Govt, Partners..
Lack of process for collection of budget information and standardization (criteria) across all the sub counties (Lack of involvement of Sub counties in the budgeting process)		Development of a process of budget collection and standardization (Develop a Sub county MTEF template as a guide for budgeting)	Chief Officer of Health									County Government
Capacity of County Health Department to effectively allocate finances based on county health priority needs												
No financial manual for collection and banking for health facilities		Development a financial manual for collection and banking for health facilities	COH/County Treasury									County Government, TUPIME county (palladium
Lack of documented mechanisms to ensure equitable distribution of funds to the sub-county health teams.		Development of a manual for ensuring equitable distribution	COH/County Treasury									County Government, TUPIME county (palladium
Capacity of County Health Department to monitor and ensure accountability for finances at the county and sub-county levels												
No performance based contracting in procurement at county and sub county level		Sensitization and advocate for Performance based contracting (contract management)	CDH/ County Procurement officer									County Government, partners

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				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Building Block 6: Delivering Essential Health Services												
Extent of interaction between the county health department and sub-counties												
Indequate interaction between the county health dept and sub county health administrators(budgeting, planning, maintenance & coordination & assessment		Planning and budgeting for adequate interaction between county health dept and sub county dept/facility	County Director of Health (CDH0									
Inadequate assesment & planning for community health needs		Community participation in planning	CDH									Kenya School of Government, AMREF Health Africa, Aphia Halisi
		Conduct needs assesment	M&E focal person									Tupime Kaunti
Capacity of the County Health Department to develop and distribute (to the sub-counties and health facilities) policies, strategic plans, guidelines, protocols and standards for key health service areas												
Irregular monitoring compliance in the use of standards and guidelines at sub county and health facility level		Adequate financing M&E to monitor compliance	CDH									KCG/Danida/ Palladium /PS Kenya/Amref/NASCOP/A+
Inadequate dissemiantion of the standards and guidelines at sub county and facility level		Create a repository for health standards & guidelines	CHPO									KCG/PS Kenya
Capacity of County Health Department to supervise sub-counties in the use of Health Service Delivery Standards, Guidelines, protocols.												
lack of joint planning for monitoring compliance in the use of standards and guidelines		Development of joint plans for monitoring	CDH									KCG/ All partners
lack of adherence to monitoring at the health facility level		Fund M&E unit to conduct regular monitoring	CDH									KCG/ All partners
Number of operational public, private and faith based health facilities as compared to the total that routinely report complete and accurate data												
Lack of system of quarterly review of complete and accurate data		Establish a functional M&E unit	CoH									KCG/HRH/Palladium
Capacity of County Health Department to develop and implement priority health programs per county health strategy												
a.Inadequate funding for health programs		Increased partner engagement and resources	CoH									KCG/ MNCH - funded by World Bank to improve indicators, GAVI - funded

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					Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Assessed Standard	**Building Block 1: Governance and Leadership**												
Standard 1.1.1	**Capacity of County Health Department to develop and implement a County Health Strategy**												
	Lack of a comprehensive county health department policy and program policies to guide operations of county health department		Develop county health policy and program health policies	CEC working with CDH									County government
	Lack of capacity to develop work plans at lower facility level which affects quality of work plans at the county level		Capacity building on annual work plan development	County health records officer and CHMT team									University of Maryland, Afya Halisi,
Standard 1.2.1	**Capacity of County Health Department to communicate and coordinate within the County and Sub-County Health Department and other Departments in the county**												
	Lack of a communication strategy (poor engagement from community, sub-county, county, partners; no JDs, scheme of service; organogram)		Develop and disseminate a county communication strategy (Organogram and JDs being developed)	Director of health, HR manager, & Chief officer of Health									IntraHealth (JDs), IntraHealth (organogram), County Dept of Health

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					Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Assessed Standard	**Building Block 2: Health Workforce**												
Standard 2.1.1	**Ability to recruit and retain human resources for health worker positions, staff health facilities as per staffing guidelines, make working conditions and rural and hard to reach areas more attractive and safe.**												
	Lack of strategy to attract, recruit and retain manpower		Develop attraction and retention strategy;	HR manager									CDH, potentially IntraHealth. Afya Halisi
			Develop HRH strategic plan	HR manager									CDH, potentially IntraHealth. Afya Halisi
			Develop an operation plan for staff attraction and retention	HR manager									CDH, potentially IntraHealth. Afya Halisi
Standard 2.1.2	**Capacity of County Health Department to staff health facilities as per Staffing Norms, Standards and Guidelines**												
	Poor accountabilty mechanisms (official secrecy act, enforcement systems)		Include HR in support supervision, recruitment// dissemination of code of regulation, HR policies n procedures	HR manager									CDH, potentially IntraHealth. Afya Halisi
Standards 2.2.1	**Capacity of County Health Department to institutionalize systems for measuring performance and competence of health workforce; strengthen HRH development systems and practice including continuous professional development, communication, ethics and values systems.**												
	Lack of performance appraisal system		Ensure that staff performance appraisal is conducted	HR manager									CDH, potentially IntraHealth. Afya Halisi
Standard 2.2.2	**Capacity of County Health Department to coordinate capacity development of Human Resources for Health**												
	Lack fo Training Needs Assessment		Conduct a training needs assessment and produce a report	HR manager									CDH, potentially IntraHealth. Afya Halisi

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Gaps Identified from Capacity Assessment			Proposed Actions to Address Gaps	Person Responsible	Year 1				Year 2				Organisations Providing Support
					Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Assessed Standard	**Building Block 3: Health Information Systems**												
Standard 3.1.1	**Capacity of County Health Department to develop and implement HMIS policies, strategies, guidelines, and protocols appropriate to the data needs of the county**												
	Inadequate data collection tools		Procurement of data collection tools	CHRIO									TUPIME Kaunti, Aphia Halisi, UMB, NASCOP, National Government
	Indequate dissemination of M&E framework, plan, protocols and guidelins to the sub counties		Disseminaton of M&E framework, plans, protocol and guidelines at sub ocunty level	M&E officer									TUPIME Kaunti, County Govt
	Indequate mentorship on the use of health information forms and protocols		Capacity building on use of health information systems	CHRIO									UMB, TUPIME Kaunti, Aphia Halisi,HIGDA
Standard 3.1.2	**Capacity of County Health Department to collect quality health data**												
	Indequate integration of health information systems		Interoperate/interfacing the other softwares to DHIS	CHRIO									County Government, Afya Ugavi, Afya Halisi,HIGDA
	Not all indicators are uploaded and tracked by DHIS		Develop county specific tools to track non-DHIS indicators	CHRIO									County Government, TUPIME Kaunti,HIGDA
	Irregular reviews and data quality assessment at county and sub county level		Conduct quartery DQA and reviews	M&E unit									TUPIME Kaunti, Afyia Halisi, UMB, NASCOP, National Government
	The MOH's National Data Quality protocol and standards have not been institutionalized at the county health department		Customization of National quality data protocols and standards and dissemination	M&E unit									TUPIME Kaunti, Aphia Halisi, UMB, NASCOP, National Government
Standard 3.1.3	**Capacity of Health Department to manage data**												
	Underutilization of the DHIS2 at the county level e.g. resource centre		Capacity building on use of DHIS various platofroms	M&E unit									TUPIME Kaunti, Aphia Halisi, UMB, NASCOP, National Government ,HIGDA
	Indequate data storage of records (hard and soft versions -		Procurement of storage facilities (hard and online versions)	COH									County Government
	Indequate ICT equipment and maintenance		Procurement of ICT equipment and maintenance service contracts	COH									County Government
Standards 3.2.1	**Capacity of County Health Department to use routine performance, surveys and surveillance data for planning including performance management, rational budgeting and policy making**												
	Indequate periodic systematic evaluation of programmes and strategies		Public private partnerships on systematic evaluation of programmes and strategies	Planning, M&E, PPP unit									County Government
	7.4												
	7.5												
	7.6												
	Indequate skills to develop policy briefs		Capacity building on develoment of policy briefs	CDH									County Government
	Lack of data analysis framework		Develop a data anaysis framework										HIGDA
	Indeqauate guidelines for data analysis and reviews for informed decision making		Develop and customize guidelines for data anlaysis, review and supprot supervision for the county	CDH/CHRIO									County Government
	Irregular review meetings and feedback to health faciities		Develop a system for regular reviews and feedback mechanism to health facilities and community units	M&E unit									County Government
	Indequate linkage between data decisions and budget		Early preparation of AWP to inform the budget	M&E unit									County Government

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					Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Assessed Standard	**Building Block 4: Access to Essential Medicines & Other Health Commodities**												
Standard 4.1.1	**Capacity of the County Health Department to provide oversight to commodity management to downstream facilities (ref: - existence of a functional commodity security committee).**												
	Indequate quality assurance of essential commodities		Capacity building on pharmacovigilance and Minilab testing Provision of Pharmacovigilance tools (Afya Ugavi)	County Pharmacist									Aphia Halisi, Afya Ugavi, County Government
Standard 4.1.2	**County Health Department's capacity to estimate commodity needs, develop a supply plan and procure/source these commodities**												
	Inadequate resources to conduct annual forecasting and quantification		Mobilize resources to conduct annual forecasting and quantification	County Pharmacist									Aphia Ugavi/Chemonics, Aphia Halisi
	Data quality issue for programme reports e.g. Malaria (don't capture actual physical county and results in supply error		Conduct regular data quality assurance (bi-annually)	County Pharmacist									Aphia Ugavi/Chemonics, TUPIME kaunti (Palladium)
Standard 4.1.3	**County Health Department capacity to develop and/or adopt and use a National or County owned Health Commodities Logistics Management Information System (LMIS)**												
	Lack of Logistic Information Management System (LMIS) for Essesntial Medicines and Comoodities		Pilot an LMIS for priority medicines and medical supplies in a few sub counties	County Pharmacist									County Government, Afyia Halisi, Afya Ugavi
	Inadequate reporting tools and job aids for commodities		Procure commodity reporting tools and job aids	Chief Officer of Health (CoH)									Aphia Halisi, Afya Ugavi (distribution of job aids)
Standard 4.1.4	**Health facility's capacity to effectively store and account for health commodities through appropriate records and reports.**												
	Indequate storage facilities, shelves and pallets		Procure storage facilities, shelves, pallets	Chief Officer of Health (CoH)									County Government, Afya Halisi, Afya Ugavi
	Lack of incinerators		Procure and service existing incinerators	Chief Officer of Health (CoH)									County Government
	Inadequate financial resources to conduct redistribution of commodities (except malaria commodities)		Mapping of health facilities for redistribution of commodities and mobilize resources	County Pharmacist									County Government, Aphia Ugavi, HSDSA (Path)
	Inadequate commodity management tools		Procure commodity management tools	Chief Officer of Health (CoH)									County Government
	Weak commodity mangement supervision of private and public health faciities		Mobilize resources and conduct quarterly support supervision on commodity management Supporting commodity supervision and follow up bi-annually	Chief Officer of Health (CoH)									County Government, Aphia Halisi, ESHE (Palladium), Afya Ugavi

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					Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Assessed Standard	**Building Block 5: Health Systems Financing**												
Standard 5.1.1	**Capacity of the County Health Department to develop evidence-based budget request justifications that ensures adequate funds from the total county government budget are allocated to key areas such as HRH, health commodities and programs.**												
	Indequate allocation for county health budget (less than 23%)		Advocacy to more budgetary allocation and completion of the county health bill and policy	Chief Officer for Health									County Government, TUPIME Kaunti, Aphia Halisi, Path, UNICEF, UNFPA
Standard 5.2.1	**Capacity of County Health Department to plan for, create and allocate a sustainable budget**												
	Not all key stakeholders are involved in the budget making process at county health department		Mapping of key stakeholders and involve in the budget makinig process and bottom up approach in budgetment	CDH									County Government and partners, HPP+
	Indequate budgetary allocation for primary health care services		Form a joint partner forum (includoing CSO's) for advocacy of health care financing	CEC									County Government and all partners, private sector
			Advocacy forum for Governor and MCA's and coounty health department	CEC									County Government and all partners, private sector
	Indequate use of evidence based data to inform budget prioritization allocation at county		Annual work plan and annual report to inform budget process	Planning, M&E unit									County Government and partners
Standard 5.2.2	**Capacity of County Health Department to effectively allocate finances based on county health priority needs**												
	No proper systems for tracking distribution and utilization of funds		Develop a financial tracking tool (electronic votebook) at county health department and lower levels	COH									County Government
	The county health department does not have direct control of revenue collection (user fees) from its health facilities		Creation of a health sector services fund	CEC									County Government
Standard 5.2.3	**Capacity of County Health Department to monitor and ensure accountability for finances at the county and sub-county levels**												
	Weak accountability sytems at county and sub county levels at the health department		Strengthen financial reporting, auditing county and sub county levels at the health department,	CEC									County Government
			Conduct quarterly support supervision										County Government
			Conduct internal audits										County Government
	Procurement is centralized at county headquarters, health facilities have challenges on procurement (huge delays and inefficient system)		Department, county and sub county and facilities as procurement entities	Procurement Unit									County Government
			Sensitization on procurement	Procurement Unit									County Government
			Recruitment of Supply Chain Management officers at sub county and health facility levels	Chief Officer of Health									County Government
			Ammendment of PFM act and procurement act	Chief Officer of Health									County Government

			Asset/Inventory management system at county level	Procurement Unit									County Government

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					Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Assessed Standard	**Building Block 6: Delivering Essential Health Services**												
Standard 6.1.1	**Extent of interaction between the county health department and sub-counties**												
	Inadequate involvement of community units in the annual work planning		Structured and regular engagements with community units	Community Health Services Focal person									Afya Halisi, LVCT (Scale) County Government,
	Indequate engagement with sub counties health administrators on service delivery		Regular engagement (at least 4 times a year) with sub counties	County Director of Health (CDH)									County Government
Standard 6.1.2	**Capacity of the County Health Department to develop and distribute (to the sub-counties and health facilities) policies, strategic plans, guidelines, protocols and standards for key health service areas**												
	Indequate number of clinical standards and guidelines at the county		Customize and disseminate clinical standards and guidelines	County Director of Health (CDH)									Afya Halisi, UMB, TUPIME Kaunti, County Government
Standard 6.2.1	**Capacity of County Health Department to supervise sub-counties in the use of Health Service Delivery Standards, Guidelines, protocols.**												
	Lack of joint plans for conducting guideline adherence monitoring at the county level		Develop, disseminate and distribute guidelines adhering standards and check lists	M&E unit									County Government, TUPIME Kaunti, Afya Halisi
	Indequate support supervision skills at county and sub county levels		Training on support supervision skills using standard guidelines at county and sub county levels	County Director of Health (CDH)									County Government, TUPIME Kaunti, Afya Halisi, University of Maryland
	Irregular support supervision at all levels		Regular joint support supervision plans developed and disseminated to all relevant parties	County Director of Health (CDH)									County Government, TUPIME Kaunti, Afya Halisi, University of Maryland
Standard 6.2.2	**Number of operational public, private and faith based health facilities as compared to the total that routinely report complete and accurate data**												
	Indequate data quality audits		Conduct quarterly focused data quality assurance	County Health Records Information Officer (CHRIO)/M&E unit/Sub county MOH									County Government, TUPIME Kaunti, Afya Halisi
	Less than 75% of the reporting health facilities report complete and accurate data		Regular mentorship and support supervision	CHRIO									County Government, TUPIME Kaunti, Afya Halisi
	Low understanding of the health indicators		Facility based CME and on spot mentorship	CHRIO									County Government, TUPIME Kaunti, Afya Halisi, Afya Ugavi
Standard 6.3.1	**Capacity of County Health Department to develop and implement priority health programs per county health strategy**												

	Indequate integrated planning on TB and HIV planning at service delivery activities		Integrated planning of TB and HIV planing and monitoring	TB and HIV County Coordinators (CTLC & CASCO)									County Government, TUPIME Kaunti, HSDSA (Path), University of Maryland, LVCT (Scale)
	Indequate knowledge for technical modules for community health volunteers (CHV's)		Training of CHV's on technical modules	Community Health Services Focal person									County Government, TUPIME Kaunti, Afya Halisi, LVCT (Scale)
	Indequate capacity on Integrated Management of Childhood Illnesses (IMCI), immunization and Integrated Community Case Management (ICCM)		Training on IMCI, immunization, ICCM	County Focal Person for Child Health (IMCI) Community Strategy Focal person(ICCM) Nursing Officer (Immunization)									County Government, TUPIME Kaunti, Afya Halisi
	Indequate cold chain equipment		Procuring of cold chain equipment	Chief officer of Health									Afya halisi
	Inadequate training on family planning package to CHV's		Training CHV's on package for family planning	County Nursing Officer									County Government, TUPIME Kaunti, Afya Halisi
	Indequate capacity to underyake Community Led Total Sanitation (CLTS) approach		Training on CLTS for health workers and CHVs	Community Health Services Focal person									County Government, TUPIME Kaunti, Afya Halisi
	Incomplete verification and certification of villages on Open Defecation Free (ODF)		ODF Certification and verification in all villages	Community Health Services Focal person									County Government, TUPIME Kaunti, Afya Halisi, Chuodho Women Group
	Inadequate knowledge among health care providers on nutrition		Training, CME's and community sensitization for Health care providers and CHVs on nutrition knowledge	County Nutrition officer									County Government, TUPIME Kaunti, Afya Halisi, World Vision
	Indequate equipment on nutrition and poor maintenance		Procurement of nutrition related equipment	Head of Procurement Unit Head of Maintenance Unit									County Government, TUPIME Kaunti, Afya Halisi, University of Maryland

MOMBASA COUNTY INSTITUTIONAL CAPACITY ASSESSMENT (CICA)
ACTION PLAN
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Identified from Capacity Assessment		Proposed Actions to Address Gaps	Person Responsible (County Official)	Year 1 (Govt Cycle)				Year 2 (Govt Cycle)				Organisations Providing Support
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Building Block 1: Governance and Leadership												
Capacity of County Health Department to develop and implement a County Health Strategy												
Lack of a stand alone M&E framework to track County Health Strategic and Investment Plan (CHSIP) progress		Develop a stand alone M&E framework	Assistant Director M&E									AFYA PWANI/COUNTY/HIGDA/PS KENYA
Poor coordination of external actors/stakeholders activities		Develop a governance structure to streamline stakeholder activities	County Chief Officer of Health Medical Services									AFYA PWANI/COUNTY/HIGDA
Capacity of County Health Department to communicate and coordinate within the County and Sub-County Health Department and other Departments in the county												
Lack of communication strategy outlining plans and protocols for communication flow and effective communication management		Develop a county health communication strategy	County Director of Health (CDH)									PS KENYA/COUNTY
Capacity of the County Health Department to lead and engage (coordination) with different health actors working towards the same county goals												
Lack of policy/guidelines for collaboration		Develop policy guidelines for collaboration	Head Promotive & Preventive (HP&P)									AFYA PWANI/COUNTY
Iregular meetings between county and partners which makes it difficult to effectively coordinate partners		Nominate a county stakeholders' coordinator and develop terms of reference for the position	Chief Officer of Health (CO Health)									COUNTY
		Organize regular quarterly stakeholder forums	CDH									
Capacity of County Health Department to hold responsibility and ownership for the health system												
Inadequate funding for Preventive and Promotive divison		Resource mobilization and advocacy at the county assembly on preventive health and increased public awareness of budgeting cycle process	CO Health									COUNTY/AFYA PWANI/PWANI LISHE BORA/DSW/MEDIA HOUSES
Inadequate coverage of community units		Engagement with other sectors to ring fence allocated funds for Community Units	CO Health									COUNTY/AFYA PWANI/PWANI LISHE BORA/DSW
Lack of access to allocated funds		Create an account at Central Bank for the county health department to ensure transfer of allocated funds	CO Health									COUNTY

MOMBASA COUNTY INSTITUTIONAL CAPACITY ASSESSMENT (CICA)
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s Identified from Capacity Assessment		Proposed Actions to Address Gaps	Person Responsible (COUNTY Official)	Year 1 (Govt Cycle)				Year 2 (Govt Cycle)				Organisations Providing Support
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Building Block 2: Health Workforce												
Ability to recruit and retain human resources for health worker positions, staff health facilities as per staffing guidelines, make working conditions and rural and hard to reach areas more attractive and safe.												
Lack of HRH periodic training needs asssements		Conduct annual Training Needs Assessments (TNA) and generate a TNA report for action on recommendations	HRH DIRECTOR									COUNTY/Intrahealth/AFYA PWANI
Weak induction system for newly posted/deployed staff		Development of an Induction Manual/guideline for county health staff	HRH DIRECTOR									COUNTY /Intrahealth
		Induction of new staff/Institutionalization as staff are brought on board	HRH DIRECTOR									COUNTY /Intrahealth
Capacity of County Health Department to institutionalize systems for measuring performance and competence of health workforce; strengthen HRH development systems and practice including continuous professional development, communication, ethics and values systems.												
Poor dissemination and lack of implementation of a Performance Appraisal System (PAS)		Prioritize the dissemination and give timelines for the same.	HR Director									COUNTY/Intrahealth/AFYA PWANI
		Implementation of reward and sanction mechanisms										
Capacity of County Health Department to coordinate capacity development of Human Resources for Health												
Lack of Operational Plan to guide the retention of workforce		Evaluate and review of the current HRH Strategic Plan and develop a costed HRH Strategic Plan (current expires in June 2018) with an operational plan to support development of annual work plans.	HR Director									COUNTY/Intrahealth/AFYA PWANI
Lack of succession plan		Develop and embed the succession plan at all levels, into the new HRH Strategic Plan.										
Lack of Training Coordination mechanisim		Develop training coordination mechanism and nominate a County Training Coordinator and give clear roles and responsibilities	Chief Officer of Health									COUNTY/Intrahealth/AFYA PWANI
Lack of harmonized data on trained staff at the county health deaprtment		Provide the training coordinate with rights to iHRIS to manage the trianing data management	HR Director									COUNTY/Intrahealth/AFYA PWANI
Lack of incentives for the staff that complete requisite in -service trainings		Develop incentive guidelines	HR Director									COUNTY/Intrahealth/AFYA PWANI
Instructors from pre-training institutions do not accompany and offer regular supervision to students that they send to the hospitals.		Institute mandatory procedures for pre-service institutions to accompany students for practicals in hospitals	HR Director									COUNTY /Training Institutions

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ACTION PLAN
AS AT FEBRUARY 2018

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				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Building Block 3: Health Information Systems												
Capacity of County Health Department to develop and implement HMIS policies, strategies, guidelines, and protocols appropriate to the data needs of the county												
Lack of County HMIS M&E Framework		Develop a County Health Management Information System (HMIS) M&E Framework	Head Planning M&E									PALLADIUM/AFYA PWANI
Inadequate HMIS tools		Allocate funds for designing,printing and distribution of tools	Head Planning M&E									COUNTY/ PALLADIUM
		Capacity building of staff on the tools										
		Develop an integrated Electronic Medical Records (EMR) at facility level										
Inadequate number of HRIOs		Recruit adequate number of health records information officer	CO Health									COUNTY
Capacity of County Health Department to collect quality health data												
Lack of inclusive policy to ensure accountability and reporting by private facilites to the County Health		Develop an inclusive HIS policy to include HMIS Reporting as per the health bill	Head Planning M&E									COUNTY, HIGDA/AFYA PWANI/PS KENYA and

MOMBASA COUNTY INSTITUTIONAL CAPACITY ASSESSMENT (CICA)
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				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Building Block 4: Access to Essential Medicines & Other Health Commodities												
Capacity of the County Health Department to provide oversight to commodity management to downstream facilities (ref: - existence of a functional commodity security committee).												
Irrational use of medicines		Formulate medical and theraputic committees at Sub County level and Sensitization of clinicians and Implement KQMH standards and checklists	Health Products and Technologies Dept (HPTD)									County
Weak Supply chain system in place leading to poor estimation of supplies		Develop key supply chain performance indicators of commodities distribution based on data.	HPTD									AFYA PWANI, Afya Ugavi,
Inadequate feedback from high to low level		Ensure consistent data quality & commodity meetings are held	HPTD									County
Inconsistent Support supervision		Allocate funds to conduct integrated support supervision	CDH									County
Accumulation of expired drugs in the facility		Formalization of the County Disposal Committee.Allocate funds for drugs disposal. Early tracking of short expiry medicine/Allocate funds for medical waste disposal and purchase an incinerator	COH,HPTD									County
Poor tracking tracer commodities		Allocate fund to allocate funds to purchase an electronic inventory management tool	COH									County
County Health Department's capacity to estimate commodity needs, develop a supply plan and procure/source these commodities												
Inadequate capacity to analyze supply chain data for forecasting and quantification		Capacity building for pharmaceutical staff	COH ,HPTD									County
		Allocate funds for Forecasting and Quantification exercise, F&Q report and procurement of commodities as per plan	HPTD									County
County Health Department capacity to develop and/or adopt and use a National or County owned Health Commodities Logistics Management Information System (LMIS)												
Lack of electronic system for essential commodities		Develop an electronic LMIS	Head Planning M&E									AFYA PWANI
Health facility's capacity to effectively store and account for health commodities through appropriate records and reports.												

Weak inventory management system		Recruitment of pharmaceutical staff	COH								County
		Deployment of medical supplies staff	COH								County
		Construction of County warehouse	COH								County
		Engage private health facilities in facilitating storage of commodities and advocate for Corporate Social Responbility	COH								County

MOMBASA COUNTY INSTITUTIONAL CAPACITY ASSESSMENT (CICA)
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				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Building Block 5: Health Systems Financing												
Capacity of the County Health Department to develop evidence-based budget request justifications that ensures adequate funds from the total county government budget are allocated to key areas such as HRH, health commodities and programs.												Afya Pwani, HP plus,
Lack of quarterly financial reviews at department level		Establish a finance committee and provide terms of refernce to enable budget preparations and funds usage for department of health	Chief Officer Haelth									
Lack of skills to develop evidence to justify and lobby for adequate funding to be allocated to key areas		Recruitment of a health economist with clear terms of reference	COH									COUNTY/AFYA PWANI
Capacity of County Health Department to plan for, create and allocate a sustainable budget												
Delayed disbursement of funds		Advocacy for the timely disbursement of funds targeting county treasury	CEC Health									Afya Pwani, HP plus, DSW,
Limited health administrators and accountants, leading to challenges in coordinating development of the county health budget		Increase the number of health administrators	COH									Afya Pwani, HP plus, DSW
		Engage the County Treasury to open a special purpose account for the Health Department	COH									County Health Dept.
Inadequate funds for programmes and key service delivery areas		Lobby for more funds to be allocated to the health sector	COH									County Health Dept.
Capacity of County Health Department to effectively allocate finances based on county health priority needs												
Weak tracking of funds		a. Develop a simplified tracking system	CDH									Afya Pwani
		b. Capacity building on finance management at all levels (Facilities, Sub-county and County)	CO Health									Afya Pwani
PFM Policy in place but not effectively implemented		a. Benchmark with counties that have managed to overcome this challenge e.g. Kilifi	CO Health									Afya Pwani, HP Plus, DSW
		b. Develop a County health fund bill to ringfence the health department funds	CEC Health/CO Health									Afya Pwani
		c. Delegate the responsibility to manage health finances allocated to the sub-counties (Learn from Kilifi)	CEC Health/CO Health									County Health Dept., World Bank UHC
Capacity of County Health Department to monitor and ensure accountability for finances at the county and sub-county levels												
Weak internal audit systems		a. Request for an internal auditor for the Health Department from County Treasury	CEC Health/CO Health									County Health Dept.
		b. County to carry out quarterly supervision to the sub-counties	CDH/County Administator									World Bank

		c. Advocate for County to hire accountants for the sub-county level	CEC Health/CO Health									intra Health, Afya Pwani, County

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				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Building Block 6: Delivering Essential Health Services												
Capacity of the County Health Department to develop and distribute (to the sub-counties and health facilities) policies, strategic plans, guidelines, protocols and standards for key health service areas												
Inconsistent sub-county and health facility visits to monitor compliance in the use of standards and guidelines.		Strengthen coordination and support regular supervision visits to strengthen adherance of standards and guidelines	Head, Clinical services									CDOHS, Afya Pwani, Intrahealth,PS Kenya, CHS
Irregular support supervison		Strengthen support supervision by the CHMT	Head, Clinical services									CDOHS, Afya Pwani, Intrahealth,PS Kenya, CHS
Lack of access to essential county documents such as policies,strategic plans,guidelines,protocals and standards for key health service areas		Establish and continuous update of a health document repository	Head Planning and M&E									
Capacity of County Health Department to supervise sub-counties in the use of health service delivery policies, strategies, guidelines and standards												
Inconsistent support to sub-counties for adherence monitoring at the facility level.		Strengthen adherence monitoring	County Director Health									CDOHS, Afya Pwani, Intrahealth,PS Kenya, CHS
High Workload which affects quality of care		Sensitize work force on spreading workload and scheduling visits in a day.	County Director Health									Intrahealth
Limited customer and health workforce satisfaction surveys		Conduct customer and employee satisfaction surveys	Focal QI person									CDOHs, Afya Pwani, PS Kenya
Number of operational public, private and faith based health facilities as compared to the total that routinely report complete and accurate data												
Late,inaccurate and incomplete data reports		Implement and ensure compliance to the county HIS policy in reporting by all stakeholders as per the health Bill.	CHRIO/CDH									CDOH, Private Sector Umbrella bodies, Afya Pwani, PS Kenya,Afya Ugavi
		Mentorship to private facilities										
		Hold regular data review meetings.										
Limited inclusion of consultant clinics		Mapping of private facilities and sensitize on reporting										
Capacity of County Health Department to develop and implement priority health programs per county health strategy												
Inability to address the 90-90-90 gap in relation to HIV		Recruit relevant staff (nurses, Clinical officers, laboratory techecncians, counselors)	County Chief Officer of Health									CDOHs, Afya Pwani, PS Kenya
		Conduct integrated RRI and outreaches.	Head, Promotive and Preventive									CDOHs, Afya Pwani, PS Kenya
		Increased Advocacy and communication										

		Communication and advocacy on lifestyle and behavior targeting the public	and Preventive									Kenya
Poor sanitation		Establishment of a TWG between the health department and other departments such as Department of sanitation and Environment	Head, Promotive and Preventive									KANCO, Afya Pwani, PS Kenya, NACC, KELIN
		Allocate funds for the recruitment of public health officers to carry out surveillance	County Chief Officer of Health									
		Capacity build Public Health Officers to prosecute cases	County Chief Officer									Intrahealth

TURKANA COUNTY INSTITUTIONAL CAPACITY ASSESSMENT (CICA)
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				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Building Block 1: Governance and Leadership												
Capacity of County Health Department to develop and implement a County Health Strategy												
Lack of a comprehensive a health sector strategic plan		Review , harmonize contents of existing strategic plans and mobilize funds to support funding for development and dissemination of a comprehensive strategic plan	County Directors of health									Afya Timiza
Inadequate support for the Division of Policy and Planning		Prioritize funding to the PP divsion as continued insuficient funding is reflected on the lack of strategic plans and communication strategy	Chief Officer of Health COH									Palladium. (Proposed)
Capacity of County Health Department to communicate and coordinate within the County and Sub-County Health Department and other Departments in the county												
Lack of county Communication Strategy		Prioritize funding to the PP division as continued insuficient funding is reflected on the lack of strategic plans and communication strategy	Chief Officer of Health COH									Afya Timiza

TURKANA COUNTY INSTITUTIONAL CAPACITY ASSESSMENT (CICA)
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				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Building Block 2: Health Workforce												
Ability to recruit and retain human resources for health worker positions, staff health facilities as per staffing guidelines, make working conditions and rural and hard to reach areas more attractive and safe.												
The HRH strategy is partly in line with WHO regulations on recruitment and training of some cadres since the incentive policy is not fully implimented		Impliment the HRH guideline as stipulated for enhancing managemment and retention of health workers	Chief Officer Health									Intra Health, Funzo Kenya
The HRH division is decentralized to sub county but no funding availed to facilitate its operations		The County HRH plan needs to be supported with funds for intervention /operation costs and not just salaries	Chief Officer Health									Afya Timiza,UNICEF
Capacity of County Health Department to coordinate capacity development of Human Resources for Health												
Staff trainings are at times diven by development partners and not the County HRH plans		Ensure adherence to County HRH plan and guidelines and support the unit with financing for training funds	County Director Health									Afya Timiza, UNICEF

TURKANA COUNTY INSTITUTIONAL CAPACITY ASSESSMENT (CICA)
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				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Building Block 3: Health Information Systems												
Capacity of County Health Department to develop and implement HMIS policies, strategies, guidelines, and protocols appropriate to the data needs of the county												
There is limited support for in-service training ON HMIS		1. Advocate for adequate support for mentorship activities in the sub counties.	CHRIO									PARTNERS
		2. Train HCW on the documentation(Registers and reporting tools) and indicator definition.										PARTNERS
Capacity of County Health Department to collect quality health data												
There is no regular review and feedback provided to all health facilities on data accuracy.		Conduct DQA and share feedback on the findings to th facility staff. Carry out regular facility in charges meeting on performance review and give out feedback .	SCHRIOs									COH, PARTNERS
Capacity of Health Department to manage data												
Lack of a fully intergrated information system at the health facilities.		Liase with the supporting partners in the county to provide full support on process of making service delivery electronic. The county should own the system for onward running of the system i.e advocate for funds allocation to the department. Ensure capacity building of the individuals manning the system.	Director M&E Research, Policy and Planning.									WHO, AFRICA RESEARCH,
Inexistence of Policy and planning framework		Customize the national HIS policy for the county and develop planning framework that details national development goals, health sector priority planning, county health priority goals, bugdetry and and donor allocations.	Director M&E Research, Policy and Planning.									MOH, PARTNERS (TO BE IDENTIFIED)
Capacity of County Health Department to use routine performance, surveys and surveillance data for planning including performance management, rational budgeting and policy making												

TURKANA COUNTY INSTITUTIONAL CAPACITY ASSESSMENT (CICA)
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				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
		Building Block 4: Access to Essential Medicines & Other Health Commodities										
County Health Department's capacity to estimate commodity needs, develop a supply plan and procure/source these commodities												
Limited M&E key performance indicators		Review, adoption & Implementation of a Monitoring & Evaluation plan specific to measurement of Pharmacy performance & supply chain performance at all levels including indicators	County Pharmacist									SAVE THE CHILDREN, AFYA UGAVI,UNICEF,AFYA TIMIZA,EGPAF
Inadequate supplies of pharmaceuticals		More resources to be allocated to the health department (financial, human resources, transport facilities, storage space and equipment);	County Director									County Government with donor support
		Training on quantification for commodity managers; Quantification to be based on consumption data;	County Pharmacist									County Government with donor support
County Health Department capacity to develop and/or adopt and use a National or County owned Health Commodities Logistics Management Information System (LMIS)												
Non-existent county-owned LMIS system (for record keeping, commodity tracking & reporting)		Development, adoption and use of a county Health LMIS, Medical workers &	County Pharmacist									KEMSA,TIMIZA,AMREF,EGPAF,WHO
		Training on the LMIS and development	County Pharmacist									KEMSA,TIMIZA,AMREF,EGPAF,WHO
		Adoption of a DQA and Data improvement plan for the county	County Pharmacist									KEMSA,TIMIZA,AMREF,EGPAF,WHO
Health facility's capacity to effectively store and account for health commodities through appropriate records and reports.												
Poor storage conditions for health commodities (no space, no shelves & storage cabinets, lack of pallets; no fridges)		Construction of medical warehouses/stores at County, Sub county and designate high volume facilities, construction of shelves & drug storage cabinets, purchase and distrbution of pallets to over 80% of the county Health facilities	County Director of Medical services									Save the Children,UNICEF,MOH

TURKANA COUNTY INSTITUTIONAL CAPACITY ASSESSMENT (CICA)
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				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Building Block 5: Health Systems Financing												
Capacity of the County Health Department to develop evidence-based budget request justifications that ensures adequate funds from the total county government budget are allocated to key areas such as HRH, health commodities and programs.												
Inadequate funding for the county health sector		Priority be given to the health sector by the national and county governments; County to improve local revenue collection and channel part of this revenues to the health; department;	Chief Officer (CEC has a major role to play)									National and county governments; Partner Timiza, Save the Children; IRC; World Vision; Unicef
		Capacity building in expenditure tracking, priority setting and linking funding to outputs	Chief Officer (CEC has a major role to play)									National and county governments; Partner
Capacity of County Health Department to plan for, create and allocate a sustainable budget												
Lack of skills in program-based budgeting at the sub-counties (only CHMT members at headquarters were trained in PBB)		Need to train sub-county managers and health facility in-charges on program-based budgeting	Chief Officer									County government; he Palladium Group, Nathan Associates Inc. have been active in this area
Capacity of County Health Department to effectively allocate finances based on county health priority needs												
Poor or weak mechanisms for resource allocation		Politicians and health sector managers to work together so that allocations to health programs can be based on evidence to reflect population health needs; Regular flow of funds to primary facilities; Build capacity in healthcare financing; Establish health financing committee/unit at the county	Chief Officer									National and county governments
Capacity of County Health Department to monitor and ensure accountability for finances at the county and sub-county levels												
Inefficient use of existing resources (corruption, poor accountability structures and allocation mechanisms)		Strengthen accountability and transparency mechanisms from the county to the sub-counties	Chief Officer (as well as accounting officers at sub-county)									County and national governments

TURKANA COUNTY INSTITUTIONAL CAPACITY ASSESSMENT (CICA)
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				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Building Block 6: Delivering Essential Health Services												
Extent of interaction between the county health department and sub-counties												
Very poor communication and interaction between the county and sub-counties		Develop a county communication strategy	County director									County Government with donor support
Capacity of the County Health Department to develop and distribute (to the sub-counties and health facilities) policies, strategic plans, guidelines, protocols and standards for key health service areas												
Poor logistical support in the development and distribution of policies, strategic plans, protocols & standards, etc		1) Investment in administrative and policy & planning programs to be able to deliver develop and distribute essential documents.	County Director of health									County Government with donor support
		2) Develop a county communication strategy	County Director of health									
Capacity of County Health Department to supervise sub-counties in the use of Health Service Delivery Standards, Guidelines, protocols.												
Poor access (access to facilities, lack of skills on EmONC) to support MNCH services		Training nurses on EmONC;invest in existing facilities including MNCH equipment;	County Director									County Government with donor support
		facilitate electrification of facilities (solar installation);	County Director									County Government with donor support
		Construction of additional facilities and recruitment of additional nurses	County Director									County Government with donor support
Ineffective quality improvement system		Establish QA/QI teams across all levels of service delivery;	County Director									County Government with donor
		Provide adequate funding for the existing quality improvement	QI coordinator									
		Training for QA&QI teams to facility level and support supervison of QA/QI teams including availing QI/QA guidelines and protocols	QI coordinator									
Number of operational public, private and faith based health facilities as compared to the total that routinely report complete and accurate data												
Poor and uncoordinated data capture and reporting		Empower M&E sub-program through training and funding	County directors									National and county governments with donor support
Capacity of County Health Department to develop and implement priority health programs per county health strategy												
Slow withdrawal of development partners from HIV/AIDS programs		Mobilise local revenue to support the financing gaps left by donors	Chief Officer of Health									County Government with donor support

Score Standard	
Score	**Likert Scale**
0 - 1	No Capacity
2	Low Capacity
3	Moderate Capacity
4	High (Functional) Capacity

Overall Score	
Score	**Likert Scale**
20 & Below	No Capacity
21 -39	Limited Capacity
40 -59	Limited Capacity
60 - 79	Significant (Functional) Capacity
80+	Very Significant (Functional) Capacity

County Institutional Capacity Assessment (CICA)
Summary of CICA Results

Summary of CICA Results	Turkana	Kakamega	Busia	Mombasa	Migori
Governance & Leadership	44%	44%	44%	25%	38%
Health Workforce	63%	31%	19%	63%	44%
Health Information Systems	81%	50%	69%	69%	75%
Access to Essential Medicines & Other Health Commodities	38%	63%	50%	38%	63%
Health Systems Financing	50%	75%	50%	44%	31%
Delivering Essential Health Services	50%	75%	80%	85%	65%
Overall percentage score	**54%**	**57%**	**53%**	**55%**	**53%**

County Institutional Capacity Assessment (CICA)
Analysis of Results

Turkana County						CICA Dates: 19th & 20th Feb 2018	Score
CICA Standard \ Capacity Score		0	1	2	3	4	
Building Block 1: Governance and Leadership						**Max Score**	**16**
1.1.1	Capacity of County Health Department to develop and implement a County Health Strategy	• No current county health strategy • Aligned with Kenya Health Sector Strategic Plan (KHSSP) 2014 – 2018	• The current county health sector strategy is aligned with KHSSP 2014 – 2018. • Adopted by the county health management team/county health department.	• The county health strategy adopted; • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area.	• The county health strategy adopted • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area. • Evidence of at least one annual work plan/operational/action plan developed for at least 50% of the county health strategy priority areas	• The county health strategy adopted • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area.; • Evidence of annual work plan/operational/action plan developed for at least 80% of the county health strategy priority areas; • Monitoring and evaluation framework developed to track progress. • A Governance structure that properly sorts out the roles and responsibilities of key stakeholders in achieving county health strategy goals exists.	**1**
1.2.1	Capacity of County Health Department to communicate and coordinate within the County and Sub-County Health Department and other Departments in the county	• No evidence of communication plan and protocols for information flow within the county and sub-county and to other departments within the county.	• There is a communication plan, and protocols are clearly established to guide the plan.	• There is a communication plan, and protocols are clearly established to guide the plan. • At least 50% of CHMT are aware of the internal communication plan and protocols but no evidence of use of the plan and protocols	• There is a communication plan, and protocols are clearly established to guide the plan. • More than 50% of CHMT are aware of the internal communication plan and protocols but no evidence of use of the plan and protocols	• There is a communication plan, and protocols are clearly established to guide the plan. • More than 50% of key county staff are aware of the internal communication plan and protocols and evidence exists of use the plan and protocols more than once a year.	**0**
1.2.2	Capacity of the County Health Department to lead and engage (coordination) with different health actors working towards the same county goals	• No evidence of coordination framework that maps out different stakeholders working in the health sector	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Occasional meetings are held between the county and different health actors, but these are irregular, and do not involve all of them. Implementing partners and other key stakeholders have no opportunity to present and review health priorities and their contributions towards health goals	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals.	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals. • The county health leadership receives regular performance updates in the form of reports from at least 50% - 75% of different health actors working in the county.	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals. • County health leadership receives regular performance updates in the form of reports from all different health actors. • All different health actors are fully involved in annual sector performance reviews, county health annual work plan development and in policy development affecting the county population and health services (Partnership Code of Conduct exists).	**3**

1.2.3	Capacity of County Health Department to hold responsibility and ownership for the health system	• The county primary health care system at community level is over 50% funded by health implementing partners, with gaps existing where implementing partners are not implementing services.	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) below 50%, with significant input from development partners for health and implementing partners.	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) over 50%, with significant input from development partners for health and implementing partners. • Functionality of community units is at 50% per the reporting rates (MOH515)	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) over 50%, with significant input from development partners for health and implementing partners. • Functionality of community units is over 50% per the reporting rates (MOH515) • Annual accountability platform for reviewing committed funding against results achieved at community level in place.	**3**
						Sub Total	**7**
						Percentage Score	**44%**

Building Block 2: Health Workforce						**Max Score**	**16**
2.1.1	Ability to attract, recruit and retain human resources for health worker positions	• Job descriptions do not exist	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure)	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place.	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place. • Incentives for staff retention are in place but not effectively.	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place. • Incentives for staff retention are in place but not effectively. • Working conditions attractive and safe, financial and non-financial incentives for rural and hard to reach places are made more attractive and HRH wellness and welfare improved	**3**
2.1.2	Capacity of County Health Department to staff health facilities as per Staffing Norms, Standards and Guidelines	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards, and development of the health work force for staffing of each level of the health system do not exist.	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists.	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists. • A iHRIS has been developed to track staffing levels and needs,	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists. • A system has been developed to track staffing levels and needs, • iHRIS monthly updated (upon exit and recruitment).	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists. • A system has been developed to track staffing levels and needs, • iHRIS monthly updated (upon exit and recruitment). • Staffing data on needs by staffing cadre is being used to advocate for resources to meet staffing gaps.	**3**
2.2.1	Capacity of County Health Department to conduct staff performance appraisals	• There are no policies or guidelines at the county on staff performance appraisals at all levels of health care management and delivery.	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists.	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted.	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted as scheduled in the guidelines. • Supervisor performance monitoring is ad hoc	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted as scheduled in the guidelines. • Supervisor performance monitoring is ad hoc. • System exists for rewards and sanctions based on performance.	**3**

2.2.2	Capacity of County Health Department to coordinate capacity development of Human Resources for Health	• No system for coordinating in-service training for HRH exists, (HRH trainings are completely ad hoc).	• System for coordinating in-service training for HRH exists, no adhered to.	• System for coordinating in-service training for HRH exists, • The county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments not coordinated by the county,	• System for coordinating in-service training for HRH exists, • The county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments conducted and coordinated by the county. • Training schedules are not fully coordinated/ communicated to all relevant stakeholders.	• System for coordinating in-service training for HRH exists, county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments conducted and coordinated by the county. • Training schedules are fully coordinated/ communicated to all relevant stakeholders. • Assessments of the impact of trainings to improved service delivery is conducted annually and feedback used during performance appraisals.	**1**
						Sub Total	**10**
						Percentage Score	**63%**

Building Block 3: Health Information Systems						**Max Score**	**16**
3.1.1	Capacity of County Health Department to develop and implement HMIS policies, strategies, guidelines, and protocols appropriate to the data needs of the county	• The county does not have national health information system policy and strategy.	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are not readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms.	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms • Sub-counties, facilities and community units do not have adequate supply	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms • Sub-counties, facilities and community units have adequate supply • Mentorship program on correct use of HIS forms institutionalized in less than 75%of sub-counties and/or facilities.	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms • Sub-counties, facilities and community units have adequate supply • Mentorship program on correct use of HIS forms institutionalized in at least 75% of sub-counties and/or facilities.	**4**
3.1.2	Capacity of County Health Department to collect quality health data	• There are no county-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) in place.	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data are not routinely collected using standard data collection forms.	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data routinely collected using standard data collection forms. • County department of health receives timely and complete reports from less than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization)	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data routinely collected using standard data collection forms. • County department of health receives timely and complete reports from more than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization) • County department of health receives accurate reports from less than 75% of health facilities (public, private and faith based)	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist; data are routinely collected using standard data collection forms. • County department of health receives timely and complete reports from less than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization) • County department of health receives accurate reports from more than 75% of health facilities (public, private and faith based) • Health performance data reviewed regularly and regular feedback provided to all health facilities on data accuracy.	**3**

3.1.3	Capacity of County Health Department to manage data	• No one single county-wide preferred electronic or paper based exists.	• Separate information management systems (paper or electronic) exist for the various components of the HIS. • It's difficult or impossible to manipulate or extract data from the system.	• One Single County preferred Electronic Health Information Systems platforms (databases) exist for the various components of HIS • Data are not routinely extracted for reports and other use.	• One Single County preferred Electronic Health Information System platforms (databases) exist at the county for the various components of the HIS, • Data are routinely extracted (at least annually) for use. • Integration of information from other health management systems (i.e., service statistics, financial, human resource, logistics information, and physical assets data systems) not yet fully operational.	• One Single County preferred Electronic Health Information System platforms (databases) exist at the county for the various components of the HIS, • Data are routinely extracted (at least annually) for use. • Integration of information from other health management systems (i.e., service statistics, financial, human resource, logistics information, and physical assets data systems) is evident. • County Data Management Guidelines exist including policy on health/research data sharing policy.	**3**
3.2.1	Capacity of County Health Department to use routine performance, surveys and surveillance data for planning including performance management, rational budgeting and policy making	• No evidence of data use for strategic planning including rational budgeting and decision making.	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county health committee and other state and non-state actors. • No evidence of data use for strategic planning including rational budgeting and decision making.	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings.	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county assembly health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings. • The county can identify at least two examples of how data have been integrated into a decision-making process including rational budgeting in the past year.	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county assembly health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings. • The county can identify at least two examples of how data have been integrated into a decision-making process including rational budgeting in the past year. • Policy and planning framework (that details national development goals, national health sector priority goals, county health priority goals, county budgetary and donor allocations, and county health development outcomes) exists.	**3**
						Sub Total	**13**
						Percentage Score	**81%**

Building Block 4: Access to Essential Medicines & Other Health Commodities						**Max Score**	**16**
4.1.1	Capacity of the County Health Department to provide oversight to commodity management to downstream facilities (ref: - existence of a functional commodity security committee).	• The county does not have an organized unit (of more than three persons) to oversee and coordinate commodity security in the entire county.	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate.	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate. • The County Commodity Security Committee structure has been adopted, operationalized and implemented at the sub-county level for all the sub-counties in the county.	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate. • The County Commodity Security Committee structure has been adopted, operationalized and implemented at the sub-county level for all the sub-counties in the county. • Supply chain performance statistics are maintained at county, sub-county and facility levels and reflect improving trends overtime.	**2**

4.1.2	County Health Department's capacity to estimate commodity needs, develop a supply plan and procure/source these commodities	• No capacity (external or internal to the county) available to conduct a forecasting and quantification exercise (estimate commodity needs, develop a supply plan, and procure essential commodities).	• The county is reliant on external technical assistance to estimate commodity needs, and develop a supply plan, no mechanism exists to fully procure or source (i.e. buy or secure donations of) essential commodities.	• The county is reliant on external technical assistance to estimate commodity needs, and develop a supply plan, • County partially has capability to fully procure or source (i.e. buy or secure donations of) essential commodities.	• The county has capacity to estimate commodity needs, and develop a supply plan, • County partially has capability to fully procure or source (i.e. buy or secure donations of) essential commodities, • County requires minimal external technical assistance to estimate commodity needs.	• The county has capacity to estimate commodity needs, and develop a supply plan, • County has capacity to fully procure or source (i.e. buy or secure donations of) essential commodities, • County requires no external technical assistance to estimate commodity needs, • Health commodity procurement done at least once annually.	**3**
4.1.3	County Health Department's capacity to develop and/or adopt and use a National/County-owned Logistics Management Information System (LMIS)	• County currently uses no Health Commodities' LMIS system.	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records.	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, reporting of LMIS data is below 50% for all facilities annually.	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, county has access to limited logistics data including: stock on hand within the system and consumption/usage for the past reporting period and demonstrates reporting rates of least 50% from the sub-counties. • County has a plan for routine DQA exits, DQA of LMIS data conducted at least once annually	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, county has access to logistics data including: stock on hand within the system and consumption/usage for the past reporting period and demonstrates reporting rates of least 75% from the sub-counties. • County has a plan for routine DQA exits, DQA of LMIS data conducted semi annually • Data Quality Improvement Plan for LMIS data developed for every DQA and implemented	**0**
4.1.4	Health facility's capacity to effectively store and account for health commodities through appropriate records and reports.	• No system exists for proper storage and distribution of commodities, including essential medicines. (special storage requirements of medicines and other commodities are not followed, poor records keeping and consumption reporting)	• Warehouse/stores(s) for commodity storage exists at either county, sub-county or facility level, with some accommodation for items requiring special storage.	• The county/sub-county warehouse and health facility store meets at least two of the following four criteria: warehouse/store size is adequate, storage spaces are is well maintained and clean (including pest, lighting, temperature and humidity control), • County warehouse has designated storage equipment for special storage needs, and re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance.	• The county/sub-county warehouse and health facility store meets at least three of the following four criteria: warehouse/store size is adequate, storage spaces are well maintained and clean (including pest, lighting, temperature and humidity control) • County warehouse has designated storage equipment for special storage needs, • Re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance.	• The county/sub-county warehouse and health facility store is adequate – meets all four criteria (i.e. large enough, regularly cleaned, dry, well organized) with all special needs storage areas clearly designated with correct signage, • County warehouse has an established re-order and stocking plan, including the use of protocols (such as first expiry, first out), job aides (such as SOP for emergency procurements) • Re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance. • Stock-control records such as stock cards and bin cards are well maintained	**1**
						Sub Total	**6**
						Percentage Score	**38%**

Building Block 5: Health Systems Financing	**Max Score**	**16**

5.1.1	Capacity of the County Health Department to develop evidence-based budget request justifications that ensures adequate funds from the total county government budget are allocated to key areas such as HRH, health commodities and programs.	• The county health department has no input into the development of the county budget estimates.	• The county health department has input into the county budget estimates development, • But public health expenditures are not systematically calculated on an annual basis and total at least 20% of the overall county government budget.	• The county health budget is developed annually, with input from county health department • County health expenditures are not systematically calculated on an annual basis as part of budget formulation process • It's less than 25% of the overall county government budget.	• The county health budget is developed annually, with input from county health department • Estimated actual county health expenditures are systematically calculated on an annual basis as part of budget formulation process. • Health budget is between 25% and 30% of the overall county government budget.	• The county health budget is developed annually, with input from county health department. • Estimated actual county health expenditures are systematically calculated on an annual basis as part of budget formulation process • Program, surveys and surveillance data used as justification for budget requests • County health budget is at least between 30% - 40% of the overall county government budget.	**3**
5.2.1	Capacity of County Health Department to plan for, create and allocate a sustainable budget	• No sustainable budget exists	• Three of the budget sustainability criteria need improvement	• Two of the budget sustainability criteria need improvement	• One of the budget sustainability criteria needs improvement	• All of the budget sustainability criteria are completed and sustainable, with the county and sub-county health administrators' offices taking the lead on developing the county health budget *Budget sustainability criteria:* *Planning* *Input* *Allocation* *Initiative*	**1**
5.2.2	Capacity of County Health Department to effectively allocate finances based on county health priority needs	• No system to distribute funds exists	• Three of the budget distribution factors need improvement	• Two of the budget distribution factors need improvement	• One of the budget distribution factors needs improvement	• All of the four (4) budget distribution factors are completed and sustainable *The factors are:* *Financial System* *Tracking* *Policies* *Responsibility*	**2**
5.2.3	Capacity of County Health Department to monitor and ensure accountability for finances at the county and sub-county levels	• No tracking/monitoring system exists.	• Three of the factors necessary to effectively monitor finances need improvement	• Two of the factors necessary to effectively monitor finances need improvement	• One of the factors necessary to effectively monitor finances need improvement	• All of the four (4) factors necessary to effectively monitor finances are completed and sustainable *The factors are:* *Financial System* *Tracking* *Policies* *Responsibility*	**2**
						Sub Total	**8**
						Percentage Score	**50%**

Building Block 6: Delivering Essential Health Services						**Max Score**	**20**
6.1.1	Extent of interaction between the County Health Department and Sub-County Health Administration Offices	• No structured interaction with sub-counties	• The health department interacts at least once a year with sub-county health administrators on: o Budget-related issues only.	• The health department interacts at least once a year with sub-county health administrators on: o Budget related issues o Health service planning activities.	• The health department interacts at least once a year with sub-county health administrators on: o Budget related issues o Health service planning activities, o Maintenance and coordination of facilities.	• The health department interacts at least four times a year with sub-county health administrators on: o Budget related issues o Health service planning activities, o Maintenance and coordination of facilities, o Assessments and planning for community health needs.	**0**

6.1.2	Capacity of the County Health Department to develop and distribute (to the sub-counties and health facilities) policies, strategic plans, guidelines, protocols and standards for key health service areas	• No County Health Department's Health Strategy exists	• The county has a health strategy aligned to national health strategy (2014 – 2018)	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities.	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities. • The county clinical standards and guidelines are currently used by least 50% of sub-counties within the last two years.	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities. • The county clinical standards and guidelines are currently used by least 80% of sub-counties within the last two years. • The county health department conducts regular sub-county and health facility visits to monitor compliance in the use of standards and guidelines.	**1**
6.2.1	Capacity of County Health Department to supervise sub-counties in the use of health service delivery policies, strategies, guidelines and standards	• No system exists at the county to monitor adherence of sub-counties to standards, guidelines, protocols	• Some elements of a basic system exist for monitoring adherence to standards, guidelines and protocols.	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities), but use of these guidelines is not consistent by the county health department or sub-counties.	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities) • County provides support to sub-counties to monitor adherence at the facility level, but not consistently.	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities) • County provides support to sub-counties to monitor adherence at the facility level. • The county jointly with sub-counties has joint plans for conducting adherence monitoring at the health facility level.	**3**
6.2.2	Number of operational public, private and faith based health facilities as compared to the total that routinely report complete and accurate data	• The county does not have a list of the number of public, private and faith based health facilities.	• The county has a list of the number of public, private and faith based health facilities, but there is no system to determine and report which of the facilities by type report complete and accurate data	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities, but less than 50% of the total report complete and accurate data	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities (at least 75% of operational public, private and faith based health facilities of the total number are operational routinely report monthly) • About 75% of the reporting health facilities report complete and accurate data.	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities (at least 80% of operational public, private and faith based health facilities of the total number are operational routinely report monthly) • About 85% of the reporting health facilities report complete and accurate data. • County has a system for quarterly review of complete and accurate data.	**3**
6.3.1	Capacity of County Health Department to implement health programs. NOTE: This question can be asked of HIV/AIDS, TB/HIV, RMNCH, Nutrition, Water & Sanitation, and Malaria and sub programs as appropriate	• Program does not have capacity to identify priority areas for implementation	• Program has capacity to identify priority health areas and develop standards for health programs	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs.	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs. • The program has capacity to conduct periodic monitoring and evaluation (M&E) of priority health programs.	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs. • The program has capacity to conduct periodic monitoring and evaluation (M&E) of priority health programs. • The program has capacity to promote data sharing, communication, and collaboration within individual priority health programs.	**3**
						Sub Total	**10**
						Percentage Score	**50%**

		CICA Dashboard	
Building Blocks	**Max Score Possible**	**CICA Score**	**Percentage Score**

1	Governance and Leadership	16	7	44%
2	Health Workforce	16	10	63%
3	Health Information Systems	16	13	81%
4	Access to Essential Medicines & Other Health Commodities	16	6	38%
5	Health Systems Financing	16	8	50%
6	Delivering Essential Health Services	20	10	50%
		100	54	

Overall Score	54%

County Institutional Capacity Assessment (CICA)
Analysis of Results

Kakamega County					CICA Dates: 22nd & 23rd Feb 2018	Score
CICA Standard / Capacity Score	0	1	2	3	4	
Building Block 1: Governance and Leadership					**Max Score**	**16**
1.1.1	Capacity of County Health Department to develop and implement a County Health Strategy	• No current county health strategy • Aligned with Kenya Health Sector Strategic Plan (KHSSP) 2014 – 2018	• The current county health sector strategy is aligned with KHSSP 2014 – 2018. • Adopted by the county health management team/county health department.	• The county health strategy adopted; • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area.	• The county health strategy adopted • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area. • Evidence of at least one annual work plan/operational/action plan developed for at least 50% of the county health strategy priority areas	• The county health strategy adopted • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area.; • Evidence of annual work plan/operational/action plan developed for at least 80% of the county health strategy priority areas; • Monitoring and evaluation framework developed to track progress. • A Governance structure that properly sorts out the roles and responsibilities of key stakeholders in achieving county health strategy goals exists.	**3**
1.2.1	Capacity of County Health Department to communicate and coordinate within the County and Sub-County Health Department and other Departments in the county	• No evidence of communication plan and protocols for information flow within the county and sub-county and to other departments within the county.	• There is a communication plan, and protocols are clearly established to guide the plan.	• There is a communication plan, and protocols are clearly established to guide the plan. • At least 50% of CHMT are aware of the internal communication plan and protocols but no evidence of use of the plan and protocols	• There is a communication plan, and protocols are clearly established to guide the plan. • More than 50% of CHMT are aware of the internal communication plan and protocols but no evidence of use of the plan and protocols	• There is a communication plan, and protocols are clearly established to guide the plan. • More than 50% of key county staff are aware of the internal communication plan and protocols and evidence exists of use the plan and protocols more than once a year.	**0**
1.2.2	Capacity of the County Health Department to lead and engage (coordination) with different health actors working towards the same county goals	• No evidence of coordination framework that maps out different stakeholders working in the health sector	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Occasional meetings are held between the county and different health actors, but these are irregular, and do not involve all of them. Implementing partners and other key stakeholders have no opportunity to present and review health priorities and their contributions towards health goals	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals.	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals. • The county health leadership receives regular performance updates in the form of reports from at least 50% - 75% of different health actors working in the county.	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals. • County health leadership receives regular performance updates in the form of reports from all different health actors. • All different health actors are fully involved in annual sector performance reviews, county health annual work plan development and in policy development affecting the county population and health services (Partnership Code of Conduct exists).	**1**
1.2.3	Capacity of County Health Department to hold responsibility and ownership for the health system	• The county primary health care system at community level is over 50% funded by health implementing partners, with gaps existing where implementing partners are not implementing services.	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) below 50%, with significant input from development partners for health and implementing partners.	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) over 50%, with significant input from development partners for health and implementing partners. • Functionality of community units is at 50% per the reporting rates (MOH515)	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) over 50%, with significant input from development partners for health and implementing partners. • Functionality of community units is over 50% per the reporting rates (MOH515) • Annual accountability platform for reviewing committed funding against results achieved at community level in place.	**3**
						Sub Total	**7**
						Percentage Score	**44%**
Building Block 2: Health Workforce					**Max Score**	**16**

2.1.1	Ability to attract, recruit and retain human resources for health worker positions	• Job descriptions do not exist	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure)	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place.	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place. • Incentives for staff retention are in place but not effectively.	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place. • Incentives for staff retention are in place but not effectively. • Working conditions attractive and safe, financial and non-financial incentives for rural and hard to reach places are made more attractive and HRH wellness and welfare improved	**1**
2.1.2	Capacity of County Health Department to staff health facilities as per Staffing Norms, Standards and Guidelines	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards, and development of the health work force for staffing of each level of the health system do not exist.	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists.	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists. • A iHRIS has been developed to track staffing levels and needs,	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists. • A system has been developed to track staffing levels and needs, • iHRIS monthly updated (upon exit and recruitment).	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists. • A system has been developed to track staffing levels and needs, • iHRIS monthly updated (upon exit and recruitment). • Staffing data on needs by staffing cadre is being used to advocate for resources to meet staffing gaps	**2**
2.2.1	Capacity of County Health Department to conduct staff performance appraisals	• There are no policies or guidelines at the county on staff performance appraisals at all levels of health care management and delivery.	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists.	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted.	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted as scheduled in the guidelines. • Supervisor performance monitoring is ad hoc	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted as scheduled in the guidelines. • Supervisor performance monitoring is ad hoc. • System exists for rewards and sanctions based on performance.	**2**
2.2.2	Capacity of County Health Department to coordinate capacity development of Human Resources for Health	• No system for coordinating in-service training for HRH exists, (HRH trainings are completely ad hoc).	• System for coordinating in-service training for HRH exists, no adhered to.	• System for coordinating in-service training for HRH exists, • The county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments not coordinated by the county,	• System for coordinating in-service training for HRH exists, • The county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments conducted and coordinated by the county. • Training schedules are not fully coordinated/ communicated to all relevant stakeholders.	• System for coordinating in-service training for HRH exists, county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments conducted and coordinated by the county. • Training schedules are fully coordinated/ communicated to all relevant stakeholders. • Assessments of the impact of trainings to improved service delivery is conducted annually and feedback used during performance appraisals.	**0**
						Sub Total	**5**
						Percentage Score	**31%**

Building Block 3: Health Information Systems						**Max Score**	**16**
3.1.1	Capacity of County Health Department to develop and implement HMIS policies, strategies, guidelines, and protocols appropriate to the data needs of the county	• The county does not have national health information system policy and strategy.	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are not readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms.	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms • Sub-counties, facilities and community units do not have adequate supply	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms • Sub-counties, facilities and community units have adequate supply • Mentorship program on correct use of HIS forms institutionalized in less than 75%of sub-counties and/or facilities.	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms • Sub-counties, facilities and community units have adequate supply • Mentorship program on correct use of HIS forms institutionalized in at least 75% of sub-counties and/or facilities.	**2**

3.1.2	Capacity of County Health Department to collect quality health data	• There are no county-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) in place.	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data are not routinely collected using standard data collection forms.	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data routinely collected using standard data collection forms. • County department of health receives timely and complete reports from less than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization)	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data routinely collected using standard data collection forms. • County department of health receives timely and complete reports from more than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization) • County department of health receives accurate reports from less than 75% of health facilities (public, private and faith based)	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist; data are routinely collected using standard data collection forms. • County department of health receives timely and complete reports from less than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization) • County department of health receives accurate reports from more than 75% of health facilities (public, private and faith based) • Health performance data reviewed regularly and regular feedback provided to all health facilities on data accuracy.	**3**
3.1.3	Capacity of County Health Department to manage data	• No one single county-wide preferred electronic or paper based exists.	• Separate information management systems (paper or electronic) exist for the various components of the HIS. • It's difficult or impossible to manipulate or extract data from the system.	• One Single County preferred Electronic Health Information Systems platforms (databases) exist for the various components of HIS • Data are not routinely extracted for reports and other use.	• One Single County preferred Electronic Health Information System platforms (databases) exist at the county for the various components of the HIS, • Data are routinely extracted (at least annually) for use. • Integration of information from other health management systems (i.e., service statistics, financial, human resource, logistics information, and physical assets data systems) not yet fully operational.	• One Single County preferred Electronic Health Information System platforms (databases) exist at the county for the various components of the HIS, • Data are routinely extracted (at least annually) for use. • Integration of information from other health management systems (i.e., service statistics, financial, human resource, logistics information, and physical assets data systems) is evident. • County Data Management Guidelines exist including policy on health/research data sharing policy.	**3**
3.2.1	Capacity of County Health Department to use routine performance, surveys and surveillance data for planning including performance management, rational budgeting and policy making	• No evidence of data use for strategic planning including rational budgeting and decision making.	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county health committee and other state and non-state actors. • No evidence of data use for strategic planning including rational budgeting and decision making.	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings.	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county assembly health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings. • The county can identify at least two examples of how data have been integrated into a decision-making process including rational budgeting in the past year.	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county assembly health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings. • The county can identify at least two examples of how data have been integrated into a decision-making process including rational budgeting in the past year. • Policy and planning framework (that details national development goals, national health sector priority goals, county health priority goals, county budgetary and donor allocations, and county health development outcomes) exists.	**0**
						Sub Total	**8**
						Percentage Score	**50%**

Building Block 4: Access to Essential Medicines & Other Health Commodities						**Max Score**	**16**
4.1.1	Capacity of the County Health Department to provide oversight to commodity management to downstream facilities (ref: - existence of a functional commodity security committee).	• The county does not have an organized unit (of more than three persons) to oversee and coordinate commodity security in the entire county.	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate.	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate. • The County Commodity Security Committee structure has been adopted, operationalized and implemented at the sub-county level for all the sub-counties in the county.	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate. • The County Commodity Security Committee structure has been adopted, operationalized and implemented at the sub-county level for all the sub-counties in the county. • Supply chain performance statistics are maintained at county, sub-county and facility levels and reflect improving trends overtime.	**3**

4.1.2	County Health Department's capacity to estimate commodity needs, develop a supply plan and procure/source these commodities	• No capacity (external or internal to the county) available to conduct a forecasting and quantification exercise (estimate commodity needs, develop a supply plan, and procure essential commodities).	• The county is reliant on external technical assistance to estimate commodity needs, and develop a supply plan, no mechanism exists to fully procure or source (i.e. buy or secure donations of) essential commodities.	• The county is reliant on external technical assistance to estimate commodity needs, and develop a supply plan, • County partially has capability to fully procure or source (i.e. buy or secure donations of) essential commodities.	• The county has capacity to estimate commodity needs, and develop a supply plan, • County partially has capability to fully procure or source (i.e. buy or secure donations of) essential commodities, • County requires minimal external technical assistance to estimate commodity needs.	• The county has capacity to estimate commodity needs, and develop a supply plan, • County has capacity to fully procure or source (i.e. buy or secure donations of) essential commodities, • County requires no external technical assistance to estimate commodity needs, • Health commodity procurement done at least once annually.	**3**
4.1.3	County Health Department's capacity to develop and/or adopt and use a National/County-owned Logistics Management Information System (LMIS)	• County currently uses no Health Commodities' LMIS system.	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records.	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, reporting of LMIS data is below 50% for all facilities annually.	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, county has access to limited logistics data including: stock on hand within the system and consumption/usage for the past reporting period and demonstrates reporting rates of least 50% from the sub-counties. • County has a plan for routine DQA exits, DQA of LMIS data conducted at least once annually	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, county has access to logistics data including: stock on hand within the system and consumption/usage for the past reporting period and demonstrates reporting rates of least 75% from the sub-counties. • County has a plan for routine DQA exits, DQA of LMIS data conducted semi annually • Data Quality Improvement Plan for LMIS data developed for every DQA and implemented	**3**
4.1.4	Health facility's capacity to effectively store and account for health commodities through appropriate records and reports.	• No system exists for proper storage and distribution of commodities, including essential medicines. (special storage requirements of medicines and other commodities are not followed, poor records keeping and consumption reporting)	• Warehouse/stores(s) for commodity storage exists at either county, sub-county or facility level, with some accommodation for items requiring special storage.	• The county/sub-county warehouse and health facility store meets at least two of the following four criteria: warehouse/store size is adequate, storage spaces are is well maintained and clean (including pest, lighting, temperature and humidity control), • County warehouse has designated storage equipment for special storage needs, and re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance.	• The county/sub-county warehouse and health facility store meets at least three of the following four criteria: warehouse/store size is adequate, storage spaces are well maintained and clean (including pest, lighting, temperature and humidity control) • County warehouse has designated storage equipment for special storage needs, • Re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance.	• The county/sub-county warehouse and health facility store is adequate – meets all four criteria (i.e. large enough, regularly cleaned, dry, well organized) with all special needs storage areas clearly designated with correct signage, • County warehouse has an established re-order and stocking plan, including the use of protocols (such as first expiry, first out), job aides (such as SOP for emergency procurements) • Re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance. • Stock-control records such as stock cards and bin cards are well maintained	**1**
						Sub Total	**10**
						Percentage Score	**63%**

Building Block 5: Health Systems Financing						**Max Score**	**16**
5.1.1	Capacity of the County Health Department to develop evidence-based budget request justifications that ensures adequate funds from the total county government budget are allocated to key areas such as HRH, health commodities and programs.	• The county health department has no input into the development of the county budget estimates.	• The county health department has input into the county budget estimates development, • But public health expenditures are not systematically calculated on an annual basis and total at least 20% of the overall county government budget.	• The county health budget is developed annually, with input from county health department • County health expenditures are not systematically calculated on an annual basis as part of budget formulation process • It's less than 25% of the overall county government budget.	• The county health budget is developed annually, with input from county health department • Estimated actual county health expenditures are systematically calculated on an annual basis as part of budget formulation process. • Health budget is between 25% and 30% of the overall county government budget.	• The county health budget is developed annually, with input from county health department. • Estimated actual county health expenditures are systematically calculated on an annual basis as part of budget formulation process • Program, surveys and surveillance data used as justification for budget requests • County health budget is at least between 30% - 40% of the overall county government budget.	**3**
5.2.1	Capacity of County Health Department to plan for, create and allocate a sustainable budget	• No sustainable budget exists	• Three of the budget sustainability criteria need improvement	• Two of the budget sustainability criteria need improvement	• One of the budget sustainability criteria needs improvement	• All of the budget sustainability criteria are completed and sustainable, with the county and sub-county health administrators' offices taking the lead on developing the county health budget *Budget sustainability criteria:* *Planning* *Input* *Allocation* *Initiative*	**2**

5.2.2	Capacity of County Health Department to effectively allocate finances based on county health priority needs	• No system to distribute funds exists	• Three of the budget distribution factors need improvement	• Two of the budget distribution factors need improvement	• One of the budget distribution factors needs improvement	• All of the four (4) budget distribution factors are completed and sustainable *The factors are:* *Financial System* *Tracking* *Policies* *Responsibility*	**4**
5.2.3	Capacity of County Health Department to monitor and ensure accountability for finances at the county and sub-county levels	• No tracking/monitoring system exists.	• Three of the factors necessary to effectively monitor finances need improvement	• Two of the factors necessary to effectively monitor finances need improvement	• One of the factors necessary to effectively monitor finances need improvement	• All of the four (4) factors necessary to effectively monitor finances are completed and sustainable *The factors are:* *Financial System* *Tracking* *Policies* *Responsibility*	**3**
						Sub Total	**12**
						Percentage Score	**75%**

Building Block 6: Delivering Essential Health Services						**Max Score**	**20**
6.1.1	Extent of interaction between the County Health Department and Sub-County Health Administration Offices	• No structured interaction with sub-counties	• The health department interacts at least once a year with sub-county health administrators on: o Budget-related issues only.	• The health department interacts at least once a year with sub-county health administrators on: o Budget related issues o Health service planning activities.	• The health department interacts at least once a year with sub-county health administrators on: o Budget related issues o Health service planning activities, o Maintenance and coordination of facilities.	• The health department interacts at least four times a year with sub-county health administrators on: o Budget related issues o Health service planning activities, o Maintenance and coordination of facilities, o Assessments and planning for community health needs.	**3**
6.1.2	Capacity of the County Health Department to develop and distribute (to the sub-counties and health facilities) policies, strategic plans, guidelines, protocols and standards for key health service areas	• No County Health Department's Health Strategy exists	• The county has a health strategy aligned to national health strategy (2014 – 2018)	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities.	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities. • The county clinical standards and guidelines are currently used by least 50% of sub-counties within the last two years.	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities. • The county clinical standards and guidelines are currently used by least 80% of sub-counties within the last two years. • The county health department conducts regular sub-county and health facility visits to monitor compliance in the use of standards and guidelines.	**3**
6.2.1	Capacity of County Health Department to supervise sub-counties in the use of health service delivery policies, strategies, guidelines and standards	• No system exists at the county to monitor adherence of sub-counties to standards, guidelines, protocols	• Some elements of a basic system exist for monitoring adherence to standards, guidelines and protocols.	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities), but use of these guidelines is not consistent by the county health department or sub-counties.	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities) • County provides support to sub-counties to monitor adherence at the facility level, but not consistently.	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities) • County provides support to sub-counties to monitor adherence at the facility level. • The county jointly with sub-counties has joint plans for conducting adherence monitoring at the health facility level.	**3**
6.2.2	Number of operational public, private and faith based health facilities as compared to the total that routinely report complete and accurate data	• The county does not have a list of the number of public, private and faith based health facilities.	• The county has a list of the number of public, private and faith based health facilities, but there is no system to determine and report which of the facilities by type report complete and accurate data	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities, but less than 50% of the total report complete and accurate data	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities (at least 75% of operational public, private and faith based health facilities of the total number are operational routinely report monthly) • About 75% of the reporting health facilities report complete and accurate data.	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities (at least 80% of operational public, private and faith based health facilities of the total number are operational routinely report monthly) • About 85% of the reporting health facilities report complete and accurate data. • County has a system for quarterly review of complete and accurate data.	**3**

6.3.1	Capacity of County Health Department to implement health programs. NOTE: This question can be asked of HIV/AIDS, TB/HIV, RMNCH, Nutrition, Water & Sanitation, and Malaria and sub programs as appropriate	• Program does not have capacity to identify priority areas for implementation	• Program has capacity to identify priority health areas and develop standards for health programs	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs.	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs. • The program has capacity to conduct periodic monitoring and evaluation (M&E) of priority health programs.	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs. • The program has capacity to conduct periodic monitoring and evaluation (M&E) of priority health programs. • The program has capacity to promote data sharing, communication, and collaboration within individual priority health programs.	**3**
						Sub Total	**15**
						Percentage Score	**75%**

			CICA Dashboard	
Building Blocks		**Max Score Possible**	**CICA Score**	**Percentage Score**
1	**Governance and Leadership**	**16**	**7**	**44%**
2	**Health Workforce**	**16**	**5**	**31%**
3	**Health Information Systems**	**16**	**8**	**50%**
4	**Access to Essential Medicines & Other Health Commodities**	**16**	**10**	**63%**
5	**Health Systems Financing**	**16**	**12**	**75%**
6	**Delivering Essential Health Services**	**20**	**15**	**75%**
		100	**57**	

Overal Score	**57%**

County Institutional Capacity Assessment (CICA)
Analysis of Results

Busia County						CICA Dates: 26th & 27th Feb 2018	Score
CICA Standard / Capacity Score		0	1	2	3	4	
Building Block 1: Governance and Leadership						**Max Score**	**16**
1.1.1	Capacity of County Health Department to develop and implement a County Health Strategy	• No current county health strategy • Aligned with Kenya Health Sector Strategic Plan (KHSSP) 2014 – 2018	• The current county health sector strategy is aligned with KHSSP 2014 – 2018. • Adopted by the county health management team/county health department.	• The county health strategy adopted; • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area.	• The county health strategy adopted • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area. • Evidence of at least one annual work plan/operational/action plan developed for at least 50% of the county health strategy priority areas	• The county health strategy adopted • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area.; • Evidence of annual work plan/operational/action plan developed for at least 80% of the county health strategy priority areas; • Monitoring and evaluation framework developed to track progress. • A Governance structure that properly sorts out the roles and responsibilities of key stakeholders in achieving county health strategy goals exists.	**3**
1.2.1	Capacity of County Health Department to communicate and coordinate within the County and Sub-County Health Department and other Departments in the county	• No evidence of communication plan and protocols for information flow within the county and sub-county and to other departments within the county.	• There is a communication plan, and protocols are clearly established to guide the plan.	• There is a communication plan, and protocols are clearly established to guide the plan. • At least 50% of CHMT are aware of the internal communication plan and protocols but no evidence of use of the plan and protocols	• There is a communication plan, and protocols are clearly established to guide the plan. • More than 50% of CHMT are aware of the internal communication plan and protocols but no evidence of use of the plan and protocols	• There is a communication plan, and protocols are clearly established to guide the plan. • More than 50% of key county staff are aware of the internal communication plan and protocols and evidence exists of use the plan and protocols more than once a year.	**0**
1.2.2	Capacity of the County Health Department to lead and engage (coordination) with different health actors working towards the same county goals	• No evidence of coordination framework that maps out different stakeholders working in the health sector	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Occasional meetings are held between the county and different health actors, but these are irregular, and do not involve all of them. Implementing partners and other key stakeholders have no opportunity to present and review health priorities and their contributions towards health goals	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals.	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals. • The county health leadership receives regular performance updates in the form of reports from at least 50% - 75% of different health actors working in the county.	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals. • County health leadership receives regular performance updates in the form of reports from all different health actors. • All different health actors are fully involved in annual sector performance reviews, county health annual work plan development and in policy development affecting the county population and health services (Partnership Code of Conduct exists).	**1**
1.2.3	Capacity of County Health Department to hold responsibility and ownership for the health system	• The county primary health care system at community level is over 50% funded by health implementing partners, with gaps existing where implementing partners are not implementing services.	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) below 50%, with significant input from development partners for health and implementing partners.	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) over 50%, with significant input from development partners for health and implementing partners. • Functionality of community units is at 50% per the reporting rates (MOH515)	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) over 50%, with significant input from development partners for health and implementing partners. • Functionality of community units is over 50% per the reporting rates (MOH515) • Annual accountability platform for reviewing committed funding against results achieved at community level in place.	**3**
						Sub Total	**7**
						Percentage Score	**44%**
Building Block 2: Health Workforce						**Max Score**	**16**

2.1.1	Ability to attract, recruit and retain human resources for health worker positions	• Job descriptions do not exist	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure)	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place.	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place. • Incentives for staff retention are in place but not effectively.	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place. • Incentives for staff retention are in place but not effectively. • Working conditions attractive and safe, financial and non-financial incentives for rural and hard to reach places are made more attractive and HRH wellness and welfare improved	**0**
2.1.2	Capacity of County Health Department to staff health facilities as per Staffing Norms, Standards and Guidelines	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards, and development of the health work force for staffing of each level of the health system do not exist.	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists.	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists. • A iHRIS has been developed to track staffing levels and needs,	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists. • A system has been developed to track staffing levels and needs, • iHRIS monthly updated (upon exit and recruitment).	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists. • A system has been developed to track staffing levels and needs, • iHRIS monthly updated (upon exit and recruitment). • Staffing data on needs by staffing cadre is being used to advocate for resources to meet staffing gaps.	**2**
2.2.1	Capacity of County Health Department to conduct staff performance appraisals	• There are no policies or guidelines at the county on staff performance appraisals at all levels of health care management and delivery.	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists.	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted.	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted as scheduled in the guidelines. • Supervisor performance monitoring is ad hoc	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted as scheduled in the guidelines. • Supervisor performance monitoring is ad hoc. • System exists for rewards and sanctions based on performance.	**1**
2.2.2	Capacity of County Health Department to coordinate capacity development of Human Resources for Health	• No system for coordinating in-service training for HRH exists, (HRH trainings are completely ad hoc).	• System for coordinating in-service training for HRH exists, no adhered to.	• System for coordinating in-service training for HRH exists, • The county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments not coordinated by the county,	• System for coordinating in-service training for HRH exists, • The county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments conducted and coordinated by the county. • Training schedules are not fully coordinated/ communicated to all relevant stakeholders.	• System for coordinating in-service training for HRH exists, county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments conducted and coordinated by the county. • Training schedules are fully coordinated/ communicated to all relevant stakeholders. • Assessments of the impact of trainings to improved service delivery is conducted annually and feedback used during performance appraisals.	**0**
						Sub Total	**3**
						Percentage Score	**19%**

Building Block 3: Health Information Systems						**Max Score**	**16**
3.1.1	Capacity of County Health Department to develop and implement HMIS policies, strategies, guidelines, and protocols appropriate to the data needs of the county	• The county does not have national health information system policy and strategy.	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are not readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms.	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms • Sub-counties, facilities and community units do not have adequate supply	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms • Sub-counties, facilities and community units have adequate supply • Mentorship program on correct use of HIS forms institutionalized in less than 75%of sub-counties and/or facilities.	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms • Sub-counties, facilities and community units have adequate supply • Mentorship program on correct use of HIS forms institutionalized in at least 75% of sub-counties and/or facilities.	**2**

3.1.2	Capacity of County Health Department to collect quality health data	• There are no county-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) in place.	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data are not routinely collected using standard data collection forms.	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data routinely collected using standard data collection forms. • County department of health receives timely and complete reports from less than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization)	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data routinely collected using standard data collection forms. • County department of health receives timely and complete reports from more than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization) • County department of health receives accurate reports from less than 75% of health facilities (public, private and faith based)	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist; data are routinely collected using standard data collection forms. • County department of health receives timely and complete reports from less than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization) • County department of health receives accurate reports from more than 75% of health facilities (public, private and faith based) • Health performance data reviewed regularly and regular feedback provided to all health facilities on data accuracy.	**3**
3.1.3	Capacity of County Health Department to manage data	• No one single county-wide preferred electronic or paper based exists.	• Separate information management systems (paper or electronic) exist for the various components of the HIS. • It's difficult or impossible to manipulate or extract data from the system.	• One Single County preferred Electronic Health Information Systems platforms (databases) exist for the various components of HIS • Data are not routinely extracted for reports and other use.	• One Single County preferred Electronic Health Information System platforms (databases) exist at the county for the various components of the HIS, • Data are routinely extracted (at least annually) for use. • Integration of information from other health management systems (i.e., service statistics, financial, human resource, logistics information, and physical assets data systems) not yet fully operational.	• One Single County preferred Electronic Health Information System platforms (databases) exist at the county for the various components of the HIS, • Data are routinely extracted (at least annually) for use. • Integration of information from other health management systems (i.e., service statistics, financial, human resource, logistics information, and physical assets data systems) is evident. • County Data Management Guidelines exist including policy on health/research data sharing policy.	**3**
3.2.1	Capacity of County Health Department to use routine performance, surveys and surveillance data for planning including performance management, rational budgeting and policy making	• No evidence of data use for strategic planning including rational budgeting and decision making.	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county health committee and other state and non-state actors. • No evidence of data use for strategic planning including rational budgeting and decision making.	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings.	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county assembly health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings. • The county can identify at least two examples of how data have been integrated into a decision-making process including rational budgeting in the past year.	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county assembly health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings. • The county can identify at least two examples of how data have been integrated into a decision-making process including rational budgeting in the past year. • Policy and planning framework (that details national development goals, national health sector priority goals, county health priority goals, county budgetary and donor allocations, and county health development outcomes) exists.	**3**
						Sub Total	**11**
						Percentage Score	**69%**

Building Block 4: Access to Essential Medicines & Other Health Commodities						**Max Score**	**16**
4.1.1	Capacity of the County Health Department to provide oversight to commodity management to downstream facilities (ref: existence of a functional commodity security committee).	• The county does not have an organized unit (of more than three persons) to oversee and coordinate commodity security in the entire county.	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate.	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate. • The County Commodity Security Committee structure has been adopted, operationalized and implemented at the sub-county level for all the sub-counties in the county.	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate. • The County Commodity Security Committee structure has been adopted, operationalized and implemented at the sub-county level for all the sub-counties in the county. • Supply chain performance statistics are maintained at county, sub-county and facility levels and reflect improving trends overtime.	**2**

4.1.2	County Health Department's capacity to estimate commodity needs, develop a supply plan and procure/source these commodities	• No capacity (external or internal to the county) available to conduct a forecasting and quantification exercise (estimate commodity needs, develop a supply plan, and procure essential commodities).	• The county is reliant on external technical assistance to estimate commodity needs, and develop a supply plan, no mechanism exists to fully procure or source (i.e. buy or secure donations of) essential commodities.	• The county is reliant on external technical assistance to estimate commodity needs, and develop a supply plan, • County partially has capability to fully procure or source (i.e. buy or secure donations of) essential commodities.	• The county has capacity to estimate commodity needs, and develop a supply plan, • County partially has capability to fully procure or source (i.e. buy or secure donations of) essential commodities, • County requires minimal external technical assistance to estimate commodity needs.	• The county has capacity to estimate commodity needs, and develop a supply plan, • County has capacity to fully procure or source (i.e. buy or secure donations of) essential commodities, • County requires no external technical assistance to estimate commodity needs, • Health commodity procurement done at least once annually.	**3**
4.1.3	County Health Department's capacity to develop and/or adopt and use a National/County-owned Logistics Management Information System (LMIS)	• County currently uses no Health Commodities' LMIS system.	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records.	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, reporting of LMIS data is below 50% for all facilities annually.	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, county has access to limited logistics data including: stock on hand within the system and consumption/usage for the past reporting period and demonstrates reporting rates of least 50% from the sub-counties. • County has a plan for routine DQA exits, DQA of LMIS data conducted at least once annually	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, county has access to logistics data including: stock on hand within the system and consumption/usage for the past reporting period and demonstrates reporting rates of least 75% from the sub-counties. • County has a plan for routine DQA exits, DQA of LMIS data conducted semi annually • Data Quality Improvement Plan for LMIS data developed for every DQA and implemented	**2**
4.1.4	Health facility's capacity to effectively store and account for health commodities through appropriate records and reports.	• No system exists for proper storage and distribution of commodities, including essential medicines. (special storage requirements of medicines and other commodities are not followed, poor records keeping and consumption reporting)	• Warehouse/stores(s) for commodity storage exists at either county, sub-county or facility level, with some accommodation for items requiring special storage.	• The county/sub-county warehouse and health facility store meets at least two of the following four criteria: warehouse/store size is adequate, storage spaces are is well maintained and clean (including pest, lighting, temperature and humidity control), • County warehouse has designated storage equipment for special storage needs, and re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance.	• The county/sub-county warehouse and health facility store meets at least three of the following four criteria: warehouse/store size is adequate, storage spaces are well maintained and clean (including pest, lighting, temperature and humidity control) • County warehouse has designated storage equipment for special storage needs, • Re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance.	• The county/sub-county warehouse and health facility store is adequate – meets all four criteria (i.e. large enough, regularly cleaned, dry, well organized) with all special needs storage areas clearly designated with correct signage, • County warehouse has an established re-order and stocking plan, including the use of protocols (such as first expiry, first out), job aides (such as SOP for emergency procurements) • Re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance. • Stock-control records such as stock cards and bin cards are well maintained	**1**
						Sub Total	**8**
						Percentage Score	**50%**

Building Block 5: Health Systems Financing						**Max Score**	**16**
5.1.1	Capacity of the County Health Department to develop evidence-based budget request justifications that ensures adequate funds from the total county government budget are allocated to key areas such as HRH, health commodities and programs.	• The county health department has no input into the development of the county budget estimates.	• The county health department has input into the county budget estimates development, • But public health expenditures are not systematically calculated on an annual basis and total at least 20% of the overall county government budget.	• The county health budget is developed annually, with input from county health department • County health expenditures are not systematically calculated on an annual basis as part of budget formulation process • It's less than 25% of the overall county government budget.	• The county health budget is developed annually, with input from county health department • Estimated actual county health expenditures are systematically calculated on an annual basis as part of budget formulation process. • Health budget is between 25% and 30% of the overall county government budget.	• The county health budget is developed annually, with input from county health department. • Estimated actual county health expenditures are systematically calculated on an annual basis as part of budget formulation process • Program, surveys and surveillance data used as justification for budget requests • County health budget is at least between 30% - 40% of the overall county government budget.	**3**
5.2.1	Capacity of County Health Department to plan for, create and allocate a sustainable budget	• No sustainable budget exists	• Three of the budget sustainability criteria need improvement	• Two of the budget sustainability criteria need improvement	• One of the budget sustainability criteria needs improvement	• All of the budget sustainability criteria are completed and sustainable, with the county and sub-county health administrators' offices taking the lead on developing the county health budget *Budget sustainability criteria:* *Planning* *Input* *Allocation* *Initiative*	**1**

5.2.2	Capacity of County Health Department to effectively allocate finances based on county health priority needs	• No system to distribute funds exists	• Three of the budget distribution factors need improvement	• Two of the budget distribution factors need improvement	• One of the budget distribution factors needs improvement	• All of the four (4) budget distribution factors are completed and sustainable *The factors are:* *Financial System* *Tracking* *Policies* *Responsibility*	**1**
5.2.3	Capacity of County Health Department to monitor and ensure accountability for finances at the county and sub-county levels	• No tracking/monitoring system exists.	• Three of the factors necessary to effectively monitor finances need improvement	• Two of the factors necessary to effectively monitor finances need improvement	• One of the factors necessary to effectively monitor finances need improvement	• All of the four (4) factors necessary to effectively monitor finances are completed and sustainable *The factors are:* *Financial System* *Tracking* *Policies* *Responsibility*	**3**
						Sub Total	**8**
						Percentage Score	**50%**

Building Block 6: Delivering Essential Health Services						**Max Score**	**20**
6.1.1	Extent of interaction between the County Health Department and Sub-County Health Administration Offices	• No structured interaction with sub-counties	• The health department interacts at least once a year with sub-county health administrators on: o Budget-related issues only.	• The health department interacts at least once a year with sub-county health administrators on: o Budget related issues o Health service planning activities.	• The health department interacts at least once a year with sub-county health administrators on: o Budget related issues o Health service planning activities, o Maintenance and coordination of facilities.	• The health department interacts at least four times a year with sub-county health administrators on: o Budget related issues o Health service planning activities, o Maintenance and coordination of facilities, o Assessments and planning for community health needs.	**3**
6.1.2	Capacity of the County Health Department to develop and distribute (to the sub-counties and health facilities) policies, strategic plans, guidelines, protocols and standards for key health service areas	• No County Health Department's Health Strategy exists	• The county has a health strategy aligned to national health strategy (2014 – 2018)	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities.	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities. • The county clinical standards and guidelines are currently used by least 50% of sub-counties within the last two years.	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities. • The county clinical standards and guidelines are currently used by least 80% of sub-counties within the last two years. • The county health department conducts regular sub-county and health facility visits to monitor compliance in the use of standards and guidelines.	**3**
6.2.1	Capacity of County Health Department to supervise sub-counties in the use of health service delivery policies, strategies, guidelines and standards	• No system exists at the county to monitor adherence of sub-counties to standards, guidelines, protocols	• Some elements of a basic system exist for monitoring adherence to standards, guidelines and protocols.	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities), but use of these guidelines is not consistent by the county health department or sub-counties.	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities) • County provides support to sub-counties to monitor adherence at the facility level, but not consistently.	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities) • County provides support to sub-counties to monitor adherence at the facility level. • The county jointly with sub-counties has joint plans for conducting adherence monitoring at the health facility level.	**3**
6.2.2	Number of operational public, private and faith based health facilities as compared to the total that routinely report complete and accurate data	• The county does not have a list of the number of public, private and faith based health facilities.	• The county has a list of the number of public, private and faith based health facilities, but there is no system to determine and report which of the facilities by type report complete and accurate data	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities, but less than 50% of the total report complete and accurate data	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities (at least 75% of operational public, private and faith based health facilities of the total number are operational routinely report monthly) • About 75% of the reporting health facilities report complete and accurate data.	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities (at least 80% of operational public, private and faith based health facilities of the total number are operational routinely report monthly) • About 85% of the reporting health facilities report complete and accurate data. • County has a system for quarterly review of complete and accurate data.	**3**

6.3.1	Capacity of County Health Department to implement health programs. NOTE: This question can be asked of HIV/AIDS, TB/HIV, RMNCH, Nutrition, Water & Sanitation, and Malaria and sub programs as appropriate	• Program does not have capacity to identify priority areas for implementation	• Program has capacity to identify priority health areas and develop standards for health programs	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs.	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs. • The program has capacity to conduct periodic monitoring and evaluation (M&E) of priority health programs.	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs. • The program has capacity to conduct periodic monitoring and evaluation (M&E) of priority health programs. • The program has capacity to promote data sharing, communication, and collaboration within individual priority health programs.	**4**
						Sub Total	**16**
						Percentage Score	**80%**

			CICA Dashboard	
Building Blocks		**Max Score Possible**	**CICA Score**	**Percentage Score**
1	**Governance and Leadership**	**16**	**7**	**44%**
2	**Health Workforce**	**16**	**3**	**19%**
3	**Health Information Systems**	**16**	**11**	**69%**
4	**Access to Essential Medicines & Other Health Commodities**	**16**	**8**	**50%**
5	**Health Systems Financing**	**16**	**8**	**50%**
6	**Delivering Essential Health Services**	**20**	**16**	**80%**
		100	**53**	

Overal Score	**53%**

County Institutional Capacity Assessment (CICA)
Analysis of Results

Mombasa County						CICA Dates: 1st & 2nd Mar 2018	Score
CICA Standard \ Capacity Score		0	1	2	3	4	
Building Block 1: Governance and Leadership						**Max Score**	**16**
1.1.1	Capacity of County Health Department to develop and implement a County Health Strategy	• No current county health strategy • Aligned with Kenya Health Sector Strategic Plan (KHSSP) 2014 – 2018	• The current county health sector strategy is aligned with KHSSP 2014 – 2018. • Adopted by the county health management team/county health department.	• The county health strategy adopted; • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area.	• The county health strategy adopted • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area. • Evidence of at least one annual work plan/operational/action plan developed for at least 50% of the county health strategy priority areas	• The county health strategy adopted • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area.; • Evidence of annual work plan/operational/action plan developed for at least 80% of the county health strategy priority areas; • Monitoring and evaluation framework developed to track progress. • A Governance structure that properly sorts out the roles and responsibilities of key stakeholders in achieving county health strategy goals exists.	**3**
1.2.1	Capacity of County Health Department to communicate and coordinate within the County and Sub-County Health Department and other Departments in the county	• No evidence of communication plan and protocols for information flow within the county and sub-county and to other departments within the county.	• There is a communication plan, and protocols are clearly established to guide the plan.	• There is a communication plan, and protocols are clearly established to guide the plan. • At least 50% of CHMT are aware of the internal communication plan and protocols but no evidence of use of the plan and protocols	• There is a communication plan, and protocols are clearly established to guide the plan. • More than 50% of CHMT are aware of the internal communication plan and protocols but no evidence of use of the plan and protocols	• There is a communication plan, and protocols are clearly established to guide the plan. • More than 50% of key county staff are aware of the internal communication plan and protocols and evidence exists of use the plan and protocols more than once a year.	**0**
1.2.2	Capacity of the County Health Department to lead and engage (coordination) with different health actors working towards the same county goals	• No evidence of coordination framework that maps out different stakeholders working in the health sector	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Occasional meetings are held between the county and different health actors, but these are irregular, and do not involve all of them. Implementing partners and other key stakeholders have no opportunity to present and review health priorities and their contributions towards health goals	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals.	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals. • The county health leadership receives regular performance updates in the form of reports from at least 50% - 75% of different health actors working in the county.	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals. • County health leadership receives regular performance updates in the form of reports from all different health actors. • All different health actors are fully involved in annual sector performance reviews, county health annual work plan development and in policy development affecting the county population and health services (Partnership Code of Conduct exists).	**1**
1.2.3	Capacity of County Health Department to hold responsibility and ownership for the health system	• The county primary health care system at community level is over 50% funded by health implementing partners, with gaps existing where implementing partners are not implementing services.	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) below 50%, with significant input from development partners for health and implementing partners.	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) over 50%, with significant input from development partners for health and implementing partners. • Functionality of community units is at 50% per the reporting rates (MOH515)	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) over 50%, with significant input from development partners for health and implementing partners. • Functionality of community units is over 50% per the reporting rates (MOH515) • Annual accountability platform for reviewing committed funding against results achieved at community level in place.	**0**
						Sub Total	**4**
						Percentage Score	**25%**
Building Block 2: Health Workforce						**Max Score**	**16**

2.1.1	Ability to attract, recruit and retain human resources for health worker positions	• Job descriptions do not exist	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure)	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place.	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place. • Incentives for staff retention are in place but not effectively.	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place. • Incentives for staff retention are in place but not effectively. • Working conditions attractive and safe, financial and non-financial incentives for rural and hard to reach places are made more attractive and HRH wellness and welfare improved	**3**
2.1.2	Capacity of County Health Department to staff health facilities as per Staffing Norms, Standards and Guidelines	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards, and development of the health work force for staffing of each level of the health system do not exist.	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists.	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists. • A iHRIS has been developed to track staffing levels and needs,	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists. • A system has been developed to track staffing levels and needs, • iHRIS monthly updated (upon exit and recruitment).	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists. • A system has been developed to track staffing levels and needs, • iHRIS monthly updated (upon exit and recruitment). • Staffing data on needs by staffing cadre is being used to advocate for resources to meet staffing gaps.	**4**
2.2.1	Capacity of County Health Department to conduct staff performance appraisals	• There are no policies or guidelines at the county on staff performance appraisals at all levels of health care management and delivery.	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists.	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted.	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted as scheduled in the guidelines. • Supervisor performance monitoring is ad hoc	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted as scheduled in the guidelines. • Supervisor performance monitoring is ad hoc. • System exists for rewards and sanctions based on performance.	**1**
2.2.2	Capacity of County Health Department to coordinate capacity development of Human Resources for Health	• No system for coordinating in-service training for HRH exists, (HRH trainings are completely ad hoc).	• System for coordinating in-service training for HRH exists, no adhered to.	• System for coordinating in-service training for HRH exists, • The county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments not coordinated by the county,	• System for coordinating in-service training for HRH exists, • The county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments conducted and coordinated by the county. • Training schedules are not fully coordinated/ communicated to all relevant stakeholders.	• System for coordinating in-service training for HRH exists, county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments conducted and coordinated by the county. • Training schedules are fully coordinated/ communicated to all relevant stakeholders. • Assessments of the impact of trainings to improved service delivery is conducted annually and feedback used during performance appraisals.	**2**
						Sub Total	**10**
						Percentage Score	**63%**

Building Block 3: Health Information Systems						**Max Score**	**16**
3.1.1	Capacity of County Health Department to develop and implement HMIS policies, strategies, guidelines, and protocols appropriate to the data needs of the county	• The county does not have national health information system policy and strategy.	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are not readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms.	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms • Sub-counties, facilities and community units do not have adequate supply	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms • Sub-counties, facilities and community units have adequate supply • Mentorship program on correct use of HIS forms institutionalized in less than 75%of sub-counties	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms • Sub-counties, facilities and community units have adequate supply • Mentorship program on correct use of HIS forms institutionalized in at least 75% of sub-counties and/or facilities.	**2**

3.1.2	Capacity of County Health Department to collect quality health data	• There are no county-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) in place.	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data are not routinely collected using standard data collection forms.	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data routinely collected using standard data collection forms. • County department of health receives timely and complete reports from less than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization)	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data routinely collected using standard data collection forms. • County department of health receives timely and complete reports from more than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization) • County department of health receives accurate reports from less than 75% of health facilities (public, private and faith based)	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist; data are routinely collected using standard data collection forms. • County department of health receives timely and complete reports from less than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization) • County department of health receives accurate reports from more than 75% of health facilities (public, private and faith based) • Health performance data reviewed regularly and regular feedback provided to all health facilities on data accuracy.	**3**
3.1.3	Capacity of County Health Department to manage data	• No one single county-wide preferred electronic or paper based exists.	• Separate information management systems (paper or electronic) exist for the various components of the HIS. • It's difficult or impossible to manipulate or extract data from the system.	• One Single County preferred Electronic Health Information Systems platforms (databases) exist for the various components of HIS • Data are not routinely extracted for reports and other use.	• One Single County preferred Electronic Health Information System platforms (databases) exist at the county for the various components of the HIS, • Data are routinely extracted (at least annually) for use. • Integration of information from other health management systems (i.e., service statistics, financial, human resource, logistics information, and physical assets data systems) not yet fully operational.	• One Single County preferred Electronic Health Information System platforms (databases) exist at the county for the various components of the HIS, • Data are routinely extracted (at least annually) for use. • Integration of information from other health management systems (i.e., service statistics, financial, human resource, logistics information, and physical assets data systems) is evident. • County Data Management Guidelines exist including policy on health/research data sharing policy.	**3**
3.2.1	Capacity of County Health Department to use routine performance, surveys and surveillance data for planning including performance management, rational budgeting and policy making	• No evidence of data use for strategic planning including rational budgeting and decision making.	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county health committee and other state and non-state actors. • No evidence of data use for strategic planning including rational budgeting and decision making.	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings.	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county assembly health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings. • The county can identify at least two examples of how data have been integrated into a decision-making process including rational budgeting in the past year.	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county assembly health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings. • The county can identify at least two examples of how data have been integrated into a decision-making process including rational budgeting in the past year. • Policy and planning framework (that details national development goals, national health sector priority goals, county health priority goals, county budgetary and donor allocations, and county health development outcomes) exists.	**3**
						Sub Total	**11**
						Percentage Score	**69%**

Building Block 4: Access to Essential Medicines & Other Health Commodities						**Max Score**	**16**
4.1.1	Capacity of the County Health Department to provide oversight to commodity management to downstream facilities (ref: - existence of a functional commodity security committee).	• The county does not have an organized unit (of more than three persons) to oversee and coordinate commodity security in the entire county.	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate.	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate. • The County Commodity Security Committee structure has been adopted, operationalized and implemented at the sub-county level for all the sub-counties in the county.	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate. • The County Commodity Security Committee structure has been adopted, operationalized and implemented at the sub-county level for all the sub-counties in the county. • Supply chain performance statistics are maintained at county, sub-county and facility levels and reflect improving trends overtime.	**2**

4.1.2	County Health Department's capacity to estimate commodity needs, develop a supply plan and procure/source these commodities	• No capacity (external or internal to the county) available to conduct a forecasting and quantification exercise (estimate commodity needs, develop a supply plan, and procure essential commodities).	• The county is reliant on external technical assistance to estimate commodity needs, and develop a supply plan, no mechanism exists to fully procure or source (i.e. buy or secure donations of) essential commodities.	• The county is reliant on external technical assistance to estimate commodity needs, and develop a supply plan, • County partially has capability to fully procure or source (i.e. buy or secure donations of) essential commodities.	• The county has capacity to estimate commodity needs, and develop a supply plan, • County partially has capability to fully procure or source (i.e. buy or secure donations of) essential commodities, • County requires minimal external technical assistance to estimate commodity needs.	• The county has capacity to estimate commodity needs, and develop a supply plan, • County has capacity to fully procure or source (i.e. buy or secure donations of) essential commodities, • County requires no external technical assistance to estimate commodity needs, • Health commodity procurement done at least once annually.	**3**
4.1.3	County Health Department's capacity to develop and/or adopt and use a National/County-owned Logistics Management Information System (LMIS)	• County currently uses no Health Commodities' LMIS system.	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records.	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, reporting of LMIS data is below 50% for all facilities annually.	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, county has access to limited logistics data including: stock on hand within the system and consumption/usage for the past reporting period and demonstrates reporting rates of least 50% from the sub-counties. • County has a plan for routine DQA exits, DQA of LMIS data conducted at least once annually	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, county has access to logistics data including: stock on hand within the system and consumption/usage for the past reporting period and demonstrates reporting rates of least 75% from the sub-counties. • County has a plan for routine DQA exits, DQA of LMIS data conducted semi annually • Data Quality Improvement Plan for LMIS data developed for every DQA and implemented	**0**
4.1.4	Health facility's capacity to effectively store and account for health commodities through appropriate records and reports.	• No system exists for proper storage and distribution of commodities, including essential medicines. (special storage requirements of medicines and other commodities are not followed, poor records keeping and consumption reporting)	• Warehouse/stores(s) for commodity storage exists at either county, sub-county or facility level, with some accommodation for items requiring special storage.	• The county/sub-county warehouse and health facility store meets at least two of the following four criteria: warehouse/store size is adequate, storage spaces are is well maintained and clean (including pest, lighting, temperature and humidity control), • County warehouse has designated storage equipment for special storage needs, and re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance.	• The county/sub-county warehouse and health facility store meets at least three of the following four criteria: warehouse/store size is adequate, storage spaces are well maintained and clean (including pest, lighting, temperature and humidity control) • County warehouse has designated storage equipment for special storage needs, • Re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance.	• The county/sub-county warehouse and health facility store is adequate – meets all four criteria (i.e. large enough, regularly cleaned, dry, well organized) with all special needs storage areas clearly designated with correct signage, • County warehouse has an established re-order and stocking plan, including the use of protocols (such as first expiry, first out), job aides (such as SOP for emergency procurements) • Re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance. • Stock-control records such as stock cards and bin cards are well maintained	**1**
						Sub Total	**6**
						Percentage Score	**38%**

Building Block 5: Health Systems Financing						**Max Score**	**16**
5.1.1	Capacity of the County Health Department to develop evidence-based budget request justifications that ensures adequate funds from the total county government budget are allocated to key areas such as HRH, health commodities and programs.	• The county health department has no input into the development of the county budget estimates.	• The county health department has input into the county budget estimates development, • But public health expenditures are not systematically calculated on an annual basis and total at least 20% of the overall county government budget.	• The county health budget is developed annually, with input from county health department • County health expenditures are not systematically calculated on an annual basis as part of budget formulation process • It's less than 25% of the overall county government budget.	• The county health budget is developed annually, with input from county health department • Estimated actual county health expenditures are systematically calculated on an annual basis as part of budget formulation process. • Health budget is between 25% and 30% of the overall county government budget.	• The county health budget is developed annually, with input from county health department. • Estimated actual county health expenditures are systematically calculated on an annual basis as part of budget formulation process • Program, surveys and surveillance data used as justification for budget requests • County health budget is at least between 30% - 40% of the overall county government budget.	**3**
5.2.1	Capacity of County Health Department to plan for, create and allocate a sustainable budget	• No sustainable budget exists	• Three of the budget sustainability criteria need improvement	• Two of the budget sustainability criteria need improvement	• One of the budget sustainability criteria needs improvement	• All of the budget sustainability criteria are completed and sustainable, with the county and sub-county health administrators' offices taking the lead on developing the county health budget *Budget sustainability criteria:* *Planning* *Input* *Allocation* *Initiative*	**2**

5.2.2	Capacity of County Health Department to effectively allocate finances based on county health priority needs	• No system to distribute funds exists	• Three of the budget distribution factors need improvement	• Two of the budget distribution factors need improvement	• One of the budget distribution factors needs improvement	• All of the four (4) budget distribution factors are completed and sustainable *The factors are:* *Financial System* *Tracking* *Policies* *Responsibility*	**1**
5.2.3	Capacity of County Health Department to monitor and ensure accountability for finances at the county and sub-county levels	• No tracking/monitoring system exists.	• Three of the factors necessary to effectively monitor finances need improvement	• Two of the factors necessary to effectively monitor finances need improvement	• One of the factors necessary to effectively monitor finances need improvement	• All of the four (4) factors necessary to effectively monitor finances are completed and sustainable *The factors are:* *Financial System* *Tracking* *Policies* *Responsibility*	**1**
						Sub Total	**7**
						Percentage Score	**44%**

Building Block 6: Delivering Essential Health Services						**Max Score**	**20**
6.1.1	Extent of interaction between the County Health Department and Sub-County Health Administration Offices	• No structured interaction with sub-counties	• The health department interacts at least once a year with sub-county health administrators on: o Budget-related issues only.	• The health department interacts at least once a year with sub-county health administrators on: o Budget related issues o Health service planning activities.	• The health department interacts at least once a year with sub-county health administrators on: o Budget related issues o Health service planning activities, o Maintenance and coordination of facilities.	• The health department interacts at least four times a year with sub-county health administrators on: o Budget related issues o Health service planning activities, o Maintenance and coordination of facilities, o Assessments and planning for community health needs.	**4**
6.1.2	Capacity of the County Health Department to develop and distribute (to the sub-counties and health facilities) policies, strategic plans, guidelines, protocols and standards for key health service areas	• No County Health Department's Health Strategy exists	• The county has a health strategy aligned to national health strategy (2014 – 2018)	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities.	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities. • The county clinical standards and guidelines are currently used by least 50% of sub-counties within the last two years.	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities. • The county clinical standards and guidelines are currently used by least 80% of sub-counties within the last two years. • The county health department conducts regular sub-county and health facility visits to monitor compliance in the use of standards and guidelines.	**3**
6.2.1	Capacity of County Health Department to supervise sub-counties in the use of health service delivery policies, strategies, guidelines and standards	• No system exists at the county to monitor adherence of sub-counties to standards, guidelines, protocols	• Some elements of a basic system exist for monitoring adherence to standards, guidelines and protocols.	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities), but use of these guidelines is not consistent by the county health department or sub-counties.	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities) • County provides support to sub-counties to monitor adherence at the facility level, but not consistently.	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities) • County provides support to sub-counties to monitor adherence at the facility level. • The county jointly with sub-counties has joint plans for conducting adherence monitoring at the health facility level.	**3**
6.2.2	Number of operational public, private and faith based health facilities as compared to the total that routinely report complete and accurate data	• The county does not have a list of the number of public, private and faith based health facilities.	• The county has a list of the number of public, private and faith based health facilities, but there is no system to determine and report which of the facilities by type report complete and accurate data	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities, but less than 50% of the total report complete and accurate data	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities (at least 75% of operational public, private and faith based health facilities of the total number are operational routinely report monthly) • About 75% of the reporting health facilities report complete and accurate data.	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities (at least 80% of operational public, private and faith based health facilities of the total number are operational routinely report monthly) • About 85% of the reporting health facilities report complete and accurate data. • County has a system for quarterly review of complete and accurate data.	**3**

6.3.1	Capacity of County Health Department to implement health programs. NOTE: This question can be asked of HIV/AIDS, TB/HIV, RMNCH, Nutrition, Water & Sanitation, and Malaria and sub programs as appropriate	• Program does not have capacity to identify priority areas for implementation	• Program has capacity to identify priority health areas and develop standards for health programs	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs.	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs. • The program has capacity to conduct periodic monitoring and evaluation (M&E) of priority health programs.	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs. • The program has capacity to conduct periodic monitoring and evaluation (M&E) of priority health programs. • The program has capacity to promote data sharing, communication, and collaboration within individual priority health programs.	**4**
						Sub Total	**17**
						Percentage Score	**85%**

			CICA Dashboard	
Building Blocks		**Max Score Possible**	**CICA Score**	**Percentage Score**
1	**Governance and Leadership**	**16**	**4**	**25%**
2	**Health Workforce**	**16**	**10**	**63%**
3	**Health Information Systems**	**16**	**11**	**69%**
4	**Access to Essential Medicines & Other Health Commodities**	**16**	**6**	**38%**
5	**Health Systems Financing**	**16**	**7**	**44%**
6	**Delivering Essential Health Services**	**20**	**17**	**85%**
		100	**55**	

Overal Score	**55%**

County Institutional Capacity Assessment (CICA)
Analysis of Results

Migori County						CICA Dates: 2nd & 3rd Mar 2018	Score
CICA Standard \ Capacity Score		0	1	2	3	4	
Building Block 1: Governance and Leadership						**Max Score**	**16**
1.1.1	Capacity of County Health Department to develop and implement a County Health Strategy	• No current county health strategy • Aligned with Kenya Health Sector Strategic Plan (KHSSP) 2014 – 2018	• The current county health sector strategy is aligned with KHSSP 2014 – 2018. • Adopted by the county health management team/county health department.	• The county health strategy adopted; • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area.	• The county health strategy adopted • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area. • Evidence of at least one annual work plan/operational/action plan developed for at least 50% of the county health strategy priority areas	• The county health strategy adopted • Mechanism exists for implementation of strategy overseeing and coordinating the implementation of each priority area.; • Evidence of annual work plan/operational/action plan developed for at least 80% of the county health strategy priority areas; • Monitoring and evaluation framework developed to track progress. • A Governance structure that properly sorts out the roles and responsibilities of key stakeholders in achieving county health strategy goals exists.	**3**
1.2.1	Capacity of County Health Department to communicate and coordinate within the County and Sub-County Health Department and other Departments in the county	• No evidence of communication plan and protocols for information flow within the county and sub-county and to other departments within the county.	• There is a communication plan, and protocols are clearly established to guide the plan.	• There is a communication plan, and protocols are clearly established to guide the plan. • At least 50% of CHMT are aware of the internal communication plan and protocols but no evidence of use of the plan and protocols	• There is a communication plan, and protocols are clearly established to guide the plan. • More than 50% of CHMT are aware of the internal communication plan and protocols but no evidence of use of the plan and protocols	• There is a communication plan, and protocols are clearly established to guide the plan. • More than 50% of key county staff are aware of the internal communication plan and protocols and evidence exists of use the plan and protocols more than once a year.	**0**
1.2.2	Capacity of the County Health Department to lead and engage (coordination) with different health actors working towards the same county goals	• No evidence of coordination framework that maps out different stakeholders working in the health sector	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Occasional meetings are held between the county and different health actors, but these are irregular, and do not involve all of them. Implementing partners and other key stakeholders have no opportunity to present and review health priorities and their contributions towards health goals	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals.	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals. • The county health leadership receives regular performance updates in the form of reports from at least 50% - 75% of different health actors working in the county.	• Evidence of coordination framework that maps out different stakeholders working in the health sector • Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions towards health goals. • County health leadership receives regular performance updates in the form of reports from all different health actors. • All different health actors are fully involved in annual sector performance reviews, county health annual work plan development and in policy development affecting the county population and health services (Partnership Code of Conduct exists).	**3**
1.2.3	Capacity of County Health Department to hold responsibility and ownership for the health system	• The county primary health care system at community level is over 50% funded by health implementing partners, with gaps existing where implementing partners are not implementing services.	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) below 50%, with significant input from development partners for health and implementing partners.	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) over 50%, with significant input from development partners for health and implementing partners. • Functionality of community units is at 50% per the reporting rates (MOH515)	• The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners • Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) over 50%, with significant input from development partners for health and implementing partners. • Functionality of community units is over 50% per the reporting rates (MOH515) • Annual accountability platform for reviewing committed funding against results achieved at community level in place.	**0**
						Sub Total	**6**
						Percentage Score	**38%**
Building Block 2: Health Workforce						**Max Score**	**16**

2.1.1	Ability to attract, recruit and retain human resources for health worker positions	• Job descriptions do not exist	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure)	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place.	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place. • Incentives for staff retention are in place but not effectively.	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place. • Incentives for staff retention are in place but not effectively. • Working conditions attractive and safe, financial and non-financial incentives for rural and hard to reach places are made more attractive and HRH wellness and welfare improved	**1**
2.1.2	Capacity of County Health Department to staff health facilities as per Staffing Norms, Standards and Guidelines	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards, and development of the health work force for staffing of each level of the health system do not exist.	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists.	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists. • A iHRIS has been developed to track staffing levels and needs,	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists. • A system has been developed to track staffing levels and needs, • iHRIS monthly updated (upon exit and recruitment).	• The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists. • A system has been developed to track staffing levels and needs, • iHRIS monthly updated (upon exit and recruitment). • Staffing data on needs by staffing cadre is being used to advocate for resources to meet staffing gaps.	**4**
2.2.1	Capacity of County Health Department to conduct staff performance appraisals	• There are no policies or guidelines at the county on staff performance appraisals at all levels of health care management and delivery.	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists.	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted.	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted as scheduled in the guidelines. • Supervisor performance monitoring is ad hoc	• Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists • Staff performance appraisals are conducted as scheduled in the guidelines. • Supervisor performance monitoring is ad hoc. • System exists for rewards and sanctions based on performance.	**1**
2.2.2	Capacity of County Health Department to coordinate capacity development of Human Resources for Health	• No system for coordinating in-service training for HRH exists, (HRH trainings are completely ad hoc).	• System for coordinating in-service training for HRH exists, no adhered to.	• System for coordinating in-service training for HRH exists, • The county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments not coordinated by the county,	• System for coordinating in-service training for HRH exists, • The county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments conducted and coordinated by the county. • Training schedules are not fully coordinated/ communicated to all relevant stakeholders.	• System for coordinating in-service training for HRH exists, county coordinates all trainings including those conducted by vertical programs and implementing partners. • Training needs assessments conducted and coordinated by the county. • Training schedules are fully coordinated/ communicated to all relevant stakeholders. • Assessments of the impact of trainings to improved service delivery is conducted annually and feedback used during performance appraisals.	**1**
						Sub Total	**7**
						Percentage Score	**44%**

Building Block 3: Health Information Systems						**Max Score**	**16**
3.1.1	Capacity of County Health Department to develop and implement HMIS policies, strategies, guidelines, and protocols appropriate to the data needs of the county	• The county does not have national health information system policy and strategy.	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are not readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms.	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms • Sub-counties, facilities and community units do not have adequate supply	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms • Sub-counties, facilities and community units have adequate supply • Mentorship program on correct use of HIS forms institutionalized in less than 75%of sub-counties and/or facilities.	• County health department has the national health information system policy and strategy • Data collection tools systems for all key components are readily available: o source registers o birth/death registration, o reporting forms, o data quality assessment protocol forms, o disease surveillance forms • Sub-counties, facilities and community units have adequate supply • Mentorship program on correct use of HIS forms institutionalized in at least 75% of sub-counties and/or facilities.	**2**

3.1.2	Capacity of County Health Department to collect quality health data	• There are no county-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) in place.	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data are not routinely collected using standard data collection forms.	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data routinely collected using standard data collection forms. • County department of health receives timely and complete reports from less than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization)	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist, data routinely collected using standard data collection forms. • County department of health receives timely and complete reports from more than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization) • County department of health receives accurate reports from less than 75% of health facilities (public, private and faith based)	• County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist; data are routinely collected using standard data collection forms. • County department of health receives timely and complete reports from less than 75% of health facilities (public, private and faith based) o MOH 731 (HIV) o MOH 515 (Community) o MOH 710 (Immunization) • County department of health receives accurate reports from more than 75% of health facilities (public, private and faith based) • Health performance data reviewed regularly and regular feedback provided to all health facilities on data accuracy.	**3**
3.1.3	Capacity of County Health Department to manage data	• No one single county-wide preferred electronic or paper based exists.	• Separate information management systems (paper or electronic) exist for the various components of the HIS. • It's difficult or impossible to manipulate or extract data from the system.	• One Single County preferred Electronic Health Information Systems platforms (databases) exist for the various components of HIS • Data are not routinely extracted for reports and other use.	• One Single County preferred Electronic Health Information System platforms (databases) exist at the county for the various components of the HIS, • Data are routinely extracted (at least annually) for use. • Integration of information from other health management systems (i.e., service statistics, financial, human resource, logistics information, and physical assets data systems) not yet fully operational.	• One Single County preferred Electronic Health Information System platforms (databases) exist at the county for the various components of the HIS, • Data are routinely extracted (at least annually) for use. • Integration of information from other health management systems (i.e., service statistics, financial, human resource, logistics information, and physical assets data systems) is evident. • County Data Management Guidelines exist including policy on health/research data sharing policy.	**3**
3.2.1	Capacity of County Health Department to use routine performance, surveys and surveillance data for planning including performance management, rational budgeting and policy making	• No evidence of data use for strategic planning including rational budgeting and decision making.	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county health committee and other state and non-state actors. • No evidence of data use for strategic planning including rational budgeting and decision making.	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings.	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county assembly health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings. • The county can identify at least two examples of how data have been integrated into a decision-making process including rational budgeting in the past year.	• The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county assembly health committee and other state and non-state actors. • Presentations and discussions of data are part of the county health performance review meetings. • The county can identify at least two examples of how data have been integrated into a decision-making process including rational budgeting in the past year. • Policy and planning framework (that details national development goals, national health sector priority goals, county health priority goals, county budgetary and donor allocations, and county health development outcomes) exists.	**4**
						Sub Total	**12**
						Percentage Score	**75%**

Building Block 4: Access to Essential Medicines & Other Health Commodities						**Max Score**	**16**
4.1.1	Capacity of the County Health Department to provide oversight to commodity management to downstream facilities (ref: existence of a functional commodity security committee).	• The county does not have an organized unit (of more than three persons) to oversee and coordinate commodity security in the entire county.	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate.	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate. • The County Commodity Security Committee structure has been adopted, operationalized and implemented at the sub-county level for all the sub-counties in the county.	• A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership • Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate. • The County Commodity Security Committee structure has been adopted, operationalized and implemented at the sub-county level for all the sub-counties in the county. • Supply chain performance statistics are maintained at county, sub-county and facility levels and reflect improving trends overtime.	**4**

4.1.2	County Health Department's capacity to estimate commodity needs, develop a supply plan and procure/source these commodities	• No capacity (external or internal to the county) available to conduct a forecasting and quantification exercise (estimate commodity needs, develop a supply plan, and procure essential commodities).	• The county is reliant on external technical assistance to estimate commodity needs, and develop a supply plan, no mechanism exists to fully procure or source (i.e. buy or secure donations of) essential commodities.	• The county is reliant on external technical assistance to estimate commodity needs, and develop a supply plan, • County partially has capability to fully procure or source (i.e. buy or secure donations of) essential commodities.	• The county has capacity to estimate commodity needs, and develop a supply plan, • County partially has capability to fully procure or source (i.e. buy or secure donations of) essential commodities, • County requires minimal external technical assistance to estimate commodity needs.	• The county has capacity to estimate commodity needs, and develop a supply plan, • County has capacity to fully procure or source (i.e. buy or secure donations of) essential commodities, • County requires no external technical assistance to estimate commodity needs, • Health commodity procurement done at least once annually.	**3**
4.1.3	County Health Department's capacity to develop and/or adopt and use a National/County-owned Logistics Management Information System (LMIS)	• County currently uses no Health Commodities' LMIS system.	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records.	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, reporting of LMIS data is below 50% for all facilities annually.	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, county has access to limited logistics data including: stock on hand within the system and consumption/usage for the past reporting period and demonstrates reporting rates of least 50% from the sub-counties. • County has a plan for routine DQA exits, DQA of LMIS data conducted at least once annually	• The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. • Most staff have been trained in use of the LMIS, county has access to logistics data including: stock on hand within the system and consumption/usage for the past reporting period and demonstrates reporting rates of least 75% from the sub-counties. • County has a plan for routine DQA exits, DQA of LMIS data conducted semi annually • Data Quality Improvement Plan for LMIS data developed for every DQA and implemented	**2**
4.1.4	Health facility's capacity to effectively store and account for health commodities through appropriate records and reports.	• No system exists for proper storage and distribution of commodities, including essential medicines. (special storage requirements of medicines and other commodities are not followed, poor records keeping and consumption reporting)	• Warehouse/stores(s) for commodity storage exists at either county, sub-county or facility level, with some accommodation for items requiring special storage.	• The county/sub-county warehouse and health facility store meets at least two of the following four criteria: warehouse/store size is adequate, storage spaces are is well maintained and clean (including pest, lighting, temperature and humidity control), • County warehouse has designated storage equipment for special storage needs, and re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance.	• The county/sub-county warehouse and health facility store meets at least three of the following four criteria: warehouse/store size is adequate, storage spaces are well maintained and clean (including pest, lighting, temperature and humidity control) • County warehouse has designated storage equipment for special storage needs, • Re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance.	• The county/sub-county warehouse and health facility store is adequate – meets all four criteria (i.e. large enough, regularly cleaned, dry, well organized) with all special needs storage areas clearly designated with correct signage, • County warehouse has an established re-order and stocking plan, including the use of protocols (such as first expiry, first out), job aides (such as SOP for emergency procurements) • Re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance. • Stock-control records such as stock cards and bin cards are well maintained	**1**
						Sub Total	**10**
						Percentage Score	**63%**

Building Block 5: Health Systems Financing						**Max Score**	**16**
5.1.1	Capacity of the County Health Department to develop evidence-based budget request justifications that ensures adequate funds from the total county government budget are allocated to key areas such as HRH, health commodities and programs.	• The county health department has no input into the development of the county budget estimates.	• The county health department has input into the county budget estimates development, • But public health expenditures are not systematically calculated on an annual basis and total at least 20% of the overall county government budget.	• The county health budget is developed annually, with input from county health department • County health expenditures are not systematically calculated on an annual basis as part of budget formulation process • It's less than 25% of the overall county government budget.	• The county health budget is developed annually, with input from county health department • Estimated actual county health expenditures are systematically calculated on an annual basis as part of budget formulation process. • Health budget is between 25% and 30% of the overall county government budget.	• The county health budget is developed annually, with input from county health department. • Estimated actual county health expenditures are systematically calculated on an annual basis as part of budget formulation process • Program, surveys and surveillance data used as justification for budget requests • County health budget is at least between 30% - 40% of the overall county government budget.	**2**
5.2.1	Capacity of County Health Department to plan for, create and allocate a sustainable budget	• No sustainable budget exists	• Three of the budget sustainability criteria need improvement	• Two of the budget sustainability criteria need improvement	• One of the budget sustainability criteria needs improvement	• All of the budget sustainability criteria are completed and sustainable, with the county and sub-county health administrators' offices taking the lead on developing the county health budget *Budget sustainability criteria:* *Planning* *Input* *Allocation* *Initiative*	**1**

5.2.2	Capacity of County Health Department to effectively allocate finances based on county health priority needs	• No system to distribute funds exists	• Three of the budget distribution factors need improvement	• Two of the budget distribution factors need improvement	• One of the budget distribution factors needs improvement	• All of the four (4) budget distribution factors are completed and sustainable *The factors are:* *Financial System* *Tracking* *Policies* *Responsibility*	**1**
5.2.3	Capacity of County Health Department to monitor and ensure accountability for finances at the county and sub-county levels	• No tracking/monitoring system exists.	• Three of the factors necessary to effectively monitor finances need improvement	• Two of the factors necessary to effectively monitor finances need improvement	• One of the factors necessary to effectively monitor finances need improvement	• All of the four (4) factors necessary to effectively monitor finances are completed and sustainable *The factors are:* *Financial System* *Tracking* *Policies* *Responsibility*	**1**
						Sub Total	**5**
						Percentage Score	**31%**

Building Block 6: Delivering Essential Health Services						**Max Score**	**20**
6.1.1	Extent of interaction between the County Health Department and Sub-County Health Administration Offices	• No structured interaction with sub-counties	• The health department interacts at least once a year with sub-county health administrators on: o Budget-related issues only.	• The health department interacts at least once a year with sub-county health administrators on: o Budget related issues o Health service planning activities.	• The health department interacts at least once a year with sub-county health administrators on: o Budget related issues o Health service planning activities, o Maintenance and coordination of facilities.	• The health department interacts at least four times a year with sub-county health administrators on: o Budget related issues o Health service planning activities, o Maintenance and coordination of facilities, o Assessments and planning for community health needs.	**3**
6.1.2	Capacity of the County Health Department to develop and distribute (to the sub-counties and health facilities) policies, strategic plans, guidelines, protocols and standards for key health service areas	• No County Health Department's Health Strategy exists	• The county has a health strategy aligned to national health strategy (2014 – 2018)	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities.	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities. • The county clinical standards and guidelines are currently used by least 50% of sub-counties within the last two years.	• The county has a health strategy aligned to national health strategy (2014 – 2018) • The county has clinical standards, guidelines already distributed to sub-counties and health facilities. • The county clinical standards and guidelines are currently used by least 80% of sub-counties within the last two years. • The county health department conducts regular sub-county and health facility visits to monitor compliance in the use of standards and guidelines.	**2**
6.2.1	Capacity of County Health Department to supervise sub-counties in the use of health service delivery policies, strategies, guidelines and standards	• No system exists at the county to monitor adherence of sub-counties to standards, guidelines, protocols	• Some elements of a basic system exist for monitoring adherence to standards, guidelines and protocols.	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities), but use of these guidelines is not consistent by the county health department or sub-counties.	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities) • County provides support to sub-counties to monitor adherence at the facility level, but not consistently.	• A system of monitoring of adherence to standards, guidelines and protocols • County has guidelines for one or two of the following areas (lines of responsibility, supervision schedule, supervision guidelines/checklists for health facilities) • County provides support to sub-counties to monitor adherence at the facility level. • The county jointly with sub-counties has joint plans for conducting adherence monitoring at the health facility level.	**2**
6.2.2	Number of operational public, private and faith based health facilities as compared to the total that routinely report complete and accurate data	• The county does not have a list of the number of public, private and faith based health facilities.	• The county has a list of the number of public, private and faith based health facilities, but there is no system to determine and report which of the facilities by type report complete and accurate data	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities, but less than 50% of the total report complete and accurate data	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities (at least 75% of operational public, private and faith based health facilities of the total number are operational routinely report monthly) • About 75% of the reporting health facilities report complete and accurate data.	• The county has a list of the number of public, private and faith based health facilities • The county has a tracking system for all operational public, private and faith based health facilities (at least 80% of operational public, private and faith based health facilities of the total number are operational routinely report monthly) • About 85% of the reporting health facilities report complete and accurate data. • County has a system for quarterly review of complete and accurate data.	**3**

6.3.1	Capacity of County Health Department to implement health programs. NOTE: This question can be asked of HIV/AIDS, TB/HIV, RMNCH, Nutrition, Water & Sanitation, and Malaria and sub programs as appropriate	• Program does not have capacity to identify priority areas for implementation	• Program has capacity to identify priority health areas and develop standards for health programs	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs.	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs. • The program has capacity to conduct periodic monitoring and evaluation (M&E) of priority health programs.	• Program has capacity to identify priority health areas and develop standards for health programs. • The program has capacity to develop an implementation plan for priority health programs. • The program has capacity to conduct periodic monitoring and evaluation (M&E) of priority health programs. • The program has capacity to promote data sharing, communication, and collaboration within individual priority health programs.	**3**
						Sub Total	**13**
						Percentage Score	**65%**

			CICA Dashboard	
Building Blocks		**Max Score Possible**	**CICA Score**	**Percentage Score**
1	**Governance and Leadership**	**16**	**6**	**38%**
2	**Health Workforce**	**16**	**7**	**44%**
3	**Health Information Systems**	**16**	**12**	**75%**
4	**Access to Essential Medicines & Other Health Commodities**	**16**	**10**	**63%**
5	**Health Systems Financing**	**16**	**5**	**31%**
6	**Delivering Essential Health Services**	**20**	**13**	**65%**
		100	**53**	

Overal Score	**53%**

ANNEX 5: ADDITIONAL INPUT –NATIONAL IMPLEMENTING PARTNERS

During the CICA, three USG IPs (Implementing Partners) who had been invited were not able to send representatives to participate in the assessment and validation workshops in some of the five counties. These three partners are HPP+ (Health Policy Project Plus), HRH Kenya (Human Resources for Health, Kenya) and (GHSC-PSM) Global Health Supply Chain Program-Procurement and Supply Management.

After the assessment was completed, detailed results of the assessment for the five counties were therefore shared with the COPs (Chief of Party) of these three IPs. They were requested to review the results for the building blocks that they are currently supporting in the counties, and give their feedback and input.

Two IPs, HRH Kenya and GHSC-PSM provided their feedback and input as per the details below.

Feedback from HRH Kenya

Contact Person:	Wasunna Owino, PhD
Position Title:	Country Director, Chief of Party
Workshops attended by IP:	Busia, Kakamega, Migori validation workshops and Mombasa assessment workshop

HRH Kenya concurred with the scores for all the standards/questions in the CICA tool except standard 2.1.1 for Migori County. For this standard Migori County CICA participants provided a score of 1 while HRH Kenya gave a score of 2.

Building Block 2: Health Workforce	
Standard 2.1.1: Ability to attract, recruit and retain human resources for health worker positions	
0	• Job descriptions do not exist,
1	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure)
2	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place.
3	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place. • Incentives for staff retention are in place but not effectively.
4	• The county develops standard job descriptions for health workers • Harmonized pay system exists (pay structure) • Structure for staff attraction and recruitment in place. • Incentives for staff retention are in place but not effectively. • Working conditions attractive and safe, financial and non-financial incentives for rural and hard to reach places are made more attractive and HRH wellness and welfare improved

HRH Kenya gave the following reasons for providing a different score from the CICA participants

The county has a structure for staff attraction and recruitment in place. This is a functional County HRM advisory committee, which deals with all HRM issues including promotions, sanctions, trainings and recruitment of staff based on the identified needs. The names for officers to be promoted have been identified and shared with the county public service board. However, the challenge is the budgetary allocation for training and promotions.

Feedback from GHSC-PSM

Contact Person: Jayne Waweru
Position Title: Chief of Party
Workshops attended by IP: Migori validation workshop

GHSC – PSM concurred with all the scores for all the standards/questions in the CICA tool except standards 4.1.1, 4.1.3 and 4.1.4.

	Standard 4.1.1: Capacity of the County Health Department to provide oversight to commodity management to downstream levels of service delivery	**Standard 4.1.3: County Health Department's Capacity to Develop and/or adopt and Use a National/County-owned Health Commodities' Logistics Management Information System (LMIS)**	**Standard 4.1.4: Health facility's capacity to effectively store and account for health commodities through appropriate records and reports.**
0	-The county does not have an organized unit (of more than three persons) to oversee and coordinate commodity security in the entire county.	-County currently uses no Health Commodities' LMIS system	-No system exists for proper storage and distribution of commodities, including essential medicines. (special storage requirements of medicines and other commodities are not followed, poor records keeping and consumption reporting)
1	-A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership.	-The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records.	-Warehouse/stores(s) for commodity storage exists at either county, sub-county or facility level, with some accommodation for items requiring special storage.
2	-A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership	-The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for	-The county/sub-county warehouse and health facility store meets at **least two** of the following four criteria: warehouse/store size is adequate, storage spaces are being well maintained and clean (including

	-Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate.	distributing/resupplying these records. -Most staff have been trained in use of the LMIS, reporting of LMIS data is below 50% for all facilities annually.	pest, lighting, temperature and humidity control), -County warehouse has designated storage equipment for special storage needs, and re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance.
3	-A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership -Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate. -The County Commodity Security Committee structure has been adopted, operationalized and implemented at the sub-county level for all the sub-counties in the county.	-The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records. -Most staff have been trained in use of the LMIS, county has access to limited logistics data including: stock on hand within the system and consumption/usage for the past reporting period and demonstrates reporting rates of least 50% from the sub-counties. -County has a plan for routine DQA exits, DQA of LMIS data conducted at least once annually	-The county/sub-county warehouse and health facility store meets at **least three** of the following four criteria: warehouse/store size is adequate, storage spaces are well maintained and clean (including pest, lighting, temperature and humidity control) -County warehouse has designated storage equipment for special storage needs, -Re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance.
4	-A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership -Commodity Security Committee's Terms of Reference (TORs) have	-The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records.	-The county/sub-county warehouse and health facility store is adequate – meets all four criteria (i.e. large enough, regularly cleaned, dry, well organized) with all special needs storage areas clearly designated with correct signage, -County warehouse has an established re-order and stocking plan, including the use of protocols (such as first expiry, first out), job

	been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate. -The County Commodity Security Committee structure has been adopted, operationalized and implemented at the sub-county level for all the sub-counties in the county. -Supply chain performance statistics are maintained at county, sub-county and facility levels and reflect improving trends overtime.	-Most staff have been trained in use of the LMIS, county has access to logistics data including: stock on hand within the system and consumption/usage for the past reporting period and demonstrates reporting rates of least 75% from the sub-counties. -County has a plan for routine DQA exits, DQA of LMIS data conducted semi annually -Data Quality Improvement Plan for LMIS data developed for every DQA and implemented	aides (such as SOP for emergency procurements) Redistribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance. -Stock-control records such as stock cards and bin cards are well maintained

GHSC- PSM gave the following reasons for providing different scores from those provided by the CICA participants

- 4.1.1: GHSC – PSM have the same TA approach in all the counties where they provide support. Therefore, they feel that the score for 4.1.1 should be the same in Migori and Busia. In Busia, the SC TWGs were formed in early December 2017 .The score for Busia should therefore be at least 3 instead of 2. In Turkana GHSC are working in only half the county. All the 4 TWGs (County and 3 sub counties where GHSC are working have a Community Focal person as a member.

- 4.1.3: Busia should have scored 3 instead of 2 because they have SANITAS software at some health facilities and DHIS and KEMSA LMIS in all. In Mombasa for HIV assessment, each and every HIV site uses a different commodity data collection and reporting system: for instance IQCare, Health Commodities Management Platform (to be phased out once HIV commodities DHIS2 reporting takes effect) and KEMSA LMIS. GHSC therefore feel that the score should not have been zero. Turkana County uses the KEMSA LMIS (for ordering) as well as National DHIS for commodity data reporting. All the Pharmacists responsible for commodity reporting and all HRIOs are trained. GHSC therefore feel that Turkana should not score zero on this standard

- 4.1.4: Busia should have scored at least 3 instead of 1 considering that they have a County store