KENYA AND EAST AFRICA

USAID KENYA & EA

COUNTY MEASUREMENTS LEARNING AND ACCOUNTABILITY PROGRAM:

TUPIME KAUNTI

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USAID KENYA AND EAST AFRICA

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ACRONYMS AND ABBREVIATIONS

USAID	United States Agency for International Development
HIV	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
COP	Country Operational Plan
CHSSIP	County Health Sector Strategic and Investment Plan
M&E	Monitoring and Evaluation
CDH	County Director of Health
DDU	Data, Demand and use
DCS	Department of Children Services
AAC	Area Advisory Council
NASCOP	National AIDS & STI Control Programme
DQA	Data Quality Audits
C/SCASCO	County/Sub County AIDS and STI Coordinator
C/SCHRIO	County/Sub County Health Records and Information Officers
C/SCHMT	County/Sub County Health Management Team
MOH	Ministry of Health
RDQA	Routine Data Quality Assessment
CPIMS	Child Protection Information System
OVC	Orphans and Vulnerable Children
CDC	Centers for Disease Control and Prevention
DoD	Department of Defense
IPs	Implementing Partners
ICD10	International Statistical Classification of Diseases and Related Health Problems
CME	Continuous Medical Education
CAPR	Community AIDS Programs Reporting
IDSR	Integrated Disease Surveillance and Response
MOH	Ministry of Health
HTS	HIV Testing Services
DQA	Data Quality Assurance
SDPs	Service Delivery Partners
HIS/M&E	Health Information Systems/Monitoring and Evaluation
MLA	Measurements, Learning and Accountability
LDG	Leadership, Development and Governance
SOPs	Standard Operating Procedures

LIPs	Local Implementing Partners
CECM	County Executive Committee Member
COH	Chief Officer of Health
CDH	County Director of Health
DQIP	Data Quality Improvement Plan
HMT	Health Management team
TA	Technical Assistance
SWG	Sector Working Group
TWG	Technical Working Group
CHAMPS	Child Health and Mortality Prevention Surveillance
UHC	Universal Health Coverage
AWP	Annual Work Plan
TOR	Terms of Reference
ANC	Antenatal Care
FP	Family Planning
PLHIV	Persons Living with HIV
PMTCT	Prevention of Mother to Child Transmission
eMTCT	elimination of Mother to Child Transmission
HMIS	Health Management Information System
FY	Fiscal/Financial Year
MCH	Maternal and Child Health
HCWs	Health Care Workers
DMAs	Data Management Assistants
DQI	Data Quality Improvement
PEPFAR	US President's Emergency Plan for AIDS Relief
NMCP	National Malaria Control Program
MER	Monitoring, Evaluation, and Reporting
CMLAP	County Measurements, Learning and Accountability Program
ESI	Essential Survey Indicators
MEAL	Monitoring, evaluation, accountability, and learning
WHO	World Health Organization
OJT	On Job Training
GOK	Government of Kenya
NACC	National AIDS Control Council |
SCACC	Sub-County AIDS Control Coordinators

CSOs	Civil Society Organizations
CHS	Community Health Strategy
CHEW	Community Health Extension Workers
RH	Reproductive Health
PNS	Partner Notification Services
LLINs	Long-lasting insecticidal nets
APR&P	Annual Performance Review & Planning
CHAMPS	Child Health and Mortality Prevention Surveillance
PPS	Probability Proportional to Size
KNEAD	Kisii Network for Ecological Agriculture and Development

I. TUPIME KAUNTI EXECUTIVE SUMMARY

Tupime Kaunti is a USAID-funded activity with two main sub purposes: to increase leadership and management capacity of County governments for effective outcome measurements, learning, and accountability systems and to increase the availability, analysis and use of high-quality data for decision-making. The project works in eight counties of Kisumu, Migori, Kakamega, Busia, Bungoma, Vihiga, Kisii Homa Bay in addition to Siaya where the support is for malaria and OVC programs. The focus is to strengthen capacity and strategic information at county level in the program areas of Malaria, HIV and RMNCAH. This report covers the progress made by Tupime Kaunti project in quarter 2 of FY19. The report provides a summary of the progress made under each of the two sub-purposes, detailed key achievements, and constraints during implementation, opportunities and lessons learned. The progress report also details milestones attained towards the COP18 benchmarks.

Qualitative Impact

Sub-Purpose 1: Increase leadership and management capacity of County Governments for effective outcome measurements, learning, and accountability systems

Key Achievements

Output 1.1: Improved CHMT leadership and management capacity to develop and implement outcome measurements, learning and accountability policies, strategies, frameworks, guidelines and standard protocols.

- Increased leadership, ownership and improved capacities among the county and sub county management teams in the development of key strategic policy documents. Seven out of the eight counties (a part from Kisumu) developed their respective M&E plans to track the implementation of the 2018-2023 strategic plans using county-led consultative processes.
- Increased evidence of improved governance structures at the county level that steered implementation of the measurement, learning and accountability action plans. For example, during the quarterly County Directors of Health (CDH) caucus forum, a standard partner's reporting template was adopted for use. To enhance accountability, the caucus forum directed that all the implementing partners will share their quarterly reports to their respective County Departments of Health
- Evidence of increased collaboration and networking was noted in Kakamega, Migori and Busia counties when health partners developed work plans for prioritized activities to be undertaken jointly. The synergy has promoted leveraging on each other resources for the specific counties; adoption of best practices in implementation and has minimized duplication.
- The project, under the leadership of the Kenya School of Government (KSG) developed standard curricula for M&E and Data Demand and Use (DDU). Using the M&E curriculum, the project trained 19 M&E unit officers from nine counties including Siaya County as a means of improving their capacity to provide M&E leadership at their respective counties. A DDU training for thirty-six (36) officers drawn from the Department of Children Services (DCS) in Homa Bay, Kisumu, Migori and Kakamega counties. The training offered skills building in analysis and use of child protection data for planning and management. This will provide other counties and DCS at large an opportunity to send their staff to train at KSG using the standardized M&E for health systems and DDU for child protection courses.
- Enhanced efforts on M&E practices were institutionalization at county level. In particular, the project steered the formation of a community of practice for the M&E health practitioners to inculcate cross learning across the target counties. In addition, the project sensitized the CDOH – M&E units on the M&E Unit maturity model and the functionality assessment tool in 6 out of the 8 counties (except Bungoma and Migori). These are efforts to increase the counties' capacity to operationalize and measure M&E system strengthening initiatives as implementation go on.
- The project made progress in increasing capacities among the county and sub county management teams to conduct outcomes measurement. The project conducted a skills building session in Homa Bay County to granulate the 2018 HIV estimates in all the seven Sub Counties and 205 facilities using the probability proportionate to size technique. Granulating the estimates to Sub County and facility levels is a crucial step in tracking progress to 90-90-90 and achievement of epidemic control.

- Kisumu County convened Area Advisory Council (AAC) meeting to advance collaborative discussions in addressing child protection issues. Leveraging on NASCOP DQA 2018 dissemination, the project sensitized CASCOs, CHRIOs, SCASCOs, SCHRIOs, other select CHMT and select facility staff on the DQA protocol, 90-90-90 cascade and tracking, 2018 HIV estimates, and select indicators in the revised HIV M&E tools. 348 health staff were sensitized drawn from Busia, Bungoma, Kisii, Kisumu, Kakamega and Homa Bay counties.

Sub-Purpose 2: Increase availability, analysis and use of high-quality data

- The project increased its efforts of improving the quality of data through: a) promoting standardization of data quality initiatives among the CDHs and partners who support the various programs. This was accomplished by holding a joint MOH (Kisumu, Kakamega and Migori counties) and partner's data quality reviews in order to synthesize the DQA reports and develop a common approach to address data quality issues. b) The project established a standard practice to track data changes through development a data change documentation standard operating procedure. NASCOP adopted the data change SOP and in collaboration with NASCOP, disseminated the SOP in six counties together with the HIV DQA report. c) The project-facilitated automation of the NASCOP HIV DQA tool in MS-Excel to ease data collection and report regeneration for use by the counties during RDQAs and piloted it in Busia County.
- To address gaps in malaria data and strengthen quality monitoring of key malaria indicators, the project supported the development of data quality scorecards for malaria and disseminated it in four counties (i.e. Kisumu, Kakamega, Migori and Busia).
- Initiatives to improve effective use of CPIMS data entailed mentorship to 15 local implementing partners under MWENDO, conducting analysis of CPIMS data to inform OVC programming, monthly meetings with DCS, disseminating Kenya OVC DQA findings to CDC and DoD IPs and linking up with HealthIT to resolve the CPIMS end user needs on a weekly basis.
- The project improved quality and use of mortality data by conducting mentorship and supportive supervision on certification, mortality coding and reporting in DHIS2 in over 30 health facilities in Bungoma, Busia, Kakamega, Vihiga, Kisii, Kisumu and Migori. As a result, the counties developed data quality improvement action plans.
- The counties demonstrated improved capacity in data analytics by producing HIV profiles in 6 out of 8 counties (75%). In addition, Busia county developed a mortality fact sheet for the Busia County referral hospital as part of the efforts to generate data to inform decision making by the hospital management and county health leadership.
- To increase availability and quality of community data, the project sensitized Homa Bay county on CAPR to improve quality of data from community AIDS interventions. Further, the project supported Kakamega and Vihiga CDoH to conduct sensitization on IDSR tools and Kisii on CHIS tools to promote quality reporting.

Constraints and Opportunities

Constraints

- Health worker attrition (trained certifiers and coders) in health facilities affects continuity in implementation of ICD-10 as is the case now in Busia county. This warrants a need for regular continuous medical education. The project is working closely with the county ICD-10 resource team to conduct CMEs in select high volume facilities as per the arising needs.
- DHIS2 event report down time affects consistency in reporting at health facilities. The project is working closely with the county departments to engage MOH through the DHIS2 service desk and to ensure timely feedback on the issues raised. An issue log that documents DHIS2 system challenges is in place for regular escalation and tracking with HealthIT for action.

Opportunities

- The newly formed M&E community of practice for M&E officers, which is an online WhatsApp group platform, will provide an avenue for knowledge sharing, exchange of ideas and cross learning among M&E officers.

- NASCOP has capacity and resources that may be beneficial to the counties—for example, C&T and HTS DQA tools, county performance review templates and data use training curriculum. Cascading these to county level will result in savings (time and money) especially in materials production. However, these resources may require customization prior to application at the county level—for example; the NASCOP DQA tool- mobile app for data collection and requires retooling in Excel to make it appropriate for the counties and SDPs.
- Demand for dissemination and use of DCS data at lower levels by the County Commissioner is an opportunity to strengthen evidenced-based and targeted child protection interventions.

Subsequent Quarter's Work Plan

Output 1.1: Improved CHMT leadership and management capacity to develop and implement outcome measurements, learning and accountability policies, strategies, frameworks, guidelines and standard protocols.

- Facilitate Kisii, Migori, Kakamega and Busia LDG groups' module 3 training[1] and initiate modular training for Kisumu, Vihiga, Homa Bay and Bungoma counties in line with the capacity building plans.
- Support all counties to conduct quarterly M&E TWG meetings to advance HIS/M&E agenda.
- Support the LDG groups to convene quarterly meetings to advance their leadership and governance agenda, reporting to county assembly, LDG functionality and monitoring progress in the implementation of MLA system strengthening plan.
- Provide technical support to HIV TWGs to track the 90-90-90 HIV cascade.
- Mentor counties in use of quarterly reporting template to the County Assembly and advocate for partners to report to the department of health using the newly adopted partner-reporting template.
- Mentorship for county M&E unit officers to execute their M&E roles and functions.
- Facilitate LDG and M&E unit functionality assessment and use findings to inform capacity-building interventions.

Output 1.2: Strengthened county- and sub-county level outcome measurements, learning and accountability systems.

- Support the focus counties to complete development of M&E Plans and kick-start implementation. In particular, support Migori to implement new M&E Plan, Busia to share M&E Plan draft with broad stakeholders, and Kakamega, Vihiga, Homa Bay, and Bungoma to finalize and to share M&E Plan's drafts with stakeholders.
- Support Homa Bay to track progress of the HIV 90-90-90 targets and epidemic control at Sub County and facility levels.
- Support the remaining seven focus counties to granulate the 2018 HIV estimates and support them to track progress towards attainment of the 90-90-90 targets at Sub County and facility levels.
- Conduct sensitizations for M&E/HIS Units and CASCOs to standardize application of outcome measurements methods for HIV estimations and performance reviews.
- Disseminate SOPs for HIV 90-90-90 tracking and distribution or granulation of county estimates to Sub County and facility levels.
- Support Counties to document and share outcome measurements results in learning forums.
- Provide technical assistance to the M&E/HIS Units and CASCOs on using basic reproduction number (*R_0, or R naught*)[2] to measure and track epidemic control at the county level.

Output 2.1: Improved capacity of county health management teams in data management systems (DHIS2, CHIS, LMIS, EMR, COBPAR, CRVS, and CPMIS) to generate high-quality data.

- Support counties to track implementation of data quality improvement plans.
- Facilitate counties to hold data quality forums including the mortality data.

1 Communication strategy, Resource mobilization and Budget execution

[2] This metric is useful because it helps determine whether or not an infectious disease can spread through a population. When $R_0 < 1$ the infection will die out in the long run. But if $R_0 > 1$ the infection will be able to spread in a population. Generally, the larger the value of R_0, the harder it is to control the epidemic.

- Conduct a Data Demand and Use training for DCS staff from Siaya, Kisii, Busia, Vihiga and Bungoma counties.
- Undertake CPIMS mentorship for OVC Local Implementing Partners (LIPs) and DCS staff.
- Steer OVC LIPs to conduct OVC data validation to improve on quality data reporting.
- Conduct routine data quality assessments with county DCS staff in the focus counties.
- Continuous Medical Education sessions (CMEs) and/or mentorship on death certification and mortality coding in Homa Bay, Kisii, Kisumu and Bungoma counties.
- Enhance accountability in ICD-10 implementation by supporting department of health to monitor implementation of action plans at facility level and track reporting rate in the DHIS2 event report.
- Support CAPR sensitization and data review meetings in Migori and Kisumu counties to improve quality reporting of community AIDS interventions.
- Support Kisumu and Siaya CDoH to conduct sensitization on IDSR tools and reporting to promote quality reporting.
- Support Kisumu, Kakamega and Vihiga counties to conduct sensitization on CHIS tools and reporting to promote quality reporting.
- Enhance the DHIS2 skills of program and data managers in Homa Bay and Kakamega counties to mine, analyze, visualize and share programmatic dashboards that promote data quality and program management through sensitization in development of DHIS2 Dashboard.

Output 2.2: Increased capacity of county health management teams in data analytics.

- Support capacity building (follow-up/mentorship) on data analysis and visualization techniques for Migori and Bungoma.
- Mentor Bungoma county on mortality data analysis.
- Support counties in the development of quarterly HIV profiles and semi-annual HIV scorecards and other information products (World Malaria Day Fact sheets).

Output 2.3: Strengthened capacity of county health management teams to demand for and use routine programs, surveys, and surveillance data for program planning and management.

- Finalize draft data use plans for Kisii, Vihiga, Kakamega, Bungoma, Homabay and Busia.
- Support Busia, Homabay and Migori counties to consolidate AWP 2019/20.
- Support data demand and use training for Kisii, Bungoma, Vihiga and Busia and Siaya DCS officers.

II. KEY ACHIEVEMENTS (QUALITATIVE IMPACT)

Sub-Purpose 1: Increase leadership and management capacity of County Governments for effective outcome measurements, learning, and accountability systems

Output 1.1: Improved CHMT leadership and management capacity to develop and implement outcome measurements, learning and accountability policies, strategies, frameworks, guidelines and standard protocols:

1.1.1: Institutional capacity strengthening for the LDGs to deliver their mandate

To track COP18 benchmark that seeks to enhance HIS and M&E policy implementation, learning and accountability mechanisms, the project supported the LDG groups in the focus counties to implement their work plans and capacity building plans. Kisii, Migori and Kakamega LDG groups undertook modular training sessions aimed at building their skills on identified MLA gaps. Further, a training on budget execution and resource mobilization was conducted for the LDG group in Busia to address a key gap on lack of a resource mobilization strategy for health.

In the reporting period, the project continued to mentor LDG group members on policy development to address some of the gaps identified during the MLA baseline and the recently conducted pulse assessment[3]. The mentorship package included; providing templates for development of policy documents, joint reviews of the draft policy documents with experts and peer to peer review of the policy documents. As a result of these interventions, Migori developed a draft communication strategy while Kakamega and Busia commenced development of the respective county resource mobilization strategies for the department of health. In addition, Kakamega County constituted a budget execution committee as a result of the knowledge gained from the budget execution training. This committee comprises of the CECM, CoH, CDH, Treasury and Planning; and is charged with the mandate of reviewing budget requests for the department of health to inform disbursement and execution. The strategic value of the internal budget execution committee is in ensuring balanced and justified budget sharing among the various units. The skills obtained from LDG group modular training have proved to be effective in developing policy documents from the targeted trainings.

Text box 1: LDG Group Policy Development Progress

- **Migori** – Communication Strategy (Draft)
- **Kakamega** – Resource mobilization strategy (Draft)
- **Busia** – Resource mobilization strategy (Draft)

The project also provided technical assistance (TA) to Bungoma CHMT to synthesize the sector working group report (SWG) and generated evidence to inform the agenda for an advocacy forum with the County Assembly. The CHMT utilized the evidence in advocating for increased resource allocation to health prior to submission of the supplementary budget. Migori and Vihiga LDG groups, through their CECMs also engaged the respective county assemblies to validate their CHSSIP 2018 – 2023.

In the next reporting period, the project will facilitate counties to hold quarterly LDG meetings, support Migori, Kisii, and Kakamega and Busia LDG groups to complete their modular training session as well as initiate modular trainings for Kisumu, Vihiga and Homa Bay. In Bungoma, the project will prioritize efforts to sensitize the CHMT on adoption of the LDG concept and once this is achieved, proceed to develop their work plan, identify capacity gaps before commencement of modular trainings. Further, the project will provide mentorship to LDG/CHMT in reporting to county assembly health committee using the adopted quarterly reporting template.

1.1.2: Institutionalize MLA systems and monitor implementation of existing M&E and HIS policies, guidelines and standards

The project supported all counties to advance development of County Health Sector Strategic and Investments Plans 2018 – 2023. Details of this progress is covered under 1.2.1. Kakamega, Vihiga and Bungoma counties utilized the draft CHSSIP in the development of Annual Work Plan (AWP) for FY 2019/20.

During the reporting period, the project facilitated 6/8 counties to develop draft M&E plans 2018-2023 except Kisumu. The plans were informed by the findings of the end term reports for CHSSIP 2013-2017. The M&E plans outline how the tracking of the CHSSIP 2018-2023 will be conducted. Kisumu developed a costed roadmap for the development of M&E plan in the subsequent quarter. With technical support from the project, Kisii County validated the department of health M&E plan in collaboration with stakeholders. The project is providing support to remaining counties to finalize and validate their M&E plan in the next quarter.

To track progress of HIS/M&E policy implementation, Kisumu reviewed the status of implementation of action plans developed during the last HIS/M&E policy review. The remaining counties will be supported to review status of implementation of action plans and findings discussed in the next M&E TWG/CHMT meetings. As a way forward, the project will facilitate all counties to finalize and disseminate CHSSIP and M&E plans to all stakeholders for their operationalization. In addition, the project will facilitate

[3] One of the key findings of the pulse assessment was that counties lacked resource mobilization strategies, which was an impediment to their proactive search for resources to support health initiatives. In addition, the counties did not have communication strategies which meant that some staff did not get effective communication to act on timely.

LDG/CHMT to develop and disseminate HIS/ M&E policy implementation monitoring SOPs as well as provide technical assistance towards implementation of gaps identified from the policy monitoring exercise.

1.1.3: Strengthen and align stakeholder coordination and strategic partnership mechanisms for the department of health, DCS and CRS

Management of health sector stakeholders and partners is critical to improve coordination and increase efficiency. Kakamega LDG group developed a stakeholders' coordination framework with TA from the project. To further streamline stakeholder coordination, the project provided technical support to focus counties to operationalize the earlier developed stakeholder's frameworks through Technical Working Groups (TWGs) and AAC meetings. In particular, Kisumu, Vihiga and Kisii counties utilized their stakeholder coordination framework developed by the LDG groups to invite participants during stakeholder's forum conducted within the quarter.

The stakeholder's forum in Kisumu provided a platform for harmonization of TWGs and sub committees by program/thematic area. As a result, the county harmonized the number of TWGs, disseminated preliminary findings of the ongoing Child Health and Mortality Prevention Surveillance (CHAMPS) and invited participation of stakeholders in the upcoming UHC conference planned for May 2019. In Vihiga, the county stakeholder's forum adopted the quarterly partner-reporting template and agreed to update partners' contacts in the electronic inventory. The forums in Kisumu and Vihiga also emphasized the need for partners to align their activities to the departmental work plan and partners' participation in joint planning as a means to strengthening effective collaboration.

The Department of Children Services (DCS) - Kisumu held a quarterly Area Advisory Council (AAC) meeting. This is in line with the project's COP18 Benchmark, which requires public participation in planning, management, monitoring and evaluation of child protection. The project provided technical support to the County Children's Coordinator to extract data from CPIMS and summarize the number of case categories per sub-county for the period July 2018 to February 2019 for discussion during the meeting. AAC members noted an increase in child neglect and custody for children cases; calling for enhanced collaboration among stakeholders. The AAC requested Tupime Kaunti to sustain data analysis support to DCS and implementing partners to ensure sustained use during AAC meetings for informed decision-making as part of the capacity systems strengthening initiatives.

The departments of health in Kakamega, Vihiga, Migori, Kisii, Busia and Bungoma counties convened quarterly M&E TWG meetings to review HIS/M&E activities in the AWP 2018/19 utilizing a tracking template developed by the project. A key gap noted across the six counties, was inadequate capture of M&E activities in the FY 2018/19 AWP. To address this gap, the TWG members resolved to ensure inclusion of all M&E/HIS activities in the AWP for FY2019/2020; in line with the draft CHSSIP 2018 – 2023, for ease of tracking their implementation in subsequent quarterly M&E TWG meetings.

Kisumu, Bungoma, Vihiga and Homa Bay counties conducted quarterly HIV TWGs. The Kisumu, Vihiga, Bungoma and Homa Bay HIV TWGs finalized development of and adopted ToRs and further developed activities for the April – June 2019 implementation period. In addition, the HIV TWG in Kisumu conducted a sensitization for its members on the proposed outcome measurement framework and members requested to provide feedback on the proposed framework.

In strengthening public participation in planning, management, monitoring and evaluation, the project will continue supporting counties to conduct quarterly TWGs, AAC and stakeholder's forums in the subsequent quarters. The project will also provide technical support to DCS during quarterly AAC to streamline data-driven discussions on child protection issues.

1.1.4: Strengthen platforms for learning and institutionalize learning to inform evidence based planning and accountability

To realize COP18 benchmark that seeks to strengthen learning and accountability structures, the project facilitated participatory learning interventions by institutionalizing learning as part of the agenda for the LDG groups and M&E TWG meetings. Kisii M&E TWG identified two learning agenda; on understanding the barriers to utilization of RMNCAH services (4th ANC, FP and Vitamin A supplementation) and the

status of data quality. These learning questions will be addressed through synthesis of DQA reports and collaborative discussions at the M&E TWG.

To enhance learning at leadership level, the project facilitated CDH from the nine counties to hold the second quarterly CDH caucus meeting. The Kenya School of Government facilitated this meeting which provides a platform for peer to peer cross-county learning as well mentorship on leadership and governance. During this forum, the project sensitized CDHs on the status of mortality reporting for each county; the importance of accurate and timely mortality data in the DHIS2 event capture module and the outcomes of previous malaria data quality initiatives. The CDH team also reviewed and adopted the partner quarterly reporting template and department of health quarterly reporting template to the county assembly.

The project supported LDG groups of Vihiga and Migori to enhance accountability mechanisms with the County Assembly. Notably, Migori and Vihiga counties engaged the respective County Assemblies to approve and sign off the departments' CHSSIPs. In next reporting period, the project will support the LDG groups, TWGs and other forums to advance the learning agenda towards institutionalization of learning to inform evidence-based planning and accountability.

1.1.5: Strengthen capacity of the M&E units

During the reporting period, the project undertook targeted activities to strengthen M&E systems in all focus counties (except Bungoma which has not deployed a dedicated M&E officer). The project interventions focused on strengthening the capacities of the newly appointed M&E officers. The M&E units contribute significantly to the implementation and monitoring of the HIS and M&E policies as per the COP18 benchmarks. To build capacities of the newly appointed M&E officers, the project conducted a modular M&E training for M&E officers and representatives from nine counties that covered the scope of work for the M&E units. The M&E training sought to address the limited capacities to implement M&E systems strengthening activities.

Text box 2: Support to M&E Unit

- Trained 19 M&E officers on M&E
- Established community of practice for all M&E officers
- M&E unit functionality assessment
- Mentorship in the development of M&E plan

Following the training, all the 19 M&E officers received support to undertake a work place assignment that informed a forum for peer-to-peer review. At the end of the review and feedback session, the M&E officers who participated in the training reported that the skills gained were beneficial to them in the ongoing development of M&E plan. The project continues to strengthen Bungoma HIS unit to provide leadership in the development of M&E plan for the department of health.

The project also developed and sensitized all trained M&E officers on a M&E maturity model. The maturity model outlines the progressive steps that the M&E officers should attain towards a fully functional and sustainable M&E unit. The project also developed an M&E unit functionality assessment tool that will be utilized to assess M&E units' functionality status in the subsequent quarter. Sensitization on the tool was conducted for M&E officers from seven counties (except Migori and Bungoma) in readiness for assessment. In the next reporting period, the project will support the M&E officers to assess their progress towards full functionality.

To enhance continuous learning and peer-to-peer support, the project sensitized M&E officers on the value of communities of practice. The sensitization emphasized the need for structured informative discussions as a way of promoting learning in M&E. The M&E officers established a WhatsApp group community of practice platform, which is being moderated by three county M&E officers with technical support from the project. In the next reporting period, the project will facilitate the M&E officers to enhance peer to peer learning.

Output 1.2: Strengthened county- and sub-county level outcome measurements, learning and accountability systems.

1.2.1: Strengthen institutional and individual capacity to carry out outcome measurements for HIV, malaria and RMNCAH

The purpose of M&E Plan for CHSSIP 2018 - 2023 is to steward the sector towards establishing one M&E system for improved transparency and accountability in health at all levels. It provides a framework for monitoring, reporting and evaluation of the CHSSIP by elaborating indicators, performance targets, data analysis and use, and M&E activities. This is in line with project sub-purpose 1.1 of increased leadership and management capacity of county governments for effective outcome MLA systems. It is also in line with the project's COP18 benchmark which requires that at least 30% of focal counties evaluate or review the effectiveness of implemented policies, guidelines and/or standards.

During the quarter, focus counties prioritized development of M&E Plan for CHSSIP 2018 - 2023. The Migori M&E plan, developed and validated in Quarter 1, was approved by top leadership. Kakamega, Vihiga, and Homa Bay counties commenced development of the M&E Plan 2018-2023 with the support of the project. For each county, the process was guided by a roadmap developed by the M&E TWG.

"Although Kakamega county had developed a M&E plan for the first CHSSIP 2013-17, the current draft is more comprehensive and reflective of the health sector priorities. Furthermore, unlike the previous one, the plan for CHSSIP 2018-2023 was developed by the department; not a consultant. Increased understanding of the plan and its purpose will therefore enhance ownership and in turn implementation. The consolidation exercises were supported by the USAID Tupime Kaunti project. Tupime Kaunti also trained the county's M&E Unit staff in preparation for the development of the M&E plan." **Dr. John Otieno (Seated second from left), M&E unit focal person Kakamega.**

Tupime Kaunti project provided both technical and financial support during the M&E plan drafting workshop. Kisii County mobilized other implementing partners who co-funded the M&E plan drafting process. During these workshops, the M&E plan development teams led by the CDOH consolidated the first drafts. To ensure ownership and meaningful involvement in the development process, CDOHs also shared the drafts with CHMT and stakeholders for input and feedback.

During the quarter, Kisii and Busia counties finalized review of the M&E plan draft. The drafts incorporated both the stakeholders and CHMT inputs. Importantly, both counties costed and aligned the M&E plan drafts to the draft CHSSIPs, validated, and included all the requisite tools (i.e. data management SOPs, and data use plans among others). This penultimate step of the M&E Plan development was supported by the project. In addition, Kisii shared the final M&E draft with broad stakeholders for inputs and buy-in ahead of endorsement by top leadership pending the launch under the support of the project.

"Development of the first M&E plan for Busia county commenced three months ago with support from Tupime Kaunti project. My expectation is that the plan will facilitate operationalization of our newly established M&E unit. Importantly, the plan will expand the functions of the unit beyond provision of ad hoc routine service delivery reports and thus enhance access to information on the sector's performance against the targets in the CHSSIP and county investments. To ensure effective implementation of the M&E plan, the department will prioritize among

them recruitment of special cadres including an economist for the M&E unit and continuous capacity building on functions such as data analysis and reporting." - Dr. Melsa Lutomia, County Director of Health - Busia.

All the counties except Kisumu (87.5%) developed and/or completed the M&E plan 2018 - 2023 through a county-led and consultative process. The project worked with all the counties in the development of the M&E plans to ensure alignment to Kenya Health Sector M&E Framework, Kenya Health Sector Strategic and Investment Plan and CHSSIP. To ensure sustained capacities and foster ownership, the project worked closely with all the M&E plan development teams to facilitate transfer of knowledge and skills. For example, application of activity-based costing to develop costed M&E work plan. Activity-based costing is a preferred methodology for programme-based budgeting. This approach further ensured prioritization of outcome measurements, data analytics, and Data Demand and Use. The guiding principles of the project's support for M&E plan development were skills transfer, county ownership, effective stakeholder engagement, and institutionalization of outcome measurement. For example, the M&E Unit in Kisii County consolidated a draft M&E plan on their own prior to constituting a M&E plan development team. This is reflective of increased capacities in policy development attributable to skills impacted through LDG group trainings and from development of the outgoing M&E plan. The development of the outgoing M&E plan was supported by the project. In the subsequent quarters, the project will support the focus counties to finalize the M&E plans and to usher in the implementation phase.

1.2.2: Standardize outcome measurements across policies and guidelines and monitor their implementation

Regular performance review of the HIV prevention and treatment efforts at the county level is required to gauge programme effectiveness to inform planning, implementation, and resource allocation. During the quarter, the project leveraged on NASCOP DQA 2018 dissemination to sensitize CASCOs, CHRIOs, SCASCOs, SCHRIOs, and other select CHMT and select facility staff on the DQA protocol, 90-90-90 cascade and tracking, 2018 HIV estimates, and the selected indicators in the revised HIV M&E tools. The NASCOP DQA 2018 dissemination was undertaken jointly with NASCOP, Tupime Kaunti and HIV Service Delivery Partners (SDPs). A total of 348 health workers from Kisii, Busia, Kakamega, Kisumu, Homa Bay, and Bungoma counties participated in the DQA dissemination (See Table I)).

Through this activity, focus counties were sensitized on monitoring 90-90-90 targets using 2018 HIV estimates. As a result, counties committed to apply the NASCOP guidance on distribution of the HIV estimates to sub-county and facility levels using Probability Proportional to Size[4] (PPS) with the number of patients Current on ART as the proxy for number of HIV infected persons identified (i.e. 1st 90). In the subsequent quarter and as follow up to this orientation, the project will disseminate SOPs for 90-90-90 tracking and distribute granulated county estimates to sub-county and facility levels.

Table 1 Health Staff Sensitized on the 90-90-90 HIV cascade Tracking, 2018 HIV Estimates and the Revised MOH HIV Tools

	County Staff	Sub County Staff	Facility Staff
Kakamega	6	24	34
Homa Bay	6	16	40
Kisii	6	18	32
Busia	6	14	32
Kisumu	6	14	36
Bungoma	6	20	32
Total	**36**	**106**	**206**

During the quarter and as a follow up to the sensitization on monitoring 90-90-90 targets, the project provided technical support to Homa Bay in target setting targets using the 2018 HIV estimates. The county

[4] **Probability proportional to size** (PPS) sampling is a method of sampling from a finite population in which a **size** measure is available for each population unit before sampling and where the **probability** of selecting a unit is **proportional** to its **size**

distributed 2018 HIV estimates to seven sub counties and 205 facilities and further granulated data on the PLHIV or HIV burden for children, adolescents, young adults, and adults. Granulating the estimates to sub county and facility level is a crucial step in tracking progress towards 90-90-90 and achievement of epidemic control at the lower levels. Homa Bay is now ready to undertake localized estimation of 90-90-90 for geographic prioritization and evidence-based allocation of resources in a way that maximizes impact and efficiency. In the subsequent quarter, the project will support Homa Bay to granulate PMTCT need based on the 2018 HIV estimates and improve tracking of progress towards 90-90-90 targets and epidemic control at sub county and facility levels. The project will also support the other focus counties to granulate their 2018 HIV estimates for effective tracking and progress monitoring.

During the quarter, the project continued to standardize outcome measurements across policies and guidelines with Kakamega, Vihiga and Homa Bay counties prioritizing outcome measurement for HIV, malaria and RMNCAH in their draft M&E plans. All the three focus counties commenced developing their M&E plans in the quarter. So far, a total of seven focus counties have agreed to include priority outcome measures in M&E plan 2018 - 2023. The project had already successfully engaged all the focus counties on inclusion of priority outcome measures in CHSSIP 2018 - 2023. The priority outcome measures for the HIV program are 1st 90, 2nd 90 and 3rd 90 indicators together with the eMTCT indicators. Priority outcome indicators are county-specific core HMIS indicators for HIV, malaria and RMNCAH programs identified in FY18 through stakeholder engagement approach supported by the project. The standardization is an important step towards increasing capacity of county governments for effective outcome measurements, learning and accountability systems. In subsequent quarter, the project will engage the counties to ensure that outcomes measurement is also standardized in AWP 2019/2020.

Sub-purpose 2: Increased availability, analysis and use of quality data

Output 2.1: Improved capacity of county health management teams in data management systems (DHIS2, CHIS, LMIS, EMR, COBPAR, CRVS, and CPMIS) to generate high-quality data.

2.1.1: Support the Health Management Teams at county and sub-county levels to conduct data quality assurance activities.

During the quarter, the project strengthened the data quality assurance initiatives in all counties towards standardization and institutionalization of DQA/DQI activities in line with COP18[5] benchmark. These initiatives included HIV DQA dissemination, joint MOH and partners DQA forum, development of the data change documentation SOP, dissemination of national health DQA protocol and follow up of data quality improvement initiatives.

Tupime Kaunti project convened a joint MOH and partner's data quality assurance (DQA) forum for Kisumu, Kakamega and Migori counties. The forum provided a common understanding of the national health sector DQA protocol, the need to harmonize partner DQA interventions and commitment by partners on mutual accountability to the counties DQA initiatives. During the forum, both the county teams and implementing partners teamed up and synthesized recent HIV, Malaria and RMNCAH DQA reports to bring to focus the underlying DQA issues. Several issues emerged during the forum and joint resolutions to strengthen data quality assurance were reached as shown in table 2.

Table 2 Data Quality Gaps and Proposed Interventions

EMERGING ISSUES	FORUM RESOLUTIONS
• **Different DQA tools used by different partners leading to lack of uniformity.**	• Establish Data Quality improvement teams at county and other health levels. • County and partners to harmonize the DQA tools per program area for uniformity.
• **Limited or lack of RDQA reports hence no evidence.**	• Write DQA reports and disseminate to all the relevant stakeholders for all DQAs done.

[5] Standardized DQA/DQI activities institutionalized as part of targeted data reviews and data alignment by DCS, CASCOs and PEPFAR funded IMs in 8 counties. 100% counties plan and implement DQA/DQI with support from external partners

• **Data changes not documented as they happen resulting in lack of trail.**	• Implement the data change documentation SOP.
• **Lack of involvement of county structures in the RDQA activities resulting in lack of ownership. Limited implementation and follow up of DQI plans which devalues the role of DQA.**	• Jointly implement DQA and track data quality improvement plans.
• **Limited awareness on the DQA protocol by sub counties and facilities resulting in limited use.**	• Continuous dissemination and sensitization of health care workers on the DQA protocol
• **Poor data quality across indicators, sites and programs from the RDQA reports synthesis.**	• Conduct RDQA report synthesis to guide in implementing targeted interventions • Capacity build the data management staff on data management process and DQA processes. • Institutionalize DQA initiatives

The participants also shared best practices on DQA implementation among them: color coding of attendance of MCH ANC mother's visits in Kisumu and Migori; Use of WhatsApp group in Kakamega and Migori to share the community reporting rates across the stakeholders and the sub county meeting and paper-based reporting using HTS data-pairing HTS counsellor and an M&E officer to review data.

To initiate and standardize the procedure for tracking the submission, review, implementation, and approval of all data changes in summary tools and DHIS2 at facility level, the projected in consultation with the counties developed and disseminated the data change documentation SOP. The SOP was presented during the DQA forum. In addition, NASCOP adopted the SOP and the project disseminated it in six counties; where it is being piloted. In the next quarter, the project will work with the counties to pilot the SOP, collect feedback and finalize it.

In next quarter, the project will continue providing technical support to Kisii, Kisumu and Busia counties to hold data quality forum towards realizing unified DQI/DQA initiatives.

Text box 3: Other areas participant were sensitized on during dissemination

- Data change documentation SOPs
- National DQA protocol
- Indicator definition
- Select HIV tools

The project in collaboration with HIV Service delivery partners worked with NASCOP and the counties to disseminate the 2018 HIV DQA findings in Bungoma, Kakamega, Busia, Kisii, Kisumu and Homa Bay counties. The participants from facilities and sub-counties jointly with partners developed data quality improvement plans. During the dissemination the project also sensitized the counties on the need to document data changes in manual and electronic tools including DHIS2. The project in collaboration with county teams also undertook a joint review of the proposed data change SOP resulting in buy pending further engagement with HIS unit in NASCOP for formal adoption of the SOP and the tool. Led by the respective County AIDS and STIs Coordinators (CASCOs) and County Health Records and Information Officers (CHRIOs), Tupime Kaunti and NASCOP supported counties and the implementing partners to interrogate findings, discuss the root causes of the identified data quality issues and develop joint Data Quality Improvement (DQI) plans for facilities, counties, sub county level managers and implementing partners. It was agreed that the facilities and sub-counties should work with IPs to support implementation of DQI plans and HCWs should utilize available online training opportunities on the revised tools. The forum further proposed strengthening of the HIV TWGs to drive the DQA agenda. The agenda includes continued sensitization on the DQA protocol and standardized DQA activities across all facilities, implementation and monitoring of the data quality improvement plans. In the next quarter, the project will provide technical support to CHRIOs, CASCOs and Data Management Assistants (DMAs) to track the implementation of the DQIPs across the counties.

The project provided TA to Vihiga county to conduct a HIV DQI implementation follow up in facilities and a follow up meeting for all facilities where HIV DQA had been conducted in 2018 to track the implementation status. The two facilities visited showed varied implementation levels of the DQIPs where

Coptic had implemented most of the actions whereas Vihiga County referral hospital had completed a few of the actions. Coptic hospital HIV DQIP status is shown in Table 3 as an illustration.

Table 3 Coptic Hospital DQIP Status

Gaps	Status
Data discrepancies and lack of registers	• Tools were ordered and received except the MOH 731 summary tool
Knowledge gap on tools	• 7 staff completed the online tools training • Mentorship done by SCASCO • Other staff on course with the online training
Lack of forum to discuss data	• Facility HMT data review was operationalized
Facility not conforming to recommended MOH tools	• Facility not using green cards; the form in use captures all the required details • Plans to go paperless and adopt IQCare in April 2019

During the follow up meeting, facilities presented the progress and challenges encountered during implementation. Issues identified were addressed and new actions developed. Notably, most of the facilities had implemented their DQIPs. To sustain the gains, the project encouraged represented facilities to upload data into data warehouse. The meeting further agreed to incorporate actions from the ongoing AMPATH Plus HIV DQA in the current DQI Plans for joint follow up. The project will, in the next quarter, work with the CASCO, DMA, CHRIO and partners to track the implementation of all active DQIPs.

To ease data collection and RDQA report generation, the project automated the NASCOP DQA tool and worked with Busia and AMPATH Plus to apply the tool during RDQA conducted in seven facilities. In preparation for the RDQA, the project took the MOH and AMPATH Plus team through, the draft NASCOP DQA guidelines, selection of sites and indicators, administration of the NASCOP tool and action plan development. The results realized towards improving quality of data contributes to strengthening data quality assurance systems necessary for the realization of the 90-90-90 targets. Subsequently, the project will advocate for use of the automated tool by other counties and partners for HIV RDQA.

To further strengthen the identification and monitoring of malaria data quality gaps, the project developed a scoreboard tool based on aggregate malaria data in DHIS2. The tool highlights facility, sub county and county level malaria data quality gaps. The tool was disseminated and adopted during various data reviews and TWGs in Kakamega, Busia, Bungoma, Kisumu, Siaya, Homa Bay counties. The tool was further shared with NMCP for review and adoption. In the subsequent quarters, the project team will seek feedback on the scoreboard from the users and enhance the tool based on user requirements while scaling up its use to improve malaria data quality in all focus counties.

2.1.2: Institutional capacity strengthening for the DCS and USG OVC IPs at county and sub-county levels to conduct data quality assurance activities.

In the reporting period, the project supported analysis of OVC data in CPIMS, dissemination of the 2018 DQA report to CDC and DOD supported local OVC implementing partners, preparatory meetings for CPIMS OVC data validation with DCS and dissemination of monitoring, evaluation and reporting essential survey indicators with MEASURE Evaluation. These activities are steps towards achieving COP benchmark which envisions standardized DQA/DQI activities are institutionalized as part of targeted data reviews and data alignment by DCS and PEPFAR-funded implementing partners in the eight counties.

The project supported analysis of system generated data for all MWENDO LIPs. The focus was on identifying data quality gaps in OVC registration list and service provision to OVC. The gaps formed the basis for data quality review meetings with 15 MWENDO LIPs. Next steps include quarterly RDQA with MWENDO LIPs, monthly reviews of system generated reports and monthly data quality reviews to track progress.

The project supported the dissemination of 2018 Data Quality Audit (DQA) findings to CDC and DOD supported OVC LIPs. The goal of the DQA was to verify the routine PEPFAR MER indicators, namely OVC_SERV and OVC_HIVSTAT and to assess whether the local implementing partners' M&E systems have been appropriately adapted to collect and analyze OVC MER indicator data as per the new MER 2.3 guidelines. Key gaps among the LIPs included use of non-standard OVC tools, incomplete records and poor documentation of services provided. The project developed action plans jointly with the implementing partners to support tracking of data quality improvement plans by instituting quality controls and SOPs in data management; triangulation of data from source documents and provision of early signal for missing information from CPIMS generated reports as part of the efforts to enhance data quality and improve case management. In the next quarter, the project will also work with OVC IPs to conduct RDQAs at the LIP level in addition to tracking DQI plans and review of data quality for system generated data.

In order to achieve a unitary system for both child protection and OVC data, the project in collaboration with DCS, CMLAP II, HealthIT and OVC IPs kicked off initial steps for OVC data validation. The validation process is spearheaded by DCS. The initial tasks included developing the methodology and tool for OVC data validation. The validation exercise will be conducted in the next quarter and the results will be used to inform the merging of child protection data and OVC program data into a single database.

The project, working with MEASURE Evaluation, disseminated the findings of OVC essential survey indicators of 2018 for MWENDO, Timiza 90 and Henry Jackson Foundation as part of PEPFAR's requirements for monitoring, evaluation, and reporting (MER) of OVC programs which includes collection of nine essential survey indicators (ESIs) every two years. A comparison with the 2016 showed marked improvements in the positive indicators and a reduction in the negative ones in the nine indicators. The project will use CPIMS generated program data for tracking progress in outcome indicators on a quarterly basis to inform improvement in OVC programming.

2.1.3: Strengthen data management capacity at county and sub county levels on CPIMS

In order to strengthen data management capacities on CPIMS, the project supported mentorship visits to OVC LIPs, a data demand and use (DDU) training and system functionality meetings with HealthIT and OVC IPs. These activities are in line with COP benchmarks which requires 50% of CPIMS users to demonstrate system use competency score of 3.0 out of 5.0 and 100% fulltime CPIMS system availability for targeted users.

The project in collaboration with MWENDO project conducted CPIMS mentorship to 15 MWENDO LIPs. The LIPs supported included Mother Francesca, Catholic Diocese of Kitale, Diakonia Compassionate Ministry, CABDA, Life skills, KWOSP, Make me Smile, Jiu Pachi, WIMA, FLEP, Church of Province Western Kenya services, Hope for Victoria Children, Blue Cross, CREADIS and Green Zone Agencies. The visits were informed by the results of the capacity assessment that provided insight into the level of confidence in utilization of CPIMS. The mentorship focused on troubleshooting of CPIMS challenges, data entry processes and generation and use of CPIMS reports. Realignment challenges impacting on permissions and rights of the users in CPIMS were also addressed. The mentorship improved access and enhanced the end users' capacities to optimally utilize CPIMS. CPIMS data management standard operating procedures and user manual were provided for further reference. The project in collaboration with MWENDO will continue to utilize the quarterly meeting with MEAL officers to provide mentorship to the LIPs.

To increase demand for and use of child protection and OVC data in planning, programming and decision making, the project conducted a training for 36 DCS staff from Kisumu, Kakamega, Homa Bay and Migori counties and one IP staff on data demand and use of CPIMS data. This was facilitated using the DDU modular curriculum developed in collaboration with DCS and KSG. The training focused on partnership and collaboration, communication, data analysis, and data demand and use. The immediate outcome showed an improvement in the participants' scores from 53% in pre-test to 66% in the post-test. The project will work with DCS to monitor utilization of DDU skills gained and instances of data use.

Tupime Kaunti worked with DCS to convene monthly meetings with the sub-county children officers and statutory institution managers in Kisumu, Migori, Kakamega and Busia counties. The meetings provided an opportunity to review data entry gaps using the case record sheets and excel tools into CPIMS for the current financial year. Based on the gaps, the sub counties and institutions received support to conduct data

entry to CPIMS and lay out sustainable strategies for regular update of CPIMS. Next steps include implementation of daily capture of data in CPIMS using available DCS staff; review of all pending cases in CPIMS to determine closure in CPIMS; provision of monthly updates on data entry progress and convention of monthly data quality review meetings.

To ensure 100% of CPIMS availability and functionality, the project held meetings with HealthIT and CMLAP II on system requirements by the OVC IPs. Among the system requirements raised by OVC IPs for prioritization include system development to capture the new case management OVC tools for supporting MER Version 2.3 indicators. Other system enhancements raised include enhanced user-friendly interface and data validation rules. As a follow up, the project supported working sessions to test the system for case plans, wellbeing assessment and case plan readiness assessment tools already developed in the system. The meeting also raised the need to align the system tools to the physical ones. The project also supported a user acceptance meeting with OVC IPs. Next steps include completion of reporting module to capture MER Version 2.3 reporting requirements, regular update of system enhancements made and gathering of new enhancements for escalation to the system developers.

In collaboration with DCS and HealthIT the project conducted systems requirement gathering for DCS in line with the issues frequently encountered and raised by the end users. Key items discussed fronted inclusion of case management in the institutions to enhance follow-up and referrals, addition of online abuse case categories and strategic interventions categories, inclusion of a comprehensive Presidential Bursary program and integration of “Child helpline-116” within CPIMS. The next steps include working with CPIMS developers to enhance the system with the DCS requirements.

2.1.4: Strengthen the quality of mortality data

The project has through mentorship, support supervision, continuous medical education sessions and utilization of existing department of health coordination structures such as technical working groups, championed increase in coverage of death registration and use of ICD-10 in targeted health facilities. These interventions have created opportunities for informed discussions and data sharing among health workers and managers guided by mortality and cause of death data. In quarter 2, the project mentored a total of 91 health care workers from 25 health facilities in Migori, Busia, Bungoma, Kisii, Kakamega and Vihiga counties on certification and coding based on gaps identified during facility based mortality and cause of death data quality reviews. The county ICD-10 resource team conducted support supervision in health facilities in Kisumu and Busia counties for accountability in the implementation of ICD-10 and as part of continuous post training follow-up.

At St Camillus Mission hospital in Migori, the project conducted an on the job training on certification of deaths in line with the ICD-10 standards through facility based Continuous Medical Education (CMEs) sessions. The project sustained regular advocacy and engagement on mortality reporting and use with county leadership through the various forums including the County Directors Caucus meeting, Migori M&E technical working group and Kisii County consultants review meeting. The activities conducted in the quarter aimed to enhance use of ICD-10 mortality data at all levels for health (HIV) program response in line with COP18 benchmarks.

In quarter 2, certifiers and coders in target facilities in Bungoma, Kakamega, Kisii, Busia, Migori and Vihiga reviewed and discussed mortality and cause of death data for the period FY2018 for respective facilities. The data presented included: reporting rate in the DHIS2 event report, cause of death data disaggregated by leading causes of death, deaths disaggregated by sex, age and ward, data entry and data quality errors observed. The review formed part of facility level mentorship and the gaps observed from the data guided the county mentor’s/resource persons in provision of on the job mentorship on certification and coding as per WHO ICD-10 standards and event capture module in DHIS2. These interventions are key to improving the use of ICD-10 at health facility level.

During the quarter, the project supported mentorship sessions targeting certifiers and coders based on the emerging gaps from the data. The mentorship reached 91 health care workers from 24 health facilities in Migori, Busia, Bungoma, Kisii, Kakamega and Vihiga counties (Table 4). The county resource team (certifier

and coder) held group sessions with the facility certifiers and coders to address questions and provide OJT in the specific areas emerging as per the data. The resource persons also spearheaded practical sessions for coders focused on the DHIS2 event capture (do's and don'ts), downloading the event report from DHIS2 and editing entries in the event report such as removing duplicate entries. These sessions for certifiers were based on certification (W.H.O cause of death flyer), review of case notes in mortality files and filling of D1 forms and discussion on sequencing of the cause of death in order to improve the quality of the data.

As a result, facilities developed action plans based on the areas identified for action, and where possible some of the gaps were addressed immediately. Interventions currently ongoing to address data quality gaps identified in Busia and Migori county referral hospitals include data cleaning for the 2018 data in the DHIS2 event report. The exercise will be completed in Q3 for Migori County Referral Hospital where over 80% of the entries in the event report require recertification by certifiers and editing in the event report. In Busia County Referral Hospital, the data quality errors identified were addressed in the quarter by the health records team and a mortality fact sheet developed for use and dissemination of cause of death data in the facility.

In Migori, the project supported a CME session on certification of deaths and filling of the death certificate (D1) as per ICD-10 standards in St Camillus Mission Hospital. The CME session was based on findings from mentorship conducted earlier in the quarter. The mentorship revealed that all the trained clinical and medical officers had left the health facility. With support from the civil registration department, the health facility streamlined the reporting and filing process for the D1 forms. As a result, the health records and information office that was initially not steering the filing process is now in charge. In quarter 3, the project through the County ICD-10 resource team will follow up implementation of actions plans developed by the health facilities and monitor reporting in the DHIS2 event capture module. In Kisii, Homa Bay and Kisumu counties, the county resource team will conduct data quality reviews and mentorship in the county referral hospitals.

Table 3 List of facilities and health workers mentored

COUNTY	HEALTH FACILITIES REACHED FOR MENTORSHIP	TOTAL HEALTH FACILITIES	CERTIFIERS MENTORED	CODERS MENTORED
Bungoma	Bungoma County Referral Hospital, Naitiri Sub county hospital, Mt Elgon Sub county hospital, Kimilili Sub county hospital, Sirisia Sub county hospital, Webuye Sub county hospital, Chwele Sub county hospital, Friends Lugulu Mission Hospital, Cheptais Hospital and St Damiano Medical centre	10	12	20
Busia	Busia County Referral Hospital	1	1	3
Kakamega	Mukumu and St Mary's Mission Hospitals, Matungu, Likuyani, Navakholo and Shibwe sub county hospitals, Malava and Lumakanda County Hospital	8	14	13
Vihiga	Vihiga County Referral Hospital, Jumuia Kaimosi Hospital, Coptic Hospital	3	4	10
Migori	Migori County Referral Hospital, St Joseph's mission hospital	2	2	4
Kisii	Kisii Teaching and Referral hospital	1	0	8
Total		**25 facilities**	**33 certifiers**	**58 coders**

The project sustained engagements with the county department of health leadership to scale up use of ICD-10 standards in certification and coding of deaths, and advocate for mortality and cause of death reporting in DHIS2 in all public health facilities with inpatient services. In Kisii, the quarterly mortality review meeting convened by the County Director of Medical Services provided a platform to address quality gaps in mortality reporting and cause of death data. The Sub County medical officer of health committed to demand for mortality data in order to address and improve reporting in health facilities with inpatient services under their jurisdiction. In Kisii teaching and referral hospital, mortality audits were reinstated and the county resource persons tasked to participate in all the meetings for quality assurance.

Further, discussions on mortality reporting were pursued in the County Director Caucus meeting. A presentation on the status of mortality reporting was made - per county- for the period October to December 2018 for discussion. Kisumu, Homa Bay and Kisii County Directors of Health committed to enforce reporting in the county referral hospitals that were not reporting in the DHIS2 event capture module. All the county directors re-committed to identifying a county champion to steer the upscaling of cause of death reporting.

During the Migori M&E TWG, the CHRIO advocated for the SCHRIO to steer health facilities to report mortality in the event report. Concurrence of the DHIS2 MOH 717 and the DHIS2 event report was emphasized. In quarter 3, Kisumu County Department of Health will convene meetings with medical teams[6] from Jaramogi Oginga Odinga Teaching and Referral Hospital and Kisumu County Hospital to streamline mortality and cause of death reporting in the two high volume facilities. The project will also pursue implementation of commitments by the County Directors of Health from Kisumu, Homa Bay and Kisii counties on reporting by the county referral hospitals.

The county ICD-10 resource team in Kisumu, Migori and Busia spearheaded supportive supervision on ICD-10 implementation in eight health facilities Kisumu (1), Migori (3) and Busia (7). The supervision team

[6] Medical officers, medical interns, Medical superintendents, clinical officers

engaged the health workers on the poor reporting rates in the event report. Some of the emerging challenges that affect reporting were: poor or lack of internet connectivity; limited capacity in use of DHIS2 report; staff attrition especially in Busia; where there had been a major staff reshuffle in GOK health facilities and inadequate infrastructure. The supervision team engaged the facility management and shared the gaps that required management support. Regular supervision and mentorship will be essential to strengthen ICD-10 reporting in the health facilities, particularly due to the frequent staff rotation and attrition.

Table 4 Health facilities visited for support supervision in Kisumu, Busia and Migori counties

County	Health facilities
Kisumu	Kisumu County Hospital
Busia	Teso North, Alupe, Samia, Port Victoria and Khunyangu Sub-County hospitals, Tanaka and Holy Family Nangina Hospitals
Migori	St Camillus Mission Hospital, Rongo sub county hospital and Awendo sub county

In Kakamega, the project oriented SCHRIOs and re-oriented facility-based HRIOs on ICD-10 principles. The orientation covered an overview of certification of deaths, mortality coding, the principle of underlying causes of death, mortality data quality and analysis. The basis of the orientation was to strengthen the health system to demand for mortality reporting through the sub county management structures. The project will prioritize orientations in select counties based on arising needs in quarter 3.

2.1.5: Strengthen capacity in data management at county levels on Health Information Systems including DHIS2, EMR, LMIS, CHIS, CAPR and IDSR

2.1.5.1: Conduct sensitization on CAPR tools and reporting platform targeting SCACCs, NGOs/FBOs/CBOs (with capacity)

In Y2Q3, the project jointly with NACC, conducted a supportive supervision and mentorship in Homa Bay to determine challenges in CAPR data quality. The activity revealed knowledge gaps on tools and the reporting system among other challenges. To address these gaps, in the reporting period, the project conducted a sensitization on CAPR tools and the reporting system for Sub-County AIDS Control Coordinators (SCACCs), Civil Society Organizations (CSOs), Sub-county AIDS & STIs Coordinators (SCASCOs) and county partners to improve quality of reported data. The sensitization provided guidance on the CAPR data cycle from data entry, analysis to reporting. The activity aimed at building the capacity of participants on the various CAPR tools and the CAPR reporting system. The activity contributed to the COP18 Benchmark 6 which seeks to promote DQA/DQI county-led interventions and utilization of quality program data in reviews, planning and program management. During the workshop, the sub-county teams also reviewed their respective CAPR data to identify data quality gaps.

The manual system of CAPR reports impedes timely submission of reports from the Civil Society Organizations (CSOs). The lack of knowledge in CAPR tools and the reporting system coupled with lack of its access hampers prompt hierarchical review and feedback on the quality of submitted reports. Thus, quality of CAPR reports is greatly compromised. As a result of the sensitization, eight SCACCs and eight program and data managers from CSOs were assigned CAPR login credentials and CAPR datasets. It is therefore anticipated that the assignment of CAPR login credentials and datasets will promote first-hand experience by data generators in reviewing and submitting timely reports.

During the sensitization, the sub-county teams also developed actions plans aimed at improving quality of CAPR data. The action plans included: cascaded sensitization and mentorship to other CSOs on the CAPR tools and the reporting system; distribution of CAPR tools by NACC reporting units experiencing inadequacy and assignment of login credentials and datasets to additional CSOs with capacity. In the subsequent quarters, the project will support Migori and Kisumu counties to conduct CAPR data quality reviews to strengthen quality data on community AIDS response.

2.1.5.4 Conduct sensitization on the CHIS tools and reporting platform to targeted SCCHSFP, CHEW, CHA

In the reporting quarter, as part of a broader strategy to improve the capacity of the county team to generate high quality data, the project conducted a sensitization workshop for Kisii on Community Health Information System (CHIS) to improve quality of data. The activity targeted 22 participants including Community Health Strategy (CHS) focal persons, HRIOs and county partners implementing CHS such as Living Goods, Kisii Network for Ecological Agriculture and Development (KNEAD) and CRS-Mwendo.

The project conducted a sensitization on various CHIS data collection and reporting tools namely: MOH514 (CHV Reporting Tool), MOH515 (CHEW Summary Tool), MOH516 (Community Chalkboard), MOH100 (Referral Tool) targeting data and program managers. The gathered knowledge on the various data collection and reporting tools is expected to strengthen collection and reporting of quality data. As part of the sensitization, the sub-county teams extracted CHIS data from DHIS2, analyzed and teased out the data quality gaps prompting development of data quality improvement plans. KNEAD committed to distribute revised tools to reporting units facing acute shortage to address the shortage and use of old tools within the county. The county also committed to pursue printing and distribution of the same tools.

In the subsequent quarter, the sub-county leads will cascade the sensitization to lower reporting levels and health care workers.

2.1.5.9: Conduct sensitization on IDSR tools and reporting platform to disease surveillance officers

To improve reporting of malaria surveillance and response data, the project conducted a sensitization meeting on IDSR tools in Kakamega and Vihiga counties. The 72 participants included Disease Surveillance Officers, Health Records Information Officers and Malaria Control Coordinators. The participants were sensitized on IDSR data collection and reporting tools including MOH502, MOH503, MOH504 and MOH505. The sub-county teams mined, analyzed and reviewed the IDSR data for the period January to December 2018. The county teams also developed dashboards in DHIS2 highlighting data quality gaps such as inconsistent reporting on suspected, tested and positive malaria cases owing to limited understanding of the indicators. The dashboards also revealed that either more patients tested positive than the suspected or more patients were treated than the confirmed positives. To address the identified data quality gaps and poor reporting of IDSR indicators, the project also support Sub counties to develop action plans. Some of the remedial action plans included cascaded sensitization and mentorship to facilities on IDSR tools and reporting system, procurement and distribution of revised tools and routine data quality review meetings.

To expand and ensure reporting, the project also facilitated provision of DHIS2 log in credentials for Surveillance Officers and shared the dashboards among the teams. In subsequent quarters, the sub-county teams will be supported to cascade the knowledge gained from the meetings to health facilities through sensitizations. The sub-county teams will also support routine data reviews and streamlining of reporting from the lower levels. The project will prioritize similar IDSR data reviews and sensitizations for Kisumu and Siaya counties in the subsequent quarters.

2.1.6.2. Conduct integrated HIS training on DHIS2, CAPR, CHIS, IDSR, LMIS, EMR, KHMFL, Service Desk, DSL, and KHMCUL in collaboration with HealthIT.

To enhance the DHIS2 skills of county and sub county HRIOs and program managers, the project sensitized the Kisumu county team on DHIS2. The sensitization benefitted 37 health care workers namely HRIOs, RH, Malaria and HIV program managers. The skills building session focused on data management in DHIS2 including data entry, data mining, analysis, reporting and visualization. As a result, participants developed scorecards and dashboards in DHIS2 highlighting data quality gaps leading to development of action plans to improve data quality.

In the subsequent quarters, the project will follow-up with Kisumu county and sub-county teams to strengthen the use of scorecards and dashboards in DHIS2 to steer evidence-based decision-making processes. The project team will also target Migori county with similar sensitization.

Output 2.2: Increased capacity of county health management teams in data analytics

2.2.1: Support capacity building on data analysis and visualization techniques

During the reporting period, the project addressed capacity gaps in data analysis, visualization and interpretation of mortality data by providing mentorship to the Kakamega and Homa Bay County Referral Hospital HRIOs and the ICD-10 resource persons to increase capacity in management and analysis of mortality data. The participants were mentored on basic Excel functions, use of pivot tables and presentation skills. The project conducted mentorship for the previously trained data analytics trainees in Busia and Vihiga. During the mentorship, the trainees were oriented on the difference between percentage and rate and the computations as well use of QGIS to generate maps. The trainees are now able to compute the rate using the standardized population as well as visualize data using QGIS (Maps) for targeted interventions.

The project supported Kisumu County Data analytics TOTs in cascading the analytics training to sub-county HIV, Malaria and RMNCAH program officers. During the capacity building of the county and sub-county malaria control coordinators in M&E, the project supported provision of analytics mentorship to the team in an effort to improve their skills in data analytics so that they can apply appropriately the skills in the county business processes. The project also supported capacity building in data analytics for county M&E officers for all the focus counties. During the training, the teams also received support to prioritize indicators for tracking and sensitized on types of analysis to be performed. This included the frequency of analysis and data visualization techniques.

"Prior to this training, I lacked knowledge and skills on mining data from DHIS2 and data interpretation. Although I had access to the DHIS2 system, I would rely on our sub county HRIO for data mining, analysis and visualization support. Similarly, data for me, seemed like a health records and information function/ 'thing'. Through this training, I have realized a number of things. First, is that as a program officer I really need to understand my program data and how to use the same to inform appropriate decisions. Secondly, I have acquired skills in using the pivot table among other functionalities in DHIS2. This means that I am able to view program performance, extract data including specific indicator data, do basic analysis on Excel and present data using PowerPoint. I can comfortably and confidently use the pivot table – my main learning goal achieved! With my skills, I will be able to interrogate data more, identify poor performance and quality issues and initiate and/or propose appropriate action! **Dorothy Oketch – HIV Services Coordinator, Kisumu Central Sub County**

In addition, the project trained DCS data officers in basic data analytics during training on data demand and use. During the training, the officers were taken through basic steps in data management, summarizing data as well simple data presentation methods. In the subsequent quarter, the project will continue to build the capacity of the other county teams in data analytics through mentorship.

2.2.2: Strengthen capacity of county health M&E/HIS units to institutionalize data analytics

During the quarter, the focus counties developed various information products (fact sheets and quarterly HIV profiles). This process was led by the county data analytics TOTs. Six counties (Kisii, Kisumu, Kakamega, Bungoma, Migori and Busia) developed quarterly HIV profiles with TA from the project. These profiles are line with the COP benchmark that requires counties to produce quarterly HIV profiles towards tracking the 90-90-90 target. Kisumu developed UHC factsheet and Malaria Bulletin. The UHC factsheet was used during the launch of the UHC health program. The project also supported all the counties in developing RMNCAH and Malaria factsheets that were disseminated during the CDH Caucus meeting.

Table 5 List of Information Products Developed in the Quarter

INFORMATION PRODUCT	COUNTY
Malaria, RH factsheets	**ALL**
Quarterly HIV profiles	**Migori, Busia, Kakamega, Kisii Bungoma and Kisumu**
UHC factsheet	**Kisumu**
Malaria Bulletin	**Kisumu**

In the subsequent quarters, the project will continue providing counties with the overall technical and financial support in the development of various information products.

Output 2.3: Strengthened capacity of county health management teams to demand for and use routine programs, surveys, and surveillance data for program planning and management:

2.3.1: Upscale evidence-based planning and budgeting

During the quarter Kisii, Kakamega, Busia and Vihiga counties reviewed the status of implementation of M&E/HIS activities as per the AWP 2018/19. This is in line with COP18 benchmark 1 that seeks to have at least 30% of focal counties evaluating or reviewing effectiveness of implemented policies, guidelines and/or standards. As for Malaria, Busia, Homa Bay, Siaya and Kakamega counties tracked status of implementation of planned activities for malaria program. On the other hand, Vihiga county tracked the implementation status of the HIV program. The status of the AWP implementation showed that approximately 23% of the activities implemented were completed and 23% were delayed. On the delayed activities, the teams came up with actions on how to fast track their implementation. Table 7 provides a summary of the status of implementation of the M&E system strengthening activities in the AWPs.

Table 6 AWP 2018/19 Implementation status

County	Program	Completed	On-Going	On-Schedule	Delayed
Vihiga	HIS/M&E	49%	10%	31%	10%
Kakamega	Malaria	13%	25%	21%	42%
Busia	HIS/M&E	8%	54%	23%	15%
	Malaria	17%	67%	0%	17%
Kisii	HIS/M&E	15%	41%	15%	15%
Siaya	Malaria	12%	47%	18%	24%
Homa Bay	Malaria	48%	5%	10%	38%

Data source: AWP Implementation tracking tools

The project will continue to support the counties to ensure implementation of the developed plans (AWPs, CHSSIPs).

The project also provided technical assistance to Migori during the bi-annual review. Key highlight from the review was a best practice shared by Rongo sub-county on data capture and reporting of 1st and 4th ANC visits in MOH465. The practice is such that when a pregnant woman attends 1st ANC visit, the healthcare worker documents it using a red pen while a 4th ANC visit is captured using a blue pen. During

reporting time, the health care workers aggregate the visits captured in reds and the greens separately and documents in the MOH711. This strengthens reporting and use of quality ante-natal clinic visits data. Notably is the improvement in timeliness of MOH711 reporting across the Sub-counties with Kuria Sub-county being the most improved from 76% to 96%. The county teams also presented the RMNCAH scorecard which showed that all sub-counties except Kuria West achieved the target 80% on Children Fully immunized. In terms of the 90-90-90 HIV targets, the county performance is at 85-99-92 among the adults whereas the pediatrics cascade is at 94-99-76. The low identification of HIV positive adult clients is attributed to untargeted testing and weak implementation of HIV Partner Notification Strategy (PNS) strategy; the sub-counties prioritized interventions to address the gaps. The county is at 86% in regards to distribution of the LLINs among the under 1s. The teams developed action plans to address gaps in performance based on the presentation and recommendations. The county also appraised the sub-county AWPs 2019/20. During the appraisal, the project sensitized the sub-county teams on the need to track implementation of AWPs and to link performance/outcomes to activities implemented. In the subsequent quarter, the sub-county teams plan to track implementation of the AWPs.

In preparation for the development of AWP2019/20, Kisii, Migori and Kakamega county M&E/HIS unit officers sensitized the county and sub-county teams on AWP development. Core in the discussion was the need to ensure priorities for the year as set out in the CHSSIP 2018/23 were mapped out and planned for in the AWP2019/20.

During the quarter, Vihiga, Bungoma and Kakamega counties developed draft AWP 2019/20. The AWP drew priorities from the CHSSIP and APR&P 2017/18 and programmatic strategic plans. To institutionalize use of data in decision making, Kisii, Vihiga, Kakamega, Bungoma, Homa Bay and Busia counties developed draft data use plans that were embedded in the county M&E plans. This is in line with COP18 benchmark 5, whose system barrier was the lack of data use frameworks /plans in the county. The Data Use Plans will be used to help the counties in tracking progress made in achieving the county priorities regularly.

2.3.2: Strengthen purpose driven HIV data reviews

Kisumu county conducted an HIV data review during the quarter. Key observations included the completion of roll out of the new tools in all the sub-counties and improved reporting rates - over 80% for all the datasets using the revised tools. Further, there were errors in the calculation of the 90-90-90 targets by the SCASCOs. To address this, the CASCO provided guidance on how to calculate the 90-90-90 proportions. The CASCO provided additional guidance on how to access and navigate Viral load data from the NASCOP EID website. During the review, findings from DQA conducted in September 2018 were shared and discussed by the teams. The review meeting also noted erroneous reporting of PrEP and VMMC data from facilities that do not offer the services. During the quarter, the CHRIO provided technical support to SCHRIOs to correct allocation of datasets with the DHIS2 platform to the health facilities.

Kisumu County synthesized MPDSR data for 2018 and thereafter conducted a data review on the same. From the review, it was noted that only 58% of patients with MDR forms had data on ANC, which has a negative impact in identifying issues that may have resulted in the maternal deaths during the audit. The county team committed to sensitize the teams on documentation on MPDSR reviews and documentation with technical guidance form the national Division of Family Health (DFH) teams. It was also noted that 50% of mothers who died were referred in from other health facilities, and 70% of the deaths were caused by hemorrhage. The county committed to increase availability of blood in the blood bank, improve skills in management of Post-Partum hemorrhage and improve the referral system to reduce delays in mother getting emergency care. During the quarter, the Muhoroni Sub-County Hospital launched a theatre that will handle maternal obstetric emergency cases.

Kisumu County also held an RMNCAH data review. During the review it was noted that the county has improved on the documentation and reporting of data on adolescent pregnancies. Consequently, that resulted in reduction of adolescent pregnancies reported in 2017 from 39% to 24% in 2018. This is attributable data cleaning and indicator definition sensitization in the county with support from Tupime Kaunti Project in collaboration with Afya Halisi. The county put in place measures in the PIPs to promote

better performance in RMNCAH indicators which included maternity open days, community outreaches and capacity building of health workers in management in service delivery during ANC and post-delivery.

2.3.3: Strengthen capacity of DCS to demand and use routine and survey child protection data in planning and portfolio management

Towards increased use of data in reporting, planning and portfolio management among DCS officers, the project trained 36 DCS officers from Kisumu, Kakamega, Migori and Homa Bay counties on data demand and use. The results from the training showed an improvement in knowledge scores, from 53% in pre-test scores to 66% in post test scores. Specifically, the participants' knowledge on linking data to action and data presentation rose from 27% to 63% and from 15% to 51% respectively. In the subsequent quarter, the project will mentor the officers on the skills gained as well as train other officers from Kisii, Bungoma, Vihiga and Busia and Siaya counties on data use. The project will also provide technical assistance to the DCS officers to use data in identifying child protection priorities and upscaling the same to the county stakeholder forums and the national level for use in program and portfolio management.

During the quarter, Kisumu county held an Area Advisory Council (AAC) forum; a platform that brings together child protection stakeholders. Prior to the forum, the project supported the DCS officers to package data from CPIMS DCS platform that highlighted the cases for presentation to the children department. The presentation highlighted cases of neglect and custody contributing 54% and 24% respectively of the total cases affecting children in the county. This was the first time the County Children's Coordinator was sharing data from CPIMS with the stakeholders. This depicted the confidence the DCS department has had in the data reported within the system. The data presented and discussed created demand for data from the County Commissioner who reiterated the need to have the data disseminated at sub-county level by the Sub-county children officers through forums such as the county commissioner's or chief's barazas, Ward administrator forums, Sub-county AAC meetings, religious gatherings among others. The emphasis was to inform targeted interventions at lower levels. Other issues that emerged was the need to track the bursary beneficiaries from the different stakeholders (MCA, IPs, DCS office, MP) to avoid duplication. The County Children's Coordinator was tasked to coordinate with other stakeholders and furnish the AAC with the information in the sub-sequent meeting.

III. ACTIVITY PROGRESS (QUANTITATIVE IMPACT)

Tables 7 and 8 provide COP18 benchmark status for FY19 Q2 and progress toward achievement of MEL Plan targets respectively.

Table 7: COP18 Annual Benchmark Status for FY19 Q2

#	Year One (COP18) Annual Benchmark (Planned)	Status	Achievements and Next Steps
1	At least 30% of focal counties have evaluated/reviewed effectiveness of implemented policies, guidelines and/or standards. Improved reporting and use of data from HMIS&M&E systems at county. Improved collection, reporting and use of quality data at focal counties	Started, On Track	During the quarter, the project built on the gains made in the preceding quarter to strengthen counties capacity to evaluate /review all HIS & M&E policies, guidelines and standards. In addition, the project facilitated counties to improve data reporting and use. The key achievements are as follows: - • All focus counties except Kisumu County (87.5%) initiated the development of their respective M&E Plans for monitoring the implementation of their CHSSIPs. Migori and Vihiga finalized their CHSSIPs. • Four counties (50%) completed development of the CHSSIP 2018 – 2023 (Migori, Kisii, Kisumu and Vihiga) with the rest reviewing their plans. • The project steered the development of three Course curriculum (M&E and DDU and Support Supervision for health managers). DDU training for 35DCS staff and 29 M&E unit officers on M&E. • 50% of the counties (Kisii, Busia, Vihiga and Migori) reviewed the status of implementation of the AWP for the HIS/M&E activities. • 100% of the counties reviewed the status of implementation of the AWP for the HIS/M&E component • The project improved reporting through feedback to counties from various DHIS2 data analysis and feedback as well as use of data across counties in the development of CHSSIP 2018/23, M&E plan 2018/23, SWG report, during data review forums, TWGs and stakeholders' forums.
2	County learning and accountability agenda institutionalized, owned and supported by at least 50% of key stakeholders as measured by before and after OCAT results.	Started, On Track	During the quarter, the project continued to institutionalize county learning and accountability agenda by holding the County Assembly Health Committee forums, Data Reviews, Performance reviews, County HSSIP review, CDH/ Core leadership meetings, Technical Working Groups for M&E, Malaria, HIV and RMNCAH, LDG Group and stakeholders Forums. The following key achievements were realized: - • Kisumu, Kakamega, Vihiga and Busia counties (50%) conducted LDG forums • Kisumu HIV data review brought out errors in the calculation of the 90-90-90 targets by the SCASCOs. The CASCO provided guidance on how to calculate the 90-90-90 proportions. In addition, skills building for the SCASCO on how to access and navigate viral load data from the NASCOP EID website. • Kakamega, Kisumu, Busia and Migori LDG conducted modular training to addressed identified capacity gaps • Bungoma and Busia shared their sector work Group findings with the county assembly and advocated for increase in resource allocation • County Directors of Health adopted the partner and county assembly reporting template for accountability • M&E unit officers trained on M&E to enhance their capacity

			• The project steered the establishment of community of practice that provide a learning platform for M&E practitioners • Kisumu, Busia and Kakamega (38%) conducted Area Advisory Council Meeting understanding number of county case categories per sub county • The project working with the HIS/M&E units and the TWGs facilitated the dissemination of RDQA findings during TWGs meetings, CHMT meetings, data reviews, stakeholder meeting and LDG group orientation in Busia, Migori, Vihiga, Bungoma, Kisii, and Kisumu counties.
3.	ICD10 mortality data increasingly used in data review forums and county HIV response program evaluations.	Started, on track	The project used mentorship, support supervision, continuous medical education sessions, on the job training sessions and utilization of existing department of health coordination structures (such as the Mortality TWGs) to champion the upscaling of death registration coverage and use of mortality data. The following are the key achievements: - • Mortality and cause of death data has increasingly become available (from 20 health facilities reporting in DHIS2 event report in September 2017 to 40 health facilities reporting in December 2018) in DHIS2 in all the TK focus counties. • The project through the county ICD-10 certifiers and coders conducted ICD-10 support supervision including continuous CMEs (in Migori and Kisii county referral hospitals) and mortality reporting in 5 out of 8 focus counties. The project conducted mentorship on certification, mortality coding and reporting in DHIS2 in 25 health facilities in Bungoma (10), Busia (1), Kakamega (8), Vihiga (3), Kisii (1) and Migori (2). As a result, the counties developed data quality improvement action plans. • The project conducted mortality data quality meeting in Kakamega county referral hospital. Further, Kakamega County held a quarterly HIV data review meeting with the support of the project with mortality data review as one of the key agenda. • The project mentored ICD-10 resource persons and facility health records and information officers in Vihiga (5 HRIOs), Migori (2 HRIOs), Kakamega (2 HRIOs) and Busia (15 HRIOs) county referral hospitals on mortality reporting. • The project held regular engagement with health managers on mortality and cause of death reporting and quality through Kisii Consultants review meeting, Migori M&E TWG and County Directors Caucus meeting. • The project steered Busia and Migori county referral hospitals to do data cleaning in DHIS2 event report on the basis of the data quality gaps identified during facility mentorship on mortality certification and coding • Conducted on the job training on certification of deaths per ICD10 standard through facility based Continuous Medical Education sessions in St Camillus Mission Hospital, Migori and Kisii county referral hospitals • Busia County developed a mortality fact sheet for the Busia County referral hospital as part of the efforts to generate data to inform decision making by the hospital management and county health leadership.
4	Public participation in health planning, management, monitoring and evaluation improved. Ownership and leadership HIV response by civil society organizations and community increasingly evident.	Started, on track	The focus here is to strengthen counties to engage public and civil societies in planning, management and monitoring activities through stakeholder coordination mechanisms. Key achievements recorded are: - • Kisumu, Kisii, Bungoma and Vihiga Counties conducted their stakeholder's forums with substantial engagement of health stakeholders • Kakamega, Vihiga and Bungoma counties developed draft AWP 2019/20 with participation by community and civil societies

			• All counties except Kisii (87.5%) developed SWG report, which is a key planning, and budgeting tool in MTEF cycle. In Homabay *Bunge la Mwananchi* participated in the development process of the SWG report. • Kakamega and Migori convened health partner's forum for collaborative implementation of activities • Kisumu County convened a stakeholder's forum with representation from key population and civil society that advocate for gender equality • Kisumu, Vihiga, Bungoma and Homa Bay Counties (50%) convened HIV TWG • Focus counties except Homa Bay and Kisumu (75%) convened M&E TWG • Kisumu, Kakamega and Busia counties (37.5% held Area Advisory Council meetings to discuss Child Protection issues with representation from community based organization local implementing partners and community representative
5.	Quarterly production and dissemination of standard HIV county profiles on priority outcomes institutionalized.	Started, on track	• 75% counties (6 out of 8) produced quarterly HIV profiles. These counties are Migori, Busia, Kakamega, Kisii Bungoma and Kisumu.
6	Standardized DQA/DQI activities institutionalized as part of targeted data reviews and data alignment by DCS, CASCOs and PEPFAR funded IMs in 8 counties. 100% counties plan and implement DQA/DQI with support from external partners	Started, on track	The project contributed to the standardization and institutionalization of the DQA/DQI interventions within MOH, DCS and OVC IPs and the following key achievements were recorded: - • To institutionalize the DQA/DQI activities, the project oriented 32 MOH staff and 4 partners staff on the DQA processes in Siaya County as outlined in the protocol, and conducted field visit to select facilities as part of a data quality assurance practicum. Developed data quality improvement plans based on gaps identified during the field practicum. • The project advocated for use of the county structures to support the data quality improvements as a means to promote ownership and sustainability. • The project provided technical support to the MOH and partners during the NASCOP HIV Data Quality Assessment dissemination and DQI development meetings in eight focus counties. • Improved systems capacity to identify the data discrepancies in real time and regularly and call for action through DHIS2 dashboards linked to the program officers and key stakeholders in Kisii, Kisumu, and Vihiga counties. • As part of the institutionalization, the project advocated for the DQA/DQI agenda is anchored in the MOH structures (i.e. the TWGs, stakeholders' forums and LDG meetings) and empowered counties to take lead in DQA agenda. • The project steered a joint MOH (Kisumu, Kakamega and Migori counties) and partner's data quality review to help partners and MOH synthesis data quality issues and agree on common solutions. • To promote standardization, the project disseminated the national DQA in 6 counties and also developed a data change documentation SoP that was adopted by NASCOP and disseminated to the counties for adoption during the dissemination of the HIV findings. • The project automated and sensitized CHMT on the NASCOP HIV DQA tool and piloted in Busia county to ease collection of RDQA data and generation of RDQA reports • To strengthen the identification and monitoring of malaria data quality gaps, the project developed a scoreboard tool based on DHIS2 malaria data and disseminated to 4 counties (50%) to identify malaria data quality gaps.

			• Sixteen CAPR data and program sensitized on CAPR tools and CAPR data sets in the DHIS2 to promote quality reporting and improved coverage of Community HIV data.
7	100% fulltime CPIMS System Availability for targeted users	Started, on track	• System enhancement requirements gathering • Testing of case management tools included in CPIMS with OVC implementing partners
8.	50% of CPIMS users demonstrating system use competency score of 3.0 out of 5.0	Started, on track	• 38 end users trained on CPIMS • CPIMS Competency Tests conducted in 8 out of 9 counties (89%) • Provided technical support during monthly data quality meetings with counties to review data completeness in CPIMS in Kisumu, Migori, Kakamega and Busia • Sensitized 9 DCS Champions from Migori, Kakamega, Kisumu and Homabay on DCS RDQA processes • To improve OVC data quality, the project disseminated the Data Quality Assessment of selected PEPFAR-funded programs for OVC in Kenya report to the DOD and CDC local implementing partners.
9.	100% (300) of all targeted counties demonstrate increased use of program and survey data in reporting, planning and portfolio management.	Started, on track	• 35 DCS staff trained on DDU using the curriculum developed with KSG. • Counties demonstrated use of program and survey data during the development of the strategic plans and M&E plans

Table 8: Performance Data Tables

Performance Table Q2.docx

IV. CONSTRAINTS AND OPPORTUNITIES

Opportunities

- The formed M&E community of practice for M&E officers, which is an online what sup group platform, will provide an avenue for knowledge sharing, exchange of ideas and cross learning among M&E officers.

- NASCOP has capacities and resources that may be beneficial to the County level—for example C&T and HTS DQA tools, County performance review templates, and data use training curriculum. Cascading these to County level will result in savings (time and money) especially in material development. However, these resources may require customization prior to application at the County level—for example NASCOP DQA tool is optimized for mobile data collection and requires retooling to Excel to make it appropriate for the Counties and SDPs.

- Demand for dissemination and use of DCS data at lower levels by the County Commissioner is an opportunity to strengthen evidenced based and targeted child protection interventions

Constraints

- Bungoma County has not been able to provide a date for CHMT sensitization on LDG concept. The project will continue to strengthen CHMT as we advocate for establishment of LDG group and M&E unit.
- Due to competing tasks, the LDG members for Migori, Kisii and Kakamega have not been able to complete their Module 2 (work place assignment) as scheduled. The project will continue to provide mentorship for the counties LDG group to develop the work place assignments.
- AWP guidelines developed by the national are not in tandem with the updated AWP tools thus leaving room for inconsistencies during planning

V. PERFORMANCE MONITORING

Tupime Kaunti project continued to hold internal M&E technical working group meetings with the head office to chart ways and means of improving the tracking of the project outcomes. On a routine basis, the project ensured timely forecasts of the planned activities, clear documentation of project deliverables and timely feedback to the technical project team by holding staff meetings to discuss the project's implementation rate and identifying areas of focus for improved program performance. The project also continued to monitor the implementation of the approved work plan for FY19 and conducted meetings with top county leadership such as the quarterly caucus meeting with CDHs with an intention to discuss any lessons learned for replication and most importantly, to discuss on strategies needed to ensure counties move towards journey to self-reliance (J2SR).

VI. PROGRESS ON GENDER STRATEGY

Tupime Kaunti implements gender-sensitive programming and emphasizes sex disaggregation in data collection and analysis as required by agency guidelines on all individual level data.

VII. PROGRESS ON ENVIRONMENTAL MITIGATION AND MONITORING

Initial Environmental Examination determined that a negative determination with conditions applied for the project i.e. 22 CFR 216 §216.2 (c) Categorical Exclusions. So, the project is not required to prepare environmental mitigation and monitoring plan or a project Mitigation and Monitoring plan. Tupime Kaunti has not undertaken new activities outside the scope of the approved Regulation 216.

VIII. PROGRESS ON LINKS TO OTHER USAID PROGRAMS

In FY 19 Q2, main activities conducted with other USAID programs were as follows: -

HIGDA

- None

HealthIT

- The project held weekly meetings with HealthIT to resolve the CPIMS end user needs.

SDPs: Afya Halisi, Afya Ugavi and Afya Ziwani

- The project held malaria TWG meetings in collaboration with Afya Ugavi, HCM and Impact Malaria mechanisms in Kisumu, Busia, Kakamega and Homabay and Siaya counties. During the meetings, partners tracked Malaria AWP and DQI plans.

OVC IPs: CASEOVC, MWENDO, Nilinde and COGRI

- Initiatives to improve effective use of CPIMS data entailed mentorship to 15 local implementing partners under MWENDO, conducting analysis of CPIMS data to inform OVC programming, held monthly meetings with DCS, disseminated Kenya OVC DQA findings to CDC and DoD IPs.

IX. PROGRESS ON LINKS WITH GOK AGENCIES

In FY 19 Q2, main activities conducted with other GOK agencies were as follows:

National

- The project leveraged on NASCOP DQA 2018 dissemination, the project sensitized CASCOs, CHRIOs, SCASCOs, SCHRIOs, other select CHMT and select facility staff on the DQA protocol, 90-90-90 cascade and tracking, 2018 HIV estimates, and select indicators in the revised HIV M&E tools. A total of 348 health staffs from Busia, Bungoma, Kisii, Kisumu, Kakamega and Homa Bay counties participated.

CDH

- Developed strategic documents with the CDH across all counties. These included the finalization and launch of the CHSSIPs and the M&E plans in some counties such as Migori and Vihiga.

- Steered counties in policy development with Busia and Kakamega counties developing the resource mobilization strategy and Migori developing the communication strategy.
- Conducted mentorship on certification, coding and reporting mortality data in DHIS2 in selected facilities across the counties and developed facility data quality improvement action plans. In addition, the project engaged health managers in Migori and Kisii on mortality and cause of death reporting.
- Developed a data change documentation SOPs for use by all focus counties
- Reviewed the AWP 2018/19 implementation status for Kakamega, Busia, Homa Bay Vihiga and Kisii counties.
- Developed the DHIS2 dashboard for Kisumu county
- The project automated the NASCOP HIV DQA tool in MS-Excel to ease data collection and report regeneration during RDQAs and piloted it in Busia County.
- The project steered counties to develop information products including HIV profiles and mortality fact sheets as a means to generate evidence for data use

DCS

- The project trained Thirty-six (36) officers from the Department of Children Services (DCS) from Homa Bay, Kisumu, Migori and Kakamega counties using the internally developed DDU curriculum to build their skills in analyzing and using child protection for planning and management.
- Kisumu County convened Area Advisory Council (AAC) meeting to advance collaborative discussions in addressing child protection issues. As a result, there was increased demand for dissemination of child protection data at the lower levels.

X. PROGRESS ON USAID FORWARD

Tupime Kaunti contributes to USAID FORWARD through capacity building of CDOH and DCS in the focus counties as outlined in Sections VIII and IX.

XI. SUSTAINABILITY AND EXIT STRATEGY

The project's sustainability strategy was conceptualized from FY17 and guides all technical solutions. The strategy is measured using Five-Year Sustainability Benchmarks and Indicators – See Table 8. It emphasizes sustainability of both MLA systems strengthening processes and results. The strategy aims is to improve the external environment for MLA systems through institutional capacity building. Second, the strategy seeks to ensure availability and use of quality data through individual capacity building.

Table 8: Tupime Kaunti Five-Year Sustainability Benchmarks and Indicators

Year	Benchmark	Indicator
FY17	MLA Systems Strengthening Plan in place	**Indicator 0.1:** County MLA Systems Strengthening Plan implementation rate
FY18	County M&E unit established	**Indicator 0.2:** County monitoring and evaluation capacity index
FY19	County M&E unit staffed	**Indicator 0.3:** Number of people trained
FY20	County has policies on outcomes measurement and MLA systems	**Indicator 1.1.1:** County MLA systems leadership and management capacity index **Indicator 1.1.2A:** Percentage of counties effectively implementing existing policies, guidelines and/or standards **Indicator 1.1.2B:** Percentage of implemented policies reviewed and adjusted **Indicator 1.2.1:** County outcome measurements capacity index

Year	Benchmark	Indicator
FY21	Increase in budget allocation for county M&E Increase in county HIS, CPIMS and CRVSS data quality Increase in county DDU scores	**Indicator 1.1.3**: Number of counties with functional learning and accountability forums **Indicator 2.1.1**: County data quality capacity index **Indicator 2.2.1:** County data analytics capacity index **Indicator 2.2.2**: Number of county-specific information products developed **Indicator 2.3.1**: County data use capacity index **Indicator 2.3.2**: Number of instances when counties use health data for decision making

XII. GLOBAL DEVELOPMENT ALLIANCE (IF APPLICABLE)

N/A

XIII. SUBSEQUENT QUARTER'S WORK PLAN

Table 9 provide description of planned versus actual activities and explanations for any deviations.

Table 9.docx

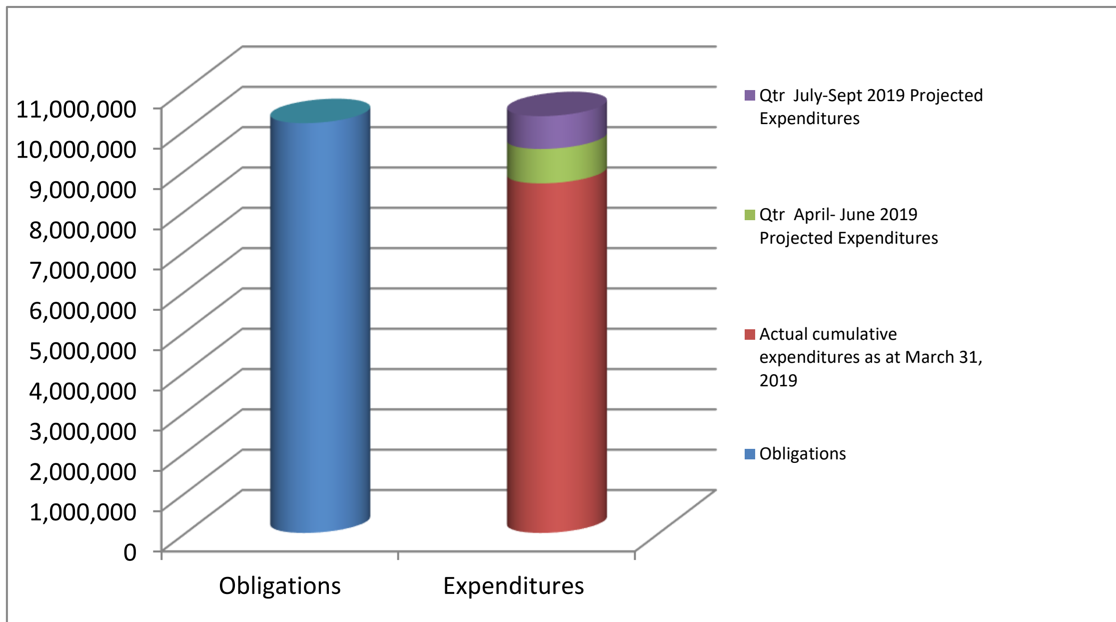
XIV. FINANCIAL INFORMATION

The Project's expenditure and forecasts for the reporting period were consistent with the programmatic implementation progress.

Overall Financial Status Summary as at March 31, 2019		
	Amounts	**% age**
T.E.C:	$17,417,910	
Cumulative Obligations:	$10,165,014	58%
Cumulative Actual Expenditures:	8,670,867	85%
Estimated Pipeline March 31,2019	$1,494,146	
Year 3 Approved Budget: October 2018- September 2019	$3,545,771	
Actual Expenditures for Year 3 Quarter 2, as at 31 March 2019	$1,798,985	50.7%

Cash Flow Report and Financial Projections (Pipeline Burn-Rate)

The following chart compares the total obligated funds and actual expenditures as of March 31, 2019, and projected expenditures for FY 2019 Quarter 3 through to September 30, 2019. Actual cumulative expenditure from inception to March 31, 2019 at **$ 8,670,867.** Projection for the quarter ending June 30, 2019 is at $853,518



The cash flow chart (Chart 1) is derived from the financial table (Table 2), also provided below. Both provide a visual representation of the "burn rate" of the activity – both actual and projected. The main categories include personnel; fridge benefits; travel, transport & per diem; equipment; supplies; contractual; other direct and indirect costs.

TABLE 2: Projections for Year 3

	Projections		
	Cumulated Exp to March 2019	**Qtr Apr-June 2019**	**Qtr Jul-Sept 2019**
Personnel	$2,205,605.60	$260,000.00	$345,000.00
Fringe Benefits	$873,875.99	$50,000.00	$54,000.00
Travel, Transportation & Per Diem and Misc	$356,600.62	$18,000.00	$20,000.00
Equipment	$51,237.00	$ -	$ -
Supplies	$82,691.00		$ -
Contractual	$738,346.86	$80,280.00	$85,000.00
Construction	$0.00	$ -	$ -
Other Direct Costs	$3,128,940.84	$285,000.00	$150,000.00
Total Direct Costs	$7,437,297.91	$693,280.00	$654,000.00
Total Indirect Costs	$1,233,569.00	$160,237.91	$160,000.00
Total Estimated Costs plus Fixed Fee	**$8,670,867**	**$853,518**	**$814,000**

The budget notes below explain the dollar figures presented in the details. Both include past and projected expenditure

Salary and wages	Salaries and wages are in line with the organization's HR policies and USAID FSN scale with all staff interviewed on-board. Incorporated into the personnel budget is the expected COLA adjustment to be done in Quarter 3
Fringe Benefits	Calculated as per Awards conditions and prevailing Palladium International, LLC approved NICRA rates.

Travel	Travel costs are in relation to Project staff. Participant travel is generally charged to Programmatic Costs that fall under Other Direct Costs.
Equipment	Equipment costs relates to cumulative expenditure since inception.
Contractual	The contractual consists of cumulative payments made as per the agreements signed with Plan International and Kenya School of Government.
Other Direct Costs	Other direct costs include programmatic activities aligned to the detailed implementation plan and general office operating costs.
Total Indirect Costs	Calculated as per award conditions.

TABLE 3: YEAR 3 PEPFAR (HVSI&HKID) BUDGET DETAILS - BY BENCHMARK

Benchmark	**Budget**	**Spent to March 2019**	**Balance**
	USD	**USD**	**USD**
Benchmark 1	326,771.00	176,526.77	150,244.23
Benchmark 2	385,066.00	217,945.44	167,120.56
Benchmark 3	288,941.00	129,440.56	159,500.44
Benchmark 4	314,045.00	145,058.12	168,986.88
Benchmark 5	298,786.00	140,553.09	158,232.91
Benchmark 6	282,175.00	208,578.87	73,596.13
Benchmark 7	60,780.00	54,067.05	6,712.95
Benchmark 8	74,312.00	63,032.34	11,279.66
Benchmark 9	114,762.00	71,183.66	43,578.34
Total	**2,145,638.00**	**1,206,385.92**	**939,252.08**

TABLE 4: NEW SUB-AWARD DETAILS

Total Amount in the approved budget for sub-awards: $ 1,084,960

Total Amount sub-awarded to date: $ 738,346

Sub Awardee: Plan International USA

Name of Sub-Awardee: Plan International USA

Activity Title: Personnel, Direct and other Indirect costs.

Agreement Performance Period:_Sep 30,2016_______ to _Sep 30. 2021_________

Agreement Amount (Total Estimated Cost): $ 2,445,621.11

Geographic Locations for Implementation: *(As defined in Section XIII.D.)*

Activity Description: To develop the capacity building strategy and support the monitoring of that strategy and support the implementation of that strategy across sub purpose 1 and 2. The Sub Awardee provides expertise in some of the health areas: RMNCAH, Malaria and HIV and information systems such as DHIS2, CHIS, EMR, CRVS, CPIMS, LMIS, COPBAR, and IDRS.

Sub Awardee: Kenya School of Government

Name of Sub-Awardee: Kenya School of Government (KSG)

Activity Title: Personnel, Direct and other Indirect costs.

Agreement Performance Period:_Sep 30, 2016_______ to _Sep 30. 2021_________

Agreement Amount (Total Estimated Cost): $ 425,708.91

Geographic Locations for Implementation: *(As defined in Section XIII.D.)*

Activity Description: KSG is supporting the establishment and maintenance of county health departments' Leadership Development Groups on MLA systems in 8 counties and provide on-going support to the groups to adapt and implement MLA system strengthening activities.

XV. ACTIVITY ADMINISTRATION

Personnel

The Knowledge Management Specialist position fell vacant in FY19 Q1. Recruitment concluded and the new staff came on board in January 2019.

XVII. GPS INFORMATION

Table 10: Tupime Kaunti GPS Information for Jan –March, 2019

Copy of Tupime
Kaunti GPS Info Jan-

Annex I: Schedule of Future Events

Date	Location	Output (e.g.1.1)	Activity
April 2019	TBC	1.1	Training for HIV, RH and HIV program officers on Support Supervision for Health Managers Course
June	TBD	1.1	CDH Quarterly Caucus meeting
April	Kisii, Homa Bay, Vihiga, Busia, and Bungoma	1.2	Joint stakeholder validation meetings for CHSSIP and M&E Plan
April	Migori, Kisii, Vihiga, Busia, and Bungoma	1.2	HIV Target Setting Meetings
April to June	All Counties	1.2	Sensitizations for M&E/HIS Units and CASCOs to standardize application of outcome measurements methods
May	Kisii	2.1	Joint MOH and Partners DQA forum
May	Busia	2.1	Joint MOH and Partners DQA forum
April – June, 2019	Homa Bay, Bungoma	2.2	Sensitization workshop of county, **sub-county** and facility HMT on DHIS2 dashboard development
April – June, 2019	Migori, Kisumu	2.1	CAPR Data Quality Review meeting with NACC & CHMT/SCHMT.
April – June, 2019	Kisumu, Siaya	2.1	IDSR Data Quality Review meetings with CHMT & SCHMT.
April – June, 2019	Vihiga	2.1	CHIS Data Quality Review meetings with CHMT & SCHMT.
April – June, 2019	Migori	2.1	Conduct HIS training for RH Coordinators on RH Data Management System – DHIS2
Apr	Migori, Busia	2.3	AWP 2019/20 consolidation
Apr	Homabay	2.3	Bi-annual performance review
Apr	Siaya, Kisii, Vihiga, Bungoma and Busia	2.3	DCS DDU training
Apr	All TK Malaria focused counties	2.3	Malaria joint review meeting
Apr – Jun	All	2.3	HIV performance review
8-26 April, 2019	All counties	2.1	Mentorship to DCS and OVC LIPs
April 29th –May 3rd , 2019	All counties	2.3	DDU Training to DCS staff from Kisii, Vihiga, Busia, Bungoma and Siaya
April 15th -26th, 2019	All counties	2.1	OVC data validation exercise

Date	Location	Output (e.g.1.1)	Activity
April 2019	Bungoma	2.1	Continuous Medical Education sessions in Webuye Sub County hospital
April 2019	Kisumu	2.1	Continuous Medical Education sessions (Jaramogi Oginga Odinga Teaching and referral Hospital and Kisumu County Hospital)
April	Migori	2.1	Data cleaning in DHIS2 event report (Migori county referral hospital)
April 2019	Kisumu	2.1/2.3	Mortality data review meeting
May 2019	Homa Bay, Kakamega, Kisii	2.1	Facility level mentorship on certification, coding and mortality reporting
May 2019	Busia, Bungoma	2.1/2.3	Mortality data review meeting
May 2019	TBD	M&E	Conduct a rapid assessment to demonstrate the extent to which ICD10 interventions have improved mortality reporting.
June 2019	Homa Bay	2.1	Orientation of CHMT on ICD10 tools

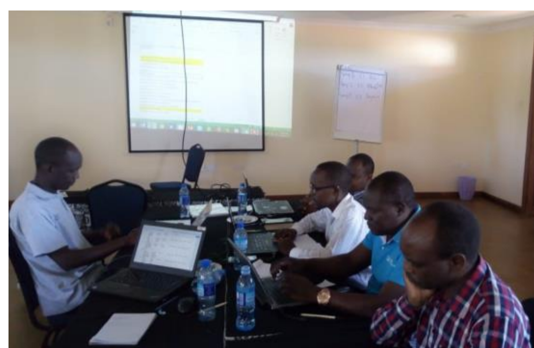
Annex II: List of Deliverable Products

Deliverable	County	Output (e.g. Output 1.1)	Status (Final/ Draft)
Communication strategy	Migori	1.1	**Draft**
Resource Mobilization strategy	Busia, Kakamega	1.1	**Draft**
M&E Plan 2018 - 2023	Migori	1.1	**Final**
M&E Plan 2018 - 2023	Kisii, Kakamega, Homa Bay, Vihiga, Busia, Bungoma, Kisumu	1.1	**Draft**
ICD-10 Facility action plans	Bungoma, Kakamega, Busia, Migori, Vihiga	2.1	**Final**
Data change documentation SOP	ALL	2.1	**Final**
Joint partners forum Report	Kisumu, Kakamega and Migori	2.1	**Final**
Malaria scoreboard	ALL	2.1	**Draft**
DHIS2 Dashboards	Kisumu	2.1	**Final**
IDSR Data Review and Sensitization. Activity Reports and Sub-county Action Plans	Kakamega, Vihiga	2.1	**Final**
CHIS Data Review and Sensitization. Activity Reports and Sub-county Action Plans	Kisii	2.1	**Final**
CAPR Data Review and Sensitization. Activity Reports and Sub-county Action Plans	Homa Bay	**2.1**	**Final**
AWP 2019/20	Kakamega, Bungoma, Vihiga	2.3	**Draft**
HIV PIPs	Kisumu	2.3	**Final**
AWP 2018/19 implementation status (Malaria)	Kakamega, Busia, Homabay, Vihiga	**2.3**	**Final**
AWP 2018/19 implementation status (HIS/M&E)	**Busia, Kisii, Vihiga**	**2.3**	**Final**
DDU training report	Kisumu, Kakamega, Homabay, Migori,	2.1	**Final**
DDU Training Curriculum	ALL	2.1	**Final**
DQIPs developed	**All**	**2.1**	**Final**

Annex III: Success Stories

TOWARDS STRENGTHENED HEALTH SECTOR MONITORING AND EVALUATION: HOMA BAY DEVELOPS FIRST M&E PLAN

Monitoring and evaluation (M&E) play a critical role in building evidence by assessing a diverse range of interventions. As a function, M&E tracks implementation and outputs to determine if inputs are yielding the desired impact. M&E thus, provides a basis for evidence-based strategic planning, design and implementation of health interventions, outcome measurement and effective prioritization in resource allocation while promoting good governance and accountability in county health management.



Homa Bay County M&E unit during a M&E Plan development workshop

To realize effective measurement of progress towards attainment of health sector goals and objectives, the department of health Homa Bay has developed a robust M&E plan; the first for the department. The plan, developed with technical support from Tupime Kaunti, provides a framework to guide implementation of M&E functions and particularly, continuous tracking of implementation of the County Health Sector Strategic and Investment Plan (CHSSIP) 2018-2023 and outcomes measurement.

> The department of health Homa Bay did not develop a M&E plan to effectively monitor implementation of the CHSSIP 2013-2017. Lack of a M&E plan was one of the key gaps identified in the end-term review report.

The M&E plan 2018-2023 outlines all the M&E processes/activities that will be undertaken and highlights the data requirements as well as the collection and analysis processes. Given the multi-pronged and systematic natures of M&E, the plan also incorporates a data use plan and assigns roles for collective responsibility.

> The plan provides guidance on key M&E processes including coordination structures, collection of routine and non-routine data, resource mobilization and tracking, timely planning and collaboration with stakeholders. It will inform and guide continuous monitoring and evaluation and thus provide a solid basis for review of various health systems strategies.

In developing the M&E plan, the department was able to effectively align the M&E plan to the CHSSIP indicators. Importantly, the M&E unit was sensitized on and facilitated to delineate outcome and process indicators for effective measurement.

> Minimal monitoring was undertaken at outcome level during the 2013-2017 implementation period. As such, outcome level indicators such as mortality rates and ART coverage were not adequately monitored during the periodic performance reviews. In addition, indicators whose data is not available in the mainstream data systems were not identified and neither was a data collection plan for the same developed. In addition, there was no clear guidance on the resource requirement for

M&E implementation therefore; activities did not receive adequate budgetary allocation.

The M&E unit also received technical assistance in costing the proposed M&E activities to support continuous advocacy for resource allocation and ensure successful implementation of the newly developed plan. Tupime Kaunti will prioritize support to the M&E/HIS units to build sustainable M&E capacities and further support the department leadership, development and governance (LDG) group to advance the county MLA advocacy agenda towards strengthening one functional M&E system; in line with the department's MLA systems strengthening plan.

Importantly, the project will collaborate with the department of health to build systems and partnerships to ensure full implementation of the M&E plan, prioritization of outcome level measurement and sustained learning at all levels of health management.

The M&E plan was one of the policy documents that was highlighted as critical together with the stakeholder coordination framework. The LDG during their periodic MLA progress review developed a roadmap for M&E plan development. With support from USAID/Tupime Kaunti, the team developed an M&E plan that is ready for validation together with Health Sector Strategic and Investment Plan.

EMBRACING INNOVATIVE STRATEGIES TO IMPROVE STAKEHOLDERS' ENGAGEMENT IN VIHIGA

Effective coordination of health sector partners is crucial for enhancing collaboration, ownership and mutual accountability in health implementation. To improve efficacy in partner coordination, the department of health -Vihiga, with support from Tupime Kaunti, developed a stakeholders' coordination framework. This framework outlines mechanisms for structured engagement with health partners on strategies for addressing the county's existing and emerging priorities.

The health sector stakeholders' coordination framework aims to address inadequacies in the department's previous coordination mechanism. These include irregular stakeholders' meetings and limited and/or unstructured collaboration as a result of among them lack of updated partner information/inventory to facilitate coordination of partners on engagement processes such as joint health planning, implementation and monitoring and evaluation (M&E) and resource mobilization.

A section of Vihiga county health stakeholders during a quarterly HIV TWG meeting

To address the lack of up-to-date and incorrect stakeholders' information, Tupime Kaunti project provided the department of health with technical support in establishing an online inventory. The google docs-based inventory allows for real-time update and therefore, access to crucial information for enhanced coordination and partnership.

Stakeholders are now able to update their information remotely using telephones or laptops. This means that the department of health is also able to collect partner information at any given time. Notably, the e-inventory, as a method for stakeholders mapping is cost-effective compared to the previous manual paper-based system that required regular expensive, time-consuming physical meetings between the

county leadership and partners. To date, more than 30 partners have updated their information on the inventory.

As an enabler for effective collaboration, real-time access to updated partner information has enhanced engagement with health partners in Vihiga. Particularly, this informed and facilitated reconstitution of the HIV technical working group (TWG) in February 2019 and prior to that, the revitalization of key stakeholders' engagement forums including the health stakeholders' forum and other TWGs.

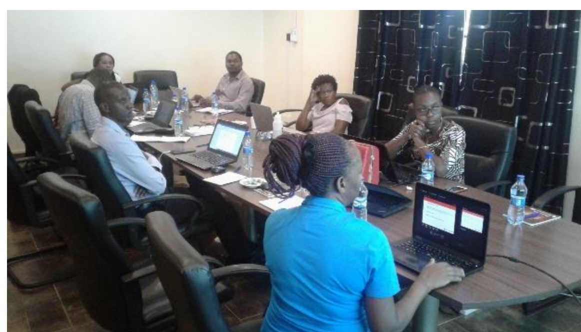
The e-inventory captures crucial partner information including; among other details, a summary on stakeholders by category, number of implementing partners per sub-county, partner support per focus area and partner investment in the county. Notably, the inventory has and continues facilitate key decisions and processes including engaging stakeholders in different forums like TWGS, targeted collaborations and resource mobilization toward key county processes like annual work plan (AWP) development and M&E plan development.

In addition to the forums, the web-based inventory has created opportunities for synergy in health response among partners through joint planning and implementation. Collaboration in implementation of joint activities for Malaria, HIV and reproductive health (RH) programs has improved significantly; therefore, reducing duplication of effort and ensuring effective use of available resources.

To sustain the gains realized through effective stakeholder coordination, Tupime Kaunti will continue supporting the department to further enhance the functionality of stakeholders' coordination forums including TWGs. The project will also prioritize support to ensure increased sharing and use of information in stakeholder engagement forums and joint development and implementation of departmental policies and plans for increased ownership and mutual accountability.

PARTNERSHIP FOR PURPOSE! BUILDING SYNERGY FOR IMPROVED HEALTH RESPONSE IN BUSIA

The measurements, learning and accountability (MLA) systems strengthening plan for Busia seeks to accelerate priority activities towards a strengthened and functional monitoring and evaluation (M&E) system. The plan prescribes responses to various systems and skills gaps including policy formulation and weak structures for coordination of health sector stakeholders.



Members of the Busia JHIP during the quarterly meeting

At project inception, the department of health – Busia demonstrated weak coordination of partners leading to diluted potential hence sub-optimal impact across the spectrum of programs implemented by health partners. Evident attempts to strengthen collaboration were less coordinated, ad hoc, unstructured and therefore less effective. In addition, the department did not have a documented and updated stakeholder inventory with information on scope and programs supported by health implementing partners.

The MLA plan for Busia envisages effective health sector partnerships as a strategic imperative for delivery of the sectoral objectives. In this regard, the department; in collaboration with Tupime Kaunti project, initiated efforts to strengthen and sustain coordination of partners support in health. The goal is to deep collaboration among health-implementing partners, expanding opportunities for integration, optimizing synergy to maximize results and promoting accountability.

These efforts led to the initial Joint Health Implementing Partners (JHIP) meeting in October 2018. The meeting which brought together eight USG and non-USG partners focused on synergizing support to health department through joint planning, integration, resource mobilization, coordination of technical assistance and implementation of the stakeholder inventory.

In the inaugural meeting, partners shared periodic activity plans, prioritized the collaborative activities and identified lead delivery mechanisms. In addition, the partners developed an action plan to guide implementation of the meeting's resolutions including quarterly meetings. Partners also committed to support the quarterly meetings, endorsed formation of the JHIP and nominated Tupime Kaunti as the convener. The JHIP further nominated Save the Children International and Tupime Kaunti as focal reference for county health management team (CHMT) liaison and advocacy.

In January 2019, the JHIP held the second meeting; attended by 14 partners with six partners participating for the first time. The meeting reviewed the implementation status of activities for the quarter (October – December 2018) which showed 67% implementation rate. Partners further developed an action plan for January – March and forecasted activities for the next quarter. To ensure successful implementation of the JHIP activities, partners also committed financial support. Importantly, the stakeholder inventory was updated to include the details of the additional six partners. To further position JHIP as a leader in coordination of health stakeholders, the partners also initiated discussions on engagement with other stakeholder structures including HENNET.

The JHIP's sustainability approach is anchored on institutionalizing the quarterly meetings through partner support, participatory leadership, goodwill from high-level leadership of the participating organizations, recognition by health department leadership and extended collaboration through other structures e.g. TWGs, HENNET and stakeholder forums.

ENHANCING ALIGNMENT OF HEALTH SECTOR PLANS TOWARDS IMPROVED OWNERSHIP OF COUNTY TARGETS IN KISII

Health sector plans outline sector priorities and strategies for addressing various priorities to improve population health outcomes. These plans provide a framework to guide implementation of targeted health interventions and building resilient health systems. Importantly, county plans facilitate harmonization of efforts and resources towards achieving common goals.

The end-term report for the County Health Sector Strategic and Investment Plan (CHSSIP) 2013-2017 for Kisii revealed gaps in policy formulation. For instance, the monitoring and evaluation (M&E) plan was developed in year four of the CHSSIP implementation period. Also noted was limited involvement of health stakeholders in key health sector processes including planning. Weak alignment of priorities in the sector plans; County Integrated Development Plan, CHSSIP, Annual Work Plan (AWP) and M&E plan, was also observed. Further to this, the health stakeholders were not effectively involved in development of the county plan thus their activities were not aligned to the county plans. As a result, the department's and health stakeholders' ownership of the documents was limited therefore undermining their implementation.

Kisii County Department of Health and stakeholders during a M&E Plan development workshop

To address these gaps and realize effective alignment with health stakeholders' priorities, the department of health – Kisii provided leadership in the development of the CHSSIP and M&E plan 2018-2023. The development processes brought together various partners in an effort to align the department and partners' priorities to the CIDP and national goals. Through these processes, the department successfully aligned the M&E plan targets to the CHSSIP and CIDP priorities. The department further linked targets in the AWP for FY 2019/20 to the CHSSIP targets and

In addition to aligning targets in the county plans, meaningful involvement of stakeholders set the foundation for ownership of targets at the county, sub county and facility levels. Clarity on the targets will streamline performance monitoring and improve mutual accountability between the department and partners.

To sustain this collaboration, Tupime Kaunti will continue supporting the department of health to strengthen partners' coordination mechanisms. Specifically, the project will provide technical support in health stakeholders' forums and technical working groups (TWGs) to ensure sustained engagement on and prioritization of health sector priorities. In addition, the project will support the department of health through the M&E unit to implement the M&E plan and undertake other M&E functions as highlighted in the department's measurements, learning and accountability (MLA) systems strengthening plan.

STRENGTHENING MPDSR REVIEW MEETINGS USING THE RMNCAH SCORECARD IN KAKAMEGA

Improving Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) outcomes remains a top priority for the department of health Kakamega. The County Integrated Development Plan, County Health Sector Strategic and Investment Plan 2018-2023 and the Governor's manifesto 2017-2022 underscore the county's commitment to adopt, invest and implement high impact strategies towards attainment of positive health outcomes for mothers, babies and adolescents.

To improve efficacy of RMNCAH programming and strengthen accountability and monitoring, the Department of Health has adopted the scorecard as a means to enriching performance reviews to inform key programming decisions including data quality improvement. Notably, the scorecard has enabled standardization of RMNCAH performance reviews; by focusing on a core set of indicators. Further, the scorecard has entrenched a data-driven approach in performance reviews.

To increase demand for and use of RMNCAH data in planning and management, the project has sustained support to the county to streamline data use in various decision making processes including Maternal Perinatal Death Surveillance Response (MPDSR) review meetings. Notably, the project continues to provide targeted support to build health management teams' capacities to provide leadership in data demand, analysis and use of quality information.

As a result, the project has been supporting the County Reproductive Health Coordinator to oversee production of quarterly RMNCAH scorecards and dissemination of the same during MPDSR meetings. The meeting which are attended by CHMT members, various health workers' cadres including nurses, health records and information officers, RH coordinators has created opportunities for performance reviews based on the scorecards jointly with health sector partners. Importantly, the data-driven reviews have created opportunities for advocacy for joint planning and implementation as well as resource pooling for optimal impact.

Data-driven MPDSR committees have further strengthened sustained implementation of MPDSR guidelines at sub county level with most sub counties holding quarterly meetings. Among the emerging issues raised during MPDSR meetings are weak referral system/ambulatory services and shortage of blood and blood products to attend to the anemic cases or complications on postpartum hemorrhage or pre-eclampsia presentations.

As a way forward, the project will support the department to track implementation of the RMNCAH actions and identify facilities for targeted DQA support based on performance across all sub counties. The project will also sustain its support for the quarterly integrated performance and data reviews using the RMNCAH scorecard to ensure effective use of data in programming.

BUILDING SYSTEMS FOR SUSTAINABLE HIV PROGRAMMING OVERSIGHT IN BUNGOMA

HIV technical working groups (TWGs) play a critical role in harmonizing efforts of HIV stakeholders at county level. They facilitate multi-stakeholder involvement in HIV programming and particularly, in design and implementation of strategies for HIV prevention and treatment. TWGs also provide county health management with opportunities to leverage stakeholders' knowledge, expertise and resources.

To effectively respond to HIV priorities, the department of health – Bungoma has embraced a progressive shift towards building collaborative systems that are county-owned and led. The efforts which are part of the county's measurements, learning and accountability (MLA) systems building processes have enhanced the county's partners' coordination mechanism and created opportunities for continuous stakeholder engagement among them the HIV TWG.

Bungoma County HIV TWG members following proceedings in one of the quarterly HIV TWG meetings

In addition to providing leadership in the HIV TWG, the department continues to mobilize health partners to ensure meaningful involvement in strengthening HIV programming oversight. As a result, the department has realized improved partner coordination and streamlined collaboration between the department of health and HIV partners. Similarly, collaboration among HIV partners has improved.

The HIV TWG has enhanced synergy between service delivery and strategic information partners in addressing emerging issues and TWG meeting actions. Notably, the inaugural TWG meeting successfully lobbied for strengthened partnership between sub counties and ministry of health (MOH) staff; through joint work planning and implementation. To ensure sustainability of this partnership, Tupime Kaunti further lobbied for financial support from AMPATH Plus resulting in continuous engagement between sub counties and MOH.

In creating a single forum for meaningful engagement of partners, the department has created a platform for sustained engagement on the HIV program. The TWG has enhanced ownership of the program plans and results and enhanced mutual accountability. A key result of the TWG is regular sub county and high volume facilities data reviews currently led by AMPATH Plus; the service delivery partner in the county.

Going forward, the project will continually support the department to coordinate and ensure HIV partners' involvement in HIV programming. The project will further support the department to develop and implement a systematic approach for action plan implementation follow up to ensure realization of various objectives.

TOWARDS IMPROVED HEALTH SECTOR IMPLEMENTATION AND MONITORING; MIGORI DEVELOPS M&E PLAN

Routine monitoring and evaluation (M&E) is crucial in tracking implementation and impact of health programs and interventions captured in county health sector strategic and investment plans (CHSSIP). M&E provides evidence on the efficacy, efficiency, relevance and sustainability of health responses and therefore informs the design and application of appropriate health sector strategies.

During implementation of the CHSSIP 2013-2017, the department of health - Migori County developed an M&E plan in 2016. The delay in developing the plan was attributed to among them lack of requisite technical resource capacity. As a result, the department did not track/monitor the CHSSIP effectively. Key M&E processes including mid and end-term evaluations were also not undertaken, undermining the scope and quality of assessment of implementation progress of the CHSSIP.

To address the existing M&E gaps, the department of health-Migori prioritized implementation of key actions in the measurements, learning and accountability (MLA) systems strengthening plan, developed in collaboration with Tupime Kaunti Project. These actions include establishment and strengthening of the M&E unit to coordinate M&E functions for the department of health.

In addition to supporting establishment of the M&E unit, the project provided technical support in the development of an M&E plan for the CHSSIP 2018-2023. The plan outlines among them the indicators to be tracked, data to be collected, data collection tools, data collection methods, timelines for data collection and analysis of findings/results as well as reporting mechanisms and responsibilities of the officers directly involved in data management.

The process which was led by the M&E unit involved Tupime Kaunti project and other health implementing partners facilitated alignment of the M&E plan to the relevant national policy guidelines and the health sector priorities in the CHSSIP 2018-2023. The project will provide additional support to ensure implementation of the plan and particularly in the mid and end term reviews of the CHSSIP to inform decision making and for better planning and mobilization of resources for the department of health.

KISUMU COUNTY'S JOURNEY TO DATA QUALITY IMPROVEMENT

Health care is information intensive in nature and therefore demands a strategic and proactive approach for ensuring data quality. Whereas opportunities for interaction between data users and producers exist, poor data quality has continued to undermine the impact of HIV programming. This is despite the investments and efforts towards data quality improvement (DQI) initiatives.

Findings of a recent data review revealed data quality gaps including under reporting on post exposure prophylaxis (PREP) and voluntary medical circumcision (VMMC) services. An analysis of the root cause of the underreporting revealed erroneous data set allocation to facilities that do not provide the said services.

To address these gaps, the department targeted to address erroneous allocation of VMMC data sets to 56 facilities within the county. Correction of the VMMC data sets on DHIS2 was done by the county and sub county health records and information officer (C/SCHRIO) and the HIV/AIDS coordinators with the support from various partners. Besides VMMC, the department also prioritized similar activities for HIV/TB, methadone assisted therapy (MAT) and post exposure prophylaxis programs.

SUB COUNTY	ACTUAL VMMC SITES	DHIS 2 EXPECTED SITES AS AT DEC 2018	DATASET TO BE REMOVED	DHIS 2 (CURRENT) EXPECTED SITES AS AT APRIL 2019
Kisumu Central	3	4	1	3
Kisumu East	2	2	0	2
Kisumu West	3	19	16	3
Nyando	2	13	11	2
Nyakach	4	21	17	4
Muhoroni	9	23	14	9
Seme	2	2	0	2

So far, Kisumu has updated VMMC data sets for 25 VMMC sites; thus providing a critical foundation for ensuring accurate reporting. Efforts to correct data sets for the remaining sites in Nyakach, Nyando and Kisumu West sub counties are ongoing.

In addition to this, Tupime Kaunti will continue supporting the department of health to follow up on implementation of HIV data quality improvement plans in collaboration with other partners to ensure availability of quality data for decision making. The project will also prioritize support for data verification before submission of facility reports, mentorship on data elements/documentation and introduction of inventory of registers in use at facility levels. The project is also prioritizing support to the department to harmonize DQA activities to ensure mutual accountability for improved quality of data.

Attachment I: Partners Interacted with During the Quarter

Mechanism/ Project	Lead Organization	Agency: USAID, DFID etc.	Activity	Role of Partner	Role of Tupime Kaunti
Tamia	UMB	CDC	M&E Plan Development for Kisii	Technical and Financial Support	Technical and Financial Support
AHF	AHF		M&E Plan Development for Kisii	Technical Support	Technical and Financial Support
Living Goods	Living Goods		• M&E Plan Development for Kisii • CHIS Data Review and Sensitization to Kisii County	Technical Support	Technical and Financial Support Technical lead in the activity
THS UHC	World Bank		HIV Target Setting for Homa Bay	Technical Support	Technical and Financial Support
			M&E Plan Development for Homa Bay	Technical Support	Technical and Financial Support
AMPATH Plus	Moil University	USAID	-M&E Plan Development for Kakamega and Busia AWP consolidation- Vihiga and Kakamega HIV Data review - Kisumu	Technical Financial Financial	Technical and Financial Technical Technical
			HIV TWG for Bungoma	Technical and Financial Support	Technical Support
LVCT	LVCT	USAID	- M&E Plan Development for Kisii - HIV data review - Kisumu	Technical Support Technical	Technical and Financial Support Technical
Afya Ugavi	GSM	USAID	Kisumu HIV TWG meetings IDSR Data Review cum Sensitization	Technical contribution	Financial Technical lead Technical lead
Ampath		USAID	Vihiga Stakeholders forum TWG	Financial and technical contribution	Technical contribution
World Bank - THS	World Bank		Bungoma County M&E plan	Technical contribution	Technical and financial contribution
MAAYGO and Trans Alliance			Kisumu Stakeholders forum	Financial contribution	Technical and financial contribution
Impact Malaria	Afya Halisi	USAID	Vihiga M&E TWG	Technical contribution	Technical Lead

Mechanism/ Project	Lead Organization	Agency: USAID, DFID etc.	Activity	Role of Partner	Role of Tupime Kaunti
KeHMIS		USAID	Kisumu M&E TWG	Technical contribution	Financial and Technical Lead
KMET		USAID	Kisumu M&E TWG	Technical contribution	Financial and Technical Lead
KCCB-KARP		USAID	Kisumu M&E TWG	Technical contribution	Financial and Technical Lead
Afya Halisi		USAID	Kisumu M&E TWG	Technical contribution	Financial and Technical Lead
Afya Ziwani		USAID	Kisumu M&E TWG HIV data review- Kisumu	Technical contribution Technical	Financial and Technical Technical
CRS Mwendo		USAID	Kisumu AAC	Financial and Technical Lead	Technical contribution
Jilinde			Kisii M&E TWG	Technical contribution	Financial and Technical Lead
NACC, Afya Halisi			CAPR Data Review and Sensitization		Technical lead in the activity
FACES		CDC	HIV data review - Kisumu	Technical	Technical
Walter Reed		CDC	HIV data review - Kisumu	Technical	Technical
LVCT		CDC	HIV data review - Kisumu	Technical	Technical and financial
KARP		CDC	HIV data review - Kisumu	Technical	Technical and financial
KeHMIS		USAID	HIV data review - Bungoma	Technical	Technical and financial
PSK		USAID	AWP consolidation - Kakamega	Technical and Financial	Technical and Financial
HealthIT	HealthIT	USAID	CPIMS Weekly meetings	System enhancements	Escalation of end user needs
HealthIT, CASEOVC, MWENDO, Nilinde, COGRI	HealthIT	USAID	User Acceptance Test	System enhancement	Facilitation on CPIMS requirements
MWENDO	MWENDO	USAID	Quarterly MEAL Officers meeting	Logistics for MEAL Officers	Facilitation of CPIMS challenges session