Republic of Kenya
Ministry of Health

HEALTH DATA COLLABORATIVE
DATA FOR HEALTH AND SUSTAINABLE DEVELOPMENT

Report of the Kenya HDC

Resource Mapping for Health Information and Monitoring & Evaluation Systems

March 2017
Version 0.0

Acronyms

AMREF	Africa Medical Research Foundation
BMGF	Bill and Melinda Gates Foundation
CHAI	Clinton Health Assistance Initiative
CMLAP	County Measurements Learning and Accountability Program
DFID	Department for International for International Development
DHIS	District Health Information System
DPT	Data Processing Tool
FA	Focus Area
GF	Global Fund
HDC	Health Data Collaborative
HIGDA	Health, Informatics, Governance and Data Analytics
HISM&E	Health Information Systems and Monitoring and Evaluation
JICA	Japan International Cooperation Agency
KHDC	Kenya Health Data Collaborative
KHSSP	Kenya Health Sector Strategic Plan
MoH	Ministry of Health
MTP	Medium Term Plan
RRI	Rapid Result Initiative
SDG	Sustainable Development Goals
SO	Strategic Objective
SWOT	Strength, Weakness ,Opportunity and Threats
TA	Technical Assistants
UN	United Nations
UNICEF	United Nations International Child Emergency Fund
WHO	World Health Organization

Foreword

In September 2015, The UN Sustainable Development Goals set an ambitious agenda for a fairer, safer and healthier world, with 17 goals and 169 targets that were adopted by all Countries. It's clear that achieving the goals will require reliable data, in order to properly understand the scale of the work to be done, and to make good decisions about how to allocate resources for the most efficient and effective results. Lack of reliable data makes it harder to make good decisions about where to target resources to improve health and help people to live longer, healthier and more productive lives.

Over the last two decades, Kenya has received massive support towards strengthening Health Information systems. To accomplish the vision for the health sector which is "to provide equitable and affordable quality health services to all Kenyans", the first Medium Term Plan 2008- 2012 of the Vision 2030 identified the need to strengthen the national health information systems with timely and understandable information on health. Furthermore, Health Information was identified as a key investment area in the Kenya Health Sector Strategic and Investment Plan (2014-2018) for better coordination and alignment of health care resources.

Various assessments done using standardized tools revealed that while progress has been made in improving data quality and level of analysis and use, Kenya was still having challenges in ensuring better resourcing, integration and harmonization of efforts from stakeholders. This is essential to minimize duplication of activities in HISM&E and ensure efficient use the available resources in strengthening health information systems.

The Kenya Health Data Collaborative conference held in May 2016 brought all health sector stakeholders together to discuss one common M&E framework and set various milestones. Some of the key quick win milestones were the mid-term review of the KHSSP and this resource mapping for HIS/M&E activities.

As a country, we are proud to show leadership being among the initial set of countries who have embraced the Health Data Collaborative Initiative. We are also keen to learn from this platform what is working well elsewhere and adapt it to help improve our Health Information and M&E Systems. The future looks bright indeed.

Dr Cleopa Mailu , EGH
Cabinet Secretary

Acknowledgement

The Ministry of Health wishes to acknowledge various organizations and individuals who have contributed to the successful completion of the HISM&E resource mapping in the health sector as part of the Kenya Health Data Collaborative priority quick wins as spelt out I the KHDC roadmap.

Special thanks and appreciation go to the Cabinet Secretary – Dr. Cleopa Mailu, and the Director of Medical Services- Dr. Jackson Kioko for the overall stewardship. We also acknowledge the contribution of UNICEF; USAID and WHO in the development of the resource mapping tool and the subsequent data analysis; and also ICF - Measure Evaluation who provided the lead Technical Assistance for the entire implementation process. Special thanks to Bennett Nemser of UNICEF; Kathryn Oneil and Eduardo Celades of WHO; Kathleen Handley and Edward Kunyanga of USAID for the support and Technical assistance in the exercise. We are also grateful to the partners, stakeholders, Heads of Divisions and programs, and all others who participated in one way or another towards facilitating and providing key information for the HISM&E resource mapping exercise to make it a success.

Finally, we would like to thank the staff from the Ministry of Health for their commitment and hard work in stewarding and coordination of the process. Special mention goes to Dr. Isabella Maina, the Head of the Health sector M/E unit who was responsible for the overall coordination. My sincere gratitude also goes to the other staff; Dr Peter Cherutich, the head of Division of M&E, HIS and health Research; Dr. Helen Kiarie, Dr. Mercy Mwangangi, Dr. Elizabeth Wangia , Wanjala Pepela, Tom Mirasi, Benedette Ajwang, Samuel Cheburet, Njuguna David, Rose Muthee, Clara Gitonga, Anne Nduta, Joseph Mwangi and Bartilol Paul. From the County Departments of Health Abdi Shale (Garissa County), Luke Kiptoon (Nakuru Couny) and Jacinta Mbindyo (Machakos County). From Measure Evaluation Dr Helen Gatakaa and Dr Josephine Karuri. And also Dr Joseph Munga'tu and Jane A Akinyi from Jomo Kenyatta University of Agriculture and Technology (JKUAT) who participated in the data analysis and report writing

Finally the Ministry would like to thank all those whose names may have been inadvertently left out but who were either consulted during the development and administration of the HIS/M&E instruments, or who in one way or another contributed to this process. We wish to state that without their contributions this work would not have been possible. We are greatly indebted to them.

Dr Nicholas Muraguri
Principal Secretary

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1.0 Introduction and Background

The UN Sustainable Development Goals (SDGs) set an ambitious agenda for a fairer, safer and healthier world, with 17 goals and 169 targets that were adopted by all Countries. The SDG health goal 3 is to ''Ensure healthy lives and promote well-being for all at all ages'. 13 targets were set under this health goal and many indicators that will be required to show progress toward achieving the set goal and targets. Monitoring progress towards achievement of the health SDG will require countries to produce reliable health data and to make good evidence-based decisions about how to allocate resources for the most efficient and effective results.

In June 2015, the leaders of global health agencies endorsed the Health Measurement and Accountability Post 2015 Roadmap and Five Point Call to Action. Implementation of the roadmap and call to action requires specific country-led activities by country stakeholders and development partners. This is with a focus on strengthening the country Monitoring and Evaluation (M&E) systems or improved measurement of results and accountability. The Five Point Call to Action on Measurement and Accountability are:

i) Investments: levels and efficiency (domestic and international)
ii) Capacity strengthening (from data collection to use)
iii) Well-functioning population health data sources
iv) Effective open facility and community data systems, including surveillance and administrative resources
v) Enhanced use and accountability (inclusive transparent reviews linked to action)

1.1. The Health Data Collaborative (HDC)

Global stakeholders interested in collaborating on health data investments joined together to form the Health Data Collaborative (HDC). The main purpose of HDC is to enhance country statistical capacity and stewardship and for partners to align their technical and financial commitments around strong nationally owned Health Information Systems and a common Monitoring and Evaluation plan. The work at global level to establish common standards, indicators and databases will be geared to contribute to countries Health Information Systems. The collaborative is a unique initiative in helping countries improve on measurement and accountability using existing country systems.

HDC missions globally aim to promote technical and political support to the country-led health sector information and accountability platform in line with the common agenda for the post-2015 era and the 5-Point Call to Action for measurement and accountability of health results. The specific objectives of HDC are to:

i) Enhance country capacity to monitor & review progress towards the health SDGs through better availability, analysis and use of data

ii) Improve efficiency and alignment of investments in health data systems through collective actions
iii) Increase impact of global public goods on country health data systems through increased sharing, learning and country engagement

1.2 The Kenya Health Data Collaborative

For Kenya health sector to achieve the goals and objectives that are set out in the country health policy, strategic and operational documents, there is need to establish and implement an accompanying robust and efficient HIS/M&E system. Recognizing this fact, the sector through the stewardship of the Ministry of Health sought to bring all stakeholders in Health together to forge a common course for M/E through the holding of an initial Kenya Health Data Collaborative (KHDC) conference. In organizing this conference Kenya worked closely with the Global HDC whose global mission is to promote technical and political support to the country-led health sector information and accountability platform in line with the common agenda for the post-2015 era and the 5-Point Call to Action for measurement and accountability of health results.

Over 150 participants attended that first KHDC conference and they were drawn from different groups, namely: National Government, County Governments, Civil Society, Private Sector and Development Partners each representing their different constituencies

The specific objectives of the conference were to;
i) Raise profile of SDGs and global effort in strengthening Country HIS/M&E systems as a Platform for information and accountability
ii) Rally all stakeholders towards supporting a common country M&E Framework through ensuring that there is a clear plan on provision of long term support
iii) Agree on a high level roadmap for implementation of priority HIS/M&E actions in Kenya
iv) Launch the Kenya Health Data Collaborative (KHDC)

A key highlight of the conference was the launch of the KHDC whose main purpose will be to enhance country statistical capacity and stewardship, and for partners to align their technical and financial commitments around strong nationally owned Health Information Systems and a common monitoring and evaluation plan. To this end partners signed a joint communiqué outlining their major areas of commitment, and identified six (6) key priority areas to advance commitments to one M&E framework for the health sector in Kenya. Finally partners deliberated on and adopted the Health Data Collaborative (KHDC) Roadmap which was informed by a SWOT analysis of Kenya HIS/M&E system and the overall health sector M&E plan.

The roadmap consists of quick wins to be implemented through a rapid results initiative (RRI), short term priorities as well as long term priorities.

1.3. Mapping of Support for HIS/M&E in Kenya

Achievement of the KHDC objective of rallying all stakeholders in Kenya's health sector towards one M&E framework that enjoys full support and implementation by all actors in health is intertwined with the need for partners to align their technical and financial commitments around strong nationally owned health information systems and common monitoring and evaluation (M&E) plan. Thus one of the quick wins recommended for implementation was the comprehensive mapping of partner support to HIS/M&E activities in the health sector.

In accordance to this recommendation, a partners' mapping activity was initiated in August 2016. The goal of the Activity Mapping exercise was to document an estimate of existing resources for Health information system in Kenya from all the sector stakeholders. This would allow more informed and efficient investments in health information systems in future. The Activity Mapping was also intended to help identify gaps and potential duplicative investments at the national and county level. Overall the outcome of this activity would provide stakeholders with the evidence necessary to inform modification of their future investments as per the priorities set out in the Kenya health plans and especially the M/E plan. The activity once completed would inform the development of a multiyear, multi stakeholder's investment plan for M/E. This would align technical and financial assistance with country-defined priorities, reduce fragmentation and duplication of efforts and lower the burden of reporting resulting to more efficient and aligned investments in M&E.

2.0 Objectives of the Resource Mapping Activity

The Objectives of this resource mapping exercise were to:

i) Take stock of resource distribution and allocation for HIS/M&E activities across all the stakeholders
ii) Identify Potential duplicative investments in key focus areas at the national and county level
iii) Consolidate gaps in focus areas and geographical distribution
iv) Inform/ Initiate the development of joint investment case for HIS/M&E in the health sector.

Expected outcomes:

i) More informed and efficient investments in health information systems in future budget cycles.
ii) Informed modification of future investments by all stakeholders to cover critical areas of most pressing need.

iii) Clarity on the relative contribution of each partner to overall outcomes or impact – nationally and by county
iv) Consolidation of resources and efforts in HIS/M&E in focus areas across national and county levels.

The activity was implemented through the use of a detailed Excel Mapping tool which was designed to help identify the who, what, where and when of investments in HIS/M&E. Each organization (e.g. donors, implementers, government agencies, etc) contributing to the development of Kenya HIS was expected to complete the tool. Once completed and the data analyzed, the stakeholders would then be able to see where investments may be duplicative (e.g. multiple agencies working on the same activity in the same county) or where gaps exist (e.g. no investment in specific activity in an area).

In summary, the mapping tool addressed the following areas with regard to partners' investment in HIS/M&E Activities in Kenya:

i) Who: all government agencies, funders and implementing partners contributing to HIS
ii) What: the activities being invested in (e.g. DHIS roll-out, HIS strategy, Analytic training, etc)
iii) How: the cost categories included within the focus area (e.g. training, equipment, etc)
iv) Where: investments by county and national level
v) When: current budget year as well as a few future years (if available)
vi) How much: the budget (or best estimate) for the activity in the respective geographic area(s)

3.0 Methodology

3.1 The Implementation Approach

The M&E Unit of the Ministry of Health was the custodian and the coordinator of the partners' activity mapping exercise. The activity kicked off with the adaptation of the tools with help of partners who including UNICEF, WHO and MEASURE EVALUATION. This was followed by consultative meeting with all partners/stakeholders for inputs to the tool. Partners who completed the initial version of the tool pointed out some areas requiring further refinement. This feedback was received from USAID, UNICEF, WHO and GIZ and revisions were made accordingly. Additionally, partners were sensitized during a Development Partners for Health in Kenya (DPHK) meeting. During these sensitization meetings, stakeholders/partners were briefed on the need to conduct the activity and also taken through detailed steps on how to complete the tool.

Data collection started November 2016 and went on for a period of three months. Partners had the opportunity to ask questions, receive remote or on site support, as

well as any other feedback concerning any part of the exercise that required further clarification.

3.2 Targeted Sample

The Ministry of Health coordinating undertook the responsibility of identifying participants for the resource mapping activity. The participants were identified through purposive sampling where partners implementing HIS/M&E activities were identified from available information. This information was obtained from the Development Partners in Health in Kenya (DPHK) and Health NGOs Network (HENNET) who maintain a comprehensive inventory of activities that their members support in the country. Accordingly thirty (30) partners (including the GoK) that contribute substantially to the HIS/M&E activities at different levels were identified. These are: HIGDA (Palladium), CMLAP (Palladium), SUDK2 (UoN), PIMA (University of Carolina), PS Kenya, Global Affairs Canada/DFATD, CHAI, DANIDA, MoH, BMGF, GDC-GIZ, JAPAN/JICA, DFID, KHMIS - Palladium (CDC Funding), AMREF, Kenya REDCROSS, TB Program (GF), HIV Program (GF), MALARIA program (GF), UNICEF, WHO, IOM, UNAIDS, WORLD BANK, APHRC, ICL - I Choose Life, ICRH – Kenya, PATHFINDER, EGPAF, Mhealth – Kenya and GoK-MoH Support. 28 out of these 30 participants submitted their activity mapping templates completed well enough for use in further data analysis. This translates to a high positive response rate of 93%. Of the 28 however, only 26 provided committed budgets for 2016/2017 and these are ones whose data has been analyzed.

The MoH through the M&E unit attempted to contact another ten multinational organizations for information on whether they support any M&E/HIS activities for activity completion purposes, however there was no positive response from these organizations. These multinational organizations were: EU, FRANCE - Health Dept, KOICA (Korea), Swiss Dev. Cooperation, WFP, AFDB, UNODC, UNDP, UNFPA and GAVI.

3.3 The Activity Mapping Tool

The Activity Mapping process required each participating organization to provide their estimated budget commitments by project, activity, implementing partner(s) and Geography (e.g. by county or national). An Excel-based Activity Mapping Tool provided a basic template for recording these disaggregated budget estimates, as well as other activity details. The tool was made easy to understand and complete by including explanation comments as well as drop down list of input choices where possible. The following categories of information were collected from each partner.

3.3.1 Activity and Actors

i) Programme/project Name
ii) Activity Name
iii) Source of Financing / Funder
iv) Financing Agent
v) Implementing Agent

3.3.2 Activity programmatic classification

(a) Focus Areas

Each activity from the partners were linked to at least one of six focus areas were adapted from the classification Health Information systems/M&E activities in the Health Sector Strategic and Investment Plan (HSSIP). These six focus areas were identified as follows:-

i) Health Information policy, planning and monitoring
ii) Facility based information
iii) Community based information systems
iv) Health Research information
v) Disease surveillance and response
vi) Health Surveys information

(b) Sub-Focus / DP investment area

Each focus area was further sub classified into to the Sub-Focus area for further clarity as on the development partners' investment areas. This sub-classification was as illustrated on the table below.

	FOCUS AREA	**SUB-FOCUS AREAS**
1	Health Information policy, planning and monitoring	• *Health Information policies & planning* • *HIS data verification & quality assurance* • *HIS systems operations & maintenance* • *Annual sector performance reporting*
2	Facility based information	• *Facility-based information systems (training, printing forms)* • *Establishing & expanding electronic reporting systems* • *e-Health records system*
3	Community based information systems	• *Community based monitoring of vital events* • *Community-based health information*
4	Health Research information	• *Health & operations research* • *Health Observatory*

5	Disease surveillance and response	• *Disease surveillance & response (IDRS) systems*
6	Health Surveys information	• *Health surveys - service delivery section*

(c) Link to KHSSP Strategic Objectives
Additionally the partners' investments in Health Information/M&E were further linked to the KHSSP (2014-18) Strategic Objectives and Health investment areas; as well as to the KHSSP (2014-18) Services. Thus each participant identified, for each of their supported activity, the disease programs they were working under, and the service delivery level that was targeted for support.

3.3.3 Geography
This category of information was to clarify whether the activity was to be implemented at the National or Counties. In the case of county-level activity, the list of 47 counties was provided for participants to indicate the specific counties where implementation would be done. There was the option of selecting 'Across all Counties' for the case where an activity's implementation would span all the 47 counties.

3.3.4 Cost Category
This information was necessary to show the approximate allocation, in percentage, of each activity's budget across key cost categories that had been identified for this exercise. The six expense categories were:

i) Personnel
ii) Training
iii) Equipment
iv) Professional Services
v) Operating Expenses
vi) Other Cost

(v) Budget Commitments
This section sought to find out the budget commitments for each activity for the next three fiscal years, including the current fiscal year (FY 2016/2017). Participants were requested to align their budget estimates to the government of Kenya's fiscal year cycle which runs from July to June. The budgets were provided in the participant's preferred currencies which would then be automatically converted to US Dollars. The participants were requested to also record any assumptions used in generating their respective budget estimates as these could later be used to help in ensuring consistency over time and across agencies. At a minimum the respondents had to provide the activity budget for the current fiscal year to enable inclusion of their data in subsequent analysis.

3.4 Data Collection

The MOH team worked closely with a technical assistance (TA) from MEASURE EVALUATION to administer the mapping tool and provide customized support for the data collection process. Onsite support was provided by the TA by jointly (with the partner teams) updating the tool with their data where necessary. The coordination team developed and regularly updated a submission tracking sheet listing all organizations that were expected to complete the mapping tool, along with their contact details and their current status in completing the tool. This was very useful for progress monitoring and follow-up during roll out of this activity.

In summary the following are the five key steps that were followed in the resource mapping process:

i) *Step 1:* Each organization completed the Mapping tool – both the "Organizational INPUT" and "Program INPUT" worksheets
ii) *Step 2:* Organizations submitted the completed tool to the Coordination Team (Ministry of Health and TA support)
iii) *Step 3:* The Coordination Team then conducted a data quality review and assessed double counting between funders and implementing partners. The Coordination Team liaised with each respective Organization regarding potential errors and double counting issues.
iv) *Step 4:* Organizations then submitted any final inputs to correct errors and/or the identified double counting issues.
v) *Step 5:* Finally the Coordination Team compiled the final spreadsheet with the consolidated data across all partners, and added a Pivot Table in Excel as an easy-to-use data analysis tool.

3.5 Data Processing

Elaborate data processing procedures were developed for the resource Mapping of Kenya's Health Information System. These procedures took into account the need to ensure that the data submitted by the partner organizations was complete and of high quality, and also to eliminate any double reporting of support between different partners. Once each partner data was checked for completeness and accuracy, they were merged into an All Partners database that was eventually used for the data analysis. The following is a summary of the data processing steps followed in this exercise.

i) **Submission**: Each participating organization submitted a completed Resource Mapping (AM) template updated with information on the HIS/M&E activities they support in Kenya's health sector
ii) **Archiving**: The Data Processing Team (DPT) received each submission and stored the original version based on the agreed upon standard

protocol. A copy of the data was also made and this is what was used in the subsequent data processing steps.

iii) **Merging**: Each quality checked submission was processed and merged into the full (or 'all partner') dataset for final data cleaning and analysis.

iv) **Quality Checks**: The DPT reviewed each submission – and each row - for completeness and accuracy.

v) **Identify Double Counting**: The DPT also reviewed each submission - relative to the full (or 'all partner') dataset – for potential double counting of investments. Double counting resulted from the situation whereby the donor / financier as well as the implementing partners submitted their support information. Where double counting was identified, repeated rows were NOT removed, but they were clearly marked to allow accurate analysis.

vi) **Partner Clarifications**: Where necessary the DPT contacted the partner for any clarifications from the review of quality checks or double counting. Steps #4-6 were repeated as many times as needed to ensure quality and completeness of the final dataset.

vii) **Edit Dataset (if needed)**: If sufficient clarification from partners was not received in a timely manner, then the DPT had the discretion to do minor edits on the dataset to enable further analysis. All edits were clearly marked or documented in the dataset with comments / notes.

viii) **Reformat Dataset**: For easier analysis, the full (or 'all partner') dataset was slightly reformatted for convenient and effective analysis using the Pivot Table tool in Excel.

ix) **Create Pivot Table**: The final dataset was used in creation of user-friendly Pivot Table (in Excel) for easy analysis and to derive the key findings from the data.

3.6 Limitations

The limitations experienced in undertaking this activity were mostly due to the fact that the tool was new and thus there was need for significant capacity support for some organizations to input their data correctly. Specific challenges included:

i) Classification of budget information detail is likely to be different for different Organizations. Consequently, these budgets may not easily have conformed to the reporting tool and thus the information may not be easily comparable across organizations.

ii) There was room for mis-interpretation of the meaning of some data elements. For example one cannot be sure whether the budget presented by the partner is all for activity–based expenses; or whether this includes the partners own expenses e.g. for their own staff operating expenses when supporting the

activities. This should be well defined and clarified to all in subsequent mapping exercises.

iii) The meaning of the different focus and sub-focus areas may not have been uniformly understood across the different partners who completed the tool. Since the focus and sub-focus information provides the necessary link of the partners' activities to the KHSSP, in future there will be need for closer engagement with the partners for a common understanding of the range of activities that fall under each focus and sub-focus areas of M&E/HIS.

iv) Some of the respondents who were still using older versions of MS Excel (2007 and below) had challenges accessing some of the drop-down options inbuilt in the tool. This caused them to use manual methods of data entry, sometimes keying in the wrong values which necessitated additional effort during the data cleaning phase.

4.0 Results

4.1 Overall Investment in HIS/M&E

This section describes the key findings based on analysis of the combined data received from the 26 partners who participated in the mapping activity and provided budget commitments for FY2016/2017. The total FY2016/2017 budget commitment from all these partners was US Dollars 50,364,355.

4.1.1 Distribution of Budget across Implementation Levels

The chart below shows how the overall budget was distributed across the different levels (National or County). The national level got a large allocation at 27% while the rest of the budget was either allocated to specific counties or across all counties. A few partners did not indicate the level at which their budgets were allocated.

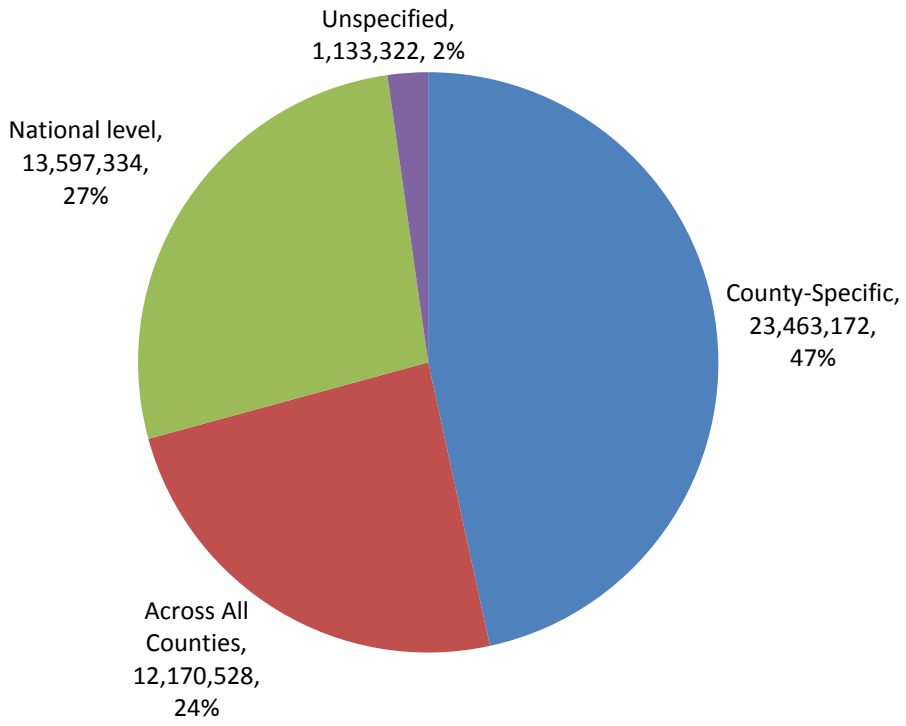


Fig 4.1: FY 2016/17 Budget Distribution across Implementation Levels

4.1.2 Budget Distribution across Focus Areas

The chart below indicates that over 50% of the stakeholders' investment in HIS/M&E was spent on Health information policy, planning and monitoring, followed by investment in facility based information systems at 20% and disease surveillance and response at 14%. Health surveys, health research and facility based information systems received the least resources at less than 10% each.

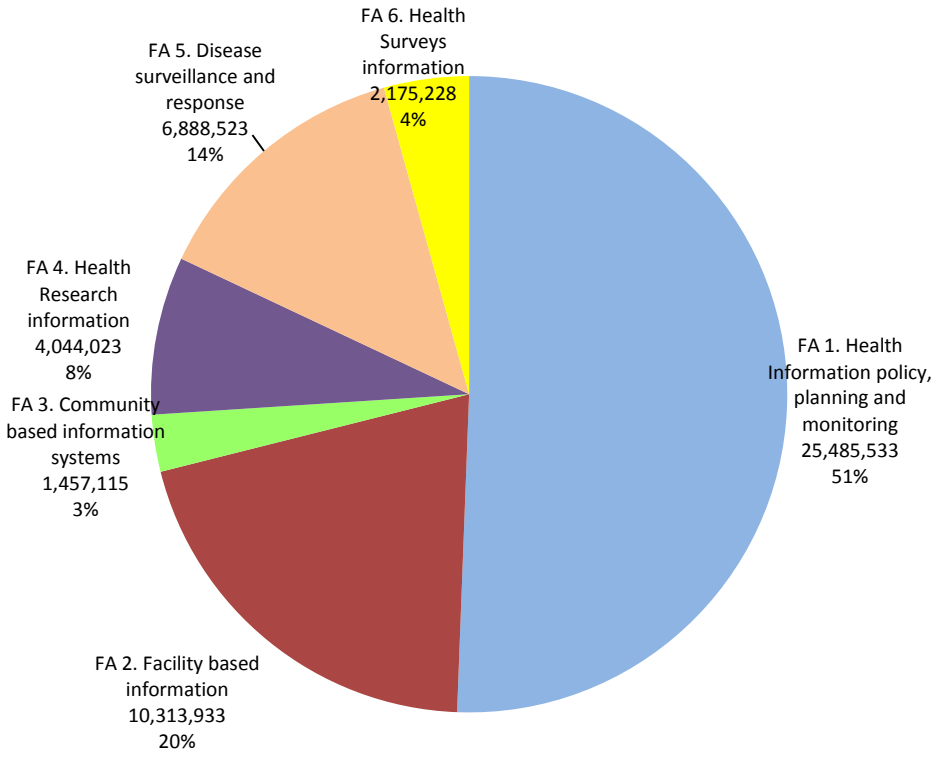


Fig 4.2: FY 2016/17 Budget Distribution across HIS Focus Areas

4.1.3 Distribution of Funds across Cost Categories for each Focus Area

A closer look at the six focus areas shows that the distribution of funds across the different cost categories differs depending on the focus area. For example Operating Expenses took up the largest proportion of the budget for focus area 6 (Health Surveys Information) while personnel and equipment took up the larger proportion for FA 5 (Disease Surveillance and Response). For the other focus areas other undefined costs seem to take up the largest proportion of the budget.

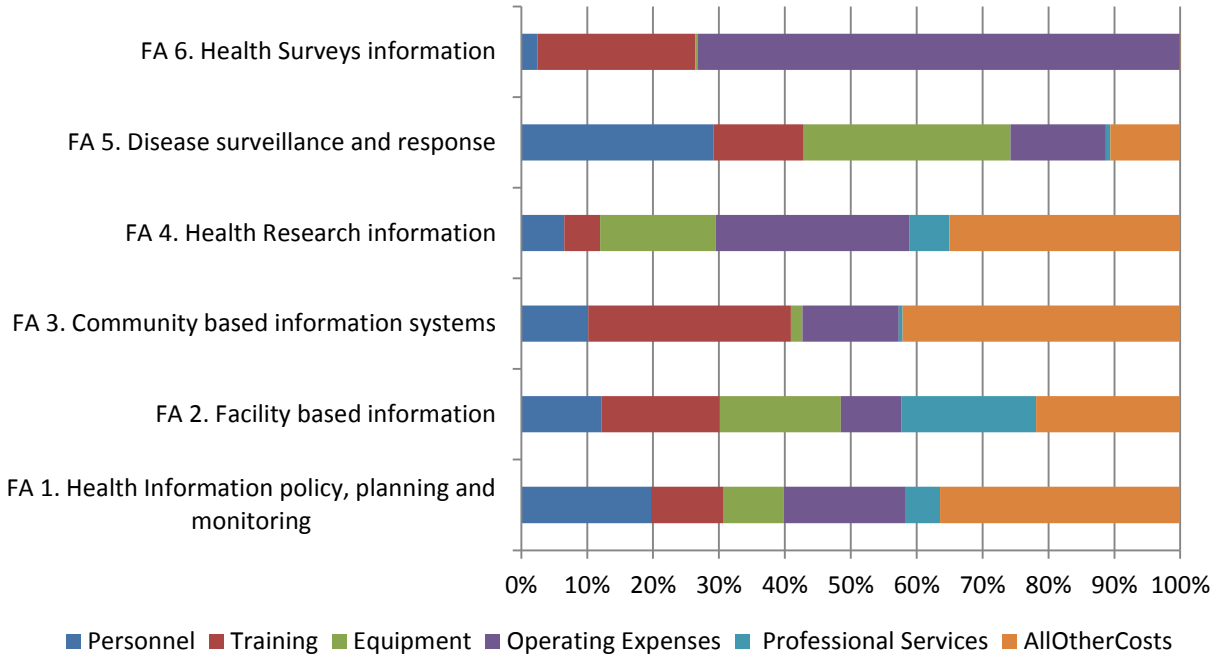


Figure 4.7: Distribution of Funds across Cost Categories for each Focus Area

4.1.4 Individual Partner's Budget Allocation

The chart below shows the total FY 2016/17 funding from the various sources in respect to the different HIS/M&E focus areas. Majority of the partners have allocated budget to focus area 1 (Health Information Policy and Monitoring). Global Affairs Canada contributes the highest budget allocation, with lowest being IOM. However the average partner budget allocations stand at $1,937,091 US Dollars.

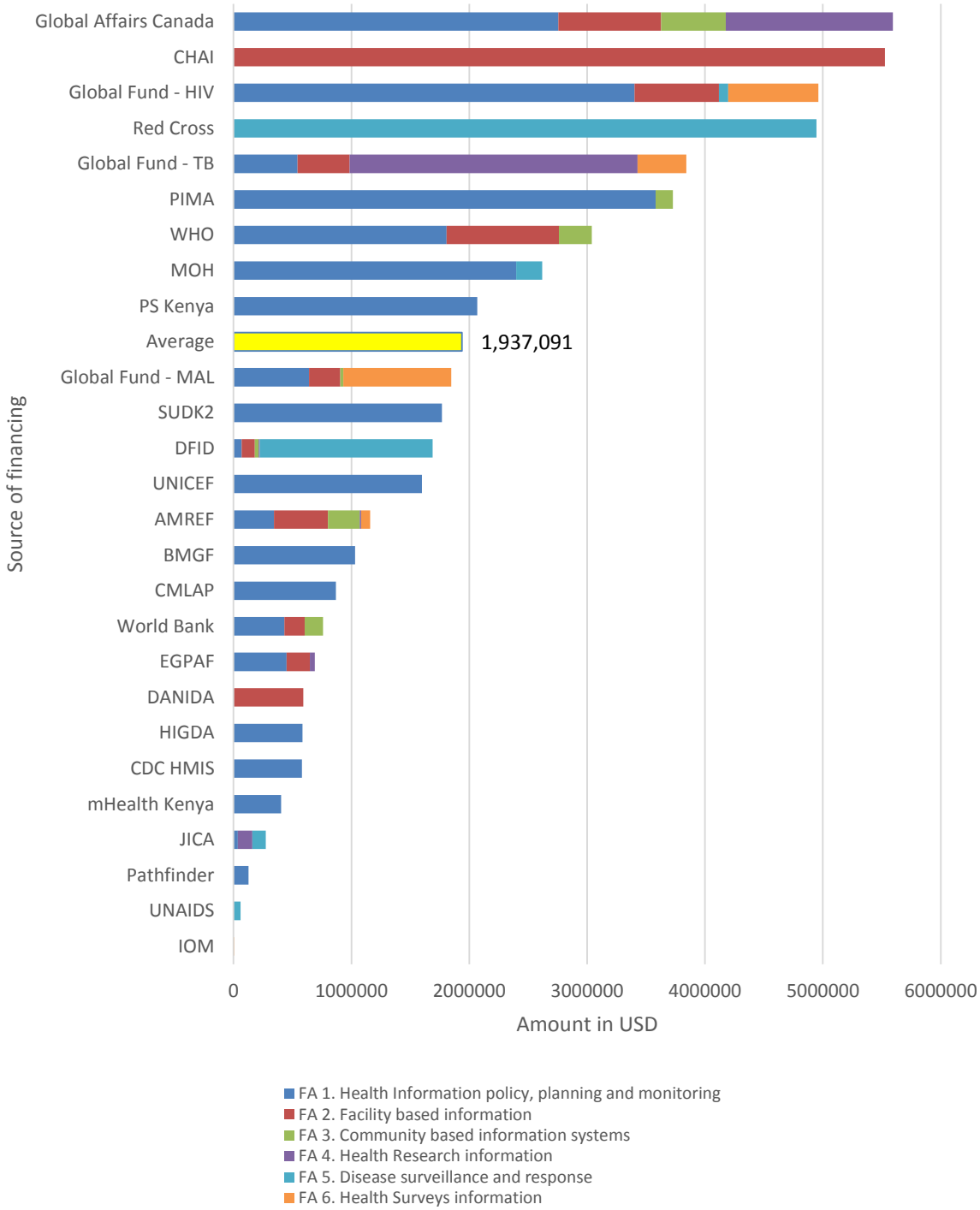


Fig 4.3: Distribution of each Partner's Budget across HIS Focus Areas

4.1.5 Allocation of Investment in Different Counties

The chart below shows the HIS/M&E focus areas that are funded across the different counties. From the diagram it is clear that budget distribution across the counties is disproportionate with some getting a large share while others get minimal support or none support at all. It is also apparent that none of the counties has support in all the six focus areas. Further, only eleven counties (23.4%) receive support for more than three focus areas. Additionally, only 15 out the 40 counties (35%) receive

support of above the average amount of $586,579 based on the total FY2016/17 budget allocation by all stakeholders. Seven counties did not receive any budgetary support, namely Laikipia, Embu, Isiolo, Kirinyaga, Kitui, Narok and Tana River.

Focus area 1 (Health information policy, planning and monitoring) was the most funded in nearly all the counties while focus area 4 (health research information) having the least support in the counties.

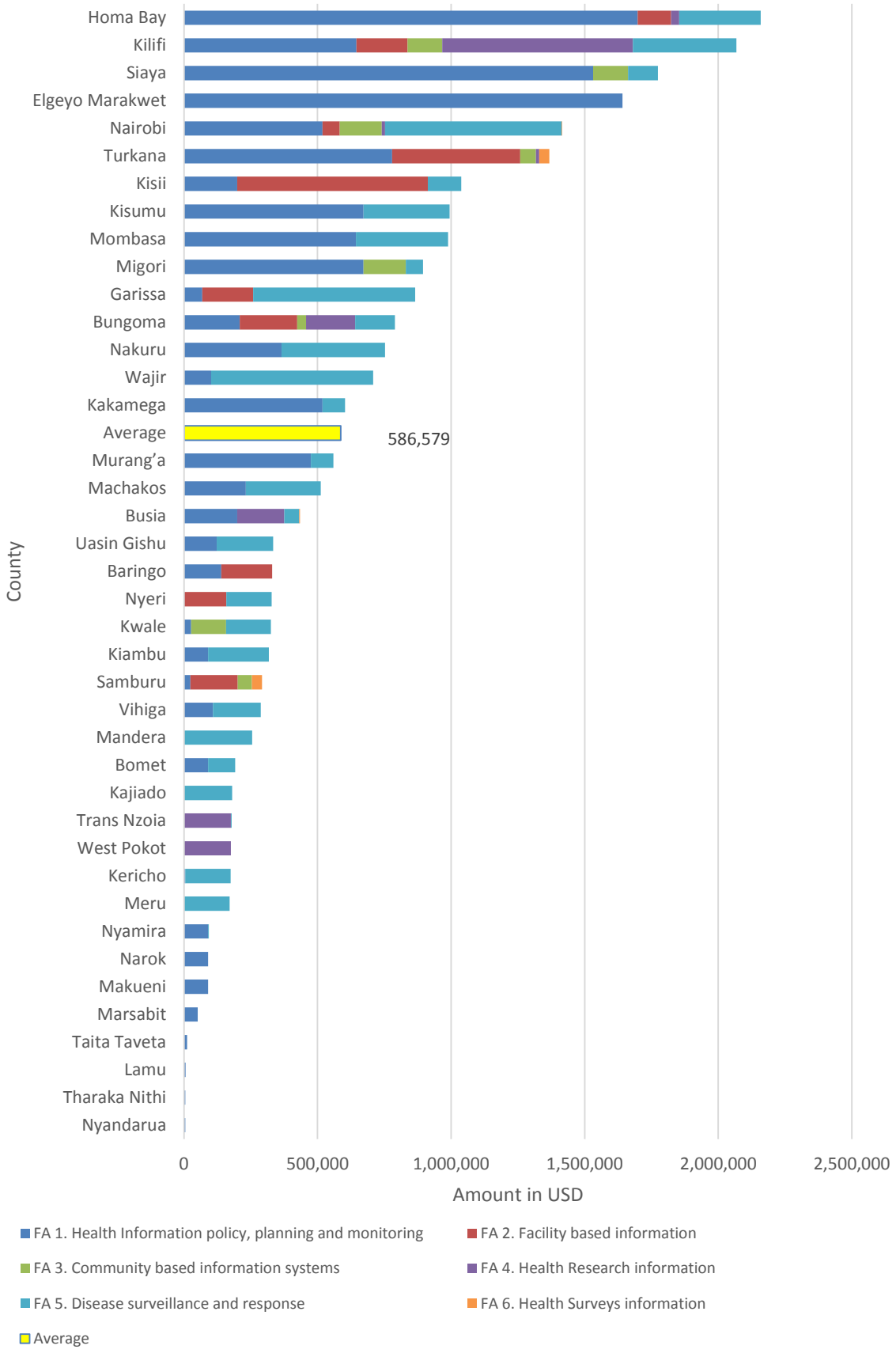


Fig 4.4: Allocation of Investment in Different Counties

4.1.6 Distribution of funds at both national level and across all counties

The chart below shows the specific budgetary support towards the various HIS/M&E focus areas within the national and county levels. This diagram clearly shows that counties receive support in all the six focus areas while national level does not receive support in two of the focus areas i.e. Focus area 4 (Health research information) and Focus area 5 (Disease surveillance and response)

It is also depicted that Focus area 1 (Health information policy planning and monitoring) received the highest allocation ($15,251,264) while focus area 6 (Health surveys and information) had least allocation in the counties ($495,238). Additionally, Focus area 1 received the highest allocation at the national level while focus area 3 (Community based systems) received the least allocation ($451,259) at this level.

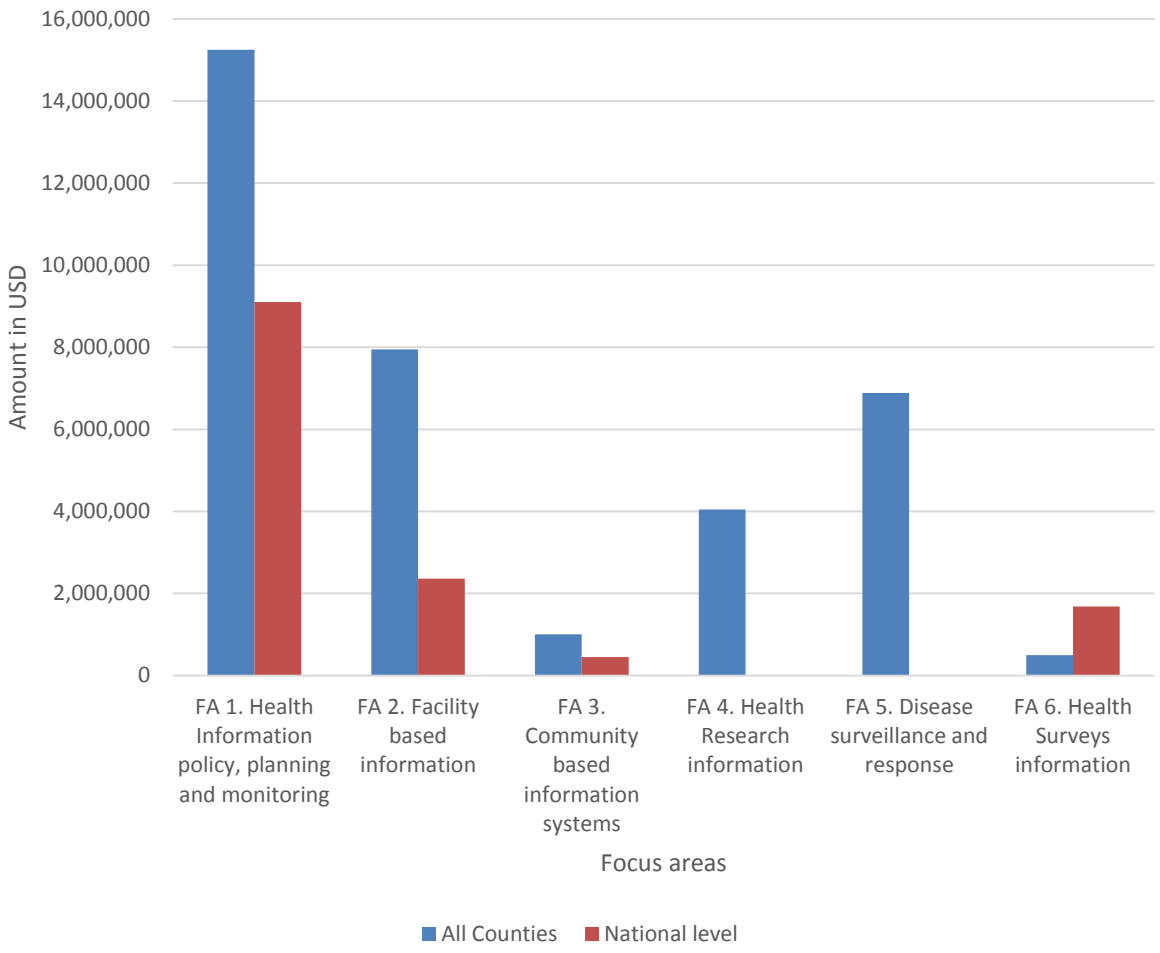


Fig 4.5: Funds Allocation at National and County Levels

4.1.7 Distribution of Funds across Cost Categories: National and County Levels

At a glance, Counties were allocated more resources across all the cost categories than the national level. However keeping in mind that there are 47 counties, the average allocation per county is less than the national level allocation for each cost category. Among the classified categories, Operating Expenses had the highest budget allocation followed by Personnel, Equipment and Training while Professional Services had the least budget allocation. Section 4.1.8 drills down further to show the contribution by stakeholders to each of these cost categories, as well as by each county.

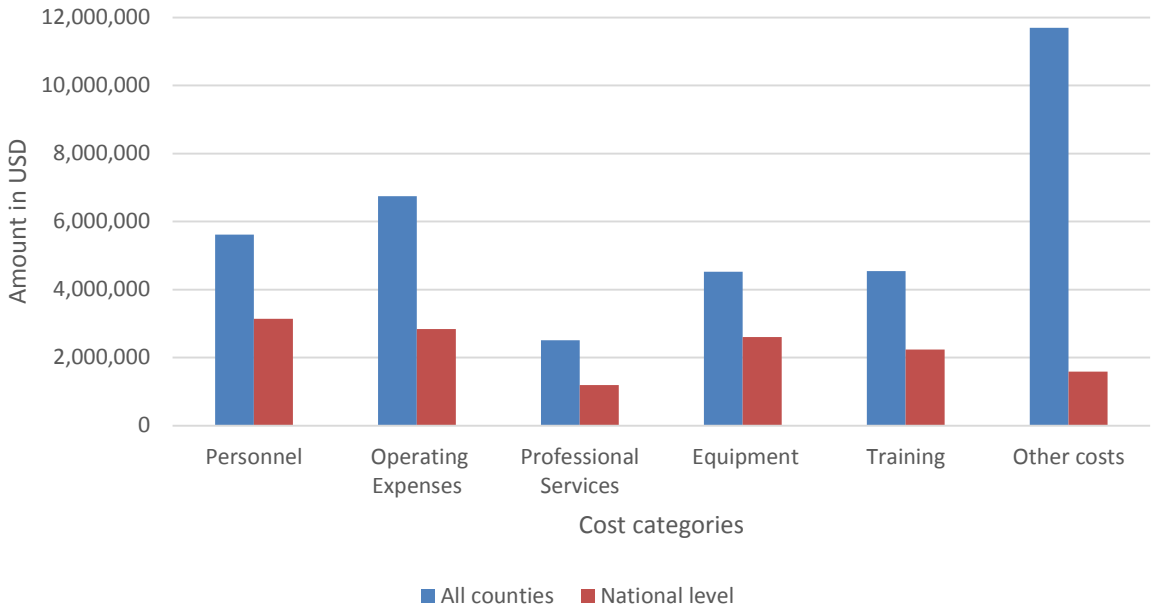


Figure 4.6: Distribution of funds across the cost categories: National and County Levels

4.1.8 Distribution of funds across the cost categories

Chart 4.8 (a) shows that partners classified their supported activities' budget mostly under 'other costs' followed closely by costs pertaining to personnel expenses. And focusing on each county, a similar pattern of budget distribution across the cost categories is also evident from chart 4.8 (b).

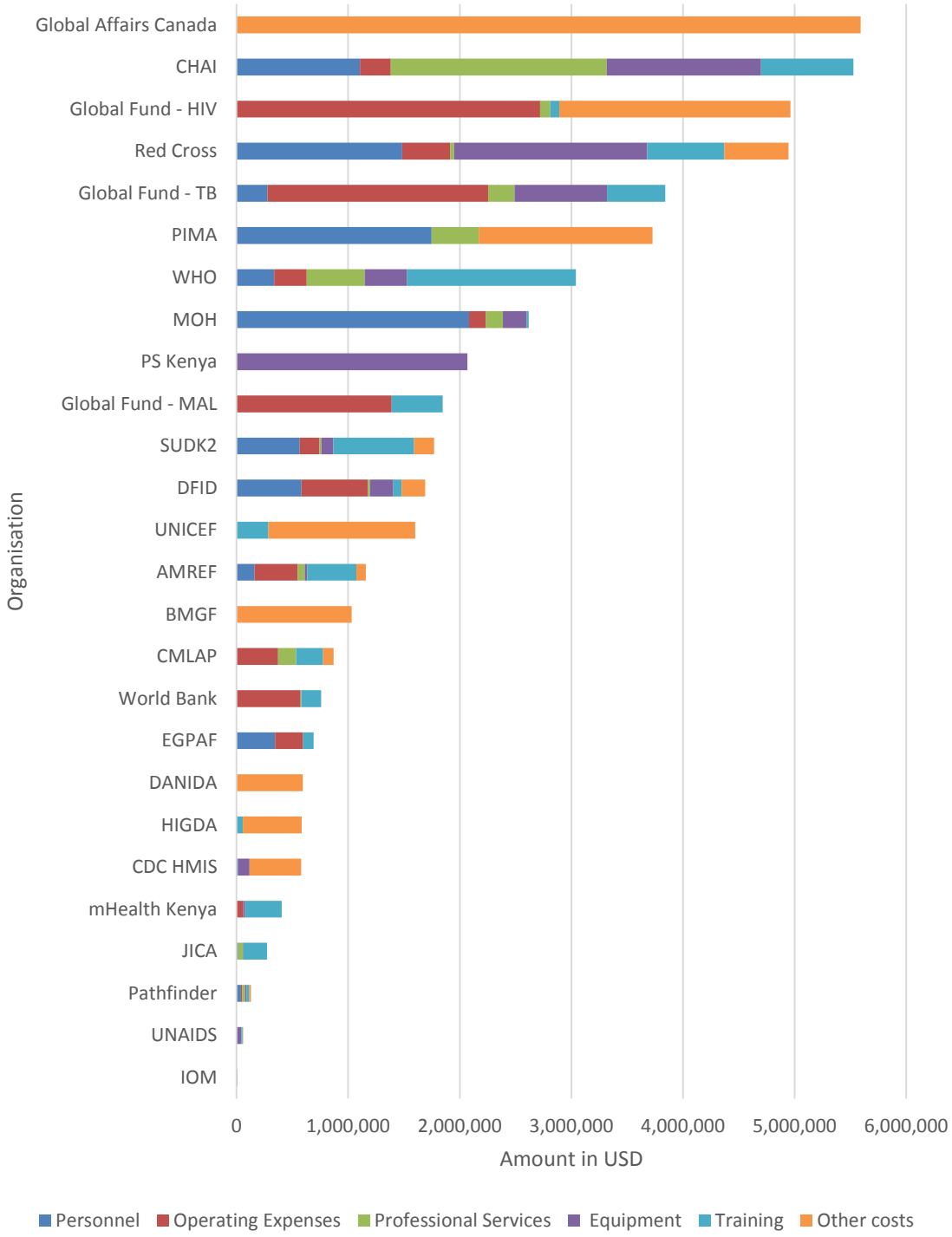


Figure 4.8 (a): Budget Commitment across Cost Categories for each Organization

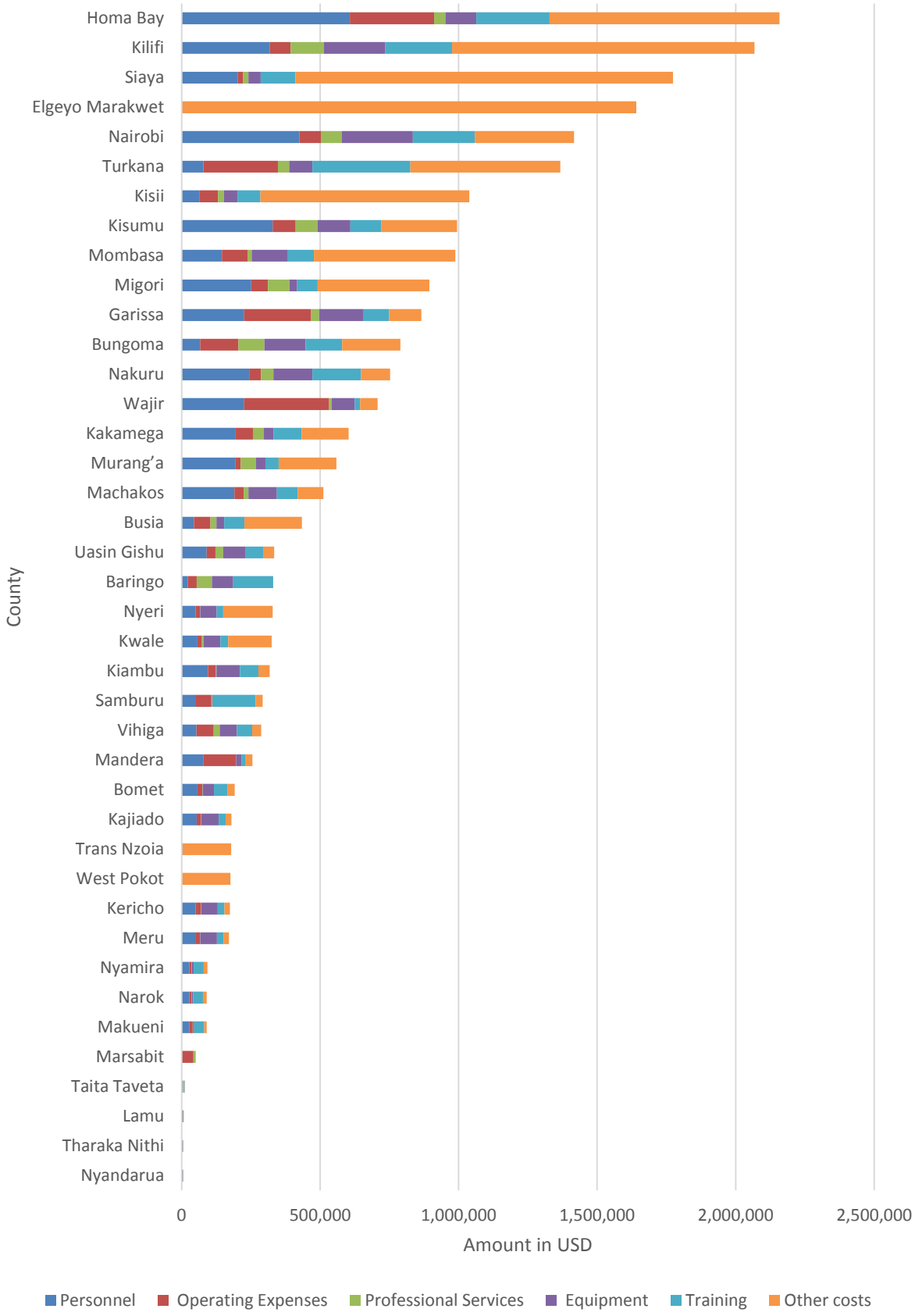
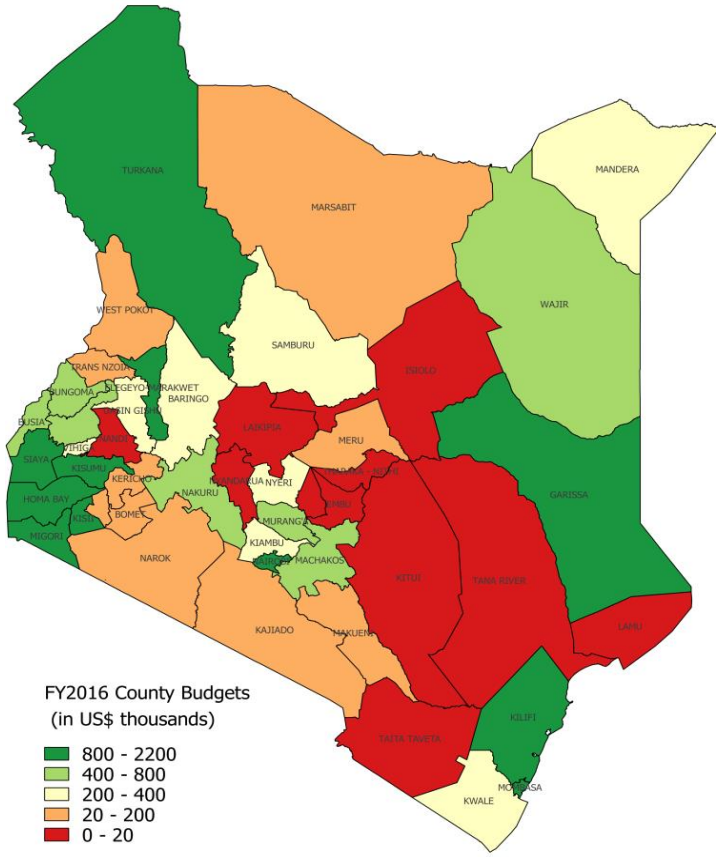


Figure 4.8 (b): Budget Commitment for each County across Cost Categories

4.1.9 Visual Representation of the County Budgets

The map below is visual representation of the geographic distribution of the budget across the counties. It emphasizes the fact that this distribution has a very wide variation throughout the entire country.

County	FY 2016/17 Budget
Homa Bay	2159
Kilifi	2068
Siaya	1774
Elegeyo-Marakwet	1642
Nairobi	1416
Turkana	1368
Kisii	1038
Kisumu	995
Mombasa	989
Migori	895
Garissa	865
Bungoma	790
Nakuru	753
Wajir	708
Kakamega	603
Murang'a	559
Machakos	512
Busia	435



County	2016/17	County	2016/17	County	2016/17
Uasin Gishu	334	Bomet	192	Taita Taveta	12
Baringo	330	Kajiado	180	Lamu	6
Nyeri	328	Trans Nzoia	179	Nyandarua	5
Kwale	325	West Pokot	176	Tharaka - Nithi	5
Kiambu	318	Kericho	174	Embu	0
Samburu	292	Meru	171	Isiolo	0
Vihiga	287	Nyamira	93	Kirinyaga	0
Mandera	255	Narok	91	Kitui	0
		Makueni	90	Laikipia	0
		Marsabit	51	Nandi	0
				Tana River	0

Figure 4.9: A Visual Map of FY 2016/17 Budget by County (in US$ thousands)

4.2 FOCUS ON NATIONAL LEVEL

From the analysis, approximately 27% of the total budget was allocated to support M&E / HIS activities at the national level. Additional analysis was done to further explore how the allocated funds were distributed across the HIS Focus and Sub-Focus Areas at this level. It was also interesting to see which organizations were supporting those activities and by what budgetary amounts; and the overall distribution of these funds across the different cost categories.

4.2.1 Budget Distribution across Focus Areas - National

The chart below shows that four out of the six HIS Focus areas have been allocated some budgetary support at the National level. The first focus area, Health Information Policy, Planning and Monitoring takes up the bulk of the allocation at 67%.

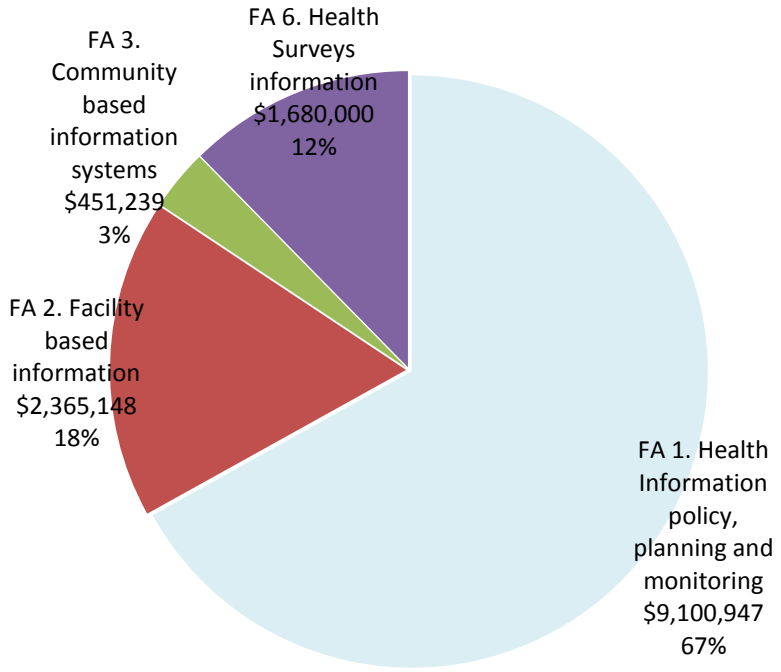


Figure 4.10 Distribution of National Budget across Focus Areas

4.2.2 Budget Commitments across Sub-Focus Areas - National

Drilling down further to understand how this budget was allocated across sub-focus areas, the chart below shows that at the national level the budget commitments is across eight sub-focus area. The largest proportion of this budget is allocated to Health Information policies & planning. The other sub-focus areas that seem to receive a sizeable amount of the budget are:

i) HIS systems operations & maintenance
ii) Establishing & expanding electronic reporting systems
iii) Annual sector performance reporting, and

iv) Health Surveys

The other information we get from this chart is that 14 out of the 28 partners who participated in the mapping are supporting implementation of HIS/M&E activities at the National level. It is notable that the Health Information Policies and Planning sub-focus area has the supported of nine partners.

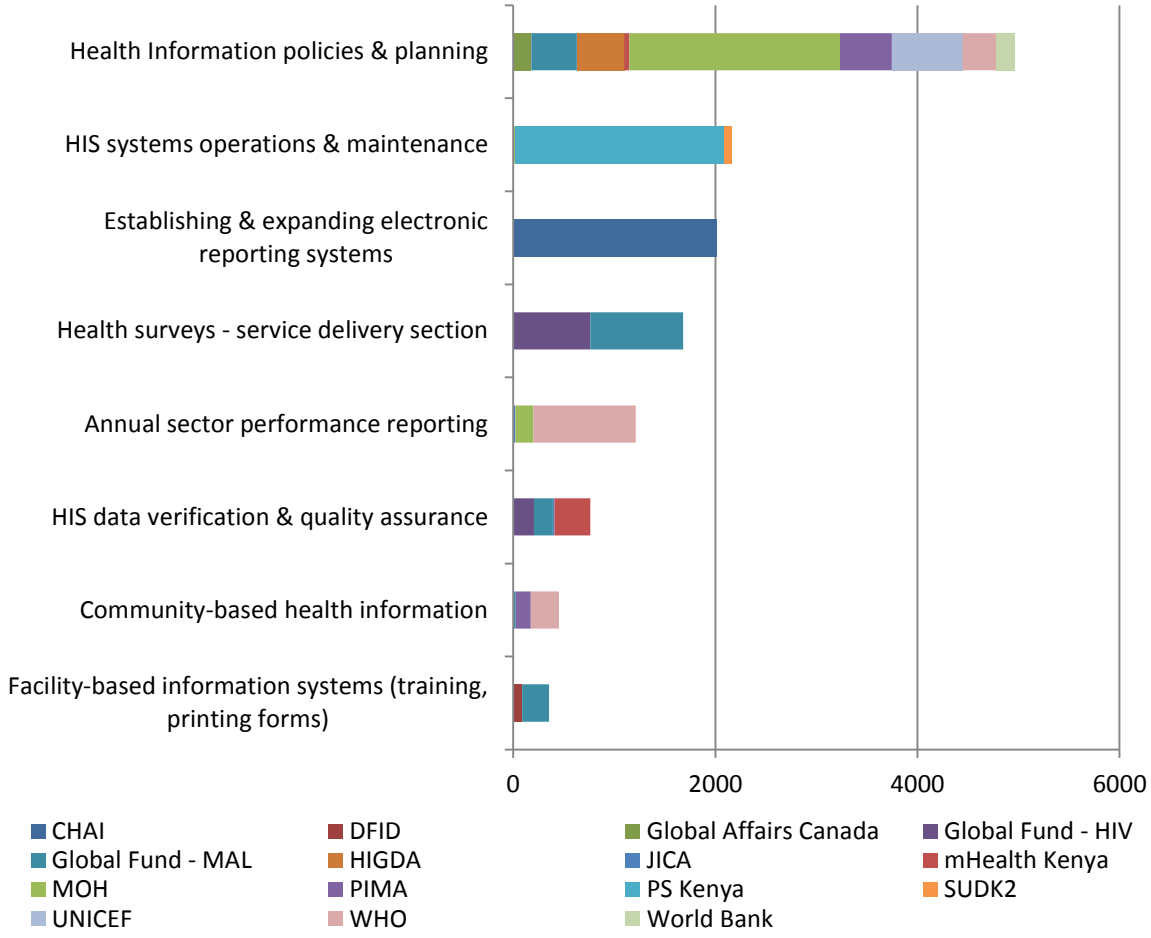


Figure 4.11 Partner support across Sub-Focus Areas at the National Level

4.2.3 Budget Distribution across Cost Categories - National

The following chart shows the distribution of the National level budget across cost categories. Personnel, Operating expenses and Equipment took up the bulk of the total budget at this level.

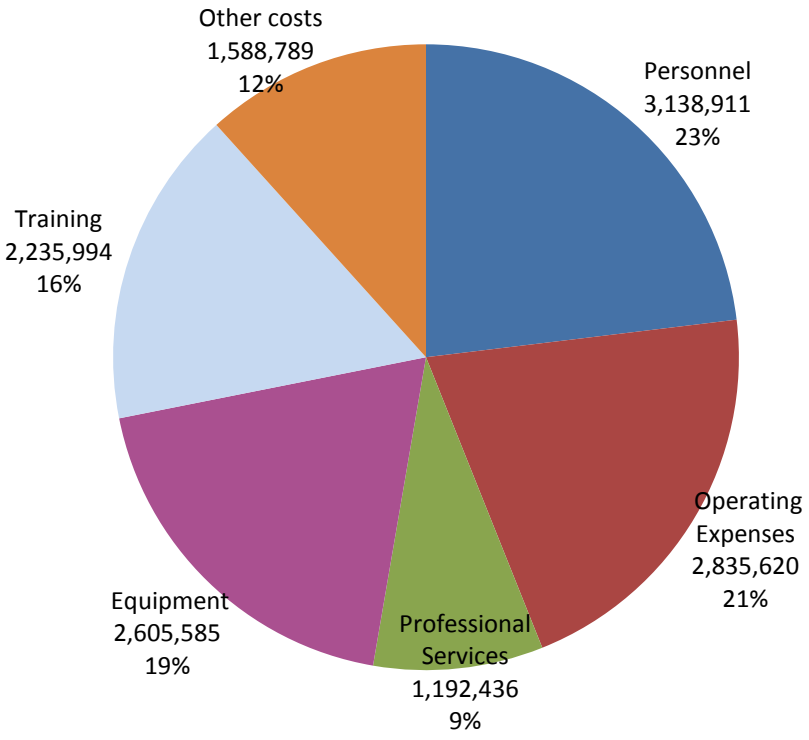


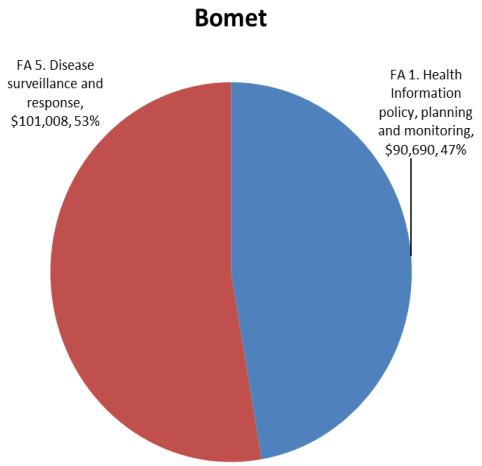
Figure 4.12 Budget across Cost Categories at the National Level

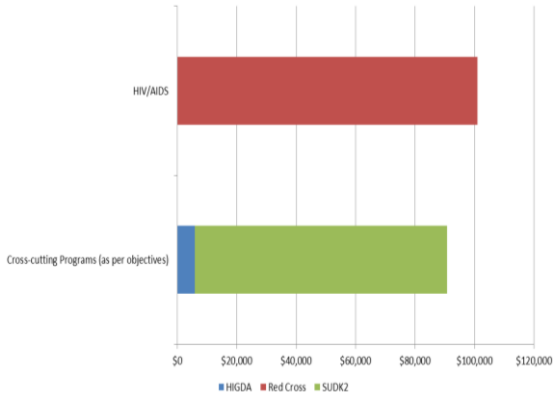
4.3 COUNTY SPECIFIC ANALYSIS

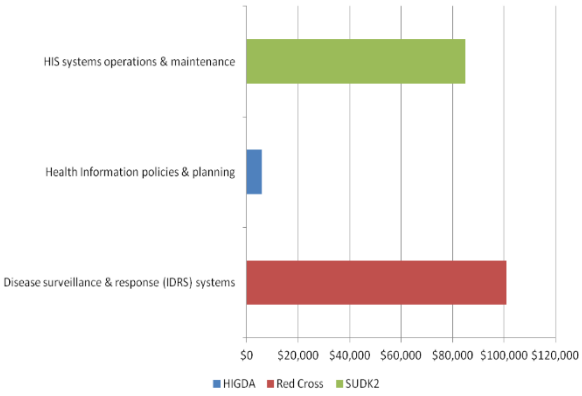
Bomet County:

The chart shows that on 2 out of 6 focus areas in the county of Bomet i.e. FA1(health information policy, planning and monitoring) and FA 5(Disease surveillance and response received budget allocation of $ 90,690 and 5101,008 respectively. Disease surveillance and response received more funds (53%) than Health information policy, planning and monitoring and evaluation (47%). It depicts scenario where partners are not evenly distributed and allocation of budget is not tailored to all focus areas to achieve better allocation of funds. It is also possible that there is no mapping of partners support and what is observed is duplication of resource in one focus area.

Focus areas







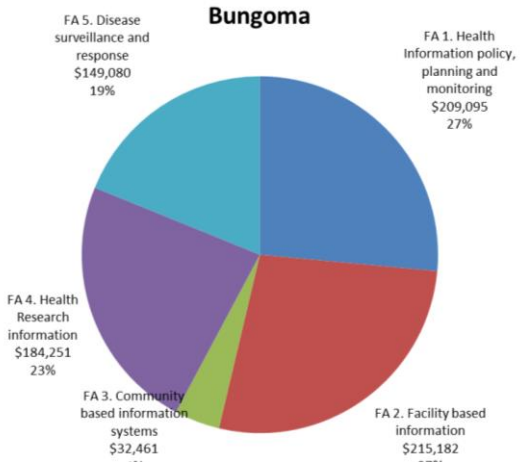
Disease programs ***Specific focal areas of investment***

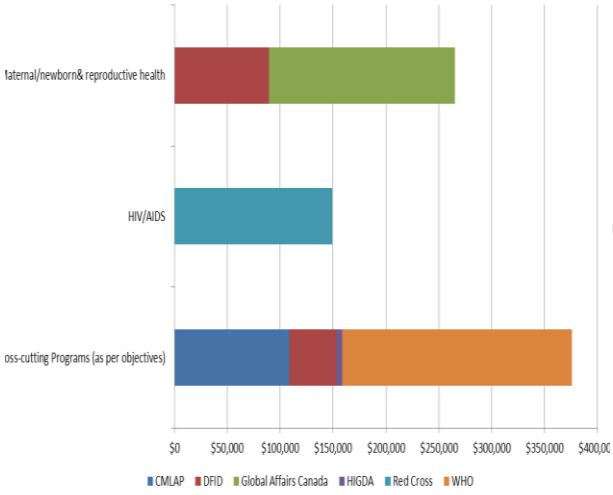
According to disease program areas activities are supported by , partners within the county (HIGDA, REDCROSS AND SUDK2) Red cross focused mainly on HIV/AIDS activities (about $1000,000), and HIGDA/SUDK2 Supported cutting programs (combined about $90,000) major support is from SUD

Red Cross is the leading partner in the county supporting disease surveillance and response (approximately $ 100,000) followed closely by SUDK2 supporting health system operation and maintenance with approximately $85,000. HIGDA Supports policies and planning with approximately $ 5,000

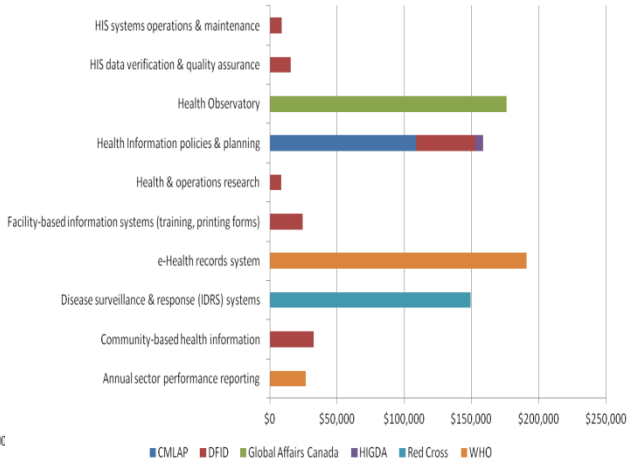
Bungoma County:

The pie chart shows that 5 out of the 6 HIS/ME Focus areas have been allocated some budgetary support in Bungoma. Facility based information is allocated the highest amount ($215,182) while Community based information system allocated the least ($32,461)





Disease programs



Specific focal areas of investment

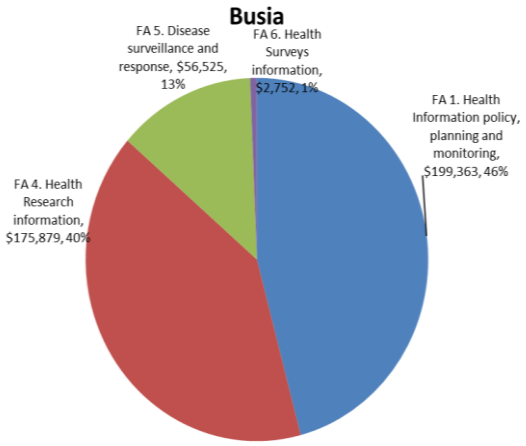
Concerning the disease focus area, four partners CMLAP, DFID, HIGDA and WHO support cross cutting programs as per objectives, red cross funds HIV/AIDs while DFID and Global Affairs Canada supports Maternal/Newborn and Reproductive health.

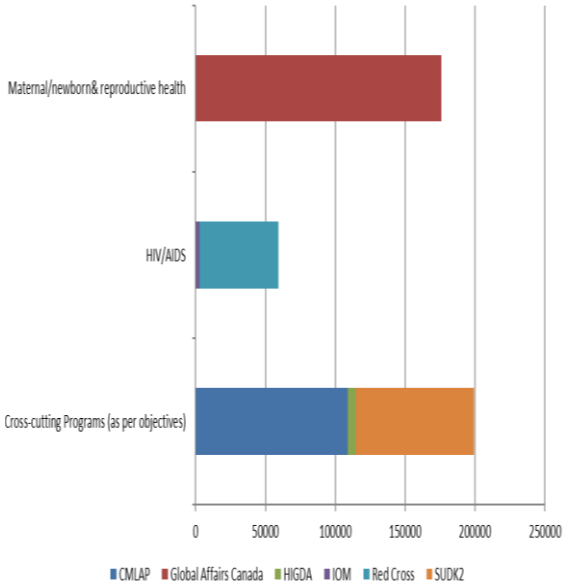
Busia County:

The chart below show that 4 out of the 6 HIS Focus areas have been allocated some budgetary support in Busia. However Health Surveys Information had only 1% of the total budget Busia budget allocation while facility and community based information systems had no budget at all.

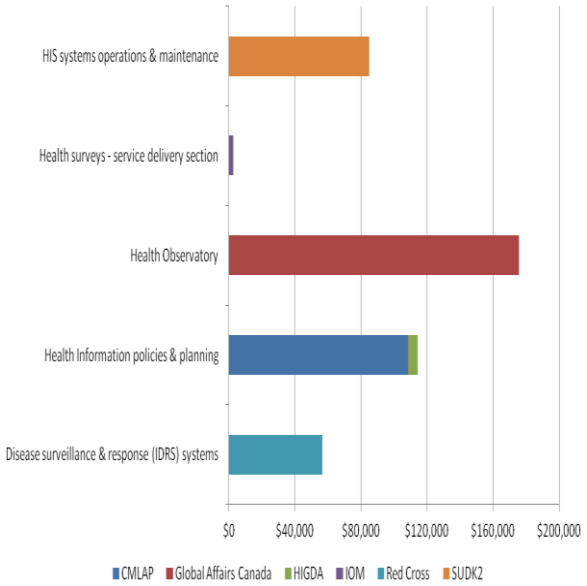
Maternal/Newborn & Reproductive health program has the highest budget allocation of US $175,000.However, cross cutting programs had been allocated around US $200,000 for the county.

Focus areas:





Disease programs



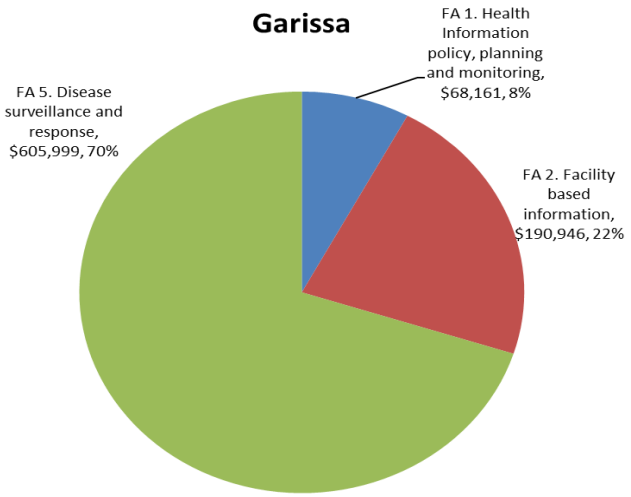
Specific focal areas of investment

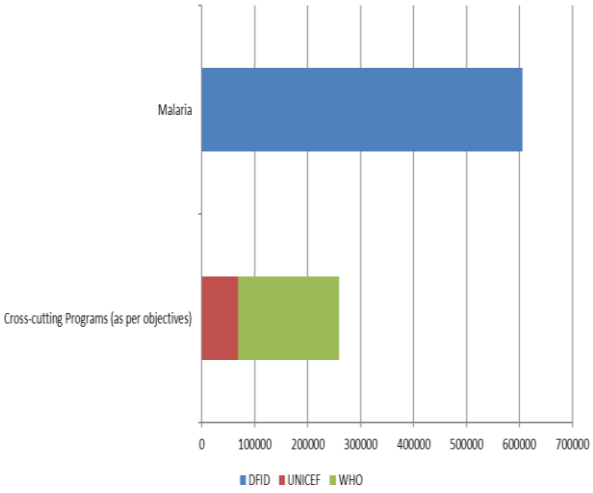
Maternal/Newborn & Reproductive health program has the highest budget allocation of US $175,000.However, cross cutting programs had been allocated around US $200,000 for the county. The main investment area being funded in the county is the Health Observatory with around US $175,000 while the least was Health surveys with less than US $10,000.

Garissa County:

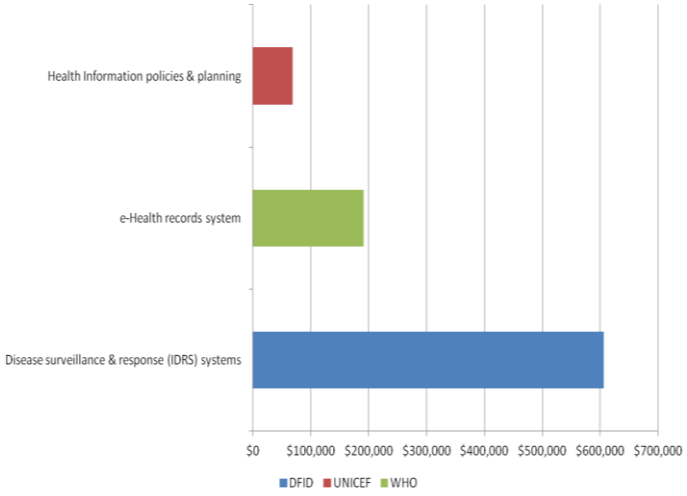
Results show that disease surveillance and response got the most support ($605,999) while health information, policy planning and monitoring got the least ($68,161).

Within disease surveillance and response, the support, which was from DFID was directed specifically to Malaria accounting for most of the resources going to Garissa county.





Disease programs



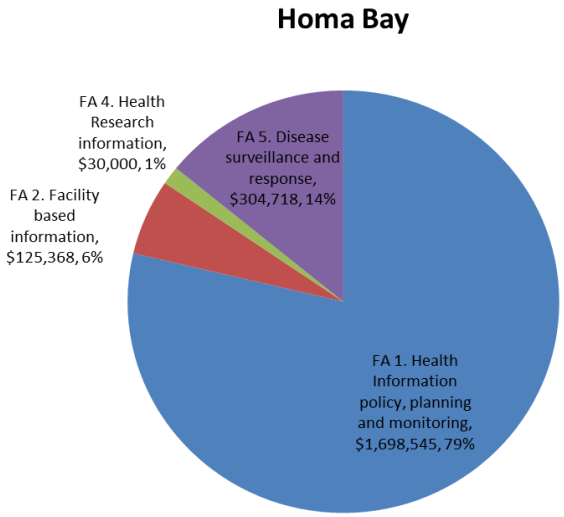
Specific focal areas of investment

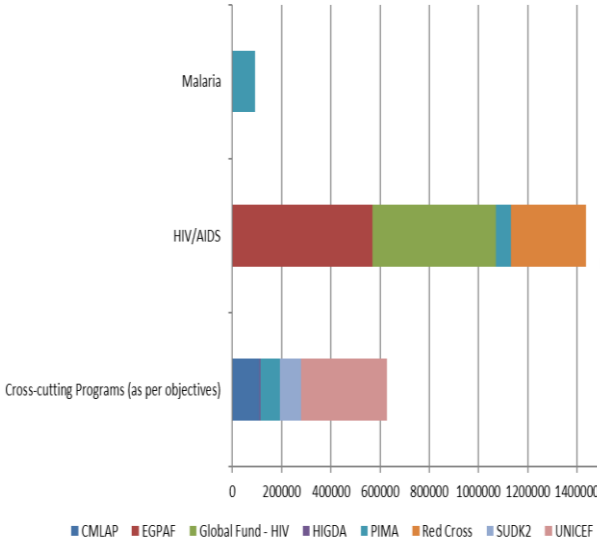
Homa Bay County:

The chart on Focus Areas shows that 4 out of the 6 HIS Focus areas has been allocated some budgetary support in Homa Bay County. Health Information, Policy, Planning and Monitoring has got the highest budgetary allocation (79%) and Health Research information has the lowest (1%).

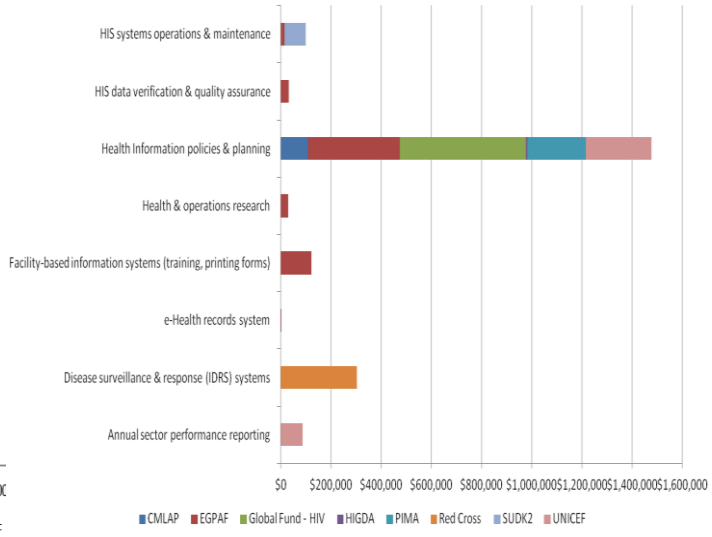
HIV/AIDS has got the highest budgetary allocation, with four partners supporting it. Malaria has the least budgetary allocation with only one partner (CMLAP) supporting it. Health Information, policy and Planning as an investment area has got the highest budgetary allocation with five partners supporting it and e- health records system has got the least allocation and being supported by only one partner (UNICEF).

Focus Areas





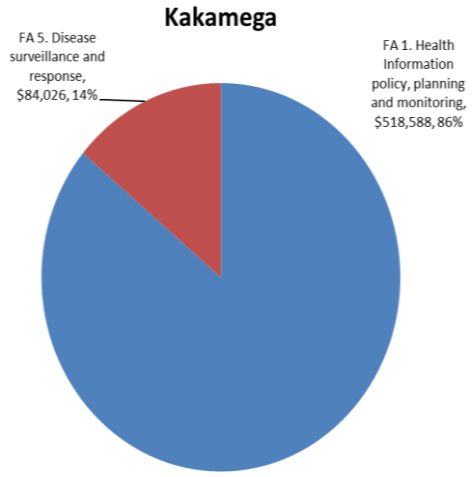
Disease programs

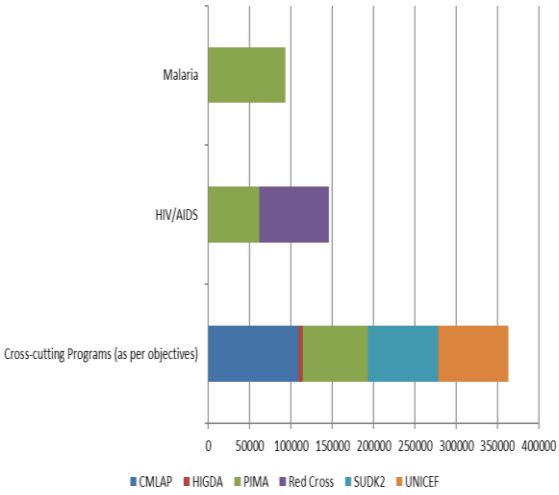


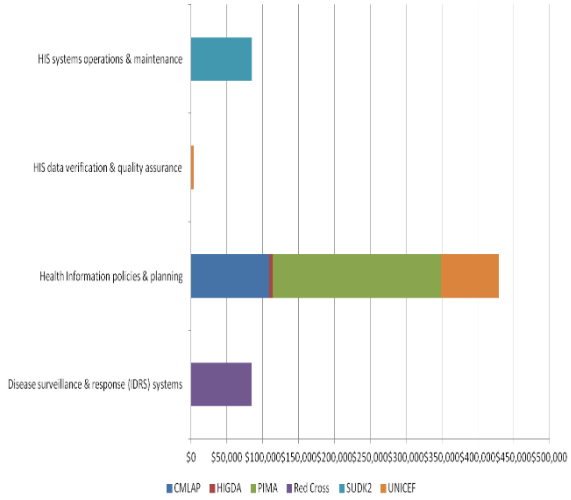
Specific focal areas of investment

Kakamega County:

The main focus area for HIS/ME investment was in Health Information, policy, planning and monitoring, at $518,588(86%), with specific support to health information policies and planning at just over $400,000, supported by a number of partners (CMLAP,HIGDA,PIMA,UNICEF) and HIS Systems operations and maintenance (SUDK2 at about $80,000). The other focus area for HIS/ME investment was in disease surveillance and response ($84,026), with specific investment in disease surveillance and response systems (Red Cross, at around $80,000) and HIS data verification and quality assurance by HIGDA at less than $10,000





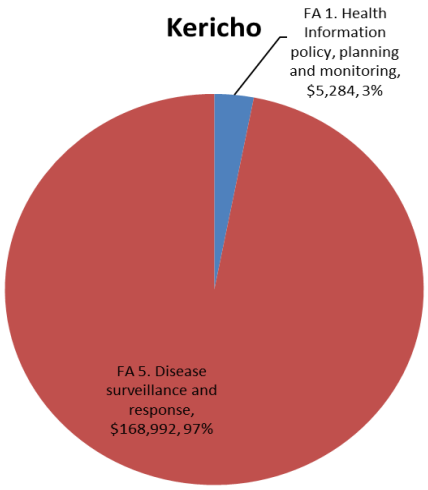


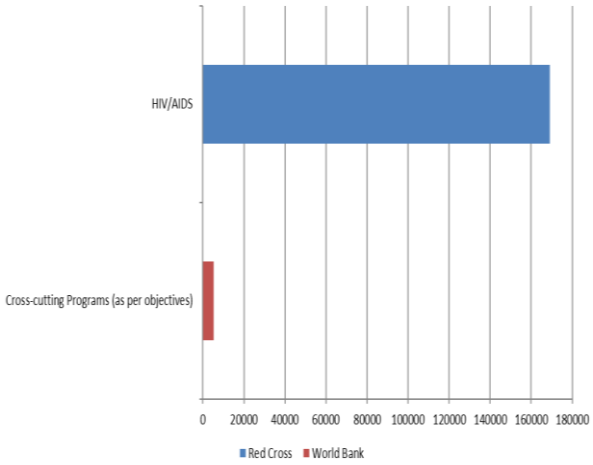
Disease programs ***Specific focal areas of investment***

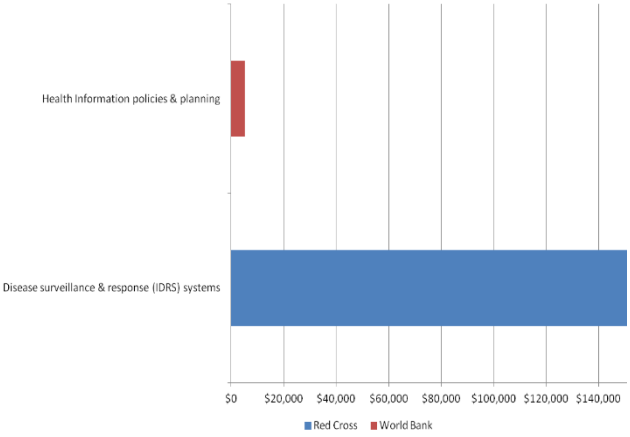
According to disease program areas, partners within the county (PIMA, CMLAP, HIGDA, SUDK2, UNICEF and Red cross) focused their HIS/ME resources on HIV (about $150,000), Malaria ($100,000) and cross cutting programs ($350,000), with PIMA supporting all the three program areas, Red cross focusing mainly on HIV, and the rest on cross cutting programs.

Kericho county:

The main focus area for HIS/ME investment was in disease surveillance and response, at $168,992(97%), with the main partner being the Red Cross. Health information policy planning and monitoring only had an allocation of 3% supported by the World Bank In terms of disease programme, all the funds (97%) were directed towards HIV/AIDS with a paltry 3% catering for cross-cutting programs as per objective







Disease programs

Specific focal areas of investment

Kiambu County:

From the pie chart we observe that Kiambu receives support in two focus areas: FA 1 (Health Information Policy, Planning and Monitoring) and FA 5 (Disease Surveillance and Response).
FA5 is allocated the least share of the total funding, receiving a proportion of 71%, equivalent to $227,002.

Focus areas

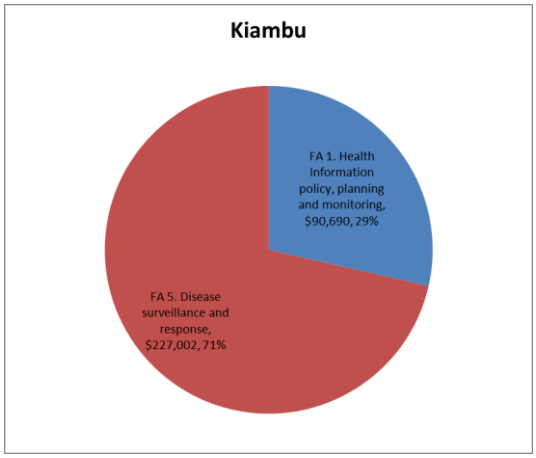


Figure 1

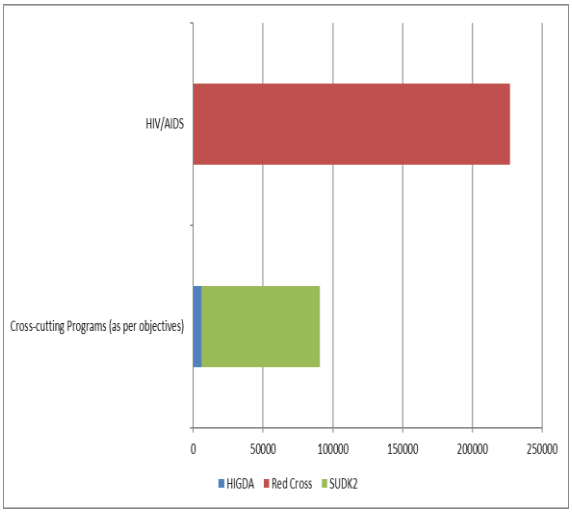
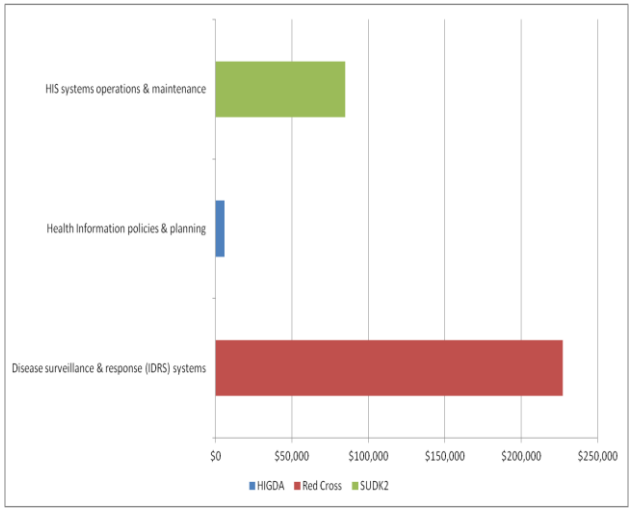


Figure 2



Disease programs

Specific focal areas of investment

Figure 1 above shows that most of the funding support in Kiambu is received from Red Cross and it goes to the HIV/AIDS disease program area. HIGDA and SUDK2 are also providing some support to Cross Cutting programs in Kiambu.
Figure 2 confirms that the Disease Surveillance and Response (IDSR) systems receive the largest proportion of HIS/M&E funding in Kiambu. HIS systems Operations and Maintenance sub-focus areas is supported by SUDK2 at slightly less than $100,000 while there is some minimal support by SUDK2 for Health Information Policies and Planning sub-focus area.

Kilifi County:

Kilifi is one of the counties which has high support in Focus areas. Out of the six focus areas the county has support in five FAs. FA 1(Health research information) has the highest support with a total funding of $713,286 which is 35% of the total funding to focus areas.

FA 3(Commodity based information systems) has the least share of funding of $130,281 which is 6% of the funds

Focus areas

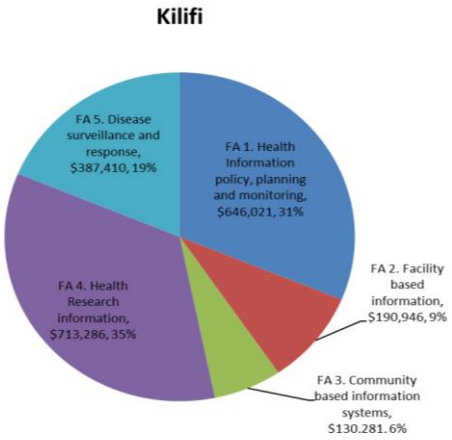


Figure 1

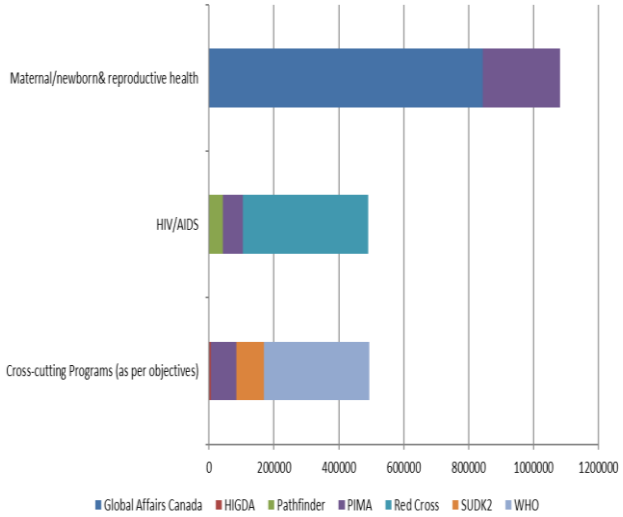
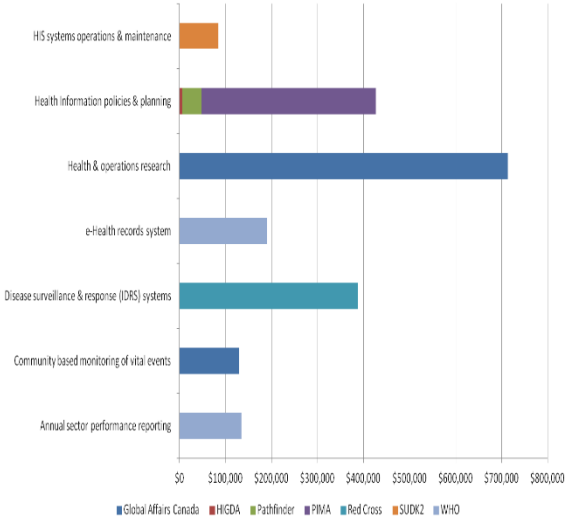


Figure 2



Disease programs ***Specific focal areas of investment***

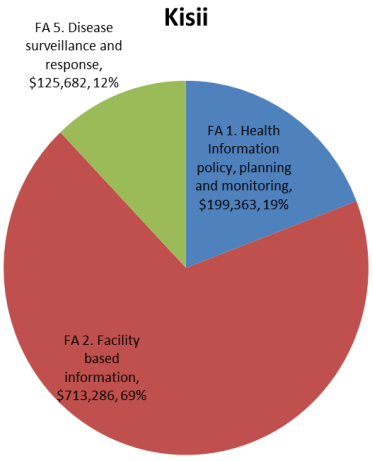
Figure 1 above shows how Kilifi county resource allocation is spread in the county. In the county maternal, newborn and reproductive health has the highest funding in all the [program funding, being supported by Global Affairs Canada and PIMA. Other programs which nearly have same resource allocation are HIV/AIDS supported by Red Cross, PIMA and Pathfinder. Additionally, cross cutting programs as per KHSSP objective areas have support from SUDK2, PIMA, HIGDA and WHO.

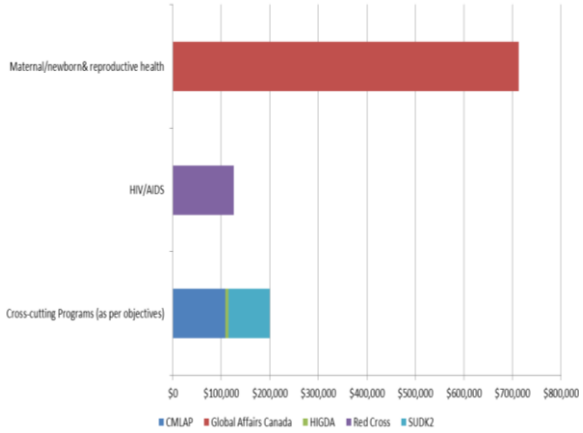
Figure 2 indicates that Health operations research has a highest funding from Global Affairs Canada while HIS systems operations and maintenance has least resource allocation from SUDK2. Further, Health information policy and planning has relatively high support from three partners (Pima, HGDA and Pathfinder

Kisii County:

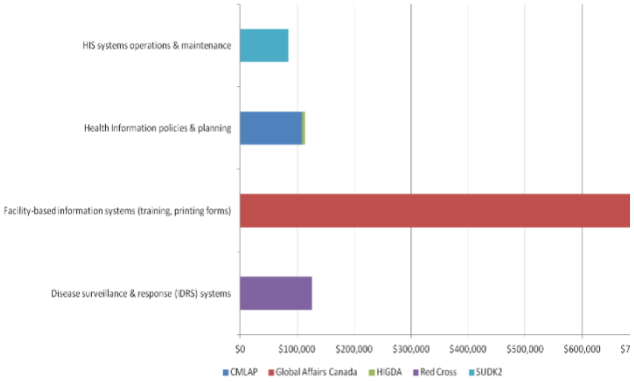
The Chart above shows that 3 out of 6 focus areas of HIS/M&E got budget allocations or support totaling to $1038,331. Focus area 2: Facility based information received the highest allocations(69%) followed by by FA 1: Health information policy, planning and monitoring(19%) and FA 5: Disease surveillance and response received 12%.These shows that the rest of focus areas FA3,4 and 6 was insignificantly supported or never received any kind of support at all.

Focus areas





Disease programs



Specific focal areas of investment

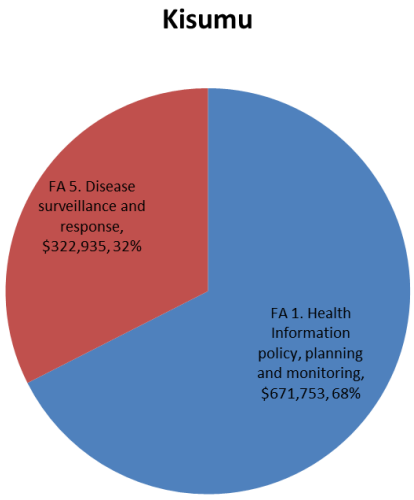
Analysis by disease program areas indicated there are five partners in the county. The leading partners is Global affairs Canada which supports Maternal and Neonatal Reproductive health activities(about $ 700,000),followed by Red Cross which supports HIV/AIDS activities(about $ 120.000),the rest i.e. HIGBA,CMLAP and SUDK2 supported cross cutting programs as per objectives with about $ 200,000
Facility health information systems trainings, printing forms is the most supported investment area in the county. It received a total of $ 705,000 through global affairs Canada. Followed by disease surveillance and responds supported by Red-cross approximately $ 105,000. Two partners supported health information policy and planning with approximately $102,000. HIS System operation and maintenance is supported by SUDK2 ($98,000).

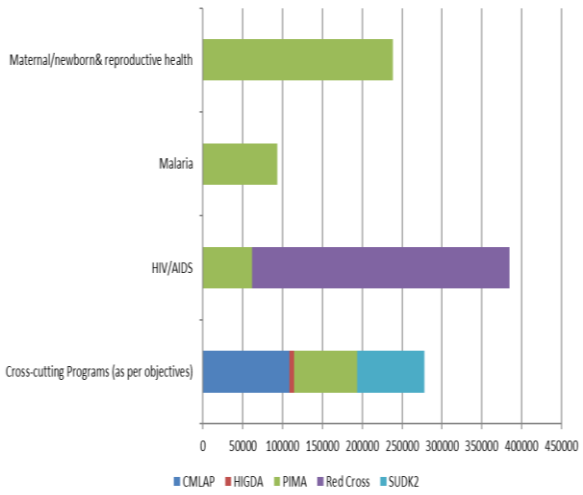
Kisumu County:

The Pie chart besides shows that HIS/ME investment partners support focused mainly 2 out of the 6 areas (Health Information policy, planning allocated $671,753 (68%) while Disease Surveillance and Response assigned 332,932 (32%)

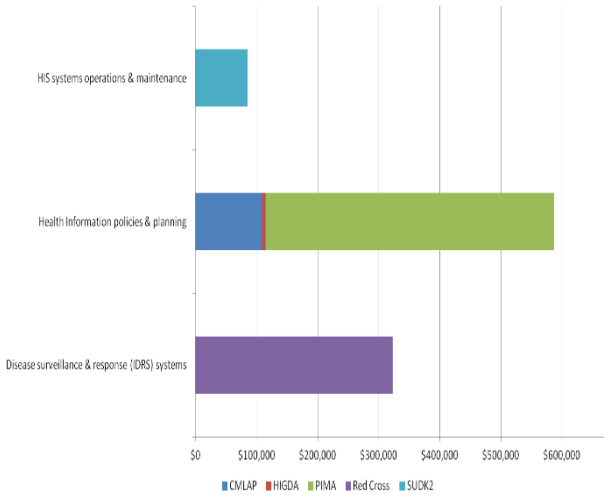
The chart on disease program on the left below shows that Cross cutting programs; as per objectives) is supports by three partners (CMLAP, HIGDA, PIMA, Red Cross and SUDK2). HIV/AIDS is supported by two partners PIMA and Red Cross, PIMA is seen to support both Malaria and Maternal, Newborn and Reproductive Health

Focus areas





Disease programs



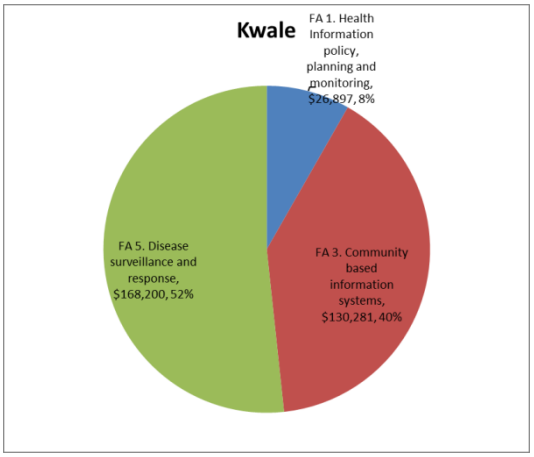
Specific focal areas of investment

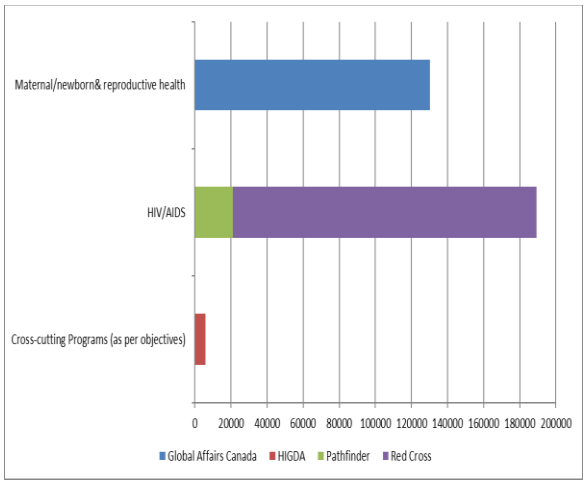
Based on the specific focus area, SUDK2 supports HIS system operations& maintenance, CMLAP, HIGDA and PIMA supports Health Information policy & Planning while Red Cross funds Disease surveillance & Response (DSR) system

Kwale County:

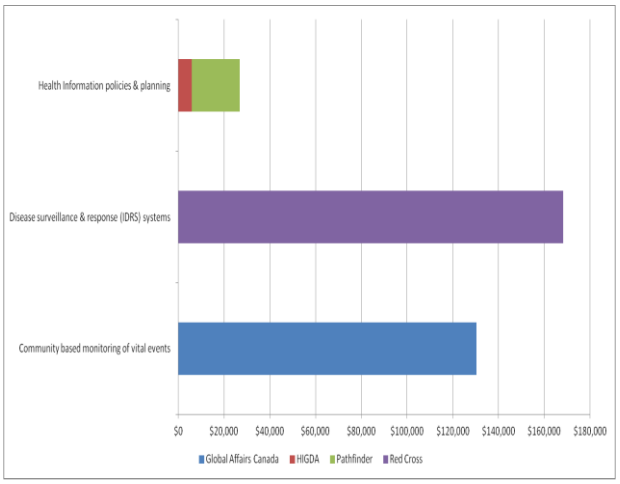
The Chart above shows that 3 out of 6 focus areas of HIS/M&E got budget allocations with the support totaling to $ $325,378. Focus area 5 (Disease Surveillance and Response) received the highest allocations at 52% while FA3 (Community based Information Systems) received 40% and FA1 (Health Information Policy, Planning and Monitoring) received 8%.

Focus areas





Disease programs



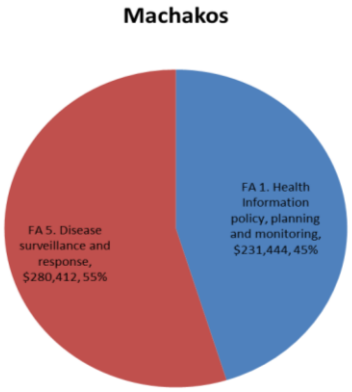
Specific focal areas of investment

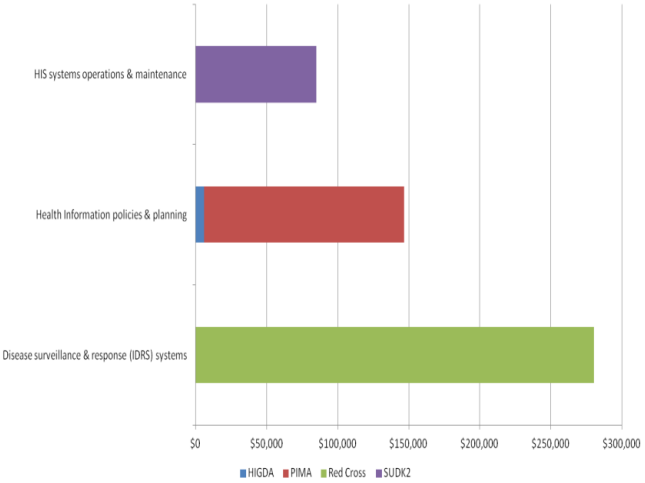
HIV/AIDS was the highest supported disease program received approximately $200,000 from Pathfinder and RedCross. However RedCross provided the bulk of this support. Another well supported disease program is the Maternal, Newborn and Reproductive Health which was allocated budgetary support by Global Affairs Canada. Some minimal funds are allocated to Cross Cutting Disease Programs by HIGDA. In terms of subfocus areas, Disease Surveillance & Response was most highly supported followed closely by Community-based monitoring of vital events. This funding commitment was provided by RedCross and Global Affairs Canada respectively

Machakos County:

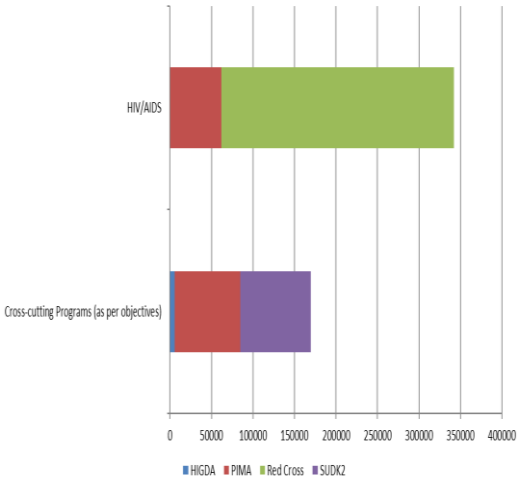
Machakos County has got only 2 out of the 6 HIS Focus Areas being supported. The two focus areas are Health Information, Policy, Planning and Monitoring and Disease Surveillance and Response. They both have got almost comparable allocation. HIV/AIDS has got the allocation in terms of the disease specific area with support from two partners Disease surveillance and response system has got the highest allocation being supported by Red Cross.

Focus areas





Disease programs

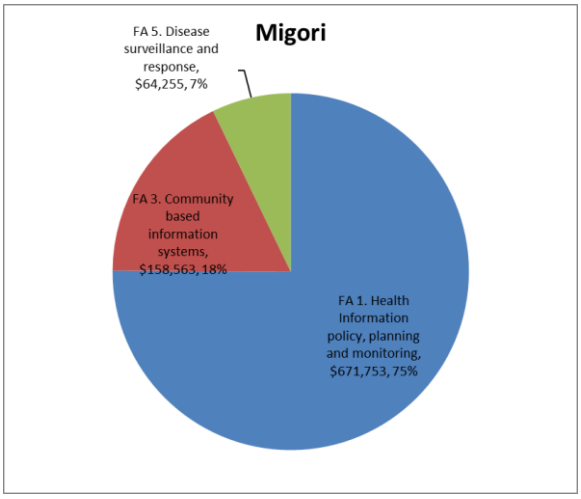


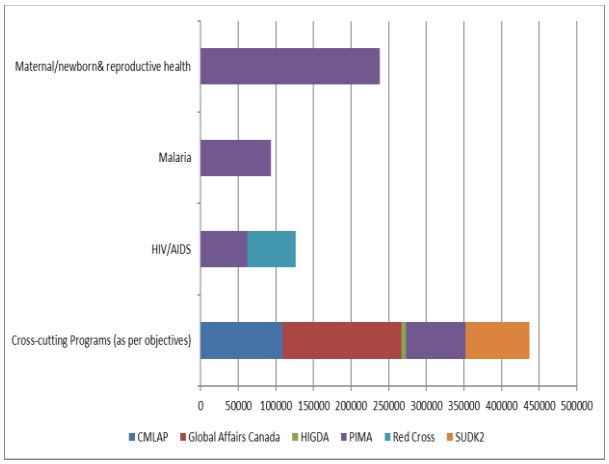
Specific focal areas of investment

Migori County:

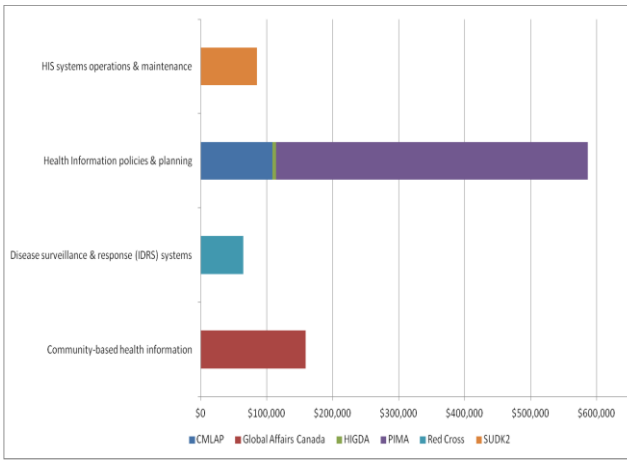
The Chart shows that three out of the six HIS/M&E focus areas are supported in Migori. The bulk of this support goes to FA1 (Health Information Policy, Planning and Monitoring) which received 75% of the total allocation of $894,572. The other supported focus areas are FA3 (Community based Information Systems) and FA5 (Disease Surveillance and Response).

Focus areas





Disease programs



Specific focal areas of investment

A total of six partners indicated some budgetary support to HIS/M&E activities in Migori. Cross Cutting Programs were allocated the bulk of the budgetary support and this came from 5 partners, namely CMLAP, Global Affairs Canada, HIGDA, PIMA and SUDK2. RedCross indicated support for HIV/AIDS, Malaria and Maternal, Newborn & Reproductive Health. The HIV/AIDS disease program was also supported by PIMA. Drilling down to the sub-focus areas we find that the bulk of the support is pegged to the Health Information Policies and Planning sub-focus area. Other supported subfocus areas are Community-based health information, Disease Surveillance & Response systems, and HIS systems operations and maintenance.

Mombasa County:

The county has two out six focus areas being supported (Disease surveillance and response system and Health information policy planning and monitoring.

Health information policy planning and monitoring has the highest resource allocation of 655 of the total funds allocated. Disease surveillance and response has an allocation of $344,652 which is 35% of total allocation.

Focus Areas

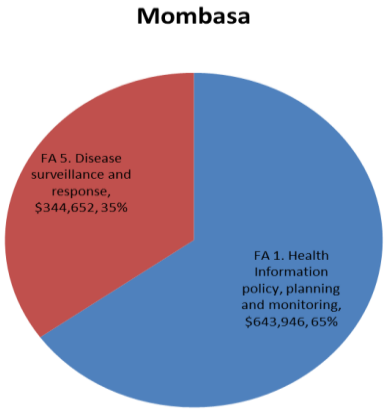


Figure 1

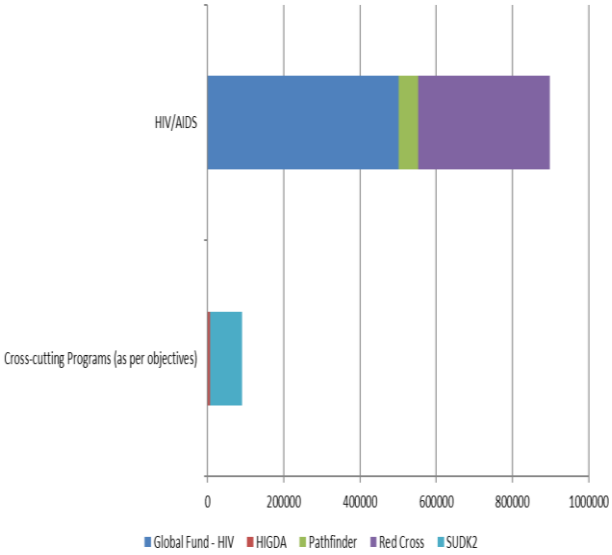
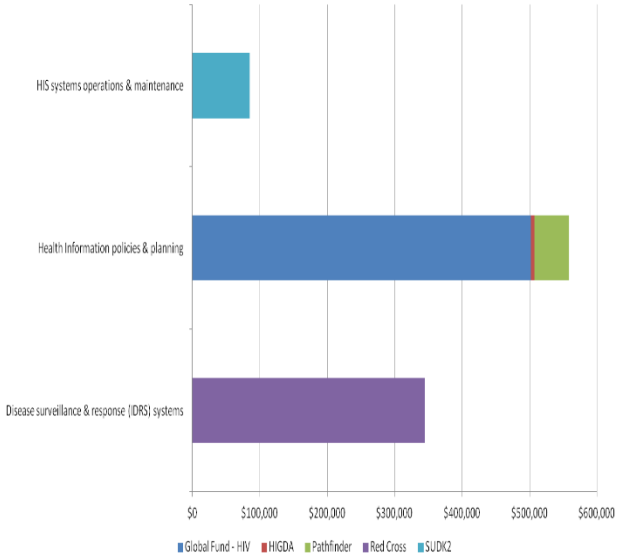


Figure 2



Disease programs

Specific focal areas of investment

Two health programs are being supported in the county; Fight against HIV/AIDS and crosscutting (Funds allocated to all other programs).Red cross ,pathfinder and Global affairs Canada are partners who have funds allocated to HIV/AIDS program and is the highest allocated. HIGDA and SUDK2 has allocation which are distributed across all other programs.

Figure 2 shows the allocation across health investment areas. Health information policy planning and monitoring has the highest allocation (Supported by HIGDA, Global affairs Canada and Pathfinder) while health system operations and maintenance has least support by SUDK2.

Murang'a County:

The county has two out six focus areas being supported (Disease surveillance and response system and Health information policy planning and monitoring.

Health information policy planning and monitoring had the highest resource allocation receiving 85% of the total budget commitment. Disease surveillance and response had an allocation of $83,960 which is 15% of total budget of $558,978

Focus Areas

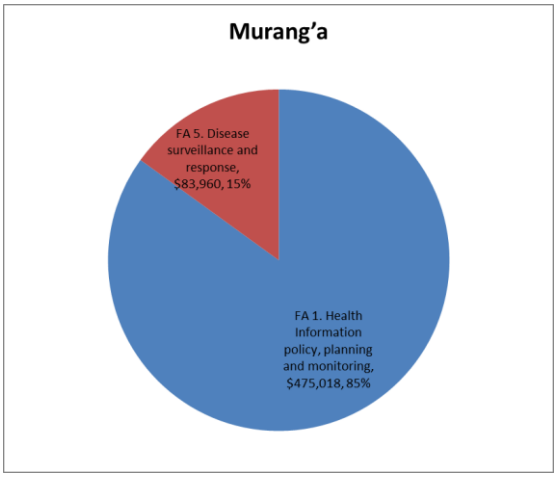


Figure 1

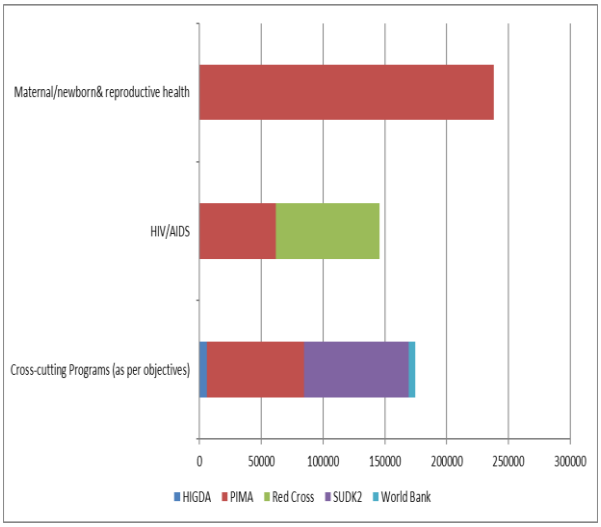
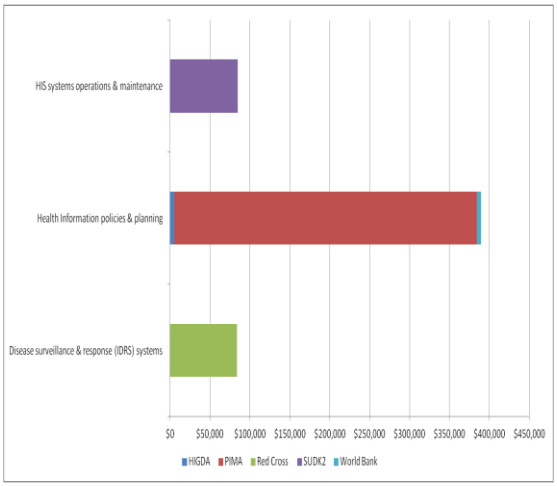


Figure 2



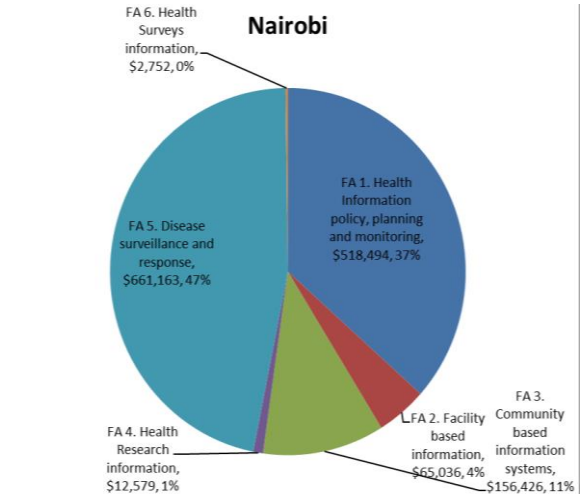
Disease programs ***Specific focal areas of investment***

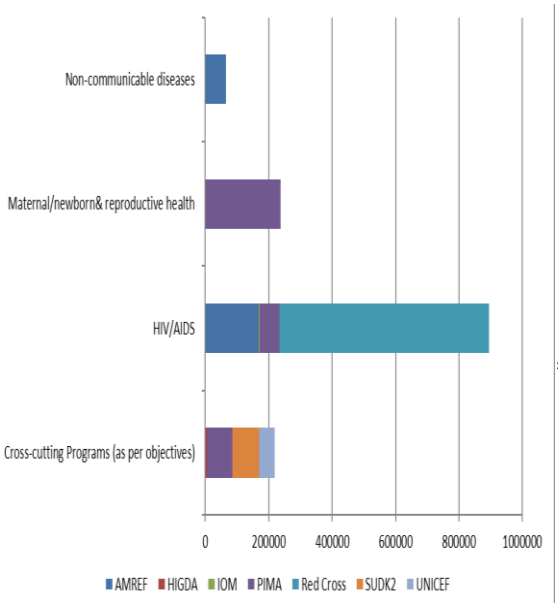
A total of five partners indicated some budgetary support to HIS/M&E activities in Murang'a. Maternal, Newborn & Reproductive Health program area was allocated the bulk of the budgetary support and this came from PIMA. Cross Cutting Programs followed closely with a total budgetary commitment of about $170,000 from four partners (HIGDA, PIMA, SUDK2 and WorldBank). The HIV/AIDS disease program received support from PIMA and RedCross. Drilling down to the sub-focus areas we find that the bulk of the support is pegged to the Health Information Policies and Planning sub-focus area. Other supported subfocus areas are Community-based health information, Disease Surveillance & Response systems, and HIS systems operations and maintenance.

Nairobi County:

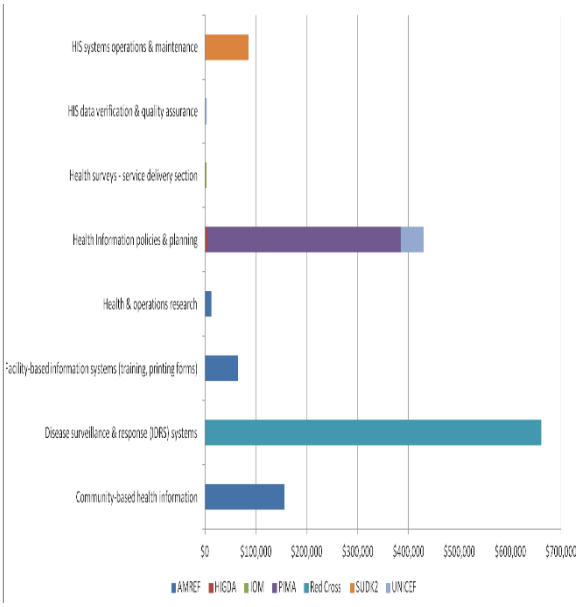
The pie chart shows the investment areas, in terms of investment into HIS/ME inputs. It showed that the county had most investment into Disease surveillance and response (47%) and Health information policy, planning and monitoring (37%), others with less than 11% are in health surveys information, community based information systems, and facility based information and Health research information.

Focus areas





Disease programs



Specific focal areas of investment

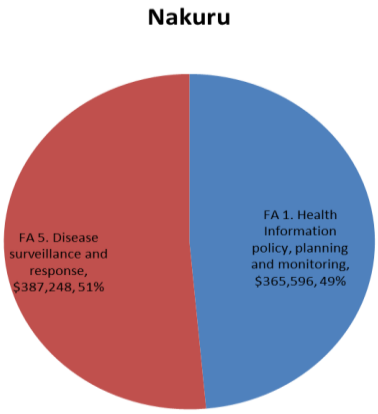
Disease programs where HIS/ME investment focused were mainly in HIV/AIDS at about $80,000. Others with investment of less than $30,000 were Maternal/newborn and reproductive health, cross cutting programs and non-communicable diseases.

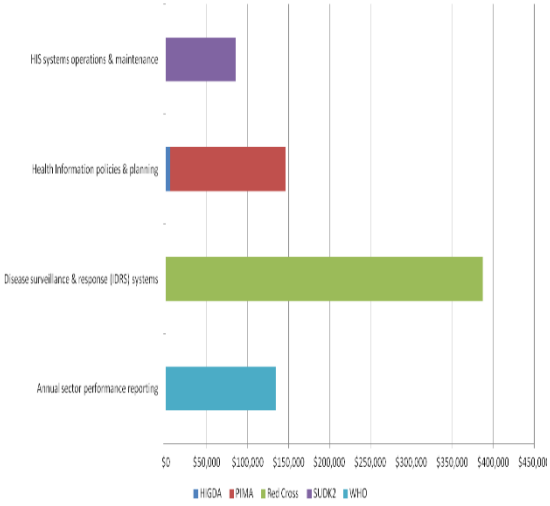
Nakuru County:

Resource input by partners on HIS/ME investments (inputs), showed that the main investment focused on Health Information policy and monitoring ($365,596 (49%)) and Disease Surveillance and Response ($ 387,248, (51%))

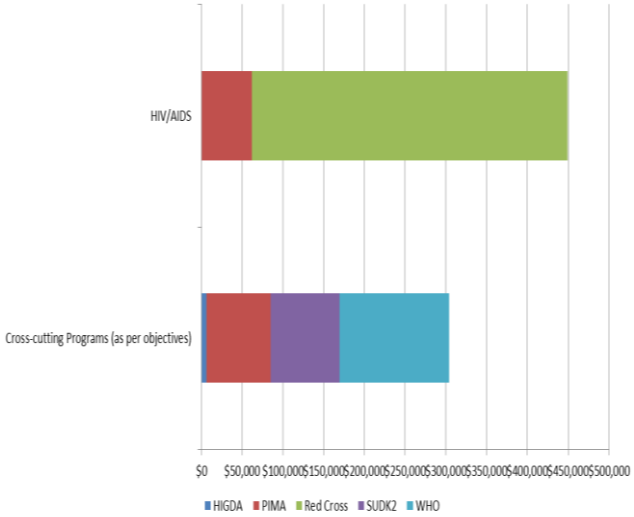
The two investment area focused mainly on specific areas such as Disease Surveillance &response (IDSR) system by Red Cross, by PIMA, HIS operations and maintenance() by SUDK2, Health Information Policy and Planning by HIGDA and PIMA, while Annual Sector performance reporting () by WHO

Focus area





Specific focus area



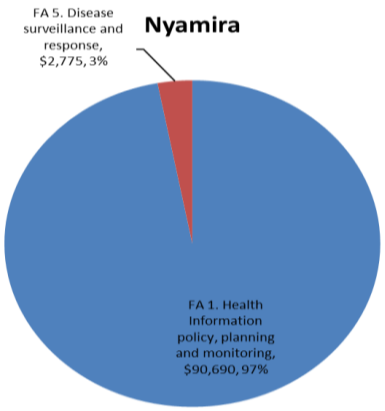
Disease program area

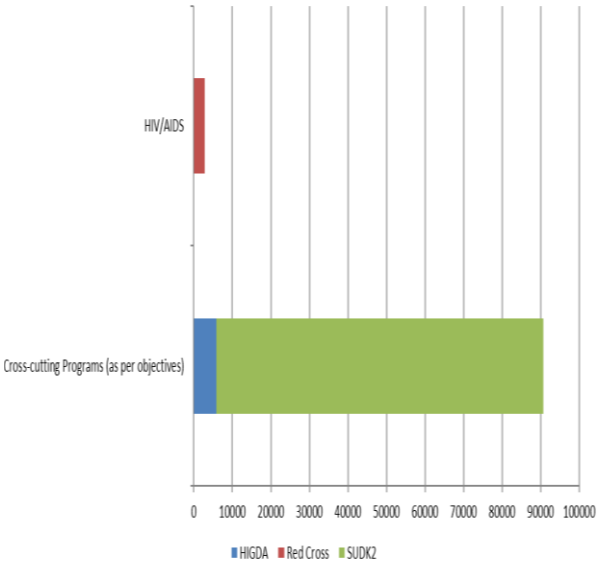
Concerning the Disease Program area PIMA and Red Cross funded HIV/AIDs, while Crosscutting Programs (as per objectives) was funded by HIGDA, PIMA, SUDK2 and WHO

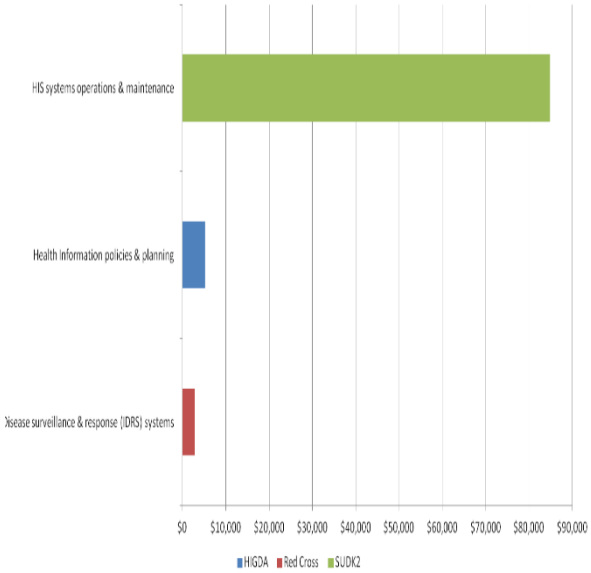
Nyamira County:

Analysis by partner HIS/ME investment (input) areas showed that the largest area of investment of resources, at $90,690, was in Health information, policy, planning and monitoring, with specific focus in HIS system operations and maintenance at about $85,000 by SUDK2, followed by health information policies and planning (HIGDA). The second focus area was in disease surveillance and response at $2,775, with a specific focus on disease surveillance systems (Red Cross) at less than $10,000.

Focus areas







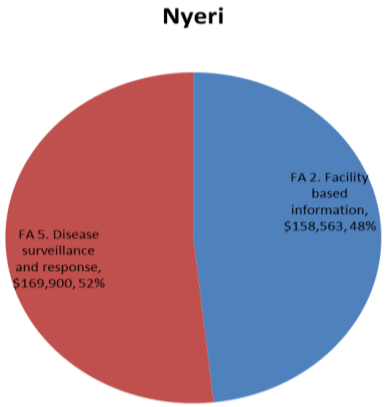
Disease programs ***Specific focal areas of investment***

Analysis by disease program areas indicated that partners within the county (SUDK2, HIGDA and Red cross) focused their HIS/ME resources on HIV (Less than $10,000), and cross cutting programs ($90,000). The main HIS/ME partner was SUDK2 supporting cross cutting programs.

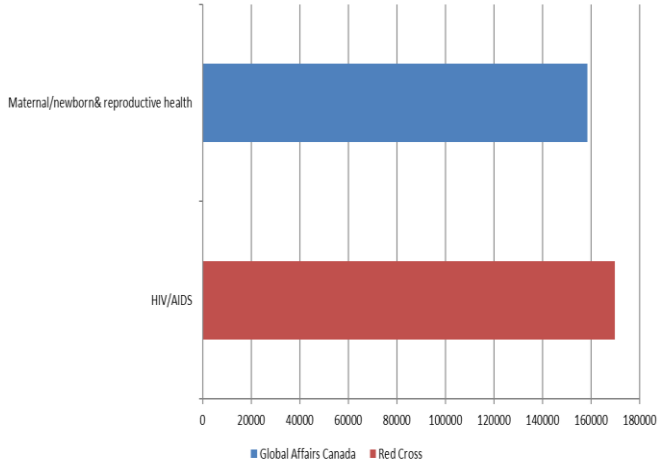
Nyeri County:

Only 2 of the 6 HIS Focus Areas have got budgetary allocation. The two focus areas include Facility based information and disease surveillance and response with both having comparable allocation. Two disease specific programs i.e. Maternal/ Newborn and reproductive health and HIV/AIDS have got allocation with each having only one partner supporting. On investment areas, facility based information system is being supported by Global Affairs Canada and Disease surveillance system by Red cross.

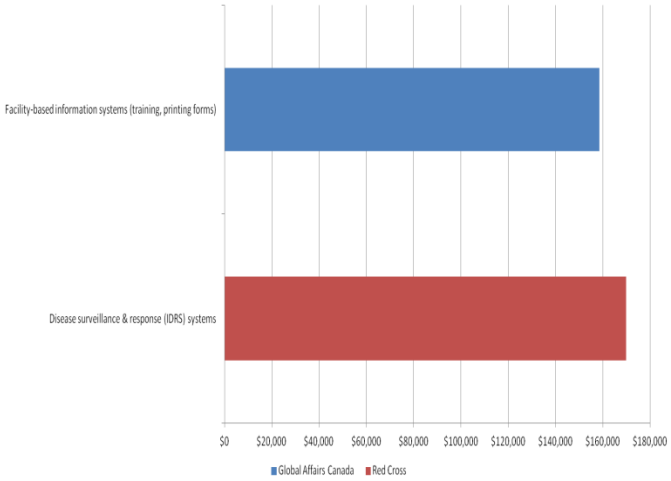
Focus Areas



Disease Specific Area

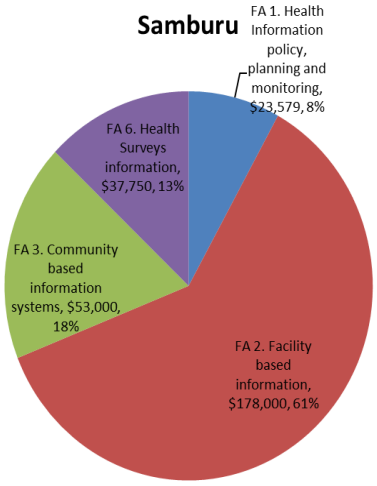


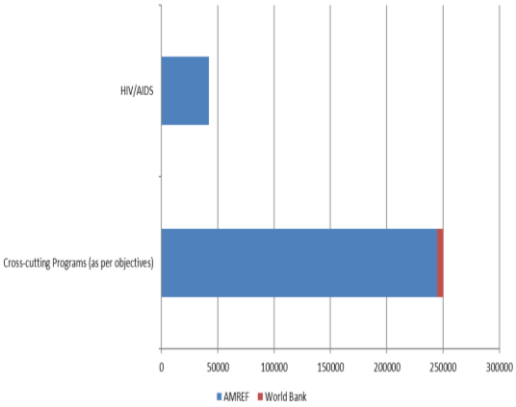
Investment Area



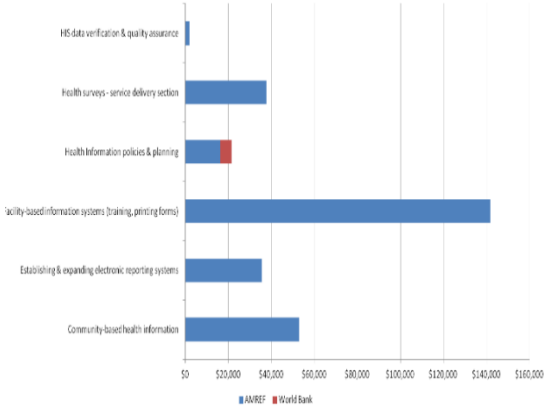
Samburu County

Analysis by area of investment to HIS/ME inputs showed that the highest investment area was in Facility based information at 61%($178,000), with a specific focus on facility based information systems, at over $140,000. Other input areas were in health information policy, planning and monitoring, health surveys information, and community based information systems, with specific focus on community based information, HIS data verification and quality assurance, health surveys on service delivery, health





Disease programs



Specific focal areas of investment

information and policy, establishment and expansion of electronic reporting systems and health information policy and planning. Analysis by disease program areas indicated that most HIS/ME investments were in cross cutting programs at $250,000 and HIV/AIDS at slightly less than $5,000.

Siaya County:

This is one of the counties with a high budgetary support for HIS/M&E activities with a total commitment of $1,774,015. The bulk of this support is for FA1 (Health Information Policy, Planning and Monitoring) focus area at 87%. The rest of the budget is shared almost equally between FA3 (Community based information systems) and FA5 (Disease surveillance and response)

Focus Areas

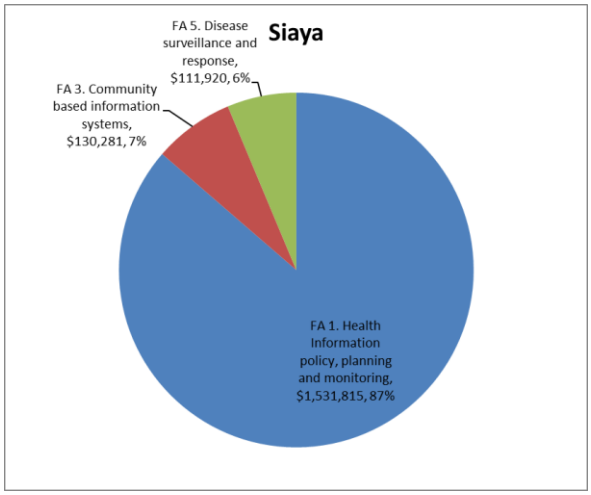


Figure 1

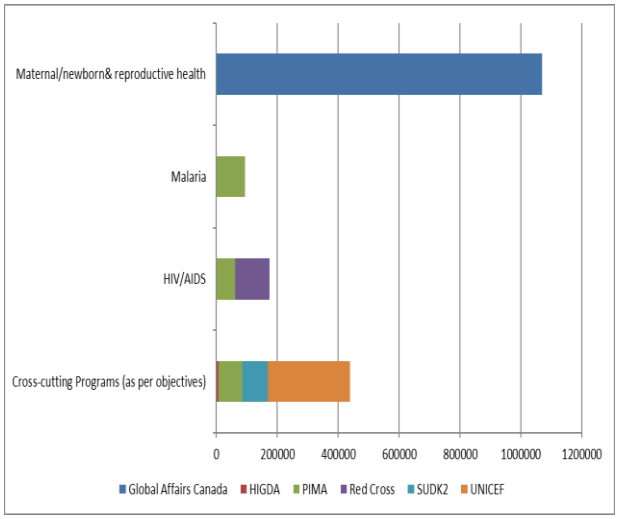
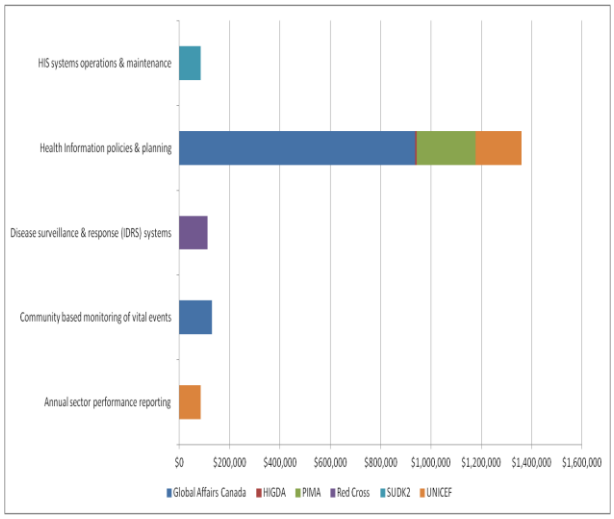


Figure 2



Disease programs ***Specific focal areas of investment***

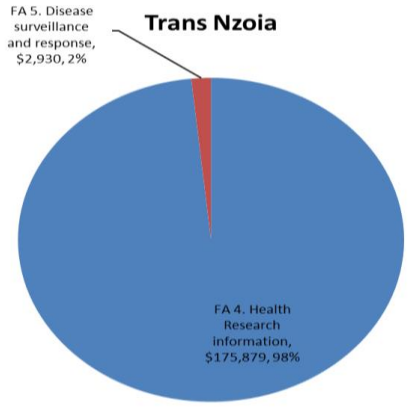
A total of six partners indicated intention to provide some budgetary support to HIS/M&E activities in Siaya. Maternal, Newborn & Reproductive Health program area was allocated the bulk of the budgetary support at almost $1.1 million with all of it coming from Global Affairs Canada. Cross Cutting Programs were supported by three partners (HIGDA, PIMA, SUDK2 and UNICEF) to the tune of about $400,000. Other supported disease programs were HIV/AIDS (by PIMA and RedCross) and Malaria (by PIMA). The Health Information Policies and Planning sub-focus area the bulk of this budgetary support at almost $1.4 million. The remaining support is allocated to Community-based health information, Disease Surveillance & Response systems, HIS systems operations and maintenance and Annual sector performance reporting.

Trans-Nzoia County:

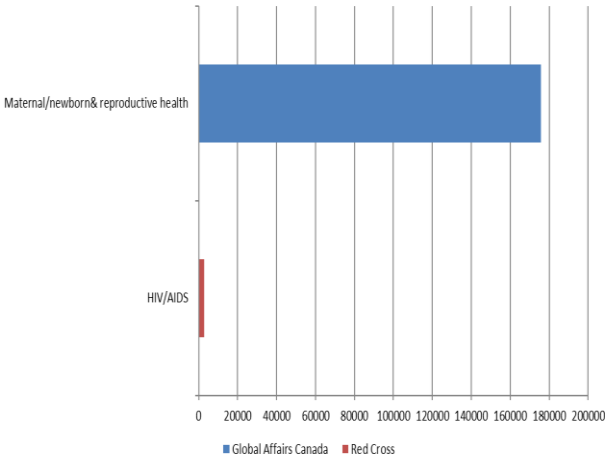
Trans-Nzoia county has only resource allocation in only two focus areas i.e (Disease surveillance and response and health research information).

Among these FAs Health research information has the highest resource allocation of $178,879 which is 98% of the total allocation while disease surveillance has only 2% of the allocation.

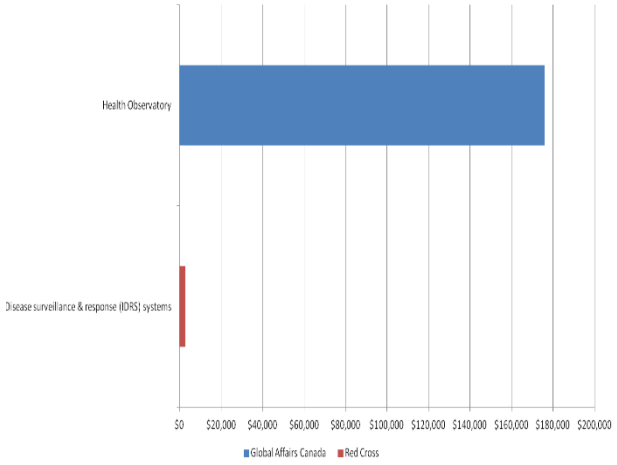
Focus areas



FS 1 (bar chart)



Fs 2 (bar chart)



Disease programs ***Specific focal areas of investment***

The county has a support in maternal newborn and reproductive health from global affairs Canada and a small allocation in fight against HIV/AIDS. Other programs has no support.

Further the county has support to develop Health observatory and has a resource allocation from Global affairs Canada. Red Cross has allocated some resources to the county to strengthen disease surveillance and response system.

Turkana County:

Turkana is another very highly supported county with a total budget commitment of $1,367,523 for FY2016/17. 57% of this support is for FA1 (Health Information policy, planning and monitoring) focus area while FA2 (Facility based information) received 35% of the allocation. The rest of the support is shared between FA3 (4%), FA6 (3%) and FA4 (1%)

Focus Areas

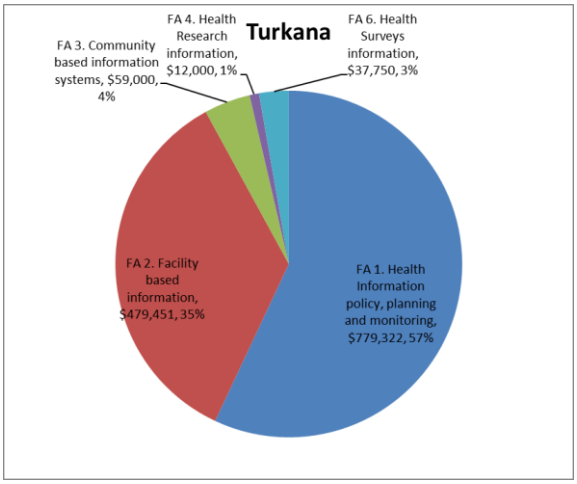


Figure 1

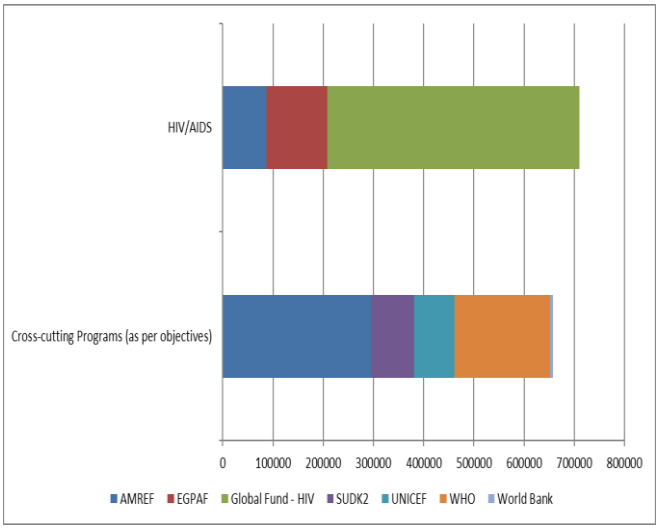
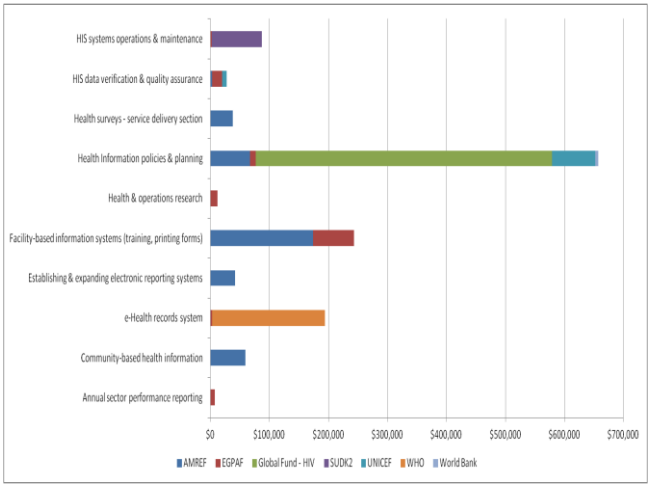


Figure 2



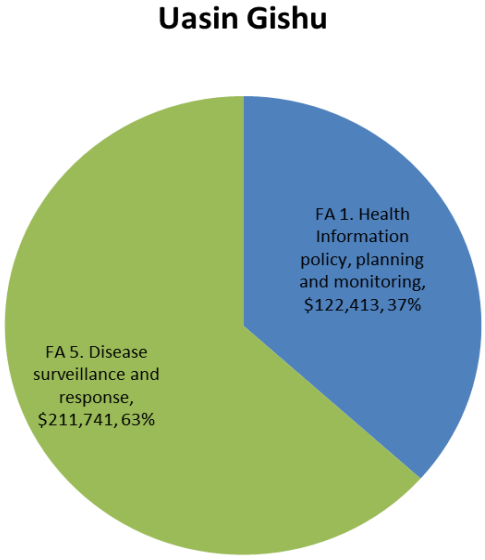
Disease programs ***Specific focal areas of investment***

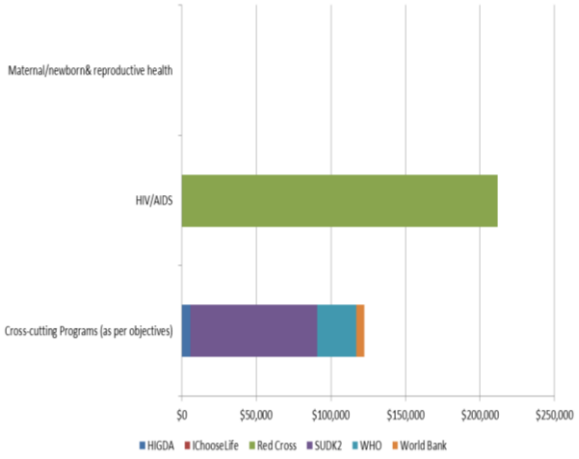
A total of seven partners indicated commitment to provide budgetary support to HIS/M&E activities in Turkana. The HIV/AIDS disease program was allocated the slightly larger portion of the budgetary support at about $700,000 and this support is from three partners (AMREF, EGPAF and UNICEF). The rest of the funds is pegged to support cross-cutting programs and this is provided by AMREF, SUDK2, UNICEF, WHO and WorldBank. Ten out of the 13 sub-focus areas received some budget commitment and this is quite impressive. However the bulk of the support goes to Health information policies and planning, which is allocated almost $700,000.

Uasin Gishu County:

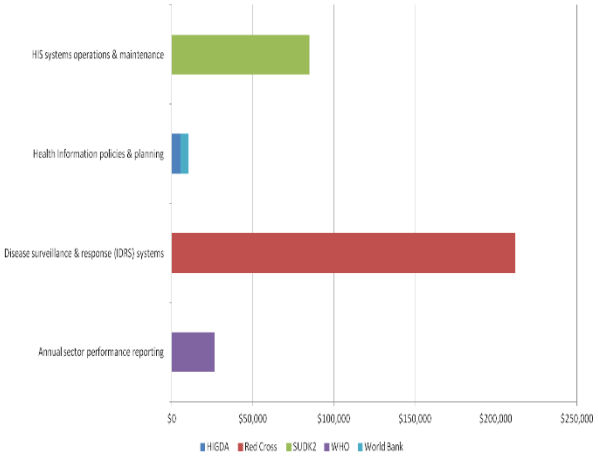
The county of Uasin Gishu received a total of $334,154 HIS/M&E activities. This was allocated to 2 out of 6 focus areas. The areas allocated these funds are; focus area FA1: Health information policy, planning and monitoring 37% and FA5: disease surveillance and response which received the highest allocation i.e. 63% ($211,741) The chart shows that there is a major gap in the areas of HIS/M&E in the county. There are only few partners supporting two focus areas meaning the remaining did not have budget allocation hence activities in these areas were not implemented fully.

Focus area





Disease programs

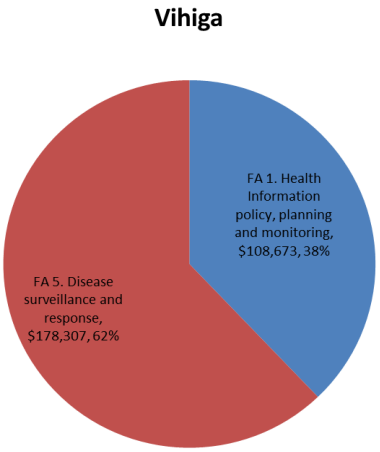


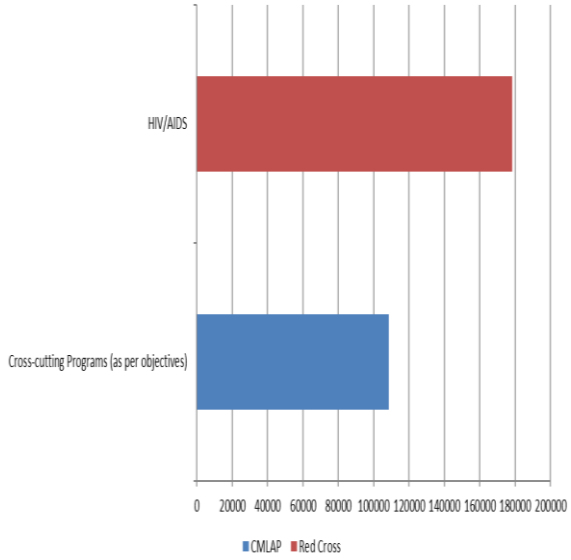
Specific focal areas of investment

HIV/AIDS is the most funded disease program in Uasin Gishu County. The chart indicated that it receive partner support of about $ 200,000 through Red Cross. Others partner including HIGDA, I choose Life, SUDK2, WHO and World Bank supported cross cutting programs as per objective with about $130,000. Note that maternal/Neonatal reproductive health did not receive any support.The county received more support for disease surveillance and response system through Red Cross ($ 110,000) and was followed closely by HIS system operation and maintenances through SUDK2 about $ 70,000. Annual sector performance reporting and health information and planning received support of less than $20,000 respectively.

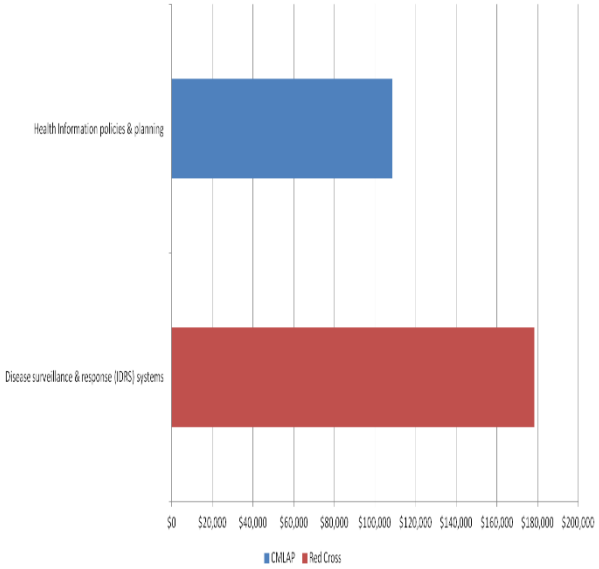
Vihiga County:

Analysis of resources by partners on HIS/ME investments (inputs), showed that the main investment into the HIS/ME inputs focused on disease surveillance and response, at $178,307, with specific focus on disease surveillance and response systems. The other focus area was in health information policy, planning and monitoring, with a specific focus on Health information policies and planning. The two partners involved were CMLAP and Red Cross, with resources ranging from $100,000 to 180,000 each.





Disease programs



Specific focal areas of investment

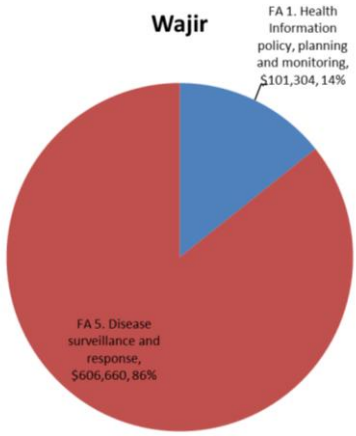
Analysis by disease program areas, indicated that partners within the county (CMLAP and Red Cross) focused their HIS/ME resources on HIV (around $180,000), and cross cutting programs (about $100,000). The main HIS/ME partner was Red Cross supporting HIV.

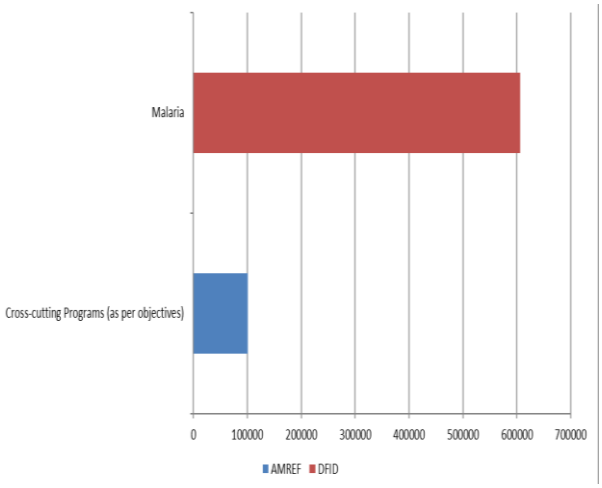
Wajir County:

The chart below shows that only 2 out of the 6 HIS Focus areas have been allocated some budgetary support in Wajir with 85% of the allocation being for Disease surveillance and Response.

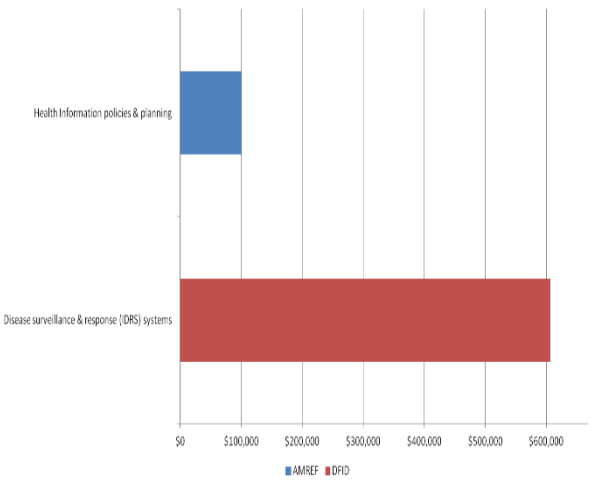
The county has only two organizations with DFID being the major one. Malaria program has the highest budget allocation of US $600,000.However, cross cutting programs had been allocated around US $100,000 for the county.

Focus area





Disease programs



Specific focal areas of investment

The main investment area being funded in the county is the Disease Surveillance & Response (DRS) systems with US $600,000 while the least was Health Information Policies& Planning with US $10,000.

Other counties

Data for the counties whose support was limited to only one or two investment areas and/or one donors was analyzed are tabulated in summary tables for easier reference rather than presenting it in charts. The counties falling under this category were: Baringo; Elgeyo Marakwet; Kajiado; Lamu; Makueni; Mandera; Marsabit; Meru; Narok; Nyandarua; Taita Taveta; Tharaka Nithi and West Pokot. Tables 4.1, 4.2 and 4.3 represent this information.

Table 4.1: Focus areas investments in the selected counties

County	FA 1. Health Information policy, planning and monitoring	FA 2. Facility based information	FA 4. Health Research information	FA 5. Disease surveillance and response	Grand Total
West Pokot			175,879		175,879
Tharaka Nithi	5,284				5,284
Taita Taveta	12,039				12,039
Nyandarua	5,284				5,284
Narok	90,690				90,690
Meru				171,064	171,064
Marsabit	51,051				51,051
Mandera				255,473	255,473
Makueni	90,144				90,144
Lamu	6,287				6,287
Kajiado				180,114	180,114
Elgeyo Marakwet	1,641,536				1,641,536
Baringo	139,436	190,946			330,382

Table 4.2: Progammes support by partners within the counties

Programme in the County	AMREF	DFID	Global Affairs Canada	HIGDA	Pathfinder	Red Cross	SUDK2	WHO	World Bank	Grand Total
Cross-cutting Programs (as per objectives)										
Baringo								325,098	5,284	330,382
Lamu									5,284	5,284
Makueni							84,860		5,284	90,144
Mandera		255,473								255,473
Marsabit	51,051									51,051
Narok				5,830			84,860			90,690
Nyandarua									5,284	5,284
Tharaka Nithi									5,284	5,284
HIV/AIDS										
Kajiado						180,114				180,114
Lamu					1,003					1,003
Meru						171,064				171,064
Taita Taveta					12,039					12,039
Maternal/newborn& reproductive health										
Elgeyo Marakwet			1,641,536							1,641,536
West Pokot			175,879							175,879
Grand Total	**51,051**	**255,473**	**1,817,414**	**5,830**	**13,042**	**351,179**	**169,720**	**325,098**	**26,421**	**3,015,227**

Table 4.3: Partner support across the sub-focus areas in the selected counties

Investment areas in the county	AMREF	DFID	Global Affairs Canada	HIGDA	Pathfinder	Red Cross	SUDK2	WHO	World Bank	Grand Total
Baringo								**325,098**	**5,284**	**330,382**
Annual sector performance reporting								134,152		134,152
e-Health records system								190,946		190,946
Health Information policies & planning									5,284	5,284
Elgeyo Marakwet			**1,641,536**							**1,641,536**
HIS systems operations & maintenance			1,641,536							1,641,536
Kajiado						**180,114**				**180,114**
Disease surveillance & response (IDRS) systems						180,114				180,114
Lamu					**1,003**				**5,284**	**6,287**
Health Information policies & planning					1,003				5,284	6,287
Makueni							**84,860**		**5,284**	**90,144**
Health Information policies & planning									5,284	5,284
HIS systems operations & maintenance							84,860			84,860
Mandera		**255,473**								**255,473**

Disease surveillance & response (IDRS) systems		255,473								255,473
Marsabit	**51,051**									**51,051**
Health Information policies & planning	51,051									51,051
Meru						**171,064**				**171,064**
Disease surveillance & response (IDRS) systems						171,064				171,064
Narok				**5,830**			**84,860**			**90,690**
Health Information policies & planning				5,830						5,830
HIS systems operations & maintenance							84,860			84,860
Nyandarua									**5,284**	**5,284**
Health Information policies & planning									5,284	5,284
Taita Taveta					**12,039**					**12,039**
Health Information policies & planning					12,039					12,039
Tharaka Nithi									**5,284**	**5,284**
Health Information policies & planning									5,284	5,284
West Pokot			**175,879**							**175,879**
Health Observatory			175,879							175,879
Grand Total	**51,051**	**255,473**	**1,817,414**	**5,830**	**13,042**	**351,179**	**169,720**	**325,098**	**26,421**	**3,015,227**

5.0 Discussions

As stated earlier, the goal of this partner mapping exercise was to document the estimated budget for planned activities across partners, which will enable more informed and efficient investments in health information systems in future budget cycles.

The specific objectives were to:

i) Take stock of **resource distribution** and allocation for HIS/M&E activities across all the stakeholders
ii) Identify **Potential duplicative investments** in key focus areas at the national and county level
iii) Consolidate **gaps in focus areas and geographical** distribution
iv) Inform/Initiate the development of **joint investment case** for HIS/M&E in the health sector.

The results obtained from this activity can be able to address each of the stated objectives to a certain extent. Additionally, being the first time this kind of activity was done in Kenya, there were a few lessons learnt on ways that the exercise can be done in future to provide even richer information.

5.1 Resource Distribution and Allocations

The total amount of budgetary support for the Health Sector M&E/HIS by the 28 partner who provided data to this mapping activity was approximately 50 million US Dollars. This is about 3.2% of the approximately 1.52 Billion US Dollars combined National plus County governments allocation to health sector for the fiscal year 2016/17. According to the data received from the Ministry of Health during this mapping exercise, the national government allocation to the M&E/HIS area of the health sector was estimated at $2,397,567 US Dollars. This is approximately 4.8% of the overall budget from the 28 partners. It would therefore seem that theirs is heavy reliance on donor funding for the Health Sector M&E/HIS budgetary support. This is all the more reason why the government needs to step up its mandate to ensure strong alignment of the partner funding to health sector strategy and the M&E plan. It also calls for a well structured M&E plan and framework that is fully costed in accordance with the identified focus and sub-focus areas.

The allocation by the county health departments to the M&E/HIS budget was however not obtained during the data collection phase of this activity. A rough estimate of the allocations have however been calculated by a Ministry of Health economist. This information is not included in the main report as it has not been confirmed by the counties, however the summary table with these estimated allocation is included in Appendix A.

5.2 Gaps and Potential Duplicative Investments

The finding form this exercise clearly show that some of the focus and sub-focus areas receive significantly higher budgetary allocation that the others. In particular the Health Information Policy, planning and Monitoring focus area received 51% of the overall budgetary allocation from all the 28 partners for the fiscal year 2016/2017. At the national level this focus area was allocated 67% of the budget. Additionally a majority of the partners have some budgetary input to this focus area which suggests that there are potentially duplicative investments in this particular focus area. It is however not possible to confirm the suspected duplicative investments based solely on the data obtained in this mapping activity. This is partially because there is no costed work plan showing the amount that had been targeted to be spent under each of the six focus area for FY 2016/2017.

5.3 Joint Planning for Future Investments

What this exercise clearly brings out is the need for all partners supporting this important segment of the health sector to have well-structured and institutionalized forum where they can come together for joint review of their work plans in relation to the Ministry of Health work plan for HIS/M&E. This also means that all these stakeholders need to be involved in development of a comprehensive and fully costed M&E plan that is in line with the health strategy and the identified focus areas for HIS/M&E. Thus there is a clear need for a common investment framework, designed to align technical and financial assistance with country-defined priorities, and to reduce fragmentation and duplication of efforts. Although the current M&E Framework for the Health Sector (2014 – 2016) is costed, the costing is not in line with the six M&E /HIS focus areas identified in the Strategic and Investment plan and it only adds up to approximately 16 million US Dollars for all the 4 fiscal years (2014 – 2016). There will also be need to engage the counties in the investment planning process and empower them to undertake a similar activity at their level.

5.4 Relative contribution of each partner

From a detailed look at the analysis, it would seem that just about 5 out of the 28 partners shouldered more than 50% of the total budgetary allocation for the 2016/17 fiscal year. If this is true, then it means that it would be beneficial for the Ministry of Health to identify such key partners and deliberate with them very early in the work planning process to ensure that their budgets are well aligned to priority areas of implementation of HIS/M&E activities. This would also provide the opportunity to ensure that at least these key partners do not duplicate their investments in the same focus and sub-focus areas. However because of the different interpretation of the mapping tool by different partners, there might be those who included their internal operational costs as part of the budget allocation to the Ministry of Health, while some other partners have clear delineation between their internal costs and the actual activities' implementation costs

Another challenge in this area was that some partners provided minimal information on the specific HIS/M&E activities that they have committed to support. Such partners only indicated the names of the projects and activities plus the budgetary estimates, but with no details on the HIS/M&E focus areas supported, the activity programmatic areas, the geographic distribution of the funds or even allocation across the cost categories. This meant that the team doing the data analysis had to make informed guesses on the missing information to enable inclusion of such data in the analysis.

5.5 Distribution across the Counties

Another area of concern based on the findings is the fact that out of the 47 counties in Kenya, a few of them seem to be receiving a huge proportion of the budgetary allocation while others receive zero or near zero budgetary allocation. A case in point is Kilifi which was allocation about 2 million US Dollars, while the neighboring Lamu which is in the same coastal region received just about 6,000 US Dollars. It will be necessary to do further investigations beyond the scope of this mapping exercise to understand whether such great disparity in budgetary allocation was justified and informed by evidence of different needs in the different counties.

Another challenge when looking at the counties budgetary allocations was that 24% of the total budget commitments (approximately $12 million) was indicated as being for support of activities 'Across all Counties'. Ideally this would mean that each of the 47 counties will benefit from this funding. However it is not clear if this was the understanding of the stakeholders' who submitted the data and it will require better clarification in future investment mapping cycles.

6. Conclusion and Recommendations

This first partners' M&E/HIS Activity mapping has yielded interesting results which are worth disseminating to all stakeholders for their understanding of how the current support map looks like. Additionally it should be a good starting point for future work planning both at the Ministry of Health and for the partners.

One gap encountered in trying to draw conclusion from the analysis is the fact that the current MoH M&E framework does not include a budget pegged to the focus and sub-focus areas for activities implementation. Ideally one should be able to link the budgets from the activity mapping exercise to the overall MoH M&E activities budget in order to establish the existing gaps between what was planned and the budget commitments available. There is also need to use the budgetary data collected from all partners for validation against the joint work plans prepared by the MoH in partnership with all stakeholders. This will show whether what each partner committed to support as per the work plan correspond to what they have reported as their committed budget in the activity mapping.

Though the tool was designed to collect data on current fiscal year (2016/2017) plus commitments for the next two fiscal years, most of the partners only included information about their budgetary allocation for the current fiscal year. When undertaking future mapping activities, there may be need to reconsider whether to restrict the data collection to the current fiscal year only. Perhaps collecting data for the out years (i.e. future fiscal years) could be misleading because budget projections and commitments do not always translate to actual expenditure. Anything could happen to cause the partner to modify their budgets. It might also be interesting to include retrospective expenditure data for at least the last one year. This could be used to understand the situation on the ground before funding subsequent projects in terms of what had already been spent in doing certain activities. One could also be able to see the continuity of funding for each activity; and also whether the same funders/projects continued supporting the same activities across the years.

Finally there is room for some enhancement of the tool based on the identified limitations, and especially to ensure that all the participants have a common understanding of all the data elements being collected.

7. Appendices

Appendix A: Estimated Allocations to HIS/M&E by the County departments of Health

S/No.	County	County Budget 2016/17	PE County	O&M - M&E - HIS	PE - M&E-HIS	M&E-HIS	%ge M&E	Per capita (USD)	
								Total Allocation	Total HIS
1	Baringo	18,136,143	10,452,796	11,717	348,828	**360,544**	**1.99%**	26.00	0.52
2	Bomet	8,533,988	4,087,114	14,534	168,871	**183,404**	**2.15%**	9.31	0.20
3	Bungoma	20,064,904	2,792,086	16,141	397,044	**413,185**	**2.06%**	12.80	0.26
4	Busia	14,518,555	8,370,722	31,304	287,293	**318,597**	**2.19%**	17.12	0.38
5	Elgeyo Marakwet	12,975,167	9,487,970	15,468	256,753	**272,221**	**2.10%**	27.93	0.59
6	Embu	18,832,179	12,099,920	47,001	372,651	**419,653**	**2.23%**	33.09	0.74
7	Garissa	14,344,992	7,548,744	8,585	283,859	**292,444**	**2.04%**	32.95	0.67
8	Homa Bay	14,912,380	8,564,253	18,791	295,086	**313,877**	**2.10%**	13.18	0.28
9	Isiolo	7,265,668	4,298,633	26,236	143,773	**170,009**	**2.34%**	45.98	1.08
10	Kajiado	15,283,399	8,295,238	8,634	302,428	**311,062**	**2.04%**	17.71	0.36
11	Kakamega	31,894,988	15,137,873	18,018	631,138	**649,156**	**2.04%**	16.85	0.34

12	Kericho	15,108,539	9,398,449	32,980	298,968	**331,948**	**2.20%**		16.00	0.35
13	Kiambu	39,106,472	21,386,935	22,091	773,839	**795,930**	**2.04%**		20.79	0.42
14	Kilifi	24,469,816	12,299,183	15,559	484,209	**499,767**	**2.04%**		17.61	0.36
15	Kirinyaga	11,387,960	9,381,560	16,694	225,345	**242,039**	**2.13%**		18.60	0.40
16	Kisii	27,103,848	15,067,860	36,918	536,331	**573,249**	**2.12%**		20.03	0.42
17	Kisumu	24,016,593	14,376,051	12,292	475,240	**487,532**	**2.03%**		21.11	0.43
18	Kitui	23,158,032	10,078,595	13,134	458,251	**471,385**	**2.04%**		20.75	0.42
19	Kwale	17,565,528	8,032,683	5,831	347,587	**353,418**	**2.01%**		21.58	0.43
20	Laikipia	5,461,896	2,723,618	12,762	108,080	**120,842**	**2.21%**		10.90	0.24
21	Lamu	6,976,070	3,715,783	24,912	138,042	**162,954**	**%**		54.85	1.28
22	Machakos	22,259,026	14,695,040	45,621	440,462	**486,083**	**2.18%**		18.38	0.40
23	Makueni	21,394,570	10,890,085	10,842	423,356	**434,198**	**2.03%**		21.94	0.45
24	Mandera	17,003,121	6,177,926	29,180	336,458	**365,638**	**2.15%**		23.72	0.51
25	Marsabit	10,807,305	6,020,184	4,800	213,855	**218,655**	**2.02%**		33.65	0.68
26	Meru	19,288,295	12,552,079	19,840	381,677	**401,517**	**2.08%**		12.90	0.27
27	Migori	11,393,064	5,365,644	5,166	225,446	**230,612**	**2.02%**		10.58	0.21
28	Mombasa	27,635,213	15,549,910	24,807	546,846	**571,653**	**2.07%**		23.50	0.49
29	Murang'a	15,620,633	10,684,422	13,784	309,101	**322,885**	**2.07%**		14.30	0.30
30	Nairobi City	68,422,111	36,918,023	59,641	1,353,937	**1,413,578**	**2.07%**		15.74	0.33
31	Nakuru	42,343,532	30,514,218	25,387	837,894	**863,281**	**2.04%**		21.04	0.43
32	Nandi	15,982,475	6,033,688	7,105	316,261	**323,366**	**2.02%**		16.91	0.34
33	Narok	12,523,669	6,449,060	8,538	247,818	**256,356**	**2.05%**		11.73	0.24
34	Nyamira	15,984,287	7,023,300	7,671	316,297	**323,969**	**2.03%**		22.76	0.46
35	Nyandarua	9,351,357	6,381,617	14,858	185,045	**199,903**	**2.14%**		13.53	0.29
36	Nyeri	23,073,266	15,931,355	27,639	456,574	**484,213**	**2.10%**		28.70	0.60
37	Samburu	7,217,946	3,896,525	4,598	142,829	**147,427**	**2.04%**		25.67	0.52
38	Siaya	19,348,516	9,808,749	22,136	382,868	**405,004**	**2.09%**		19.56	0.41
39	Taita/Taveta	10,289,523	5,922,608	7,585	203,609	**211,194**	**2.05%**		28.86	0.59

40	Tana River	11,547,739	3,270,224	9,040	228,507	**237,547**	**2.06%**	38.39	0.79
41	Tharaka Nithi	12,222,301	6,474,200	6,050	241,855	**247,905**	**2.03%**	30.35	0.62
42	Trans Nzoia	15,529,826	9,075,857	8,233	307,304	**315,538**	**2.03%**	15.11	0.31
43	Turkana	11,976,715	137,247	6,091	236,995	**243,086**	**2.03%**	11.15	0.23
44	Uasin Gishu	15,461,480	9,118,943	10,960	305,952	**316,911**	**2.05%**	13.78	0.28
45	Vihiga	10,671,522	5,085,592	8,772	211,168	**219,940**	**2.06%**	16.88	0.35
46	Wajir	11,398,132	5,775,145	5,723	225,546	**231,269**	**2.03%**	24.64	0.50
47	West Pokot	12,789,376	6,944,724	6,304	253,076	**259,380**	**2.03%**	19.87	0.40
	County total	**842,652,117**	**454,292,430**	**809,976**	**16,664,350**	**17,474,326**	**2.07%**		
	National MOH	611,949,748	-	231,544	2,083,897	**2,315,441**	**0.38%**		
	Sector	**1,454,601,866**	**454,292,430**	**1,041,520**	**18,748,247**	**19,789,766**	**1.36%**	32.08	0.44

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