

**ANALYSIS OF COMPONENTS OF HIV/AIDS MONITORING AND EVALUATION AT
THE SERVICE DELIVERY LEVEL; A CASE OF APHIA PLUS PROJECT IN
KAKAMEGA COUNTY, KENYA**

^{1*} Leonard Yosi Odiga

^{2**} Leah Onyango

^{3***} Odoch Pido

Corresponding author: lodiga@live.com

^{1,2} Department of Urban Management, School of Planning and Architecture, Maseno University, Kenya

³ Department of Design and Creative Media, School of Creative Arts and Technologies, Technical University of Kenya

Abstract: HIV/AIDS remains a major global public health issue, with Sub-Saharan Africa being the hardest hit and housing over 1.7 million people living with HIV. Kenya's long-term success in combating AIDS requires decentralization, allowing counties and local networks to take an active role in developing, implementing, and monitoring evidence-based initiatives. Current frameworks for Monitoring and Evaluating (M&E) HIV/AIDS programs are primarily focused on data collection to inform decisions at the county and national levels. As a result, there's a pressing need to boost M&E capacity at the service delivery level to ensure effective HIV/AIDS programs. This paper interrogates the AIDS, Population, and Health Integrated Assistance (APHIA plus) Western Project's success in enhancing local M&E capacity at the service delivery level in Kakamega County and the challenges of sustaining the gains beyond the project period. The study sampled 110 health facilities offering HIV/AIDS services in Kakamega County. It was established that the APHIAplus Western Project made significant strides in strengthening the M&E system by establishing M&E departments, improving collection, quality and dissemination of M&E data and hiring trained staff. The study identified the main challenges to the sustainability of the M&E system which included heavy reliance on external funding and inadequate dedicated M&E staff in county health facilities where 62% of staff carrying out M&E functions/duties were hired by the project. It also identified a challenge in the likely compromise to the prerequisites for quality M&E data after the exit of the project since there was no clear transition plan from project to county. The study results indicate that that 70% of the facilities were collecting monthly data using specified tools and storing the data in an automated system. ANOVA yields a statistically significant difference in the length of years the APHIAplus Western project has supported the health facilities and the frequency of M&E data collection at the service delivery level. The study further identified a challenge in the likely discontinuation of fora/platforms organized monthly in 94% of the facilities for dissemination of M&E findings and supported by APHIAplus Western Project. The study recommends increasing the number of dedicated M&E staff in county health facilities by developing a phased transition plan for M&E staff contracted by the project with a clear handover schedule to County Government of Kakamega, and advocating for increased budget allocation for M&E activities at the service delivery level. Additionally, health facilities are encouraged to explore strategies for diversifying funding sources for M&E activities.

Keywords: Monitoring and Evaluation, HIV and AIDS, Service Delivery Level, Sustainable System

1. Introduction

According to the World Health Organization (WHO, 2022), HIV remains a significant global public health issue, with over 40.1 million lives lost to date and an estimated 38.4 million people living with HIV by the end of 2021, predominant in the African Region where 25.6 million reside. Since the first case was officially recorded in 1984, the Kenya World AIDS Report 2022 estimates more than 2 million AIDS-related deaths, with at least 1.5 million Kenyans reported living with HIV by the end of 2019 (National Syndemic Diseases Control Council (NSDCC), 2022). The report highlighted the necessity for increased efforts to accelerate decentralization of the response, enabling districts and local networks to engage actively in developing, implementing, and monitoring evidence-based initiatives aimed at addressing the epidemic. To design and execute the best possible service delivery, in-depth data on care models is necessary given the changing landscape of care and support, particularly the growing accessibility of treatment (WHO 2014) hence the studies focus on service delivery level which addresses the M&E needs expressed by NACC and NASCOP (2012), WHO (2011) and UNAIDS, (2006). Current frameworks for Monitoring and Evaluating (M&E) HIV/AIDS programs are primarily focused on data collection to inform decisions at the county and national levels. As a result, there's a pressing need to boost M&E capacity at the service delivery level to ensure effective HIV/AIDS programs.

The HIV M&E Capacity Rapid Needs Assessment (Mbondi et al., 2013) identified several gaps in Kenya's HIV M&E system, including limited use of data for program improvement and insufficient capacity for data management at the facility level. Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN) (2017) highlighted weaknesses in the HIV/AIDS M&E Framework, noting its lack of clarity on the purpose and intended users of M&E information. The MEASURE Evaluation PIMA project, funded by USAID in 2018, conducted evaluations of M&E capacities across 17 Kenyan counties, including Kakamega County. The findings from this assessment unveiled significant M&E issues. These issues included poor M&E coordination, undeveloped governance and partnership structures, insufficient costed work plans for M&E and insufficient county-level programs to promote M&E which resulted in the counties' budgets having insufficient funds allocated to essential M&E operations

Long-term strategy for developing M&E systems at service delivery level that is consistent with national reporting standards is needed. Policymakers and donors should actively promote and recognize the importance of M&E as both a reporting tool and a management practice in order to secure greater support from health facility staff and program personnel (Ogungbemi, et al., 2012). Literature illustrates that there are existing standard M&E frameworks for HIV & AIDS that are expected to realise set objectives but they need some improvements if they are to realise the set goals of a sustainable M&E in HIV and AIDS at service delivery level. These changes can be realised through capacity building which is espoused in the project objectives of the APHIAplus Western Project.

Efforts to strengthen the HIV M&E system should align with overall health information system performance, as recommended by WHO (2016). This includes investing in M&E capacity for frontline health staff and district-level data managers, while ensuring HIV M&E requirements do not overwhelm health staff capacity (UNAIDS, 2009). UNAIDS (2008a) highlights key factors for effective HIV M&E: organizational structures, human capacity, partnerships, a multi-sectoral plan, budgeted work plans, and advocacy. MOH, Kenya (2018)

suggests integrating M&E into organizational structures, allocating specific resources for M&E initiatives, and enhancing collaboration and governance in healthcare M&E.

The Care and Support M&E Technical Working Group emphasized the need to ensure availability of resources and training for timely routine data collection, as highlighted by WHO (2004). The Guidelines for M&E Institutionalization in the Health Sector Published in 2018 by the MOH Kenya proposed that the following structures for M&E should have a similar composition, with a minimum of three full-time staff at county and sub-county levels i.e., a health information officer, a manager/coordinator, and health statistician or economist; in contrast, health centres and dispensaries ought to employ a minimum of one full-time health information officer. The guide goes on to stress that strong M&E leadership, job descriptions that are clearly written for M&E staff should all be part of the M&E structures. The guide specifies that successful implementation of this component will result in visible outcomes, such as having skilled M&E personnel capable of executing all tasks outlined in the M&E plan—including data management, analysis, reporting, dissemination, and training—in an effective and efficient manner. Adequate resources are essential for completing M&E tasks, including staffing, capacity-building/training, and other expenses such as translation, data entry for baseline surveys, facility costs, office supplies, travel and accommodation, computer hardware and software, as well as printing, publishing, and distributing M&E documents (MOH Kenya, 2016).

A well-designed M&E framework, as emphasized by United Nations Women (2019b), plays a crucial role in evaluating programmatic strategies, objectives, and planned activities to assess their suitability for implementation. According to UN Women (2019a), an M&E plan encompasses a theory of change, M&E framework, evaluation questions and tools, baseline indicators, monitoring activities and key events, timeline, budget, and resource requirements (including personnel, capacity development, and infrastructure). MOH Kenya's Guidelines for M&E Institutionalization (2018) further detail that an M&E plan should specify the background, indicators aligned with strategic or program objectives, and operational functions to facilitate measurement. Key components include a descriptive background, a logical or results framework with program goals and indicators, and management strategies for the M&E system.

WHO (2016) advises that selecting relevant indicators for inclusion in an M&E plan should be contextually appropriate and aligned with the services delivered. These indicators should be straightforward and complementary to ensure optimal resource allocation toward achieving program objectives. However, even collecting basic M&E information requires resources and a skilled workforce (WHO, 2004). WHO (2016) further suggests that data for these indicators can be gathered through various methods, such as routine reporting from all facilities or sentinel sites, facility surveys to monitor program inputs and processes, documenting human resource availability and training, and monitoring the supply of HIV medicines and diagnostics across different geographical and facility levels.

The AIDS, Population, and Health Integrated Assistance Program (APHIA plus) Western Kenya was a six-year USAID/PEPFAR-funded project led by PATH, to enhance M&E system capacity at health facilities delivering HIV/AIDS interventions. Its objectives included supporting health facilities to provide quality services and involving communities in identifying and addressing health issues. The project aimed to establish essential M&E capacities (such as dedicated M&E units with clear mandates), develop M&E plans and indicators, and conduct regular monitoring (data collection, analysis, and reporting). Key Result Areas focused on increasing the use of quality health services and information by building local capacity within government frameworks. The project aimed to address deficiencies in HIV/AIDS M&E systems and provide evidence for improving M&E practices at the service delivery level, which could be replicated by other providers. This

paper intends to assess the achievements of APHIAplus Western project efforts for additional capacity of an HIV/AIDS M&E system at service delivery level and the challenges of sustaining the gains beyond the project period

2. Research Methodology

The study was carried out in Kakamega County, situated in the western region of Kenya. Health facilities in the County have received support for HIV/AIDS programming from APHIAplus Western project and that is why it was the appropriate choice for this study. The research distributed questionnaires to two individuals in each of the 107 health facilities located within Kakamega County. The two respondents included the person in charge of the health facility's HIV/AIDS program and a staff member responsible for M&E functions at the health facility. The study utilized semi-structured questionnaires comprising both open-ended and closed-ended questions, along with in-depth interviews, for data collection. The study also conducted interviews with both the County Health Department staff and project staff. This was complimented by Interview to the County HIV/AIDS coordinator to understand the HIV/AIDS programs, footprint & role of APHIAplus Western project, Staffing for the HIV Programming. Secondary sources such as County HIV/AIDS M&E guides & APHIAplus Western project quarterly report were reviewed. Data was analysed using both qualitative and quantitative methods.

3. Results and Discussions

This section examines the health facilities to see which components exist for the HIV M&E system. It addresses the first specific objective of the study which is “analysis of the components of HIV/AIDS M&E that exist at service delivery level in Kakamega County”. These components are prescribed by the UNAIDS (2009a) that leads and inspires the world in the fight against HIV/AIDS, which includes organizational M&E structures, M&E staff for coordinating and managing the M&E System, M&E frameworks/logical framework, M&E work plan that includes data collection, data quality, analysis, dissemination and use and lastly M&E resources. To establish the organisational M&E structures in Kakamega County the results of the M&E Capacity assessment conducted in 2019 by MOH Kenya to establish the existing capacities to support the Institutionalization of M&E in the Health Sector and here are the findings for Kakamega County. M&E organisational capacity;

Table 1: M&E Health Sector M&E Capacity Assessment report using M&E Capacity Assessment Tools (MECAT) MOH Kenya, 2019)

M&E Capacity Area	Status	where 0, the least, implied no capacity, and 10, the highest, implied a high level of capacity.
1. Organizational	8.3	
2. Human Capacity for M&E	2.0	

The results from the M&E capacity assessment study by MOH Kenya (2019) revealed that Kakamega County health sector M&E organisational capacity in terms of presence of an M&E unit was rated 8.3 where 0, the least, implied no capacity, and 10, the highest, implied a high level of capacity (Ministry of Health (MOH), Kenya, 2019). The findings of M&E Capacity Assessment report established that the County Government of Kakamega Department of Health Services had prescribed in their M&E Plan 2018-2023 the organisational structure for M&E functions that need to be carried out at all levels of healthcare delivery from the County to the community level.

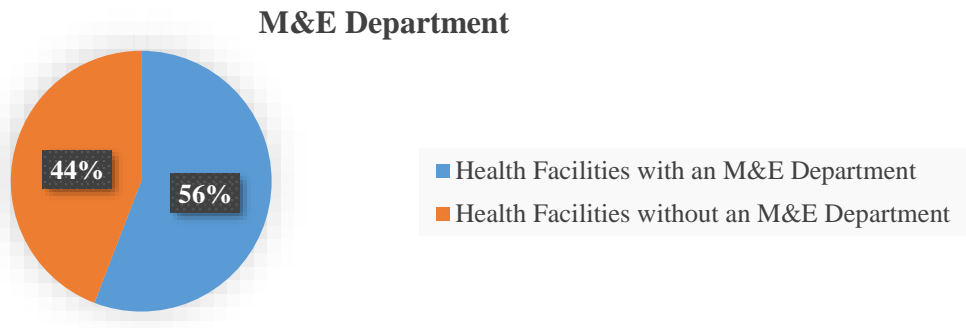


Figure 1: Health Facilities with an M&E Department

The results findings showed that 56% of the health facilities in Kakamega County had a unit called the Health Records and Information department led by a Health Information Records Officer (HRIO) who reports to the in-charges of the health facility. Those at sub-county level have the title of Sub-County Health Records and Information Officer (SCHRIO) while the one at County level bears the title of County Health Records and Information Officer (CHRIO). These departments are responsible for conducting M&E activities at the health facility, Sub-County and County levels respectively. This finding is aligned with the MOH Kenya (2018) Guidelines for the Institutionalization of M&E in the Health Sector which identified the health records information management who are at the heart of the health records information management department at every health facility. This implies availability of organisational structures for M&E at service delivery level that will ensure that the M&E function does not operate outside the formal structures i.e., has a direct link to the highest-ranking leaders within the organizational structure of healthcare facilities. As envisioned in the health sector M&E Plan 2018-2023 by MOH Kenya, (2019) these M&E Organisational structures provide overall oversight of M&E activities at their respective level of service provision. The plan continues to stress the need for all health facility departments to have a designated focal point person who provides regular reports to the M&E unit.

The human resources needed by health facilities to carry out M&E activities are referred to as M&E staff for coordinating and managing the M&E System. These resources include epidemiologists, health statisticians and economists and health records and information technologists (MOH, Kenya, 2018). These staff are responsible for carrying out M&E functions at the health facilities such as data collection, analysis, reporting, and dissemination of M&E findings. The study sought to know whether the health facilities in Kakamega County had staff for carrying out M&E functions of data collection and here is how they responded;

Do you staff have who have roles & responsibilities related to M&E?

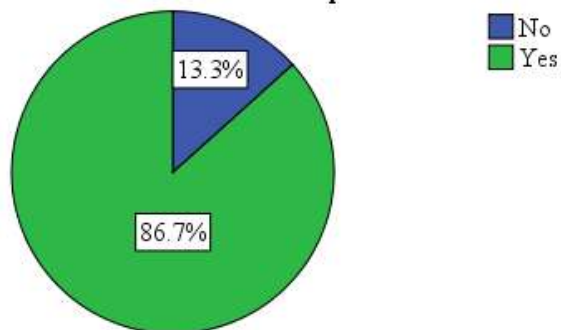


Figure 2: M&E Staff

The results findings showed that 86.7% of the health facilities in Kakamega County had staff with M&E and responsibilities while the remaining 13.3% did not. The M&E staff coordinate and manage the M&E system hence they are a key component of an HIV/AIDS M&E system at service delivery level. Data on staffing by cadres in County Health facilities from the County Health Department was analysed and the findings are shown below;

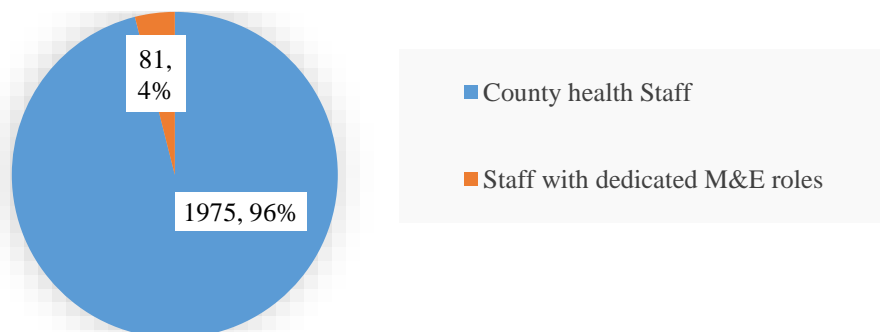


Figure 3: County Health Staffing

Further analysis of data collected from staffing reports from Kakamega County health department shows that out of the about 1,975 staff at health facilities, only 4% (81) are dedicated to undertaking M&E functions revealing that some of staff in this study act as a focal person for M&E while they perform their core non-M&E duties. The study explored further the facilities with M&E staff and here are the results;



Figure 4: M&E Staffing

Analysis of M&E staffing at the health facilities revealed that 56% of the sampled health facilities had Health Records and Information staff who perform M&E roles and this was limited to the health facilities above the sub-county level and some health centers while at lower levels such dispensaries a clinical officer or a nurse performed the functions of M&E. This fell short of Mpofu et al (2014) who had recommended that a strengthened M&E and sustainable health information systems need to be done through development of a dedicated M&E cadre. The study further explored how long the M&E staff had been performing the M&E roles and responsibilities and here is how they responded:

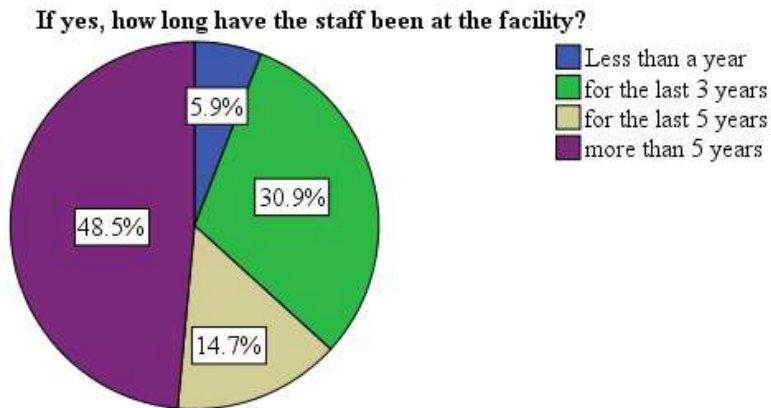


Figure 5: Period the Staff has been performing M&E roles and responsibilities

The results of the study found that 94.1% of the health facilities said that the staff had been performing the M&E roles and responsibilities for more than 3 years (63.2% of the health facilities said that the staff had been performing the M&E roles and responsibilities for more than 5 years, while 30.9% for the last 3 years) and 5.9% for less than a year. These M&E roles and responsibilities include data collection, analysis, reporting, and dissemination.

The results findings showed in Figure 5 that 56% of the health facilities in Kakamega County had a department at the health facilities with M&E functions which as envisioned in the health sector M&E Plan 2018-2023 by MOH Kenya, (2019): M&E Organisational structures that provide overall oversight of M&E activities at their respective level of service provision. The results findings showed in Figure 2 that 86.7% of the health facilities in Kakamega County had staff with roles and responsibilities related to M&E some acting as a focal person for M&E while they perform their core non-M&E duties. The study further revealed in Figure 2 that only 4% of County health staff are dedicated to undertaking M&E functions with Figure 3 revealing that 56% of the sampled health facilities were staffed with staff undertaking M&E functions. Based on Figure 4.6 counting there were health facilities with staff performing M&E roles but exclusively. This is against the Guidelines for the Institutionalization of M&E in the health sector by MOH Kenya (2018) which anticipated structures for M&E at health facilities to have at least one full-time staff. Staffing arrangement in the ideal situation recommends that 7–10% of workers ought to be committed to M&E. The Guidelines for the Institutionalization of M&E in the health sector by MOH Kenya (2018) proposed structures for M&E include full-time staff performing M&E responsibilities at service delivery level with referral hospitals to having at least three fulltime staff and that health centres and dispensaries ought to employ at least one full-time employee.

The study findings revealed in Figure 4.5 that 94.1% of the health facilities said that the staff had been performing the M&E roles and responsibilities for more than 3 years. In one of the APHIA *plus* Western Project Progress Reports for 2018, the project contracted 204 healthcare workers in the health facilities in Kakamega County with 25% being those undertaking M&E functions thereby contributing to 4% of health workforce performing M&E functions in health facilities in the County of Kakamega. The Guidelines for the Institutionalization of M&E in the health sector by MOH, Kenya (2016) recommends that 7-10% of personnel should be dedicated to M&E which implies staffing gaps for service delivery to effectively carryout HIV/AIDS program M&E activities at Kakamega County. In order to make sure that the M&E system in Kakamega County operates effectively, there must be a sufficient and dedicated number of M&E employees who possess the appropriate abilities to carry out their M&E roles at the service delivery level. This implies that there was

a shortage in the availability of dedicated M&E personnel at the service delivery level within Kakamega County. This deficiency has resulted in weakened organizational structures for M&E, which in turn poses a risk to the efficient functioning of the M&E system at the health facility level. This includes challenges in executing M&E functions and implementing the M&E plan, as outlined in the County Government of Kakamega's M&E Plan for 2018-2023 (2019).

M&E frameworks/logical framework

An M&E guideline, framework, or plan outlines the purpose of the system, its operational procedures, and the essential M&E questions to be addressed. This includes specifying indicators to measure, frequency of data collection, sources of data, tools for data collection, methods of analysis and interpretation, reporting frequency and distribution, data utilization and dissemination practices, and allocated M&E resources (MOH Kenya, 2016). The study aimed to determine if facilities had such M&E guidelines, frameworks, or plans in place for implementing their M&E systems, and the responses are detailed below;

Table 2: M&E Guidelines contents

Have an M&E Guidelines that contain?	Responses	Percent of Responses
Data to be collected	68	88.3%
Frequency of Data Collection	45	58.4%
An Individual in charge of M&E	32	41.6%
Schedule for M&E activities	26	33.8%
Plan for Dissemination of M&E Findings	20	26.0%
Individuals for specific M&E activities	18	23.4%
Total	77	

The study revealed the existence of M&E Guidelines with a majority (58.4%-88.3%) having defined data pieces and the frequency to be collected. It also revealed that M&E Guidelines for only a few (23.4%-41.6%) health facilities had individuals specific for M&E activities, individuals, in charge of M&E, schedule for M&E activities, and plan for dissemination of M&E findings. The finding shows health facilities had M&E guides with well-defined data to be collected and frequency of data collection with poorly documented individuals specific for M&E activities, individuals in charge of M&E in charge, schedule for M&E activities, and plan for dissemination of M&E findings. The Kenya Ministry of Health guideline of 2016 for institutionalization of M&E in the Health Sector, describes standard M&E guide as one that should provide background information, define what the M&E system will measure and how the M&E system will operate to enable these measurements to take place. The description of the study findings is also supported by Khan, (2003) who recommended that M&E guidelines include a detailed description of data to be collected and frequency; indicators that provide data for all levels of use, data collection, and reporting tools majorly for routine data. The study revealed existence of M&E Guidelines with defined data to be collected and frequency however, the guidelines did not document other key areas such as personnel in charge of M&E and those tasked with specific M&E roles, schedule for M&E activities and plan for dissemination of M&E findings.

This suggests that while there is a framework in place outlining defined data to be collected and the frequency of collection for an effective and efficient M&E system at the service delivery level however it wasn't comprehensive enough to establish and effectively manage others elements of an M&E guide/framework such as individuals responsible for overseeing M&E, those assigned specific M&E roles, the plan for M&E

activities, and the strategy for sharing M&E findings. This differs from the UNAIDS (2000) recommendation, which suggested the inclusion of a framework for consistently sharing information with the public in the health facility's M&E guide. Owing to these deficiencies in the M&E rules for service delivery, health facilities will be incapable of creating a dynamic and effective M&E system that will boost the effectiveness of the healthcare system overall and facilitate evidence-based planning (MOH Kenya, 2018).

Availability of Indicators

Indicators as defined by UNAIDS, (2006) are characteristics of performance that are used to track, describe, and measure key outputs, and outcomes of HIV/AIDS program service delivery. Health facility-specific indicators provide a wealth of information to support decision-making in service delivery, while national indicators matter for policy-making (WHO 2011). The study sought to establish the availability of indicators for tracking progress of HIV/AIDS, Malaria and TB services offered at the health facilities and here are the responses. Results of the study found that all (100%) health facilities had the indicators for tracking progress of HIV/AIDS, Malaria, TB, and Reproductive Health/Family Planning services that they were offering. This implies that the health facilities in Kakamega County have indicators for measuring the progress of HIV/AIDS, Malaria, TB, and Reproductive Health/ Family Planning services. The study further sought to know what level of indicators they have i.e., specific to the national, county, program or facility levels and here is how they responded:

Table 3: Indicator Levels

Are indicators specific to the following levels;	Responses	Percent of Cases
National	45	58.4%
County	43	55.8%
Facility	39	50.6%
APHIA <i>plus</i> Project	39	50.6%
Other	1	1.3%
Total	77	

The study sought to find out whether the health facilities had indicators specific to the needs of National, County, Facility and APHIA *plus* Project levels. The study findings reveal that the indicators at the service delivery level are specific to the needs of the National, County, facility, and Program levels (58.4%-50.6%). This implies that the health facilities have indicators that are equal to the needs of all the levels with national level slightly more than County, while the needs of the County level are in turn slightly more than facility and the APHIA *plus* Western Project. This also implies that the identified indicators at the service delivery level provide a measurement of results that are general to the needs at all levels rather than specific to the requirements of individual health facilities. WHO (2011) recommends locally developed indicators that lead to action at the health facility level where much of M&E data collected and analysed may not need to be reported to higher levels. Such service delivery-specific indicator metric data is critical in evaluating and determining local response strategies that work (UNAIDS, 2011). This also implies that the identified indicators at the health facility level may be relevant to providing a measurement of results for policy-making purposes rather than informing and improving decision-making at the service delivery level.

Data Collection and Reporting

Data collection and reporting for an M&E system involved various methods such as interviews with stakeholders, community or group interviews, field visits, record reviews, participant observation, focus group discussions, direct observation, questionnaires, one-time surveys, panel surveys, censuses, and field experiments (Kusek & Rist, 2004). This study sought to find out which techniques the facilities use to collect, and report service delivery data and here is how they responded.

Table 3: Data Collection, and Reporting Tools

Data collection & Reporting tools	Responses	Percent of Cases
Attendance forms (Activity Registers)	66	88.0%
Questionnaires	25	33.3%
Participant observation	15	20.0%
In-depth Interviews	12	16.0%
Focus Group Discussions (FGD)	10	13.3%
Other Specify	3	4.0%
Total	75	

The results of the study revealed that 88.0% of health facilities use attendance forms that capture clients’ bio data, appointments, vital signs, and services received. It also revealed that most of the health facilities (13.3%-33.3%) do not use questionnaires, participant observation, In-depth Interviews and Focus Group Discussions (FGD) as tools for collecting and reporting HIV/AIDS data. This implies that attendance forms (Activity registers) are the most used tools for collection of service transactional data in health facilities in Kakamega County. The purpose of using this particular data gathering approach is to gain insight into the effectiveness and service delivery of HIV/AIDS programs. It might also offer a useful context to clarify whether any changes are taking place. However, the method is dependent on information available and accessible, how it has been presented and by whom it is presented, and how it has been stored (Gebremedhin, Getachew, & Amha, 2010).

The study went further and asked the respondents to state how often they collected the service data for the supported disease program at their facility and here is their response:

Table 4: Frequency of Data Collection

How often is service data collected?	Responses	Percent of Cases
Daily	26	34.7%
Weekly	20	26.7%
Monthly	53	70.7%
Ad Hoc	3	4.0%
Total	75	100.0%

The results of the study revealed that 70.7% of health facilities collect program service data every month, while 34.7% said it’s done daily and 26.7% every week. The WHO (2010) suggests that individual health facilities and/or health professional regulating organizations submit and update their accumulated M&E data on a regular basis. This data is then combined into a single database that is kept up to date by the MOH. This is done in an effort to close significant gaps in the quality of data that are available for tracking progress toward developing policies for strengthening health systems and scaling up health interventions on a regular basis.

The study sought to establish the type of data and information storage and management system used by the health facilities and here is how they responded;

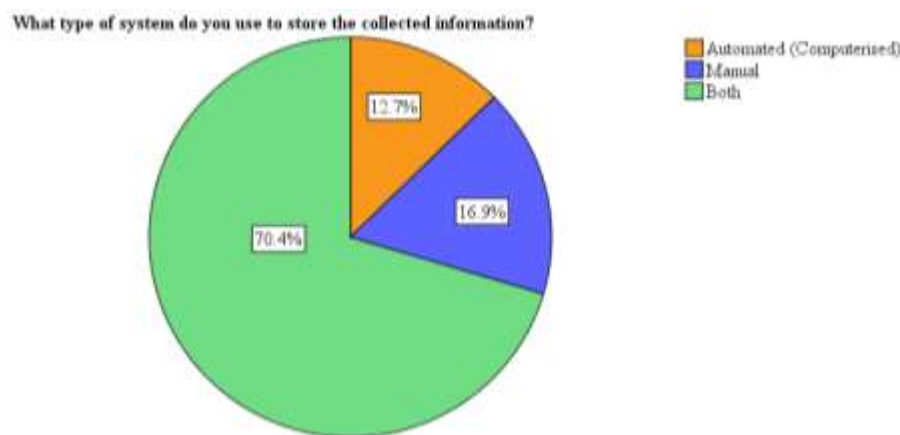


Figure 6: Type of Data Management System

Results of the study showed that a majority (70.4%) of the health facilities store their collected information in both automated (computerised) and manual systems. Only 1.9% still use the manual system exclusively. This implies that there are computerised systems at the health facility level to collect and manage service delivery data. The Guidelines for M&E Institutionalization in the Health Sector Published in 2018 by the MOH Kenya say that a sustainable M&E system to be assessed on the existence and quality of data systems and availability of technology for the same. This is also supported by recommendations for establishing a sustainable M&E system by Kusek & Rist (2004) who insisted on incorporating use of technology for data collection and analysis as a key component for internal organisational M&E capacity.

Types of Report

An M&E system strengthening tool by USAID (2007) describes a strengthened HIV/AIDS M&E system at Service delivery level as one with the capacity to collect and analyse quality data into relevant indicators for program management and reporting. The study then enquired from the health facilities on what format they share their M&E reports and here is how they responded:

Table 5: Format of the shared M&E reports

In what format do you share the reports?	Responses	Percent of Cases
Case stories	26	37.1%
Summary Statistics	54	77.1%
Total	70	

The results of the study reveal that the majority (77.1%) of the facilities share the service delivery reports in summarised statistics. This implies the health facilities analyse the collected M&E data into summarised statistics. This is in line with the Health Sector M&E plan by MOH, Kenya (2019) recommendation which urges the M&E Unit to nurture an inclusive and focused monitoring culture to make implementation effective and facilitate the collection and analysis of service delivery statistics to guide decision-making. Further, the study revealed that only 37.1% of health facilities share the report in form of case stories while the remaining 62.9% did not. This implies that the summary statistics are not complemented by patient case stories which goes against the WHO (2016) that recommends health facility-level staff present detailed information on a

sample of patient records supplemented with periodic assessments of provider-patient load, wait times, satisfaction, and measures to inform cost-effectiveness analysis. Improved analysis of data into various formats will enable the health sector to assess whether and how a programme has achieved both programme-level and population-level objectives (MOH, Kenya 2019).

Data Use

An M&E system strengthening tool by USAID, (2007) states that a sustainable HIV/AIDS M&E system at Service delivery level is one with the capacity to utilise the M&E reports to improve service delivery. The study sought to find out whether data collected and analysed by the facilities is used to change a process or improve their service delivery and here are the responses:

Is the data you collect and analyse at the facility used to change a process or improve your service delivery

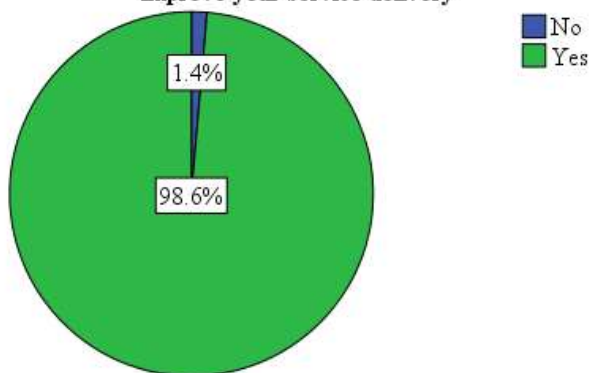


Figure 7: Data Use for service delivery improvement

Results of the study revealed that 98.6% of the facilities agreed that their collected and analysed data is used to change a process or improve their service delivery while the remaining 1.4% disagreed. The study therefore shows the M&E data collected at service delivery level is used to improve service delivery at service delivery level in the study area. This aligns with the Guide to M&E for National AIDS Programmes by UNAIDS (2000), which emphasizes that data from a robust M&E system can be utilized for advocating action, planning and improving programs, and attributing changes in the epidemic to interventions. According to WHO (2016), assessing the impact of HIV/AIDS treatment programs at the health system level is best achieved through periodic data collection and special studies, complemented by regular data review meetings where facility or district staff present detailed information to inform service delivery cost-effectiveness.

The study also investigated whether health facilities had implemented any improvements in service delivery over the past year. Below are their responses:

Are there service delivery improvements you have implemented in the last 12 months?

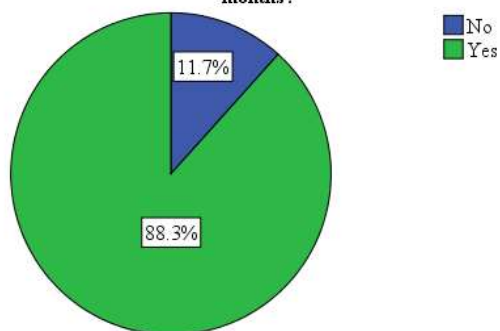


Figure 8: Implemented improvement initiatives

The study findings reveal that in the last year, a majority (88.3%) of the health facilities have implemented service delivery improvements at the health facilities in Kakamega County. The study further sought to find out whether these health facilities that had implemented service delivery improvements in the last year had documented the initiative and here are the responses:

If yes, are the improvement Initiatives documented?

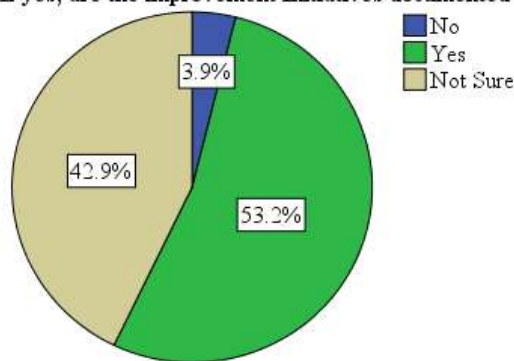


Figure 9: Documented improvement initiatives

The study results also revealed that only 53.2% of the facilities documented the improvement initiatives, 42.9% of the facilities were not sure and 3.9% did not keep such documentation. This implies that the health facilities in Kakamega County implemented the improvement initiatives and such initiatives were documented. This is well articulated by the EvalCommunity, (2023) who said that monitoring the changes made to achieve the desired result is key in ensuring the process remains optimized and effective.

Review Forums

The purpose of the performance reviews is to determine successes in relation to the program's goals, factors impacting the results and setting priorities, as well as interventions and projects for the upcoming period (MOH Kenya, 2018). These reviews offer decision-makers the opportunity to assess program performance against strategic plan priorities, review lessons learned, identify areas needing improvement, and inform future planning and implementation (The Global Fund, 2023). This study explored further whether there existed such forums in health facilities in Kakamega County and here is how they responded:

Do you have forums for reviewing service delivery data at the facility level?

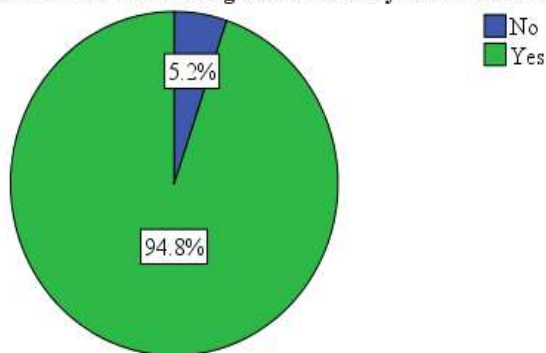


Figure 10: Facility Forums for reviewing service delivery data

The results of the study show that 94.8% of the facilities said that they have forums at their health facilities where they review service delivery data to address the gaps in the data before the same is used to make decisions. The Health Sector M&E plan by MOH, Kenya (2019) recommends that the M&E reports and information products developed be routinely disseminated to key stakeholders and the public as part of the quarterly and annual reviews to solicit feedback on the progress and make plans for corrective measures. The Guidelines for M&E Institutionalization in the Health Sector Published in 2018 by the MOH Kenya recommends that the performance reviews to begin at the lowest level units such as the sub-county health management teams and health facilities.

The study went further to enquire how regular these health facilities’ review forums are held and here is how they responded;

Table 6: Frequency of facility-level review forums

Frequency of Data review facility-level forums	Responses	Percent of Cases
Weekly	15	19.5%
Monthly	59	76.6%
Quarterly	14	18.2%
Ad hoc	4	5.2%
Total	76	100.0%

The results of the study showed that a majority which is 76.6% of the facilities said forums for reviewing service delivery data at their facilities were held monthly. This implies that in Kakamega County, health facilities conducted M&E review forums monthly. This is spelt out in the National M&E Guidelines and Standard Operating Procedures, MOH, Kenya (2011) where its definition of a strengthened M&E system is one ensuring that conferences and meetings are regularly held to promote information sharing, accountability and learning.

The study sought to find out whether there existed external forums where lessons learnt were shared from the service delivery activities the facilities offer and here is how they responded.

Do you have external forums where you share lessons learnt from the service delivery activities for your facility?

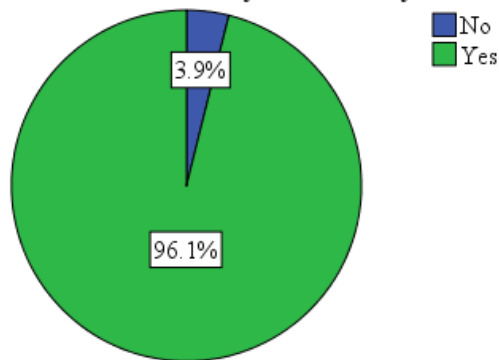


Figure 11: External Review Forums

The results of the study showed that 96.1% of the health facilities agreed that there exist external forums for sharing lessons learnt from service delivery. This is supported by Khan (2003), who suggested that an informal M&E system can be converted into a formal system and further strengthened by creating linkages with M&E sections in other organizations for sharing information and experiences, not only on issues but on M&E techniques and matters related to information management. The study went further to enquire how regular these external review forums are held and here is how they responded:

Table 7: Frequency of the external forums

How often are external sharing forums?	Responses	Percent of Cases
Monthly	54	70.1%
Quarterly	17	22.1%
Ad hoc	6	7.8%
Total	77	100.0%

The results of the study showed that 70.1% of the health facilities said the external forums for sharing M&E findings delivery took place every month. This implies that in Kakamega County, health facilities conducted external M&E performance review forums monthly. The International Organization for Migration (IOM), (2019) emphasized the importance of conducting regular Performance Reviews to identify necessary corrective actions during the implementation of program interventions. Furthermore, it highlighted that external reviews involve analysing documentation and engaging in meaningful consultations with all stakeholders, including beneficiaries, to serve as independent assessments of project or program implementations.

4. Conclusions

While the APHIAplus Western project has made considerable strides in establishing M&E roles within the organizational structure, the sustainability of these roles is uncertain. For long-term success, the County government must prioritize the recruitment and retention of M&E personnel to maintain these functions independently of donor support. The enhancement of M&E data collection practices is a notable project achievement. However, to ensure sustainability, there needs to be a concerted effort to transition the provision

and maintenance of data collection tools to the County government or other sustainable sources. The effective use of M&E data to enhance service delivery is a significant success. However, the sustainability of this practice is threatened by the potential discontinuation of external support. Developing internal mechanisms to maintain these fora is crucial for long-term impact. Furthermore, while the project successfully established regular forums for data review and dissemination of findings, these are likely to be discontinued once the project concludes. To ensure their continuation, health facilities are encouraged to integrate these data quality and program performance reviews into their routine management and departmental meetings. The provision of essential M&E resources was a key achievement for the project. However, for sustainable M&E operations, it is necessary to establish a local government mechanism for maintaining and upgrading these resources independently of donor contributions. Furthermore, inclusion of M&E in facility budgets is a positive step, the financial sustainability of these activities is not guaranteed. There is a critical need for independent, health facility sourced funding to ensure that M&E functions continue uninterrupted beyond the life of the project.

The study therefore concludes that the achievements of the APHIAplus Western project in enhancing M&E capacities in Kakamega County are substantial, but they are accompanied by significant sustainability challenges. The reliance on donor support by these health facilities for critical areas such as staffing, resources, and budgeting presents a serious risk to the long-term continuity of M&E activities. To address these challenges, health facilities receiving such donor support should implement a strategic transition plan in collaboration with the County government and other local stakeholders. This plan should prioritize establishing local funding mechanisms, recruiting dedicated personnel, ensuring that health workers such as nurses and clinicians in these facilities have completed M&E certification training, and maintaining the infrastructures essential for a robust and sustainable M&E system at the health facility level.

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