Strengthening monitoring and evaluation practices in the context of scaling-up[1]

KENYA

[1] This report was based on a mission to Ethiopia by WHO (Ties Boerma) 22-24 July 2009, related to IHP+ monitoring and the Country Health Systems Surveillance platform. The mission included consultations with Ministry of Health and in-country institutions and partners, and a desk review. The main goal was to develop a plan for an analytical review of health progress and system performance in Kenya 1994-2010 to inform development of a new Kenya health policy.

1 Background

The scale-up for better health is unprecedented in both potential resources and the number of initiatives involved. This requires a harmonized monitoring and evaluation effort that reinforces both country and global needs to demonstrate results, secure future funding, and enhance the evidence base for intervention. Eventually, the scale-up efforts will be judged by country progress towards the health-related MDGs, the degree to which major health constraints in countries have been addressed, and adherence to the Paris Declaration on Aid Effectiveness.

The IHP+ common framework for monitoring performance and evaluation of the scale-up for better health aims to ensure that the demand for accountability and results from single donors and joint initiatives is translated into well-coordinated efforts to monitor performance and evaluate progress in countries, in line with the principles of the Paris declaration. It stresses the importance of working in ways that contribute to strengthening country organizational capacity and health information systems, as well as enabling evidence-informed decision making and improved country performance.

The global framework needs to be made operational at the country level. The Country Health Systems Surveillance platform (CHeSS) aims to improve the availability, quality and use of the data needed to inform country health sector reviews and planning processes, and to monitor health-system performance.[2] There are three dimensions to this process to strengthen the monitoring and evaluation component of the country compact:

- Demand and use of information: improve the use of evidence in decision-making processes, focusing on country plans
- Supply of data and statistics: increase availability and quality of data used for decision making
- Enhance institutional capacity: support country capacity for assessment and monitoring of health systems and their performance

In August 2007 the Government of Kenya and Development Partners signed the compact on '*Scaling Up For Reaching the Health MDGs*',. For Kenya the added value of a compact relates to the prioritization and acceleration of interventions to scale up health outcomes and the National Health Sector Strategic Plan II (NHSSP II 2005-2010). This also pertains to the development of the third strategic framework and policy that will guide its strategic investments in line with supporting Vision 2030 attainment. The process has now started with a comprehensive and critical analysis of the present status of the health goals in the country.

This report describes the situation in Kenya regarding demand and use of health data, the current status of supply of data and statistics, and the institutional capacity for work on health statistics. It concludes with a workplan for the review and situation analysis to inform the development of the new health policy framework and strategy.

[2] Country Health Systems Surveillance. Report of a meeting in Bellagio, October 2008. WHO and Rockefeller Foundation.

2 Demand and use of information

2.1 Country review processes and mechanisms

The goal of the National Health Sector Strategic Plan - II (2005-2010) is to reduce health inequalities and to reverse the downward trends in health related outcome and impact indicators. NHSSP-II put much emphasis on performance monitoring with a defined set of indicators and targets and joint annual reviews and annual summits.

Joint planning meetings are usually held in the middle of the year at the end of the fiscal year, based on a bottom-up process of planning in the districts. These meetings produce the Annual Operational Plan (AOP), which includes indicators for the inputs and the achievements of results as set out in the objectives. Later in the year a joint review meeting is held to assess progress in the preceding fiscal year against the indicators and targets in the AOP and NHSSP-II. These meetings are informed by a review of data conducted by the health management information system (HMIS) department.

There is no special coordination mechanism for monitoring and evaluation. A health sector strategic plan for a health information system 2009-2014 has been developed and is about to be published[3]. The main strategic goals of the plan are related to strengthening the Health Management Information System (HMIS), such as the improvement of data management with increased ICT use, increasing staff capacity, more financial resources, and improving feedback and supervision. It also includes a strategic objective on improving the national vital registration. Health surveys, facility assessments or analyses are not addressed.

A report by the health sector reform secretariat of the Ministry of Health in 2006 provided a more comprehensive plan for the health information system, aiming to make it more performance oriented.[4] It identified the lack of a performance based monitoring and evaluation focus in an imbalanced and fragmented health information system. It proposed a smaller set of indicators derived from multiple data sources to inform the annual operational plans.

2.2 Indicators

NHSSP-II included 35 indicators which were intended to cover the domains of health status (4), service delivery outcomes and outputs (14), access (4), quality (3), efficiency (2), and financing (8). Targets were provided for most indicators.

The AOPs include a series of mostly program output (e.g. number of health facilities delivering standard youth friendly packages or having functioning community health units) and outcome (e.g. number of pregnant women receiving two doses of IPT or number of children vaccinated against measles) for each of the 73 districts in the eight provinces. In the AOP-3 (2007/08) 26 indicators were used.

[3] Ministry of Medical Services and Ministry of Public Health and Sanitation. Health sector strategic plan for health information system. 2009-2014. and Health Information System Policy. Nairobi. To be published.

[4] Ministry of Health, Health Sector Reform secretariat. Joint programme of work and funding 2006/07-2009/10 for the Kenya health sector: SWAp I. Nairobi, June 2006. and Monitoring and evaluation of health sector performance - framework and action plan 2006/07-2009/10. April 2006.

3 Supply of data and statistics

This section briefly reviews the data sources, quality control mechanisms, data compilation and access, analytical work and communication of data.

3.1 Data sources

HMIS

The Health Management Information System is a division, shared by the Ministry of Public Health & sanitation and the Ministry of Medical Services, which has the responsibility to compile data from its over 5,000 health facilities on health resources, service delivery and health status and report on regular progress to annual review and planning meetings. The Health Metrics Network supported assessment of the health information system in 2006 concluded that the Ministry has a fragmented and poorly functioning HMIS.[5] At the central, provincial and district level there were several stand-alone information systems which tend to support a vertical reporting function with little integration. As a consequence, essential information is largely unavailable for effective planning, monitoring and evaluation at all levels. There are also major concerns with the quality of data due to incomplete and inaccurate reporting.

Although the task of improving the HMIS so that it provides complete, accurate and timely health information is enormous, there are several recent signs of steps in the right direction. An indicator and standard operating procedure manual for health workers was produced in 2008.[6] This includes standard operating procedures for health indicators. Efforts are made to develop a comprehensive electronic database of all health facilities. Reporting from districts and provinces to the central level is now electronically. Spreadsheets with aggregate data are completed at the district level and put on a File Transfer Protocol site by the majority of districts and send by email by the remainder. Plans to further improve the system are being developed. In selected areas there

Surveillance

The Integrated Disease surveillance and response project (IDSR) is located in a separate division and focuses on 18 diseases of which eight are weekly reported (cholera, meningitis, measles, hemorrhagic fever, polio, plague, shigellosis and typhoid) and 10 are monthly (including malaria, HIV, pneumonia and diarrhoea). The second group of diseases overlaps greatly with the HMIS reporting system and suffers from the same problems. An Epidemiological Bulletin is published every week. Efforts are under way to introduce a mobile phone based system.

Population-based surveys

The National Bureau of Statistics is in charge of surveys and its main preoccupation is currently the 2009 census. The National Council Agency for Population & Development (NCAPD) often plays an important coordinating role in the health surveys. While there is a national strategy for

[5] Ministry of Health and Health Metrics Network. Report of the assessment of the health information system. Nairobi. 2006.

[6] Ministry of Health. Indicator and standard operating procedure manual for health workers. Nairobi. May 2008. (full and popular version).

the development of statistics there is no national health survey plan linked to the data needs of the NHSSP. The main sources of health data are:

- DHS which has been conducted every five years since 1988.
- HIV indicator surveys with testing have been conducted in 2003 and 2007
- The first malaria indicator survey was conducted in 2007.
- Household health expenditure and utilization surveys: 2003 and 2007
- Integrated household budget survey: 2005/06
- MICS: 2000

Facility assessments

A few assessments of the status of facilities and service delivery have been conducted:

- 1999, 2004, and 2009/10: Service Provision Assessment (SPA)
- 2006: IMCI health facility survey
- 2004: Service availability mapping through a district key informant survey
- 2008 and 2007: client satisfaction survey (exit survey) and also employee satisfaction surveys were conducted

Vital events

In 1971 compulsory registration of births (within 6 months) and deaths (within 3 months) was extended to all districts. It is compulsory but no penalties are reinforced. The Department of Civil Registration at the Ministry of Migration and Registration of Persons, created in 1989, is responsible for the compilation of birth and deaths records, including causes of death. Each district has several staff (district registrar and three clerks) responsible for the compilation of records which are filled by assistant chiefs at the sublocation level. Only recently, the department has begun to develop an electronic data base of birth and death records (2008 has now been entered). The central office has 28 data entry clerks and 8 statistical staff. There are about 900 staff in Kenya, including trainers and technical officers.

A recent analysis of birth and death records for 2004-07 suggests that coverage is 40-50% with wide variation between provinces. Causes of death, as recorded at the village level, were generally of poor quality, as no ICD coding rules were used. The link between hospital cause of death data and the civil registration system appears non-existent, although it might be the case that assistant chiefs use hospital medical certificates if available. The proportion of deaths occurring in hospitals is estimated at about 40%.

There are three demographic surveillance studies in Kenya: Nairobi low income areas (operated by APHRC), Kisumum (CDC/KEMRI) and Kilifi (KEMRI).

Administrative data

- Financial data: NHA was conducted in 2001/02 and 2006/07; annual public expenditure reviews
- Human resources: annual data are published on the number of health workers active in the health statistical report; in 2004 a human resource mapping exercise showed data quality problems with the existing data or even payroll database. Work is ongoing with the Capacity project on improving data on human resources.
- Infrastructure: work is on the way to develop a national database of facilities with GPS coordinates

3.2 Data quality control mechanisms

At present, there is no system of assessing data quality and making adjustments. For instance, while there are limited data on completeness, timeliness and, to a lesser extent, accuracy of reporting, no adjustments made to health facility based coverage estimates based on population-based surveys or other data quality assessment findings.

3.3 Access, analysis and dissemination

Statistics

- The Ministry has produced several publications with health statistics. There is some overlap between the publications. The major publications include:
    - Annual health sector status report: summary information reported by health facilities through the HMIS and its parallel systems (e.g. human resources, OPD morbidity, drug availability, service utilization); published for 2005-2007, 2008, 2009 in preparation
    - Facts and Figures on health and health related indicators: the most recent version compiles health statistics from all data sources and focuses on summarizing trends: published in 2006 and 2008.
    - Annual progress reports of the progress of the implementation of the AOPs.

Databases

- There is no public national database on the Ministry of Health website, only a health fact sheets derived from its publications
- The National Bureau of Statistics has no functioning databases accessible on the web at the time of this report

Synthesis and analysis

- Annual health performance report: at present there is no regular document that synthesizes and interprets all available data and statistics.
- Some disease programs or others conduct special reviews. For instance, Kenya's AIDS council (NASCOP) conducts AIDS reviews.

4 Institutional capacity

National Bureau of Statistics

Central Bureau Statistics Office is responsible for conducting the decennial census as well as large, nationally representative household surveys. It is also involved in facility surveys. It has about 60 qualified statisticians and demographers. In February, 2007 the bureau changed to Kenya National Bureau of Statistics (a semi autonomous body) formed by an Act of parliament in away of trying to achieve excellence in the provision of timely, reliable and affordable statistics for informed decision making to maximize the welfare of all Kenyans. As a parastatal, the bureau is headed by a director General and has a board of directors. Health statistics fall under the Population and Social Statistics Department. The National Strategy for the Development of Statistics (NSDS) has been completed. The KNBS also produces poverty maps.

Ministry

The HMIS department is leading the cross-cutting analytical and synthesis work and in charge of producing reports for annual reviews. The department is understaffed, especially in terms of analytical capacity, compared to the large volume of work. Other units and programmes such as IDSR and NASCOP also have data staff responsible for specific health data aspects.

Research institutions
Public health research is conducted by individuals and organization at, various institutions for example, the Department of Community Health of the University of Nairobi (UoN), Kenyatta University (KU), Kenya Trypanosomiasis Research Institute (KETRI), Kenya Medical Research Institute (KEMRI), Kenya Medical Training College (KMTC), Maseno university, Moi University Eldoret, Great Lakes University of Kenya (GLUK), Kenya Medical Training College, Aga Khan University, African Medical Research Foundation (AMREF), Kenya Medical Research Institute Wellcome Trust, Population Studies and Research Institute (PSRI), Nairobi. The African Population and Health Research Institute is Nairobi based, focused on research in sub-Saharan Africa.

KEMRI was established in 1979 and has centres in Nairobi, Kilifi and Kisumu. KEMRI has extensive expertise in tropical disease research. There are 10 research centres, including one on global health and one on public health. It also maintains the Kenya cnacer registry. KEMRI Wellcome Trust supports and runs sentinel surveillance sites in various regions in the country. Most of the sentinel sites are geographically linked and acts as representative of the geographical regions.

Kenya Institute for Public Policy Research and Analysis (KIPPRA) is an autonomous public institute whose primary mission is to provide quality public policy advice to the government of Kenya and to the private sector in order to contribute to achievement of national development goals. It published working papers on a wide range of social and economic issues, including health.

5 Conclusion and recommendations

4.1 Demand and use of information

- There is a need for a greater focus on measuring progress and performance through a defined set of indicators and targets and reporting on those in a well-prepared format on an annual basis at a broad forum, providing a good foundation for further strengthening accountability and results focus.
- It would be useful to have a national M&E steering committee that includes the major national and international partners.
- The development of a new policy framework and strategy provides an excellent opportunity to develop a fully integrated and practical M&E system and components in line with the CHeSS goals.
- The IHP Compact monitoring should be fully aligned with the NHSSP monitoring plan.

4.2 Supply of data and statistics

- Data sources: there are multiple data gaps in the availability and quality of health statistics which must be addressed to be able to implement the accountability and results framework:

  - HMIS: the implementation of electronic reporting systems as part of the new HMIS will be critical to improve data quality. Simplification of the system to a few indicators with regular data quality control at the facility level would be an important step.
  - Surveys: there is a need for a simple and clear national survey plan that informs the core indicators, using standardized survey modules, transparent data quality assessment and adjustment methods and effective communication of results. The NHSSP development could lead this development.
  - Vital events monitoring: it would be useful to invest further in exploring what needs to be done the vital registration system, starting with an in-depth analysis of data quality and issues, as the current HIS plan 2009-2014 is not specific enough about what could be done best.
  - Facility assessments: a regular (annual) system of assessment of the state of service delivery with data quality would be an important input into annual reviews, enhancing the credibility and quality of data presented.
- Data quality assessment
  - There is a need to further development a systematic approach to data quality assessment, by the HMIS department and subnational levels but also involving external institutions and global partners.
  - Increased institutional capacity and involvement in this process will be essential
- Synthesis and analysis
  - A situation analysis to inform the new health policy framework and plan needs to be done in 2009 - see Annex for detailed plan
  - A dashboard needs to be developed to effectively communicate the performance of the health system on a regular basis
  - International methods of computing key health indicators should be used to strengthen the analysis of health data.

4.3 Institutional capacity

Institutional capacity is weak, especially in the areas of data quality assessment, analysis and synthesis. More efforts need to be made to build such capacity in the Ministry of Public Health and Sanitation and Ministry of Medical Services. In addition, strengthening the capacity of several institutions is essential, such as KEMRI, NC APD, University departments or NGOs. These institutions can support the Ministry's work in this area and also present an independent view on data quality and findings.

Analytical review of health progress and system performance in Kenya 1994-2010 to inform development of a new Kenya health policy

Workplan

Background

The Kenya Health Sector has been guided by the Kenya Health Policy Framework, KHPF 1994 – 2010. A concept note "Towards a new health policy for Kenya" has been developed by a working group of the Health Sector Steering Committee. The objectives spelt out in the paper are "to review and develop a new, comprehensive National Health Policy for the health sector that will guide its strategic investments in line with supporting Vision 2030 attainment. Specific objectives are three:

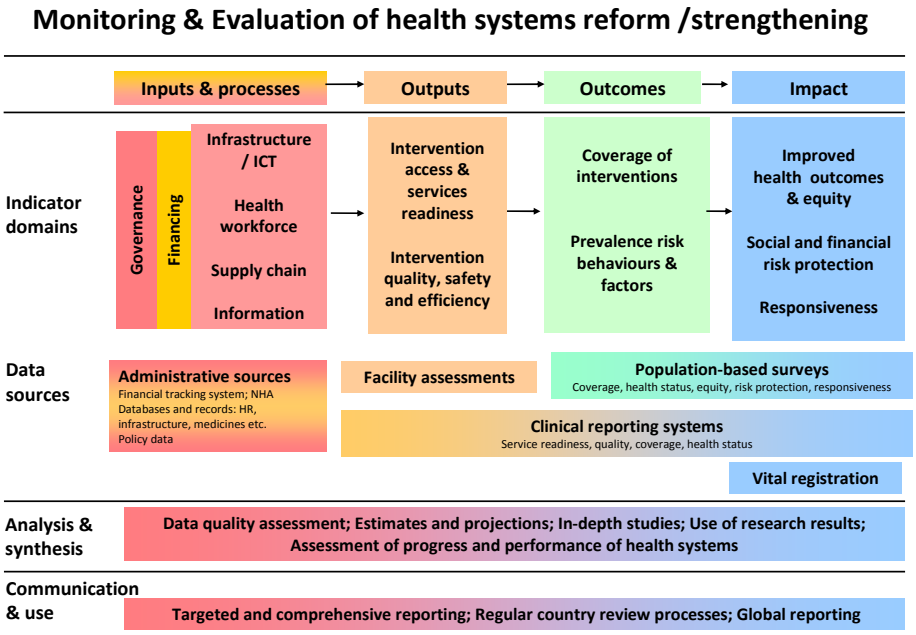
a) Carry out a comprehensive, and critical analysis of the present status of the health goals in the country (where are we?)
b) Analyze the contribution of the KHPF I towards achieving the current status of the health goals in the country (How did we get here?)
c) Develop key policy options in health that the country needs to focus on, to support attainment of Vision 2030 overall goals (Where are we going?)".

This paper describes the plan for the first of the three specific objectives, which is a critical quantitative analysis and synthesis of all relevant data and statistics that can inform the assessment of the current health situation. [7]

A framework and approach

A general framework for the analysis is presented, based on the common steps of the logical monitoring and evaluation (M&E) logical framework, in which the way in which health system inputs may lead to fulfill the basic functions of a health system, according to the WHO health system framework and as specified in the Kenya National Health Policy Framework. These include improved health outcomes, equity, financial risk protection and responsiveness of the health system to the people's needs. The framework is intended to ensure that all indicators areas - from inputs to impact - are considered in the analysis, and that pathways of influence are clarified.

[7] The workplan is based on the discussions that involved representatives from Ministry of Public Health and Sanitation, Ministry of Medical Services, KEMRI, NCAPD, Department of Civil Registration, WHO Country Office, African Population & Health Research Centre, Partner Coordination Group, GTZ, University of Nairobi, as part of a scoping mission by Ties Boerma, WHO, Geneva.



Data on the different indicator domains will be essential for a comprehensive analysis and synthesis. This should include levels, trends and differentials. There will be several cross-cutting dimensions including:

- What is the overall health situation in terms of leading causes of death and disability, and risk factors, and what will be the situation in the coming two decades?
  - General burden of disease with leading causes and leading risk factors; burden of disease projections until 2030
- What is the progress of the battle against the leading diseases and what progress has been made against the health MDGs? What has contributed to those trends?
  - General health and health system trends and determinants: child mortality, HIV, TB, Malaria, maternal health, including coverage of key interventions – progress towards MDGs; NCDs and risk factors; NTDs
  - levels and trends in health system inputs, subnational and national
- What are the levels of equity that have been achieved and what progress has been made since the early nineties? What has been the role of socio economic development in health?
  - provincial, district; urban rural; male / female; education; wealth status;
  - role underlying socioeconomic and health system determinants
- How well has Kenya's health system been performing during the past two decades? Has it achieved its own goals and how well has it performed compared to "peer" countries?:
  - Trends and targets for core indicators
  - Inputs (money, human resources) to output/outcomes/impact analyses
  - Comparative analyses and benchmarking country performance
  - Monitoring district / provincial / regional differences and performance

The approach focuses on analysis and synthesis of existing data sets and analyses. This includes primary data sets, reports of data collection efforts, existing reviews and published and grey

literature. In addition, an important subsidiary goal is capacity building in analysis and synthesis in line with the global Country Health Systems Surveillance platform (CHeSS).[8]

The subject and data areas for phase 1 reviews, analyses and syntheses can be organized as follows:

Inputs / process / outputs	
Financing of health services	Distribution within country, public / private
Human resources	
Drug availability and access	
Health infrastructure	
Access and utilization of health services	
Readiness and quality of health services	
Outcome / impact	
Maternal Neonatal Child Health	Intervention coverage, determinants/risk factors, incidence/prevalence, mortality
HIV/AIDS	
TB	
NCD	
Malaria	
Injuries	
Neglected tropical diseases (NTD)	
Impact	
Financial risk protection, health expenditure	Equity
Patient satisfaction /responsiveness	

Data sources

The focus is on analysis and synthesis of existing data, including preliminary data from very recent data collection efforts, which will be of great importance for the study:

- Health surveys:
  - DHS 1989, 1993, 1998, 2003, 2008 (not yet published)
  - MICS 2000
  - AIDS indicator survey 2003, 2008 (not yet published)
  - Malaria indicator survey 2008
  - Household health expenditure surveys 2007;
  - household budget survey 2006
  - STEPS (to be conducted 2009) and diabetes survey
  - Subnational surveys

[8]The main goal of CHeSS is to improve the availability, quality and use of the data needed to inform country health sector reviews and planning processes and to monitor health systems performance. There are three workstreams: Improving access and analysis of data; addressing data gaps: availability and quality of data used for decision making; capacity building: enhance institutional capacity to support better health systems surveillance. A grant from the Rockefeller Foundation supports WHO HQ and WHO AFRO support to the Kenya work.

- Health statistics reports and HMIS
  - AOP 1-4 reviews
  - Annual Health Status Report 2005-07; 2008
  - NHSSP II mid term review report
  - Facts and Figures on health and health related indicators 2006,2008
  - Program-specific reports and data: EPI, HIV, TB, Epidemiological Bulletins, cancer registry
- Facility assessments
  - SPA 1999 2004: SAM 2004; IMCI 2006
  - Client satisfaction surveys (MoH)
  - Subnational assessments
- Administrative data
  - Finances: PER, NHA (2001, 2006)
  - Human resources: national data base, professional databases, training institutions records
  - Road traffic accidents (KIPPRA study)
  - Infrastructure: national database of health facilities (public)
  - Poverty maps (KNBS)
- Mortality and causes of death
  - Vital registration systems
  - Demographic / AIDS Surveillance Systems (Nairobi, Kilifi, Kisumu)
- Research studies

Goal and process

The goal is to:

- Produce a final draft report by end December 2009 on the health situation and trends and systems performance in Kenya during from 1994 to 2010, to inform the first component of the reviews that will in turn inform the new health sector strategic plan and policy framework.

The report will be produced by a working group of Ministry of Public Health and Sanitation, Ministry of Medical Services, country health research institutions, and supported by international partners led by WHO and APHRC. There will an executive summary (3-5 pages) that aims at informing the policy makers, and a full report presented along the lines described above.

A core technical working group will be established (by end July).

- Co-Chairs: Ministry of Public Health and Sanitation, Director Public Health and Sanitation, and Ministry of Medical Services, Director of Medical Services
- Members: Ministry of Medical Services, HMIS, HIV, TB and malaria units, KNBS, KEMRI, NCAPD, KIPPRA, Department of Civil Registration, APHRC, Institute for Policy Analysis & Research, WHO, others; the members are expected to be able to contribute evidence/data to the process
- Terms of reference: By December 2009, produce a synthesis of (quantitative) evidence of health progress and health system performance in Kenya during 1994-2010, and projections

till 2030; ensure implementation of the workplan; meet twice a month to discuss progress and technical issues

The study will be coordinated by a small secretariat located at the HMIS unit, led by Dr Sergon Kibet, with a focal point - the technical coordinator - Wanjala Pepela, and administrative support staff, provided by WHO and partners.

- Terms of reference of the secretariat: to coordinate the process, organize meetings of technical working group, follow-up with partners in the process, and liaise with technical assistance partners and WHO country office.

Technical assistance to the technical working group and capacity building will be provided by WHO, APHRC and other interested international partners.

The workplan is divided into the following five phases:

Phases	Contents	Time period
1	Initiate preparatory sub-studies by Kenya institutions, including data and report compilation and "mining", literature reviews, following the subject areas identified in the framework (by Aug 5); conduct further analysis, literature reviews, data and report compilation (Aug-Sep)	Aug-Sep
2	Synthesis and analysis workshop, based on all step 1 outputs: all reports and data sets brought together; formulate the chapters of the final report	End Sep
3	Integrated analyses, writing of chapters	Oct-Nov
4	Final report review and analyses workshop, based on step 3 outputs	Early Dec
5	Finalization draft report	End Dec

In terms of practical work this implies that several topic-specific further analysis, synthesis and reviews can be identified to provide the necessary information:

Topic	Responsible
1 Critical review and analysis of civil registration data, analysis and report of levels and trends of age-sex specific death and birth data by district and province; causes of death summary	Department of Civil Registration with WHO
2 Survey further analysis / compilation (key tables): household budget surveys, client satisfaction survey, DHS 2008, STEPS 2009 (not yet), KAIS 2008, MICS 2000	DHS 2008 - KNBS, NCAPD Budget surveys with health component - KNBS, APHRC KAIS - CDC, MOMS, MOPHS
3 HMIS synthesis: data quality assessment and adjustment; reconciling data from multiple sources; including IDSR	MOMS/MOPHS

4 Facility readiness and quality of services synthesis; infrastructure trends	SPA 1999 2004, SAM 2004, IMCI 2007, quality of care studies; MOMS/MOPHS
5 DSS further analysis, basic reports: Nairobi, Kisumu, Kilifi	Nairobi (APHRC), Kisumu and Kilifi (KEMRI)
6 Literature and research reviews specific diseases, risk factors and other areas: NTD, cancer, violence, emerging diseases, DMI diabetes report etc.	KEMRI (tropical diseases - review are available; cancer registry analysis); tropical diseases (DVBD); NCD; emerging diseases KIPPRA (injuries, already completed)
7 HIV, TB, malaria, child and maternal health, reproductive health: information compilation, further analyses	Disease programs MOMS/MOPHS - identify lead staff for compilation and participation
8 Reviews administrative sources: financial data synthesis; human resources; essential drugs and commodities;	Financing: Department of Policy and Planning focal point MOMS/MOPHS -- identify lead staff for compilation and participation, e.g. ministry procurement unit, EMMS, MEDS (Mission for Essential Drugs Supply), KEMSA (Kenya Medical Supplies Agency)

The technical secretariat / coordinator will need to follow up with the respective responsible units and persons, supported by WHO Country Office. In some cases it will be necessary to develop a specific scope of work. (see Annex)