



# MONITORING, EVALUATION & LEARNING (MEL) FRAMEWORK

Turning Evidence into Action for Health Security.



**TDDAP2**  
Strengthening health  
systems to protect against  
public health threats





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# List of Abbreviations

AAR	After-Action Review
ADaM	All Disease Outbreak Module
AFENET	African Field Epidemiology Network
AMR	Antimicrobial Resistance
AU-CDC	Africa Centres for Disease Control and Prevention
BCC	Behaviour Change Communication
CDC	Centres for Disease Control and Prevention (U.S.)
CSO	Civil Society Organization
DQA	Data Quality Audit
DDSR	Division of Disease Surveillance and Response
DHIS2	District Health Information Software, version 2
DNLS	Division of National Laboratory Services
DOH	Department of Health
DRM	Disaster Risk Management
EQA	External Quality Assessment
ESPEN	Expanded Special Project for Elimination of NTDs (WHO)
FELTP	Field Epidemiology and Laboratory Training Program
GLASS	Global Antimicrobial Resistance Surveillance System (WHO)
GoK	Government of Kenya
HMIS	Health Management Information System
HRH	Human Resources for Health
ICT	Information and Communication Technology
IPC	Infection Prevention and Control
IPCAT	Infection Prevention and Control Assessment
IPCAF	Infection Prevention and Control Assessment Framework
IQMS	Integrated Quality Management System
IT	Information Technology
KHIS2	Kenya Health Information System
KNPHI	Kenya National Public Health Institute
LIMS	Laboratory Information Management System
MDA	Mass Drug Administration
MEL	Monitoring, Evaluation, and Learning
MMDP	Morbidity Management and Disability Prevention (NTDs)
MoH	Ministry of Health
MOU	Memorandum of Understanding
MTEF	Mid-Term Expenditure Framework
NACOSTI	National Commission for Science, Technology and Innovation
NTD	Neglected Tropical Disease
NPHEOC	National Public Health Emergency Operations Centre
One Health	A Multisectoral Approach Linking Human, Animal, & Environmental Health
PCN	Primary Care Network
PDR	Policy Development and Review
PER	Public Expenditure Review
PHC	Primary Health Care
PMO	Program Management Office
PPE	Personal Protective Equipment
SOP	Standard Operating Procedure
TAS	Transmission Assessment Survey
VHFs	Viral Haemorrhagic Fevers
WHO	World Health Organization
WASH	Water, Sanitation and Hygiene

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# List of Contributors

<b>Wandia Ikua</b>	MEL Lead Consultant, TDDAP 2
<b>Dr Kadondi Kasera</b>	Kenya Lead, TDDAP 2
<b>Dr Fred Ouma</b>	KNPHI
<b>Loyce Kihungi</b>	KNPHI
<b>Jackson Wafula</b>	KNPHI
<b>Max Mutuku</b>	KNPHI
<b>Samson Mobisa</b>	KNPHI
<b>James Rugethe</b>	KNPHI
<b>Beatrice Kinaiya</b>	KNPHI
<b>John Mwhihia</b>	KNPHI
<b>Amos Marwa</b>	KNPHI
<b>Fridah Kathuku</b>	KNPHI
<b>Samuel Sibaya</b>	KNPHI
<b>Dr Samuel Kadivani</b>	KNPHI
<b>Dr Michelle Wangui</b>	KNPHI
<b>Dr Victoria Kanana</b>	KNPHI
<b>Jennifer Njuhigu</b>	KNPHI
<b>Cecelia Wandera</b>	KNPHI
<b>Wendy Nkirote</b>	KNPHI
<b>Gerald Gikonyo</b>	KNPHI
<b>John Makau</b>	KNPHI
<b>Bill Abiola</b>	KNPHI
<b>Nelly Saiti</b>	KNPHI
<b>Florence Ogolla</b>	KNPHI
<b>Njoroge Willie</b>	KNPHI
<b>Maximillah Muro</b>	KNPHI
<b>Mercy Njuguna</b>	KNPHI
<b>Dr Daniel Langat</b>	KNPHI
<b>Dr Emmanuel Okunga</b>	KNPHI
<b>Dr Irungu Kamau</b>	KNPHI
<b>Dr Leonard Kingwara</b>	KNPHI
<b>Boniface Waweru</b>	KNPHI
<b>Wycliffe Omondi</b>	KNPHI
<b>Benjamin Murkomen.</b>	KNPHI
<b>Brenda Obura.</b>	KNPHI
<b>Yusuf Ajack.</b>	KNPHI
<b>Dr Isabella Ayagah.</b>	KNPHI
<b>Dr Richard Muthoka.</b>	KNPHI
<b>George Kamau.</b>	KNPHI
<b>Sophia Michael</b>	KNPHI

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# 1.0 Executive Summary

The Kenya National Public Health Institute (KNPHI), established under Legal Notice No. 14 of 2022, marks a bold transformation in the country's public health governance. Structured as a State Corporation under the Ministry of Health, KNPHI consolidates 13 autonomous public health divisions into a single institution tasked with driving national public health preparedness, prevention, and policy coherence. The Institute represents a strategic shift toward integrated disease surveillance, research, emergency response coordination, and the development of a resilient, responsive, and evidence-based health system.

KNPHI's is further anchored in international and national instruments such as the International Health Regulations (IHR, 2005), the Kenya Health Policy (2014–2030), and related legislation. The current Strategic Plan 2023–2027 is closely aligned with both global and national development priorities, including the Sustainable Development Goals (SDGs), the African Union's Agenda 2063, the East African Community (EAC) Vision 2050, Kenya's Vision 2030, the Bottom-Up Economic Transformation Agenda (BETA), and the Fourth Medium-Term Plan (MTP IV).

This MEL framework provides a structured system for measuring performance, enhancing accountability, and fostering institutional learning across KNPHI's 12 Strategic Objectives and 8 Key Result Areas. It harmonizes diverse divisional MEL systems including surveillance, laboratory services, field epidemiology, emergency operations, food safety, port health, risk communication, research, and biosafety into one coherent results framework that links strategy to evidence and evidence to action.

At its core, the framework is underpinned by a Theory of Change that demonstrates how KNPHI's investments in human resources, infrastructure, partnerships, and governance translate into activities, outputs, outcomes, and ultimately the impact of a healthier, safer, and more resilient Kenya. A comprehensive indicator framework, aligned to national priorities and global benchmarks, provides measurable evidence of progress.

The framework establishes clear roles and responsibilities for leadership, divisions, counties, and partners; defines data collection and management processes using KHIS2 and interoperable digital platforms; and institutionalizes data quality assurance (DQA) to ensure accuracy, completeness, timeliness, and consistency. It also embeds reporting and learning mechanisms, including dashboards, quarterly reviews, and after-action reviews, to ensure that data is not only reported but actively used for decision-making.

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Furthermore, the MEL framework integrates evaluation and research, supporting deeper assessments of effectiveness and promoting evidence translation into policy and practice. Knowledge management and communication systems ensure findings are packaged and shared with relevant audiences, while capacity building and resource mobilization strategies sustain the system over time. A strong focus on risk management and monitoring the framework itself ensures adaptability and resilience.

Through this MEL framework, KNPHI will be able to demonstrate tangible progress in strengthening health security, ensure accountability to stakeholders, and foster a culture of continuous learning and evidence-based decision-making. Ultimately, the framework positions KNPHI as a credible national and regional leader in public health security and knowledge generation.



A stylized, handwritten signature in black ink, appearing to be 'K.K.' with a flourish at the end.

Dr. Kamene Kimenye 'ndc' (K)  
**Ag. Director General**  
**Kenya National Public Health Institute (NPHI)**

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## 2.0 Introduction

The Kenya National Public Health Institute (KNPHI) has been established as the country's central hub for coordinating, implementing, and strengthening public health security functions. Guided by its Strategic Plan (2023–2027), KNPHI brings together critical divisions including disease surveillance, laboratory systems, field epidemiology, public health emergency operations, port health, food safety, risk communication, biosafety and biosecurity, and research under a unified institutional mandate.

To ensure that these diverse functions work cohesively and are accountable to both national priorities and international obligations such as the International Health Regulations (IHR, 2005), the Joint External Evaluation (JEE), and the National Action Plan for Health Security (NAPHS), KNPHI requires a robust Monitoring, Evaluation, and Learning (MEL) framework. The KNPHI MEL framework is designed to provide a structured system for tracking performance, measuring outcomes, and fostering institutional learning. At its core, the framework ensures that every Strategic Objective and Key Result Area articulated in the KNPHI Strategic Plan is accompanied by measurable indicators, clear baselines, and realistic targets. By doing so, it enables KNPHI not only to monitor progress but also to assess effectiveness, identify gaps, and adapt strategies in real time.

The framework draws from both national and global evidence. It incorporates standardized indicators from the KNPHI outcome performance matrix, aligns them with division-level operational indicators, and maps them against international benchmarks such as the IHR core capacities and JEE technical areas.

This integrated approach bridges the gap between strategic intent and operational reality, ensuring that performance is measured holistically across preparedness, response, surveillance, laboratory systems, research, RCCE, and governance.

Importantly, through regular performance reviews, data quality audits, dashboards, and dissemination mechanisms, the framework fosters a culture of evidence use within KNPHI and its stakeholders. It transforms data into actionable insights, guiding decision-making by leadership, informing resource allocation, and shaping policies at both national and county levels. The framework also ensures that lessons learned are systematically documented and shared with regional and global partners, positioning KNPHI as a thought leader in public health security. By institutionalizing monitoring, evaluation, and learning, the framework strengthens KNPHI's governance and accountability, builds confidence among partners, and ensures that Kenya remains on track to achieve its national and global health security commitments. In the long run, the KNPHI MEL framework provides the foundation for a resilient, evidence-driven institution that not only responds to today's public health threats but also anticipates and adapts to tomorrow's challenges.

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# 2.1 Purpose and Objectives of the Unified MEL Framework

## 2.1.1 Purpose of the Unified MEL Framework

The purpose of the KNPHI Monitoring, Evaluation, and Learning (MEL) Framework is to provide a coherent, institute-wide system that guides how evidence is generated, analysed, shared, and applied across all divisions of the Institute. It seeks to move KNPHI from a situation where monitoring and evaluation are fragmented and donor-driven, toward a harmonized, government-led, and learning-oriented approach that strengthens accountability and drives public health impact.

At its core, the framework is designed to ensure that every action taken by KNPHI is measurable, every output is verifiable, and every outcome is linked to the broader goal of protecting Kenya's population from public health threats. It sets out standardized tools,

common indicators, and interoperable systems that allow different divisions ranging from surveillance and laboratories to food safety, port health, and emergency operations to operate within a unified structure while maintaining flexibility for their specialized functions.

The framework also serves a dual purpose of supporting national and global accountability. Domestically, it enables KNPHI to track progress against its Strategic Plan (2023–2027), ensure efficient use of resources, and provide timely information to the Ministry of Health, counties, and citizens. Globally, it positions KNPHI to meet its obligations under the International Health Regulations (2005), including timely reporting of events of public health concern, participation in Joint External Evaluations (JEE), and contributing to the State Party Annual Reporting (SPAR) process. By embedding WHO-recommended practices and IHR core capacities, the framework ensures that Kenya's MEL system is benchmarked against international standards.

The KNPHI Strategic Plan 2023-2027 identifies seven key strategic issues that will be prioritized over the next five (5) years:

1. Inadequate preparedness and untimely response to public health events.
2. Delays in detecting and insufficient surveillance of health threats.
3. Inadequate prevention and control of preventable diseases.
4. Low levels of public health research and innovation.
5. Weak risk communication and community engagement (RCCE).
6. Weak biosafety and biosecurity measures in place for human, animal and environmental health
7. Limited governance and institutional capacity.

Eight (8) key result areas (KRAs) were identified to address these strategic issues: (1) public health events preparedness, (2) timely response, (3) surveillance and detection, (4) control of neglected tropical diseases, vector-borne and zoonotic diseases, (5) research and innovation, (6) risk communication and community engagement, (7) Bio Safety Bio Security and (8) strengthening institutional governance. The overarching goals include ensuring timely preparedness and response to public health events, detecting public health threats early, accelerating the prevention and control of diseases, conducting coordinated research to inform policy, enhancing community resilience and strengthening governance and institutional capacity.

Given this expansive mandate, the development of a unified Monitoring, Evaluation & Learning (MEL) framework is not merely a routine institutional requirement. It is a foundational instrument for achieving accountability, guiding adaptive management, and ensuring that KNPHI's interventions are informed by real-time data and learning. The MEL framework will enhance institutional performance, support knowledge management, and align division-level outputs with national and global health objectives.

Finally, the MEL framework is not only about measurement, but also about learning and adaptation. It creates mechanisms such as quarterly Data-to-Action reviews, After-Action Reviews (AARs), and biannual learning summits to ensure that evidence informs policy, resource allocation, and frontline practice. In this way, the framework transforms MEL into a strategic asset: a tool that not only monitors progress but also drives improvement, fosters innovation, and strengthens resilience across the public health system.



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## 2.1.2 Objectives of the KNPHI MEL Framework

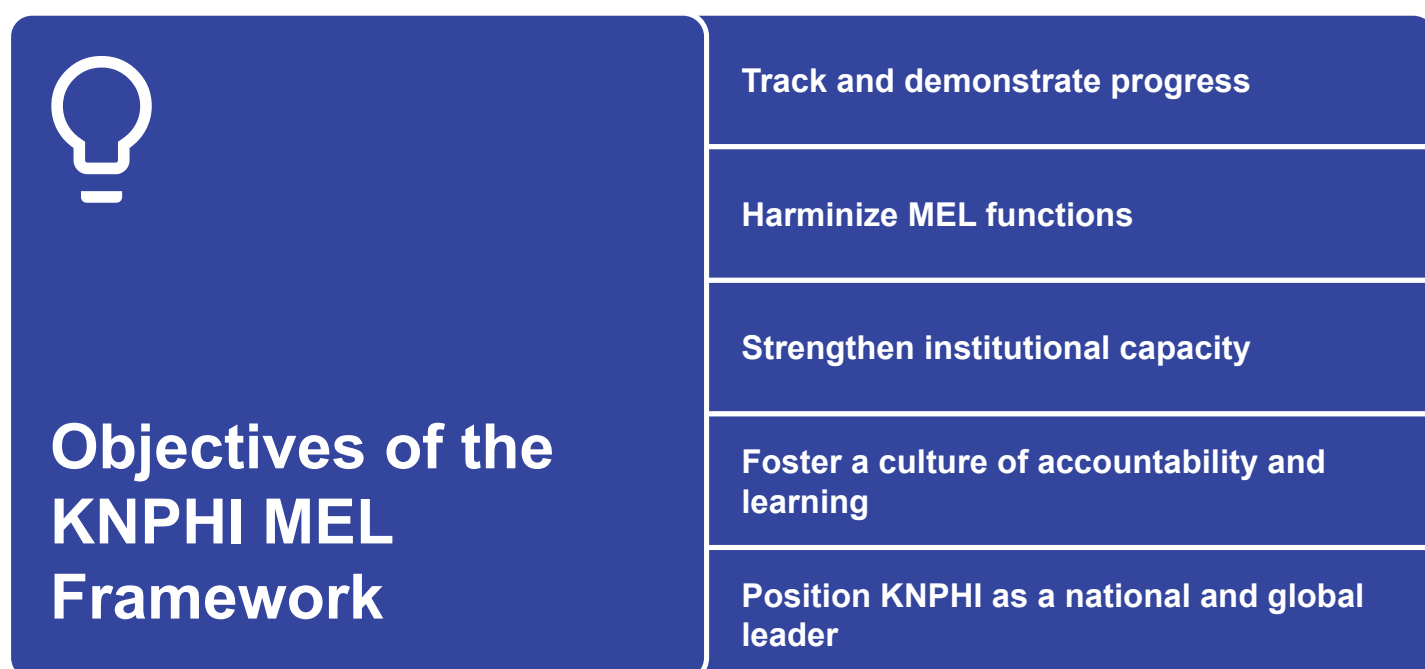
The objectives of the KNPHI MEL Framework are rooted in KNPHI's dual responsibility: strengthening national health security while ensuring compliance with global obligations under the International Health Regulations (2005). At its core, the framework seeks to unify fragmented MEL functions, strengthen capacity, and institutionalize accountability and learning so that KNPHI can credibly demonstrate progress against its Strategic Plan (2023–2027) and global health security benchmarks. It will:

- Track and demonstrate progress against KNPHI's Strategic Plan (2023–2027) while aligning with WHO-recommended standards for preparedness, detection, response, and accountability.
- Harmonize MEL functions across divisions, ensuring standardized and interoperable processes for data collection, reporting, and quality assurance across diverse mandates such as surveillance, laboratories, food safety, port health, and emergency response.
- Strengthen institutional capacity by investing in skilled personnel, adequate financing, and robust digital infrastructure, reducing reliance on donor-driven or ad hoc systems.
- Foster a culture of accountability and learning through institutionalized mechanisms such as Data-to-Action reviews, After-Action Reviews (AARs), and evaluations to drive continuous improvement and adaptive management.
- Position KNPHI as a national and global leader in evidence-based governance by embedding MEL in its core functions, ensuring timely reporting to WHO, supporting Joint External Evaluations (JEE) and SPAR assessments, and demonstrating Kenya's progress against NAPHS priorities.

### 2.1.3 Guiding Principles of the KNPHI MEL Framework

The KNPHI MEL Framework is underpinned by guiding principles that shape how monitoring, evaluation, and learning are embedded across the Institute. These principles ensure that MEL is not simply a compliance exercise, but a strategic function that drives accountability, strengthens evidence use, and positions KNPHI within both national and global health security systems. By aligning with the International Health Regulations (2005), Joint External Evaluations (JEE), and Kenya's National Action Plan for Health Security (NAPHS), the framework guarantees that MEL contributes directly to strengthening preparedness, detection, and response capacities, while also reinforcing KNPHI's Strategic Plan (2023–2027).

- **Compliance with IHR (2005) and JEE:** MEL is designed to monitor and report on IHR core capacities and track progress against JEE technical areas, including surveillance, laboratories, workforce, and emergency preparedness.
- **Alignment with Strategic Plan and NAPHS:** MEL indicators and reporting mechanisms are mapped to KNPHI's eight Key Result Areas and Kenya's National Action Plan for Health Security priorities, ensuring coherence from divisional to global levels.
- **Standardization and Integration:** Harmonized indicators, tools, and interoperable systems (KHIS, LIMS, NPHEOC, Food Safety, Port Health) provide a unified data backbone and eliminate duplication.
- **Learning Orientation:** MEL is not limited to reporting but actively supports continuous improvement through Data-to- Action reviews, After-Action Reviews (AARs), evaluations, and biannual learning summits.
- **Accountability and Transparency:** MEL findings are shared with KNPHI leadership, counties, partners, and WHO through annual reports, policy briefs, and dashboards to build trust and demonstrate results.
- **Sustainability:** By embedding MEL financing (3–5% of program budgets) into government systems, the framework reduces donor dependency and ensures long-term institutional resilience.



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## 3.0 Theory of Change and Results Framework

The KNPHI MEL Framework is structured around a clear results chain that links resources to measurable outcomes and long-term impact. This structure ensures that MEL is systematic, transparent, and actionable, while aligning with both Kenya's Strategic Plan (2023–2027) and international health security benchmarks under the International Health Regulations (2005), the Joint External Evaluation (JEE), and the National Action Plan for Health Security (NAPHS). By organizing its monitoring and evaluation functions in this way, KNPHI can demonstrate not only what activities are being undertaken, but also how these contribute to strengthening preparedness, detection, response, and resilience.

- **Impact:** A health-secure and resilient Kenya, compliant with IHR (2005) and demonstrating measurable progress in JEE and NAPHS benchmarks.
- **Outcomes:** Strengthened detection, preparedness, and response capacities; improved data quality and timeliness; institutionalized accountability and learning; sustainable MEL financing.
- **Outputs:** Standardized MEL tools and frameworks, interoperable dashboards, routine Data Quality Audits (DQAs), evaluations, After-Action Reviews (AARs), and knowledge products such as policy briefs.
- **Activities:** Training MEL focal persons, integrating divisional data systems, conducting supervision and DQAs, organizing quarterly Data-to-Action reviews, biannual learning summits, and publishing annual MEL reports.
- **Inputs:** Skilled workforce, adequate financing (3–5% of program budgets), robust ICT infrastructure, enabling policies, and partnerships with government, counties, WHO, AU-CDC, and donors.
- **Key Result Areas (KRAs):** Eight thematic areas anchor MEL across KNPHI:
  1. Public health event preparedness and timely response
  2. Disease surveillance and detection
  3. Laboratory services and quality assurance
  4. Infection prevention, AMR, and quality improvement
  5. Public health research and innovation
  6. Risk communication and community engagement
  7. Food safety and nutrition systems
  8. Institutional governance, partnerships, and sustainability

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### 3.1.1 KNPHI's Theory of Change (TOC)

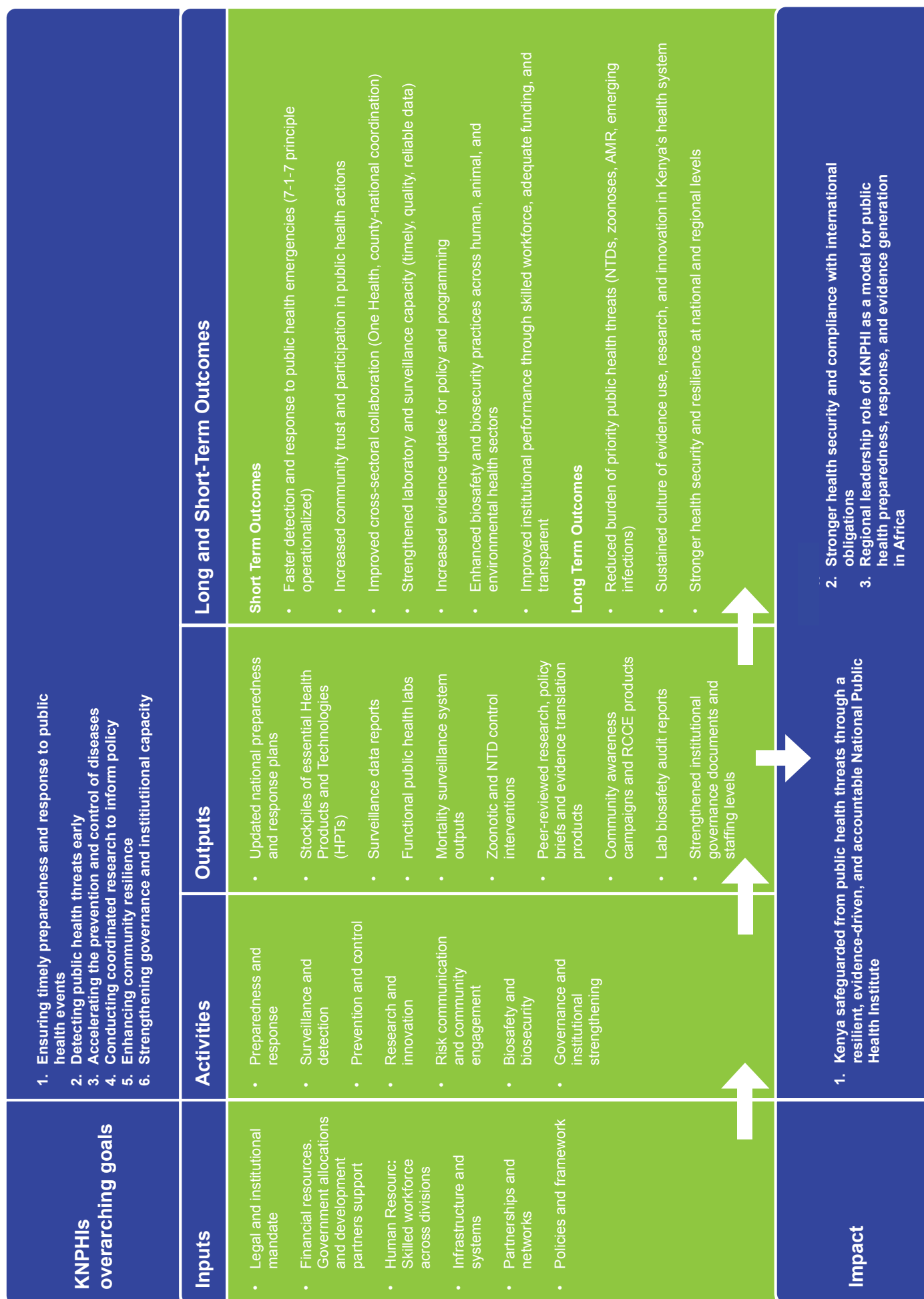
The Theory of Change for the Kenya National Public Health Institute (KNPHI) provides a structured pathway to explain how the Institute's mandate, resources, and interventions translate into tangible improvements in public health and national health security. Anchored in the KNPHI Strategic Plan (2023–2027) and aligned with international commitments such as the International Health Regulations (IHR, 2005), the Joint External Evaluation (JEE), and the National Action Plan for Health Security (NAPHS), the framework demonstrates the logical sequence through which KNPHI contributes to safeguarding the health of Kenyans.

At the foundation of this Theory of Change are the **inputs**: the Institute's legal and policy mandate, financial and technical resources, skilled workforce, partnerships, and health information systems. Through these resources, KNPHI implements a set of core activities spanning preparedness and response, surveillance and detection, disease prevention and control, research and innovation, risk communication and community engagement, biosafety and biosecurity, and governance and institutional strengthening.

These activities generate **outputs** such as preparedness and response plans, accredited laboratories, surveillance and mortality reports, community engagement campaigns, research products, biosafety audit reports, and institutional governance structures. Collectively, these outputs contribute to **short- and medium-term outcomes**, including faster detection and response to public health threats, enhanced data quality and use, stronger laboratory and surveillance systems, greater community trust, and improved cross-sectoral collaboration. Over time, these outcomes lead to long-term change, including reduced disease burden, strengthened institutional performance, and greater resilience of Kenya's health system.

Ultimately, the Theory of Change illustrates how KNPHI's work contributes to the impact of a healthier, safer, and more secure Kenya, capable of preventing, detecting, and responding to public health threats, while fulfilling its global obligations and positioning itself as a regional leader in health security.

## KNPHI's Theory of Change (TOC)



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Inputs (What KNPHI invests / enabling resources)

- **Legal and institutional mandate:** Anchored in the Kenya Health Act and KNPHI Strategic Plan (2023–2027).
- **Financial resources:** Government allocations, donor funding, and partner support.
- **Human capital:** Skilled workforce across divisions
- **Infrastructure and systems:** Public health labs, surveillance systems (IDSR, mortality surveillance, DHIS2, AMR platforms), Port of Entry systems, digital health platforms.
- **Partnerships and networks:** National (MoH, CoG, counties, universities), regional (Africa CDC, ECSA-HC), and global (WHO, CDC, IHR partners).
- **Policies and frameworks:** IHR (2005), JEE recommendations, NAPHS, Kenya Health Policy, PHC Strategy, National AMR Action Plan.

These activities generate **Outputs:**

- **Preparedness and response:** Develop, update, and test PHE preparedness and response plans; maintain HPT stockpiles; operate NPHEOC.
- **Surveillance and detection:** Strengthen integrated disease surveillance, mortality surveillance, and laboratory networks.
- **Prevention and control:** Implement NTD, zoonotic, and vector-borne disease programs; coordinate One Health approaches.
- **Research and innovation:** Conduct and translate public health research into policy and practice.
- **Risk communication and community engagement:** Implement RCCE strategies and community engagement during preparedness and response.
- **Biosafety and biosecurity:** Establish and enforce biosafety and biosecurity systems in labs, PoEs, and field operations.
- **Governance and institutional strengthening:** Build workforce capacity, leadership, governance structures, financing, and MEL systems.

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### 3.1.2 Indicator Framework

At the heart of the KNPHI MEL system is a comprehensive indicator framework that provides the backbone for measuring progress, performance, and accountability. Indicators are the building blocks through which the Institute translates its Strategic Objectives and Key Result Areas into measurable evidence of achievement. By defining what success looks like and how it will be measured, the indicator framework ensures that KNPHI can systematically monitor its progress, identify gaps, and guide strategic decision-making.

The KNPHI indicator framework is structured to reflect the 12 Strategic Objectives and 8 Key Result Areas outlined in the Strategic Plan. Each objective and result area is supported by a set of indicators that track outputs, outcomes, and long-term impacts. To maintain consistency and comparability, the framework draws heavily from the official outcome matrix in the Strategic Plan, while also integrating division-level operational indicators that capture the technical realities of surveillance, laboratories, field epidemiology, emergency response, food safety, port health, RCCE, and research.

To ensure that KNPHI remains aligned to both national and international obligations, indicators are further mapped to IHR core capacities, JEE benchmarks, and relevant SDGs. This mapping guarantees that KNPHI can simultaneously meet domestic reporting needs and global accountability requirements.

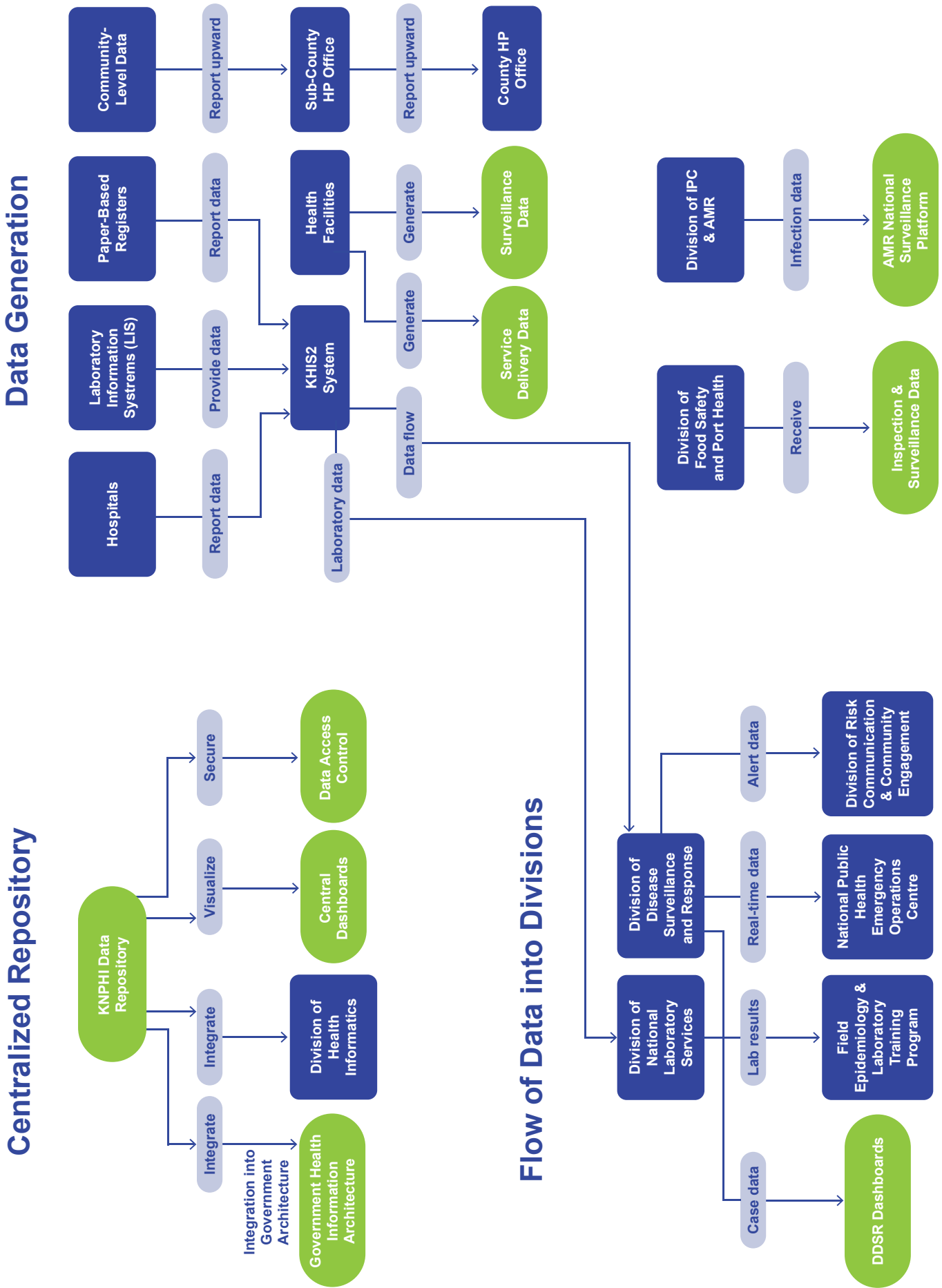
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## 4.0 Data Collection, Analysis and Management

Data is at the core of KNPHI's ability to monitor, evaluate, and learn. The MEL framework establishes an integrated approach to data collection, analysis, and management that reduces fragmentation, promotes consistency, and strengthens reliability. Routine data will be sourced from established systems such as the Integrated Disease Surveillance and Response (IDSR), the District Health Information System (DHIS2), mortality surveillance systems, laboratory information platforms, and emerging digital health tools. These will be complemented by periodic assessments, evaluations, and research studies to provide a more complete picture of institutional performance.

The framework embeds robust data quality assurance mechanisms, including regular audits, triangulation of sources, and participation in external quality assurance schemes for laboratories. Data analysis will not be limited to aggregation but will emphasize interpretation, trend analysis, and predictive insights that can inform policy and practice. Data management will be supported by a knowledge management system that ensures secure storage, ease of retrieval, and controlled access for internal and external stakeholders. Ultimately, this approach will ensure that KNPHI data is timely, accurate, consistent, and actionable.

## 4.1.1 Data Flow for KNPHI



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### 4.1.2 Data Quality Assurance (DQA) at KNPHI

High-quality data is the foundation of evidence-based decision-making. For KNPHI to be credible and effective, it must institutionalize a structured, routine, and responsive system of Data Quality Assurance (DQA) across all its divisions and county reporting channels. KNPHI should adopt the six dimensions of data quality (accuracy, completeness, timeliness, consistency, integrity, and confidentiality) but operationalize them in division-specific SOPs. For example:

- **DDSR:** Completeness and timeliness of IDSR reporting by counties.
- **DNLS:** Accuracy of lab results uploaded into LIS/AMR system compared to paper registers.
- **RCCE:** Consistency of community feedback logs across different tools.

Each division should have benchmarks (e.g., >90% completeness, >85% timeliness) built into their indicator matrix.

**Establish a Structured DQA Cycle:** KNPHI will adopt a quarterly DQA cycle, aligned to reporting periods:

- Quarter 1: Internal desk reviews (central MEL team pulls KHIS2/LIS data, checks for anomalies, missing values, outliers).
- Quarter 2: Onsite county DQAs (field visits to sampled counties/facilities to verify registers, reporting forms, and alignment with KHIS2 uploads).
- Quarter 3: Peer review between divisions (e.g., DNLS validates DDSR lab surveillance indicators against its own LIS data).
- Quarter 4: National consolidation (KNPHI MEL unit produces an annual DQA report with trends, gaps, and corrective actions).

**Use Smart Sampling and Risk-based Targeting:** KNPHI should prioritize DQA visits based on:

- High-burden counties/divisions (e.g., border counties for PoE, high-mortality counties for mortality surveillance).
- Red flags in data trends (e.g., sudden drop in completeness in KHIS2, unusual outbreak reporting, lab positivity >100%).
- New or piloted systems (e.g., new AMR modules, RCCE community reporting tools)

**Triangulate Data Across Systems:** Many discrepancies emerge because different systems (KHIS2, LIS, IDSR, NPHEOC databases) don't align. KNPHI MEL should institutionalize triangulation as part of DQA:

- Compare county IDSR weekly reports in KHIS2 against NPHEOC event-based surveillance logs.
- Compare lab AMR reports in LIS against KHIS2 AMR module aggregates.
- Compare RCCE coverage data against field activity logs from community partners.

## Feedback and Corrective Action Mechanisms

- Counties and facilities must receive scorecards showing completeness, accuracy, and timeliness.
- Divisions should receive division-specific DQA briefs highlighting systemic issues (e.g., data entry errors, reporting delays).
- Corrective actions (e.g., retraining of facility staff, improved SOPs, data cleaning) must be tracked by the KNPHI MEL unit until resolved.
- KNPHI leadership should receive an annual consolidated DQA report to inform performance reviews and resource allocation.

**Build DQA into Capacity Strengthening:** Every DQA exercise should be coupled with on-the-job training. During audits, MEL officers should demonstrate proper register completion, KHIS2 entry, or LIS use. Over time, this reduces recurrence of errors and builds a culture of data ownership at county and facility levels.

**Digitalization and Automation of DQA:** Where possible, KNPHI should embed automated DQA checks into KHIS2 and LMIS. For example:

- Auto-alerts when completeness falls below 80%.
- Validation rules to prevent impossible entries (e.g., negative values, % >100).
- Dashboards that show timeliness trends per county or divisions.



## KNPHI Data Quality Assurance Standard Operating Procedures

Establish a structured DQA cycle

Use smart sampling and risk-based targeting

Triangulate data across systems

Feedback and corrective action mechanisms

Build DQA into capacity strengthening

Digitalization and automation of DQA

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## 5.0 Roles and Responsibilities

The KNPHI MEL framework defines responsibilities across the Institute and its partners to ensure accountability and smooth implementation. The KNPHI leadership is responsible for oversight, mobilization of resources, and ensuring that MEL remains a strategic priority. The division of Monitoring and Evaluation functions as the custodian of the framework, tasked with coordinating activities, integrating divisional data, assuring quality, and producing consolidated reports. Divisional MEL focal persons act as the first point of accountability, ensuring data is collected, validated, and submitted on time from the respective divisions.

Beyond KNPHI, county health teams play a critical role in collecting primary data, which is then linked to national and global reporting systems. Partners such as WHO, Africa CDC, CDC, and other development agencies support with technical assistance, funding, and alignment to global benchmarks. Oversight and coordination will be supported by a MEL Technical Working Group (TWG), bringing together KNPHI divisions and external stakeholders to provide technical guidance, harmonization, and accountability. This clear distribution of roles ensures that MEL is not an isolated function, but an institutional culture embedded across all levels.

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## 6.0 Reporting and Learning Mechanisms

The MEL framework emphasizes that data must not only be collected but also transformed into knowledge that supports decision-making. Reporting is structured to meet the needs of diverse audiences from KNPHI leadership and MoH to county governments, partners, and the public. Products will include weekly bulletins, monthly and quarterly reports, annual performance reviews, and real-time dashboards and scorecards that visualize progress against key indicators.

Learning is integrated into the reporting cycle through after-action reviews, quarterly dissemination forums, and peer-to-peer learning platforms. These mechanisms create feedback loops that ensure data flows back to those who generate it counties, divisions, and communities and not just upward to leadership. This continuous cycle of monitoring, reporting, reflection, and adaptation will cultivate a learning culture within KNPHI, where evidence guides practice and strategies are regularly refined to address emerging realities.

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## 7.0 Evaluation, Learning and Research

While monitoring tracks progress, evaluation provides deeper insights into effectiveness, efficiency, relevance, and sustainability. The MEL framework integrates evaluation as a critical component of KNPHI's accountability and learning architecture. Evaluations will include mid-term and end-term assessments of the Strategic Plan, as well as thematic reviews focusing on areas such as outbreak response, laboratory accreditation, or RCCE effectiveness.

Importantly, evaluation is complemented by KNPHI's research function, ensuring that evidence is not only generated but also translated into policy briefs, peer-reviewed publications, and decision-making tools. Findings from evaluations and research will be systematically fed into leadership forums, technical working groups, and national health security platforms. This integration ensures that evaluation is not an end but a driver of evidence-based policy and practice.

### 7.1.1 Evaluation Framework

To strengthen this component, KNPHI will institutionalize a structured evaluation framework with the following elements:

#### Types of Evaluations

- **Strategic Plan Evaluations:** A mid-term review in 2025 will assess progress, identify bottlenecks, and guide course correction. The end-term evaluation in 2027 will measure the overall achievement of Strategic Objectives and Key Result Areas, as well as KNPHI's contribution to IHR/JEE/NAPHS benchmarks.
- **Thematic/Program Evaluations:** Targeted reviews on specific areas such as outbreak preparedness, laboratory accreditation, RCCE effectiveness, or digital health innovations.
- **Process Evaluations:** Assess implementation fidelity, efficiency of resource use, and stakeholder engagement to improve ongoing interventions.
- **Impact Evaluations:** Where feasible, assess the longer-term outcomes of KNPHI interventions on public health security and population health.

#### Methodologies

- **Mixed methods** will be adopted, combining quantitative indicator analysis (trends, modelling, cost-effectiveness) with qualitative approaches (key informant interviews, FGDs, case studies).
- **Participatory approaches** will ensure that counties, communities, and partners are involved, capturing diverse perspectives and enhancing ownership of findings.
- **Benchmarking against** IHR core capacities, JEE recommendations, and NAPHS priorities will ensure comparability with international standards.

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## **Utilization of Findings**

- Evaluation findings will be integrated into Data-to-Action Reviews, annual learning summits, and policy dialogues with MoH, counties, and partners.
- Results will be packaged into policy briefs, dashboards, and lessons-learned reports, ensuring accessibility to policymakers, practitioners, and communities.
- KNPHI will maintain an Evaluation Repository as an institutional memory resource to inform future programming and research.

## **Accountability for Evaluation**

- MEL Technical Working Group (TWG) will provide oversight of evaluation design, quality assurance, and dissemination.
- The Division of M&E will coordinate evaluations to ensure independence, methodological rigor, and the uptake of recommendations.
- Divisions and counties will contribute to evaluation planning and implementation, building ownership and strengthening capacity across levels.

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## 8.0 Knowledge Management and Communication

Knowledge management is a critical pillar of the KNPHI MEL framework, ensuring that the wealth of data generated across divisions is transformed into actionable insights and widely shared. To move beyond data collection, the framework emphasizes the deliberate production of targeted knowledge products that translate evidence into formats that are accessible, relevant, and timely for decision-makers at all levels. These include surveillance bulletins, laboratory performance scorecards, outbreak investigation reports, policy briefs, community feedback dashboards, and annual performance reviews, among others. Each division will be responsible for developing and disseminating specific products tailored to its mandate, while the MEL Unit will consolidate outputs into cross-divisional reports, scorecards, and lessons-learned documents that reflect KNPHI's overall performance.

Effective communication will be anchored in the principle of evidence for action. Knowledge products will be disseminated not only upward to KNPHI leadership, MoH, and international partners but also back to counties, facilities, and communities, creating feedback loops that foster ownership and accountability. Multiple platforms digital dashboards, policy briefs, newsletters, media releases, and community forums as proposed in Annex 2 will be leveraged to ensure that evidence reaches the right audience in the right format.

By institutionalizing knowledge management and communication, the MEL framework positions KNPHI as an evidence-driven, transparent, and learning institution, capable of shaping national policies, guiding county practices, and contributing to global health security discourse.

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## 9.0 Capacity Building and Resource Mobilization

The sustainability of the MEL framework depends on the strength of the people and resources behind it. KNPHI recognizes that capacity gaps exist across divisions and counties, and thus the framework prioritizes systematic capacity building. This will include training MEL focal persons in data analysis, visualization, and interpretation; embedding MEL modules within FELTP; and conducting mentorship and peer-learning sessions.

Resource mobilization is equally critical. The framework calls for the integration of MEL funding into KNPHI's core budget while leveraging external support from bilateral and multilateral partners. Investment in infrastructure, digital platforms, and innovative tools will ensure that KNPHI maintains a modern and responsive MEL system. By building both capacity and resources, the framework lays the foundation for a resilient MEL culture that outlives project cycles and donor shifts.

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# 10. Risk Management and Assumptions

Recognizing risks is essential to ensuring that the MEL framework remains adaptive. Key risks include funding shortfalls, staff turnover, fragmented data systems, limited capacity at county level, and political transitions. The framework addresses these by embedding mitigation strategies such as diversifying funding streams, continuous training, integrating MEL functions within governance structures, and promoting county–national harmonization.

Underlying the framework are critical assumptions: that government and partners remain committed to MEL, that technology infrastructure continues to improve, and that stakeholders at all levels value evidence for decision-making. Monitoring these risks and assumptions will ensure the MEL framework remains realistic and responsive.

## 10.1 Risk Mitigation Framework

To operationalize risk management, KNPPI will adopt a structured risk matrix that identifies categories of risks, their likelihood and impact, mitigation strategies, and the actors responsible for implementation.

<b>Risk Category</b>	<b>Description</b>	<b>Likelihood/ Impact</b>	<b>Mitigation Strategies</b>	<b>Responsible Actor(s)</b>
Financial Risks	Shortfalls in government allocation; over-reliance on donor funding	High / High	Embed 3–5% MEL allocation into KNPHI budget- Diversify funding sources (bilateral, multilateral, private sector)- Develop resource mobilization strategy	KNPHI Leadership; MoH Finance; Partners
Human Resource Risks	High staff turnover; limited MEL skills at divisions and counties	Medium / High	Continuous training and mentorship- Embed MEL modules in FELTP- Establish retention and career progression pathways for MEL officers	Division of M&E; HR Department
Data System Risks	Fragmented platforms, weak inter-operability, system downtime.	High / Medium	Strengthen interoperability across KHIS2, LIS, NPHEOC, AMR platforms- Develop ICT contingency plans- Regular system upgrades and user support	Division of ICT & M&E
Capacity Risks at County Level	Limited technical capacity, inconsistent data submission	High / High	Structured county MEL training- Onsite mentorship during DQAs- County scorecards and peer reviews	MEL Unit; County Health Departments
Political/ Policy Risks	Shifts in leadership priorities. political transitions affecting health funding.	Medium / High	Anchor MEL in legislation and national policy-Engage Parliament and policy champions- Strengthen County and community buy-in	KNPHI Leadership; MoH
Stakeholder Engagement Risks	Fragmentation or duplication of partner support	Medium / Medium	Establish MEL TWG for coordination- Align partner investments to unified MEL framework	MEL TWG; Development Partners
Technological Risks	Cybersecurity breaches; loss of data confidentiality	Low / High	Adopt data protection protocols- Secure cloud-based storage- Routine audits and security testing	ICT & Data Security Teams

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## 11. Monitoring Implementation of the MEL Framework

The meta-monitoring of KNPHI MEL framework ensures that the framework remains relevant, effective, and sustainable. The MEL unit will track key indicators of MEL performance, such as % of divisions using standardized tools, % of reports produced on time, and % of recommendations from evaluations implemented.

Annual reviews of the MEL framework will assess progress, identify gaps, and propose adjustments. A mid-term review in 2025 and an end-term review in 2027 will provide structured opportunities to refine the framework in line with evolving realities. By monitoring the MEL system itself, KNPHI ensures that MEL is not static but continuously improving, thereby reinforcing the Institute's overall mandate of accountability, learning, and resilience.

# Annexes

## 1. KNPHI Indicator Matrix

Strategic Objective	Focal Area	Indicator	Indicator Type	Target	Data Source	Frequency	Person responsible
Strategic Objective: To ensure timely preparedness and response to Public Health Events (PHEs)							
Expected outcome: Improved preparedness and timely response for PHEs							
Public health emergency preparedness	NPHEOC	# of public health emergency responders trained on Public Health Emergency Management (PHEM)	Output	50 p.a	Training report	6 monthly	National PHEOC
Public health emergency preparedness	NPHEOC	Proportion of counties with a functional PHEOC	Output	100%	Quarterly county PHEOC reports	Quarterly	National PHEOC
Public health emergency response	NPHEOC	Proportion of completed National level Public Health Emergency Responses for which an After Action Review (AAR) is done	Output	100%	After Action Review Reports	Annually	National PHEOC
Timely response to Public Health events	NPHEOC	Proportion of events responded to as per the 7-1-7 matrix	Outcome	90%	Quarterly county PHEOC reports	Quarterly	National PHEOC
Public health events preparedness	DRM	Percentage of timely contingency plans developed and or updated for PHEs	Output	60%	DRM database, preparedness and response plan	annually	DRM M&E Focal persons
Public health events preparedness	DRM	Proportion of HCWs (paramedic, EMT, nurse, clinical officer, or doctor) per county trained on disaster response	Output	40%	training logs	annually	DRM M&E Focal persons
Public health events preparedness	DRM	# of hazard specific or multihazard simulation exercises conducted	Outcome	1	simulation exercise reports	annually	DRM M&E Focal persons
Public health events preparedness	DRM	# of PHEs detected per county, Proportion of the detected PHEs that have been reported per county, Proportion of the reported PHEs that have been responded to in a timely manner	Outcome	70%	incidence reports and after action review reports	quarterly	DRM M&E Focal persons

Strategic Objective	Focal Area	Indicator	Indicator Type	Target	Data Source	Frequency	Person responsible
Preparedness and Response	ZDU	% counties with trained multidisciplinary RRTs	Outcome	30%	County RRT rosters; drill reports; EOC logs	quarterly	ZDU
Preparedness and Response	ZDU	Proportion of officially mapped LBMs inspected	Outcome	70%	Facility registers; DHIS2/KHIS	quarterly	ZDU
Preparedness and Response	ZDU	PEP initiation / total dog bite victims *100 (Rabies)	Outcome	85%	Facility registers; DHIS2/KHIS	quarterly	ZDU
Governance & Coordination	ZDU	Number of counties with active County One Health Units meeting at least quarterly	Output	20	County OH unit minutes	quarterly	ZDU
Surveillance and detection of public health threats	Surveillance	Proportion of counties that have conducted risk assessment (STAR)	Output	90%	Risk assessment reports	Annual	DSSR
Surveillance and detection of public health threats	Surveillance	% of sub-counties achieving >90% weekly reporting	Output	90%	Weekly Bulletins	Weekly	DSSR
Surveillance and detection of public health threats	Surveillance	Weekly bulletin publication rate (>90% of weeks).	Output	90%	Dashboards/ Archived bulletins	Weekly	DSSR
Surveillance and detection of public health threats	Surveillance	Proportion of target HCWs trained in IDSR 3rd Edition.	Output	60%	Training reports	Annual	DSSR
Surveillance and detection of public health threats	Surveillance	Non-polio AFP rate (Cases detected per 100000 population of <15 years)	Outcome	2 per 100,000 population of <25 years	AFP Surveillance data base and reports	Annual	DSSR
Surveillance and detection of public health threats	Surveillance	Proportion of suspected measles cases with adequate investigation	Output	80%	Measles case based surveillance reports	Annual	DSSR
Surveillance and detection of public health threats	Surveillance	Suspected measles cases per 100,000 investigated with a laboratory investigation report per year	Outcome	80%	Measles case based surveillance reports	Annual	DSSR
Surveillance and detection of public health threats	Surveillance	Proportion of sub-counties achieving < 1 case of NNT cases per 1,000 live births	Outcome	80%	NNT surveillance and line lists audit	Annual	DSSR

Strategic Objective	Focal Area	Indicator	Indicator Type	Target	Data Source	Frequency	Person responsible
Surveillance and detection of public health threats	Surveillance	Proportion of surveillance officers trained on VPD	Output	80%	Workshop and activity reports	Annual	DSSR
Surveillance and detection of public health threats	Surveillance	Proportion of samples tested and characterized by the NIC per year	Output	90%	Genomic testing lab results	Annual	DSSR
Surveillance and detection of public health threats	Surveillance	Proportion of other respiratory pathogens identified and characterized	Output	80%	Testing and characterization report for other respiratory pathogens	Annual	DSSR
Surveillance and detection of public health threats	Surveillance	Proportion of sentinel sites reporting consistently.	Output	80%	Sentinel site reports	Annual	DSSR
Surveillance and detection of public health threats	Surveillance	Proportion of respiratory outbreaks investigated using a One Health Approach	Output	80%	Outbreak investigation report	Annual	DSSR
Integrated Surveillance	ZDU	Proportion of weekly national One Health bulletins released annually	Output	52%	Weekly bulletins released	Weekly	ZDU
Surveillance and detection of Public Health Treats	Food safety	# of sub counties reporting food safety surveillance on quarterly basis.	Outcome	> 80% (> 38 counties)	DFS national surveillance database, county submissions	Quarterly	DFS Surveillance & M&E Unit with County Public Health Officer
Surveillance and detection of Public Health Treats	Food safety	Percentage reduction in the incidence rate of confirmed foodborne disease outbreaks reported through the Food Safety surveillance systems.	Outcome	30%	DFS national surveillance database, county submissions	Quarterly	DFS Surveillance & M&E Unit with County Public Health Officer
Points of entry and border security	Port Health Services	POE capacity score of above 3 (JEE) indicating improvement in IHR core capacities implementation	Outcome	16 POEs	POE capacity assessment reports. Monthly POEs service delivery reports POE capacity assessment reports. Monthly POEs service delivery reports	Annually	Head, Division of Port Health Services

Strategic Objective	Focal Area	Indicator	Indicator Type	Target	Data Source	Frequency	Person responsible
Points of entry and border security	Port Health Services	Proportion of simulation exercises (Simex) conducted at POEs	Output	5 POEs	SIMEX Reports	Quarterly	Head, Division of Port Health Services
Points of entry and border security	Port Health Services	Proportion of Port Health personnel trained on surveillance, preparedness and response to PHEs	Output	26 POEs	Training reports	Bi-annually	Head, Division of Port Health Services
Strategic Objective: To detect all public health events in a timely manner							
Expected outcome: Public Health related events detected within recommended timelines							
Surveillance and detection of public health threats	DNLS	Proportion of referred samples delivered to the testing laboratory within 48 hours from the time of collection (Sample Transport Turnaround Time – TAT).	Output	80%	Specimen referral register, Specimen transport waybill Lab reception register, Sample manifest, LIMS	Monthly and Quarterly	DNLS M&E focal person
Surveillance and detection of public health threats	DNLS	Proportion of outbreaks of public health priority conditions confirmed through laboratory testing within 72 hours	Coverage	90%	LIMS	Annually	DNLS M&E focal person
Surveillance and detection of public health threats	DNLS	Proportion of laboratories achieving <input type="checkbox"/> 80% performance score in External Quality Assurance (EQA)	Outcome	80%	kept System	Semi-Annually	DNLS M&E focal person
Surveillance and detection of public health threats	DNLS	Proportion of laboratories accredited to ISO standards (Disaggregated by type of ISO;15189 ,17043 ,17025)	Outcome	100%	KENAS website	Annually	DNLS M&E focal person

Strategic Objective	Focal Area	Indicator	Indicator Type	Target	Data Source	Frequency	Person responsible
Strategic Objective: To strengthen biosafety and biosecurity measures for human, animal and environmental health							
Expected outcome: Strengthened and sensitive biosafety and biosecurity measures in place for human, animal and environment							
Biosafety and biosecurity	DNLS	Proportion of laboratories with functional biosafety, biosecurity, and bio risk management systems	outcome	90%	National Biosafety Records	Annually	DNLS M&E focal person
Strategic Objective: To reduce the burden of NTDS, Vector-borne, and zoonotic diseases							
Expected outcome: Control/elimination/ eradication of NTDS, vector-borne and zoonotic diseases							
Control of neglected tropical diseases	NTDs	Proportion reduction in prevalence of Schistosomiasis (SCH) among the 44 counties mapped, from 3.2%	Outcome	5%	NTD database, population based surveys, Implementation Unit (IU) level impact surveys, laboratory-confirmed case records	Community or school-based surveys done annually or every 1–2 years depending on program phase and MDA frequency	Head, NTD Unit, PC Program Manager
Control of neglected tropical diseases, vector-borne and zoonotic diseases	NTDs	Proportion reduction in prevalence of Soil Transmitted Helminthes (STH) among the 44 Counties mapped, from 3.6%	Outcome	5%	NTD database, population based surveys, Implementation Unit (IU) level impact surveys, laboratory-confirmed case records	Community or school-based surveys done annually or every 1–2 years depending on program phase and MDA frequency	Head, NTD Unit, PC Program Manager
Control of neglected tropical diseases	NTDs	Proportion reduction in prevalence of Trachoma in Intervention Units(IUs)with active TF of above 5% prevalence	Outcome	5%	NTD database, population based surveys, Implementation Unit (IU) level impact surveys, laboratory-confirmed case records	Impact surveys done every 2–3 years following rounds of SAFE	Head, NTD Unit, PC Program Manager
Control of neglected tropical diseases	NTDs	Proportion reduction in incidence of Leishmaniasis in the 11 endemic counties	Outcome	10%	IDSR, DHIS2, NTD database,	Annual reports	Head, NTD Unit, Leishmaniasis Program Managers
Control of neglected tropical diseases	NTDs	Proportion of NTDS eliminated as public health problems, with official WHO validation/ certification, by 2030	Outcome	3	NTD Surveillance reports	Annual	Head, NTD Unit, Disease Program Managers

Strategic Objective	Focal Area	Indicator	Indicator Type	Target	Data Source	Frequency	Person responsible
Strategic Objective: To strengthen research and evidence based policy development to enhance public health decision making							
Expected outcome: Enhanced utilization of research and generation of evidence-based policies							
Public Health Research and Innovation	Health Informatics Division	A functional KNPHI knowledge management repository	Output	1	Repository access logs	Once	Informatics Division
Public Health Research and Innovation	Health Informatics Division	# of policy briefs developed which are informed by KNPHI led research per year	Output	5	Internal Institutional publication database	Annually	Informatics Division
Public Health Research and Innovation	Health Informatics Division	% of mapped public health data systems hosted in the KNPHI central repository	Output	100%	Repository inventory/audit report	Biannually	Informatics Division
Public Health Research and Innovation	Health Informatics Division	% divisional manual public health data systems digitized	Output	100%	system inventory audit report	Biannually	Informatics Division
Public Health Research and Innovation	Health Informatics Division	% divisional digitized manual public health data systems hosted in the KNPHI central repository	Output	100%	Repository audit report	Biannually	Informatics Division
Public Health Research and Innovation	Health Informatics Division	% of KNPHI-led research abstracts and articles published in peer-reviewed journals	Outcome	20	IRC Review Records	Biannually	Informatics Division
Public Health Research and Innovation	Health Informatics Division	# of Data Quality Audits conducted per year	Output	4	DQA Reports	Quarterly	Informatics Division

Strategic Objective	Focal Area	Indicator	Indicator Type	Target	Data Source	Frequency	Person responsible
Strategic Objective: To enhance emergency RCCE activities for emergency preparedness and response to public health events							
Expected outcome: Increased awareness in the communities with the highest risks							
Risk communication and community engagement	RCCE	Percentage of target population reached with various RCCE interventions	Output	100%	KHIS 2, Media reports(IPSOS), Implementing partner reports, Outbreak Investigation report, EAR, IAR,AAR	Quarterly, Ad hoc	National RCCE Section
Risk communication and community engagement	RCCE	Percentage of target population demonstrating positive behavior change	Outcome	100%	KAP behavioral assessments, Surveillance reports	Bi annually, Monthly, Quarterly	National RCCE Section
Risk communication and community engagement	RCCE	# of community dialogue meetings held among high risk population	Output	4	RCCE activity reports	Ad hoc	National RCCE Section
Risk communication and community engagement	RCCE	# of infodemic events tracked and responded to	Outcome		AI Infodemic management online tracking, Media scanning , Call logs, WHO AIRA Periodic Infodemic Management Report, UNICEF Infodemic dashboard, EARS	Daily, Weekly	National RCCE Section
Risk communication and community engagement	RCCE	Proportion of National and County levels with updated RCCE preparedness and response plans	Output	80%	Approved national RCCE strategic/ operational plan and mid-term review reports, County RCCE preparedness and response plans, CHMT minutes	Annually	National and County RCCE section
Risk communication and community engagement	RCCE	# of Emergency Risk Communication (ERC) campaigns conducted	Output	1	Situation Reports (SITREPs), Incident Action Plans (IAPs) & After-Action Reviews (AARs), partner activity reports, National level & County RCCE reports	Quarterly, Annually	National and County RCCE section

Strategic Objective	Focal Area	Indicator	Indicator Type	Target	Data Source	Frequency	Person responsible
Strategic Objective: To enhance Health Products and Technologies (HPT) stockpiles for emergency response							
Expected outcome: Prepositioned stockpiles for emergency response							
Public health events preparedness	HPTs	Proportion of sentinel facilities with uninterrupted availability of a core set of health-security tracer products in the last 30 days	Outcome	80%	LMIS, KHIS2	Monthly and Quarterly	National PHEOC Manager
Public health events preparedness	HPTs	No. of ADR/Side Effects reported in the PPB	Outcome		PV reporting platform	Monthly and Quarterly	National PHEOC Manager
<b>QI, IPC and AMR</b> Expected outcomes: Safer and resilient health systems							
Safer and resilient health systems	QI, IPC & AMR	% overall national hand hygiene compliance among healthcare workers, of at least 50% by the end of the year of report	Output	50%	KHIS Reports	Quarterly	Head Division QI, IPC &AMR
Safer and resilient health systems	QI, IPC & AMR	Proportion of level 4 and above (public and private) healthcare facilities routinely conducting surveillance on at least one priority healthcare-associated infection by the end of each reporting year.	Output		KHIS Reports	Annually	Head Division QI, IPC &AMR
Safer and resilient health systems	QI, IPC & AMR	% of antibiotic prescriptions at national level that are in the WHO Aware 'Access' category by the year 2030.	Outcome	70%	Prescription audits, pharmacy dispensing reports, KHIS	Annually	Head Division QI, IPC &AMR
Safer and resilient health systems	QI, IPC & AMR	# of healthcare facilities conducting routine AMR surveillance by the end of each reporting year.	Output		Central Data Warehouse	Quarterly	Head Division QI, IPC &AMR

Strategic Objective	Focal Area	Indicator	Indicator Type	Target	Data Source	Frequency	Person responsible
Strategic Objective 10: To Expand and Strengthen Institutional Capacity							
Expected outcome: Expanded and strengthened institutional capacity							
Institutional and governance capacity	PHR&I Directorate	% of technical staff trained in scientific writing or/and protocol development or/ and policy development	Output	30%	HR Training records Staff development database	Annually	Head of PHR&I
Public Health Research and Innovation	Research Division	# of institutional research committee meetings held per year	Output	4	IRC Meeting Minutes Attendance logs	Quarterly	Research Division
Public Health Research and Innovation	Research Division	# of KNPHI research abstracts, manuscripts or knowledge products developed proposals developed % reviewed % approved through the Institutional Research Committee per year % published or presentated in conferences/journals	Output	80%	IRC Review Records	Quarterly	Research Division
Public Health Research and Innovation	Research Division	% of divisions adopting Institutional Research Committee recommendations in their projects per year	Outcome	100%	IRC Meeting Reports	Biannually	Research Division
Public Health Research and Innovation	Research Division	# of KNPHI research outputs disseminated (disaggregated by National, County, and inter-agency policy documents.)	Output	5	Research dissemination reports Attendance logs	Annually	Research Division
Strategic Objective 11: To strengthen the capacity of essential public health workforce for prevention, detection and response to Public Health events							
Expected outcome: Strengthened capacity of essential public health workforce							
Strengthening institutional governance	FELTP	Proportion of FELTP graduates in advanced level who graduated per cohort	Outcome	80%	FELTP reports	Bi-annually	FELTP

## 2. KNPHI Knowledge Products

Division	Knowledge Product	Frequency	Primary Audience
DDSR	Weekly/monthly surveillance bulletins	Weekly/ Monthly	KNPHI leadership, MoH, Counties, WHO
	Outbreak investigation reports	Ad hoc (per event)	MoH, Counties, Partners
	Annual surveillance performance report	Annual	MoH, IHR/NFP, WHO, Africa CDC
DNLS	Laboratory performance scorecards (EQA, TAT, accreditation)	Quarterly	Labs, Counties, MoH
	Annual national lab network report	Annual	KNPHI leadership, MoH, Partners
	Biosafety/biosecurity audit briefs	Annual	KNPHI leadership, WHO, MoH
FELTP	Technical briefs/case studies from field investigations	Ad hoc	MoH, Counties, Global training networks
	Research summaries from fellows	Semi-annual	KNPHI leadership, Academic partners
	FELTP alumni tracer report	Annual	KNPHI leadership, Donors
NPHEOC	Situation Reports (SitReps)	During response	MoH, Counties, WHO
	After Action Reviews (AARs)	Post-incident	KNPHI leadership, MoH, Partners
	Simulation exercise reports	Annual	KNPHI leadership, Counties, WHO
IPC/AMR	IPC compliance dashboards	Quarterly	Facilities, Counties, MoH
	AMR surveillance reports	Quarterly/ Annual	KNPHI leadership, WHO, MoH
	Policy briefs on IPC/AMR	Annual	Policymakers, Partners
NTDs	MDA coverage reports	Annual	MoH, Counties, WHO
	Case study reports (best practices)	Semi-annual	KNPHI leadership, Counties
	Elimination status briefs	Ad hoc (per milestone)	WHO, MoH

<b>Division</b>	<b>Knowledge Product</b>	<b>Frequency</b>	<b>Primary Audience</b>
Port Health & Food Safety	PoE inspection reports	Quarterly	KNPHI leadership, Ports Authority, MoH
	Food safety incident reports	Ad hoc	MoH, Counties, WHO
	Annual border health security review	Annual	KNPHI leadership, IHR/NFP, WHO
RCCE	Community feedback dashboards	Quarterly	KNPHI leadership, Counties, MoH
	Rapid communication briefs (emergencies)	Within 24h of confirmation	General public, Media, Partners
	Annual RCCE performance report	Annual	KNPHI leadership, MoH, Partners
Biosafety & Biosecurity	National biosafety compliance reports	Annual	KNPHI leadership, MoH, WHO
	Lab-acquired infection incident reports	Ad hoc	KNPHI leadership, WHO
	Guideline dissemination packs	As updated	Labs, Counties, MoH
Research	Annual research compendium	Annual	KNPHI leadership, MoH, Partners
	Policy translation briefs	Quarterly	Policymakers, Counties, Donors
	Knowledge exchange reports	Semi-annual	KNPHI leadership, Academia, Africa CDC
Health Informatics	Real-time divisional dashboards	Continuous	KNPHI leadership, Counties
	Data quality trend reports	Quarterly	Divisions, Counties, MoH
	Informatics performance review	Annual	KNPHI leadership, MoH
Division of M&E (MEL Unit)	Consolidated KNPHI performance report	Quarterly/ Annual	KNPHI leadership, MoH, Donors
	Data Quality Assessment (DQA) reports	Annual	Divisions, Counties, MoH
	Lessons learned/best practice reports	Annual	KNPHI leadership, Africa CDC, WHO



Kenya National Public Health Institute:  
Afya House Annex,  
KNH Grounds,  
Hospital Road,  
P.O. Box 31-00202,  
Nairobi

[www.nphi.go.ke](http://www.nphi.go.ke)

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