Kenya President's Emergency Plan for AIDS Relief Strategic Information Reporting Guide

March 14, 2006

Kenya President's Emergency Plan for AIDS Relief Strategic Information Reporting Guide

March 14, 2006

I. Kenya President's Emergency Plan for AIDS Relief Database Overview 4

What is Strategic Information? 4

Levels of Aggregation 4

Database Format, Location and Access 4

II. Data Collation and Information Reporting for PEPFAR Program-level Indicators 5

Principles of Reporting 5

Data Collation 5

Service Outlet Information 7

Program Information 7

Information Reporting 8

Information Reporting Timeline 9

Special Issues 9

Service Outlets/Programs with Multiple Partners 9

Data Quality 10

III. Collation Sheet Specifics 10

General Comments 10

Service Outlets and Programs 10

Training 11

Details Required When Reporting Training 11

Direct and Indirect Support 12

Non-USG-supported Partner HIV/AIDS Activities 13

PEPFAR Program Area Specifics 13

Prevention: Abstinence, Being Faithful and Other Behavior Change programs 13

Blood Safety 13

Injection Safety 13

PMTCT 14

Counseling and Testing 14

Antiretroviral Services 14

Palliative Care 15

Orphans and Vulnerable Children 16

Laboratory Infrastructure 16

Strategic Information 16

Other: Policy Analysis and System Strengthening (Capacity Building) 16

IV. Contact Information and Important Dates 17

Names and contact information for USG/SI Team Members and USG Data Submission Points 17

SI Contacts by USG Agency 19

Important Dates 20

Appendix 1: How PEPFAR Partners should relate to National Information Systems 22

Appendix 2: MINISTRY OF HEALTH INTEGRATED MONITORING AND EVALUATION REPORT FORM MOH 726 NASCOP 25

I. Kenya President's Emergency Plan for AIDS Relief Database Overview

The Kenya President's Emergency Plan for AIDS Relief (PEPFAR) Database (Database) will be used to store the strategic information (SI) needed for reporting on PEPFAR indicators (as described in *The President's Emergency Plan for AIDS Relief: Indicators, Reporting Requirements, and Guidelines for Focus Countries. Revised for FY) 2006 Reporting. July 29, 2005* and referred to as *The Guidelines* in this document*)*. The primary function of the Database will be to capture information on the PEPFAR program-level indicators from implementing partners (prime partners and their sub-partners and service outlets/programs) in Kenya. Additionally, the Database will store the information necessary for the PEPFAR national outcome- and impact-level indicators (this issue will not be discussed here).

For the PEPFAR program-level indicators, prime partners submit data collation forms in Microsoft Excel spreadsheet format. The collation forms contain only PEPFAR required information, which is typically a subset of the information already collected by partners. The prime partners are responsible for distributing collation forms to their sub-partners, collecting the information on a quarterly basis and submitting to their US Government (USG) Data Submission Points. The USG Data Submission Points submit the information to the USG/Kenya Strategic Information Team (SI Team). The SI Team then compiles all information and distributes aggregated data in program update reports to partners and for the PEPFAR semi-annual and annual reporting requirements.

What is Strategic Information?

Strategic Information consists of the information from surveillance, monitoring and evaluation, and evidence-based research for multi-sectoral HIV/AIDS responses. SI is used to inform the program planning and design process. It is also used to improve programs after their inception by evaluating progress toward targets and goals. The Kenya PEPFAR Database will store the strategic information from surveillance and monitoring and evaluation that correspond to the PEPFAR indicators.

Levels of Aggregation

Within the Database, program-level information from the service outlets (health facilities and organizations providing direct services will be stored. The Database will have the ability to aggregate program-level information from service outlets by PEPFAR Program Area, geographic unit, prime partner and supporting USG agency. In most cases, theprogram level information is disaggregated by sex. In some cases (specifically ART) further disaggregation is required by age and pregnancy status.

Database Format, Location and Access

For now, the Database will be housed on a computer at CDC's offices in Nairobi. Only members of the USG/Kenya SI Team will have access to the Database and will be responsible for importing the information from prime partners and responding to requests for information.

A MS Access database is currently being developed. Eventually it will replace the MS Excel collation sheets currently in use. A web site is also in development stages for eventual use for submission of data, replacing the email submission of data by partners.

II. Data Collation and Information Reporting for PEPFAR Program-level Indicators

Principles of Reporting

1. All partners must ensure complete, effective and timely reporting though designated officials of national systems.
    a. Health service facilities report to the appropriate District Health Management Team (DHMT) officer [i.e. District Tuberculosis and Leprosy Coordinator (DTLC); District AIDS Control Officer (DASCO); HIV data manager; District ART Officer (DARTO)] who report through the District Health Records Officer (DHRO) / District Medical Officer of Health (DMOH)
    b. Community Programs (Non-health facility based programs) report to the appropriate Constituency AIDS Control Committee (CACC) or District Technical Committee (DTC) Officer.

2. USG PEPFAR partners are also expected to report to the designated USG activity manager or program officer(s). In some cases, unprocessed data may be submitted to the CDC or DOD data sections as agreed with the program officer.
    a. The designated USG program officer may be a CTO in the case of USAID and the program officer in the case of CDC or DOD (see "IV. Contact Information and Important Dates. *Data Submission Points*").
    b. Prime partners and sub partners may agree to process (enter) data at different levels before reporting to designated USG officer.
    c. Data from partners will be shared with NACC / NASCOP for verification purposes.

3. Strategic information requires the active use of data for program improvement. Data analysis and use should occur at all levels. Dissemination of national, provincial, district and local data is encouraged in order to improve service delivery, program planning and management.

Data Collation

The Kenya PEPFAR SI Reporting Collation Sheets (Collation Sheets) is the tool that will be used to collate information for the PEPFAR program-level indicators and to report the information through the chain of partners to the USG/Kenya PEPFAR SI Team. The Collation Sheets will enable a systematic and standardized method of collecting information and monitoring progress in the PEPFAR Program Areas. Currently[1], the Collation Sheets are contained in a Microsoft Excel spreadsheet file. Within the file there are separate Excel sheets for each of the PEPFAR Program Areas and their respective indicators as described in *The Guidelines*. Training spreadsheets appear separate from the rest of the program indicators to allow for easy importation.

[1] An MS Access system will eventually replace the MS Excel spreadsheets.

A table of contents appears for each worksheet allows hyper links with the spreadsheets. It also has information of general nature such as the name of the submitting organization, name of person submitting the information, name of prime partner (as applicable), dates and the supporting USG agency, name of the verifier and, contacts for the USG/SI contact person. It has also yes or no checklist on who fills what sheets.

Note: A partner may not need to fill in an entire sheet for a PEPFAR Program Area.
Example: If a partner provides VCT services at five sites, then it is expected that the partner will fill in the VCT Program Area Collation Sheet reflecting the number of female clients and number of male clients for each of the five facilities for the reporting period. That same partner may notice that the VCT Collation Sheet includes fields for training information, but the partner never conducts trainings. Those fields should be left blank.

Prime partners have been funded to provide HIV/AIDS-related interventions/services in the program areas of:
Prevention / Abstinence and Being Faithful (ABY)
Prevention / Other Behavior Change
Prevention / Medical Transmission / Blood Safety
Prevention / Medical Transmission / Injection Safety
Prevention of Mother-to-Child Transmission (PMTCT)
Counseling and Testing (CT)
HIV/AIDS Treatment / ARV Services
Palliative Care (Including TB/HIV care)
Orphans and Vulnerable Children
Laboratory Infrastructure
Strategic Information
Other / policy development and system strengthening

In some cases prime partners manage these services directly, in others they sub-contract to sub-partners. In all cases services are provided through service outlets (health facilities and non-health facilities) to enumerable individuals or through programs where the target audience cannot to be enumerated (e.g., mass media campaigns, community education, guideline or curriculum development, etc…). In the Collation Sheets each service outlet and program is named and listed on a separate row on the sheet.

On a quarterly basis the prime partners will ensure that the number of clients served (actual numbers for service outlets and estimated numbers for programs) and the number of providers trained for each of their supported service outlets and programs is entered into the Collation Sheets. Prime partners may delegate the task of collecting the information from the service outlets and programs to their sub-partners, but only prime partners will submit a single Collation Sheets file to the USG Data Submission Points. See list at the end this guideline)

Note: For the purposes of PEPFAR reporting, the number of clients served is enumerated. This does not mean client-visits or client-visits-services. This is particularly important for services provided over an extended period of time (ART, Palliative Care, long term prevention activities). Prime partners will ensure that mechanisms are in place

so that service outlets are not reporting on a client more than once within a quarter or within a half-year or within a full year, depending on the reporting period in question.

As the data flows from sub-partners to prime-partners to USG Data Submission Points to the SI team, it will be collated. This means that aggregation will not occur beyond the service outlet/program level. As the data flows to higher levels, rows (each row representing one service outlet or program) will be added to the data set.

Service Outlet Information

Service outlets[2], such as health facilities or community-based organizations providing home-based care or support to identifiable orphans and vulnerable children or supporting peer education, provide service directly to an **enumerable** individual. These service outlets collect data on their clients and the services that they receive on a daily basis (routine information). At the service outlet, this information should be aggregated every month, quarter, and year for internal purposes.

A distinction is made between service outlets that are health facilities and those that are not because of the existing information systems – the NASCOP ART, VCT, and PMTCT databases and the MOH TB databases and HMIS – that already collect this information. In order to avoid duplication of effort at the health facility, prime partners are required to obtain the information needed for the PMTCT, VCT, ART and Palliative Care Collation Sheets from the health facilities monthly report. In addition, for each health facility supported, prime partners are also required to submit with their Collation Sheets file a copy of the facility's monthly HMIS reports with the District Records and Information Officer's signature and date of receipt. The *section* below provides information on how the information from the HMIS report (MOH 726) can be transferred to the appropriate Collation Sheet.

Program Information

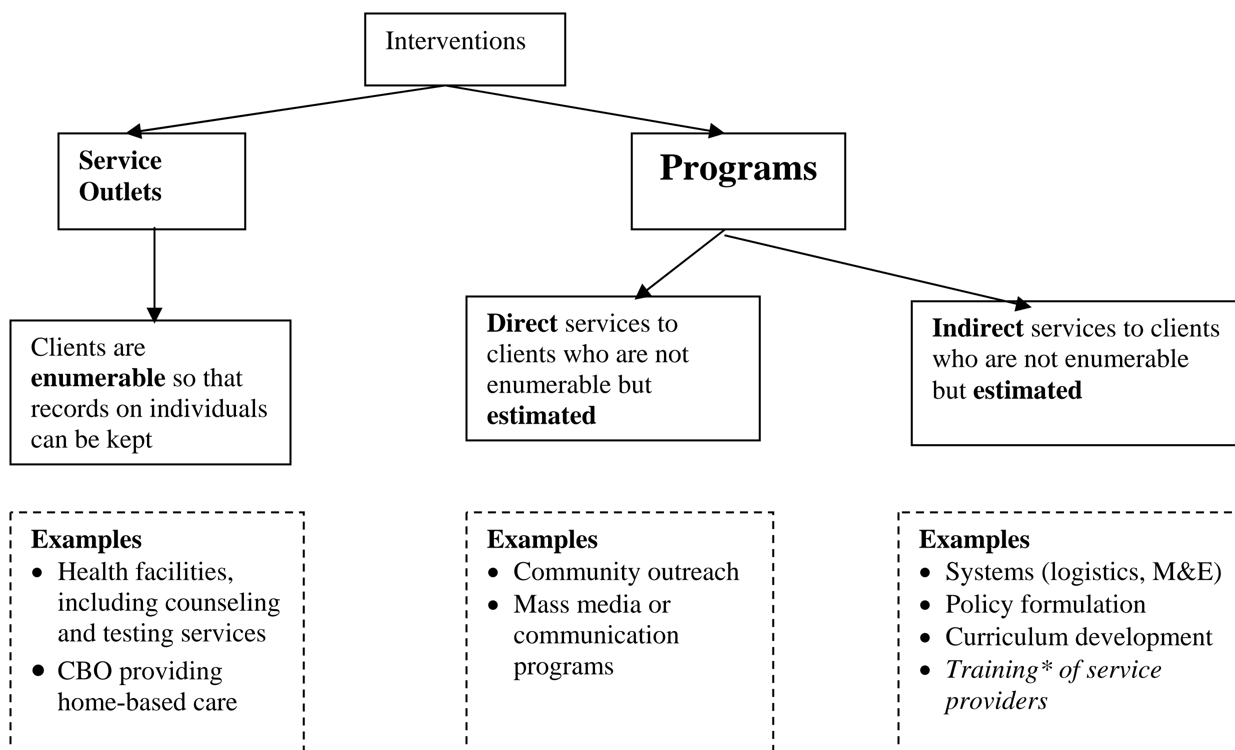
For program interventions where a physical service outlet cannot be identified, such as community outreach and mass media programs, curriculum development, or logistics systems, and where clients are not enumerable, the number of clients served is an estimate. Refer to the PEPFAR Program Area Specifics section for more specific guidance.

Programs in which service providers (not family members) are trained, the number of people trained is enumerable and a separate section of the program area's collation sheet is used to capture that information.

(See schematic diagram below for more illustration)

---

[2] See below for more clarifications about service outlets.



Information Reporting

The Collation Sheets will be disseminated to prime partners through forums organized by the SI team. Prime partners are expected to report within program areas based on the services that they have been funded by PEPFAR to provide. ADDITTIONAL POSSIBLE REPORTING>>> If a prime partner has significant efforts in a program area they may report it even if they are not specifically funded in that particular PEPFAR program area. Two tests to determine whether reporting is acceptable in a program area under this exception:

1. The efforts must be significant (i.e., if only a few people were reached by a partner's efforts, then it would not be considered significant).
2. The achievements should have only been possible as a result of PEPFAR support (i.e., do not report on achievements made through NON-PEPFAR financial means)

Prime partners are responsible for ensuring that all service outlets and programs funded through them are represented in the Collation Sheets. Prime partners may choose to collate the information from their supported service outlets/programs themselves, or they may delegate that to their sub-partners or the service outlets/programs. The information flow process should be documented with brief descriptions at every level to point out any inconsistencies or data flow gaps. Ideally, if information is to be used at the various administrative levels, the Collation Sheets should flow from service outlets/programs to sub-partners to prime partners to USG Data Submission Points to USG/Kenya PEPFAR SI Team.

Prime partners return the completed Collation Sheets to the Data Submission Points three weeks after the end of a quarter. USG Data Submission Points will ensure that all prime partners have submitted Collation Sheets and verify the information that is provided and submit the prime partners' Collation Sheets to the USG/Kenya PEPFAR SI Team. A data entry clerk within the USG/Kenya PEPFAR SI team will enter all of the received collated information.

After the SI team compiles the quarterly data and enters it into the Database, it will be distributed back to partners. To begin, the data can be shared quarterly as well as on-request. Once the system is running smoothly, automated data analyses can be run to send reports to the partners on partner specific or overall performance of the PEPFAR.

Note: During the reporting process, there is no aggregation beyond the service outlet/program level. This means that rows of information within a PEPFAR Program Area are compiled and stacked, NOT summed or totaled.

> **Example**: If a partner supports a PMTCT program in 15 facilities, then for each facility, the partner would aggregate patient information to facility-summarized information. No more aggregation should be done after this nor should any totals (summations of the multiple facilities) be produced. Each row of information on the collation sheet should reflect the information for one facility or a program. If 15 facilities are supported, then there should be 15 rows of information on the collation sheet.

Information Reporting Timeline

USG/Kenya PEPFAR has a semi-annual reporting requirement to the Office of the Global AIDS Coordinator in Washington, DC.

- The Annual Report is due in mid-November and covers the period of October 1 to September 30. This incorporates two half-cycles of funding. For example, the 2006 Annual Report due November 2006 will cover funding from 2005 for October 1, 2005 to March 31, 2006 and funding under COP2006 for April 1 to September 30, 2006.
- The Semi-Annual Report is due in mid-May and covers the period of October 1 to March 31. The 2006 Semi-Annual Report is due May 16, 2006.

Given these requirements, the USG/Kenya SI Team will expect prime partners to submit Collation Sheets quarterly[3] to their USG Data Submission Points within 3 weeks after the end of the quarter. Specific reports submission dates will be communicated to partners every quarter.

Special Issues

Service Outlets/Programs with Multiple Partners

If multiple partners support the same service outlet/program to provide the same service, or even different services but to same clients then double counting of clients served may occur. To prevent double counting of clients served in such situation, the multiple

[3] The Collation Sheets due April 21, 2006 to the USG Data Submission Points are an exception in that they cover a six-month period: October 1, 2005 to March 31, 2006.

partners with guidance from the SI team will select only one of them to report on the activities.

This raises the issue that other partners may miss an opportunity to be given credit for their support. Partners will use other forms of reporting such as specific project quarterly reports to their respective USG agencies for purposes of demonstrating accountability.

Data Quality

As information flows from service outlets and programs to the sub-partners, prime partners, and eventually the USG/Kenya PEPFAR SI team, simple checks can support data quality. Data Submission Points, program managers and/or monitoring and evaluation staff should look at the data they receive using basic criteria such as making sure each facility has submitted data and whether that data seems realistic. Another method of assuring data quality is to randomly select service outlets to look into with more depth to see if client records were appropriately aggregated.

III. Collation Sheet Specifics

General Comments

Service Outlets and Programs

The Guidelines require reporting on the number of "service outlets" and "programs" that the PEPFAR is supporting and the number of clients served by both service outlets and by non-service outlet based programs. Whereas the definition of a "service outlet" is relatively concrete, that of "program" is not. The ambiguity of the word "program" is a result of the multiple definitions of the term that are used. For the purposes of PEPFAR reporting, "service outlets" and "programs" are defined as the lowest level of management of an intervention. The distinction between the two is the ability to count the number of clients receiving services. Service outlets provide services to **enumerable** clients through service providers who maintain records on the clients that they serve. Programs provide services indirectly to clients; and the number served can only be estimated.

In general there are two types of service outlets: health facilities and non-health facilities. The distinction is made between these two types of outlets because of the existing information systems that health facilities maintain. Non-health facilities, such as community-based organizations providing home-based palliative care or orphan and vulnerable children support, do not have a formal system for information management[4].

Note: In a quarterly reporting period, the number of service outlets should be the total number of operating sites, not just the new service outlets opened during the reporting period. The total number of sites at the end of the year will not be the quarterly totals but those that will have been operational through the year.

[4] NACC/NASCOP are envisioning the creation of an information system that will capture community-based care using the CACC/DTC/NACC system of coordination.

There are several different types of "programs" that the USG is funding: national and sub-national mass media initiatives, community outreach, peer and formal education, guideline development, logistic systems, social marketing, and training (see below), to name a few specifics. The common thread is that the organization is not providing services directly to a client who can be counted. If the clients can be counted, then the organization providing the service should be considered to be a service outlet.

Training

For the purposes of PEPFAR reporting, training is considered separately as the number of people trained in a PEPFAR Program Area. Training indirectly provides services to clients, because the people trained are the service providers. People trained to provide services directly to clients should be trained to keep records of the people they serve and maintain those records during service provision. One exception should be noted: training a person in a household to provide palliative care should not be considered as training unless that person is expected to provide services to other households and to maintain records of the clients served. In order to be counted as training these components must be present:

- Specific learning objectives
- A course outline (implies structured instruction)
- Attendees must attend and complete the course

For most PEPFAR program areas, we count "individuals" trained with a few exceptions. The exceptions are with OVC where trained "providers/caretakers" are counted; with PMTCT and ARV treatment, trained "health workers" are counted. Providers/caretakers is defined as anyone involved in the provision of care or support for OVCs.

The partner that conducts a training is the one responsible for reporting on the number of individuals trained. AN EXCEPTION>> If a partner pays for training, but a non-PEPFAR supported organization conducts the training, then the PEPFAR partner that paid for the training should count the persons trained (otherwise this would be uncounted PEPFAR supported training). If a partner sends any of its employees to a training that is conducted by another partner, the same rule applies. The partner conducting the training reports on individuals trained, not the partner that had some of its employees trained. If a partner trains Government of Kenya staff, the partner should also count those persons trained.

If the same person goes to multiple trainings in a reporting period, then that person should only be counted again if the training is in a different PEPFAR Program Area. Partners will need a system that can uniquely identify the individuals who are trained so that a person is not counted multiple times if trained multiple times in the same PEPFAR Program Area during a reporting period. Once again, this is a case where you can't add up quarters to get an annual or semi-annual number.

Details Required When Reporting Training

1. Supporting USG agency.
2. Partner – i.e., the name of your organization.

3. Name of the training. The name of the training should be descriptive to allow USG program officers discern the relevance of the training to the program area. Names of the training ought to reflect relevance to the program area. An entry such as AIDS coordinators training or Splash training are not descriptive enough (These were listed under abstinence and be faithful programs but could possibly fit in any other program area).
    a. Avoid the use of abbreviations that may not be easy for everyone to decode (e.g., KA AB TRG-CTS)
    b. Avoid insertion of dates in some of the titles of the training (KA PEER TRG FEB 05)
4. Start data of the training. Use date format dd/mm/yy.
5. End date of the training. Use date format dd/mm/yy.
6. Cadre trained. Provide a concise description of who was trained (could be, community leaders, program managers, teachers, doctors, nurses, youth educators, lab technicians, national youth service recruits, street children/families, high school students, PLWHA, couples, hospital administrators, procurement officers, pharmacists, women's groups, police officers, fishermen, army recruits, USG program managers, media staff, church leaders, orphans, caregivers, M & E officers, etc.… If mixed groups, list the two main groups targeted).
7. Length of training, in hours. Indicate duration of training in hours. If the training was a one week training, please indicate the number of hour rather than reporting "1 week" (e.g., 32hrs, 80hrs).
8. Number of individuals trained.
9. Training location. Indicate the district where each individual training was conducted (e.g., Nairobi, Nyeri, Moyale…).
10. Comment on curriculum used. Insert a small comment on the curriculum used (e.g. MOH VCT curriculum, FHI BCC Module…).

Direct and Indirect Support

Most of the USG partners are providing direct support to service outlets or programs and clients and therefore this section does not affect such partners. The government of Kenya through the Ministry of health has, however, increasingly become a key partner of USG programs. These programs have wide reaching effect on clients and therefore their outputs are best captured as indirect support.

USG direct support accomplishments are individuals receiving interventions through service outlets that are directly supported by USG PEPFAR funds (that may or may not be funneled through prime or sub-partners). This support can be through commodity provision, management support, financial resources, or infrastructure building. One test of direct support would be whether or not the service would be provided if the USG funding were not available. Support through the development of national policies/guidelines and systems and strengthening of human capacity are considered indirect support.

Indirect support is support that the USG Agencies and its partners contribute in a general sense at the national/regional/district levels. The following formula is used to calculate indirect counts:

$$\text{USG Indirect} = p(\text{National Total - USG Direct}),$$

p is equal to a proportion of the service provision that the activity supports. For example, the USG may have supported the development of national guidelines. In this case, p is equal to the proportion of clients utilizing service outlets that provide services following the national guidelines with the proportion further discounted by a subject sense as to how much a guideline actually contributes to service provision.

USG Totals = USG Indirect + USG Direct or

$= p(\text{National Total} - \text{USG Direct}) + \text{USG Direct}$

Non-USG-supported Partner HIV/AIDS Activities

If a partner is implementing an intervention under PEPFAR support, then they need to report on all relevant PEPFAR indicators. If that same partner also implements other HIV/AIDS activities that are not supported by PEPFAR funds, then they must NOT report on indicators of such an activity. To do so would be an inaccurate claim of achievement from PEPFAR support.

PEPFAR Program Area Specifics

Prevention: Abstinence, Being Faithful and Other Behavior Change programs

The Abstinence program area is a subset of the Abstinence and Being Faithful program area. If a partner supports an Abstinence only program, then that partner should report in the Abstinence collation sheet and in the Abstinence and Being Faithful collation sheet. If a partner supports an Abstinence and Being Faithful program, then that partner should report in the Abstinence and Being Faithful collation sheet but NOT in the Abstinence collation sheet.

The community outreach and mass media programs that are USG PEPFAR funded usually involve interventions that are delivered to groups of people who are not individually identified and, therefore, the number served are often estimates. Examples include classroom education, outreach programs in markets, radio soap operas. Each line in the Collation Sheet should represent the lowest level of intervention management that is supported by USG funding.

If a program is nation-wide indicate that in the *Province and District* columns. If the program is delivered in a single district, name the district in the column. If the program is delivered in multiple districts, list each district as a separate program on separate rows (but do not double count individuals). This is important if we are interested in geographic coverage.

Blood Safety

According to *The Guidelines*, this PEPFAR Program Area is specific to the transfusion of blood. Blood safety activities include those that support policies, infrastructure, equipment, and supplies; blood donor recruitment activities; blood collection, distribution/supply chain/logistics, testing, screening, and/or transfusion; waste management; training; and/or management to ensure a safe and adequate blood supply. The unit of measurement is the site, not the activity. A site will only count once during a reporting period regardless of the number of on-going activities at the site.

Injection Safety

The Guidelines define injection safety as only pertinent to medical injections. Despite the inclusive definition, the only unit quantified is the number of people trained in injection safety.

PMTCT

As with other PEPFAR Program Areas, the first indicator for this Program Area is the number of service outlets providing the minimum package of PMTCT services:

1. Counseling and testing for pregnant women;
2. ARV prophylaxis to prevent MTCT;
   Note: The ARV prophylaxis must be physically available in the ANC or maternity. Giving a prescription for the woman to fill is not acceptable, even if the pharmacy is housed within the same facility.
3. Counseling and support for safe infant feeding practices;
4. Family planning counseling or referral.

Each row on the PMTCT Collation Sheet should represent an ANC or maternity receiving USG-support (as defined above) to provide all these PMTCT services.

The second indicator is the number of women receiving PMTCT services including counseling and testing. Counseling and testing is the minimum service that women should receive. HIV-positive women will receive additional services; those who receive ARV for prevention of HIV transmission will be counted in the third indicator.

Values for this second and third indicator should be taken from health facilities *MOH/NASCOP Integrated Monitoring And Evaluation Report Form* (MOH 726). For ANC the total number of women counseled and tested is PMTCT Row C and the total number who received ARV is PMTCT Row E. For maternities, the values are PMTCT Rows G and I, respectively. For each reporting period, the values on these lines from the monthly reports within the reporting period should be totaled.

Note: There is a possibility that women will receive duplicate services in ANC and maternity. Duplicate counting at this time cannot be avoided.

Comment: There are two limitations of these PEPFAR indicators:

1. The efficiency of services cannot be assessed because the proportion of the HIV-positive population of that is served at these outlets is not known.
2. Women who do not receive nevirapine are not enumerated.

Counseling and Testing

According to *The Guidelines*, in order to be considered as a service outlet providing counseling and testing services, the outlet must do so in accordance with national guidelines (National Guidelines for Voluntary Counseling and Testing, Ministry of Health of Kenya, 2001).

Values for the number of people counseled and tested should be taken from health facilities *MOH/NASCOP Integrated Monitoring And Evaluation Report Form* (MOH 726). This information for males and females is found in the Column “No tested”.

Antiretroviral Services

Each row of the Antiretroviral Services Collation Sheet should represent USG-supported (as defined above) service outlets that are providing antiretrovirals according to national guidelines (A Strategy for the Implementation of Antiretroviral Therapy in Kenya, 2003).

Values for the number of individuals with advanced HIV infection receiving antiretroviral therapy are found on rows C and D of the ARV section of *MOH/NASCOP Integrated Monitoring And Evaluation Report Form* (MOH 726). The values are obtained by totaling the "No. previously on ARV's" (ARV Row C) from the first monthly MOH form 726 of the reporting period with the **Total** "No. of (*sic*) people who commenced ARV's within the month." (ARV Row D) from each month of the reporting period.

Note: Because the "No. previously on ARV's" (ARV Row C) includes PMTCT patients, this total will include some of those clients. A note to this effect will accompany the Semi-annual and Annual reports.

The number of new individuals is the sum of the [**Total – PMTCT mothers – PMTCT spouses** found in "No of people who commenced ARV's within the month." (ARV Row D)] for each month of the reporting period.

New, cumulative and Current clients on ARVs per facility should be reported. "New" refers to individuals newly initiated on antiretroviral therapy during a reporting period. "Cumulative" refers to the total number of individuals who were ever on ART since the start of PEPFAR support to the service outlet. "Current" refers to those individuals on antiretroviral therapy at the end of a reporting period.

Palliative Care

This program category includes TB and non-TB related care. For the TB patients this refers to HIV positive patients who are also being treated for TB and not the other way round. These data should be reported directly to National Tuberculosis and Leprosy Programme (NLTP) as well as to USG Data Submission Points.

HIV-related palliative care is patient and family-centered care that optimizes the quality of life of adults and children living with HIV through the active anticipation, prevention, and treatment of pain, symptoms and suffering from the onset of HIV diagnosis through death. Palliative care includes and goes beyond the medical management of infectious, neurological or oncological complications of HIV/AIDS to comprehensively address symptoms and suffering throughout the continuum of illness. The means by which this is achieved will vary according to stage of illness but always with the understanding that quality of life involves clinical, psychological, spiritual, and supportive care.

Palliative care is a patient and family-centered service, therefore clients provided with general HIV-related palliative care/basic health care and support during the reporting period may include patients and family members. How much care is needed in order to count within the indicator is currently left to national standards – all persons served during the reporting period will be counted once by a unique program regardless of frequency. HIV-infected individuals and families have varying needs for services depending on the stage of illness, type of service, and available resources of HIV-infected persons.

There are two other palliative care indicators that are subsets of the overall palliative care indicator. They are:

8.2.A Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease
8.2.B Number of HIV-positive clients given TB preventive therapy

Orphans and Vulnerable Children

Mechanisms need to be in place so that HIV-positive orphans and vulnerable children receiving palliative care (excluding TB/HIV) are counted for that program area and not under this one. The number of OVCs served at the end of the year or semi annually will not necessarily be the totals from the quarters. It will be those supported at the beginning of the first quarter plus all new cases that join within the year.

Laboratory Infrastructure

Only laboratories receiving direct USG-support can be listed in each row.

Strategic Information

Only people being trained for purpose of generating strategic information will be counted here. They include people trained in various monitoring and evaluation capacity building programs as well as those who participate in surveys that are USG funded.

Other: Policy Analysis and System Strengthening (Capacity Building)

Other HIV/AIDS-related activities including strengthening policies and systems to address stigma and discrimination, and to support national prevention, care, and treatment efforts; other activities to strengthen systems or build capacity to combat HIV/AIDS, including activities to support the implementation of national and/or multilateral programs. This could include the provision of technical assistance through small grants or assistance with proposal development, organizational management, network or coalition building, advocacy, and/or public/private partnership building.

The number of HIV service outlets/programs provided with technical assistance or implementing programs related to policy and/or capacity building, including stigma and discrimination reduction programs should be counted. The number of individuals trained in implementing programs related to policy and/or capacity building, including stigma and discrimination reduction programs should also be counted.

IV. Contact Information and Important Dates

Names and contact information for USG/SI Team Members and USG Data Submission Points

CDC Data Submission Points				
PEPFAR Program Area	**Program Officer**	**Email of Program Officer**	**Data manager**	**Email of Data Manager**
ABY	Mercy Muthui	mmuthui@ke.cdc.gov	P Kamau	pkamau@ke.cdc.gov
Prevention Other (PO)	Mercy Muthui	mmuthui@ke.cdc.gov	P Kamau	pkamau@ke.cdc.gov
Blood Safety	Jane Mwangi	jwmwangi@ke.cdc.gov	T Oluoch	toluoch@ke.cdc.gov
Injection Safety	Jane Mwangi	jwmwangi@ke.cdc.gov	T Oluoch	toluoch@ke.cdc.gov
PMTCT	Winnie Mutsotso	wmutsotso@ke.cdc.gov	A Isavwa	aisavwa@ke.cdc.gov
CT	Jane Tipton	jtipton@ke.cdc.gov	P Kamau	pkamau@ke.cdc.gov
ART	Marta Ackers	mackers@ke.cdc.gov	A Isavwa	aisavwa@ke.cdc.gov
Palliative Care	Marta Ackers	mackers@ke.cdc.gov	A Isavwa	aisavwa@ke.cdc.gov
TB/HIV Palliative Care	John Mansoer	JMansoer@ke.cdc.gov	T Oluoch	toluoch@ke.cdc.gov
Lab Infrastructure	Peter Tukei	ptukei@ke.cdc.gov	T Oluoch	toluoch@ke.cdc.gov
SI	Lawrence Marum	lmarum@ke.cdc.gov	T Oluoch	toluoch@ke.cdc.gov
Other Policy Development	Lawrence Marum	lmarum@ke.cdc.gov	T Oluoch	toluoch@ke.cdc.gov
KDOD program	Dorothy Njeru	dnjeru@wrp-nbo.org	T Oluoch	toluoch@ke.cdc.gov
Uniformed Services – Prison	Dr. Stephen Karau	skarau@ke.cdc.gov	T Oluoch	toluoch@ke.cdc.gov
Uniformed Services – Kenya Police	Dr. Stephen Karau	skarau@ke.cdc.gov	T Oluoch	toluoch@ke.cdc.gov
Uniformed Services – NYS	Mercy Muthui	mmuthui@ke.cdc.gov	T Oluoch	toluoch@ke.cdc.gov

USAID Data Submission Points by Implementing Partner			
USAID Partner	**CTO's Name**	**CTO's Email**	**USAID SI Email**
ACQUIRE INTRAHEALTH	JERUSHA KARITHIRU	JKaruthiru@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
Academy for Educational Dev - Capable Partners	DAVID ELKINS	DElkins@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
Academy for Educational Devt. - Speak for the child	JERUSHA KARITHIRU	JKaruthiru@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
ADVENTIST DEVELOPMENT AGENCY	CHERYL SONNICHSEN	CSonnichsen@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
American Fed of Teachers Educational Foundation	CHERYL SONNICHSEN	CSonnichsen@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
African Union Inter African Bureau for Animal Resources	BEDAN GICHANGA	BGichanga@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
AVSI	JERUSHA KARITHIRU	JKaruthiru@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
CARE KENYA	JERUSHA KARITHIRU	JKaruthiru@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov

Centre for British Teachers	CHERYL SONNICHSEN	CSonnichsen@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
CHRISTIAN CHILDREN FUND	JERUSHA KARITHIRU	JKaruthiru@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
CHRISTIAN AID	JERUSHA KARITHIRU	JKaruthiru@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
Catholic Medical Mission Board	LUCY MATU	LMatu@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
CRS KENYA	JERUSHA KARITHIRU	JKaruthiru@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
Elizabeth Glaser Pediatric AIDS Foundation	LUCY MATU	LMatu@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
Engender Health - Amkeni Project	SHEILA MACHARIA	SMacharia@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
Family Health International / Impact	EMMA MWAMBURI	EMwamburi@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
Family Health International/Institute of Family Health	BEDAN GICHANGA	Bgichanga@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
HOPE WORLDWIDE	JERUSHA KARITHIRU	JKaruthiru@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
INDIANA UNIVERSITY	JOHN WASONGA	JWasonga@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
Insta Products	RACHEL CINTRON	RCintron@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
Internews Network	EMMA MWAMBURI	EMwamburi@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
JHPIEGO/ACCESS	SHEILA MACHARIA	SMacharia@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
JSI-DELIVER	BEDAN GICHANGA	BGichanga@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
Kenya Medical Supplies Agency	BEDAN GICHANGA	BGichanga@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
MARQUETTE UNIVERSITY	JERUSHA KARITHIRU	JKaruthiru@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
MEASURE EVALUATION	BEDAN GICHANGA	Bgichanga@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
Mission for Essential Drugs & Supplies	JOHN WASONGA	Jwasonga@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
MSH/RPM Plus	BEDAN GICHANGA	BGichanga@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
National Council for Population & Development	BEDAN GICHANGA	Bgichanga@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
National TB Program / JSI	BEDAN GICHANGA	BGichanga@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
ORC Macro	BEDAN GICHANGA	Bgichanga@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
PATH	JERUSHA KARITHIRU	JKaruthiru@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
PLAN INTERNATIONAL	JERUSHA KARITHIRU	JKaruthiru@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
Pathfinder International	JOHN WASONGA	Jwasonga@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov

Peace Corps OVC Scholarships	EMMA MWAMBURI	Emwamburi@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
Policy Project	DAVID ELKINS	DElkins@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
Population Council - Frontiers in RH	BEDAN GICHANGA	Bgichanga@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
Population Council/Horizons	BEDAN GICHANGA	Bgichanga@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
Population Services International	MIKE STRONG	MStrong@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
SALESIAN MISSIONS	CHERYL SONNICHSEN	CSonnichsen@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
SAMARITAN'S PURSE	CHERYL SONNICHSEN	CSonnichsen@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
University of Kwazulu-Natal Mobile Task Team	CHERYL SONNICHSEN	CSonnichsen@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
UNICEF Kenya Country Office	JANET PAZ-CASTILLO	JPaz-Castillo@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
United Nations Office on Drugs and Crime	DAVID ELKINS	DElkins@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov
WORLD VISION KENYA	CHERYL SONNICHSEN	CSonnichsen@usaid.gov	Bgichanga@usaid.gov Womwomo@usaid.gov

DOD Data Submission Points	
All DOD Partners submit to Charles Sigei and Dickens Otieno	ckiptemas@wrp-kch.org dotieno@wrp-kch.org

SI Contacts by Agency

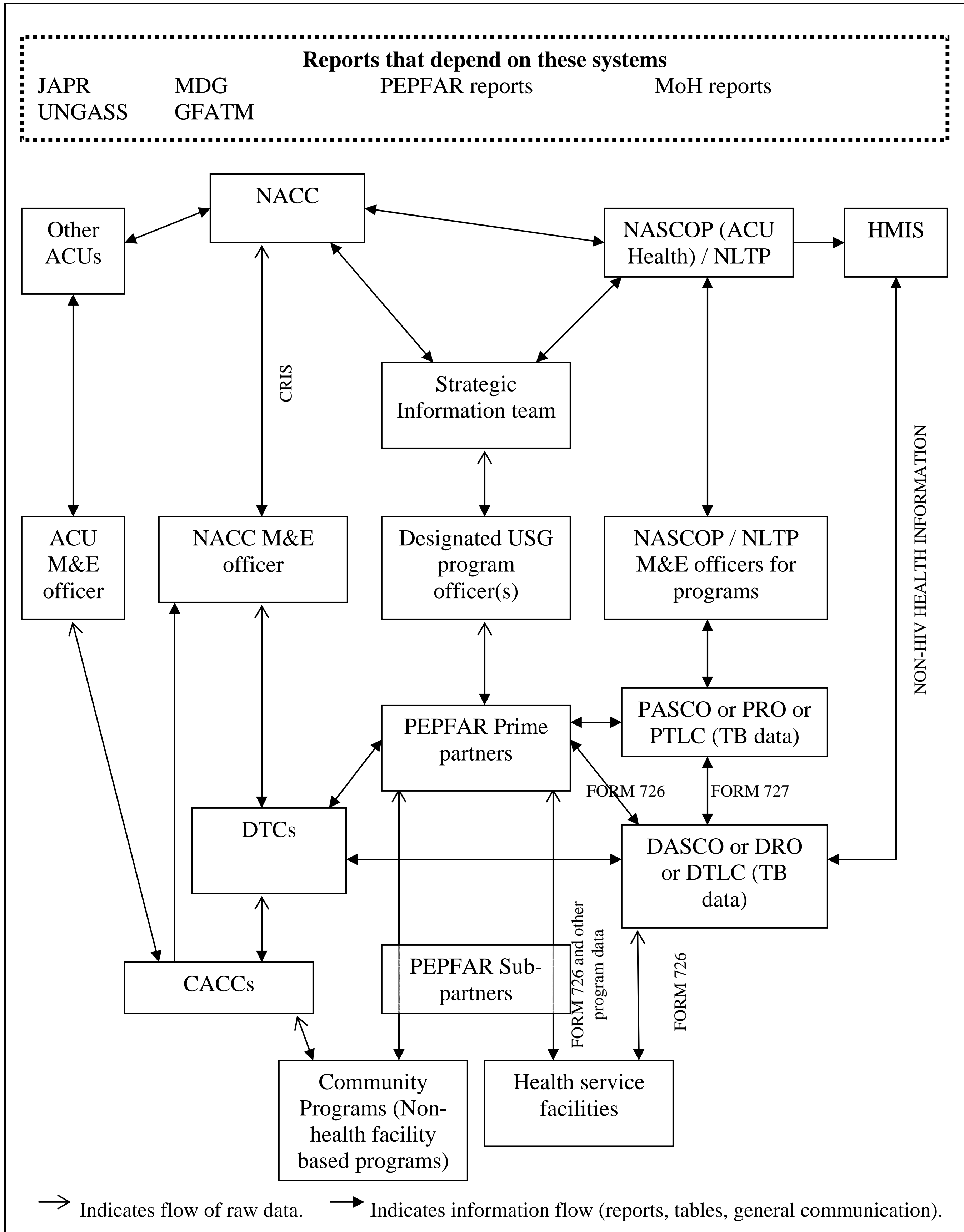
Agency	Name	Email	Phone
CDC	Lawrence Marum	lmarum@ke.cdc.gov	20 271 3008
USAID	Washington Omwomo	womwomo@usaid.gov	20 862 2000
DOD, Walter Reed	Dickens Otieno	dotieno@wrp-kch.org	
	Charles Sigei	ckiptemas@wrp-kch.org	052 32101
Peace Corps	Susan Mugwe	smugwe@ke.peacecorps.gov	20 444 8694
	Antony Okonji	aokonji@ke.peacecorps.gov	20 444 8694
Interagency Advisor, MEASURE Evaluation	Matthew Saaks	Matthew.B.Saaks@orcmacro.com	20 2 71 3008

Important Dates

Date	Reporting Deadlines	Other PEPFAR Dates
2005		
December 31		End of 1st Quarter Reporting Period
2006		
January 1		Start of 2nd Quarter Reporting Period
January 20	Prime Partners' 1st Quarter Collation Sheets DUE to USG Data Submission Points This covers the period October 1, 2005 – December 31, 2005	
February 3	USG Data Submission Points submit Prime Partners' 1st Quarter Collation Sheets to USG SI Team This covers the period October 1, 2005 – December 31, 2005	
March 31		End of Semi-Annual and 2nd Quarter Reporting Period
April 1		Start of FY06 and 3rd Quarter Reporting Period
April 21	Prime Partners' Semi-Annual Collation Sheets DUE to USG Data Submission Points This covers the period October 1, 2005 – March 31, 2006	
April 28	USG Data submission points submit verified and cleaned data to SI Team.	
May 2	SI Team reviews cleaned data and consolidated all data into master file. SI Team assists in preparation of USG agency heads briefing.	
May 5	USG agency heads briefing.	
May 8	Review of results with USG and GOK.	
May 11	USG PEPFAR team submits report to USG agency heads.	
May 15	Kenya PEPFAR Semi-Annual Report DUE to OGAC This covers the period October 1, 2005 – March 31, 2006	
June 30		End of 3rd Quarter Reporting Period
July 1		Start of 4th Quarter Reporting Period
July 21	Prime Partners' 3rd quarter data DUE to USG Data Submission Points. Submission will be by Access data system for the first time. This covers the period April 1, 2006 – June 30, 2006.	

Date	Reporting Deadlines	Other PEPFAR Dates
July 28	USG Data submission points submit verified and cleaned data to SI Team.	
August 3	SI Team ready to share quarterly data with USG PEPFAR leadership.	
September 30		End of 4th Quarter and Annual Reporting Period
October 1		Start of 1st Quarter and 2007 Annual Reporting Period
October 19	Prime Partners' 4th quarter data DUE to USG Data Submission Points. Submission will be by Access data system only. This covers the period July 1, 2006 – September 30, 2006.	
October 27	USG Data submission points submit verified and cleaned data to SI Team.	
October 30	SI Team reviews cleaned data and consolidated all data into master file. SI Team assists in preparation of USG agency heads briefing.	
November 3	USG agency heads briefing.	
November 6	Review of results with USG and GOK.	
November 9	USG PEPFAR team submits report to USG agency heads.	
November 15	Kenya PEPFAR Annual Report DUE to OGAC. Data from the current and previous three quarters will be combined to produce the Annual Report. This covers the period October 1, 2005 – September 30, 2006.	
December 31		End of 1st Quarter Reporting Period

Appendix 1: How PEPFAR Partners should relate to National Information Systems



Acronyms used in the framework above

ACUs	AIDS Control Units within ministries (eg. NASCOP is the ACU for MoH)
CACCs	Constituency AIDS Control Committees
CRIS	Country Response Information System
DASCO	District AIDS Control Officer
DTCs	District Technical Coordinators
DTLC	District Tuberculosis and Leprosy Coordinator
DRO	District Records Officer
GFATM	Global Fight Against AIDS Tuberculoses and Malaria
HMIS	Health Management Information System
JAPR	Joint AIDS Program Review
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MoH	Ministry of Health
NACC	National AIDS Control Council
NASCOP	National AIDS & STD Control Programme
NLTP	National Tuberculosis and Leprosy Programme
PASCO	Provincial AIDS Control Officer
PEPFAR	President's Emergency Plan for AIDS Relief
PRO	Provincial Records Officer
PTLC	Provincial Tuberculosis and Leprosy Coordinator
UNGASS	United Nations General Assembly Special Session on HIV/AIDS

The following paragraphs explain the PEPFAR Kenya information system components and how they should relate to Government of Kenya information systems as depicted in the framework above. All arrows are double pointed to show that the flow of data should move from facilities and community based programs toward the top row in the diagram (Other ACUs, NACC, Strategic Information Team, NASCOP, HMIS) and general communication and reports should flow in both directions.

Health service facilities and community programs

Primary data collection occurs at the health service facility level as well as the community programs level. From this level, health facility data in MoH Form 726 is submitted to PEPFAR sub-partners or prime partners (if there is no sub partner under a prime partner) as well as the DASCO or DRO. From this same level, the non-health facility, i.e. community program data is submitted to PEPFAR partners as well as the CACCs.

PEPFAR Prime partners

PEPFAR Prime partners are those partners with direct agreements with a US Government agency. PEPFAR sub-partners are those partners with agreements with PEPFAR prime partners rather than a direct agreement with a US Government agency. Prime partners are expected to support government of Kenya information systems. A part of that support should be in using the MoH form 726 to fulfill reporting requirements for NASCOP as well as PEPFAR. The MoH form 726 captures nearly all of the PEPFAR information requirements. The collation sheets ensure that any PEPFAR required information not included in MoH form 726 is still captured.

USG and Strategic Information Team
The SI team and the USG agencies communicate with Government of Kenya counterparts to ensure that PEPFAR programs and information collection systems contribute to the Kenya HIV/AIDS national plan. The SI team shares information collected and submitted by implementing partners.

Appendix 2: MINISTRY OF HEALTH INTEGRATED MONITORING AND EVALUATION REPORT FORM MOH 726 NASCOP

Facility ________________Manning Agency(e.g _GOK,Mission,Private)_____________District____________Month________Year_______

N/B: Indicate N/S where there is no service and N/D where there is service but no data

PMCT			ANC	Maternity	Postnatal clinic	Totals
Measure						
A	No. Of Visits	1st Visits				
		Re-Visits				
B	No. of Women	Counseled				
		Tested				
		Received test results				
		HIV+				
C	No. of women counseled and tested at first visit					
D	No. of women issued with preventive ARVs					
E	No. of infant Nevirapine	Issued				
		Administered				
F	No initiated cotrimoxaxole	Women				
		Infants				
G	No. of partners	Counselled				
		Tested				
		Hiv+				
H	HIV+ Referred for follow up	Mothers				
		Infants				
		Partners				
I	No.of mothers counseled on infant feeding options					
J	No. of infants tested for HIV	At 6 wks				
		After 3 Months				

ART:			Children 0-14yrs		Adults >14yrs		Totals		Grand Totals
Measure			M	F	M	F	M	F	
A	No of new patients enrolled within the month for HIV care by entry point	PMCT clients							
		VCT clients							
		TB patients							
		In patients							
		CWC							
		All others							
		Sub-total							
B	Cumulative No. of persons enrolled in HIV care at this facility at end of the month								
C	Number of patients starting ARVs within the month by WHO stage	WHO stage 1							
		WHO stage 2							
		WHO stage 3							
		WHO stage 4							
		Sub-total							
D	Cumulative No. of persons started on ARVs at this facility at end of the month.								
E	Total No. of patients currently on ARVs	Pregnant women							
		All others							
		Sub-total							
F	No. of persons who are enrolled and eligible for ART but have not been started on ART								
G	Post exposure prophylaxis(PEP)	Sexual assault							
		Occupational							
		All others							
		Sub-total							
H	Total No. of patients currently on prophylaxis	Cotrimoxazole							
		Fluconazole							
		Sub-total							

VCT:		<15yrs		15-24 yrs		≥ 25yrs		Total
		M	F	M	F	M	F	
VCT clients	Tested							
	HIV+							
No. of couples	counseled							
	Tested							
	Both HIV+							
	With discordant results							

STD		Type of visit	Males	Females	Total
Measure					
A	Urethral Discharge	Initial visit			
		Re-att			
		Sub-total			
		Referrals			
B	Cases of Genital ulcer disease(GUD)	Initial visit			
		Re-att			
		Sub-total			
		Referrals			
C	Cases of Ophthalmia Neonatorum	Initial visit			
		Re-att			
		Sub-total			
		Referrals			
D	Cases of Syphilis Serology				
	Grand Totals				

DTC:			Children 0-14yrs		Adults. >14yrs		Totals
Measure			Male	Female	Male	Female	
A	No. Counseled	Out patient					
		In patient					
B	No. tested	Out patient					
		In patient					
C	No. HIV+	Out patient					
		In patient					

BLOOD SAFETY:		
Measure		**Number**
A	Blood units collected from Regional Blood Transfusion Centers	
B	Blood units collected from other sources and screened at health facility	
C	Blood units screened at health facility that are HIV+	
D	Blood Units transfused	

General Remarks:____

____

____

____

____

Report compiled by…………………………..……………Design…………………………….Date…………..…..…..………Sign…..………………
N/B This form should be completed and send to the DMOH to reach by 5th of the following Month. e.g Report of January 2006 should reach the DMOH by 5th of February, 2006 etc. (ATT: DASCO)