REPUBLIC OF KENYA

HEALTH SECTOR

2ND EDITION INDICATORS

And

Standard Operating Procedure Manual

HEALTH INFORMATION SYSTEM

September, 2012

CONTENTS

PREFACE

The second edition indicator manual and standard operating procedures is an elaborate document guide to the Health sector Monitoring Framework. The document outlines the Minimum data sets that will be used by the Health sector for the next implementing and reporting period for the Medium term plans for the Kenya Health Policy Framework 2012 – 2030 and Kenya Health Sector Strategic Plans.

These key indicators for programme or Health system monitoring are defined using the application form and criteria developed by the indicators secretariat. Each indicator elaborates the Goal, important definitions, the purpose of the indicator, how the indicator should be calculated, the important tools to be used as well as data management guidelines. Specific areas of applicability are also highlighted.

The standard operating procedures are put in the annexes. It is envisaged that this manual will be used by all healthcare workers across the country to have uniformity of purpose and reporting. Each level is expected to use the data generated for evidence based care and therefore it is important that all service providers, development partners, implementing partners in Kenya's health sector as well as managers get acquitted with this vital tool and use it appropriately in planning, monitoring and evaluation of health services. The practice, main Guiding principles or criteria for selecting or review of the Health sector indicators and tools therefore will be to;

- Avoid overburdening or proliferation of tools to service providers.
- Restriction to basic minimum data sets and indicators that are action oriented or high impact interventions.
- Balance between the 4 levels of KEPH delivery and the Kenya policy Framework strategies/ orientations.
- Balance between impact, outcome, output, input and process indicators.
- Any additional indicator to the list must be vetted by the National Health Information System Coordinating committee (NHISCC) or selected formal Technical Work Group and should be monitored for a while to support evaluation of the process, inputs, outputs, outcome and impact.
- The indicator should be monitored for at least a period of 3 years consistently before review to allow for trend analysis and proper interpretations.

Capacity of health staff both in numbers and skills is critical and we should ensure that alongside this document, build in-house capacities more so in mid-level managers/workers for sustainability and retention. This indicator manual forms the basis of standard operations at all levels of health care with minimum data sets, indicators and procedures. As a sector a properly functional health information system is critically required to support service delivery and report the performance. All are encouraged to read carefully this indicator and standard operating procedure manual to guide you in ensuring that your practice are in line with the HIS sector approaches. Your suggestions and improvement towards this manual in future is highly appreciated.

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REPRODUCTIVE HEALTH

INDICATOR NAME	Proportion of women who attended at least one ANC visit during the last completed pregnancy
HIS CODE:	**HIS001**

PROGRAMME GOAL	Reduction of both maternal and child morbidity and mortality

REFERENCES	WHO	MDG
CODES	#81	5.5

DEFINITION OF IMPORTANT TERMS	**Attended at least one ANC**: The percentage of women aged 15-49 with a live birth in a given time period that received antenatal care provided by skilled health personnel (doctors, nurses, or midwives) at least once during pregnancy.According to WHO guidelines, antenatal care visits should include, at a minimum, the measurement of blood pressure, testing of urine for bacteraemia and proteinuria, and blood tests to detect syphilis and severe anaemia. **Skilled Health Personnel**: A skilled health worker/attendant is an accredited health professional - such as a midwife, doctor, Clinical officer or nurse - who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and new-borns. Both trained and untrained traditional birth attendants (TBA) are excluded.
NUMERATOR	Number of pregnant women aged 15-49 years who had at least one prenatal visit attended by trained health personnel during their last completed pregnancies
DENOMINATOR	Total number of expected deliveries
UNIT OF MEASURE	Percent
DISAGGREGATION	Number of visits (1 or 4), Age, educational level, urban , rural, district, constituency, county, regional and national levels
INDICATOR LEVEL	Output
PURPOSE	Maternal and neonatal mortality in Kenya are unacceptably high. Antenatal care coverage is an indicator of access and use of health care during pregnancy (Health service coverage). The antenatal period presents opportunities for reaching pregnant women with interventions that may be vital to their health and wellbeing and that of their infants. WHO recommends at least four visits.
FREQUENCY	**COLLECTION**: Data is recorded on daily basis as part of service provision and summarised at the end of the reporting period. **REPORTING**: Reports are compiled monthly (on MOH 711) and submitted for entry at district level. Once entered into the DHIS, data are available throughout the hierarchy. **UTILISATION**: Data are utilised routinely at facility level, quarterly at county level or higher
DATA SOURCE	**NUMERATOR:** ANC Register MOH 405 and reported on summary form MOH 711 **DENOMINATOR**: Demographic estimation
DATA	**CALCULATION** = (Number of women aged 15-49 attended at least once during

MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	pregnancy by skilled health personnel for reasons related to the pregnancy)/ (Total expected number of deliveries) X 100 NOTE: Service/facility reporting system can be used where the coverage is high, usually in middle and industrialized countries. At the global level, data from facility reporting are not used.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR:	Proportion of pregnant women attending 4 ANC visits according to FANC
HIS CODE:	HIS002
PROGRAMME GOAL	Reduction of both maternal and child morbidity and mortality

REFEREES	AOP	WHO					
Codes	#4						

DEFINITION OF IMPORTANT TERMS:	4 ANC visits: - The proportion of pregnant women attending 4 comprehensive personalized visits: 1st visit: >16weeks 2nd visit: 16 – 28 weeks 3rd visit: 28-32 weeks 4th visit: 32 – 40 weeks FANC: Objective is for early detection and treatment of problems, prevention of complications using safe, simple and cost effective interventions, birth preparedness and complications readiness, provision of care by a skilled attendant.
NUMERATOR	Number of women (from same period) who made 4 visits during antenatal care
DENOMINATOR	Number of pregnant women attended 1st ANC visits during the period Estimated number of deliveries in the catchment area or estimated number of pregnant women
REPORTABLE DATA ELEMENTS	
DISAGGREGATION	By age, urban/rural, district, county, regional and national levels
PURPOSE	The World Health Organization (WHO) recommends a minimum of four antenatal visits. Safe motherhood aims at assisting every woman to go through pregnancy and childbirth in order to achieve the desired outcome of a live and health baby and mother. Core safe motherhood interventions include provision of antenatal care. However, less than half of all pregnant women in developing countries benefit from the minimum recommended four antenatal visits.. This

	indicator measures the utilization and coverage ANC coverage for safe motherhood. To detect any abnormalities for the mother and child
FREQUENCY	Monthly,
DATA SOURCE	*Numerator*: ANC register MOH 405 *Denominator*: KNBS or KDHS population estimates, MOH 405
DATA MANAGEMENT GUIDELINES	Frontline service provider summarizes the monthly service statistics and fills summary form for ANC; the HRIO or site/program in-charge completes the MOH 711 form and submits to the DHRIO who aggregates the district level statistics and uploads summary to web-based database which is accessed at central level by HIS and NASCOP for quarterly program reviews
INTERPRETATION	This indicator provides insight on access and uptake of the package of ANC services by pregnant women. However, it does not provide insight on how comprehensive the delivery of ANC services nor the effectiveness of the advice given. Between the 2003 DHS and 2008 DHS, there is a significant change in that women seem to prefer doing 2-3 visits than 4+ visits, the proportion for those doing 4+ visits has reduced by almost the same margin (around 8%) as the increase in proportion of is observed in those doing 2-3 visits. Rather than collecting this data routinely one can use the DHS results to institute interventions.

INDICATOR NAME	Proportion of women in Reproductive Age (15 -49 years) who have received two (2) doses of Tetanus Toxoid
HIS CODE:	**HIS003**

PROGRAMME GOAL	To prevent neonatal morbidity and mortality arising from tetanus

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	Tetanus Toxoid: Is a vaccine given to women of child-bearing age either during pregnancy or outside pregnancy. This protects the baby against tetanus - through a transfer of tetanus antibodies to the fetus. A pregnancy is considered protected if a woman has received at least two doses of tetanus Toxoid before delivery.
NUMERATOR	Number of pregnant who have received at least 2 doses of tetanus vaccines
DENOMINATOR	Number of estimated live births
UNIT OF MEASURE	Percent
DISAGGREGATION	Age, Parity, urban , rural, district, constituency, county, regional and national levels)
INDICATOR LEVEL	Output
PURPOSE	People of all ages can get tetanus but the disease is particularly common and serious in new-born babies "neonatal tetanus"). Neonatal tetanus, which is mostly fatal, is particularly common in rural areas where deliveries are at home without adequate sterile procedures. Tetanus can be prevented through immunization with tetanus-Toxoid (TT) -containing vaccines.

FREQUENCY	**COLLECTION:** Data are collected as an integral part service provision. Previous doses are transferred from previous records to update the MC booklet and the ANC Register. Data from the register are then summarised at the end of the reporting period. **REPORTING:** Reports are compiled monthly (on MOH 711) and submitted for entry at district level. Once entered into the DHIS, data are available throughout the hierarchy. **UTILISATION:** Data are utilised routinely at facility level, quarterly at county level or higher
DATA SOURCE	**NUMERATOR:** ANC register MOH405 and reported on MOH 711 **DENOMINATOR:** Demographic estimation/ Maternity Register MOH 333 and reported on MOH 711
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = (Number of WRA who have received at least 2 doses of tetanus) /(Number of estimated of live births) X 100 Note: To be protected throughout life, an individual should receive 3 doses of DTP in infancy, then TT-containing booster at school-entry age (4-7 years), in adolescence (12-15 years), and in early adulthood. Due to unreliable records, this history is usually ignored a first pregnancy and TT dose count is initialised to 1. A woman with a first pregnancy will be given 2 doses during that pregnancy (according to schedule) and the 3rd dose is only given during the next pregnancy. Data is generated from the TT service register and TT immunisation tally sheet

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Proportion of women provided with IPT2 during the ANC visits
HIS CODE:	**HIS004**

PROGRAMME GOAL	To reduce morbidity and mortality due to malaria in pregnancy

REFERENCES	AOP	MDG
CODES	#1	

DEFINITION OF IMPORTANT TERMS	**Intermittent Presumptive Treatment (IPT)**: IPTof malaria during pregnancy is based on the assumption that every pregnant woman living in areas of high malaria transmission has malaria parasites in her blood or placenta, whether or not she has symptoms of malaria. Every woman therefore is provided with antimalarial to reduce malaria episodes among pregnant women attending ANC services. WHO recommends that at least 2 doses of *Sulfadoxine-pyrimethamine* (SP) are given during regularly scheduled antenatal visits after the first trimester **Regularly-scheduled antenatal visits**: These visits that form part of the schedule for providing focussed antenatal care.
NUMERATOR	Number of women attending ANC visits provided with two doses of IPT in a given period
DENOMINATOR	Number women attending 1st ANC visit during the period

UNIT OF MEASURE	Percent					
DISAGGREGATION	By Age, educational level, urban , rural, district, constituency, county, regional and national levels					
INDICATOR LEVEL	Output					
PURPOSE	Pregnant women are one of the most vulnerable groups to malaria. In the malaria endemic areas of the African region, each year around 25 million of pregnant women are at risk of Plasmodium falciparum infection during their pregnancy. (WHO/AFR/MAL/04/01). Three risk categories of malaria in pregnancy can be summarized as - Non-immune pregnant women are at risk as malaria causes high rates of miscarriage (up to 60% in P. falciparum infection) and maternal death rates of 10–50%. - Semi-immune pregnant women in areas of high transmission. Malaria can result in miscarriage and low birth weight, especially during the first and second pregnancies. An estimated 200 000 infants die annually as a result of malaria infection during pregnancy. - Semi-immune HIV-infected pregnant women in stable transmission areas are at increased risk of malaria during all pregnancies. Women with malaria infection of the placenta also have a higher risk of passing HIV infection to their WHO recommends a package of interventions for the prevention and control of malaria during pregnancy. This comprises Intermittent Preventive Treatment (IPT) to address the heavy burden of asymptomatic infections among pregnant women in areas of moderate or high transmission of P. falciparum, use of insecticide treated nets ITNs), and access to effective case management for malaria illness and anaemia. Presently, sulfadoxine- pyrimethamine (SP) is the only antimalarial medicine for which data on efficacy safety for IPT is available from controlled clinical trials.					
FREQUENCY	COLLECTION: Data are recorded onto the register upon provision of the service (cumulated dosage of up to 2 doses). From the register data are then summarised at the end of the reporting period. REPORTING: Reports are compiled monthly (on MOH 711) and submitted for entry at district level. Once entered into the DHIS, data are available throughout the hierarchy. UTILISATION: Data are utilised routinely at facility level, quarterly at district and county level or higher					
DATA SOURCE	NUMERATOR: ANC Register MOH 405 and reported on form MOH 711 DENOMINATOR: ANC Register MOH 405 and reported on form MOH 711					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION: (Number of women attending ANC visits provided with two doses of IPT in a given period)/Number women attending 1st ANC visit during the period X 100 DATA MANAGEMENT: "Two doses" includes only those women who made an antenatal visit during the reporting period, to whom the second dose of SP was issued. It is not recommended to analyse data for this indicator on short time intervals (e.g. a month) due to potential mismatch between the numerator and denominator. The recommended interval is a 3 months or longer. An increase, over time, in the proportion of pregnancies receiving two doses of IPT during pregnancy, signals good practice by health workers and potential reduction in cases and consequences of malaria as outlined in the "Purpose" above.					
INDICATOR	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY

APPLICATION LEVEL		✓	✓	✓	✓	

INDICATOR NAME	Proportion of deliveries conducted by skilled health personnel
HIS CODE:	**HIS005**

PROGRAMME GOAL	Reduction of both maternal and child morbidity and mortality

REFERENCES	AOP	WHO	MDG5
CODES	#3	#25	#17

DEFINITION OF IMPORTANT TERMS	**Skilled Health Personnel**: A skilled health worker/attendant is an accredited health professional - such as a midwife, doctor, Clinical officer or nurse - who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and new-borns. **Note:** Both trained and untrained traditional birth attendants (TBA) are excluded.
NUMERATOR	Number of births attended by skilled health personnel
DENOMINATOR	Number of live births in the same period.
UNIT OF MEASURE	Percent
DISAGGREGATION	By place of delivery; type of skilled health personnel; urban/rural, age, health facility, district, region/ county and national levels
INDICATOR LEVEL	Output
PURPOSE	All women should have access to skilled care during pregnancy and childbirth to ensure prevention, detection and management of complications. Assistance by properly trained health personnel with adequate equipment is cardinal in lowering maternal deaths. This indicator measures coverage, access and use of safe motherhood programmes. It is also used to measure the health system's functioning and potential to provide adequate coverage for deliveries at national and sub-national levels. It is highly correlated with maternal and infant mortality levels. Since it is difficult to accurately measure maternal mortality, and model-based estimates of the maternal mortality ratio cannot be used for monitoring short-term trends, the proportion of births attended by skilled health personnel is used as a proxy indicator for this purpose
FREQUENCY	**COLLECTION:** Data are collected as part of service provision at the facility level and recorded on the maternity register (MOH 333) or through retrospective household hold surveys. These data are then summarised at the end of the month onto form MOH 711 for submission. **REPORTING:** Each facility will report both indicator components (numerator and denominator) at the end of each month using MOH 711. The data will be entered into the DHIS software at district level. Thereafter, the data will be available to all levels of administration. **UTILISATION:** Monthly at service delivery units, quarterly and annually at high levels. Adhoc data analysis is however encouraged at every level.
DATA SOURCE	**NUMERATOR:** Maternity register MOH 333 or household surveys questionnaire **DENOMINATOR:** Household survey data; birth registration data if considered complete; census (crude birth rate multiplied by total population), population estimates by KNBS
DATA	**CALCULATION** = (Number of births attended by skilled health personnel)/

MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	(Number of live births in the same period) X 100. DATA MANAGEMENT: In household surveys, such as the Demographic and Health Surveys, the Multiple Indicator Cluster Surveys, and the Reproductive Health Surveys, the respondent is asked about each live birth and who had helped them during delivery for a period up to five years before the interview. Service/facility records could be used where a high proportion of births occur in health facilities and therefore they are recorded.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Still Birth Rate (per 1000 total births)
HIS CODE:	**HIS006**

PROGRAMME GOAL	Improved ante-partum and intra-partum care

REFERENCES	AOP	WHO
CODES	#1	# 2444

DEFINITION OF IMPORTANT TERMS	**Still Births**: Is defined as third trimester foetal deaths (› or = 1000 grams or › or = 28 weeks). **Live birth**: The complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. (ICD-10) Total Births: Is the sum of live births and still births
NUMERATOR	Depending on the data source, the indicators constituent may vary: **Data from civil registration**: the number of still births divided by the number of total births.
DENOMINATOR	**Data from surveys:** the number of pregnancy losses during or after the seventh month of pregnancy for the 5 years preceding the interview, divided by the sum of live births and late pregnancy losses in the same time period. **Data from administrative reporting systems/registries**: the number of still births divided by the number of total births. **Data from health facilities**: the number of stillbirths divided by the number of total births documented in the facility.
UNIT OF MEASURE	Rate
DISAGGREGATION	Still Born type (Fresh or Macerated); Level (District, County, National level)
INDICATOR LEVEL	Output
PURPOSE	Stillbirths can occur antepartum or intrapartum. In many cases, still births reflect inadequacies in antenatal care coverage or good quality intrapartum care. The Kenya's health sector is concerned with the fresh still births. The aim therefore is to improve the nurseries and newborn units so as to minimize the

	fresh still births in health facilities.
FREQUENCY	**COLLECTION:** In routine (facility) data collection, data are collected as part of service delivery, summarised/aggregated and reported for data entry at the end of the month. **REPORTING:** Once data have been entered into the DHIS, these data are available to all the levels for use **UTILISATION:** Data are used as part of care provision and monthly for health unit management; quarterly or annually for health system management. Dissemination is recommended to take place in 3-5 years.
DATA SOURCE	**NUMERATOR:** Register MOH 333 **DENOMINATOR**: Register MOH 333
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** (Routine only) = (Number of still births divided)/ (Number of total births) X 1000. NOTE: According to the KDHS of 2008, 92 percent of women reported having received antennal care from qualified personal in a health institution. This is in contrast to 43 percent of births delivered in a health in facility, while 56 percent of births take place at home. From this information, the rate of still births as reported through routine facility-based data is gross representation of what may be taking place (and unreported) in 56 percent of the deliveries. However, data from service statistics are still useful in providing pointers in the quality of care in deliveries/pregnancies attended to in health facilities.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Caesarean Section Rate (per 1000 total births)
HIS CODE:	**HIS007**
PROGRAMME GOAL	To ensure that Caesarean section threshold is maintained

REFERENCES	AOP	WHO
CODES	#1	#68

DEFINITION OF IMPORTANT TERMS	**Caesarean Section**: Is surgical procedure performed for a sole purpose of delivery a product of conception in preference for a vaginal delivery. The method is chosen because that is the safest method to either the mother or the baby or both. There are also instances where the method is preferred for non-medical reasons. **Still Births**: Is defined as third trimester foetal deaths (› or = 1000 grams or › or = 28 weeks). **Live birth**: The complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. (ICD-10) **Total Births:** Is the sum of live births and still births

	Household surveys: birth history—detailed questions on the last-born child or all children a woman has given birth to during a given period preceding the survey (usually 3 to 5 years), including characteristics of the birth(s). The number of live births to women surveyed provides the denominator. **Service or facility records**: the number of women having given birth by caesarean section (numerator). Census projections or, in some cases, vital registration data can be used to provide the denominator (numbers of live births).
NUMERATOR	Number of caesarean sections done
DENOMINATOR	Total number of births
UNIT OF MEASURE	Rate
DISAGGREGATION	Type (elective or emergency); Level of Care, district, county and national levels
INDICATOR LEVEL	Outcome
PURPOSE	The percentage of births by caesarean section is an indicator of access to and use of health care during childbirth.
FREQUENCY	**COLLECTION**: Collected monthly upon the occurrence of an event. **REPORTING:** Monthly from facility and entered monthly into the DHIS at district level. **UTILISATION:** It is recommended that the indicator is reviewed monthly because at times the changes reflect the practice of health care providers and not necessarily the need to Caesarean section
DATA SOURCE	Preferred data source is "Facility reporting system" – Register MOH 333 for both numerator and denominator
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** (from Service or facility records) = (Number of women having given birth by caesarean section) / (numbers of births). NOTE: This indicator does not provide information on the reason for undergoing caesarean section, and includes caesarean sections that were performed without a clinical indication as well as those that were medically indicated. The extent to which caesarean sections are performed according to clinical needs, therefore, is not possible to determine.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Proportion of clients receiving post natal care after delivery
HIS CODE:	**HIS008**

PROGRAMME GOAL	Reduction of both maternal and child morbidity and mortality

REFERENCES CODES	WHO	MDG

DEFINITION OF IMPORTANT TERMS	**Postnatal:** This is the first six weeks after birth – which is critical to the health and survival of a mother and her newborn. The most vulnerable time for both is during the first few hours and days after birth. Lack of care in this time period may result in death or disability as well as missed opportunities to promote healthy behaviour, affecting women, newborns, and children.
NUMERATOR	Number of clients receiving postnatal care (PNC) after delivery
DENOMINATOR	Number of deliveries during the reporting period
UNIT OF MEASURE	Percent
DISAGGREGATION	By timing of the visit: 48 hours, 2 weeks, 2 months and 6 months, urban/rural, age, health facility, district, region/ county and national levels By HIV status
INDICATOR LEVEL	Outcome
PURPOSE	According to WHO, half of all postnatal maternal deaths occur during the first week after delivery, and the majority of these occur during the first 24 hours post-delivery. Each year, in sub-Sahara Africa, at least 1.16 million infants die in the first 28 days of life – and 850,000 of these babies do not live past the first one week of their life. Yet postnatal care (PNC) programmes are among the weakest of all reproductive and child health programmes in the region. The Kenya DHS of 2008 shows that 53 percent of women do not receive postnatal care. This indicator is meant to routinely monitor the demand and delivery of postnatal services.
FREQUENCY	**COLLECTION:** Recording of data is done as services are provided. Collation is done monthly. **REPORTING:** Reports are prepared monthly at facility level, submitted within the reporting month to the district for entry into the DHIS. **UTILISATION**: It is recommended that the indicator is analysed monthly, especially in rural areas were seasonal or cultural factors may influence this indicator.
DATA SOURCE	NUMERATOR: Post Natal Clinic register, MOH 406 DENOMINATOR: Maternity register MOH 333, expected deliveries ,KNBS
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Number of clients receiving PNC after delivery) / (Number of deliveries during the reporting period) X 100 NOTE: This indicator provides insight on access and uptake of the postpartum care by newly delivered mothers. However, it does not provide insight on how comprehensive the provision of PNC services

INDICATOR	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY

APPLICATION LEVEL		✓	✓	✓	✓	

INDICATOR NAME	Maternal Mortality Ratio (MMR)
HIS CODE:	**HIS009**
PROGRAMME GOAL	To reduce both maternal and child morbidity and mortality

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Maternal Death:** According to WHO "Maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (ICD 10)
NUMERATOR	Number of maternal deaths
DENOMINATOR	Number of "live births"
UNIT OF MEASURE	Ratio
DISAGGREGATION	Level (Health facility, district, county, regional and national levels)
INDICATOR LEVEL	Impact
PURPOSE	Complications during pregnancy and childbirth are a leading cause of death and disability among women of reproductive age in developing countries. The maternal mortality ratio represents the risk associated with each pregnancy - the obstetric risk. The indicator monitors deaths related to pregnancy and childbirth. It reflects the capacity of the health systems to provide effective health care in preventing and addressing the complications occurring during pregnancy and childbirth.
FREQUENCY	**COLLECTION**: Monthly, Annually **REPORTING:** Annually **UTILISATION:** Annually
DATA SOURCE	**Preferred source**: Vital registration with complete coverage and medical certification of cause of death **Other sources:** Household surveys, population census, Sample or sentinel registration systems **NOTE:** Data from facility sources should be reported and analysed as absolute numbers. See Maternal Deaths Audited. Partial data can be obtained from the maternity register for levels 2-6 or ratio to population.
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Number of maternal deaths) / (Number of "live births") X 100,000 To facilitate the identification of maternal deaths in circumstances in which cause of death attribution is inadequate, ICD 10 has introduced a new category. It is called "pregnancy-related death" and defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death. This reduces the chances of over reporting on maternal deaths.

INDICATOR	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY

APPLICATION LEVEL	✓	✓	✓	✓	✓	

INDICATOR NAME	Proportion of Maternal Deaths Audited
HIS CODE:	**HIS010**

PROGRAMME GOAL	Reduction of both maternal and child morbidity and mortality. To establish the main causes of deaths and if there are any delays caused

REFERENCES	AOP	WHO	MDG
CODES	#10		

DEFINITION OF IMPORTANT TERMS	**Maternal Death Audit**: A maternal death audit is an in-depth systematic review of maternal deaths to delineate their underlying health social and other contributory factors; the lessons learned from such an audit are used in making recommendations to prevent similar future deaths.
NUMERATOR	Number of maternal deaths Audited (reviewed) in Health facilities
DENOMINATOR	Total number of maternal deaths reported
UNIT OF MEASURE	Percent
DISAGGREGATION	Age groups; Level(health facility, district, county, regional and national levels)
INDICATOR LEVEL	Output
PURPOSE	In most countries such as Kenya with high maternal mortality (488), health facility records are usually deficient. The causes of some maternal deaths in obstetric registers are ill-defined, which makes it difficult to compile the causes of maternal deaths. Maternal deaths audit exists to identify and learn lessons from the remediable factors that might save the lives of more mothers in future. Although this audit process empowers local authorities to understand and take steps to improve maternal health, most of the countries with high maternal mortality have not fully instituted it. It is imperative to establish or strengthen maternal death audits in these settings, both to generate evidence for determining interventions and to provide the data needed to feed into the national civil registration system for the computing of Maternal Mortality Ratio (MMR).
FREQUENCY	**COLLECTION:** Monthly, Quarterly **REPORTING:** Quarterly **UTILISATION:** Although reviews are recommended be conducted quarterly, information arising from these reviews should be used daily to inform delivery of care and reduce the occurrence of maternal deaths.
DATA SOURCE	**NUMERATOR:** Rapid surveys and support supervision at levels 2-6. Maternal review form, Review register/folder. **DENOMINATOR:** Register MOH 333 register for level 2-6 and MOH 268 diseases index card or death register.
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Number of maternal death records reviewed in a health facilities) / (Total number of maternal deaths reported) X 100 Data are collected through continuous audit reviews using specific checklists which are completed or administered by the DHMTs during their supervision. NOTE: Focusing on higher level facilities may over-estimate of maternal deaths.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Proportion of Women (15-49) with Unmet Need for Family Planning
HIS CODE:	**HIS011**

PROGRAMME GOAL	To increase access to modern methods of family planning so as to reduce the unmet need for FP in the population

REFERENCES	AOP	MDG
CODES	#1	

DEFINITION OF IMPORTANT TERMS	**Unmet Need for Family Planning:** This includes the following categories of women: • All pregnant women (married or in consensual union) whose pregnancies were unwanted or mistimed at the time of conception. • All postpartum amenorrhic women (married or in consensual union) who are not using family planning and whose last birth was unwanted or mistimed. • All fecund women (married or in consensual union) who are neither pregnant nor postpartum amenorrhic, and who either do not want any more children • All women who wish to postpone the birth of a child for at least two years or do not know when or if they want another child (spacing), but are not using any contraceptive method.
NUMERATOR	Number of new FP acceptors during the reporting period
DENOMINATOR	Number of new FP acceptors targeted during the reporting period
UNIT OF MEASURE	Percent
DISAGGREGATION	Type of family planning method: Pills (OC), Condom, Injectables (INJ), IUCD, (tubaligation) TL
INDICATOR LEVEL	Outcome
PURPOSE	Despite 98% of men and women being aware of at least one modern method, the level of unmet need for family planning information and services among couples and sexually active unmarried individuals remains high. This indicator is useful for measuring the utilization of the FP services and coverage of contraceptive services.
FREQUENCY	**COLLECTION:** The numerator is collected as an integral component of FP service delivery. The denominator is estimate/adjusted once (usually at the beginning of the year) **REPORTING:** Data are reported every monthly to the district for entry. **UTILISATION:** Once data are entered, they are available on-demand at all levels of care for both ad hoc and routine utilisation.
DATA SOURCE	NUMERATOR: From Family planning register MOH 512 DENOMINATOR: Population Estimates
DATA MANAGEMENT AND INDICATOR	**CALCULATION** = (Number of new FP acceptors) / (Number of new FP acceptors targeted for the period) X 100

COMPUTATION GUIDELINES	NOTE: Kenya plans to increase the Contraceptive Prevalence Rate (CPR, proportion of married women using any method) from 46% to 56% by 2015.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Proportion of women targeted for family planning currently using a method
HIS CODE:	**HIS012**

PROGRAMME GOAL	To increase access to modern methods of family planning and reduce the unmet need for family planning

REFERENCES	AOP	WHO
CODES	#1	

DEFINITION OF IMPORTANT TERMS	**Currently Using a Method**: Is an estimated number of women (15-49), obtained by adding the product of the CPR with the number of new acceptors, expressed as a percentage of the total number women (15-49) expected to be using a family planning method.
NUMERATOR	Number of women currently using a method family planning method
DENOMINATOR	Number of women targeted for modern family planning methods
UNIT OF MEASURE	Percent
DISAGGREGATION	By type of family planning services: Type of contraceptive method By age of clients: e.g. <25 and 25+, district, county, region and nation
INDICATOR LEVEL	Outcome
PURPOSE	Despite 98% of men and women being aware of at least one modern method, the level of unmet need for family planning information and services among couples and sexually active unmarried individuals remains high. This indicator is useful for measuring the utilization of the FP services and coverage of contraceptive services.
FREQUENCY	**COLLECTION:** The numerator is collected upon provision of a FP service. The denominator is estimate/adjusted once (usually at the beginning of the year) **REPORTING:** Data are reported every monthly to the district for entry. **UTILISATION:** Once data are entered, they are available on-demand at all levels of care for both ad hoc and routine utilisation.
DATA SOURCE	NUMERATOR: From Family planning register MOH 512 to summary form MOH 711 monthly reporting tool DENOMINATOR: Population Projections or estimates from KNBS
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION =(Number of women currently using a method family planning method) / (Number of women targeted for modern family planning methods) X 100 Where "currently" = (CPR X Women of child-bearing age) + (New Acceptors) at the end of the year. "Targeted" = ("Currently" on a method) X 1.02. Two percent is the targeted annual rate increment by the programme NOTE: The targets are computed at the beginning each year and distributed to

	each level of jurisdiction. The user should not recompute the target every time the indicator is used.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Proportion of new family planning acceptors who are tested for HIV
HIS CODE:	**HIS013**
PROGRAMME GOAL	Prevent the transmission of HIV from mother to child and between couples

REFERENCES	WHO	KNASP
CODES		2.2.4

DEFINITION OF IMPORTANT TERMS	**New Family Planning Acceptor**: Is an acceptor of a modern family planning method, with not prior history of having used a modern contraceptive as method of family planning. Women changing methods or restarting a method should be excluded from this definition.
NUMERATOR	New FP acceptors tested for HIV in the reporting period
DENOMINATOR	All new FP acceptors in the reporting period
UNIT OF MEASURE	Percentage
DISAGGREGATION	District, county, region and nation level
INDICATOR LEVEL	Output
PURPOSE	Reducing HIV transmission among persons of reproductive age begins with HIV counselling and testing followed by antiretroviral therapy or prophylaxis for eligible mothers, safe obstetric interventions and safer infant feeding options. This indicator measures utilization and coverage of HIV testing and counselling services in the PNC and FP settings and for continued monitoring to identify gaps and inform future scale up.
FREQUENCY	**COLLECTION**: The numerator is collected in an FP setting upon provision of the HIV test. The denominator is summarised from MOH 512 at the end of the reporting period. **REPORTING**: Data are reported every month to the district for entry. **UTILISATION**: Once data are entered, they are available on-demand at all levels of care for both Adhoc and routine utilisation.
DATA SOURCE	**NUMERATOR:** HTC Register/Edited version of the existing MOH 405 **DENOMINATOR: R**egister MOH 405
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (New FP acceptors tested for HIV in the reporting period)/ (All new FP acceptors in the reporting period) X 100. **NOTE:** The HCT Register is placed in ANC, L&D and PNC. See indicator number HIV02-01 under NASCOP. Testing data in family planning are captured as part of the general HTC indicator number HIV01-01.For HCT done in family planning clinics, the FP Register's column BB should be modified to cater for those with known HIV+ status on entry, i.e. Tested (Yes/No/Known HIV+). However, it there may just be a need to harmonise the two registers so that only one data source (in FP) is maintained

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Percentage of total 1st ANC attendance that are a result of adolescent pregnancies
HIS CODE:	**HIS014**

PROGRAMME GOAL	To reduce the prevalence of unwanted pregnancy

REFERENCES	WHO	DHS08/9	MDG
CODES		4.10	

DEFINITION OF IMPORTANT TERMS	**Adolescent Pregnancy**: Is any pregnancy occurring to a woman aged from 10 to 19, taking gravida into consideration.
NUMERATOR	Number of adolescent females presenting with a pregnancy for antenatal services
DENOMINATOR	Total number of 1st ANC attendees in a given period
UNIT OF MEASURE	Percentage
DISAGGREGATION	Gravida: 1, 2+, age
INDICATOR LEVEL	Outcome
PURPOSE	In Kenya fertility levels have remained high among adolescents despite notable declines among older age groups. Sexual activity begins early among Kenyan youth and is often unprotected giving rise to unintended pregnancies. Adolescents are more likely to suffer pregnancy and birth related complications for various reasons. The expected outcome of youth friendly services is whether adolescent pregnancy and HIV transmission have been prevented. In DHS 2003, 18.5% of women 15-19 years had given birth, while in DHS 2008/9 it was 14.5%. Although there is a reduction the rates are still high. The proportion of teenagers who have begun childbearing increases dramatically from 2 percent at age 15 to 36 per cent at age 19. The levels of teenage childbearing are highest in Nyanza (27 percent) and Coast (26 percent) provinces and lowest in Central province (10%)
FREQUENCY	**COLLECTION:** Data is recorded on daily basis as part of service provision and summarised at the end of the reporting period. **REPORTING:** Reports are compiled monthly (MOH 711) and submitted for entry at district level. Once entered into the DHIS, data are available throughout the hierarchy. **UTILISATION:** Data are utilised routinely at facility level, quarterly at county level or higher
DATA SOURCE	**NUMERATOR:** ANC register MOH 405 **DENOMINATOR**: ANC register MOH 405
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Number of adolescent females presenting with a pregnancy for antenatal services) / (Total number of 1st ANC attendees in a given period) X 100 **NOTE:** This indicator provides insight on the potential demand for the YFS or ANC care by pregnant adolescents. It does not however, do so on the quality and comprehensive of ANC services provided during these interactions. In terms of

	coverage, this indicator may under represent the problem as it only focuses on those adolescents who visit the ANC.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Proportion of Health facilities providing Basic Emergency Obstetric care (BEOC)
HIS CODE:	**HIS015**

PROGRAMME GOAL	Reduction of both maternal and child morbidity and mortality

REFERENCES	WHO	AOP	MDG
CODES		#8	

DEFINITION OF IMPORTANT TERMS	**Basic Emergency Obstetric care (BEOC):** includes the following components: i) administration of parenteral antibiotics, ii) oxytocic and iii) anticonvulsants; iv) manual removal of the placenta; v) removal of retained products (e.g. manual vacuum aspiration); and vi) assisted vaginal delivery (vacuum extraction or forceps) Facility qualifies only if there proof that it was able to provide all the six components for three months before data collection.
NUMERATOR	Number of Health Facilities (Level 2-6) providing Basic Emergency Obstetric Care (BEOC)
DENOMINATOR	Total number of Health facilities (levels 2-6) in the catchment area surveyed or on Master Facility List (MFL).
UNIT OF MEASURE	Percentage
DISAGGREGATION	Level (2, 3, 4, 5, 6), district, County, Regional and National levels
INDICATOR LEVEL	Process
PURPOSE	Universal access to BEOC services is vital to assure the desired pregnancy outcome of a live and health mother and infant(s). This indicator can be used to measure the need, coverage or availability and progress with scale up of safe motherhood interventions.
FREQUENCY	COLLECTION: Both numerator and denominator are collected annually through designated management survey REPORTING: Annually UTILISATION: Annually
DATA SOURCE	NUMERATOR: Rapid facility surveys or support supervision at levels 2-6 or update on Master Facility List (MFL). DENOMINATOR: Rapid facility surveys or support supervision at levels 2-6 or update on Master Facility List (MFL).
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = (Number of Health Facilities (Levels 2-6) providing Basic Emergency Obstetric Care (BEOC)) / (Total number of Health facilities (levels 2-6) in the catchment area surveyed X 100. NOTE: A random sample of all facilities may be assessed and available service

	statistics reviewed to confirm whether each of the six signal functions for BEOC have been performed at least once in the past three months. Mapping may be useful for assessing geographical distribution.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Proportion of Health facilities providing Comprehensive Emergency Obstetric Care (CEOC)
HIS CODE:	**HIS016**

PROGRAMME GOAL	Reduction of both maternal and child morbidity and mortality

REFERENCES	WHO	AOP	MDG
CODES		#9	

DEFINITION OF IMPORTANT TERMS	**Comprehensive Emergency Obstetric care (CEOC):** Besides the six components of BEOC includes performing surgery (caesarean section) and blood transfusion: A facility qualifies only if there is proof that it was able to provide all the eight components for three months before data collection.
NUMERATOR	Number of Health Facility (Level 4-6) providing Comprehensive Emergency Obstetric Care (CEOC)
DENOMINATOR	Total number of Health facilities (levels 4-6) in the catchment area surveyed
UNIT OF MEASURE	Percentage
DISAGGREGATION	Rural/Urban, district, County, Regional and national levels
INDICATOR LEVEL	Process
PURPOSE	Universal access to CEOCs is vital for management of life-threatening obstetric conditions. MMR can be reduced if there is good coverage and quality of CEOCs. This indicator can be used to assess needs, monitor progress and plan for interventions at national and sub-national levels.
FREQUENCY	**COLLECTION:** Both numerator and denominator are collected annually through designated management survey or update on Master Facility List (MFL). **REPORTING**: Annually **UTILISATION:** Annually
DATA SOURCE	**NUMERATOR:** Rapid facility surveys or support supervision at levels 4-6 or update on Master Facility List (MFL). **DENOMINATOR**: Rapid facility surveys or support supervision at levels 4-6 or update on Master Facility List (MFL).
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Number of Health Facilities (Levels 4-6) providing Comprehensive Emergency Obstetric Care (CEOC)) / (Total number of Health facilities (levels 4-6) in the catchment area surveyed X 100. **NOTE:** A random sample of all facilities may be assessed and available service statistics reviewed to confirm whether each of the functions for CEOC have been performed at least once in the past three months. Mapping may be useful for assessing geographical distribution.

INDICATOR	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY

APPLICATION LEVEL	✓	✓	✓	✓	✓	

INDICATOR NAME	Proportion of Health facilities providing youth friendly services
HIS CODE:	**HIS017**

PROGRAMME GOAL	To contribute to the improvement of the quality of life and well-being of Kenya's adolescents and youth

REFERENCES CODES	AOP	MDG
	#27	

DEFINITION OF IMPORTANT TERMS	**Youth Friendly Services**: Include education, counselling, life-skills building, safe motherhood, prevention and treatment for HIV/STI and drug and substance abuse, post-rape care. May be stand alone or integrated services. **Youth:** All males and females aged from 10-24years
NUMERATOR	Number of Health facilities offering youth friendly services
DENOMINATOR	Total number of Health facilities in the catchment area
UNIT OF MEASURE	Percentage
DISAGGREGATION	Facility level, Administrative levels (district, county, regional and national levels)
INDICATOR LEVEL	Process
PURPOSE	Adolescents and youth have limited knowledge about their sexuality and risks associated with early or pre-marital sex and multiple partners. Although most health facilities offer reproductive health services, providers lack the capacity to address adolescent reproductive health issues and the range of services is limited hence the need to improve access and quality of care through provision of youth friendly and non-clinical services. This indicator measures access and coverage of YFS coverage. Tracking of this indicator over time can guide how to improve access of health services to the adolescent and youth. Provision Assessment Survey (KSPA 2004), youth-friendly services are not widely available in Kenya. Only about 5 percent of all facilities say they have services especially tailored for young people.
FREQUENCY	**COLLECTION:** Both numerator and denominator are collected annually through designated management survey **REPORTING/ UTILISATION**: Annually
DATA SOURCE	Data is collected through Service Provision Assessment (SPA) or through semi-annual DHMT Facility Assessment Tool (which is yet to be improved/structured). The DHMT tool need to ensure that the indicator used in KSPA is the one used or improved for future SPAs to ensure data comparability.
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Number of Health facilities offering youth friendly services) / (Total number of Health facilities in the catchment area surveyed) X 100 **NOTE:** A random sample of all facilities may be assessed and available service statistics reviewed to confirm whether each of the essential components for YFS

	have been performed at least once in the past three months. Mapping may useful for assessing geographical distribution.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

Indicator:	Number of clients seeking post rape care services
HIS Code:	HIS018
Programme Goal	Reduce incidences of rape, unwanted pregnancies and co-infections

Referees	AOP	
Codes		

Definition of Important Terms:	Proportion of clients reporting a rape/sexual assault incident to the health facility. These are the number of persons who made at least one visit to clinic for post rape care during the reporting period. Use OPD register and service register. This could be a routine indicator but should measure those who came and were treated appropriately, but not prevalence of rape in the population, since this should be captured from a survey.
Numerator	Total number of clients seeking post rape care
Denominator	None
Reportable data elements	Number of clients with sexual assaults, number co-infected, number with unwanted pregnancies
Disaggregation	By sex, age (<15, 15+), district, county, regional and national levels
Purpose	To determine level of awareness & utilization of the service
Frequency	Monthly
Data Source	Numerator: Supervisory reports, GBV service Register (PRC) Denominator: None
Data Management Guidelines	Frontline service provider summarizes the monthly service statistics and fills summary form for the service delivery point; the HRIO or site/program in-charge completes the form, ROW 33 (Sexual Assault) of MOH 705B –OP Summary Sheet (over 5yrs), MOH 711 and submits to the DHRIO who aggregates the district level statistics and uploads summary to web-based database which is accessed at central level by HIS and NASCOP MARP Manager for quarterly program reviews
Interpretation	There is need to ensure there is no double counting of clients accessing post-rape care services during the reporting period. While the indicator provides information on access to post rape care, it does not provide insight into quality of care and treatment outcomes. (My suggestion, let us get absolute numbers and forget about the denominator)

	The past 12 months is what is critical for facility-based interventions since some of those that ever experienced may have already accessed services. According to KSPA 2004, the proportion of health facilities offering PEP was 13% which indicates that since the service is not available in over 87% of the facilities, it might be more useful to monitor service availability rather than people served.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

Indicator:	Proportion of Women of Reproductive Age screened for cervical cancer
HIS Code:	HIS019
Programme Goal	To improve women's health and reduce morbidity and mortality due to cervical cancer.

Referees	AOP	WHO
Codes		

Definition of Important Terms:	The proportion of women of Reproductive age screened for cervical Cancer using VIA/VILI or Pap smear method.
Numerator	Number of women of reproductive age screened for cervical cancer
Denominator	Estimated Number of women of reproductive age (KNBS)
Reportable data elements	
Disaggregation	Age, HIV status, district, county, regional and national levels
Purpose	Cancer of the cervix is a common reproductive health issue in Kenya. If detected early, pre-cancerous lesions can be treated before progression into full-blown cancer. This indicator measures the availability of cervical screening and subsequent cancer treatment
Frequency	Monthly
Data Source	ANC register, Post natal register, Family planning, Cervical cancer service register, OPD register.
Data Management Guidelines	Frontline service provider summarizes the monthly service statistics and fills summary form for the service delivery point; the HRIO or site/program in-charge completes the MOH 711 form and submits to the DHRIO who aggregates the district level statistics and uploads summary to web-based database which is accessed at central level by HIS for quarterly program reviews
Interpretation	There is need to ensure there is no double counting of clients undergoing multiple treatment interventions during the reporting period (e.g. cryotherapy, surgical excision)

	While the indicator provides information on access to cervical cancer treatment, it does not provide insight into the timeliness of treatment nor the quality of care and treatment outcomes.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

Indicator:	Proportion of women diagnosed with obstetric Fistula
HIS Code:	HIS020
Programme Goal	To contribute to improvement of quality of life of those with obstetric fistula.

Referees	AOP	
Codes	#1	

Definition of Important Terms:	Obstetric Fistula: abnormal communication between urinary bladder /anus and the vagina that occurs after delivery. The fistula can be due to prolonged obstetric labour or iatrogenic. Vesicovaginal fistula (VVF): abnormal communication between the urinary bladder and the vagina. Recto-vaginal fistula (RVF): abnormal communication between the rectum/anus and the vagina. There could be other forms like leakage from the ureter(s).
Numerator	Number of women diagnosed with obstetric Fistula
Denominator	Number of live births
Reportable data elements	
Disaggregation	Age, Educational level ,district, county, regional and national levels
Purpose	Currently there is no national data on obstetric fistula, yet many incidences and repairs are noted. Obstetric fistula reflects poor health system and failure to address human rights and
Frequency	Monthly
Data Source	Proposed tool: Postnatal Register, MOH 406, maternity register MOH 333.
Data Management Guidelines	Frontline service provider summarizes the monthly service statistics and fills summary form for the service delivery point; the HRIO or site/program in-charge completes the MOH 711 form and submits to the DHRIO who aggregates the district level statistics and uploads summary to web-based database which is accessed at central level by HIS for quarterly program reviews

Interpretation						
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

VACCINATIONS AND IMMUNISATIONS

INDICATOR NAME	Percentage of 1-year-old children immunized against BCG
HIS CODE:	**HIS021**

PROGRAMME GOAL	To reduce infant and childhood morbidity and mortality due to tuberculosis

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	1-year old children immunised: Is a count of all children who receive BCG vaccine within their first year of life. BCG - Bacillus Calmette Guerin Vaccination: Process of Receiving the vaccine Immunized: Process of the Body Sero converting
NUMERATOR	Number of children immunized with BCG by 12 months of age
DENOMINATOR	Estimated number of children below the age of one year (in the reference time/area)
UNIT OF MEASURE	Percentage
DISAGGREGATION	Levels 2, 3, 4 5, and 6 Health Facilities, district, regions/county and national levels
INDICATOR LEVEL	Output
PURPOSE	Immunization is an essential component for reducing under-five mortality. Immunization coverage estimates are used to monitor coverage of the service and to guide disease eradication and elimination efforts. It is a good indicator of health system performance. Tuberculosis (TB) is still the biggest challenge in the country. Kenya is ranked 13th among the 22 high TB burden countries in the world which contributes 80% of the global TB burden. The absolute number of TB cases notified increased more than tenfold since 1990 while the TB case notification rates for all cases has increased from below 50 per 100,000 in 1990 to 329 per 100,000 populations in 2008.
FREQUENCY	COLLECTION/REPORTING: It is recommended that this data are disseminated annually. However, collection of the numerator should be integral the routine provision of the service; aggregation and reporting should conform to the routine data flow policy (monthly). If a household survey is used, periodicity that governs that survey will be followed. UTILISATION: At facility level, it advisable that this indicator is monitored monthly as progress towards a quarterly/annual target set at the beginning of the year. At higher levels (than facilities), the indicator

	should be analysed at the end of the year.
DATA SOURCE	NUMERATOR: Immunization Register MOH 510and MOH 702 (tally sheet) MOH 710 (Summary sheet) for level 2,3, 4,5 and 6 DENOMINATOR: Kenya National Bureau of Statistics (KNBS)
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = (Number of children immunized with BCG by 12 months of age) / (Estimated number of children below the age of one year (in the reference time/area) X 100 DATA MANAGEMENT Management of data is primarily performed by service providers (e.g. district health centres, vaccination teams, physicians) are used for estimates based on service/facility records. The estimate of immunization coverage is derived by dividing the total number of vaccinations given by the number of children in the target population, often based on census projections. Household surveys: Survey items correspond to children's history in coverage surveys. The principle types of surveys are the Expanded Programme on Immunization (EPI) 30-cluster survey, the UNICEF Multiple Indicator Cluster Survey (MICS), and the Demographic and Health Survey (DHS). The indicator is estimated as the percentage of children ages 12–23 months who received at least one dose of measles vaccine either any time before the survey or before the age of 12 months

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Proportion of 1-year-old children immunized against measles
HIS CODE:	**HIS022**

PROGRAMME GOAL	To Reduce childhood disease against measles and increase child survival

REFERENCES	MDG4.A		
CODES	#3		

DEFINITION OF IMPORTANT TERMS	1-year old children immunised: Is a count of all children who received measles vaccine within their first year of life. Measles: A highly contagious, serious disease caused by a virus. It remains a leading cause of death among young children globally, despite the availability of a safe and effective vaccine. Measles is transmitted via droplets from the nose, mouth or throat of infected persons. Initial symptoms, which usually appear 10–12 days after infection, include high fever, runny nose, blood shot eyes, and tiny white spots on the inside of the mouth. Several days later, a rash develops, starting on the face and upper neck and gradually spreading downwards.
NUMERATOR	Number of children under one year of age who received at least one dose of measles containing vaccine
DENOMINATOR	Estimated number of children surviving infants under the age of one year
UNIT OF MEASURE	Percentage
DISAGGREGATION	Levels 2, 3, 4 , 5 and 6 Health Facilities, district, regions/county and national levels
INDICATOR LEVEL	Output

PURPOSE	Immunization is an essential component for reducing under-five mortality. Immunization coverage estimates are used to monitor coverage of immunization services and to guide disease eradication and elimination efforts. It is a good indicator of health system performance. In Kenya, like many other countries, measles is under case-based surveillance, earmarked for eradication/elimination or control and hence the additional need for coverage to justify the certification and movement to next level.
FREQUENCY	**COLLECTION/REPORTING**: It is recommended that this data are disseminated annually. However, collection of the numerator should be integral the routine provision of the service; aggregation and reporting should conform to the routine data flow policy (monthly). If a household survey is used, periodicity that governs that survey will be followed. **UTILISATION:** At facility level, it advisable that this indicator is monitored monthly as progress towards a quarterly/annual target set at the beginning of the year. At higher levels (than facilities), the indicator should be analysed at the end of the year.
DATA SOURCE	**NUMERATOR:** Immunization Register MOH 510 and MOH 702 (tally sheet) MOH 710 (Summary sheet) for level 2,3, 4,5 and 6 **DENOMINATOR**: Kenya National Bureau of Statistics (KNBS)
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Number of children under one year of age who received at least one dose of measles containing vaccine) / (Estimated number of surviving infants under the age of one year) X 100 **DATA MANAGEMENT** **Service/facility reporting system** ("administrative data"): Reports of vaccinations performed by service providers (e.g. district health centres, vaccination teams, physicians) are used for estimates based on service/facility records. The estimate of immunization coverage is derived by dividing the total number of vaccinations given by the number of surviving infants in the target population, often based on census projections. **Household surveys:** Survey items correspond to children's history in coverage surveys. The principle types of surveys are the Expanded Programme on Immunization (EPI) 30-cluster survey, the UNICEF Multiple Indicator Cluster Survey (MICS), and the Demographic and Health Survey (DHS). The indicator is estimated as the percentage of children ages 12–23 months who received at least one dose of measles vaccine either any time before the survey or before the age of 12 months.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Proportion of children younger than one year who were fully immunized
HIS CODE:	**HIS023**

PROGRAMME GOAL	To reduce infant and childhood morbidity and mortality and increase child survival

REFERENCES	MDG4.A		
CODES	#3		

DEFINITION OF IMPORTANT	**Fully- immunised**: refers to children who have received all the required doses of

TERMS	vaccines within the first year of life. The vaccines most recently added to the immunisation schedule are not yet considered when working out immunisation coverage. However, the most crucial vaccines that prevent serious childhood infections in young children are taken into account
NUMERATOR	Number of children under 1 year who received three doses of Oral Polio Vaccine (OPV), three doses of diphtheria, pertussis , and tetanus (DPT), and one dose each of Bacillea Calmette-Guerin (BCG) and measles vaccine (static and outreach) before age 12 months
DENOMINATOR	Estimated number of children younger than one year for a given period
UNIT OF MEASURE	Percentage
DISAGGREGATION	Levels 2, 3, 4 , 5and 6 Health Facilities, district, regions/county and national levels
INDICATOR LEVEL	Outcome
PURPOSE	Immunization is an essential component for reducing under-five mortality. Immunization coverage estimates are used to monitor coverage of immunization services and to guide disease eradication and elimination efforts. It is a good indicator of health system performance. According to DHS 2008/9, the percentage of children 12-23 months old who were fully immunized was 77% but only 65% were immunized below 1 yr. Thus, about 12% of all fully immunized children were immunized after 12 months of age which means their immunization was not very effective. From the same data it shows that about 23% of children are not immunized at all. The indicator attempts to monitor the 12% of children that are immunized late.
FREQUENCY	**COLLECTION/REPORTING:** It is recommended that this data are disseminated annually. However, collection of the numerator should be integral the routine provision of the service; aggregation and reporting should conform to the routine data flow policy (monthly). If a household survey is used, periodicity that governs that survey will be followed. **UTILISATION:** At facility level, it advisable that this indicator is monitored monthly as progress towards a quarterly/annual target set at the beginning of the year. At higher levels (than facilities), the indicator should be analysed at the end of the year.
DATA SOURCE	**NUMERATOR:** Immunization Register MOH 510 and MOH 702 (tally sheet) MOH 710 (Summary sheet) for level 2, 3, 4, 5 and 6. If surveys are used, data are collected through those survey's protocols. **DENOMINATOR**: Kenya National Bureau of Statistics (KNBS)
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = [Number of children under 1 year who received three doses of Oral Polio Vaccine (OPV), three doses of diphtheria, pertussis , and tetanus (DPT), and one dose each of Bacille Calmette-Guerin (BCG) and measles vaccine (static and outreach) before age 12 months] / [Estimated number of children younger than one year for a given period] X 100 **DATA MANAGEMENT**: The quality of the estimates is determined by the quality and availability of empirical data. Vaccination is relatively easy to measure and two methods -facility reports and surveys - have been developed, each of which, when properly designed and implemented, provides accurate and reliable direct measures of coverage levels. Implemented jointly, they provide a validation of coverage levels. However, both methods are subject to biases. In some instances, these biases may be identified and corrected and attempts to do so have been made.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

ADOLESCENT AND CHILD HEALTH

INDICATOR NAME	Percentage of Health Facilities with functional Oral Rehydration Therapy corner
HIS CODE:	**HIS024**

PROGRAMME GOAL	To reduce childhood morbidity and mortality

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	Health Facilities with functional: This is the proportion of health facilities with equipment, supplies for oral rehydration therapy for management of diarrhoea.
NUMERATOR	Number health facilities with equipment, supplies for oral rehydration therapy for management of diarrhoea
DENOMINATOR	Total number of existing health facilities in the catchment area.
UNIT OF MEASURE	Percentage
DISAGGREGATION	District, county, regional and national levels
INDICATOR LEVEL	Process
PURPOSE	Diarrhoea is the third most common cause of mortality and mortality in the country with a case facility fatality of up to 21 per cent. A National IMCI Health Facility Survey in 2010 shows a decline in the functional oral rehydration therapy (ORT) corners. Further, a review of the various Kenya Demographic and Health Surveys (KDHS) shows a continued decline in ORS use in the last 10yrs. Oral Rehydration Therapy (ORT) corners were established in out-patients departments of most health facilities to facilitate the management of diarrhoea, but there is decline in the operational use of these corners. The Ministry of Public Health and Sanitation with various stakeholders developed policy guidelines on control and management of diarrhoea diseases in 2010 and there is a concerted effort to revitalize the ORT comers
FREQUENCY	COLLECTION/REPORTING: During supervision and rapid assessments UTILISATION: At facility level, health workers should review this indicator as part of their routine self-assessment. District staff may review the indicator as part of their supportive supervision to the facility; This indicator is analysed quarterly from district level upwards.
DATA SOURCE	NUMERATOR: Supervision reports DENOMINATOR: Supervision reports or Master Facility List (MFL)
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = (Number health facilities with equipment, supplies for oral rehydration therapy for management of diarrhea) / (Total number of existing health facilities in the catchment area) X 100.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Percentage of children 1-5 years de-wormed at least twice at health facility during the year
HIS CODE:	**HIS025**

PROGRAMME GOAL	To reduce childhood morbidity and mortality

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	None
NUMERATOR	Number of children 1-5 years de-wormed at health facility at least twice in health facilities.
DENOMINATOR	Total number of children under 5 years of age attending CWC X 2 visits per year.
UNIT OF MEASURE	Percentage
DISAGGREGATION	District, county, regional and National levels
INDICATOR LEVEL	Output
PURPOSE	Worm infestation negatively affects the growth and development of children. Children 1-5 years are supposed to be de-wormed twice in a year so as to prevent parasitic infections. It should be a routine part of service during well-child under-fives clinics conducted at health institutions and/or through outreach programmes. The information should be recorded in the mother child booklet.
FREQUENCY	**Data collection**: During every child health clinic, data should be collected by health providers and aggregates are reported at the end of the month. **Reporting:** Aggregated data to be reported to the district every month. **Analysis:** At facility level, health workers should review this indicator as part of their routine self-assessment. District staff may review the indicator as part of their supportive supervision to the facility. Analysis of the indicator at national and district levels should be done annually.
DATA SOURCE	NUMERATOR/DENOMINATOR: The primary data source for this indicator is the "Mother-child Health Booklet – MOH 216" and Under five register MOH 204A
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = (Number of children 1-5 years de-wormed at health facility at least twice in health facilities /(Total number of children under 5 years of age attending CWC X 2 visits per year) X 100. NOTE: The numerator will count each instance of deworming, in anticipation that each child, by the end of the year would have been dewormed twice. As such the denominator will be computed from the estimated number of children <5 years multiplied by the expected number of deworming instances, each is expected to experience. It is recommended that this indicator is analysed annually due to the insistent on six monthly deworming

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Availability of Zinc tablets for management of diarrhoea for children under five years
HIS CODE:	**HIS026**

PROGRAMME GOAL	To reduce childhood morbidity and mortality

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	**Availability**: implies the physical presence of Zinc and its potential use by patients. **Time out of stock**-the number of days that zinc was not present in a health facility during the month under review
NUMERATOR	Total number days on which Zinc tablets were out stock
DENOMINATOR	Number of days in the reporting period
UNIT OF MEASURE	Percentage
DISAGGREGATION	District, county, regional and National level
INDICATOR LEVEL	Input
PURPOSE	The prevalence of diarrhoea is 16 per cent and contributes to almost 20 per cent of under-five mortality in Kenya. Children weakened by frequent diarrhoea episodes are more likely to be undernourished and suffer from opportunistic infections. The key interventions to combat diarrhoeal disease have focused on case management and use of zinc for management. It has been shown that zinc reduces the duration and severity of episodes, and lowers incidence of diarrhoea. All patients with diarrhoea should therefore be given zinc supplements immediately after diarrhoea has started.
FREQUENCY	COLLECTION: A record is made every time any of the tracer medicines gets out of stock and aggregates are reported at the end of the month REPORTING: Aggregated data is reported to the district every month UTILISATION: At the facility, district and provincial levels the health management teams should review the indicator as part of supportive supervision/service delivery assessment whereas at the central level the indicator is assessed annually to evaluate supply chain performance.
DATA SOURCE	NUMERATOR/DENOMINATOR: Updated stock control cards (SCC) or any other stock status record in the pharmacy; Daily activity registers (DAR)/ Dispensing records in the service point; OPD register MOH 204A
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = (Total number days on which Zinc tablets were out stock)/(Number of days in the reporting period) X 100 NOTE: Stock control cards or inventory sheets should be consistently and properly maintained for this indicator to be reliable.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Percentage of Newborns with Low Birth Weights (LBW) –(less than 2500 grams)
HIS CODE:	**HIS027**

PROGRAMME GOAL	To promote growth monitoring and to reduce infant mortality

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	**Low Birth Weight**: This refers to the weight (less than 2500 grams up to and including 2499 grams) of the newly born infants, which is obtained after birth (but within less than 1 hour) –ICD 10
NUMERATOR	Number of newly born infants with low birth weights less than 2500 grams
DENOMINATOR	Actual number of live births whose birth weight were measured
UNIT OF MEASURE	Percentage
DISAGGREGATION	District, County, Regional/province and National levels
INDICATOR LEVEL	Outcome
PURPOSE	To promote growth monitoring for new born babies and to reduce infant mortality
FREQUENCY	**COLLECTION**: Routinely **REPORTING**: Monthly **UTILISATION**: Monthly at facility level and quarterly or broader at higher levels
DATA SOURCE	**NUMERATOR/DENOMINATOR**: Maternity Register (MOH 333)
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Number of newly born infants with low birth weights less than 2500 grams) / (Actual number of live births (in health facilities) X 100.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Infant Mortality Rate (IMR)
HIS CODE:	**HIS028**

PROGRAMME GOAL	To achieve maximum child survival and health status for the children under 1 year

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	**Infant Mortality**: Is the number of deaths within the first year of life (expressed as a percentage of the total live births in a defined geographical area per year.					
NUMERATOR	Number of deaths of children under 1 year of age.					
DENOMINATOR	Total live births in the catchment area.					
UNIT OF MEASURE	Rate					
DISAGGREGATION	District, County, region and National levels					
INDICATOR LEVEL	Outcome					
PURPOSE	To achieve maximum child survival. The measurements can also be narrowed to Health Facility infant mortality rate which will be specific for the health facility and can also determine the quality of care for infants.					
FREQUENCY	**COLLECTION/REPORTING**: 5-10 years through population based survey or censuses. The health facility can be done every month and reported as health facility deaths. **UTILISATION:** Health facility and Administratively when the need demands.					
DATA SOURCE	**NUMERATOR/DENOMINATOR**: population based survey or censuses or health facility deaths.					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Number of deaths of children under 1 year of age) / (Total live births in the catchment area) X 100. **NOTE:** Although it is possible to collect data on deaths occurring in infants in a health facility, this is not adequate for use in calculating the IMR. Only population-based data should be used.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Under-five Mortality Rate (U_5MR)
HIS CODE:	**HIS029**

PROGRAMME GOAL	To achieve maximum child survival and health status for the children under 1 year

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	**Under-five Mortality**: Is the number of deaths within the 59 months of life (expressed as a percentage of the total live births in a defined geographical area per year.					
NUMERATOR	Number of deaths of children under 5 year of age.					
DENOMINATOR	Total number of children under the age of five in a catchment area.					
UNIT OF MEASURE	Rate					
DISAGGREGATION	District, county, regional and national levels					
INDICATOR LEVEL	Outcome					
PURPOSE	To achieve maximum child survival. Establish health facility under five mortality rate.					
FREQUENCY	COLLECTION/REPORTING: 5-10 years through population based survey or censuses. Also the health facility deaths for under five. UTILISATION: Health facility and Administratively when the need demands.					
DATA SOURCE	NUMERATOR/DENOMINATOR: population based survey or censuses and health facility deaths.					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = (Number of deaths of children under 5 years of age) / (Total number of children under the age of five in a catchment area) X 100. NOTE: Although it is possible to collect data on deaths occurring in children age below 60 months in a health facility, this is not adequate for use in calculating the U5MR. Only population-based data should be used.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Percentage of school children correctly de-wormed at least once in the year:
HIS CODE:	**HIS030**

PROGRAMME GOAL	To improve health status of school children

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	**Correctly Dewormed**: This refers school children de-wormed using Mebendazole 500mg or Albendazole 400mg once in the year.
NUMERATOR	Number of school children de-wormed in the year.
DENOMINATOR	Total number of school children in the year within the catchment area.
UNIT OF MEASURE	Percentage
DISAGGREGATION	District, County, Region and National levels
INDICATOR LEVEL	Output
PURPOSE	Worm infestation negatively affects the growth and development of children. Children 1-5 years are supposed to be de-wormed twice in a year so as to prevent parasitic infections. It should be a routine part of service during well-child under-fives clinics conducted at health institutions and/or through outreach programmes. The information should be recorded in the mother child booklet MOH 216.
FREQUENCY	**COLLECTION:** Data should be collected during the de-worming activities in learning institutions, outreach in the community and health facility. Deworming register should be introduced to record the activity. **REPORTING:** Aggregated data are reported to the district every month **UTILISATION:** Monthly at facility level and quarterly/annually at higher levels
DATA SOURCE	**NUMERATOR/DENOMINATOR**: School de-worming register,
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = (Number of school children de-wormed in the year) / (Total number of school children in the year within the catchment area) X 100. NOTE: Harmonization between the MOPHs, MOM and MOE on data reporting

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	✓

Indicator Name	Percentage of Health Facilities providing treatment as per the IMCI guidelines
HIS Code:	**HIS031**

Programme Goal	To achieve maximum child survival

References		
Codes		

Definition of Important Terms	**As per the IMCI guidelines**. : Health facilities with equipment, supplies and at least 60% of clinical staff with skills in management of childhood illnesses.					
Numerator	Number of health facilities with equipment, supplies and clinical staff who have skills in management of childhood illnesses.					
Denominator	Health facility inventory using the Master Facility List (MFL), MOH 715 template and Health Facility Assessment (HFA) or Service Availability Readiness Assessment Mapping (SARAM) or Service Availability Mapping (SAM).					
Unit of measure	Percentage					
Disaggregation	Level 2-6, district, County, Regional and National levels					
Indicator Level	Output					
Purpose	To assess the care given to children under five years using the standard protocol and the readiness of health systems					
Frequency	Collection: During supervision and rapid assessments **Reporting**: Annually **Utilisation**: At facility level, health workers should review this indicator as part of their routine self-assessment. District staff may review the indicator as part of their supportive supervision to the facility, otherwise this indicator is analysed quarterly from district level upwards					
Data Source	**Numerator/Denominator**: Rapid surveys and support supervision reports at levels 2 – 6 (clinics to referral health facilities).					
Data Management and indicator computation Guidelines	**Calculation** = (Number of health facilities with equipment, supplies and clinical staff who have skills in management of childhood illnesses) / (Health facility inventory using MOH 715 template and Health Facility Assessment (HFA), Service Availability Readiness Assessment Mapping (SARAM) or Service Availability Mapping (SAM)) X 100 **Note:** Need to advocate for integrated support supervision.					
Indicator Application Level	Sector	Programme	National	County	Facility	Community
		✓	✓	✓	✓	

NUTRITION

INDICATOR NAME	Percentage of pregnant women attending ANC supplemented with Iron/folate
HIS CODE:	**HIS035**

PROGRAMME GOAL	To prevent and treat iron deficiency anaemia in women during pregnancy and in the postpartum period in order to improve maternal and perinatal health.

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	Iron is an essential micronutrient in the diet. Its functions includes: formation of hemoglobin and certain enzymes, transporting oxygen to all parts of the body, metabolic reactions and the regulation of cell growth and differentiations, immune activity, proper functioning of the liver, and protection against the actions of free radicals.
NUMERATOR	Number of pregnant women who received iron folic acid supplements at ANC during the month
DENOMINATOR	Total number of pregnant women attending ANC.
UNIT OF MEASURE	Percentage
DISAGGREGATION	District, County, Regional and National levels
INDICATOR LEVEL	Outcome
PURPOSE	All pregnant women should be given iron/folate to prevent deficiency in pregnancy which is an underlying cause of maternal mortality, Intra Uterine Growth Retardation (IUGR), low birth-weight in new-borns, stunting and neural tube defects in children.
FREQUENCY	**COLLECTION**: During every ANC visits data should be collected by health providers and aggregates are reported at the end of the month. **REPORTING**: Aggregated data are reported to the district every month. **UTILISATION**: At facility level, health workers should review this indicator as part of their routine self-assessment. District staff shall review the indicator as part of their supportive supervision to the facility; otherwise this indicator is analyzed monthly from Health Facility level upwards.
DATA SOURCE	**NUMERATOR/DENOMINATOR**: The primary data source for this indicator is the ANC register– MOH 405". Data should be recorded as pregnant women who are given iron/folate supplements (numerator) and the denominator as the total number of pregnant women attending ANC. These data are collated and aggregated to form MOH 711, MOH 717 and MOH 105 for monthly reporting. Summary tool needs to be updated (MOH 711).
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Number of pregnant women who received iron folic acid supplements at ANC during the month) /(Total number of pregnant women attending ANC) X 100 **NOTE**: Some women who miss to receive iron in their visit due to stock out or other reasons are issued in their second and/or subsequent visits. This indicator assumes the ideal practice that every woman is given iron during their first visit to use for the entire pregnancy period.(seek clarity from IFA/MICRONUTRIENTS)

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Proportion of infants (Newborns) initiated on breast milk within 1 hour after delivery
HIS CODE:	**HIS036**

PROGRAMME GOAL	To promote child survival.

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	Early initiation of breastfeeding is the commencement of breastfeeding within the first hour after birth					
NUMERATOR	Number of new born's breastfed within the first hour after birth					
DENOMINATOR	Total number of live births in the maternity ward/catchment area (Surveys).					
UNIT OF MEASURE	Percentage					
DISAGGREGATION	District, County, region and National levels					
INDICATOR LEVEL	Outcome					
PURPOSE	Early initiation of breastfeeding helps in contraction of the uterus and expulsion of the placenta. It also reduces post-partum bleeding. Maintain the warm temperature of babies, regulate breathing and heart rate, baby's skin and gut bacterial colonization with mother's normal bacterial body, reduce babies crying which reduces stress and energy, sets the level of blood sugar, and other bio-chemicals in baby's body, speed up the release of meconium, Assist the development of babies nervous system, Obtain colostrum to boost immune system, prevent loss of 'sucking reflex' in babies that occurs 20-30 minutes after birth. If lost it only reappears in sufficient levels 40 hours later.					
FREQUENCY	**COLLECTION:** Individual mothers' records should be updated within the one hour after delivery. This is important to reduce on the errors associated with misclassification of timings due to recall problems. Data are summarised monthly for reporting **REPORTING:** Data are reported monthly from the service delivery units to the district for entry. Once entered, the data are available at all levels. **UTILISATION:** Data should be reviewed monthly at facility level and quarterly/annually at all the higher levels.					
DATA SOURCE	**NUMERATOR:** Maternity Register MOH 333 [to be updated] **DENOMINATOR**: Maternity Register MOH 333 **SUMMARY TOOL IS MOH 711**					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Number of new born's breastfed within the first hour after birth) / (Total number of live births in the maternity ward/catchment area) X 100. **NOTE**: A New Born Baby Chart on which post-delivery events are recorded may require to be adjusted to include a data object on time of initiation of breastfeeding. Since this event is correlated with birth order, the programme should consider introducing birth order in the maternity register					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Percentage of infants less than 6 months old on Exclusive Breastfeeding
HIS CODE:	**HIS037**

PROGRAMME GOAL	To improve child survival and development.

REFERENCES	**WHO**	
CODES	**#130**	

DEFINITION OF IMPORTANT TERMS	**Exclusive Breastfeeding:** This refers to the proportion of infants less than 6 months of age who are fed exclusively with breast milk. Exclusive breastfeeding, based on the WHO definition, refers to the practice of feeding only breast milk (including expressed breast milk) but excluding water, breast milk substitutes, other liquids and solid foods are excluded.
NUMERATOR	Number of infants less than 6 months of age attending Child Welfare Clinic (CWC) who received only breast milk during the previous day (24hours ago)
DENOMINATOR	Number of infants less than 6 months of age attending CWC in the month
UNIT OF MEASURE	Percentage
DISAGGREGATION	Gender, district, County, region and national levels
INDICATOR LEVEL	Outcome
PURPOSE	Exclusive breastfeeding is meant to provide the child with required vitamins and minerals, among other benefits. In 2001, the World Health Organization (WHO) changed its recommendation for exclusive breastfeeding from four to six months of age to exclusive breastfeeding until six months of age and thus the purpose of this indicator is to check for compliance. Exclusive breast feeding has been demonstrated to have the potential of reducing childhood mortality by 13 per cent. Further this indicator is crucial for sourcing support to increase the number of children being exclusively breast fed from less than 32% to 80%.
FREQUENCY	**COLLECTION:** Data are routinely collected as a component of service delivery. On MOH 704 tally, Summaries are made at the end of the month in preparation for reporting **REPORTING:** Once summarised data are reported monthly from the service delivery point to the district for entry. Once entered onto the DHIS, the data are available at all levels. **UTILISATION:** Data should be reviewed monthly at facility level and quarterly/annually at all the higher levels.
DATA SOURCE	**NUMERATOR/DENOMINATOR**:CHANIS revised , MOH 704 and survey tools
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Number of infants less than 6 months of age attending CWC who received only breast milk during the previous day (24hours ago))/Number of infants less than 6 months of age attending CWC in the month) X 100

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Percentage of children under 5 years who are attending CWC for growth monitoring for the first time
HIS CODE:	**HIS038**

PROGRAMME GOAL	Improve access maternal and Child Health interventions.

REFERENCES CODES		

DEFINITION OF IMPORTANT TERMS	**Growth Monitoring**: Is the routine assessment of growth trend of a given child (0-5 years using anthropometric indices. It is a general index of the health of a given child
NUMERATOR	Number of Children under 5 years who are attending CWC for growth monitoring for the first time in a the calendar year
DENOMINATOR	Total number of children under five years old in the catchment area
UNIT OF MEASURE	Percentage
DISAGGREGATION	District, County, Region and National levels
INDICATOR LEVEL	Output
PURPOSE	To assess early detection of malnutrition to facilitate remedial action, strengthen preventive health programmes and to assess the promotion of the satisfactory nutrition of children, and provides an opportunity for uniting other low-cost child health interventions. It is platform to assess child growth and to provide essential health package for the mother and the child.
FREQUENCY	**COLLECTION:** Data are routinely collected using the CWC register – MOH 511 and Mother and Child booklet MOH 216 as a component of service delivery. Summaries are made at the end of the month in preparation for reporting **REPORTING:** Once summarised data are reported monthly from the service delivery point to the district for entry. Once entered onto the DHIS, the data are available at all levels. **UTILISATION**: Data should be reviewed quarterly at facility level and quarterly/annually at all the higher levels.
DATA SOURCE	**NUMERATOR**:" New visits" in the CWC register – MOH 511. These data are collated and aggregated to form MOH 717, 105 for monthly reporting and the revised CHANIS MOH 704. **DENOMINATOR**: Under 5 population in the catchment area/ KNBS estimates
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** =(Number of Children under 5 years who are attending CWC for growth monitoring for the first time) / (Number of children under five years old in the catchment area) X 100 **DATA MANAGEMENT ISSUES:** The indicator as presented assumes that all children (denominator) should make a first growth monitoring (GM) visit in a given period.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Percentage of children under five years of age who are underweight

HIS CODE:	**HIS039**

PROGRAMME GOAL	Improve nutritional status and child survival

REFERENCES	MDG	WHO
CODES	1.8	#27

DEFINITION OF IMPORTANT TERMS	**Underweight**: refers to nutritional status of inadequate food intake and directly related to hunger that is a composite measure for wasting and stunting for children under-five. It includes children under 5 years who fall below minus two standard deviations from median weight for age of reference population. a) Moderate - Fall below minus two standard deviations b) Severe- Fall below minus three standard deviations from the median weight for age of the reference population.
NUMERATOR	Number of children under 5 years of age attending CWC during the month/surveys with weight for age below -2 SD
DENOMINATOR	Total number of children under 5 years weighed at CWC during the month /Surveys
UNIT OF MEASURE	Percentage
DISAGGREGATION	Male/Female; Age group (0-5, 6-23- 24-59 months), district, county, regional, national
INDICATOR LEVEL	Outcome/Impact
PURPOSE	Child growth is the most widely used indicator of nutritional status in a community and is internationally recognized as an important public-health indicator for monitoring health in populations. In addition, children who suffer from growth retardation as a result of poor diets and/or recurrent infections tend to have a greater risk of suffering illness and death
FREQUENCY	COLLECTION/REPORTING: Data are routinely collected as a component of service delivery using MOH register CWC MOH 511 and Mother and Child booklet MOH 216. Summaries are made at the end of the month in preparation for reporting to the district for data entry. UTILISATION: Once entered onto the computer, the data are available at all levels.. Data should be reviewed quarterly at facility level and quarterly/annually at all the higher levels.
DATA SOURCE	NUMERATOR/DENOMINATOR: The primary data source in the routine system for this indicator is the "Mother-child Health Booklet – MOH 216". Upon plotting the weight of the child against the age, the child should be marked as weighed (denominator) and if below the recommended line, should be recorded as underweight (numerator). These data are collated and aggregated to form revised MOH 704/MOH 711 for monthly reporting. Surveys data collection tools
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = (Number of children under 5 years of age attending CWC during the month/surveys with weight for age below -2 SD) / (Total number of children under 5 years weighed at CWC during the month /Surveys) X 100

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Percentage of children less than five (< 5) years who are stunted
HIS CODE:	**HIS040**

PROGRAMME GOAL	Improve nutritional status and child survival

REFERENCES	WHO	
CODES	#72	

DEFINITION OF IMPORTANT TERMS	**Stunting:** is a reduced growth rate in human development. Stunted children may never regain the height lost as a result of stunting, and most children will never gain the corresponding body weight. It also leads to premature death later in life because vital organs never fully develop during childhood. Height-for-age less than -2 standard deviations of the WHO Child Growth Standards median **Severe stunting:** Height-for-age less than -3 standard deviations of the WHO Child Growth Standards median.
NUMERATOR	Number of children aged 0-5 years that fall below minus two standard deviations from the median height-for-age of the WHO Child Growth Standards
DENOMINATOR	Total number of children under five years old in the catchment area.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Gender and age groups, district, county, region and national levels
INDICATOR LEVEL	Outcome/Impact
PURPOSE	To assess provision of nutritional advice alongside growth monitoring and promotion, enhance initiation of breastfeeding and to prolong exclusive breastfeeding. Child growth is the most widely used indicator of nutritional status in a community and is internationally recognized as an important public-health indicator for monitoring health in populations. In addition, children who suffer from growth retardation as a result of poor diets and/or recurrent infections tend to have a greater risk of suffering illness and reduced growth or developmental milestones.
FREQUENCY	COLLECTION/REPORTING: Data are routinely collected as services are offered. Summaries are done at the end of the month in preparation for reporting to the district for data entry. UTILISATION: Once entered onto the computer, the data are available at all levels. Data should be reviewed quarterly at facility level and quarterly/annually at all the higher levels.
DATA SOURCE	NUMERATOR/DENOMINATOR: The CWC registers MOH 511 at the health facility or community unit. The child and mother booklets MOH 216 and reported using CHANIS MOH 704.
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = (Number of children aged 0-5 years that fall below minus two standard deviations from the median height-for-age) / (Total number of children under five years old in the catchment area) X 100 NOTE: Only age and height measurement done as part of the growth monitoring should be recorded under this indicator requirement.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Percentage of children under the age of five years, who are wasted.
HIS CODE:	**HIS041**

PROGRAMME GOAL	Improve nutritional status, child survival and avert childhood deaths

REFERENCES CODES		

DEFINITION OF IMPORTANT TERMS	**Wasting:** Wasting (weight-for-height) or thinness indicates a recent and severe process of weight loss, which is often associated with acute starvation and/or severe disease. The "Weight-for-height" Z-score should be below -2 standard deviation (Sd) on the WHO growth reference charts.					
NUMERATOR	Number of children (0 < 5 years) who are wasted					
DENOMINATOR	Number of children (0 <5 years) whose measurements for wastage were taken					
UNIT OF MEASURE	Percentage					
DISAGGREGATION	Sex (male/female); age groups, district, county, region and national levels					
INDICATOR LEVEL	Outcome/Impact					
PURPOSE	Wasting rate is a measure for detecting the level of acute malnutrition and risk of mortality of under-fives. It detects if levels of acute malnutrition are increasing or decreasing. Provided there is no severe food shortage, the prevalence of wasting is expected to be below 5%. A prevalence exceeding 5% is alarming while prevalence between 10-14% is regarded as serious, and above or equal 15% as critical. To inform on the nutrition status of children under-five years, detect the levels of acute malnutrition both for a group of children or the population and guide appropriate intervention when necessary.					
FREQUENCY	**COLLECTION/REPORTING:** Data are routinely collected as services are offered. Summaries are done at the end of the month in preparation for reporting to the district for data entry. **UTILISATION**: Once entered onto the computer, the data are available at all levels.. Data should be reviewed quarterly at facility level and quarterly/annually at all the higher levels.					
DATA SOURCE	NUMERATOR:/DENOMINATOR: IMAM tool, survey tool					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = [Number of children (0 < 5 years) who are wasted] / [Number of children (0 < 5 years) whose measurements for wastage were taken] X 100 NOTE: Only Weight and height measurement done as part of the growth monitoring should be recorded under this indicator requirement.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Percentage of children aged 6 to 59 months receiving at least two doses of Vitamin A supplementation within one year
HIS CODE:	**HIS042**

PROGRAMME GOAL	To improve/ boost the immune status of the children and increase child survival

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	**Vitamin A supplementation**: Promote growth and repair of body tissues; reduce susceptibility to infections; aid in bone and teeth formation and maintain smooth skin.
NUMERATOR	Number of children supplemented with two doses of Vitamin A within one year
DENOMINATOR	Total number of children who aged below 6-59 months
UNIT OF MEASURE	Percentage
DISAGGREGATION	By age group: 6 - 11 months, 12 – 59 months, district, county, region and national
INDICATOR LEVEL	Output
PURPOSE	Supplementation with vitamin A is considered to be a critically important intervention for child survival owing to the strong evidence that exists for its impact on reducing child mortality. Therefore, measuring the proportion of children who have received vitamin A within the last 6 months is crucial for monitoring coverage of interventions towards child survival.
FREQUENCY	**COLLECTION:** Individual mothers' records should be updated within the one hour after delivery. This is important to reduce on the errors associated with misclassification of timings due to recall problems. Data are summarised monthly for reporting **REPORTING:** Data are reported monthly from the service delivery units to the district for entry. Once entered, the data are available at all levels. **UTILISATION**: Data should be reviewed monthly at facility level and quarterly/annually at all the higher levels.
DATA SOURCE	**NUMERATOR:** The primary data source for this indicator is the MOH 702 & 710" **DENOMINATOR**: Population estimate. (KNBS)
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Number of children supplemented with two doses of Vitamin A within one year) / (Total number of children who aged below 6-59 months) X 100 NOTE: This indicator will be tracked on a monthly basis by cumulating the numbers achieved against the set annual target. Coverage is computed on semester basis i.e. 6 months interval (January to June and July to December as first and second semester respectively). To compute annual coverage the lowest coverage of the two semesters is considered.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

Percentage of children with severe acute malnutrition receiving treatment		
HIS CODE:	HIS043	

PROGRAMME GOAL	Reduce Childhood Morbidity and Mortality

REFERENCES		
Codes		

DEFINITION OF IMPORTANT TERMS:	SAM (Severe acute malnutrition) is defined by low weight for height below -3z score of the median (WHO growth standards), Outpatient Therapeutic Programme provides nutrition care and treatment of severely malnourished children with no medical complication In-patient Therapeutic programme (ITP) provides nutrition care and treatment of severely malnourished children with medical complication. MUAC (Mid Upper Arm Circumference) <11.5cm and or presence of bilateral pitting oedema.
NUMERATOR	Total Number of new children (admitted into Outpatient Therapeutic Program (OTP) and In-patient care) with severe acute malnutrition receiving treatment at the end of the reporting month
DENOMINATOR	Total number of children screened for malnutrition in the health facility/district/ county and Nationally
UNIT OF MEASURE	Percentage
DISAGGREGATION	Sex, Age (0-6months, 6-59 months, above 5)
INDICATOR LEVEL	Output
PURPOSE	The indicator determines the number of severely malnourished children identified and receiving treatment through Outpatient Therapeutic Programme (OTP)/In-patient management of severe acute malnutrition. Assess continuous improvement of practice in the management of severely Malnourished children and the gaps in health workers knowledge in case management to reduce high case-fatality rates that occur in health institutions
FREQUENCY	**COLLECTION:** Data is collected for clients admitted to the Outpatient Therapeutic Program (OTP) and inpatients therapeutic program with Severe Acute Malnutrition (SAM) at the health facility and outreaches. **REPORTING:** Data are reported monthly from the service delivery units to the district for entry onto DHIS. Once entered, the data are available at all levels. **UTILISATION**: Data should be reviewed monthly at facility level and quarterly/annually at all the higher levels.Data collected at health facility, It is summarized on a monthly basis at the district level and later to the provincial and national level
DATA SOURCE	The primary sources of data for this indicator are the OTP and in patient data collection tools which include the client cards, OTP/SC register and facility summary tools.
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Total Number of new children (admitted into OTP and In-patient care) with severe acute malnutrition receiving treatment at the end of the reporting month/ Total number of children screened for malnutrition in the health facility/district/ county and Nationally) X 100 Data collected at health facility and outreach sites, It is summarized on a monthly

	basis at the district level and later to the county and national level Note : data is collected for this indicator once the client has been screen and admitted into the OTP and the inpatient therapeutic program					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

Percentage of new cases with moderate malnutrition receiving treatment		
HIS CODE:	HIS044	

PROGRAMME GOAL	To reduce the rate and deaths due to malnutrition

REFERENCES		
Codes		

DEFINITION OF IMPORTANT TERMS:	Moderate acute malnutrition is defined by weight for height > -3z score and <-2 Z score (WHO growth standards), MUAC >11.5 cm and <12.5cm Children with moderate malnutrition have an increased risk of dying and need special nutritional support.
NUMERATOR	Number of new children (admitted into SFP) with moderate acute malnutrition at the end of the reporting month
DENOMINATOR	Total number of children screened for malnutrition in the health facility/district/county/nationally.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Sex, Age (0-6months, 6-59 months, above 5, Pregnant and lactating mothers),
INDICATOR LEVEL	Output
PURPOSE	The indicator determines the number of moderately malnourished children identified and receiving treatment through Supplementary Feeding Programme (SFP). It also assesses the impact on mortality rates over time emanating from moderate malnutrition.
FREQUENCY	**COLLECTION:** Data is collected for clients admitted to the Supplementary feeding Program (SFP) with moderate Acute Malnutrition (MAM) at the health facility and outreaches. **REPORTING:** Data are reported monthly from the service delivery units to the district for entry onto DHIS. Once entered, the data are available at all levels. **UTILISATION**: Data should be reviewed monthly at facility level and quarterly/annually at all the higher levels.Data collected at health facility is summarized on a monthly basis and sent to the district level for entry into DHIS thus available at the county and national level
DATA SOURCE	The primary sources of data for this indicator are the SFP data collection tools which include the client cards, SFP register and facility summary tools.
DATA MANAGEMENT AND INDICATOR GUIDELINES	**CALCULATION** = (Number of new children (admitted into SFP) with moderate acute malnutrition at the end of the reporting month / Total number of children screened for malnutrition in the health facility/district/ county and Nationally) X 100 Data collected at health facility and outreach sites, It is summarized on a monthly basis at the district level and later at the county and national level Note: data is collected for this indicator once the client has been screened and admitted into the SFP program.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

MALARIA CONTROL

INDICATOR NAME	Number of children sleeping under long-lasting Insecticides Nets (LLIN)
HIS CODE:	**HIS045**

PROGRAMME GOAL	By 2013, to have at least 80% of people living in malaria risk areas using appropriate malaria preventive interventions

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	For programme-level application 'receiving' is used as a proxy for utilisation (sleeping under), listed as #7 on MDG #6. ITN being defined as a mosquito net that has been treated within 12 months or is a long-lasting insecticidal net (LLIN).
NUMERATOR	Routine facility data: Numerator - Total number of <1 year children who have received LLINs per year Denominator [if needed] - Estimated number of infants in the catchment area
DENOMINATOR	Survey data: Numerator - Number of children under five years of age in malaria endemic areas that slept under an ITN the previous night. Denominator – [if needed] Number of children (<5) surveyed.
UNIT OF MEASURE	Number
DISAGGREGATION	Age: <1 yr, 1-4 yrs, district, county, region and national
INDICATOR LEVEL	Process
PURPOSE	In areas of intense malaria transmission, malaria-related morbidity and mortality are concentrated in young children, and the use of insecticide-treated nets (ITN) by children under 5 has been demonstrated to considerably reduce malaria disease incidence, malaria-related anaemia and all cause under-five mortality. Vector control through the use of ITNs constitutes one of the four intervention identified to reduce the burden of malaria.
FREQUENCY	COLLECTION/REPORTING/UTILISATION: Data for this indicator are collected monthly routinely and cumulated to the end of the year. The resultant figure is then compared to the annual target
DATA SOURCE	NUMERATOR/DENOMINATOR: **Facility-based**: *Numerator*: CWC register(MOH 511), <estimated <1 children from KNBS **Surveys:** Household surveys such as Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), Malaria Indicator Surveys (MIS).
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION: Routine facility data = [Total number of <1 year children who have received LLINs per year] / [(if needed) Estimated number of infants in the catchment area

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	✓

INDICATOR NAME	Number of pregnant women who received LLINs
HIS CODE:	**HIS046**

PROGRAMME GOAL	By 2013, to have at least 80% of people living in malaria risk areas using appropriate malaria preventive interventions

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	LLINs: Long Lasting Insecticide Nets
NUMERATOR	Total number of pregnant women who received LLINs per year
DENOMINATOR	[if needed] - Estimated number of pregnant women in the catchment area or [if needed] - Total number of ANC 1st visits in the health facility
UNIT OF MEASURE	Number
DISAGGREGATION	District, county, region and national
INDICATOR LEVEL	Process
PURPOSE	ANC offer a good opportunity for targeting pregnant women with the delivery of ITNs. The aim of delivering an ITN through this channel is that the recipient will use the ITN while pregnant and share the ITN with the newborn child for at least one year. In this way, ANCs provide a delivery channel for ITNs to both pregnant women and young children during their most vulnerable period.
FREQUENCY	**COLLECTION:** Individual mothers' records should be updated upon . This is important to reduce on the errors associated with misclassification of timings due to recall problems. Data are summarised monthly for reporting **REPORTING:** Data are reported monthly from the service delivery units to the district for entry. Once entered, the data are available at all levels. **UTILISATION**: Data should be reviewed monthly at facility level and quarterly/annually at all the higher levels.
DATA SOURCE	NUMERATOR: ANC register MOH 405 , DENOMINATOR:[If required] - KNBS
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = [Total number of pregnant women who received LLINs per year] / [(if needed - Estimated number of pregnant women in the catchment area] or [Total number of ANC 1st visits in the health facility] X 100 DATA MANAGEMENT: This indicator should be used in conjunction with the one above (LLIN in children). Studies have shown that ANC coverage tends to be slightly higher than EPI coverage. Provision of ITNs through ANC allows women to use the ITN during pregnancies, and the child to be protected by the ITN from birth. Provision of ITNs through EPI loses the benefits of pregnancy coverage, but means that the ITN will remain intact until the child is a little older.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	✓

INDICATOR NAME	Incidence of malaria per 1000 population
HIS CODE:	**HIS047**

PROGRAMME GOAL	To have reduced morbidity and mortality caused by malaria in the various epidemiological zones by two thirds of the 2007/2008 level by 2017.

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	**Malaria:** An infectious disease caused by the parasite Plasmodium and transmitted via the bites of infected mosquitoes. Symptoms of uncomplicated malaria usually appear between 10 and 15 days after the mosquito bite and include fever, chills, headache, muscular aching and vomiting. **Incidence:** Is the number of new cases (diagnosis) in a given period **Cases of malaria**: The sum of confirmed cases of malaria (confirmed by slide examination or RDT)and probable (unconfirmed) cases of malaria (cases that were not tested but treated as malaria)
NUMERATOR	Number of OPD First Attendances plus Discharges plus Deaths (due to malaria)
DENOMINATOR	Estimated catchment population at risk
UNIT OF MEASURE	Rate
DISAGGREGATION	Confirmed (>5, 5+); Clinical (>5, 5+), district, county, region and national
INDICATOR LEVEL	Outcome
PURPOSE	To reduce morbidity and mortality among the population to achieve maximum child survival
FREQUENCY	**COLLECTION:** Upon diagnosis and collated/summarised at end the month using register MOH 204A and B and In patient register (MOH 301). **REPORTING:** Data are collated monthly from the service delivery units to the district for entry onto the DHIS. Once entered, the data are available at all levels. **UTILISATION:** At facility level, monthly trends [plot on a chart] should be reviewed. On a quarterly basis compare aggregates from this quarter with similar quarters from previous years. Endemic areas should plot epidemic curves.
DATA SOURCE	**NUMERATOR:** In patient register MOH 301 **DENOMINATOR**: KNBS
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = [Number of OPD First Attendances plus Discharges plus Deaths (due to malaria)] / [Estimated catchment population at risk] X 1000 **NOTE:** Malaria is difficult to identify without specialized laboratory tests that are often not available in remote facilities. In settings where cases are identified through clinical signs and symptoms alone, there is considerable over-diagnosis of malaria and numbers from such places may not be comparable with other districts/regions. It is important therefore to report the cases separately – confirmed vs. suspected.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Admission Rate of Confirmed Malaria Cases
HIS CODE:	**HIS048**

PROGRAMME GOAL	To have reduced morbidity and mortality caused by malaria in the various epidemiological zones by two thirds of the 2007/2008 level by 2017.

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	**Malaria:** An infectious disease caused by the parasite Plasmodium and transmitted via the bites of infected mosquitoes. Symptoms of uncomplicated malaria usually appear between 10 and 15 days after the mosquito bite and include fever, chills, headache, muscular aching and vomiting. **Admission rate**: Is the number of diagnosed cases that get admitted **Confirmed cases of malaria**: The sum of confirmed cases of malaria confirmed by slide examination or RDT.
NUMERATOR	Number of admissions due to confirmed malaria (OPD & IPD) X 1000
DENOMINATOR	Number of confirmed malaria cases (OPD & IPD)
UNIT OF MEASURE	Rate
DISAGGREGATION	Age: (>5, 5+), district, county, region and national
INDICATOR LEVEL	Outcome
PURPOSE	To reduce morbidity and mortality among the population to achieve maximum survival
FREQUENCY	**COLLECTION**: Upon diagnosis and collated/summarised at end the month using In patient register MOH 301. **REPORTING:** Data are collated monthly from the service delivery units to the district for entry onto the DHIS. Once entered, the data are available at all levels. **UTILISATION:** At facility level, monthly trends [plot on a chart] should be reviewed. On a quarterly basis compare aggregates from this quarter with similar quarters from previous years.
DATA SOURCE	**NUMERATOR**: In patient register MOH 301 and disease index card MOH 268 **DENOMINATOR** :OPD and IP registers MOH 204A and B and In patient register MOH 301 or disease index card MOH 268
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = [Number of admissions due to confirmed malaria (OPD & IPD)] / [Number of confirmed malaria cases (OPD & IPD)] X 100 **NOTE:** Malaria is difficult to identify without specialized laboratory tests that are often not available in remote facilities. In settings where cases are identified through clinical signs and symptoms alone, this indicator will be under-reported due to emphasis on admissions due to confirmed cases only.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Malaria Case Fatality Rate
HIS CODE:	**HIS049**

PROGRAMME GOAL	

REFERENCES	MDG 6	WHO
CODES	#6	#16

DEFINITION OF IMPORTANT TERMS	**Malaria:** An infectious disease caused by the parasite Plasmodium and transmitted via the bites of infected mosquitoes. Symptoms of uncomplicated malaria usually appear between 10 and 15 days after the mosquito bite and include fever, chills, headache, muscular aching and vomiting **Malaria case fatality** -The number of deaths due to malaria per 1,000 or per 100, 000 populations per year.
NUMERATOR	Number of institutional deaths due to malaria X 1000
DENOMINATOR	Number of deaths + discharges due to malaria
UNIT OF MEASURE	Rate
DISAGGREGATION	Age: < 5 years, 5+ years, district, County, Region and National levels
INDICATOR LEVEL	Outcome
PURPOSE	Information on malaria death rates can help to judge the success of program implementation, and may point to failures of programs in terms of prevention of malaria or access to effective treatment. Malaria is not only important in its own right but the disease can contribute to deaths arising from other conditions. In addition, malaria imposes an economic burden on families particularly those who are least able to pay for prevention and treatment and most affected by loss of income due to the disease. The disease also represents a financial burden to malaria-endemic countries that must use scarce resources to fund bed nets, insecticides and drugs in an effort to control the disease.
FREQUENCY	**COLLECTION**: Upon diagnosis and collated/summarised at end the month using In patient register MOH 301 or disease index MOH 268 or death register. **REPORTING:** Data are collated monthly from the service units to the district for entry onto the DHIS. Once entered, the data are available at all levels. **UTILISATION**: Once data have been entered they are not only available to the source facility but to all potential users.
DATA SOURCE	**NUMERATOR :**In patient register MOH 301 or disease index MOH 268 or death register
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Number of institutional deaths due to malaria) /(Number of deaths + discharges due to malaria) X 1000 NOTE: This indicator will always under estimate deaths due to malaria in the population as only cases that end up in health facilities are considered. Another potential problem with the indicator may arise due to continuous availability of diagnostic capabilities. It is important therefore that the estimates obtained are interpreted with this in mind.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Proportion of malaria films examined which were positive for malaria parasites
HIS CODE:	**HIS050**

PROGRAMME GOAL	By 2013, to have at least 80% of people living in malaria risk areas using appropriate malaria preventive interventions

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	**Positivity Rate**: Is the proportion positive malaria test results compared with total tests done.
NUMERATOR	Number of malaria slides which were positive for Plasmodium falciparum
DENOMINATOR	Total number of malaria slides examined
UNIT OF MEASURE	Rate
DISAGGREGATION	District, County, region and National levels
INDICATOR LEVEL	Output
PURPOSE	Prevention of malaria to all ages and strengthening of diagnostics in malaria investigation. To identify the malaria disease burden
FREQUENCY	**COLLECTION**: Positivity rates should be calculated at the facility level and sent to the district using form MOH 706 **REPORTING**: Data are submitted monthly to the district for data entry onto the DHIS **UTILISATION**: Once entered into the DHIS, data can be uploaded in MIAS.
DATA SOURCE	**NUMERATOR/ DENOMINATOR**: Lab /Treatment registers
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Number of malaria slides which were positive for Plasmodium falciparum) / (Total number of malaria slides examined)

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

HIV/AIDS

INDICATOR NAME	Number of individuals who received Testing Counselling services for HIV and received their test results
HIS CODE:	HIS051

PROGRAMME GOAL	To help individuals learn their HIV status and increase uptake and improve access to HIV health services

REFERENCES	KNASP	WHO	PEPFAR	GFTAM	NASCOP
CODES	2.2.4	UA-A2	P11.1.D	HIV-P8B	HIV02-01

DEFINITION OF IMPORTANT TERMS	**Testing and counselling services**: refers to provision of information and prevention counselling. All clients must receive information about the rapid test and give informed consent for testing. **Receiving results**: refers to provision of HIV test results to a client following an HIV testing and counselling session.
NUMERATOR	Total number of individuals who received HTC services including their test results
DENOMINATOR	[Optional] Total number tested
UNIT OF MEASURE	Number
DISAGGREGATION	Disaggregate by: **Client type** (1st test, retest); **Client tested as** (individual, couple+); **Setting** (static, outreach); **Test results** (positive, negative, discordant); **Sex** (male, female); **Age** (<15, 15-24, 25+); **Pregnant; Tested (CSW, IDU, MSM, Other MARPS)**[1]; **MARPS Tested positive or District, county, national**
INDICATOR LEVEL	Process
PURPOSE	This indicator is meant to measure both the volume of people accessing the service [useful for projecting programmatic needs such as test kits and other staffing resources] and individuals' level of knowledge of their HIV status. Testing is only useful if an individual is made aware of the outcome of the testing so that informed decisions about the future are made.
FREQUENCY	Data should be collected, reviewed, and cleaned continuously at the facility level (or community level) and aggregated monthly for routine reporting.
DATA SOURCE	HTC Lab Register. The data is then summarised on integrated reporting form (MOH 711, MOH 731) and monthly data entered in DHIS where this data will be accessible to all.

[1] See Indicator code # HIV08-03

<table>
<tr><td>DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES</td><td colspan="6"><u>CALCULATION</u> = (Total number of individuals who received HTC services including their test results) / ([Optional] Total number tested)

NOTE: To adequately collect data for this indicator, a minimum provision of the following services is required: counselling, testing, return and receipt of test results.
*Couples counselling describe those sessions where two or more people in a relationship come together for HIV T&C services. If a couple comes for services together, they should be counselled together and receive their test results together, where possible. When this happens data should be collected for each individual and it should be indicated on the form that this was a couple session as opposed to an individual session.
This indicator is intended to monitor trends in the uptake of testing and counselling over time. However, in some cases, data for this indicator might include repeat testers. Repeat testing is common practice among most HIV T&C programs and it is important to recognize this and interpret the aggregated data with caution.
Over time, the number of people who are expected to be tested and counselled will vary depending on numerous factors such as, the numbers of people with previously confirmed positive status, or the number of people who may be at perceived risk of HIV infection, and hence this indicator should be interpreted accordingly.
Finally, this indicator does not provide information on whether those who were tested were adequately referred to and are receiving follow up services to benefit from knowing their HIV status.</td></tr>
<tr><td rowspan="2">INDICATOR APPLICATION LEVEL</td><td>SECTOR</td><td>PROGRAMME</td><td>NATIONAL</td><td>COUNTY</td><td>FACILITY</td><td>COMMUNITY</td></tr>
<tr><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td></td></tr>
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INDICATOR NAME	Number of pregnant women with known HIV status
HIS CODE:	HIS052

PROGRAMME GOAL	To increase the number of pregnant women who know their HIV status

REFERENCES	PEPFAR	NASCOP
CODES	P1.1.D	HIV02-02

DEFINITION OF IMPORTANT TERMS	**Pregnant women with known HIV status**: these are women who knew their HIV positive status prior to the first ANC visit; those tested (regardless of test results) during ANC, in labour and delivery or tested within 72 hours of delivery. **Pregnant women with known HIV-infection**: women who were tested and confirmed HIV-positive at any point prior to the current pregnancy and those tested positive (for the first time) at any point between the first ANC visit and within 72 hours post-delivery.
NUMERATOR	Number of pregnant women with known HIV status
DENOMINATOR	Optional: All pregnant women (seen at ANC, L&D, PNC<72hrs)
UNIT OF MEASURE	Number
DISAGGREGATION	Disaggregate by Known positives at entry; Tested and picked results at (ANC, L&D, PNC<72hrs), district, county and national levels
INDICATOR LEVEL	Outcome
PURPOSE	Knowing ones HIV status in pregnancy is main entry point to prevention services against mother-to-child transmission of HIV and other HIV care and treatment services. It should be monitored over time to see the increase in the proportion of women knowing their HIV status during pregnancy.
FREQUENCY	Data should be collected continuously at the facility level and aggregated monthly for routine reporting.
DATA SOURCE	Both **numerator(s)** and denominators are collected using integrated HIV/AIDS-maternal health data collection tools: antenatal, labour and delivery (L&D) and the postnatal registers and summarised on reporting forms (MOH 711, MOH 731) and monthly data entered in DHIS.
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Number of pregnant women with known HIV status) / [Optional](All pregnant women (see at ANC, L&D, PNC<72hrs)) X 100 The numerator is the sum of the following categories of women at ANC, L&D and PNC: o Number of pregnant women who received an HIV test and result during ANC o Number of pregnant women attending L&D with unknown HIV status who were tested in the L&D and received results o Women with unknown HIV status attending postpartum services within 72 hours of delivery who were tested and received results o Pregnant women with known HIV infection attending ANC for a new

	pregnancy. This indicator monitors trends in HIV testing among pregnant women and uptake of testing at PMTCT sites. The points at which drop-outs occur during the testing and counselling process and the reasons why they occur are not captured by this indicator. This indicator does not measure the quality of the testing or counselling. It also does not capture the number of women who received pre- or post- test counselling. There is a risk of double counting with this indicator, as a pregnant woman could be tested multiple times during ANC, L&D, or postpartum. This is particularly true where women get re-tested in different facilities, or where they come to the L&D without documentation of their test. However, double counting should be minimized by ensuring data collection and reporting system are using patient held and facility held ANC records to document that testing took place.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Percentage of pregnant women whose male partners were tested for HIV in the setting
HIS CODE:	HIS053

PROGRAMME GOAL	Increase the participation and support of male partners in antenatal HIV counselling and testing

REFERENCES	NASCOP	
CODES	HIV02-02	

DEFINITION OF IMPORTANT TERMS	**Male partners testing for HIV in the PMTCT setting**: refers to male partners of pregnant women in attendance at antenatal clinic and being provided with HIV counselling and testing services together with their partner.					
NUMERATOR	Number of male partners of pregnant women who tested for HIV within PMTCT setting during reporting period.					
DENOMINATOR	Number of pregnant women visiting the facility within reporting period					
UNIT OF MEASURE	Percentage					
DISAGGREGATION	District, County, region and national levels					
INDICATOR LEVEL	Output					
PURPOSE	It is recommended male partners be involved in PMTCT as part of process to reduce stigma and discrimination as well as allow for provision of the necessary physical and psychological and support and making joint decisions with partner about care for infant beyond PMTCT.					
FREQUENCY	Data are collected routinely but analysis should be done quarterly at facility and annually at provincial and national levels					
DATA SOURCE	Antenatal Register MOH 405. The data is then summarised on reporting forms (MOH 711, MOH 731) every month and entered in DHIS.					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Number of male partners of pregnant women who tested for HIV within PMTCT setting during reporting period) / (Number of pregnant women visiting the facility within reporting period) X 100 In practice, women do not usually come with their partners during the first ANC visit such that even when partner testing takes place in ANC, it is usually on subsequent visits. As such there is a mismatch if data are analysed over short time interval such as months due the lag in time between numerator and denominator. It is therefore advised that analysis is done for broader periods					
	Involving men not only in the general prevention of HIV but in PMTCT specifically could significantly increase the success of PMTCT. Increase in male involvement is proxy for the support that pregnant will get both during and after delivery including care for the newly born.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Number of HIV positive pregnant women who received antiretroviral medicines to reduce the risk of mother-to-child transmission
HIS CODE:	HIS054

PROGRAMME GOAL	Scale up and increase access to PMTCT services all pregnant women who need them and implementation of an evidence-based package of prevention of mother to child transmission (PMTCT) interventions built around the use of antiretroviral drugs

REFERENCES	KNASP	PEPFAR	NASCOP
CODES	2.3.1	P1.2.D	HIV02-03

DEFINITION OF IMPORTANT TERMS	**Mother-to-child transmission (MTCT):** is when an HIV-infected woman passes the virus to her baby. This can occur during pregnancy, labour and delivery, or breastfeeding. Without treatment with ARV prophylaxis, around 15-30% of babies born to HIV positive women will become infected with HIV during pregnancy and delivery. A further 5-20% will become infected through breastfeeding. **PMTCT**: refers to preventing the transmission of HIV from HIV positive mothers to their infants during pregnancy, labour, delivery and breastfeeding. In addition, use of antiretroviral drugs in integration of HIV care, treatment and support for pregnant women found to be positive and their families.
NUMERATOR	Number of HIV positive pregnant women who received antiretroviral medicines to reduce the risk of mother to child transmission (Disaggregated by Single dose, Niverapine, AZT Based Regimen, HAART for treatment or prophylaxis). The data is then summarised on reporting forms (MOH 711, MOH 731) and entered in .
DENOMINATOR	None
UNIT OF MEASURE	Number
DISAGGREGATION	Disaggregate by Single dose Niverapine, AZT based regimen & HAART for prophylaxis or treatment. Can be by district, county, regional and national levels
INDICATOR LEVEL	Output
PURPOSE	This indicator is meant to measure the provision and uptake of antiretroviral prophylaxis for the prevention of mother-to-child-transmission (PMTCT). The risk of MTCT can be significantly reduced with the use of antiretrovirals for the mother, with or without prophylaxis to the infant.
FREQUENCY	Data should be collected continuously at the facility level and aggregated monthly.
DATA SOURCE	**Numerator(s)** are collected using integrated HIV/AIDS-maternal health data collection tools: antenatal MOH 405, labour and delivery MOH 333 (L&D) and the postnatal registers MOH 406. The summary is then collated on reporting forms (MOH 711, MOH 731) Denominator: All women who are HIV positive (Includes known positives and those newly testing positive)at all the PMTCT settings
DATA MANAGEMENT AND INDICATOR COMPUTATION	The numerator can be generated by counting the number of HIV-positive pregnant women who received antiretrovirals to reduce MTCT during the reporting period, by regimen.

GUIDELINES	Two methods for CALCULATING the numerator can be used: ◦ **Counting at point of ARV provision**: In rural areas where institution deliveries are very low, the most reliable source of data for the numerator are the patient registers based on where ARVs are dispensed and where the data is being recorded. There is a risk of double counting in settings where ARVs are provided at different points in time and/or in different service units or health facilities (e.g. a woman received SD-NVP at post-test counselling and then received AZT at 28 weeks). ◦ **Counting at the end-point of labour and delivery:** In settings with high facility delivery rates (>90%), the data can be aggregated entirely from the L&D register by counting the number of HIV-positive pregnant women who had received a specific ARV regimen by the time of delivery (e.g., a woman received SD-NVP and AZT during her pregnancy; at the time of delivery she would be recorded in the L&D register as having received AZT+SD-NVP during pregnancy and included in category #2). This may be the most reliable and accurate method for calculating this indicator for settings with high facility deliveries, as the corresponding ARV regimen dispensed is counted at the end of a woman's pregnancy. **Note**: Unfortunately method #2 will under count this service in most Kenyan facilities due to low institutional deliveries.
COMMENTS	This indicator is used to monitor: 1) the coverage of antiretrovirals given to HIV-positive pregnant women to reduce the risk of HIV transmission to the child; and 2) increased access to more efficacious ARV regimens for PMTCT. One weakness of this indicator is the exclusion of mother-infant pairs who only received infant prophylaxis. Therefore, partial prophylaxis for the infant only is not measured. The indicator measures ARVs dispensed and not ARVs consumed, thus it is not possible to determine adherence to the ARV regimen. The national percentage is required for this indicator in order to better interpret performance and service delivery and uptake and progress toward national goals and scale-up.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Proportion of HIV positive women assessed for ART eligibility (by WHO staging or CD4) at 1st ANC
HIS CODE:	HIS055

PROGRAMME GOAL	To increase access to ART for HIV-infected pregnant women who meet clinical immunological criteria

REFERENCES	PEPFAR	NASCOP
CODES	P1.4.D	HIV02-04

DEFINITION OF IMPORTANT TERMS	**Assessment for eligibility:** refers to determination of whether an HIV positive individual by way of clinical or laboratory values (if CD4 or TLC available) meets the criteria to start ART. Pregnant women who are medically eligible to start ART should have been clinically diagnosed using WHO clinical staging, immunologically diagnosed using CD4 count or a combination of both

	according to programme guidelines.
NUMERATOR	Number of HIV positive women assessed for ART eligibility through either clinical staging or CD4 at 1st ANC visit.
DENOMINATOR	First ANC visit of a HIV positive woman
UNIT OF MEASURE	Percentage
DISAGGREGATION	Disaggregate by type of assessment-(WHO staging and CD4 count) By eligibility status for additional information on national trends in the percentage of pregnant women who are eligible for ART. By ART assessment type – clinical staging or CD4 testing.
INDICATOR LEVEL	Process
PURPOSE	Care and treatment should be integral to the provision of PMTCT services. Focus should not only be on averting transmission to the baby but equally important is ensuring that the health of the mother is also cared for in the same setting. This indicator therefore measures the level to which HIV-infected pregnant women are assessed for ART eligibility through CD4 or WHO staging. Assessment can be onsite or through referral.
FREQUENCY	Collected routinely but analysed annually from district upwards. Facilities should do the analysis every quarter.
DATA SOURCE	Facility maternal registers, HIV sentinel surveillance in antenatal clinic estimates.
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION =(Number of HIV positive women assessed for ART eligibility through either clinical staging or CD4 at 1st ANC visit) / (First ANC visit of a HIV positive woman) X 100 ART eligibility assessment can take place in a variety of settings, including in the ANC, the laboratory, or in the care and treatment unit, on-site or by referral. **If a patient is assessed through both the CD4 and clinically, CD4 takes prominence and should be counted under CD4**

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Proportion of HIV infected women who received family planning services at 1st post-natal visits
HIS CODE:	HIS056

PROGRAMME GOAL	Prevention of unintended pregnancies among HIV-infected women—one of four essential elements for comprehensive strategy to prevent HIV in infants

REFERENCES	NASCOP	
CODES	HIV02-05	

DEFINITION OF IMPORTANT TERMS	Family Planning: A program to regulate the number and spacing of children in a family through the practice of contraception or other methods of birth control.
NUMERATOR	HIV positive mothers at 1st post natal clinic who received FP
DENOMINATOR	All HIV positive women attending 1st post natal clinic

UNIT OF MEASURE	Percentage					
DISAGGREGATION	Disaggregate by timing of postnatal visit and type of FP service offered					
INDICATOR LEVEL	Output					
PURPOSE	It is recommended that HIV infected women their partners or simply all HIV infected women of child bearing age are provided with family planning counselling, contraceptive methods or safer pregnancy counselling as part of routine care to reduce unintended pregnancy and prevent maternal-to-child transmission. This indicator measures access to FP services by HIV positive women during postnatal.					
FREQUENCY	Data should be collected routinely but aggregated monthly for reporting and local level analysis.					
DATA SOURCE	Postnatal register MOH 406 and MOH 105 (service delivery)					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Although data are primarily obtained through a routine systems (self-report by health workers) other methods can also be used: o Observation of service provision. o Record reviews					
	The indicator suggests the extent to which women are referred to postpartum counselling on FP but does not attempt to ascertain either the different contraception options that are selected or the regularity with which they are used. Consequently, it cannot reveal anything about the effectiveness of the advice given.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Percentage of HIV-Exposed Infants initiated on CTX within two months of birth
HIS CODE:	HIS 057

PROGRAMME GOAL	Expand and increase access to care for all HIV exposed infants

REFERENCES	PEPFAR	NACOP
CODES	C4.2.D	HIV02-06

DEFINITION OF IMPORTANT TERMS	Co-trimoxazole: is a combination of two antibiotics – sulfamethoxazole and trimethoprim. It is widely available in a number of forms and is known by several brand names. The most common use of cotrimoxazole is for the first-line management of acute respiratory infections (ARI) in children, but it is also used to treat diarrhoea and PCP, as well as infections of the urinary tract and middle ear.					
NUMERATOR	No of HIV Exposed Infants initiated on CTX within two months of birth.					
DENOMINATOR	Known HIV Exposed Infants who have reached the age of two months of birth during the reporting period					
UNIT OF MEASURE	Percentage					
DISAGGREGATION	District, county, region and national levels					
INDICATOR LEVEL	Output					
PURPOSE	Cotrimoxazole prophylaxis is a simple and cost-effective intervention to prevent Pneumocystis jiroveci pneumonia (PCP) among HIV-exposed and -infected infants. This can occur before it is possible to detect HIV, therefore all infants born to HIV positive mothers should receive co-trimoxazole prophylaxis starting at 4–6 weeks after birth and continuing until HIV infection has been excluded in the absence of breastfeeding.					
FREQUENCY	Data on initiation on CTX should be collected continuously at the facility level but due to sensitivity of this indicator around the age, analysis should be done annually by reviewing HEI register for children that will have already reached 2 months – but within the review period.					
DATA SOURCE	Both numerator and denominator can be obtained from HEI registers					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = (Sum of infants having received CTX within 2 months of birth during the reporting period) / (Sum of infant cohorts that will have matured to 2 months during the reporting period) X 100.					
	This indicator is used to monitor progress in reaching HIV-exposed infants with early care and as a critical tool for providing appropriate follow-up care and treatment which includes CTX prophylaxis treatment within 2 months of birth.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Percentage of infants born to HIV-positive women who received an HIV test within 12 months of birth
HIS CODE:	HIS058

PROGRAMME GOAL	Expand and increase access to HIV testing services and care for all HIV exposed infants within 12 months of birth

REFERENCES	PEPFAR	NASCOP
CODES	C4.1.D	HIV02-07

DEFINITION OF IMPORTANT TERMS	**HIV exposed infants**: Exposed infants can be infected with HIV antepartum, intrapartum, or postpartum (through breast feeding). However, while the child with HIV infection can often be identified during the first months of life, HIV infection often cannot be excluded until after 1 year of age particularly in breast feeding babies.					
NUMERATOR	No of HIV exposed infants who received a HIV test by 12 months					
DENOMINATOR	All HIV exposed children registered at the facility who have reached the age of 12 months					
UNIT OF MEASURE	Percentage					
DISAGGREGATION	Geographic: District, County, regional and national levels By Age: Testing within 2 months and at between 9-12 months (antibody testing and confirmatory PCR)					
INDICATOR LEVEL	Output					
PURPOSE	WHO recommends national programmes to establish the capacity to provide early virological testing of infants for HIV at 6 weeks, or as soon as possible thereafter to guide clinical decision-making at the earliest possible stage. This is important because infants exposed to HIV antepartum, intrapartum or postpartum do not usually live to see their first birthday.					
FREQUENCY	Data should be collected continuously at the facility level and aggregated monthly in time for routine reporting					
DATA SOURCE	HIV-exposed infant registers					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION =(No of HIV exposed infants who received a HIV test by 12 months) / (All HIV exposed children registered at the facility who have reached the age of 12 months) X 100 The numerator, Number of infants who received an HIV test within 12 months in the last 12 months, should be disaggregated as follows: o Infants who received virological testing below 3 months or o Infants that were tested either virologically between 3 and 12 months, or by serology between 9 and 12 months. Infants tested should only be counted once. The numerator should only include the initial test and not any subsequent tests.					
	This indicator is used to monitor progress in reaching HIV-exposed infants with early infant testing as a critical tool for providing appropriate follow-up care and treatment.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Percentage of HIV-exposed children confirmed positive through a confirmatory test
HIS CODE:	HIS059

PROGRAMME GOAL	This indicator allows assessment of progress toward eliminating mother-to-child HIV transmission.

REFERENCES	UNGASS	PEPFAR	NASCOP
CODES	UNG-25	P1.7.N	HIV02-08

DEFINITION OF IMPORTANT TERMS	**Confirmatory HIV test**: HIV DNA PCR (polymerase chain reaction) should be performed at ageof six weeks (some provision upto eight weeks) followed by serial DNA PCRs. If this is not available, then all children should have HIV ELISA done at age eighteen months. Prior to diagnosis, all children are to be monitored clinically for any signs or symptoms of HIV infection. Tests for antibodies to HIV do not establish the presence of HIV infection in infants due to the transfer of maternal antibodies; therefore, a virologic test is required. PCR-based techniques that directly detect the existence of HIV in the plasma allow diagnosis by age one month.
NUMERATOR	No of HIV exposed infants confirmed positive.
DENOMINATOR	Number of confirmatory tests done.
UNIT OF MEASURE	Percentage
DISAGGREGATION	District, County, regional and national levels
INDICATOR LEVEL	Outcome
PURPOSE	In the absence of preventative interventions, infants born to, and breastfed by, HIV-infected women have roughly a one-in-three chance of acquiring infection themselves. This can happen during pregnancy, during labour and delivery, or after delivery through breastfeeding. The risk of MTCT can be reduced through the complementary approaches of antiretroviral prophylaxis for the mother, with or without prophylaxis to the infant, implementation of safe delivery practices, and use of safe alternatives to breastfeeding. Antiretroviral prophylaxis followed by exclusive breastfeeding may also reduce the risk of vertical transmission when breastfeeding is limited to the first six months. This indicator allows assessment of progress toward eliminating mother-to-child HIV transmission.
FREQUENCY	Data should be collected routinely but summaries are compiled at the end of the reporting period from the HEI register.
DATA SOURCE	**HIV-exposed infant registers and reported end of period**
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (No of HIV exposed infants confirmed HIV positive) / (Number of tests done) X 100. The numerator, **number of HIV exposed infants confirmed positive**, should be disaggregated as follows: o Infants who received virological testing in the first 2 months o Infants that were tested virologically between 2 and 9 months. o Infants confirmed HIV positive with PCR after testing positive with antibody tests at nine months The numerator should only include the confirmed HIV positive test.

	This indicator allows one to assess the impact of PMTCT programs by estimating the percentage of infants who are HIV-infected out of those born to HIV-infected pregnant women and tested. This indicator offers PMTCT program teams the tools to monitor the impact of PMTCT using actual data on the HIV status and survival of infants born to HIV-infected women, gathered during follow-up health care visits with these infants and recorded in the HIV Exposed Infants Register at health facilities.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Percentage of HIV Exposed Infants by feeding type at age six months
HIS CODE:	HIS060

PROGRAMME GOAL	Expand and increase access to appropriate infant feeding practises for all HIV exposed infants within the first 6 months of birth

REFERENCES	AOP	PEPFAR	NASCOP
CODES	AOP-12	P1.6.D	HIV02-09

DEFINITION OF IMPORTANT TERMS	The infant feeding practices measured in this indicator are defined as follows: o **Exclusive breastfeeding**: An infant receives only breast milk and no other liquids or solids, not even water, with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines for up to 6 months. Breast milk also includes milk from a wet nurse and a mother's expressed milk. o **Replacement feeding (no breast milk at all):** The process of feeding a child who is not receiving any breast milk with a diet that provides all the nutrients the child needs until the child is fully fed on family foods. During the first six months this should be with a suitable breast-milk substitute. The suitable breast-milk substitute would normally be commercial infant formula, as home-modified animal milk is no longer recommended for feeding infants during the entire first six months of life except as an emergency measure. Replacement feeding excludes breastfeeding. o **Mixed feeding:** Feeding both breast milk and other foods or liquids for infants 0 - ‹6 months. After six months, exclusive breastfeeding or giving only formula is no longer recommended.
NUMERATOR	Number of HIV exposed infants by feeding option (EBF, ERF, MF) at 6 months
DENOMINATOR	All exposed infants at 6 months
UNIT OF MEASURE	Percentage
DISAGGREGATION	Disaggregate by age-band at 6 months and feeding (EBF, ERF, MF)
INDICATOR LEVEL	Process
PURPOSE	This indicator is meant to assess the acceptability of each the available options for IYCF in HIV-exposed infants and how well protocols are adhered to.
FREQUENCY	Data should be collected routinely but summaries are compiled at the end of the reporting period from the HEI register.

DATA SOURCE	Both numerator and denominator can be obtained from the HEI register					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = [Number of HIV exposed infants by feeding option (EBF, ERF, MF) at 6 months and (BF and Not BF) at 12 months] / [All exposed infants at 6 months and 12 months] X 100 During each visit, the health provider should inquire about infant feeding practices during the previous 24 hours, asking the following questions: "What did you give your infant to eat or drink yesterday during the day and during the night?" After each response, the health provider should ask: "Anything else?" The response will be recorded as one of the following: exclusively breastfeeding (EBF), replacement feeding (RF), or mixed feeding (MF).					
	The numerator for this indicator is collected at every visit and reported at 6 months. The denominator is number of HIV-exposed infants who are being followed-up and recorded in the HIV exposed infant register. It should be noted that the indicator says nothing about the quality of replacement feeding given, or the impact of the feeding practices on child survival.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Percentage of infants born to HIV-infected women (HIV-exposed infants) receiving antiretroviral prophylaxis to reduce the risk for peripartum mother-to-child transmission
HIS CODE:	HIS061

PROGRAMME GOAL	Infant antiretroviral prophylaxis to reduce peripartum transmission

REFERENCES	NASCOP
CODES	HIV02-10

DEFINITION OF IMPORTANT TERMS	**HIV exposed infants**: Exposed infants can be infected with HIV antepartum, intrapartum, or postpartum (through breast feeding). However, while the child with HIV infection can often be identified during the first months of life, HIV infection often cannot be excluded until after 1 year of age particularly in breast feeding babies.
NUMERATOR	Number of infants born to HIV-infected women during the past 12 months who were started on antiretroviral prophylaxis to reduce peripartum mother-to-child transmission.
DENOMINATOR	Estimated number of live births to pregnant HIV-infected women in the past 12 months
UNIT OF MEASURE	Percentage
DISAGGREGATION	District, county, region and national levels
INDICATOR LEVEL	Output
PURPOSE	The risk for peripartum mother-to-child transmission can be significantly

	reduced by the complementary approaches of providing antiretroviral drugs (as treatment or as prophylaxis) for the mother with antiretroviral prophylaxis for the infant and use of safe delivery practices and safer infant feeding.
FREQUENCY	Data should be collected continuously at the facility level and aggregated monthly in time for routine reporting
DATA SOURCE	ANC MOH 405, Maternity MOH 333 and Postnatal MOH 406 Registers
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = [Number of infants born to HIV-infected women during the past 12 months who were started on antiretroviral prophylaxis to reduce peripartum mother-to-child transmission] / [Estimated number of live births to pregnant HIV-infected women in the past 12 months] X 100 The numerator is calculated from national programme records aggregated from the HEI registers at facility level. Antiretroviral drugs can be given to HIV-exposed infants shortly after delivery, at facilities for labour and delivery for infants born at facilities, at outpatient postnatal care or child clinics for infants born at home and brought to the facility, or at HIV care and treatment or other sites. Three methods for calculating the numerator can be considered: • **Counting at the point of antiretroviral drug provision**: In settings with low facility delivery rates, data for the numerator should be compiled from the sites where antiretroviral drugs are dispensed and where the data are recorded. There is a risk of double-counting when antiretroviral drugs are provided during more than one visit or at different health facilities. • **Counting at the time of labour and delivery:** In settings where a high proportion of women give birth in health facilities, the numerator can be estimated from only the labour and delivery register by counting the number of HIV-exposed infants who received a specific antiretroviral drug regimen before discharge from the labour and delivery ward. This may be the most reliable and accurate method for calculating this indicator in settings with a high proportion of facility deliveries, as the corresponding antiretroviral drug regimen dispensed is counted at the time of provision to the infant. • **Counting at postnatal or child health sites**: Reporting units can count and aggregate the number of HIV-exposed infants who received antiretroviral prophylaxis recorded at postnatal or child health clinics if attendance is high and the exposure status of the child is likely to be known (e.g. from postnatal registers, stand-alone registers or integrated HIV-exposed infant registers). All public, private and nongovernmental organization-run health facilities that provide antiretroviral drugs to HIV-exposed infants for the prevention of mother-to-child transmission of HIV should be included. To estimate the denominator: multiply the number of women who gave birth in the past 12 months (which can be obtained from estimates by central statistics office) by the most recent national estimate of HIV prevalence in pregnant women (which can be derived from HIV sentinel surveillance in antenatal care clinics).

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Percentage of infants born to HIV-infected women (HIV-exposed infants) who are breastfeeding provided with ARV drugs (either mother or infant) to reduce the risk of HIV transmission during the breastfeeding period
HIS CODE:	HIS062

PROGRAMME GOAL	Antiretrovirals to reduce mother to child transmission during breastfeeding

REFERENCES	NASCOP	
CODES	HIV02-11	

DEFINITION OF IMPORTANT TERMS	**HIV exposed infants:** Exposed infants can be infected with HIV antepartum, intrapartum, or postpartum (through breast feeding). However, while the child with HIV infection can often be identified during the first months of life, HIV infection often cannot be excluded until after 1 year of age particularly in breast feeding babies. Breastfeeding refers to either of the two practices: o **Exclusive breastfeeding**: An infant receives only breast milk and no other liquids or solids, not even water, with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines for up to 6 months. o **Mixed feeding:** Feeding both breast milk and other foods or liquids for infants 0 - <6 months.
NUMERATOR	Number of infants born to HIV-infected women who, during the past 12 months, are breastfeeding and protected by an antiretroviral intervention to reduce mother-to-child transmission through breastfeeding, namely either maternal or infant antiretroviral drugs – **Data obtained through record reviews.**
DENOMINATOR	Estimated number of infants born to HIV-infected women (HIV-exposed infants) who are breastfeeding during the past 12 months
UNIT OF MEASURE	Percentage
DISAGGREGATION	District, county, regional and national levels
INDICATOR LEVEL	Output
PURPOSE	The overall risk of MTCT can be significantly reduced by providing antiretroviral drugs (as lifelong therapy or as prophylaxis) to the mother and by complementary practices related to safe delivery and appropriate infant feeding. In breastfeeding populations, antiretrovirals interventions to mothers or infants can specifically reduce the risk of transmission through breastfeeding.
FREQUENCY	Data should be collected routinely, reported monthly but summaries are compiled at the end of the reporting period from the HEI register.
DATA SOURCE	Both numerator and denominator can be obtained from the HEI register
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION:** The numerator is calculated from national programme records aggregated from HEI registers at facility level. Antiretroviral drug interventions to reduce HIV transmission through breastfeeding can be initiated shortly after delivery at facilities for labour and delivery if infants are born at facilities, at outpatient postnatal care or child clinics for infants born at home and brought to the facility, or at HIV care and treatment or other sites.

	The data for the numerator should be collected at the infant's 6 week visit (2-3 months) and distinguished from ARV interventions given to prevent peripartum transmission. Data on whether maternal or infant antiretrovirals to reduce post-natal transmission were provided should be recorded for breastfeeding infants. HIV-infected pregnant women who are eligible for antiretroviral therapy and are receiving a treatment regimen and whose infants therefore benefit from the prophylactic effect of ART in reducing the risk of transmission through breastfeeding are also included in this indicator. Three methods for calculating the denominator can be considered: **Counting at the time of labour and delivery**: In settings where a high proportion of women give birth in health facilities, the denominator can be estimated from only the labour and delivery register, by recording and counting the number of HIV exposed-infants whose initial feeding practice was breastfeeding, as a proxy for the denominator. **Counting at postnatal or child health sites**: In settings where a high proportion of women and children attend post-natal and child health sites, reporting entities can count and aggregate the number of HIV-exposed infants who are breastfeeding recorded at postnatal or child health clinics if the exposure status of the child is likely to be known (e.g. from postnatal registers or stand-alone or integrated HIV-exposed infant registers). **Combining data from labour and delivery + post-natal/child health sites**: In some settings, data for the numerator will need to be compiled from the labour and delivery and postnatal and child health sites, to estimate the total number of HIV-exposed infants who are breastfeeding. However, data collection and reporting systems should be established to minimize double-counting. All public, private and nongovernmental organization-run health facilities that provide antiretroviral drugs to HIV-exposed infants for PMTCT should be included.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Percentage of PLHIV who know their status and are receiving Cotrimoxazole prophylaxis
HIS CODE:	HIS063

PROGRAMME GOAL	The goal for KNASP III is to ensure that all HIV positive patients receive CTX regardless of their treatment or care status, CD4 level or clinical stage

REFERENCES	KNASP	PEPFAR	GFTAM	NASCOP
CODES	1.3.1	C2.2.D	HIV-CS1	HIV03-01

DEFINITION OF IMPORTANT TERMS	**Receiving Cotrimoxazole**: Individuals should be considered to be "receiving" Cotrimoxazole prophylaxis if Cotrimoxazole has been prescribed and obtained by the patient (at the facility or procured by the patient). This represents only unique individuals receiving CTX within the reporting period therefore a patient should not be counted more than once if reporting aggregates covering more than one reporting point. **Eligible for Cotrimoxazole**: These are HIV-positive individuals who meet the criteria for eligibility to commence Cotrimoxale prophylaxis based on the current treatment guideline. The goal for KNASP III is to ensure that all HIV positive patients receive CTX regardless of their treatment or care status, CD4 level or clinical stage.					
NUMERATOR	Number of adults and children living with HIV enrolled in HIV care and receiving Cotrimoxazole prophylaxis					
DENOMINATOR	Number of adults and children living with HIV enrolled in HIV care that are eligible for Cotrimoxazole prophylaxis based on national guidelines.					
UNIT OF MEASURE	Percentage					
DISAGGREGATION	By sex: Male and Female and by age: <15, 15+, district, county, region and national					
INDICATOR LEVEL	Output					
PURPOSE	Cotrimoxazole prophylaxis is a simple and cost-effective intervention that reduces the risk of opportunistic infections (OIs) and mortality in HIV-positive children and adults.					
FREQUENCY	Data should be collected continuously at the facility level (or community level). Data should be aggregated periodically, i.e. monthly or quarterly for the purposes of program management and review.					
DATA SOURCE	**Numerator:** Primary data collection tools which include Pre-ART and ART registers. Where electronic databases exist and are up-to-date in routine recording for the provision of CTX, these can provide and easy and efficient source of data. Pharmacy records can also be used in conjunction with registers. **Denominator:** This is considered in the context of the national policy on CTX and can be either, Total numbers of HIV-positive individuals in the country or the number of HIV-positive individuals receiving HIV care services.					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION:** (Number of HIV-positive individuals receiving Cotrimoxazole prophylaxis at some point during the reporting period. Facilities should focus on compiling data for the numerator from patient registers at facilities) / (Total number of individuals receiving HIV care and support services) X 100					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Number of adults and children with advanced HIV infection newly enrolled on ART
HIS CODE:	HIS064

PROGRAMME GOAL	The goal of this indicator is assesses progress in providing antiretroviral combination therapy to everyone with advanced HIV infection

REFERENCES	AOP	PEPFAR	NASCOP
CODES	AOP-29	T1.1.D	HIV03-02

DEFINITION OF IMPORTANT TERMS	**Advanced HIV infection:** Advanced HIV/AIDS disease case is defined for surveillance as: any clinical stage 3 or 4 disease or, where CD4 is available, any CD4 count of less than350. **Newly enrolled on ART:** NEW refers to a patient, who starts lifelong HAART at any facility in the country or system and is a state defined by an individual's beginning in a program, it is expected that the characteristics of new clients are recorded at the time they newly initiate into a program. Patients are counted as pregnant if they were pregnant at initiation of ART. Age represents an individual's age at initiation of therapy.					
NUMERATOR	Number of adults and children with advanced HIV infection newly enrolled on ART					
DENOMINATOR	None					
UNIT OF MEASURE	Number					
DISAGGREGATION	By sex: Male and Female, By age: <1, <15, 15+, TB patient and Pregnant women or by district, county, region and national					
INDICATOR LEVEL	Output					
PURPOSE	Measures scale-up of ART program and for pregnant women disaggregation offers a measure of the linkages between PMTCT and treatment programs.					
FREQUENCY	Data should be collected continuously at the facility level (or community level). Data should be aggregated periodically, i.e. monthly or quarterly for the purposes of program management and review.					
DATA SOURCE	Facility ART registers/databases, program monitoring tools, or drug supply management systems					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	The numerator can be generated by counting the number of adults and children who are newly enrolled in ART in the reporting period, in accordance with the national approved treatment protocol. Patients with records that transfer in from another facility, or who temporarily stopped therapy and have started again in the time period should not be counted. ART taken only for the purpose of prevention of mother-to-child transmission and post-exposure prophylaxis are not included in this indicator. However, HIV-positive pregnant women who are eligible for and initiate antiretroviral drug therapy for their own treatment are included in this indicator.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Percentage of adults and children with advanced HIV infection currently receiving ARVs
HIS CODE:	HIS065

PROGRAMME GOAL	The goal for HIV program is to ensure that all HIV positive patients who meet the treatment criteria receive ARV treatment

REFERENCES	KNASP	UNGASS	AOP	WHO	PEPFAR	NASCOP
CODES	3.0.2	UNG-4	AOP-30	UA-G2	T1.2.D	HIV03-03

DEFINITION OF IMPORTANT TERMS	**CURRENT on ART**: Refers to the number of patients currently on ART (includes all who picked ARTs within the month and those at home but with ART) at a given facility and does include patients who transfer in but exclude all Patients who transferred out, or are categorized as DROP OUT, DEAD, LOST or STOPPED.
NUMERATOR	Number of adults and children with advanced HIV infection who are currently receiving antiretroviral therapy at the end of the reporting period.
DENOMINATOR	Estimated number of adults and children with advanced HIV infection (in need of ARVs).
UNIT OF MEASURE	Percentage
DISAGGREGATION	By sex: Male and Female, By age: <1, <15, 15+ or by district, county, region and national levels
INDICATOR LEVEL	Output
PURPOSE	This indicator assists in assessing progress towards set goals. These goals can be national or regional, yearly or multi-yearly depending on the application (strategic or operational).
FREQUENCY	Data should be collected continuously at the facility level and summarized monthly for reporting.
DATA SOURCE	**Numerator:** Facility ART registers/databases, Daily activity register at CCCs, program monitoring tools, or drug supply management systems.
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION:** (Number of adults and children with advanced HIV infection who are currently receiving antiretroviral therapy at the end of the reporting period) / (Estimated number of adults and children with advanced HIV infection (in need of ARVs) X 100 Data for this indicator is generated by counting the number of adults and children who are currently receiving ART in accordance with the nationally approved treatment protocol at the end of the reporting period. The numerator should equal the number of adults and children with advanced HIV infection who ever started ART minus those patients who are not currently on treatment prior to the end of the reporting period. Patients excluded from the numerator are patients who died, stopped treatment, transferred out or are lost to follow-up (patient not seen for 3 months from last visit). Patients on ART who initiated or transferred in during the reporting period should be counted. HIV-positive pregnant women who are eligible for and on antiretroviral drugs for their own treatment are included in this indicator.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Number of adults and children with advanced HIV infection ever enrolled on ART
HIS CODE:	HIS066

PROGRAMME GOAL	The goal for the HIV Program is to ensure that all HIV positive patients who meet the treatment criteria receive ARV treatment

REFERENCES	PEPFAR	NASCOP
CODES	T1.4.D	HIV03-04

DEFINITION OF IMPORTANT TERMS	**Cumulative Ever Started on ART**: Refers to the number of patients ever started on ART as NEW at that specific facility, and does not include patients who transferred in. **Patients who transfer out, or are categorized as DROPPED OUT, DEAD, LOST or STOPPED, are not subtracted.**					
NUMERATOR	Number of adults and children with advanced HIV infection who have ever initiated ART at the specific facility, in accordance with the nationally approved treatment protocol at the end of the reporting period					
DENOMINATOR	None					
UNIT OF MEASURE	Number					
DISAGGREGATION	By sex: Male and Female, By age: <15, 15+ or by district, county, region and national levels					
INDICATOR LEVEL	Output					
PURPOSE	To assess progress towards providing ART to all people with advanced HIV infection; Coverage; Track progress towards legislative 5-year goals. Together with other ART indicators provides some understanding of ART patient attrition. As well as describes overall scale up of ART services					
FREQUENCY	Data should be collected continuously at the facility level and summarized monthly for reporting.					
DATA SOURCE	Facility ART registers/databases, program monitoring tools, or drug supply management systems.					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	The numerator can be generated by counting the number of adults and children who have ever enrolled in ART by the end of the reporting period. The numerator should equal the number of adults and children with advanced HIV infection who newly started ART since the last reporting period added to those that had ever enrolled in therapy in the last reporting period.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Percentage of adults and children with HIV known to be alive and on ART treatment 12 months after initiation on antiretroviral therapy
HIS CODE:	HIS067

PROGRAMME GOAL	One of the goals of the ART programme is to increase survival among infected individuals

REFERENCES	KNASP	UNGASS	WHO	PEPFAR	GFTAM	NASCOP
CODES	3.0.1	UNG-24	UA-G3a	T1.3.D	HIV-I3	HIV03-05

DEFINITION OF IMPORTANT TERMS	**ART Cohort analysis**: Refers to a simplified cohort analysis which is a key component of ART patient monitoring. It should not be confused with cohort studies which are a demanding research activity. In patient monitoring of ART, a cohort is an ART start-up group which consists of all patients starting ART in the same month. Cohort analysis compares baseline characteristics of patients who started on ART with their status at 6 and 12 months, then yearly. It allows comparison of the proportion of patients surviving on ART, remaining on the original first-line regimen (or substituting to an alternative first-line regimen).
NUMERATOR	Number of adults and children who are still alive and on antiretroviral therapy at 12 months after initiating treatment.
DENOMINATOR	Total number of adults and children who initiated antiretroviral therapy, 12 months ago.
UNIT OF MEASURE	Percentage
DISAGGREGATION	By district, county, region and national levels
INDICATOR LEVEL	Outcome
PURPOSE	The intention of ART provision is to prolong life of PLHIV. Therefore high retention is one important measure of programme success and is a proxy for overall quality of programme. This indicator builds up from the lower levels where additional information is required covering longevity on a given line of drugs and the causes of attrition.
FREQUENCY	Data should be collected continuously at the facility level. Data should be aggregated at the end of the year in time for national reporting. However, selected facilities can continuously monitor the trends over time (quarterly) as each month will have a cohort that matures to 12 months.
DATA SOURCE	Program monitoring tools; ART registers/databases and cohort summary sheet.
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	The numerator requires that adult and child patients must be alive and on ART at 12 months after their initiation of treatment. For a comprehensive understanding of survival, the following data must be collected: • Number of adults and children in the ART start-up groups (less TOs plus TIs) initiating ART at 12 months prior to the end of the reporting period (denominator) • Number of adults and children still alive and on ART at 12 months after initiating treatment (numerator) The reporting period is defined as a continuous 12-month period that has ended within a pre-defined number of months from the submission of the

	report.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Proportion of women receiving Care screened for Cervical Cancer
HIS CODE:	HIS068

PROGRAMME GOAL	To determine coverage of screening services for cervical cancer in HIV-positive women

REFERENCES	NASCOP	
CODES	HIV03-06	

DEFINITION OF IMPORTANT TERMS	**Cervical cancer:** is a disease in which the cells of the cervix become abnormal and start to grow uncontrollably, forming tumours. **Cervical cancer screening in HIV positive women**: HIV positive women are more prone to develop cervical cancer. It is recommended that because of this high risk, counselling and regular cervical cancer screening using pap smear is performed for all HIV positive women.
NUMERATOR	Total number of HIV infected women in care screened for Cervical Cancer within HIV care settings according to National guidelines
DENOMINATOR	Number of women in care who made a clinical visit (excl PMTCT) during the period
UNIT OF MEASURE	Percentage
DISAGGREGATION	By district, county, region and national levels
INDICATOR LEVEL	Output
PURPOSE	Cervical cancer is the biggest cause of cancer deaths among women in sub-Saharan Africa, due in large part to lack of screening. However, HIV infection and immunodeficiency exacerbate the progression of pre-cancerous lesions, and the high prevalence of cervical cancer and pre-cancerous changes in women with HIV has led to efforts to incorporate cervical screening into HIV clinics and other health services. The purpose of screening for cervical cancer is twofold. o First, screening reduces the risk of cervical cancer by identifying women with precancerous conditions that can be treated before the conditions progress to cancer. o Second, screening can identify women with cervical cancer before symptoms appear.
FREQUENCY	Data are collected/collated routinely and aggregated at the end of the reporting period.
DATA SOURCE	HIV care activity sheet
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = [Total number of HIV infected women in care screened for Cervical Cancer within HIV care settings according to National guidelines] / [Number of women in care who made a clinical visit (excl PMTCT) during the period] X 100

	Only women screened outside the PMTCT settings should be counted and only one count per women per reporting period. This indicator is intended to provide information on the proportion of HIV-positive women in HIV care and treatment who are screened for cervical cancer at last visit. It measures HIV care/ART clinical team performance in screening for cervical cancer among women at every visit.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Percentage of HIV patients screened for TB
HIS CODE:	HIS069

PROGRAMME GOAL	The goal for KNASP III is to ensure that all HIV positive patients in care are screened for TB on each visit

REFERENCES	KNASP	WHO	PEPFAR	Other	NASCOP
CODES	3.3.3	UA-E3	C2.4.D	TB-HIV1	HIV03-07

DEFINITION OF IMPORTANT TERMS	**Screening for TB:** It is important to check the TB status of patients at each HIV care visit. Between 5% and 15% of HIV patients will develop TB disease each year. It is therefore essential to determine TB status at each HIV care visit, to send sputum or refer patients promptly for investigation when TB is suspected, and to make sure that these results are used, that treatment starts promptly, and that TB and HIV care are well coordinated. TB monitoring should be linked to HIV care/ART monitoring.
NUMERATOR	Number of HIV positive patients screened for TB
DENOMINATOR	Number of HIV positive individuals in care [who made a clinical visit], during the reporting period
UNIT OF MEASURE	Percentage
DISAGGREGATION	By district, county, region and national levels
INDICATOR LEVEL	Output
PURPOSE	TB disease is the leading cause of mortality among PLWH. Screening for TB among PLWH at initial and subsequent visits is recommended to identify TB suspects and link them to diagnosis and treatment.
FREQUENCY	Data should be collected and collated continuously at the facility level and aggregated at the end of the reporting period. This indicator is reported quarterly.
DATA SOURCE	Revised versions (2010) of the Pre-ART/ART registers and Tb register
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = Number of HIV positive patients screened for TB Number of HIV positive individuals in care [who made a clinical visit], during the reporting period The numerator can be generated by counting the number of HIV-positive adults and children in HIV care or treatment (pre-ART or ART) who were screened for TB disease during the reporting period.

	Note: For details, read up the procedures [2010 edition] for completing the revised ART and Pre-ART Registers. This indicator is intended to provide information on the proportion of HIV-positive patients in HIV care and treatment who are screened for TB at last visit. It measures HIV care/ART clinical team performance in checking TB status at every visit .This could be measured by reviewing a sample of HIV care/ART cards during a visit by the TB or ART district coordinator.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Percentage of TB/HIV co-infected clients who are started on ARVs
HIS CODE:	HIS070

PROGRAMME GOAL	The TB/HIV indicators measure commitment and capacity of TB services or HIV care/ART clinics to ensure that HIV-positive TB patients are able to access ART, and that HIV/AIDS patients are regularly screened, diagnosed and treated for TB

REFERENCES	KNASP	UNGASS	WHO	NASCOP
CODES	3.3.1	UNG-6	UA-E1	HIV03-08

DEFINITION OF IMPORTANT TERMS	**TB/HIV co-morbidity**: High co-morbidity between TB and HIV requires effective coordination, referral and communication between TB and HIV/AIDS programme and co-management of TB/HIV by clinical teams to enable effective care and treatment of both diseases. Integrated monitoring and evaluation of the TB and HIV programmes captures information on how well HIV prevention, diagnosis and care or referral for HIV care take place within the TB programme and likewise, how well TB screening, prevention and treatment is occurring in HIV care/ART programme.
NUMERATOR	Number of TB/HIV co-infected adults and children on TB treatment who started on ART during the reporting period.
DENOMINATOR	Total Number of TB/HIV co-infected patients still on TB treatment
UNIT OF MEASURE	Percentage
DISAGGREGATION	By district, county, region and national levels
INDICATOR LEVEL	Output
PURPOSE	ART significantly improves the quality of life, reduces morbidity, and enhances the survival of people with advanced HIV infection or AIDS. HIV-positive TB patients are one of the largest groups already in contact with the health service who are likely to benefit from ART, and efforts should be made to identify and treat those who are eligible. This indicator measures the degree to which ART has become a component of the package of care offered to HIV-positive TB patients. As an outcome indicator it measures commitment and capacity of TB services.
FREQUENCY	Collected continuously and reported quarterly.
DATA SOURCE	Both numerator and denominator are obtained from the TB programme registers
DATA MANAGEMENT AND INDICATOR COMPUTATION	This can be measured in the ART register by adding up the number of patients with a TB treatment start date within the reporting period. This can be compared with TB/HIV indicator captured by the TB programme, the number and percentage of HIV-positive TB patients who are started on ART or continue

GUIDELINES	previously initiated ART during or at the end of TB treatment.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Percentage of eligible PLHIV (adults and children) receiving Therapeutic or Supplementary Food
HIS CODE:	HIS071

PROGRAMME GOAL	The goal of the nutrition care and support for PLHIV is to improve nutrition, health, quality of life and duration of survival of people infected with HIV

REFERENCES	KNASP	PEPFAR	NASCOP
CODES	3.4.1	C2.3.D	HIV03-09

DEFINITION OF IMPORTANT TERMS	**Nutrition**: refers to the process how food is processed and utilized by the body for growth, reproduction and maintenance of health. **Malnutrition**: a condition in the body brought about by inadequate or excess intake of required nutrients or mal-absorption.
NUMERATOR	Number of CCC clients who received the minimum nutrition care package
DENOMINATOR	Number of clients who were nutritionally assessed and found to be clinically malnourished during the reporting period.
UNIT OF MEASURE	Percentage
DISAGGREGATION	By district, county, region and national levels
INDICATOR LEVEL	Output
PURPOSE	This indicator measures the coverage achieved for food support of clinically malnourished clients. It can be used to plan interventions and allocation of resources for food and nutrition as needed, and also to assess the impact of interventions.
FREQUENCY	Data should be collected continuously at the facility level and reported monthly.
DATA SOURCE	Numerator can be obtained from the nutrition register while the denominator can be obtained from the HIV care activity sheet.(Daily activity Register for CCCs)
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = [Number of TB/HIV co-infected adults and children on TB treatment who started on ART during the reporting period] / [Total Number of TB/HIV co-infected patients still on TB treatment] X 100 The numerator can be generated by counting the number of clinically malnourished clients who received therapeutic and/or supplementary food. For details on procedures, refer to the "Kenyan Guidelines on Nutrition and HIV/AIDS" To address malnutrition and strengthen care and support, therapeutic, supplementary and supplemental food provision has been introduced in the HIV program. Results from this indicator provide information about the extent that food support is reaching eligible clients and where gaps may exist. The indicator provides information about coverage, but not about the duration of food support provided to clients, drop-out rates, quality of the foods, or existence of complementary interventions with the food.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Percentage of ART clients with improved nutrition
HIS CODE:	HIS072

PROGRAMME GOAL	The goal of the nutrition care and support for PLHIV is to improve nutrition, health, quality of life and duration of survival of people infected with HIV

REFERENCES	NASCOP
CODES	HIV03-10

DEFINITION OF IMPORTANT TERMS	An improved nutrition status is desired for ART clients because when the immune system is functioning properly, it helps slow the progression of HIV into AIDS and increases survival. The achievement of the full function of the immune system requires an array of essential micronutrients and adequate macronutrients achieved through good nutrition.					
NUMERATOR	Number of adults and children ART clients found to be malnourished at initiation of nutrition support that are considered to have recovered from malnutrition upon completion of nutritional food support at 6mths.					
DENOMINATOR	Total number of ART clients put on nutrition support who have matured to 6 months at the reporting period.					
UNIT OF MEASURE	Percentage					
DISAGGREGATION	Disaggregation in age group (0-59mths; 5-17 yrs; 18+ yrs), or By district, county, region and national levels					
INDICATOR LEVEL	Outcome					
PURPOSE	Antiretroviral drugs can have both implicit and explicit consequences for the person living with HIV/AIDS. Good nutrition is critical to the treatment, management and success of any medical intervention against diseases-including HIV/AIDS. While good nutrition cannot prevent HIV infection or cure AIDS, it can help to maintain and improve the nutritional status of persons with the virus and very possibly, delay the disease progression from HIV to AIDS—related diseases by boosting defences.					
FREQUENCY	Data should be collected continuously at the facility level and reported monthly.					
DATA SOURCE	Numerator can be obtained from the nutrition register while the denominator can be obtained from the HIV care activity sheet.					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = [Number of adults and children ART clients found to be malnourished at initiation of nutrition support that are considered to have recovered from malnutrition upon completion of nutritional food support at 6mths] / [Total number of ART clients put on nutrition support who have matured to 6 months at the reporting period] X 100 The numerator can be generated by counting the number of malnourished ART clients whose nutrition status improved from nutrition register. Results from this indicator provide information about the extent that food support is reaching eligible clients and improving their nutrition status.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Number of males circumcised as part of the minimum package of Male Circumcision (MC) for HIV prevention services
HIS CODE:	HIS073

PROGRAMME GOAL	Reduce men's risk of infection with HIV through vaginal intercourse, there by contributing to preventing the spread of HIV/AIDS in the general population

REFERENCES	KNASP	PEPFAR	NASCOP
CODES	2.4.1	P5.1.D	HIV04-01

DEFINITION OF IMPORTANT TERMS	**Male circumcision**: refers to the surgical removal of the foreskin, the tissue covering the head of the penis. It is widely practiced for religious and traditional reasons, often within the first two weeks after birth or at the beginning of adolescence as a rite of passage into adulthood. As a medical procedure, it is also performed to treat problems involving the foreskin. As a prevention for HIV prevention services.					
NUMERATOR	Number of males circumcised as part of the minimum package of MC for HIV prevention services (counselling & testing, STI screening & treatment, ABC, local anaesthesia and follow-up) per national standards and in accordance with a clinical manual within the reporting period.					
DENOMINATOR	None					
UNIT OF MEASURE	Number					
DISAGGREGATION	Disaggregate by: age group (0 -14, 15-24, 25+, HIV status)					
INDICATOR LEVEL	Output					
PURPOSE	For optimal effect on the population, uptake of male circumcision should be as high and as rapid as safely possible. The total number of males circumcised indicates either change in the supply of or demand for MC services. Additionally, disaggregated information may be useful to evaluate whether prioritized services have been successful, set targets have been achieved, and modelling inputs should be adjusted.					
FREQUENCY	Collected routinely and reported monthly					
DATA SOURCE	Theatre Register					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	The sum of clients documented as having received MC within the reporting period from the theatre register.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Number of Male Circumcision (MC) clients who experienced one or more moderate or severe adverse events within the reporting period
HIS CODE:	HIS074

PROGRAMME GOAL	Reduce men's risk of infection with HIV through vaginal intercourse, there by contributing to preventing the spread of HIV/AIDS in the general population

REFERENCES	PEPFAR	NASCOP
CODES	P5.2.D	HIV04-02

DEFINITION OF IMPORTANT TERMS	**Moderate/Severe Adverse Events**: Refers to the seriousness of the reported adverse event (AE). These events may include anaesthesia reaction, bleeding, infection, pain, wound disruption, sexual dysfunction, and injury to glands which are classified as mild, moderate or severe in accordance with the seriousness. The severity of the AE may require medical treatment or hospitalization or referral to another facility.
NUMERATOR	Number of moderate or severe adverse events as per defined standards in the clinical manual within the reporting period.
DENOMINATOR	None
UNIT OF MEASURE	Number
DISAGGREGATION	By severity (moderate / severe; By timing (during / post MC)
INDICATOR LEVEL	Outcome
PURPOSE	Like all surgeries, male circumcision is not without risk, and the performance and reporting of safe MC services depends in part upon skill and quality of surgery, effectiveness of post-operative instructions, willingness or ability of the patient to follow post-operative instructions, suitability of the surgical candidate, level of CD4 count if HIV-positive, and the judgment of the healthcare personnel assessing AEs. Intra- and post-operative complications must be monitored to ensure maximization of the provision of safe, quality MC services, and in turn engender trust in communities and foster high demand for MC services.
FREQUENCY	Data are collected during surgery and thereafter
DATA SOURCE	Adverse Events Forms
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Sum of clients experiencing moderate and severe adverse events documented in Adverse Event Form. - It is the date of surgery, not the date of AE(s) that must fall within the reporting period. - For reporting purposes, AEs include MC cases involving an occupational exposure to blood/body fluids. Occupational exposure to blood/body fluids (splash, sharps injuries) are based upon guidelines set forth in the WHO/ILO Post-exposure Prophylaxis to Prevent HIV Infection

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Proportion of people (other than in PMTCT) reported to be exposed to HIV who was provided with post-exposure prophylaxis within 72 hours of exposure
HIS CODE:	HIS075

PROGRAMME GOAL	The goal of Post exposure prophylaxis (PEP) is to provide a medical response to prevent the transmission of pathogens after potential exposure

REFERENCES	KNASP	PEPFAR	NASCOP
CODES	2.5.2	P6.1.D	HIV05-01

DEFINITION OF IMPORTANT TERMS	**Post exposure prophylaxis for HIV:** refers to a set of comprehensive services to prevent infection in the exposed person These services include first aid care, counselling and risk assessment, HIV testing following informed consent, and depending on risk assessment, the provision of short term (28 days) antiretroviral drugs, with follow up and support.					
NUMERATOR	Number of people provided with post-exposure prophylaxis (PEP)					
DENOMINATOR	Total number exposed and reported					
UNIT OF MEASURE	Percentage					
DISAGGREGATION	By sex age and reason or by district, county, region and national levels					
INDICATOR LEVEL	Output					
PURPOSE	PEP reduces the probability of HIV infection after exposure to potentially HIV-positive blood or body fluids. PEP should be provided within 72 hours after exposure for maximum effectiveness. PEP may be provided for occupational, as well as non-occupational exposure (such as after sexual assault). The data that will be collected through this indicator provides information to answer questions around prevention, program quality, human resources for health, gender, and overall health system strengthening. This information can also assist in scaling up PEP services.					
FREQUENCY	Data will be collected as the event takes place					
DATA SOURCE	[ART service register or PEP register]					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = [Number of people provided with post-exposure prophylaxis (PEP)] / [Total number exposed and reported] X 100 The indicator can be generated by counting the number of individuals receiving PEP for occupational and non-occupational purposes. Individuals should be counted only once					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Percentage of donated blood units screened for TTIs in a quality assured manner
HIS CODE:	HIS076

PROGRAMME GOAL	To eliminate or substantially reduce HIV and other transfusion-transmissible infections (TTIs) through a blood safety programme

REFERENCES	KNASP	UNGASS	AOP	PEPFAR	GFTAM	NASCOP
CODES	2.6.1	UNG-3	AOP-32	P2.1.N	HIV-P17	HIV06-01

DEFINITION OF IMPORTANT TERMS	**Quality Assured Manner**: The overall goal of the National Blood Transfusion Services is to ensure that only blood products of demonstrated quality, safety and efficacy are used. NBTS has put in quality assurance systems to control quality and safety of blood products to assure quality and safety of blood and plasma and to prevent transmission of blood-borne viral diseases via blood products.
NUMERATOR	Number of blood units screened for TTIs (Includes HIV, Hepatitis B, Hepatitis C, Syphilis) in a quality assured manner
DENOMINATOR	Total number of blood units donated
UNIT OF MEASURE	Percentage
DISAGGREGATION	By district, county, region and national levels
INDICATOR LEVEL	Process
PURPOSE	Blood safety programs aim to ensure that all blood units are screened for transfusion-transmissible infections, including HIV, and that only those units that are non-reactive on screening tests are released for clinical use. Universal screening of donated blood for HIV and other transfusion transmissible infections cannot be achieved without mechanisms to ensure quality and continuity in screening. It is crucial that all donated blood units be screened for HIV in a quality assured manner. The following methodologies are two key components of quality assurance in screening. 1. The use of documented standard operating procedures for the screening of every blood unit. 2. Participation of the laboratories in an External Quality Assessment Scheme for HIV screening in which external assessment of the laboratory's performance is conducted using samples of known, but undisclosed, content to assess its quality system and assist in improving standards of performance.
FREQUENCY	Annual
DATA SOURCE	Routine program monitoring and assessment.
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**Explanation of numerator**: For the purposes of data collection screening in a quality assured manner is defined as screening performed in blood centers/blood screening laboratories that (i) follow documented standard operating procedures and (ii) participate in an external quality assurance (EQA) scheme **Explanation of denominator**: In this context, donation refers to any blood collected for the purposes of medical use. The following information is required to measure this indicator. 1. The total number of blood units that were donated

	2. For each blood screening laboratory/center that screens donated blood for HIV: i. The number of units of blood donated in each blood laboratory/center; ii. The number of donated units screened in the blood laboratory/center; iii. If the blood screening laboratory followed documented standard operating procedures for HIV screening; iv. If the blood screening laboratory participated in an External Quality Assessment Scheme for HIV screening. From this information, the indicator can be calculated.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Number of units of whole blood collected by National Blood Transfusion Services (NBTS) networks and screened for TTIs per 1,000 population per year
HIS CODE:	HIS077

PROGRAMME GOAL	To eliminate or substantially reduce HIV and other transfusion-transmissible infections (TTIs) through a blood safety programme

REFERENCES	PEPFAR	NASCOP
CODES	P2.2.D, P2.2.N	HIV06-02

DEFINITION OF IMPORTANT TERMS	Every unit of whole blood collected by facilities in the NBTS network must be screened for HIV, HBV, HCV, and syphilis in order to be counted as "collected and screened by the NBTS network." The numerator, therefore, reflects the safety as well as the quantity of blood collected each year. NBTS program managers must be vigilant throughout the year to ensure that quality controls are maintained at all of the laboratories (public and private) contributing screened units to this numerator. In order to be available for transfusion, units must also not have been discarded for any other reason (e.g., contamination, leak).
NUMERATOR	Number of units of whole blood collected by NBTS networks and screened for TTIs per 1,000 population per year
DENOMINATOR	None
UNIT OF MEASURE	Number
DISAGGREGATION	County, Region and National levels
INDICATOR LEVEL	Process
PURPOSE	Often, even when screening does occur, the safety of blood is compromised by inaccurate test results due to the poor quality or incorrect storage of test kits. Furthermore, inadequate staff training or a lack of standard operating procedures may result in laboratory errors. This could lead to blood units being classified as safe even when they are infectious, posing a serious risk of transmission of HIV through unsafe blood. Thus, it is crucial that all donated blood units be screened for HIV in a quality assured manner.
FREQUENCY	Data on the number of whole blood units collected and screened by the NBTS network should be collected continuously at the facility level, and reported quarterly for the purpose of programmatic management and review. The

	number of whole blood units collected, screened and made available for transfusion per 1,000 populations should be reported annually.
DATA SOURCE	NBTS will enter blood collection and screening information into electronic database, including a count of the number of units discarded due to reactivity for any of the four TTI, and a count of the number of units discarded for any other reason (e.g., contamination or damage/loss during the collection or screening process). With these data, the database calculates the number of "safe and available" units after discards for TTI reactivity and other causes are subtracted from the total number of units collected. Specifically, the numerator will be drawn from the question, "Total number of whole blood units collected and screened by the NBTS that were determined to be safe and available for transfusion after TTI screening. (Units available for screening – Total discards)."
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	The number of units of whole blood collected by the National Blood Transfusion Service (NBTS) network: The NBTS network includes NBTS and non-NBTS blood collection facilities, some of which screen 100% of the blood they collect using the NBTS screening algorithm. Others send 100% of the blood they collect to be screened by an NBTS laboratory. The NBTS data service will monitor collection, screening and discard data on a routine basis and ensure these data from all network facilities are aggregated on an annual basis. To obtain the number of units collected and screened per 1,000 population per year, the aggregated annual total should be multiplied by 1,000 and divided by the national population.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Percentage of blood units screened and found positive for HIV by NBTS network
HIS CODE:	HIS078

PROGRAMME GOAL	To eliminate or substantially reduce HIV and other transfusion-transmissible infections (TTIs) through a blood safety programme

REFERENCES	PEPFAR	NASCOP
CODES	P2.4.N	HIV06-03

DEFINITION OF IMPORTANT TERMS	**Blood units screened and found HIV positive:** Refers to blood which has been collected from voluntary blood donors, tested for HIV infection and found to be reactive.
NUMERATOR	No of blood units screened and found positive for HIV by NBTS networks
DENOMINATOR	Total blood units screened for HIV by NBTS networks
UNIT OF MEASURE	Percentage
DISAGGREGATION	County, Region and National levels
INDICATOR LEVEL	Outcome
PURPOSE	A well-coordinated national blood transfusion service (NBTS) is a source of safe blood. The safety of NBTS blood is the result of two primary activities: 1) The

	collection of blood from low-risk voluntary, non-remunerated donors; and 2) Quality assured laboratory screening of all units for four main transfusion-transmissible infections, or TTI (HIV, HBV, HCV and syphilis). Based on aggregated annual data on the number NBTS-collected blood units which are screened for HIV in an NBTS network laboratory, and the number of these units which are identified as reactive for HIV. This indicator will serve as the HIV sero-prevalence estimate for the national blood donor pool. The MoH has developed standards for HIV screening and establishing safe blood transfusion status. Successful outcomes of the blood safety program can be measured by monitoring how many blood units are screened according to MoH standards.					
FREQUENCY	All NBTS laboratories maintain daily screening logs, and most report HIV reactive units to the blood bank on a daily basis to ensure these units are removed from quarantine and discarded promptly. The NBTS aggregates data on the number of units screened for HIV and HIV reactive units quarterly for programmatic reporting. These quarterly totals are aggregated at the mid-point and end of each year.					
DATA SOURCE	For the numerator and denominator: NBTS will enter blood collection and screening information into electronic database, including a count of the number of units discarded due to reactivity for any of the four TTI, and a count of the number of units discarded for any other reason (e.g., contamination or damage/loss during the collection or screening process). With this information, the database will be used to collect and aggregate data on the number of blood units screened for HIV and the number of these units which are identified as HIV reactive.					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**Numerator:** NBTS laboratories will report HIV screening results to NBTS data managers on a routine basis (often daily). NBTS data managers will enter information on HIV reactive units into the database. The database will automatically aggregate this data on a quarterly, semi-annual, and annual basis.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Number of the targeted population reached with individual and/or small group level preventive interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required
HIS CODE:	HIS079

PROGRAMME GOAL	Promotion of the ABC behavioural strategies to reduce HIV transmission

REFERENCES	PEPFAR	NASCOP
CODES	P8.2.D	HIV07-01

DEFINITION OF IMPORTANT TERMS	**ABC strategy**: refers to "population-specific interventions" that emphasise: **A**bstinence for youth, including the delay of sexual debut and abstinence until marriage **B**eing tested for HIV and being faithful in marriage and monogamous relationships **C**orrect and consistent use of condoms for those who practice high-risk behaviours. Those who practice high-risk behaviours include "prostitutes, sexually active discordant couples [in which one partner is known to have HIV], substance abusers, and others".
NUMERATOR	Number of target population reached with individual and/or small group level HIV prevention interventions that are primarily focussed on abstinence and/or be faithful and are based on evidence and/or meet the minimum required standards.
DENOMINATOR	Total number of intended target population in the catchment population
UNIT OF MEASURE	Number
DISAGGREGATION	Sex (male/female); Age(10-14, 15-19, 20-24, 25+)
INDICATOR LEVEL	Output
PURPOSE	This information will be used to report to congress on AB only interventions.
FREQUENCY	Data should be collected continuously at the organization level. Data should be periodically aggregated, i.e. quarterly, for the purposes of program management and review as well as meeting semi-annual and annual reporting requirements.
DATA SOURCE	Data can be obtained from program monitoring tools.
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**Explanation of Numerator** The numerator can be generated by counting the number of de-duplicated individuals from an activity defined target population who are reached primarily through AB prevention intervention. **Primarily focused:** The messages and content of the activities spend the majority of their time discussing; increasing individual and group's self-risk assessments; building the skills; and other supportive behavioural, cognitive and social components to increase the AB behaviours. **Abstinence and/or being faithful:** AB interventions can include programs, services, and messages which encourage sexual abstinence, delay of sexual debut and secondary abstinence, mutual fidelity, mutual knowledge of HIV status, and social and gender norms which promote mutual respect and open

	communication about sexuality. AB interventions can also include programs, services, and messages which discourage multiple and/or concurrent partnerships, cross-generational and transactional sex, sexual violence, stigma, and other harmful gender norms and practices. AB interventions targeting youth should support skills-based sexuality and AIDS education as well as involve parents and guardians to improve communication with children and parenting skills. **Explanation of Denominator:** **Catchment area:** Geographic region from which persons come to receive HIV prevention services, or from which persons are being recruited into HIV prevention services.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Number of MARPs reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards required
HIS CODE:	HIS080

PROGRAMME GOAL	Increased access to HIV/AIDS and reproductive health services for MARPs and their sexual partners

REFERENCES	PEPFAR	NASCOP
CODES	P8.3.D	HIV08-01

DEFINITION OF IMPORTANT TERMS	**MARPs** = Most at risk populations; includes female and male sex workers, men who have sex with men, injecting drug users, prisoners, truckers 2) Range of HIV/STI package of services proposed in National Guidelines for Sex Worker HIV/STI Interventions includes Basic, Clinical, Non-Clinical and Enabling Environment which comprise of the following components: • **Basic:** Outreach and peer education; Risk assessment, risk reduction counselling and skills building; demonstration and distribution of condoms and lubricants and promotion of 100% condom use • **Clinical:** HIV testing and counselling; STI screening and treatment; TB screening and referral to treatment; HIV care and treatment; Reproductive health services (FP, PAC, cervical cancer screening); emergency contraception; PEP; Substance abuse, assessment and treatment • **Non-Clinical**: Psychosocial support; Services to mitigate sexual violence; Family and social services; Support to expand choices beyond sex work • **Enabling Environment**: Community mobilization; Behaviour change communication; service provider sensitization and training; Stigma and discrimination reduction
NUMERATOR	Number of MARPS reached with individual and/or small group level prevention interventions that are based on/or meet the minimum required standards.
DENOMINATOR	Total number of intended target population in the catchment population
UNIT OF MEASURE	Number
DISAGGREGATION	Sex (male/female); MARP Type (CSW, IDU, MSM, others)
INDICATOR LEVEL	Output

PURPOSE	Individual and small-group level prevention interventions have been shown to be effective in reducing HIV transmission risk behaviours. Delivering these interventions with fidelity to the appropriate populations is an important component of combination HIV prevention strategies.
FREQUENCY	Collect daily and report monthly
DATA SOURCE	Sentinel sites and use summary form MOH 711 and COBPAR based on data from daily tally sheets and facility registers
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Frontline service provider summarizes the monthly service statistics and fills summary form for service delivery point; the HRIO or site/program in-charge completes the MOH 738 form and submits to the DHRIO who aggregates the district level statistics and uploads summary to web-based database which is accessed at central level by HIS and NASCOP MARP Manager for quarterly program reviews.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Number of MARPS reached with individual and/or small group level HIV/STI package of services as per national guidelines
HIS CODE:	HIS081

PROGRAMME GOAL	Increased access to HIV/STI and reproductive health services for MARPs and their sexual partners; Reduced HIV/STI risk and burden among MARPs and their sexual partners

REFERENCES	UNGASS	PEPFAR	GFTAM	NASCOP
CODES	Partially #9	P8.3.D	P4b	HIV08-02

DEFINITION OF IMPORTANT TERMS	1) **MARPs** = Most at risk populations; includes female and male sex workers, men who have sex with men, injecting drug users, prisoners, truckers 2) Range of HIV/STI package of services proposed in National Guidelines for Sex Worker HIV/STI Interventions includes Basic, Clinical, Non-Clinical and Enabling Environment which comprise of the following components: • **Basic:** Outreach and peer education; Risk assessment, risk reduction counselling and skills building; demonstration and distribution of condoms and lubricants and promotion of 100% condom use • **Clinical:** HIV testing and counselling; STI screening and treatment; TB screening and referral to treatment; HIV care and treatment; Reproductive health services (FP, PAC, cervical cancer screening); emergency contraception; PEP; Substance abuse, assessment and treatment • **Non-Clinical**: Psychosocial support; Services to mitigate sexual violence; Family and social services; Support to expand choices beyond sex work • **Enabling Environment**: Community mobilization; Behaviour change communication; service provider sensitization and training; Stigma and discrimination reduction The MARPs TWG intends to expand the guidelines to cover other MARPs sub-populations (MSMs, IDUs, etc.)
NUMERATOR	Number of MARPS that received one or more HIV/STI services at targeted sites

	during the reporting period					
DENOMINATOR	None					
UNIT OF MEASURE	Number					
DISAGGREGATION	By Sex-Male/Female, MARP type-MSM, SW,IDUs					
INDICATOR LEVEL	Output					
PURPOSE	Assess coverage and uptake of HIV/STI services for MARPS as per set targets; Identifying program gaps and for program planning and budgeting					
FREQUENCY	Collect daily and report monthly					
DATA SOURCE	Sentinel sites and using summary reporting forms and COBPAR based on data from daily tally sheets and facility registers					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Frontline service provider summaries the monthly service statistics and fills summary form for service delivery point; the HRIO or site/program in-charge completes the reporting forms or COBPAR form and submits to the DHRIO and CACC Coordinator who aggregates the district/constituency level statistics and uploads summary to web-based database which is accessed at central level by HIS, NASCOP and NACC					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Number of HIV positive MARPS provided with HIV care referral
HIS CODE:	HIS082

PROGRAMME GOAL	Increased access to HIV/STI and reproductive health services for MARPs and their sexual partners; Reduced HIV/STI risk and burden among MARPs and their sexual partners

REFERENCES	NASCOP
CODES	HIV08-03

DEFINITION OF IMPORTANT TERMS	1) **MARPs** = Most at risk populations; includes female and male sex workers, men who have sex with men, injecting drug users, prisoners, truckers 2) Range of health care referrals for HIV positive MARPs proposed in National Guidelines for Sex Worker HIV/STI Interventions includes: • **Clinical**: HIV care and treatment; STI screening and treatment; TB screening and referral to treatment; Prevention with Positives; Reproductive health services (FP, PAC, cervical cancer screening); emergency contraception; PEP; Substance abuse, assessment and treatment • **Non-Clinical**: Psychosocial support; Services to mitigate sexual violence **NOTE:** The MARPs TWG intends to expand the guidelines to cover other MARPs sub-populations (MSMs, IDUs, etc.)
NUMERATOR	1) Number of newly diagnosed HIV positive MARPS that were offered referral for HIV care and treatment services to targeted sites during the reporting period 2) Number of newly diagnosed HIV positive MARPS that accessed HIV care and treatment services through referral at targeted sites during the reporting period
DENOMINATOR	None
UNIT OF MEASURE	Number
DISAGGREGATION	By Sex-Male/Female, MARP type-MSM, SW, IDUs, By referral type: offered and accessed?
INDICATOR LEVEL	Output
PURPOSE	In addition to HIV/STI prevention services, a strong linkage to care and treatment is vital to meet the needs of MARPs that are diagnosed with HIV. This indicator measures the scope of MARPs interventions to serve as an entry point to care and treatment. Existing HIV care and treatment models for the general population may need adaptation to meet the additional health needs of HIV infected MARPs. Tracking both in and out referrals is likely to assess effectiveness of linkages and identify barriers to services for these populations.
FREQUENCY	Collect daily and report monthly
DATA SOURCE	Reporting forms based on data from daily tally sheets and/or facility registers
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Frontline service provider summarizes the monthly service statistics and fills summary form for service delivery point; the HRIO or site/program in-charge completes the MOH 711 form and submits to the DHRIO who aggregates the district level statistics and uploads summary to web-based database which is

	accessed at central level by HIS and NASCOP MARP Manager for quarterly program reviews					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Percentage of PLHIVs reached with a minimum package of Prevention with PLHIV (PwP) interventions
HIS CODE:	HIS083

PROGRAMME GOAL	Reduce HIV Transmission

REFERENCES	PEPFAR	NASCOP
CODES	P7.1.D	HIV09-01

DEFINITION OF IMPORTANT TERMS	The methods for reducing risk for HIV transmission are captured under the disaggregation as follows: Disclosed **HIV status to sexual partner:** Number of PLHIV who reported new disclosure of HIV status to sexual partner **Partner received on-site HIV testing**: Number of people living with HIV (PLHIV) whose sexual partner/s received on-site HIV testing **On-site screening for STIs/RTI**: Number of people living with HIV (PLHIV) who have received on-site screening for STIs/RTI **Modern contraceptive methods**: Number of women LHIV who receive modern contraceptive methods **Provided with condoms**: Number of women LHIV who were provided with condoms **Catchment area**: Geographic region from which persons come to receive HIV prevention services, or from which persons are being recruited into HIV prevention services. The size and population of this area can vary, depending on organization or agency and the services provided. For PLHIV, depending on the target sites, there may be registration available at the local health facility. Alternatively, PLHIV estimates for sub-districts/districts/regions/the nation can be used if available.
NUMERATOR	Number of PLHIVs reached with a minimum package of Prevention with PLHIV (PwP) interventions
DENOMINATOR	Estimated number of PLHIV [in the catchment area]
UNIT OF MEASURE	Percentage
DISAGGREGATION	Disaggregate by: o Disclosed HIV status to sexual partner o Partner received on-site HIV testing o On-site screening for STIs/RTI o Modern contraceptive methods o Provided with condoms
INDICATOR LEVEL	Output
PURPOSE	Prevention efforts with HIV positive persons (PwP) are part of a comprehensive prevention strategy and include both behavioural and biomedical interventions.

	The purpose of this indicator is to measure how well clinic/facility-based program of reaching PLHIV with a minimum package of prevention interventions are performing. Assessment for STIs and (if indicated) provision of or referral for STI treatment and partner treatment is part of the package of interventions designed to protect the health of the infected person and reduce the spread of HIV
FREQUENCY	Data should be collected continuously at the facility level.
DATA SOURCE	HIV care activity sheet
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = [Number of PLHIVs reached with a minimum package of Prevention with PLHIV (PwP) interventions] / [Estimated number of PLHIV (in the catchment area)] X 100 The numerator can be generated by counting the number of PLHIV who are reached with a minimum package of PwP interventions. Minimum Package of PwP interventions required for the indicator: In order to count under this indicator, PLHIV must have received at last visit (in a clinic/facility-based or community/home-based program) the following interventions that constitute the minimum package of PwP: ▪ Assessment of sexual activity and provision of condoms (and lubricant) and risk reduction counselling (if indicated) ▪ Assessment of partner status and provision of partner testing or referral for partner testing ▪ Assessment for STIs and (if indicated) provision of or referral for STI treatment and partner treatment ▪ Assessment of family planning needs and (if indicated) provision of contraception or safer pregnancy counselling or referral for family planning services ▪ Assessment of adherence and (if indicated) support or referral for adherence counselling ▪ Assessment of need and (if indicated) refer or enrol PLHIV in community-based program such as home-based care, support groups, post-test-clubs, etc

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Percentage of clients provided with HCBC services in accordance with the national guidelines
HIS CODE:	HIS084

PROGRAMME GOAL	Ensuring the provision of quality care for the HIV infected and other chronically ill people at the home and community level

REFERENCES	KNASP	NASCOP
CODES	3.2.1	HIV10-01

DEFINITION OF IMPORTANT TERMS	According to the implementation framework, the comprehensive package of Home and Community Based Care (HCBC) package includes: • Clinical and basic nursing care; • Palliative care, pain relief and symptom management, • Life skills development; • Family care and support; • Food and nutrition support; • Prevention of HIV transmission; • Linkage coordination, referral, networking Potential clients for HCBC services include people with HIV and other chronic or terminal illnesses, OVC, clinically malnourished individuals, people with special needs (disabled, nomads, internally displaced, refugees), caregivers and family members of chronically ill patients National guidelines = NASCOP's Implementation Framework for HCBC
NUMERATOR	Number of enrolled clients that received HCBC services during the reporting period
DENOMINATOR	Total number of clients that have been enrolled for HCBC (cumulative)
UNIT OF MEASURE	Percentage
DISAGGREGATION	Disaggregate by age (<15, 15+), Sex; Type of HCBC service (nursing and palliative care, clinical care with treatment literacy, family care and support, nutrition support, referrals to health care and support groups) or district, county and nation
INDICATOR LEVEL	Output
PURPOSE	It is important to ensure that sick persons and their family are able to access the minimum level of care at the community. This indicator will measure the coverage achieved for HCBC to needy sub-groups. It can be used for planning interventions and allocation of resources for specific HCBC interventions as needed. Note: Results on Percentage of PLHIVs receiving HCBC and Percentage of PLHIV receiving nutritional support is needed for reporting to the HIV program.
FREQUENCY	Data collected continuously at facility and community level but aggregated and reported monthly
DATA SOURCE	Facility and District HCBC tools aggregated from CHW/CHEW and HCBC desk diary or registers
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATOR = [Number of enrolled clients that received HCBC services during the reporting period] / [Total number of clients that have been enrolled for HCBC (cumulative)] X 100

INDICATOR	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY

APPLICATION LEVEL		✓	✓	✓	✓	

INDICATOR NAME	Percentage of clients enrolled for HCBC
HIS CODE:	HIS085

PROGRAMME GOAL	Ensuring the provision of quality care for the HIV infected and other chronically ill people at the home and community level

REFERENCES	NASCOP
CODES	HIV10-02

DEFINITION OF IMPORTANT TERMS	According to the implementation framework, the comprehensive package of Home and Community Based Care (HCBC) package includes: • clinical and basic nursing care; • Palliative care, pain relief and symptom management, • Life skills development; • Family care and support; • Food and nutrition; • Prevention of HIV transmission; • Linkage coordination, referral, networking Potential clients for HCBC services include people with HIV and other chronic or terminal illnesses, OVC, clinically malnourished individuals, people with special needs (disabled, nomads, internally displaced, refugees), caregivers and family members of chronically ill patients Although the indicator name may imply all clients, the numerator is limited to those newly enrolled during the reporting period.
NUMERATOR	Number of clients newly registered for HCBC during the reporting period
DENOMINATOR	Number of clients provided with referral to HCBC
UNIT OF MEASURE	Percentage
DISAGGREGATION	Disaggregate by age, sex and point of referral/entry, district, county and national
INDICATOR LEVEL	Process
PURPOSE	One of the objectives of the Community Strategy is strengthening of health facility and community linkages through decentralisation and partnership. This indicator measures how many clients that have been referred are able to access HCBC. It can be used to plan future interventions and to assess the impact of strengthened linkages.
FREQUENCY	Data collected continuously at facility and community level but aggregated and reported monthly
DATA SOURCE	CHW/CBO fill HCBC register and submit summary/tally sheet to HCBC focal person for respective facility who aggregates statistics and fills the MOH 711 Annex alias Facility Summary Form for HCBC. The DHRIO aggregates all facility summaries into the MOH 711 Annex alias the District Summary Form for HCBC. Data uploaded onto FTP system for HIS and NASCOP to access
DATA MANAGEMENT AND INDICATOR COMPUTATION	CALCULATION = [Number of clients newly registered for HCBC during the reporting period] / [Number of clients provided with referral to HCBC] X 100

GUIDELINES						
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Number of OVC provided with health services
HIS CODE:	HIS086

PROGRAMME GOAL	Ensuring the provision of quality care for the HIV infected and other chronically ill people at the home and community level

REFERENCES	NASCOP
CODES	HIV10-03

DEFINITION OF IMPORTANT TERMS	**OVC** = a child who is either orphaned, or made more vulnerable because of HIV/ AIDS. An orphan has lost either one or both parents to HIV/AIDS. Vulnerable is HIV- Positive; lives without adequate adult support (e.g. in a household with chronically ill parents, a household that has experienced a recent death from chronic illness, a household headed by a grandparent and/or a household headed by a child); lives outside of a family care (e.g. in a residential care or on the streets); or is marginalised, stigmatised or discriminated against. Health services may be provided directly by the CHEW/CHW or via outreach. May include HIV prevention, treatment, follow up care, nutritional support or linkage to support group. Also includes health care referral					
NUMERATOR	Number of OVC that received health care during the reporting period					
DENOMINATOR	None					
UNIT OF MEASURE	Number					
DISAGGREGATION	Disaggregate by age and sex, district, county, region and national levels					
INDICATOR LEVEL	Output					
PURPOSE	OVCs are at an increased risk of suffering psychological distress, economic hardships, exploitation, and trafficking and of HIV infection. Girls in the developing world in particular often face special vulnerability to the HIV/AIDS pandemic and its effects. This indicator measures how many OVCs have access to essential health services either directly or indirectly through a CHW/CHEW or HCBC focal person at a health facility. Results from this indicator provide information about the extent that OVCs are accessing health services and where gaps may exist. It can be used to plan OVC interventions and allocation of resources.					
FREQUENCY	Data collected continuously at facility and community level but aggregated and reported monthly					
DATA SOURCE	Data captured in HCBC client registers by the CHW or CBO will be channelled upward to facility focal points who will aggregate into a facility HCBC summary form and then submit to the divisional HCBC Coordinator who will forward to a District HCBC coordinator who will compile district data for onward flow to the provincial HCBC Coordinator who in collaboration with the PASCO will compile data for onward flow to NASCOP who will work closely with the NACC regional representative to analyse all provincial reports to produce a national HCBC summary.					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	HCBC focal person in all facilities aggregates statistics from the CHW monthly tallies and fills the MOH 711 Annex alias Facility Summary Form for HCBC. The DHRIO aggregates all facility summaries into the MOH 711 Annex alias the District Summary Form for HCBC. Data uploaded onto FTP system for HIS and NASCOP to access					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Number of HCBC commodities distributed
HIS CODE:	HIS087

PROGRAMME GOAL	Ensuring the provision of quality care for the HIV infected and other chronically ill people at the home and community level

REFERENCES	NASCOP
CODES	HIV10-04

DEFINITION OF IMPORTANT TERMS	**HCBC Commodities** = HCBC kits and the Basic Care Package (BCP) HCBC kits often issued by supplies stores to CHWs or focal person at facilities who uses for delivery of clinical and home based care services; BCP issued by the CHWs or facility desk to PLHIV for self-use
NUMERATOR	Number of HCBC commodities distributed during the reporting period
DENOMINATOR	None
UNIT OF MEASURE	Number
DISAGGREGATION	By type of commodity: HCBC Kit or Basic Care Package By recipient: CHW/CHEW; volunteers; PLHIV; HCBC focal person/desk at facility By distribution level: either received from supplier or issued to consumer, or by district, county, region and national levels
INDICATOR LEVEL	Input
PURPOSE	A reliable supply of home care kits is vital for on-going delivery of HCBC. This indicator measures the flow of commodities. This indicator measures the supply of HCBC commodities. As efforts are made to scale up HCBC it is important to ensure kits and the BCP is available for those who need them and any stock-outs may have a direct effect on uptake of HCBC services.
FREQUENCY	Data collected continuously at facility and community level but aggregated and reported monthly
DATA SOURCE	CHW/CBO fill HCBC register and submit summary/tally sheet to HCBC focal person for respective facility who aggregates statistics and fills the MOH 711 Annex alias Facility Summary Form for HCBC. The DHRIO aggregates all facility summaries into the MOH 711 Annex alias the District Summary Form for HCBC. Data uploaded onto FTP system for HIS and NASCOP to access
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	HCBC focal person in all facilities aggregates statistics from the CHW monthly tallies and fills the MOH 711 Annex alias Facility Summary Form for HCBC. The DHRIO aggregates all facility summaries into the MOH 711 Annex alias the District Summary Form for HCBC. Data uploaded onto FTP system for HIS and NASCOP to access
	This indicator measures the amount of HCBC commodities provided during the reporting period. However, it does not give information on the quality or timeliness of the distribution. Simply monitoring supplies could be misleading since a facility may have buffer stocks that are sufficient to cover gaps during stock-outs. Monitoring the distribution trends over time may provide a better understanding of the demand for HCBC commodities

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Number of deaths at the community level
HIS CODE:	HIS088

PROGRAMME GOAL	Ensuring the provision of quality care for the HIV infected and other chronically ill people at the home and community level

REFERENCES	NASCOP	
CODES	HIV10-05	

DEFINITION OF IMPORTANT TERMS	Deaths due to all causes					
NUMERATOR	Number of reported deaths at the community level					
DENOMINATOR	None					
UNIT OF MEASURE	Number					
DISAGGREGATION	By sex, age groups (<15, 15+), district, county, region and national levels					
INDICATOR LEVEL	Outcome					
PURPOSE	Majority of deaths occur at the community level and do not get reported. This indicator will track the number of deaths and over time possibly document at the local level what is the likely cause of death via verbal autopsy.					
FREQUENCY	Data collected continuously at facility and community level but aggregated and reported monthly					
DATA SOURCE	Facility and District HCBC tools aggregated from CHW/CHEW and HCBC desk tally diaries or CBO registers. The CHW will fill the CHW log book MOH 513, Household register MOH 514, CHEW summary MOH 515 and the Chalkboard MOH 516. This information should be discussed in community dialogue days and community actions designated persons.					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CHW/CBO fill HCBC register and submit summary/tally sheet to HCBC focal person for respective facility who aggregates statistics and fills the MOH 711 Annex alias Facility Summary Form for HCBC. The DHRIO aggregates all facility summaries into the MOH 711 Annex alias the District Summary Form for HCBC. Data uploaded onto FTP system for HIS and NASCOP to access By mapping where the deaths are occurring, it may be possible to identify high risk areas and root causes. This data needs to be verified through observation of the funeral or new grave-site. Tracking this indicator over time will help to determine the frequency of death but not the emergency actions taken e.g. prior to neither death nor support given to the bereaved family.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	✓

INDICATOR NAME	Number of eligible clients who received food and /or nutrition support
HIS CODE:	HIS089

PROGRAMME GOAL	Improving food security and/or nutrition services among eligible clients

REFERENCES	PEPFAR	NASCOP
CODES	C5.1.D	HIV10-06

DEFINITION OF IMPORTANT TERMS	**Nutritional Support**: refers to and includes the following food and/or nutrition services: ▪ Supplemental food support for nutritionally vulnerable children (OVC) ▪ Therapeutic and supplementary food for clinically malnourished orphans and vulnerable children whose HIV status is negative or unknown. ▪ Supplemental food support for nutritionally vulnerable PMTCT clients ▪ Micronutrient supplements ▪ Nutrition counselling ▪ Promotion of optimal infant and young child feeding ▪ Services to improve food security ▪ School and after-care feeding ▪ Household and community gardens					
NUMERATOR	Number of clients who received food and/or nutrition services in the reporting period					
DENOMINATOR	None					
UNIT OF MEASURE	Number					
DISAGGREGATION	Age: <18, 18+, Pregnant/lactating women, district, county, region and national levels					
INDICATOR LEVEL	Process					
PURPOSE	This indicator measures how many clients receive supplemental food, food security support and/or nutrition services, including therapeutic or supplementary food for OVC whose HIV status is negative or unknown. Results from the indicator provide information about the extent that food support is reaching vulnerable clients and where gaps may exist. It can be used to plan interventions and allocation of resources for food and nutrition.					
FREQUENCY	Data should be collected continuously at the facility level (or community level) and aggregated at the end of the reporting period.					
DATA SOURCE	Records that document provision of food support to clients.					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	The numerator can be generated by counting the total number of clients who received food supplementation and/or nutrition services during the reporting period. Clients that receive food supplementation and/or nutrition services more than once during the reporting period should only be counted one time. It is important to note that the indicator includes a variety of types of food support, including supplemental feeding, addressing food insecurity among PMTCT women and OVC, and other food related services. These are distinct food interventions with distinct objectives, and the total indicator does not provide information about coverage of each individually.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Percentage of HIV testing and counselling sites with quality assurance (QA) systems for HTC services – via periodic monitoring e.g. annual proficiency testing
HIS CODE:	HIS090

PROGRAMME GOAL	Improve quality of HIV testing and counselling services

REFERENCES	PEPFAR	NASCOP
CODES	P11.5.N	HIV11-01

DEFINITION OF IMPORTANT TERMS	"**Quality assurance assessments**" include one or more of the following: o Exit interviews, supervisory observations, refresher trainings, and support supervision. The following additional questions may be asked if time and resources allow: o Which QA systems are used? If a health facility survey is being conducted for other reasons then: o Are client satisfaction interviews conducted? o How has the site used QA data to make changes to HTC services?
NUMERATOR	Number of sites providing HIV testing and counselling services with a QA system
DENOMINATOR	Total number of HTC sites Systems are needed to ensure that all persons tested give consent and are provided with their test results and high quality counselling.
UNIT OF MEASURE	Percentage
DISAGGREGATION	District, county, region and national levels
INDICATOR LEVEL	Process
PURPOSE	Systems are needed to ensure that all persons tested give consent and are provided with their test results and high quality counselling.
FREQUENCY	Annually
DATA SOURCE	Review of facilities
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = [Number of sites providing HIV testing and counselling services with a QA system] / [Total number of HTC sites] X 100 Review of facilities to check whether the following is in place: o Policies, guidelines and/or standard operating procedure (SOP) for QA are in available in the testing and counselling sites; o Record of current registration and/or licensing systems for the facility is present at the facility and accessible to site reviewers; o Proficiency testing which includes QA completed by all persons at a site involved in conducting HIV counselling(QA includes observation of new trainees; supportive counselling supervision of all staff); o District managers should report: a) How many sites report QA results; b) How many sites conduct measures to assess quality of interactions such as client satisfaction interviews, etc?

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Percentage of health facilities that provide virological testing services for infant diagnosis for HIV exposed infants, on site or through DBS network
HIS CODE:	HIS091

PROGRAMME GOAL	Increase access to early infant diagnosis

REFERENCES	PEPFAR	NASCOP
CODES	C4.3.N	HIV11-02

DEFINITION OF IMPORTANT TERMS	**Dried blood spot testing (DBS)**: Is a method of screening for HIV infection and other conditions using DNA amplification.
NUMERATOR	Number of PMTCT sites offering virological testing services.
DENOMINATOR	Total no of PMTCT sites
UNIT OF MEASURE	Percentage
DISAGGREGATION	None
INDICATOR LEVEL	Process
PURPOSE	Early infant diagnosis of HIV through on-site virological testing or through dried blood spot (DBS) is a critical tool to identify HIV-infected infants for immediate referral into care and treatment, and to facilitate decision-making for health providers. This indicator measures the extent of scaled-up and increased access to early infant diagnosis of HIV for infants born to HIV-infected women.
FREQUENCY	Annually
DATA SOURCE	Programme reports and Master Facility List MOH 715
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = [Number of PMTCT sites offering virological testing services] / [Total no of PMTCT sites] X 100 Virological testing is only performed at a national reference laboratory, or sent out of country, due to the cost of buying virological testing machines. Thus, *provision* of virological testing refers to on-site testing, as well as transport of DBS filter papers to a virological testing laboratory. A site that physically refers a mother and her infant to a site that provides virological testing on-site or through DBS is not included in the numerator. This indicator measures only provision of virological testing through on-site testing or use of DBS. It does not measure the quality of the virological testing or the system in place (e.g. delays in reporting of results, stock-outs of DBS or virological testing reagents and other bottlenecks in the system).

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓		

INDICATOR NAME	Percentage of health facilities providing a package of PMTCT services
HIS CODE:	HIS092

PROGRAMME GOAL	To increase access to PMTCT services

REFERENCES	KNASP	PEPFAR	NASCOP
CODES	4.0.2	P1.3.D	HIV11-03

DEFINITION OF IMPORTANT TERMS	'**ANC facility**': Is any health facility that provides Antenatal Clinic services. 'On-site' refers to a service being offered within a health facility structure or compound. PMTCT services that are offered in separate service units but within the same health facility (e.g. HIV testing in the ANC and ARVs for PMTCT in the HIV care and treatment unit are considered to be 'on-site'. Where blood samples are sent out for HIV testing [e.g. to a national reference laboratory or health facility], this is also considered 'on-site').					
NUMERATOR	Number of health facilities providing ANC services that provide both HIV testing and ARVs for PMTCT on site					
DENOMINATOR	Total number of facilities offering ANC services					
UNIT OF MEASURE	Percentage					
DISAGGREGATION	District, County, Region and National levels					
INDICATOR LEVEL	Process					
PURPOSE	On-site availability is important to help reduce loss-to-follow-up of HIV-infected pregnant women and exposed infants. This indicator measures the *onsite* availability of HIV testing and ARVs for PMTCT at all health facilities that provide ANC services. While PMTCT programmes comprise several other interventions that are also important for preventing mother-to-child transmission, these two intervention areas were chosen based on the importance of the following: • availability of HIV testing in ANC to identify pregnant women who are infected with HIV and in need of PMTCT services; • availability of and increased access to ARVs for HIV-infected pregnant women for the prevention of mother-to-child transmission					
FREQUENCY	Annually					
DATA SOURCE	Master Facility List MOH 715					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION**: (National programme records of health facilities providing HIV testing services and ARVs for PMTCT) / (National programme records of lists of health facilities providing ANC services) X 100. This indicator is used to count facilities that provide HIV testing and ARVs for PMTCT only in the ANC and/or L&D sites among ANC (or L&D) facilities providing HIV testing. This indicator allows for monitoring the availability of and improved access to HIV testing and ARVs for PMTCT. It does not, however, measure other interventions (e.g. family planning, ART eligibility assessment), which are also critical for effective PMTCT. The indicator does not capture the quality of ARV and HIV testing services provided.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓		

INDICATOR NAME	Number of facilities with laboratories having capacity to perform clinical laboratory tests
HIS CODE:	HIS093

PROGRAMME GOAL	Improve laboratory capacity

REFERENCES	PEPFAR	NASCOP
CODES	H1.1.D	HIV11-04

DEFINITION OF IMPORTANT TERMS	**Clinical laboratory**: refers to laboratory that has the capacity (i.e. infrastructure, dedicated lab personnel, and equipment) to: ▪ Perform testing for the diagnosis of HIV infection with either rapid test, EIA or molecular methods; and, ▪ Perform clinical laboratory tests in any of the following areas: haematology, clinical chemistry, serology, microbiology, HIV/AIDS care and treatment monitoring with CD4 testing or HIV viral loads, TB diagnostic and identification, malaria infection diagnosis, and OI diagnosis.
NUMERATOR	Number of facilities with laboratories having capacity to perform ART monitoring through clinical laboratory test
DENOMINATOR	None
UNIT OF MEASURE	Number
DISAGGREGATION	District, County, region and National levels
INDICATOR LEVEL	Process
PURPOSE	An important component for clinical care is laboratory services. An adequate number of clinical laboratories are needed to perform testing for HIV/AIDS diagnostics, and care and treatment services. This indicator serves as a proxy for measuring coverage of HIV/AIDS patient monitoring testing. Knowing the number of HIV/AIDS clinical laboratories can indicate if testing coverage is adequate or if more capable laboratories are needed.
FREQUENCY	Annually
DATA SOURCE	Assessment reports and master facility list MOH 715
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	A clinical laboratory is counted if it meets the criteria of having the capacity, with infrastructure, personnel, and equipment, or is performing testing for the diagnosis of HIV infection with either rapid test, EIA or molecular methods and is performing other clinical laboratory tests in either of the following areas: haematology, clinical chemistry, serology, microbiology, HIV/AIDS care and treatment monitoring with CD4 testing or HIV viral loads, TB diagnostic and identification, malaria infection diagnosis, and OI diagnosis. A clinical laboratory can be a physical or mobile structure and must have dedicated laboratory personnel. A facility that does testing for only HIV rapid test diagnosis, such as a VCT or PMTCT site, should not be counted. The laboratory infrastructure will determine a laboratory's capacity to do serology, haematology, microbiology, clinical chemistry, and CD4 testing. All laboratories that meet the minimum definition of being capable of or actually performing HIV diagnostic *and* patient monitoring tests should be counted regardless of tiered capacity.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓		

INDICATOR NAME	Percentage of testing facilities (laboratories) that are accredited according to national or international standards
HIS CODE:	HIS094

PROGRAMME GOAL	

REFERENCES	PEPFAR	NASCOP
CODES	H1.2.D	HIV11-05

DEFINITION OF IMPORTANT TERMS	**Accreditation**: provides documentation that the laboratory has the capability and the capacity to detect, identify, and promptly report all diseases of public health significance that may be present in clinical and research specimens. The accreditation process further provides a learning opportunity, a pathway for continuous improvement, a mechanism for identifying resource and training needs, and a measure of progress.
NUMERATOR	Number of health facilities meeting accreditation standards
DENOMINATOR	Total number of health facilities
UNIT OF MEASURE	Percentage
DISAGGREGATION	District, County, region and National levels
INDICATOR LEVEL	Process
PURPOSE	Laboratory services are an essential component in the diagnosis and treatment of persons infected with the human immunodeficiency virus (HIV), and other related diseases of public health significance, including malaria and TB. Presently, the laboratory infrastructure for HIV, malaria, and TB testing and quality assurance remains weak. There is therefore an urgent need to strengthen the laboratory. The establishment of accreditation systems will help to improve and strengthen the capacity of their laboratories.
FREQUENCY	Annually
DATA SOURCE	Assessment reports and master facility list MOH 715
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = [Number of health facilities meeting accreditation standards] / [Total number of health facilities] X 100 A clinical laboratory is counted as being accredited if it has received national or international accreditation that meets the World Health Organization (WHO) Accreditation of Public Health Laboratory Networks standard. Full accreditation and levels of accreditation are assessed by a standardized set of criteria defined by WHO Accreditation of National Laboratory Systems or other acceptable international and national standards. Full accreditation is defined by meeting acceptable criteria in order to receive certification by a recognized and WHO approved accreditation organizations. Accreditation certificates are a formal recognition that a laboratory is competent to perform clinical testing.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓		

INDICATOR NAME	Percentage of health facilities providing nutritional commodities
HIS CODE:	HIS095

PROGRAMME GOAL	The goal of the nutrition support is to improve nutrition, health, quality of life and duration of survival of individuals

REFERENCES	NASCOP	
CODES	HIV11-06	

DEFINITION OF IMPORTANT TERMS	Nutritional care and support includes many components, such as: • nutrition education and counselling in health facilities; • Water, hygiene and food safety interventions to prevent diarrhoea; adequate quality/quantity of food and food aid. Nutrition support refers to intravenous nutrition or orally modified formulas necessitated by inability to consume a general diet; administered to malnourished individuals who cannot consume food in its original form.					
NUMERATOR	Number of health facilities providing nutritional commodities (FBP, CSB, F75, F100, RUTF, MM)					
DENOMINATOR	Total number of health facilities					
UNIT OF MEASURE	Percentage					
DISAGGREGATION	District, County, region and national levels					
INDICATOR LEVEL	Process					
PURPOSE	• Nutrition and HIV are strongly related to each other. A person with HIV infection is more at risk for malnutrition for reasons such as reduced food intake, poor absorption, changes in metabolism, chronic infections and illnesses, anorexia, diarrhoea, fever, nausea, oral and oesophageal infections, and anaemia. The management of those conditions and the provision of nutritional support are effective interventions that are fundamental to other HIV/AIDS care activities. • Good nutrition may result in increased resistance to infection and disease, improved energy and a person who is stronger and more productive. • Antiretroviral therapy should often be taken together with good nutrition and safe water, making access to adequate food important to effective treatment. • HIV infection has a significant impact on nutrition at the level of the family and community, as well. In places where HIV seroprevalence is high, food insecurity is often high as well.					
FREQUENCY	Annually					
DATA SOURCE	Assessment reports and master facility list MOH 715					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = [Number of health facilities providing nutritional commodities (FBP, CSB, F75, F100, RUTF, MM)] / [Total number of health facilities] X 100 National programme records of health facilities providing nutritional commodities. Results from this indicator provide information about the accessibility of food and nutrition support for individuals that need it.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓		

INDICATOR NAME	Number of health facilities that offer ART services
HIS CODE:	HIS096

PROGRAMME GOAL	To increase access to ART services

REFERENCES	KNASP	WHO	PEPFAR	GFTAM	NASCOP
CODES	4.0.1	UA-G1	T1.5.D	HIV-T2	HIV11-07

DEFINITION OF IMPORTANT TERMS	**A service outlet** refers to the lowest level of service. For example, with regard to clinical activities, the lowest level for which data exists should be a service outlet such as a hospital, clinic, or mobile unit. **ART services** refer to activities including the provision of antiretroviral drugs and clinical monitoring for antiretroviral therapy among those with HIV infection. **ART** refers to long-term combination antiretroviral therapy intended primarily to improve the health of the individual on treatment, not to prevent mother-to-child transmission.					
NUMERATOR	Number of health facilities that offer ART services					
DENOMINATOR	None					
UNIT OF MEASURE	Number					
DISAGGREGATION	By type of site: Public, Private, NGO , District, County, region and national levels					
INDICATOR LEVEL	Process					
PURPOSE	This indicator measures the progress of a program to expand the number of locations in which ART services are delivered in accordance with national or international standards.					
FREQUENCY	Annual					
DATA SOURCE	Facility ART registers/databases; health facility census; Program monitoring tools, SARAM, SAM					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Count all service outlets providing ART including designated PMTCT+ sites. The indicator is calculated by summing of the number of facilities reporting availability of ART services. Information on the availability of specific services should be kept at the national or province and district levels. The national level should regularly update their programme records on health facilities offering ART services. This indicator does not describe the geographic location or distribution of service outlets. This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓		

INDICATOR NAME	Percentage of TB treatment facilities that offer ART services
HIS CODE:	HIS097

PROGRAMME GOAL	Increased access and care offered to HIV-positive TB patients.

REFERENCES	KNASP	WHO	PEPFAR	GFTAM	NSCOP
CODES	4.0.1	UA-G1	T1.5.D	HIV-T2	HIV11-08

DEFINITION OF IMPORTANT TERMS	**A service outlet** refers to the lowest level of service. For example, with regard to clinical activities, the lowest level for which data exists should be a service outlet such as a hospital, clinic, or mobile unit. **ART services** refer to activities including the provision of antiretroviral drugs and clinical monitoring for antiretroviral therapy among those with HIV infection. **ART** refers to long-term combination antiretroviral therapy intended primarily to improve the health of the individual on treatment, not to prevent mother-to-child transmission.
NUMERATOR	Number of TB treatment facilities that offer ART services
DENOMINATOR	Number of TB treatment facilities
UNIT OF MEASURE	Percentage
DISAGGREGATION	By type of site: Public, Private, NGO , district, county, region and national levels
INDICATOR LEVEL	Process
PURPOSE	This indicator measures the progress of TB/HIV program integration. This indicator measures the degree to which TB treatment facilities have increased the care offered to HIV-positive TB patients.
FREQUENCY	Annual
DATA SOURCE	health facility census; Program monitoring tools
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Number of TB treatment facilities that offer ART services) / (Total number of TB treatment facilities) X 100 Count all TB treatment service outlets providing ART. The indicator is calculated by summing of the number of facilities reporting availability of ART services. The national level should regularly update their programme records on health facilities offering ART services. This indicator does not describe the geographic location or distribution of service outlets. This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓		

INDICATOR NAME	Percentage of health care facilities that have the capacity to provide post-exposure prophylaxis
HIS CODE:	HIS098

PROGRAMME GOAL	To measures the availability of post-exposure prophylaxis services.

REFERENCES	KNASP	WHO	PEPFAR	GFTAM	NASCOP
CODES	2.5.1	UA-B2	P6.2.N	HIV-P15	HIV11-09

DEFINITION OF IMPORTANT TERMS	This area assesses the percentage of facilities in which post exposure prophylaxis is provided and all items to support the service are available, including written protocols and guidelines, a recordkeeping and monitoring system, availability of antiretroviral drugs for post exposure prophylaxis and special storage. A facility may also refer for post exposure prophylaxis but should have available a system to follow up and monitor their employees to be considered as supporting the service. Data collection Each point-of-service area for HIV/AIDS curative care in a facility must have all the individual items and analysis in the checklist below to meet the requirements for this area.
NUMERATOR	Number of facilities that have individuals items for providing post exposure prophylaxis
DENOMINATOR	Total number of health facilities surveyed
UNIT OF MEASURE	Percentage
DISAGGREGATION	District, County, region and National levels
INDICATOR LEVEL	Process
PURPOSE	This indicator measures the availability of post-exposure prophylaxis services.
FREQUENCY	Annual
DATA SOURCE	This information should be collected through a health facility survey or supervision
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = [Number of facilities that have individuals items for providing post exposure prophylaxis] / [Total number of health facilities surveyed] X 100 Facilities offering post-exposure prophylaxis ▪ An observed written protocol for post exposure prophylaxis in the service area where post exposure prophylaxis is offered ▪ A register or record indicating post exposure prophylaxis services are provided ▪ A system to monitor clients receiving post exposure prophylaxis for full compliance with the regimen ▪ Country-specific post exposure prophylaxis antiretroviral drugs available the day of the survey ▪ Antiretroviral drugs for post exposure prophylaxis kept in a locked storage unit separate from other HIV/AIDS antiretroviral combination therapy services and maintained solely for post exposure prophylaxis This indicator examines post-exposure prophylaxis services among all health facilities. This indicator does not intend to capture the type and quality of PEP services provided. PEP services may include first AID, counselling, testing, provision of ARVs, medical care, trauma counselling, linkages with police, and other follow-up and support.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓		

INDICATOR NAME	Proportion of health facilities receiving at least 80% of their blood supply from NBTS network
HIS CODE:	HIS099

PROGRAMME GOAL	To improve safety and availability of blood supply

REFERENCES	PEPFAR	NASCOP
CODES	P2.3.N	HIV11-10

DEFINITION OF IMPORTANT TERMS	**National blood transfusion services**: The provision of safe and adequate blood is the responsibility of Government of Kenya. The formation of the nationally organized and managed blood programme is an integral part of the Governments national health care policy and health care infrastructure. The National Blood Transfusion Services (NBTS) was established in accordance with the National Blood Policy and is responsible for establishing and maintaining a national quality system, including the development of guidelines and standards, staff training, a data/ information management system and a system for monitoring and evaluation of all the blood transfusion activities in the country.
NUMERATOR	Number of all transfusing health facilities receiving at least 80 Percentage of blood supply from NBTS
DENOMINATOR	Number transfusing health facilities
UNIT OF MEASURE	Percentage
DISAGGREGATION	District, County, Region and National levels
INDICATOR LEVEL	Output
PURPOSE	A well-coordinated national blood transfusion service (NBTS) is a source of safe blood. This indicator will measure trends in the use of NBTS network blood by health facilities which perform transfusions. The objective is to create a single quality-assured national blood supply, with no blood collected or distributed outside of the NBTS network. This indicator will track progress in expanding the coverage of NBTS-supplied safe blood to facilities which perform blood transfusions.
FREQUENCY	Data on the number of hospitals performing blood transfusions and the number of these hospitals which receive at least 80% of their blood from the NBTS will be updated quarterly by the NBTS through the routine programmatic monitoring process.
DATA SOURCE	The Blood Safety Indicator System (BSIS), a Web-based data collection tool developed by HHS/CDC and the Georgia Institute of Technology. NBTS will enter the number of health facilities which are accredited by the government to perform blood transfusions into the BSIS on a quarterly basis. The BSIS will automatically aggregate these data at the end of each year. Likewise, NBTS will use the BSIS to enter the number of hospitals performing transfusions which receive at least 80% of their blood from the NBTS. The amount of NBTS blood delivered to each health facility will be drawn from NBTS logs on the issuance of blood from NBTS network blood banks to accredited hospitals.

DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = (Number of all transfusing health facilities receiving at least 80 Percentage of blood supply from NBTS) / (Number transfusing health facilities) X 100 The number of hospitals receiving at least 80% of the blood units used for transfusion from the NBTS network: The NBTS tracks the distribution of blood from blood banks and blood depots in the NBTS network. Blood bank data systems will report the number of units issued to each hospital. This will serve as the numerator to calculate whether the hospital has received at least 80% of its blood from the NBTS. The denominator for this proportion will be derived from information on the total number of units transfused annually by each hospital. This indicator is designed to measure the National Blood Transfusion Service's progress toward increasing the use of blood that has been collected from low-risk donors and tested by a quality-assured laboratory for four major TTI.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓		

INDICATOR NAME	Number of individuals who successfully completed in-service training on HIV/STI interventions for MARPs
HIS CODE:	HIS100

PROGRAMME GOAL	Availability of trained service providers to offer all packages of HIV/STI services to MARPs (Basic, Clinical, Non-Clinical and Enabling Environment); Increased access to HIV/STI interventions for MARPs

REFERENCES	PEPFAR	NASCOP
CODES	H2.3.D	HIV11-11

DEFINITION OF IMPORTANT TERMS	1) **MARPs** = Most at risk populations; includes female and male sex workers, men who have sex with men, injecting drug users, prisoners, truckers 2) National guidelines for HIV/STI interventions for Sex Workers proposes 4 intervention packages: Basic, Clinical, Non-Clinical and Enabling Environment which comprises of several components e.g. as summarized below: • **Basic**: **Outreach and peer education**; Risk assessment, risk reduction counselling and skills building; demonstration and distribution of condoms and lubricants and promotion of 100% condom use • **Clinical: HIV testing and counselling**; STI screening and treatment; TB screening and referral to treatment; HIV care and treatment; Reproductive health services (FP, PAC, cervical cancer screening); emergency contraception; PEP; Substance abuse, assessment and treatment • **Non-Clinical**: Psychosocial support; Services to mitigate sexual violence; Family and social services; Support to expand choices beyond sex work • **Enabling Environment**: Community mobilization; Behaviour change communication; service provider sensitization and training; Stigma and discrimination reduction It is assumed that the training will be tailored according to the proposed packages. **NOTE**: The MARPs TWG intends to expand these guidelines for application to other MARPs groups as needed 3) Methods of in-service training: continuing education, on the job training, computer based training with or without a short term practicum prior to certification 4) **Types of Individual**: may include clinical and non-clinical staff depending on the package e.g. community health workers, Peer Educators for Basic; nurses, doctors, clinical officers, counsellors, nutritionist, pharmacist for Clinical. 5) **MARPs**- Most At Risk populations are those populations with a concentration of risk behaviours.
NUMERATOR	A count of the number of individuals who completed the standard course on HIV/STI interventions for MARPs as per the national curriculum during the reporting period
DENOMINATOR	None
UNIT OF MEASURE	Number
DISAGGREGATION	By cadre: clinical (doctors, nurses, clinical officers, midwives) and non-clinical (program staff, peer educators) By sex: Male, female; by district, county, region and national levels
INDICATOR LEVEL	Output
PURPOSE	Help the program assess the coverage, scale-up and accessibility of services to

	MARPs					
FREQUENCY	Collect monthly and report quarterly					
DATA SOURCE	COBPAR or NASCOP Quarterly activity form draws data from certification list for completed training courses					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Training coordinator submits certification list to Program coordinator who fills quarterly activity form and submits to the DASCO and CACC coordinators by 5th of month; Aggregated summary forms for district or constituency submitted to Field Coordinator and PASCOs by 15th of month for aggregation of regional data then forwarded to the central NASCOP and NACC by 20th of month					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Number of targeted outlets that offer HIV/STI services for MARPs
HIS CODE:	HIS101

PROGRAMME GOAL	Increased access to HIV/STI and reproductive health services for MARPs and their sexual partners; Reduced HIV/STI risk and burden among MARPs and their sexual partners

REFERENCES	NASCOP	
CODES	HIV11-12	

DEFINITION OF IMPORTANT TERMS	1) **MARPs** = Most at risk populations; includes female and male sex workers, men who have sex with men, injecting drug users, prisoners, truckers 2) Targeted outlet is any fixed site identified and/or registered as an intervention site for MARPs within the NASCOP database or Master Facility List or newly targeted due to its location in MARPs hot spots. May include a health facility, VCT site, entertainment establishments, drop in centres, NGO program office 3) Services may comprise of all or selected components from the Basic, Clinical, Non-Clinical or Enabling Environment Packages • **Basic:** Outreach and peer education; Risk assessment, risk reduction counselling and skills building; demonstration and supply of condoms and lubricants and promotion of 100% condom use • **Clinical:** HIV testing and counselling; STI screening and treatment; TB screening and referral to treatment; HIV care and treatment; Reproductive health services (FP, PAC, cervical cancer screening); emergency contraception; PEP; Substance abuse, assessment and treatment • **Non-Clinical**: Psychosocial support; Services to mitigate sexual violence; Family and social services; Support to expand choices beyond sex work 4) MARPs friendly – tailored service provision i.e. culturally competent services which are responsive to the needs of the sub-population (non-judgmental, non-stigmatizing, adequate [sufficient number of trained counsellors, adequate commodities] free or affordable accessible [effective client flow, reduction in # of logistical barrier, client-driven delivery of services]
NUMERATOR	Number of targeted outlets providing HIV/STI services for MARPs as per minimum standards (to be defined in the near future) Universal Access indicator: Number of targeted service delivery points for sex workers where STI services are provided per 1000 sex workers Number of needle and syringe programme (NSP) sites per 1000 injecting drug user
DENOMINATOR	None
UNIT OF MEASURE	Number
DISAGGREGATION	By type of MARP; By type of site: Public/private/NGO; by type of services for MARPs (e.g. condom outlet, STI clinic, HTC, Post-Rape Care), district, county, region and national levels
INDICATOR LEVEL	Process
PURPOSE	Reducing HIV prevalence among MARPs and thereby the general population can only be achieved if there is good coverage of HIV/STI services for MARPs. This indicator measures the availability of HIV/STI services for MARPs. The strategy of the HIV/STI guidelines is to scale up the number of MARP-friendly sites in stand-

	alone sites as well as existing health facilities in MARPs hot spot areas. These types of sites are only effective if the owners are recognized and supportive of HIV/STI interventions for MARPs.					
FREQUENCY	Collect and report annually					
DATA SOURCE	Annual program mapping for MARP-friendly services based on review of MOH 711 and COBPAR reporting sites plus formal annual partner reports and field visits; every 2-3 years for facility surveys					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Program coordinator-CACC/DASCO collect reports from implementing partners for MARPs interventions; Submit copies of report to NASCOP MARP Program Manager for service availability mapping. Also send copy to the Division of HIS focal point for updating of web-based Master Facility List. Validation through quarterly field visits.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Percentage health facilities linked with community units
HIS CODE:	HIS102

PROGRAMME GOAL	Ensuring the provision of quality care for the HIV infected and other chronically ill people at the home and community level

REFERENCES	NASCOP	
CODES	HIV11-13	

DEFINITION OF IMPORTANT TERMS	Linkage with community refers to the presence of CHEW/CHW or focal person/desk for HCBC services
NUMERATOR	Number of health facilities with CHEW/CHW or focal HCBC person/desk providing linkage with the community
DENOMINATOR	Number of facilities
UNIT OF MEASURE	Percentage
DISAGGREGATION	District, County, Regional and National
INDICATOR LEVEL	Input
PURPOSE	Proper linkages of home and community based care programmes and health facilities need to be established through focal points at health facility who maintain lists of all CHWs and CBOs involved with HCBC. This indicator measures the proportion of health facilities with focal person/unit referred to as 'desk' that have links with CHWs or CBOs. Although the unavailability of the links should not be a barrier to delivery of HCBC services, the HCBC implementation framework recommends that such links will facilitate better HCBC service delivery. Tracking this indicator is important as any decisions to extend or expand the available HCBC services or improve the quality of care will depend on the existence of these links.
FREQUENCY	Data collected continuously at facility and community level but aggregated and reported monthly
DATA SOURCE	Data captured in HCBC client registers by the CHW or CBO will be channelled upward to facility focal points who will aggregate into a facility HCBC summary form and then submit to the divisional HCBC Coordinator who will forward to a District HCBC coordinator who will compile district data for onward flow to the provincial HCBC Coordinator who in collaboration with the PASCO will compile data for onward flow to NASCOP who will work closely with the NACC regional representative to analyse all provincial reports to produce a national HCBC summary.
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = [Number of health facilities with CHEW/CHW or focal HCBC person/desk providing linkage with the community] / [Number of facilities] X 100

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	✓

NON-COMMUNICABLE DISEASES

INDICATOR NAME	Proportion of population who consume alcohol regularly
HIS CODE:	HIS103

PROGRAMME GOAL	Harmful use of alcohol is related to many chronic non-communicable diseases such as cardiovascular diseases, cancers, diabetes, liver cirrhosis and also acute conditions such as acute mental illness, alcohol dependence and injuries. The level of per capita consumption of alcohol across the population aged 15 years and older is one of the key indicators for monitoring the magnitude of alcohol consumption in the population and likely trends in alcohol-related problems.

REFERENCES CODES	WHO	MDG

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Harmful use of alcohol*** is the consumption of any form of alcohol that exceeds the recommended consumption of not more than 2 units (1 standard beer) for men and 1 unit (250ml or 1 standard glass of beer) for women per day.					
NUMERATOR	Number of people reporting consumption of alcohol beyond minimum threshold					
DENOMINATOR	Total number of people sampled in KDHS or other survey					
UNIT OF MEASURE	Percentage					
DISAGGREGATION	Age, sex, educational level, wealth quintile, urban, rural, district, county/regional and national levels					
INDICATOR LEVEL	Outcome					
PURPOSE	The indicator is a proxy measure of the risk for development of alcohol related diseases and hence provides evidence and data to support preventive interventions in the country					
FREQUENCY	COLLECTION: data is collected after every 5 years. REPORTING: Every 5 years UTILISATION: Every 5 years at county level or higher					
DATA SOURCE	KDHS, SURVEYS					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	None- derived directly from KDHS					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓		

INDICATOR NAME	Proportion of population who smoke cigarettes or a pipe or use other tobacco products
HIS CODE:	**HIS104**

PROGRAMME GOAL	To estimate the risk in tobacco related diseases and prevent cardiovascular diseases, diabetes and cancers.

REFERENCES CODES	WHO	MDG

DEFINITION OF IMPORTANT TERMS	**Key Term 1:** ***Smoker*** is any person who smokes cigarette or any other smoked tobacco product and has used such a products during the last 24 hours of the Interview.
NUMERATOR	Number reporting smoking regularly and have smoked during the past 24 hours of interview (KDHS)
DENOMINATOR	Total number of persons interviewed in KDHS survey
UNIT OF MEASURE	Percentage
DISAGGREGATION	Age, sex, educational level, wealth quintile, urban, rural, district, county/regional and national levels
INDICATOR LEVEL	Outcome
PURPOSE	The indicator is a proxy measure of the risk for development of tobacco related diseases and prevents cardiovascular diseases, diabetes and cancers.
FREQUENCY	**COLLECTION**: data is collected after every 5 years. **REPORTING:** Every 5 years **UTILISATION:** Every 5 years at county level or higher
DATA SOURCE	NUMERATOR: KDHS DENOMINATOR: KDHS
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	None- derived directly from the KDHS

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓		

INDICATOR NAME	Proportion of all newly diagnosed cases attributable to hypertension
HIS CODE:	**HIS105**

PROGRAMME GOAL	To reduce the hypertension-related morbidity and mortality by identifying and treating hypertension cases, and monitoring of trends of hypertension incidence.

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1:** ***Hypertension*** is elevated blood pressure (BP), i.e. BP above 140/90 mmHg. It is worth noting that for certain age especially above 60 years BP of 130/90 may be considered as normal. Hypertension is now a silent killer which predisposes people to STROKE, HEART FAILURE, and PERIPHERAL VASCULAR DISEASES such as aneurysms.
NUMERATOR	Number of cases diagnosed with hypertension in a month
DENOMINATOR	Total number of all newly diagnosed cases (for all diseases) in a month.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Age, sex, educational level, urban , rural, district, county/regional and national levels
INDICATOR LEVEL	Outcome
PURPOSE	A proxy indicator for incidence of hypertension. The trend in this indicator is useful for determining if hypertension is an increasing burden and measures to prevent future population should be put in place.
FREQUENCY	**COLLECTION:** data is recorded on daily basis in the OP Over 5 Years Register. **REPORTING:** Monthly throughout the hierarchy **UTILISATION**: Monthly at facility level, quarterly at county level or higher
DATA SOURCE	**NUMERATOR**: OPD REGISTER MOH 204 B, ***OPD summary sheet (FORM 705B)*** **DENOMINATOR**: OPD REGISTER MOH 204 B ***and OPD summary sheet (FORM 705B)***
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	On daily basis, the OP Over 5 years Register records all new diagnoses which are then collated into a monthly summary sheet (FORM 705B) which is used to compute the indicator. *The indicator is computed by* ***100 X*** *the total number of cases diagnosed with hypertension in a month,* ***divided by*** *the total of all newly diagnosed cases (for all diseases) in a month.*

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Proportion of all newly diagnosed cases attributable to diabetes
HIS CODE:	**HIS106**

PROGRAMME GOAL	To reduce the diabetes-related morbidity and mortality by identifying and treating diabetes cases, and monitoring of trends of diabetes incidence.

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1:** ***Diabetes Mellitus*** is a chronic metabolic disorder characterised by elevated blood sugar, i.e. Random Blood Sugar above 7.0 mmol/l or fasting blood sugar above 6.1mmol/l.
NUMERATOR	Number of cases diagnosed with diabetes in a month
DENOMINATOR	Total number of all newly diagnosed cases (for all diseases) in a month.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Age, sex, educational level, urban , rural, district, county/regional and national levels
INDICATOR LEVEL	Outcome
PURPOSE	To identifying and treat diabetes cases, and monitor trends of diabetes incidence among the populations. Diabetes has become the most important causes of morbidity and mortality in Kenya as lifestyle diseases and prevention measures should be advocated for.
FREQUENCY	**COLLECTION**: data is recorded on daily basis in the OP Over 5 Years Register. **REPORTING:** Monthly throughout the hierarchy **UTILISATION**: Monthly at facility level, quarterly at county level or higher
DATA SOURCE	NUMERATOR: OPD REGISTER MOH 204 B *and OPD summary sheet (FORM 705B)* DENOMINATOR: OPD REGISTER MOH 204 B *and OPD summary sheet (FORM 705B)*
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	On daily basis, the OP Over 5 years Register records all new diagnoses which are then collated into a monthly summary sheet (FORM 705B) which is used to compute the indicator. *The indicator is computed by* ***100 X*** *the total number of cases diagnosed with diabetes in a month,* ***divided by*** *the total of all newly diagnosed cases (for all diseases) in a month.*

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Proportion of all newly diagnosed cases attributable to stroke
HIS CODE:	**HIS107**

PROGRAMME GOAL	To reduce the stroke-related morbidity and mortality by identifying and treating stroke cases, and monitoring of trends of stroke incidence.

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1:** ***Stroke*** is any neurological deficit of cerebrovascular cause that persists beyond 24 hours or is interrupted by death within 24 hours
NUMERATOR	Number of cases diagnosed with stroke in a month
DENOMINATOR	Total count of all newly diagnosed cases (for all diseases) in a month.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Age, sex, educational level, urban , rural, district, county/regional and national levels
INDICATOR LEVEL	Outcome
PURPOSE	To identifying and treat stroke cases, and monitor trends of stroke incidence. Due to many diseases, stroke has become more common cause of morbidity and disability and this reduces the DALYs among the populations.
FREQUENCY	**COLLECTION**: data is recorded on daily basis in the OP Over 5 Years Register. **REPORTING**: Monthly throughout the hierarchy **UTILISATION**: Monthly at facility level, quarterly at county level or higher
DATA SOURCE	**Numerator:** OPD register MOH 204B and OPD summary sheet (FORM 705B) **Denominator:** OPD register MOH 204 B and OPD summary sheet (FORM 705B)
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	On daily basis, the OP Over 5 years Register records all new diagnoses which are then collated into a monthly summary sheet (FORM 705B) which is used to compute the indicator. The indicator is computed by 100 X the total number of cases diagnosed with stroke in a month, divided by the total of all newly diagnosed cases (for all diseases) in a month.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Proportion of all newly diagnosed cases attributable to injuries
HIS CODE:	**HIS108**

PROGRAMME GOAL	To reduce morbidity and mortality resulting from injuries by treating injuries, and monitoring of injury occurrences in order to prevent and reduce the main causes of injuries in the population.

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Injury*** is any injury due to violent or non violent means
NUMERATOR	Number of new injuries in a month
DENOMINATOR	Total count of all newly diagnosed cases (for all diseases) in a month.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Age, sex, educational level, urban , rural, district, constituency, county, regional and national levels
INDICATOR LEVEL	Outcome
PURPOSE	To identify morbid and mortality cause due to injuries and institute measures to prevent the causes due to injuries. Road Traffic Injuries (RTAs) have become an increase in Kenya. Preventive Measures instituted is likely to reduce the deaths due to RTAs and other related injuries. Kenya is among the 10 countries earmarked for the Road safety project to cap these measures and reporting should improve with clear underlying causes of death reported using the ICD 10 Classifications and certifications.
FREQUENCY	**COLLECTION:** data is recorded on daily basis in the OP Over 5 Years Register. **REPORTING:** Monthly throughout the hierarchy **UTILISATION**: Monthly at facility level, quarterly at county level or higher
DATA SOURCE	**NUMERATOR:** OPD register MOH 204B and OPD summary sheet (FORM 705B) **Denominator:** OPD register MOH 204B and OPD summary sheet (FORM 705B)
DATA MANAGEMENT AND INDICATOR COMPUTATION	On daily basis, the OP Over 5 years Register records all new diagnoses which are then collated into a monthly summary sheet (FORM 705B) which is used to compute the indicator. The indicator is computed by 100 X the total number of

GUIDELINES	cases presenting with an injury in a month, divided by the total of all newly diagnosed cases (for all diseases) in a month.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Proportion of all newly diagnosed cases attributable to non-communicable diseases (NCD)
HIS CODE:	**HIS109**

PROGRAMME GOAL	To reduce the NCD-related morbidity and mortality by identifying and treating NCD cases, and monitoring of trends of NCD incidence. NCD are a major cause of morbidity, death and disability and are attributable to over 60 % of all mortalities.

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Non-communicable Diseases*** **(NCD)** is a class of diseases normally of chronic onset and which cannot be communicated from one person to another and which to a large extent usually associated with risk factors that are related to lifestyles. NCD cases included for this indicator are for those of: hypertension, diabetes, stroke, and injuries.
NUMERATOR	Number of cases diagnosed with specific NCDs (hypertension, diabetes, stroke, and injuries) in a month
DENOMINATOR	Total count of all newly diagnosed cases (for all diseases) in a month.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Age, sex, educational level, urban , rural, district, constituency, county, regional and national levels
INDICATOR LEVEL	Outcome
PURPOSE	A proxy indicator for incidence of NCDs. The trend in this indicator is useful for determining if NCD is an increasing burden and institute measures to maintain the status or reduce the burden due to NCDs.
FREQUENCY	**COLLECTION:** data is recorded on daily basis in the OPD Over 5 Years Register MOH 204 B and summarised on MOH 705B. **REPORTING:** Monthly throughout the hierarchy **UTILISATION**: Monthly at facility level, quarterly at county level or higher
DATA SOURCE	**Numerator:** OPD register MOH 204B and OPD summary sheet (FORM 705B) **Denominator:** OPD register MOH 204B and OPD summary sheet (FORM 705B)
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	On daily basis, the OP Over 5 years Register records all new diagnoses which are then collated into a monthly summary sheet (FORM 705B) which is used to compute the indicator. The indicator is computed by 100 X the total number of cases diagnosed with NCD in a month, divided by the total of all newly diagnosed cases (for all diseases) in a month.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Proportion of all facility releases attributable to non-communicable diseases
HIS CODE:	**HISI10**
PROGRAMME GOAL	To assess the change in NCD-related morbidity and mortality over time.

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Release*** refers to patients leaving the inpatient unit due to death, recovery or referral. **Key Term 2**: ***NCD releases*** refer to the cases with NCD that were released from the inpatient unit after admission. The NCD cases include those of; hypertension, diabetes, heart disease, cancer, chronic respiratory diseases, Kidney/renal diseases, and injuries.
NUMERATOR	Sum of releases (dead or alive) due to NCD (hypertension, diabetes, stroke, cancers, kidney diseases heart diseases or injuries) in a month.
DENOMINATOR	Total number of institutional releases in a month.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Age, sex, educational level, urban , rural, district, constituency, county, regional and national levels
INDICATOR LEVEL	Outcome
PURPOSE	A proxy indicator that monitors the trend in the contribution of NCD to all hospitalization cases. The appropriate indicator would have been the proportion of all admissions attributable to NCDs but this is operationally problematic since final diagnosis can only be reliably determined during hospitalization period and especially at the time of release. The assumption therefore is that the proportion of NCD-related releases to all releases is same ratio as that of admissions.
FREQUENCY	**COLLECTION:** data is recorded on daily basis in the Inpatient Register. **REPORTING:** Monthly throughout the hierarchy **UTILISATION**: Monthly at facility level, quarterly at county level or higher
DATA SOURCE	**Numerator:** Inpatient register MOH 301, Inpatient Form (FORM 718) and disease index card MOH 268 **Denominator:** Inpatient register MOH 301, Inpatient Form (FORM 718) and disease index card MOH 268
DATA MANAGEMENT	On daily basis, the Inpatient Register records all new admissions and their diagnoses which are then collated into a monthly Inpatient Morbidity and

AND INDICATOR COMPUTATION GUIDELINES	Mortality Form (FORM 718) which is used to compute the indicator. The indicator is computed by 100 X the total number of cases released (and whose main reason for hospitalization was an NCD) in a month, divided by the total of all facility releases (for all diagnoses) in a month.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Proportion of all in-patients deaths attributable to non-communicable diseases
HIS CODE:	**HIS111**

PROGRAMME GOAL	T0 establish the burden of deaths due to NCDs

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Death due to NCD*** is where the primary cause of death is NCD **Key Term 2:** ***Primary cause of death*** is determined as the third level cause of Death, e.g. immediate cause is heart attack due to breathing failure caused by stroke (NCD)
NUMERATOR	Sum of deaths due to NCD (hypertension, diabetes, stroke, cancers, kidney diseases, heart diseases or injuries) in a month.
DENOMINATOR	Total number of institutional deaths in a month.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Age, sex, educational level, urban , rural, district, county/regional and national levels
INDICATOR LEVEL	Impact
PURPOSE	The indicator monitors trends in mortality due to NCDs as compared to other conditions in the population and hence can aid in decision making by health managers
FREQUENCY	**COLLECTION**: Data is recorded on daily basis in the Inpatient Register. **REPORTING**: Monthly throughout the hierarchy **UTILISATION**: Monthly at facility level, quarterly at county level or higher
DATA SOURCE	**Numerator:** Inpatient register MOH 301, Inpatient Form (FORM 718) and disease index card MOH 268 **Denominator:** Inpatient register MOH 301, Inpatient Form (FORM 718) and disease index card MOH 268
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	On daily basis, the Inpatient Register records all releases (dead or alive) and their diagnoses which are then collated into a monthly Inpatient Morbidity and Mortality Form (FORM 718) which is used to compute the indicator. The indicator is computed by 100 X the total number of deaths due an NCD in a month, divided by the total of all facility deaths (for all diagnoses) in a month.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

TUBERCULOSIS CONTROL

INDICATOR NAME	Tuberculosis (TB) Case Notification Rate (All forms)
HIS CODE:	**HIS112**

PROGRAMME GOAL	To monitor the performance of all levels of service delivery in TB case finding.

REFERENCES CODES	WHO	MDG

DEFINITION OF IMPORTANT TERMS	**Key Term 1:** *TB Case* refers to TB patients diagnosed and registered in TB treatment and district register and notified to the health authority (TB program)
NUMERATOR	All new TB cases recorded in the TB Registers
DENOMINATOR	Population of the catchment area.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Age, sex, educational level, urban, rural, district, county/regional and national levels
INDICATOR LEVEL	Output
PURPOSE	To monitor the performance of all levels of service delivery in TB case finding.
FREQUENCY	**COLLECTION:** Data is recorded on daily basis in the TB Treatment Register. **REPORTING:** Monthly reporting to DHRIO/DTLC **UTILISATION**: Monthly at facility level, quarterly at county level or higher
DATA SOURCE	NUMERATOR: TB Treatment Register and summarised on form MOH 711 **DENOMINATOR**: Demographic Estimation
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	On daily basis and as TB case presents, the new case is recorded in the TB Treatment Register. Every month, these cases are then collated in the Facility Integrated Form (MOH 711) which is used to compute the indicator by 100 X all new TB cases recorded in the TB Registers, divided by the population of the catchment area.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	New Smear Positive Treatment Success Rate
HIS CODE:	**HIS113**

PROGRAMME GOAL	To monitor the performance on TB new smear positive case holding at each level. A treatment success rate exceeding 85 Percent is the global target.

REFERENCES CODES	WHO	MDG

DEFINITION OF IMPORTANT TERMS	**Key Term 1: *Cured Patient*:** Smear positive patients who complete, with documented smear negative results, treatment at the end of treatment (5-6 months) **Key Term 2: *Treatment Completion***: Patients who completes duration of treatment (6-8 months) under DOT supervision:
NUMERATOR	Number of new smear positive TB patients who were successfully treated (cured plus completed treatment) during the month.
DENOMINATOR	Total number (for the same cohort) that started treatment in the corresponding month 13-15 months before the current month.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Age, sex, educational level, urban, rural, district, county/regional and national levels
INDICATOR LEVEL	Output
PURPOSE	Evaluation of successful treatment outcomes of new smear-positive pulmonary TB patients is used to determine the quality and effectiveness of DOTS implementation at all levels.
FREQUENCY	**COLLECTION:** Data for all new TB cases are recorded in the TB register on daily basis or as when a case presents. **REPORTING**: Monthly **UTILIZATION**: Monthly at facility level, quarterly at county level or higher
DATA SOURCE	**NUMERATOR:** TB Treatment Register and summarised on MOH 711 **DENOMINATOR:** TB Treatment Register
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Every month, the TB Treatment Register is reviewed for all cases that have been cured and or completed treatment, against the number of the new cases that were recorded in the corresponding month 15 months before. Indicator is computed by 100 X the total number of new smear positive TB patients who were successfully treated (cured plus completed treatment) during the month, divided by the total number (for the same cohort) that started treatment in the corresponding month 13-15 months before the current month.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Proportion of eligible TB patients receiving diagnostic drug susceptibility testing for Multi-Drug Resistance Tuberculosis (MDR-TB)
HIS CODE:	**HIS114**

PROGRAMME GOAL	To monitor MDRTB TB surveillance

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1:** ***Testing Eligibility***: TB relapse, return after default, or category I and re-treatment failure
NUMERATOR	Number of MDR TB eligible suspects screened for MDR TB
DENOMINATOR	Total number of all eligible MDR TB suspects.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Age, sex, educational level, urban, rural, facility level (II and above), district, county/regional and national levels
INDICATOR LEVEL	Output
PURPOSE	This indicator measures the ability of TB programs to diagnose and collect data on smear-positive MDRTB cases.
FREQUENCY	**COLLECTION:** Data recorded in TB register on daily basis or as when an assessment is done. **REPORTING**: Monthly **UTILIZATION**: Monthly at facility level, quarterly at county level or higher
DATA SOURCE	**NUMERATOR**: TB Treatment Register and summarised on MOH 711 **DENOMINATOR**: TB Treatment Register
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Indicator is computed by 100 X the number of MDR TB eligible suspects screened for MDR TB, divided by the total number of all eligible MDR TB suspects.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Proportion of laboratory-confirmed MDR-TB patients enrolled in second-line anti-TB treatment
HIS CODE:	**HIS115**

PROGRAMME GOAL	To monitor access to MDRTB TB second line treatment

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1: *Second Line Treatment*** refers to approved MDRTB treatment regimen as per national MDRTB guidelines. The national guidelines recommend laboratory confirmation of MDRTB by documenting Rifampicin and Isoniazid through quality assured TB culture.
NUMERATOR	Number of laboratory-confirmed MDR-TB patients enrolled in second-line anti-TB treatment during a defined period
DENOMINATOR	Number of laboratory-confirmed MDR-TB patients during a defined period.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Age, sex, educational level, urban, rural, facility level (II and above), district, county/regional and national levels
INDICATOR LEVEL	Output
PURPOSE	This indicator measures access to appropriate treatment among patients with laboratory-confirmed MDR-TB.
FREQUENCY	**COLLECTION**: Data recorded in MDRTB treatment register on daily basis or as when the treatment is started. **REPORTING:** Data from facility MDRTB treatment register is submitted to the DTLC every month. **UTILIZATION:** Monthly at facility level, quarterly at county level or higher
DATA SOURCE	**NUMERATOR:** MDRTB Treatment Register **DENOMINATOR**: MDRTB Treatment Register
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Indicator computed by 100 X the number of laboratory-confirmed MDR-TB patients enrolled in second-line anti-TB treatment during a defined period, divided by the total number of laboratory-confirmed MDR-TB patients during a defined period.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Treatment success rate among MDR-TB cases
HIS CODE:	**HIS116**

PROGRAMME GOAL	Case holding of MDRTB TB patient on second line treatment

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1:** ***Second Line Treatment*** refers to approved MDRTB treatment regimen as per national MDRTB guidelines. The national guidelines recommend laboratory confirmation of MDRTB by documenting Rifampicin and Isoniazid through quality assured TB culture. **Key Term 2:*****Treatment Completion*** refers to expiry of 24, and 36 months after commencement of treatment
NUMERATOR	Number of laboratory confirmed MDR-TB patients on second line treatment who successfully completed treatment during the month
DENOMINATOR	Number of MDR-TB patients enrolled in second line anti-TB treatment 24, and 36 months before the current month.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Age, sex, educational level, urban, rural, facility level (II and above), district, county/regional and national levels
INDICATOR LEVEL	Outcome
PURPOSE	This indicator measures the success rate of the MDR-TB treatment program.
FREQUENCY	**COLLECTION:** Data recorded in MDRTB treatment register on daily basis or as when the treatment is started. **REPORTING**: Data from facility MDRTB treatment register is submitted to the DTLC every month. **UTILIZATION**: Monthly at facility level, quarterly at county level or higher
DATA SOURCE	**NUMERATOR**: MDRTB Treatment Register **DENOMINATOR**: MDRTB Treatment Register
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	This indicator can be measured only 24 to36 months after the patients are enrolled in treatment. The data are collected 24 months after the last patient in the cohort started treatment. Most of these patients will have finished treatment by 24 months, allowing preliminary assessment of success rates. Since a few patients may be receiving treatment longer than 24 months, the information is completed again at 36 months, which will then be considered the final result. Indicator computed by 100 X the number of laboratory confirmed MDR-TB patients on second line treatment who successfully completed treatment during the month, divided by the number of MDR-TB patients enrolled (same cohort as in the numerator) in second line anti-TB treatment 24, and 36 months before the current month.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Proportion of HIV positive TB patients who receive 1 dose of Co-trimoxazole preventive therapy (CPT) during their TB treatment among all HIV positive TB patients registered
HIS CODE:	**HIS117**

PROGRAMME GOAL	To monitor any reduction in the burden of HIV among TB patients.

REFERENCES CODES	WHO	MDG

DEFINITION OF IMPORTANT TERMS	**Key Term 1: *CPT*:** All HIV-positive TB patients should be given co-trimoxazole preventive therapy during their TB treatment and lifelong thereafter. TB patients may have been identified as HIV positive and started Co-trimoxazole preventive therapy before being diagnosed with TB; they should continue co-trimoxazole preventive therapy throughout TB treatment and be included in the denominator. To gain maximum benefit, TB patients should begin co-trimoxazole preventive therapy as soon as possible after HIV infection is diagnosed, as mortality is highest early in the course of TB treatment. The use in the definition of the clarifying statement – given at least one dose – is intended to capture all patients with TB who have been assessed and started on treatment. It does not imply that one dose of co-trimoxazole preventive therapy is sufficient.
NUMERATOR	Number of HIV positive TB patients who receive I dose of co-trimoxazole preventive therapy over a given period of time
DENOMINATOR	Total number of all HIV positive TB patients registered over a given period of time.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Age, educational level, urban , rural, facility level (II and above) district, county/regional ,and national levels
INDICATOR LEVEL	Output
PURPOSE	To monitor commitment and capacity of programs to provide co-trimoxazole preventive therapy to HIV-positive TB patients
FREQUENCY	**COLLECTION**: Data is recorded in the TB register on daily basis or as whenever Cotrim is given to a patient. **REPORTING**: Monthly **UTILIZATION:** Monthly at facility level, quarterly at county level or higher
DATA SOURCE	NUMERATOR: Data is collected on Form MOH 711 DENOMINATOR: Form MOH 711
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	The indicator is computed as 100 X the total number of HIV positive TB patients who receive at least one (1) dose of co-trimoxazole preventive therapy divided by the number of all HIV positive TB patients registered over a given period of time. Given at least one dose does not imply that one dose of Cotrim preventive therapy is sufficient.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Proportion of HIV+ TB patients on ARVs among eligible TB patients
HIS CODE:	**HIS118**

PROGRAMME GOAL	To monitor reduce the burden of HIV among TB patients.

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1:** ***Patient on ART***: refers to those actively taking ARVs within the reporting quarter.
NUMERATOR	Number of HIV+ TB patients on ART during the quarter. This should capture those that started on ART in the referred facilities
DENOMINATOR	Number of HIV+ TB patients in the quarter.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Age, sex, educational level, urban , rural, district, county/regional and national levels
INDICATOR LEVEL	Output
PURPOSE	This indicator measures the commitment and capacity of TB service to ensure that HIV-positive TB patients are able to access antiretroviral therapy. Antiretroviral therapy significantly improves the quality of life, reduces morbidity and enhances the survival of people with advanced HIV infection or AIDS. HIV-positive TB patients are one of the largest groups already in contact with the health service who are likely to benefit from antiretroviral therapy, and efforts should be made to identify and treat those who are eligible.
FREQUENCY	**COLLECTION**: Data recorded daily or when a HIV+TB patient starts on ART. **REPORTING:** Quarterly **UTILIZATION:** Quarterly at facility level, county level or higher
DATA SOURCE	**NUMERATOR:** TB Treatment Register and ART Registers and Data is collected on Form MOH 711 **DENOMINATOR**: Form MOH 711
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Indicator is computed 100 X the total number of HIV+ TB patients on ARVs divided by the total number of HIV+ TB patients during the quarter. The numerator should capture those that started on ART in the referred facilities which may be a challenge.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Proportion of Leprosy patients released from treatment
HIS CODE:	**HIS119**

PROGRAMME GOAL	To monitor leprosy post-elimination activities

REFERENCES CODES	WHO	MDG

DEFINITION OF IMPORTANT TERMS	**Key Term 1:** ***Leprosy Treatment***: Leprosy patients are treatment under two different regimens. Pauci-bacillary leprosy patients are treated using PB 6 month regiment and patient are released from treatment with completion of this within year. Multi-bacillary patients are treated with MB 12 month regimens and patients are released from treatment after completing 12 month regimen with 2 year period.
NUMERATOR	Number of Leprosy patients released from treatment during the month
DENOMINATOR	(1) Total number of registered Leprosy cases in the monthly cohort 12 months before (PB 6). (2) Total number of registered Leprosy cases in the monthly cohort 24 months before (MB 12).
UNIT OF MEASURE	Percentage
DISAGGREGATION	Age, sex, educational level, urban, rural, facility level (II and above), district, county/regional and national levels
INDICATOR LEVEL	Outcome
PURPOSE	This indicator measures the success rate of the Leprosy treatment program.
FREQUENCY	**COLLECTION**: Data recorded in Leprosy Treatment Register on daily basis or as when the treatment is started. **REPORTING**: Data from facility Leprosy Treatment Register is submitted to the DLTLD every month. **UTILIZATION**: Monthly at facility level, quarterly at county level or higher
DATA SOURCE	**NUMERATOR**: Leprosy Treatment Register **DENOMINATOR**: Leprosy Treatment Register
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Indicator is computed by (1) **100 X** the number of Leprosy patients released from treatment during the month, **divided by** the total number of registered Leprosy cases in the monthly cohort 12 months before (PB 6). (2) **100 X** the number of Leprosy patients released from treatment during the month, **divided by** the total number of registered Leprosy cases in the monthly cohort 24 months before (MB 12).

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Incidence rate of all forms of TB
HIS CODE:	**HIS120**

PROGRAMME GOAL	To monitor the incidence of TB in the population

REFERENCES CODES	WHO	MDG

DEFINITION OF IMPORTANT TERMS	**Key Term 1:** ***incidence rate***: This is the number of **new** TB cases per population in a given period.					
NUMERATOR	Total number of all forms of new TB cases reported					
DENOMINATOR	Estimated total national population per 100,000.					
UNIT OF MEASURE	Number					
DISAGGREGATION	Age, sex, educational level, urban, rural, facility level (II and above), district, county/regional and national levels					
INDICATOR LEVEL	Outcome					
PURPOSE	This indicator measures the risk of contracting TB.					
FREQUENCY	**COLLECTION**: Data recorded in TB treatment register on daily basis. **REPORTING**: Data from facility TB Treatment Register is submitted to the DLTLD every month and this indicator calculated annually. **UTILIZATION**: Monthly at facility level, quarterly at county level or higher					
DATA SOURCE	**NUMERATOR**: TB Treatment Register **DENOMINATOR**: National population projections and census.					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	This indicator is calculated by number of new TB cases divided by estimated population of given area, group , age or sex multiplied by 100,000					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Prevalence of the rate of bacteriologically confirmed smear positive TB
HIS CODE:	**HIS121**

PROGRAMME GOAL	To monitor the TB prevalence rate in the country

REFERENCES CODES	WHO	MDG

DEFINITION OF IMPORTANT TERMS	**Key Term 1: *Prevalence rate***: This is the total number of Tb cases divided by the total population during that period.					
NUMERATOR	Total existing TB cases.					
DENOMINATOR	Estimated total national population per 100,000 during that period.					
UNIT OF MEASURE	Number					
DISAGGREGATION	Age, sex, educational level, urban, rural, facility level (II and above), district, county/regional and national levels					
INDICATOR LEVEL	Impact					
PURPOSE	This indicator is used to estimate how common TB is in within a population over a given period of time.					
FREQUENCY	**COLLECTION**: The data will be collected during Prevalence survey. **REPORTING**: Data will be stored in a database after the survey at the national level. **UTILIZATION**: annual reports					
DATA SOURCE	**NUMERATOR**: PREVALENCE SURVEY **DENOMINATOR**: National population projections and census.					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	This indicator is calculated by number of all TB cases divided by estimated population of given area, group , age or sex multiplied by 100,000					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Treatment Default rate
HIS CODE:	**HIS122**

PROGRAMME GOAL	To monitor the rate of treatment rate

REFERENCES CODES	WHO	MDG

DEFINITION OF IMPORTANT TERMS	**Key Term 1:** ***Treatment default***: One is said to have defaulted treatment if he/she misses 2 consecutive treatment sessions.
NUMERATOR	Number of defaulters among smear positive TB cases.
DENOMINATOR	New smear positives registered during the quarter.
UNIT OF MEASURE	Percentage.
DISAGGREGATION	Age, sex, educational level, urban, rural, facility level (II and above), district, county/regional and national levels
INDICATOR LEVEL	Output.
PURPOSE	This indicator is used to measure the treatment default rate.
FREQUENCY	**COLLECTION**: The data is collected from TB treatment register. **REPORTING**: Monthly reporting to the district. **UTILIZATION**: Monthly at facility, quarterly at the national or higher levels.
DATA SOURCE	**NUMERATOR**: TB TREATMENT REGISTER **DENOMINATOR**: TB treatment register.
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	The indicator is computed by 100X number of defaulters among new smear positive TB cases divided by all new smear positive Tb cases registered during the quarter. The defaulters are recorded on regular basis as they occur at the facility level and then collated every quarter at the facility and district level.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Proportion of laboratories performing regular external quality assurance for smear microscopy.
HIS CODE:	**HIS123**

PROGRAMME GOAL	

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1:** ***External quality assurance*** is defined by the World Health Organization as 'a system of objectively checking laboratory results by means of an external agency. **Key Term 2: smear Microscopy:** Smear microscopy involves collecting a biological sample (usually sputum or some other clinical material), fixing it thinly on a glass slide and then staining it with a dye that binds specifically to mycobacteria (making them easier to identify under a microscope)
NUMERATOR	Number of AFB microscopy sites doing quarterly EQA for sputum microscopy.
DENOMINATOR	Number of TB microscopy labs in the country.
UNIT OF MEASURE	Percentage.
DISAGGREGATION	Public, Private, community and NGOs
INDICATOR LEVEL	Output
PURPOSE	The purpose of this indicator is to measure the coverage of quality assurance implementation in TB laboratories.
FREQUENCY	**COLLECTION**: Sampling of slides is done quarterly from the lab **REPORTING**: quarterly reporting to the DMLT/DTLC and national level **UTILIZATION**: quarterly National and higher levels
DATA SOURCE	**NUMERATOR**: NUMBER OF AFB MICROSCOPY SITES DOING EQA FOR SPUTUM MICROSCOPY **DENOMINATOR**: NUMBER OF TB MICROSCOPY LABS IN THE COUNTRY
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Multiply 100 by number of AFB microscopy sites doing EQA for sputum microscopy divided by the total number of TB microscopy sites in the country.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

DENTAL HEALTH

INDICATOR NAME	Dentist population ratio
HIS CODE:	**HIS124**

PROGRAMME GOAL	To ensure availability of oral health care and rationalized distribution of dentists.

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	Number of dentists serving a specific population per 10,000 people
NUMERATOR	Number of dentists
DENOMINATOR	Estimated population in a specified catchment area or in the country.
UNIT OF MEASURE	Ratio
DISAGGREGATION	District, County, Regional and National levels
INDICATOR LEVEL	Input
PURPOSE	In many countries national capacity and resources human, financial and material are still insufficient. To ensure availability of and access to essential health services of high quality to individuals and population, especially deprived communities is paramount. This is useful in the process of change in an effort to decentralize oral health services. There is important need to engage support of private sector participation. This will address equities in access to oral health services, promote universal coverage and improve the efficiency of the health system. This will improve the planning of oral health services for vision 2030.
FREQUENCY	COLLECTION: Annually REPORTING: Annually UTILISATION: Annually
DATA SOURCE	NUMERATOR/DENOMINATOR: Staff returns
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = (Number of active dentists at the end of the year) / (Estimated population in a specified catchment area) NOTE: This indicator is best left to programme level annual review and does not qualify for routine monitoring

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓		

INDICATOR NAME	Proportion of school going children who are given oral health education and examined for dental problems.
HIS CODE:	**HIS125**

PROGRAMME GOAL	Ensure continued promotion of oral health and prevention of oral diseases. To instil a healthy lifestyle.

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	The number of school going children who have received oral health education and examined
NUMERATOR	Number of school going children who are given oral health care and examined.
DENOMINATOR	Estimated number of school going children in the specified catchment area.
UNIT OF MEASURE	Percentage
DISAGGREGATION	District, County, Regional and National levels
INDICATOR LEVEL	Output
PURPOSE	Programs aimed at improving oral health of children should seek to mobilize and strengthen oral health promotion and education activities. There is need to take into consideration external factors like environment and dietary habits, for example consumption of sweets and sugary beverages. The initiative is designed to improve the oral health of children, school personnel, families and other members of the community through schools.
FREQUENCY	**COLLECTION**: Routinely collected through mostly outreach activities **REPORTING**: Monthly **UTILISATION**: Monthly/Quarterly
DATA SOURCE	**NUMERATOR/DENOMINATOR**: Dental Register
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Number of school going children who are given oral health care and examined) / (Estimated number of school going children in the specified catchment area)

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓		✓

INDICATOR NAME	Number of prosthetic cases
HIS CODE:	**HIS126**

PROGRAMME GOAL	Ensure continued provision of rehabilitative oral health care

REFERENCES	MDG	AOP
CODES	#6	#7

DEFINITION OF IMPORTANT TERMS	Prosthetics: Prosthetics involves fabrication of artificial appliances to replace lost teeth and tissues. This includes dentures – complete and partial, orthodontic appliances.
NUMERATOR	Number of prosthetics
DENOMINATOR	None
UNIT OF MEASURE	Number
DISAGGREGATION	Sex
INDICATOR LEVEL	Output
PURPOSE	Prosthetics involves fabrication of artificial appliances to replace lost teeth and tissues. This includes dentures – complete and partial, orthodontic appliances – for alignment of malpositioned teeth, obturators for replacement of lost tissues. Habit breakers for children with habits like thumb of tongue sucking. The purpose of this is to restore the facial profile, speech and mastication. This is important in awareness creation and ensures availability and accessibility of prosthetics to the community.
FREQUENCY	**COLLECTION:** Monthly **REPORTING:** Monthly **UTILISATION**: Monthly
DATA SOURCE	**NUMERATOR/DENOMINATOR**: Dental laboratory register
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = count of "Number of prosthetics" **NOTE:** To be able to obtain a reliable denominator, all patients attending dental laboratories should be registered.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Proportion of Health facilities providing oral health care services
HIS CODE:	**HIS127**

PROGRAMME GOAL	Ensure continued improvement of facilities to offer comprehensive oral health services.

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	Number of health facilities offering oral health services
NUMERATOR	Number of health facilities providing comprehensive oral health care services
DENOMINATOR	Total number of health facilities within a specified catchment area
UNIT OF MEASURE	Percentage
DISAGGREGATION	Level of service (Basic/Comprehensive), district, county, regional and national levels
INDICATOR LEVEL	Output
PURPOSE	In developing countries, oral health services are mostly offered from regional or central hospitals of urban centres and little is given to preventive or restorative dental care. Many communities have a shortage of oral health personnel and generally the capacity of the systems is limited to pain relief. There is need to reform the oral health strategy to ensure availability of and access to essential oral health services of high quality for individual and population especially in marginalized communities. This will assist in the planning for oral health services.
FREQUENCY	**COLLECTION**: Annually through supportive supervision and checklist or update on Master Facility List MOH 715 **REPORTING**: Annually **UTILISATION**: Annually
DATA SOURCE	**NUMERATOR/DENOMINATOR**: Modify **MOH 715 form to accommodate this.**
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Number of health facilities providing comprehensive oral health care services) / (Total number of health facilities within a specified catchment area) X 100

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓		

OPHTHALMOLOGY

INDICATOR NAME	Proportion of New-borns receiving Tetracycline Eye Ointment (TEO)
HIS CODE:	**HIS128**

PROGRAMME GOAL	To reduce ophthalmic morbidity due to new born conjunctivitis. The indicator therefore helps to track the practice of instilling TEO to new-born eyes immediately after birth by the health workers which is an important factor for blindness prevention. Instilling TEO in the eye immediately after birth is the prophylactic treatment for new born conjunctivitis.

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Newborn conjunctivitis*** is an eye infection occurring in neonates in the first 30 days of life, presenting with eye discharge and in severe cases swelling of eye lids. **Key Term 2**: ***Tetracycline eye ointment*** is an antibiotic used to treat and prevent eye infections including newborn conjunctivitis **Key Term 3**: ***Newborn*** means a child in the first 30 days of life (0-30 days). **Key Term 4**: ***Instilling TEO***. All children ought to receive TEO immediately after birth instilled in both eyes. Wipe babies' eyes with sterile cotton wool, each eye at a time and instil TEO under the lower lid.
NUMERATOR	Number of newborns receiving TEO in facility
DENOMINATOR	Number of life Births in a facility in a month
UNIT OF MEASURE	Percentage
DISAGGREGATION	Facility, district/county, regional and national levels
INDICATOR LEVEL	Output
PURPOSE	The indicator measures coverage of TEO within the health facilities (Not in community because currently the CHWs do not always have TEO in the community kit. Further, there is no community data capture tool for this indicator although there are plans to develop one. This indicator will be used it to improve advocacy for prophylactic treatment and prevention of blindness in children. The indicator can also help to identify challenges in procurement and distribution of TEO.
FREQUENCY	**COLLECTION**: data is recorded on daily basis **REPORTING**: Monthly throughout the hierarchy **UTILISATION**: Monthly at facility level, quarterly at county level or higher
DATA SOURCE	**NUMERATOR**: Monthly District Reports from Maternities using register MOH 333 and postnatal register MOH 406 Registers , MCH booklets- "Afya ya Mama Na mtoto" MOH 216 **DENOMINATOR**; Maternity Register MOH 333
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	All children ought to receive TEO immediately after birth instilled in both eyes. The data comes from maternities (MOH 405Registers) and MCH booklets (Afya ya Mama Na Mtoto).Indicator is computed by 100 X the number of newborns receiving TEO in the health facility, divided by the number of life Births in a facility in a month.

INDICATOR	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY

APPLICATION LEVEL		✓	✓	✓	✓	

INDICATOR NAME	Cataract Surgical Rate (number of surgeries per a million population)
HIS CODE:	**HIS129**

PROGRAMME GOAL	Reduction of in blindness in the general population

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Cataract*** is an eye disease which occurs due to the opacity of the lens. It presents with a white pupil and is more common among cohort 6, but sometimes can be congenital or caused by trauma/injuries. **Key Term 2**: ***Cataract surgical Rate (CSR)*** - Number of patients accessing cataract surgical services in a Million Population annually.					
NUMERATOR	Sum of all patients receiving cataract surgery in the annually within a geographical area (County, National etc)					
DENOMINATOR	Catchment population divided by 1,000,000.					
UNIT OF MEASURE	Ratio					
DISAGGREGATION	Age, educational level, urban , rural, county/regional and national levels					
INDICATOR LEVEL	Output					
PURPOSE	It is important in estimating the general utilization of eye care services by the population within the catchment area. This is a standard internationally used indicator and therefore useful for international comparisons.					
FREQUENCY	**COLLECTION**: data is recorded on daily basis or when surgeries are conducted. **REPORTING**: Data is aggregated and reported monthly at the District eye clinic **UTILIZATION**: Monthly at the District, quarterly at the national level					
DATA SOURCE	**NUMERATOR**: Eye Clinic Reports **DENOMINATOR**: Demographic estimation of population of District/County					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Data is collated monthly from District Eye Clinics where surgeries are conducted. The Division of Ophthalmic Services manages the programme data and calculates the denominator for the District/County Levels. The indicator is computed by the number of patients receiving Cataract Surgery annually divided by (catchment population divided by 1,000,000.)					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	✓

INDICATOR NAME	Cataract Surgery Coverage (surgeries as a percentage of the estimated need)
HIS CODE:	**HIS130**

PROGRAMME GOAL	Reduction of blindness in the general population

REFERENCES CODES	WHO	MDG

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Cataract*** is an eye disease which occurs due to the opacity of the lens. It presents with a white pupil and is more common among cohort 6, but sometimes can be congenital or caused by trauma/injuries.					
NUMERATOR	Number of patients receiving cataract surgery annually					
DENOMINATOR	Estimated number in need in the population.					
UNIT OF MEASURE	Percentage					
DISAGGREGATION	Age, educational level, urban , rural, district, county/regional and national levels					
INDICATOR LEVEL	Output					
PURPOSE	It is important in estimating the coverage of eye care services by the population in need within the catchment area. Indicator is therefore used in planning for necessary requirements like consumables and personnel for cataract surgical services					
FREQUENCY	**COLLECTION**: data is recorded on daily basis or when surgeries are conducted. **REPORTING**: Data is aggregated and reported monthly at the District eye clinic **UTILIZATION**: Monthly at the District, quarterly at the national level					
DATA SOURCE	**NUMERATOR**: Eye Clinic Reports **DENOMINATOR:** Demographic estimation of population in need of cataract surgery in the District/County					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	The estimated number requiring cataract surgery in the catchment population within the cataract endemic districts is known (xx% Population).Indicator computed by 100 X number of patients receiving cataract surgery annually, divided by the estimated number in need of cataract surgery in the population.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	✓

INDICATOR NAME	Proportion of diabetic patients screened for eye complications.
HIS CODE:	**HIS131**

PROGRAMME GOAL	To reduce avoidable blindness due to eye complication from diabetes.

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1:** ***Diabetes*** is a systemic disease which causes various organ damage including eyes. Diabetes causes complications in the eyes leading to irreversible blindness if not detected and treated early. **Key Term 2:** ***Diabetic retinopathy*** is the eye complications from diabetes and all patients diagnosed with diabetes are advised to visit the eye clinic once every year for an eye check to detect retinopathy early and to receive the relevant treatment.
NUMERATOR	Number of diabetic patients screened for retinopathy in the facility
DENOMINATOR	Total number of diabetic patients seen in the facility
UNIT OF MEASURE	Percentage
DISAGGREGATION	Age, educational level, urban , rural, district, county, and national levels
INDICATOR LEVEL	Output
PURPOSE	Indicator is used to track the management of diabetes by the health worker and especially for referrals to the eye clinic for eye examination. It helps in the planning for resources for management of diabetic retinopathy in the country
FREQUENCY	**COLLECTION**: Data for both numerator and denominator are captured daily or as the event takes place but the two uses different tools. **REPORTING**: Data aggregated and reported annually to the national **UTILIZATION:** Annual at the national
DATA SOURCE	**NUMERATOR:** DOS Reports **DENOMINATOR:** MOH 701B
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	From the District Eye Clinic /Registers, the Division of Ophthalmic Services (DOS) aggregates all cases of diabetic patients that are screened for Diabetic retinopathyin the year- this is the indicator's numerator. The Health Information System captures all new diabetic cases in the daily FORM 701B (Outpatient Over 5 Years). These cases (701B) are then aggregated to get the annual figure which is the denominator for this indicator. The Indicator is then computed by 100 X number of diabetic patients screened for retinopathy in all the District Eye Clinics nationally, divided by the number of new diabetic patients seen in all the health facilities annually.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	✓

INDICATOR NAME	Proportion of population receiving Azithromycin in targeted trachoma endemic districts.
HIS CODE:	**HIS132**

PROGRAMME GOAL	To reduce the burden of active trachoma in the endemic districts of Kenya.

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Trachoma*** is chronic infectious eye disease which affects the conjunctiva and is found in dusty, dry and dirty environment. The active infection in children has eye discharge but causes blindness in adulthood. **Key Term 2**: ***Trachoma Endemic Districts 2004 Gazette*****, Kajiado, Narok, Samburu, Pokot (Ease and West), Turkana, Isiolo, Marsabit,** and Moyale. A total of 18 districts are suspected to be endemic of trachoma in Kenya. 11 districts have been surveyed to determine the prevalence of active disease as per WHO standards. **Key Term 3**: ***Azithromycin*** is the drug recommended by WHO for use in treatment of the disease. It is taken one dose annually for 3 to 4 years depending on prevalence of the disease in the population. It is used in mass drug administration for the whole district.
NUMERATOR	Total population receiving Azithromycin
DENOMINATOR	Total population in trachoma endemic area minus population of pregnant women and children under 6 months
UNIT OF MEASURE	Percentage
DISAGGREGATION	Age, educational level, urban, rural, district/county/ regional and national levels
INDICATOR LEVEL	Output
PURPOSE	This indicator is used to assess drug coverage after mass drug administration as per WHO standards. It is used to monitor the progress made towards elimination of trachoma in the country. It is also used to plan for the doses of zithromax requested from International Trachoma Initiative for use in the endemic districts.
FREQUENCY	**COLLECTION**: Data is recorded in Trachoma Unit's Programme Registers used during mass drug administration sessions. **REPORTING**: Quarterly **UTILIZATION**: Annually at District and National
DATA SOURCE	**NUMERATOR:** Trachoma Unit's Registers **DENOMINATOR**: Demographic estimation of endemic district population
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Indicator is computed by 100 X total population receiving Azithromycin, divided by the total population in trachoma endemic area minus population of pregnant women and children under 6 months.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	✓

INDICATOR NAME	Proportion of patients referred by CHEWs seen at the eye clinics.
HIS CODE:	**HIS133**

PROGRAMME GOAL	To empower the community to seek early eye treatment and improve eye health outcome. This in turn helps to reduce blindness in community by early identification and treatment of eye diseases.

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Community Health Extension Workers (CHEWs)*** are health workers at level 1, II, III and IV who provide health services to the community on a day to day basis. They should have basic eye care knowledge and skills. **Key Term 2**: ***Referral*** is usually from at level I and II so that these referrals are checked at the eye clinic which is usually at District hospitals or specialised eye hospitals
NUMERATOR	Number of eye patients (among those from Level I and II) seen at the eye clinic
DENOMINATOR	Total number of new eye infection cases seen at level I and II annually
UNIT OF MEASURE	Percentage
DISAGGREGATION	Age, sex, facility level (I or II), District/county, regional and national levels
INDICATOR LEVEL	Output
PURPOSE	The use of this is to improve community access to eye care services at all levels.
FREQUENCY	**COLLECTION**: Data is collected each time a case from level I and II presents at the District Eye Clinic **REPORTING**: Data aggregated at, and reported from, the District Eye Clinic annually. **UTILIZATION**: Annually at national
DATA SOURCE	**NUMERATOR**: District Eye Clinic Register **DENOMINATOR**: MOH 701 A&B

DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	From the District Eye Clinic /Registers, the DOS aggregates all cases of referrals that they handle from among those of health facility level I and II in the year - numerator. The Health Information System captures all new cases of eye infections in MOH 701A, and 701B which are then aggregated to get the annual figure- denominator. The logic is that it is expected that all new cases of eye infections at facility level I and II will all be referred to the District Eye Clinic for three reasons; (1) the health workers at these two levels may not be relied on to comprehensively deal with the problem due to limited skills and equipment, (2) the MOH 701 A&B does not capture the cause (disease) of referral, (3) It would be unnecessary burden to the CHEWs at level I and II to report on data that can be collected more easily using existing tools. Programmatically, CHEWS must be encouraged to continue making referrals though data is collected using MOH 701. Indicator is computed by 100 X the number of eye patients (referred from Level I and II) seen at the District Eye Clinic in the year, divided by the total number of new cases of eye infections recorded in MOH 701 A&B for all Level I and II facilities annually.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	✓

OCCUPATIONAL THERAPY

INDICATOR NAME	Proportion of children less than 5 years with delayed developmental milestones/disability (in the Facility)
HIS CODE:	**HIS134**

PROGRAMME GOAL	Ensure continued improvement in early identification and interventions so as to reduce infant (under 1yr), and under 5yrs mortality rate and disability.

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	Key Term 1: ***Delayed Developmental Milestones*** is a condition acquired by a child at birth or at any stage of growth as a result of birth trauma, disease or nutritional defects which interfere with the normal developmental sequence of the child's reflexes, motor activities etc leading to delayed achievement of normal growth and in severe instances death.
NUMERATOR	Number of children under 5 identified as having disabilities / children identified with delayed developmental milestones.
DENOMINATOR	Total number of children under 5 years seen in the health facilities
UNIT OF MEASURE	Percentage
DISAGGREGATION	Age, urban , rural, district, county, regional and national levels
INDICATOR LEVEL	Outcome
PURPOSE	This indicator will help measure the number of children less than five years who have been identified and early intervention has been done. An increase in number of new cases of Delayed Developmental Milestones will either reflect: increased/improved awareness in place to identify and refer these cases at an early stage by skilled birth attendants, case identification through the clinics or lack of skilled birth attendants leading to increased birth traumas. A decrease in

	number of new cases of delayed developmental milestones may reflect: Lack of skilled birth attendants with the knowledge to identify and refer or increased deliveries by skilled birth attendants hence decreased birth traumas, or lack of adequate awareness in place for case identification and referral by clinicians. Double entries for cases who have been seen previously is common. Hence capture of new cases will help counter this trend. The indicator trends must therefore be interpreted with care.
FREQUENCY	**COLLECTION**: Data is recorded daily or when a case presents **REPORTING:** Monthly throughout the hierarchy **UTILISATION:** Monthly at facility level, quarterly at county level or higher
DATA SOURCE	**NUMERATOR**: All Occupational Therapy Departments country wide have a modified reporting tool for this indicator **DENOMINATOR**: MOH 704, MOH 711, MOH 702
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Clinicians and birth attendants assess children at MCH/FP Clinic, Maternity, Outpatient, Child Welfare Clinics, Paediatric Wards, any other contacts with children under 5 years. Indicator computed by 100 X number of children under 5 identified as having disabilities, divided by the number of children under 5 years seen in the health facility.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Proportion of referred children under 5 years with disabilities/delayed developmental milestones/stunted growth seen and recorded in the Rehabilitation Units' Registers (in the Facility)
HIS CODE:	**HIS135**

PROGRAMME GOAL	To improve referral system for children with delayed development milestones/disability

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Delayed Developmental Milestones*** is a condition acquired by a child at birth or at any stage of growth as a result of birth trauma, disease or nutritional defects which interfere with the normal developmental sequence of the child's reflexes, motor activities etc leading to delayed achievement of normal growth and in severe instances death. Key Term 2: ***Disability***: Refers to inability to participate partially or fully in activates of daily living/roles due to Physical, psychological. Sensory, or Developmental impairments. Key Term 3: ***Stunted growth*** is a term used to describe small for age cases.in terms of weight, height, milestones. **Key Term 4:*Rehabilitation Units' Registers*** include; Occupational Therapy, Physiotherapy, orthopaedic and Nutrition Unit Register
NUMERATOR	Number seen and recorded in the Rehabilitation Units' registers
DENOMINATOR	Total number referred to Rehabilitation Unit.
UNIT OF MEASURE	Percentage
DISAGGREGATION	District, County, regional and national levels

INDICATOR LEVEL	Process
PURPOSE	This is a process indicator capturing the practice of caregivers in relation to taking the children for therapy
FREQUENCY	**COLLECTION:** Data is recorded in the Rehabilitation Register each time a case presents. **REPORTING:** Data for both numerator and denominator are aggregated and reported quarterly. **UTILIZATION:** Monthly at facility level, quarterly at county level or higher
DATA SOURCE	**NUMERATOR**: Rehabilitation Units' Registers **DENOMINATOR**: MOH 704, MOH 711, MOH 701A, MOH 702
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Currently, all facility registers coming into contact with children under 5 years have a column for referrals. The column is general and can have all manner of referrals recorded and there is no guarantee that all cases of referral for delayed development would be captured. This makes it difficult to compute the denominator. The HIS, and the MOH Divisions, may need to deal with the tools in respect of capturing all types of referrals in all registers since this a cross-cutting gap for all referral-related indicators. The indicator is computed by 100 X number seen and recorded in the Rehabilitation Units' registers, divided by the number referred to Rehabilitation Unit.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	**Proportion of children less than 5 years with delayed developmental milestones /disability (in the community)**
HIS CODE:	**HIS136**

PROGRAMME GOAL	Ensure continued improvement in early identification and interventions so as to reduce infant (under 1yr), and under 5yrs mortality rate and disability.

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Delayed Developmental Milestones*** is a condition acquired by a child at birth or at any stage of growth as a result of birth trauma, disease or nutritional defects which interfere with the normal developmental sequence of the child's reflexes, motor activities etc leading to delayed achievement of normal growth and in severe instances death. Key Term 2: **Disability** Refers to incapacity to participate partially or fully in activities of daily living/roles due to Physical, psychological. Sensory, or Developmental impairments. **Key Term 3**: ***Community OT***: Children with disabilities are identified through outreaches using WHO guidelines i.e. Community-Based Rehabilitation (CBR) Guidelines/CHW-(Community Health Workers)
NUMERATOR	Number of children under 5 identified as having disabilities in the community
DENOMINATOR	Total number of children under 5 years screened/assessed in the community through outreaches
UNIT OF MEASURE	Percentage
DISAGGREGATION	Age, urban, rural, district, county, regional and national levels
INDICATOR LEVEL	Output

PURPOSE	This indicator will help measure the number of children less than five years who have been identified and early intervention has been done. An increase in number of new cases of Children with disability/ Delayed Developmental Milestones will either reflect: increased/improved awareness in place to identify and refer these cases at an early stage by skilled CHW Community Health Workers or increased resources for OT staff outreach activities. A decrease in number of new cases of Children with disability/ delayed developmental milestones may reflect: Lack of skilled CHW in early identification of disability which contributes to reduction of cases of delayed development/Disability .Double entries for cases which may have received the service in the past needs to be considered by capturing new cases. The Indicator trends therefore need to be interpreted carefully.
FREQUENCY	COLLECTION: Data is recorded when a case presents, i.e. encounter with a child under 5 years **REPORTING**: Data is aggregated and reported monthly or quarterly. **UTILIZATION:** Quarterly at county level or higher
DATA SOURCE	**NUMERATOR:** Community OT Tool which is to be refined(cases of under 5 with disabilities registered in the CHW register **DENOMINATOR:** Community OT Tool which is to be refined (No. Of under 5 in the given community)
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Indicator computed by 100 X number of children under 5 identified as having disabilities in the community, divided by the number of children under 5 years screened/assessed in the community through outreaches

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	✓

INDICATOR NAME	Proportion of children under 5 years, among those identified as having disability in the community, that were managed
HIS CODE:	**HIS137**

PROGRAMME GOAL	Ensure continued improvement in early identification and interventions so as to reduce infant (under 1yr), and under 5yrs mortality rate and disability.

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Managed*** refers to management on site, referral for rehabilitation, placement, or other specialized service.
NUMERATOR	Number of children under 5 years that were managed as per national guidelines
DENOMINATOR	Total number of children under 5 screened and found to be with disability
UNIT OF MEASURE	Percentage
DISAGGREGATION	Age, urban , rural, district, county, regional and national levels
INDICATOR LEVEL	Process
PURPOSE	This indicator will help measure the number of children less than five years who have been identified and early intervention has been done. An increase in number of new cases of Delayed Developmental Milestones/disability will either reflect: increased/improved awareness in place to identify and refer these cases at an

	early stage by OT staff, increased resources for their outreach activities or increased referral by CHW (Community Health Workers) who are skilled on early disability identification and referral. A decrease in number of new cases of delayed developmental milestones/disability may reflect: Lack of skilled CHW'S with the knowledge to identify and refer or Lack of adequate resources for outreach services which contributes to reduction of cases .
FREQUENCY	COLLECTION: Data is recorded when a case presents, i.e. encounter with a child under 5 years **REPORTING:** Data is aggregated and reported monthly or quarterly. **UTILIZATION**: Quarterly at county level or higher
DATA SOURCE	**NUMERATOR:** Community OT Tool which is to be refined(To be captured from CHW Register) **DENOMINATOR**: Community OT Tool which is to be refined (Number of cases in OT facility register as referral from the CHW)
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Indicator computed by 100 X of number of children under 5 years that were managed as per national guidelines, divided by the number of children under 5 screened and found to be with disability

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	✓

PHYSIOTHERAPY

INDICATOR NAME	Proportion of ANC attendees counselled on exercises
HIS CODE:	**HIS138**

PROGRAMME GOAL	Ensure continued improvement of the physical status of the expectant mother. The Millennium Development Goal (MDG) is to improve maternal health .This will be achieved through antenatal and postnatal care.

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1:** ***Obstetric Physiotherapy***: To have been counselled, a woman needs to have been taken through Obstetric Physiotherapy which entails 1. Pre-natal exercises are breathing and pelvic floor exercises mothers are taught to prepare them for delivery and how to strengthen their laxed pelvic floor and abdominal muscles after delivery, 2. Post-natal exercises are breathing and pelvic floor exercises mothers are taught after delivery to strengthen the pelvic and abdominal muscles, 3. Exercise Psychology
NUMERATOR	Number pregnant women attending prenatal (and or postnatal) exercises
DENOMINATOR	Total number of women referred for prenatal/postnatal exercises.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Age, educational level, urban , rural, facility Level, district, county, regional and national levels
INDICATOR LEVEL	Process

PURPOSE	Prenatal/postnatal exercise sessions are routine measures meant to prevent effects of pregnancy on the musculature of women of reproductive age (WRA) which will impact negatively on their health.					
FREQUENCY	COLLECTION: Data is recorded daily or when a case presents REPORTING: Annual UTILISATION: Annual					
DATA SOURCE	NUMERATOR: Obstetric Physiotherapy Register DENOMINATOR: ANC and Postnatal registers					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Currently, the ANC and Postnatal Registers have a column for referrals. The column is general and can have all manner of referrals recorded and there is no guarantee that all cases of referral for obstetric physiotherapy would be captured. This makes it difficult to compute the denominator. The HIS, and the MOH Divisions, may need to deal with the tools in respect of capturing all types of referrals in all registers since this a cross-cutting gap for all referral-related indicators. Indicator is computed by 100 X number pregnant women attending prenatal (and or postnatal) exercises, divided by the total number of women referred for prenatal/postnatal exercises. There is potential for double counting in this indicator since there are no unique client codes across ANC/Postnatal / Physiotherapy units. Data may need to be aggregated annually to minimize double counting for cases where a woman attends physiotherapy several times during the pregnancy.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	✓

INDICATOR NAME	Percentage of women of reproductive age (WRA) who are expectant receiving prenatal/postnatal exercises
HIS CODE:	**HIS139**

PROGRAMME GOAL	Ensure continued improvement of the physical status of the expectant mother. The Millennium Development Goal (MDG) is to improve maternal health .This will be achieved through antenatal and postnatal care.

REFERENCES	WHO	MDG
CODES		5

DEFINITION OF IMPORTANT TERMS	1. Pre-natal exercises are breathing and pelvic floor exercises mothers are taught to prepare them for delivery and how to strengthen their laxed pelvic floor and abdominal muscles after delivery. 2. Post-natal exercises are breathing and pelvic floor exercises mothers are taught after delivery to strengthen the pelvic and abdominal muscles.
NUMERATOR	Number of WRA expectant/pregnant receiving prenatal/postnatal exercises
DENOMINATOR	Total number of WRA referred for prenatal/postnatal exercises
UNIT OF MEASURE	Percentage
DISAGGREGATION	District, county, regional and national levels
INDICATOR LEVEL	Output
PURPOSE	Prenatal/postnatal exercise sessions are routine measures meant to prevent effects of pregnancy on the musculature of women of reproductive age (WRA) which will impact negatively on their health.
FREQUENCY	**COLLECTION:** collected every time the WRA attends pre/postnatal sessions and aggregates are reported at the end of the month. This will form the Facility monthly report. **REPORTING:** Aggregated reports to compiled and reported to District, Province and National Offices. **UTILISATION**: Analyzed annually at the district, province and national level.
DATA SOURCE	**NUMERATOR**: Physiotherapy daily register **DENOMINATOR**: ANC Register
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION**: (Number of WRA expectant/pregnant receiving prenatal/postnatal exercises) / (Total number of WRA referred for prenatal/postnatal exercises) X 100

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	✓

INDICATOR NAME	Percentage of children under 5 yrs with disability identified and managed effectively through rehabilitation/habilitation
HIS CODE:	**HIS140**

PROGRAMME GOAL	Ensure Children With Disability (CWD) are identified and managed so as to assess the progress in the management of under-fives with disability. The millennium development goal (MDG) is to reduce child mortality rate related to disability. This will be achieved through maternal child health care

REFERENCES	WHO	MDG
CODES		4

DEFINITION OF IMPORTANT TERMS	**Disability** - Means a physical, sensory, mental or other impairments, including any visual, hearing, learning or physical incapability, which impacts adversely on social, economic or environmental participation **Rehabilitation** - refers to a process aimed at enabling persons with disabilities (PWDs) to reach and maintain their optimal physical sensory, intellectual, psychiatric and/or social levels, thus providing them with the tools to change their lives towards a higher level of independence. CWD: Conditions e.g. hydrocephalus, spinal bifida, Cetv, microcephalas, autism, cerebral palsy, erbs palsy **Habilitation** - defines the co-ordinated use of medical, social, educational and vocational measures to train individuals born with limitations in functional ability. This contrasts with retraining people who have lost abilities due to disease or injuries
NUMERATOR	Number of CWD under five identified and managed through rehabilitation
DENOMINATOR	Total number of CWD under five referred for rehabilitation
UNIT OF MEASURE	Percentage
DISAGGREGATION	Male/Female, district, county, regional and national levels
INDICATOR LEVEL	Output
PURPOSE	To detect, identify disability in childhood and take appropriate intervention to correct or minimize the complications that may arise as a result of disability and therefore ensure that the child leads optimal life
FREQUENCY	**COLLECTION**: Collected every time the CWD attends rehabilitation sessions and aggregates are reported at the end of the month. This will form the Facility monthly report. **REPORTING**: Aggregated reports to be compiled and reported to District, Province and National Offices **UTILISATION**: Analysed annually at the district, province and national level
DATA SOURCE	**NUMERATOR/DENOMINATOR**: Physiotherapy daily register will be the data Source. Other sources are from Occupational Therapy, Orthopaedic
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION**: (Number of CWD under five identified and managed through rehabilitation) / (Total number of CWD under five referred for rehabilitation) X 100

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	✓

IDSR

INDICATOR NAME	Proportion of health facilities submitting weekly or monthly surveillance reports on time to the district level
HIS CODE:	**HIS141**

PROGRAMME GOAL	To facilitate immediate responses to disease outbreaks or early interventions.

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	**Reports on time**: Reports received at National database by 5pm every Monday and first Monday of the month for monthly reports.
NUMERATOR	The total number of health facilities that submitted all surveillance reports (weekly or monthly) on time to the district in a given time period.
DENOMINATOR	Total number of health facilities expected to submit weekly or monthly surveillance reports to the district during the same time period.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Level of care and ownership, district, county, regional and national levels
INDICATOR LEVEL	Output
PURPOSE	Each week and month, the health facility should report the total number of cases and deaths for the priority communicable diseases that occurred during the last week or month. This indicator measures whether reporting from health facilities to the district level is taking place and if it is taking place on time.
FREQUENCY	**COLLECTION:** Events are documented daily. **REPORTING:** Weekly **UTILISATION**: Monthly
DATA SOURCE	NUMERATOR: IDSR summary reporting form MOH 512. DENOMINATOR: IDSR summary reporting forms MOH 512.
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Number of health facilities that submitted all the reports on time to the districts) / (All existing health facilities in the catchment area (district)) X 100 NOTE: At least 80% of the health facilities should report their summary reports on time to the district.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓		

INDICATOR NAME	Proportion of districts submitting weekly or monthly surveillance reports on time to the next higher level
HIS CODE:	**HIS142**

PROGRAMME GOAL	To monitor the progress of the interventions on time as per the prescribed timelines

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	**Reports on time**: Reports received at National database by 5pm every Monday and first Monday of the month for monthly reports
NUMERATOR	Total number of districts that submitted all (weekly or monthly) surveillance reports on time to the next higher level in a given time period
DENOMINATOR	Total number of districts expected to submit weekly or monthly surveillance reports to the next higher level during the same time period.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Type of reports, by district, county, regional and National levels
INDICATOR LEVEL	Output
PURPOSE	This indicator is used by provincial and national levels to measure the timely submission of summary data reports from the district to the next higher level.
FREQUENCY	**COLLECTION:** Events are documented daily. **REPORTING:** Weekly **UTILISATION:** Monthly
DATA SOURCE	**NUMERATOR:** IDSR summary reporting forms MOH 512. **DENOMINATOR**: IDSR summary reporting forms MOH 512.
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Total number of districts that submitted all (weekly or monthly) surveillance reports on time to the next higher level in a given time period) / (Total number of districts expected to submit weekly or monthly surveillance reports to the next higher level during the same time period) X 100. **NOTE:** Data from the districts about timely reporting may show that the health facility reported on time, but the reported information is not reliable or complete. Analysis of timely reporting should consider the quality of the data that is received. When the district or next higher lever supervisor detects a problem, take action to support the area to improve its quality of reporting.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Proportion of suspected outbreaks of epidemic-prone diseases notified to the next higher level within one day of surpassing the epidemic threshold
HIS CODE:	**HIS143**

PROGRAMME GOAL	To facilitate early diagnosis, interventions needed to clarify and confirm the possible outbreak.

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	**Suspected Outbreak**: Refers to a sub-set of diseases in the IDS strategy: the epidemic-prone diseases. **Threshold:** Epidemic-prone diseases have specific thresholds that trigger a series of actions when an epidemic is suspected.
NUMERATOR	Total number of suspected outbreaks during the last year, quarter or six months notified to the next higher level within two days of surpassing the epidemic threshold in a given time period.
DENOMINATOR	Total number of suspected outbreaks notified to the next higher level during the same time period.
UNIT OF MEASURE	Percentage
DISAGGREGATION	District, count, regional and national levels
INDICATOR LEVEL	Output
PURPOSE	**Alert thresholds** suggest that further investigation is needed to clarify and confirm the possible outbreak. When the alert threshold is crossed, health staff intensifies their attention to the data and request laboratory confirmation. Investigation is undertaken to gather more information. An **epidemic threshold** triggers a definite response. When the epidemic threshold is crossed, an outbreak is suspected and action is taken to identify and confirm that the outbreak is due to a specific pathogen.
FREQUENCY	**COLLECTION**: Events are documented daily. **REPORTING**: Weekly **UTILISATION**: Monthly
DATA SOURCE	**NUMERATOR:** IDSR summary reporting form MOH 512. **DENOMINATOR**: IDSR summary reporting form MOH 512.
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Total number of suspected outbreaks during the last year, quarter or six months notified to the next higher level within two days of surpassing the epidemic threshold in a given time period.) / (Total number of suspected outbreaks notified to the next higher level during the same time period) X 100 **EXAMPLE:** A single case of suspected yellow fever is a suspected outbreak. The suspected outbreak triggers an investigation including laboratory confirmation. Similarly, when surveillance data shows that an alert threshold has been crossed for meningococcal meningitis, health staff conducts an outbreak investigation to confirm whether the outbreak is due to meningococcal meningitis.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Proportion of investigated outbreaks with laboratory results
HIS CODE:	**HIS144**

PROGRAMME GOAL	To measure the use of laboratories to confirm suspected outbreaks

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	**Investigation:** Targeted activities in response to detection or notification of a suspected outbreak **Laboratory results:** Findings of tests conducted on specimen submitted and tested to laboratories
NUMERATOR	Total number of outbreaks with laboratory results in a given time period.
DENOMINATOR	Total number of outbreaks requiring laboratory results for outbreak confirmation during the same time period.
UNIT OF MEASURE	Percentage
DISAGGREGATION	District, county, regional and national levels
INDICATOR LEVEL	Output
PURPOSE	This indicator measures whether a laboratory network for confirming suspected outbreaks is functioning. A functional laboratory network involves coordination of activities to collect, handle, store, ship and process laboratory specimens so that specimens received at the reference laboratory are adequate and viable for testing. Laboratory confirmation is key to accurately determining the aetiology of a disease/condition. The indicator addresses the link between using surveillance thresholds to detect an outbreak and triggering the steps to obtain laboratory confirmation results.
FREQUENCY	**COLLECTION**: Events are documented daily. **REPORTING**: Weekly **UTILISATION:** Monthly
DATA SOURCE	**NUMERATOR**: IDSR summary reporting forms MOH 512. **DENOMINATOR**: IDSR summary reporting forms MOH 512.
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Total number of outbreaks with laboratory results in a given time period) / (Total number of outbreaks requiring laboratory results for outbreak confirmation during the same time period) X 100

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Case-fatality rates for outbreaks of priority diseases
HIS CODE:	**HIS145**

PROGRAMME GOAL	Improve case management

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	**Case Fatality Rate**: Is the percent of deaths from a specific priority disease that was responsible for the outbreak compared with the total number of cases.
NUMERATOR	Total number of deaths reported from a priority disease causing the outbreak in a given time period.
DENOMINATOR	Total number of reported cases from the same priority disease that caused the outbreak during the same time period.
UNIT OF MEASURE	Percentage
DISAGGREGATION	District, County, Regional and National levels
INDICATOR LEVEL	Outcome
PURPOSE	This indicator measures the quality of case management, detection, and response. The measurement demonstrates the quality of surveillance activities for early detection and response to the outbreak. However, when there is delay in patients using the health facility formal nutrition and underlying diseases such as HIV infection can worsen the case fatality rate.
FREQUENCY	**COLLECTION**: Events are documented daily. **REPORTING**: Monthly **UTILISATION:** Quarterly or annually
DATA SOURCE	**NUMERATOR**: IDSR summary reporting forms MOH 512. **DENOMINATOR**: IDSR summary reporting forms MOH 512.
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Total number of deaths reported from a priority disease causing the outbreak in a given time period.) / (Total number of reported cases from the same priority disease that caused the outbreak during the same time period. X 100 **NOTE:** The target for this indicator will vary for disease to disease that is measured. The case-fatality rate for each epidemic-causing disease is set by the programs. For example, the target case fatality rate for cholera is to have less than 1% fatal cases.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

ENVIRONMENTAL HEALTH

INDICATOR NAME	Percentage contribution of food-borne diseases to total facility visitation
HIS CODE:	**HIS146**

PROGRAMME GOAL	The goal is to assess the effectiveness and impact of public (environmental) health initiatives.

REFERENCES CODES	WHO	MDG

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Food* means** any substance, whether processed, semi processed or raw, which is intended for human consumption, and includes drink, chewing gum and any substance which has been used in the manufacture, preparation or treatment of "food" but does not include cosmetics or tobacco or substances used only as drugs. **Key Term 2**: ***Food Safety*** - Assurance that food will not cause harm to the consumer when it is prepared and/or eaten according to its intended use. **Key Term 3**: ***Food hygiene*** - All condition and measures necessary to ensure the safety and suitability of food at all stages of the food chain. **Key Term 4**: ***Hazard***- A biological, chemical or physical agent in, or condition of, food with the potential to cause an adverse health effect. **Key Term 5**: ***Risk***- A function of the probability of an adverse health effect and severity of that effect, consequential to a hazard(s) in food. **Key Term 6**: ***Risk Analysis***- A process consisting of three components: risk assessment, risk management and risk communication. **Key Term 7**: ***Food-Borne Diseases*** ; Diarrhoea , Dysentery, Cholera, Typhoid fever, and Brucellosis
NUMERATOR	Number of new cases of food-borne diseases diagnosed in a month
DENOMINATOR	Total number of all new OPD cases seen in a month.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Food borne disease, urban, rural, district, county, regional and national levels
INDICATOR LEVEL	Outcome
PURPOSE	An increase of food borne illness over time period should be followed by investigation and action. A decrease of food borne illness may indicate a change in food borne disease patterns, or the efficacy of preventive measures.
FREQUENCY	**COLLECTION**: Data is recorded daily or when a case presents **REPORTING**: Monthly throughout the hierarchy **UTILISATION**: Monthly at facility level, quarterly at county level or higher
DATA SOURCE	**NUMERATOR**: Register MOH 204, MOH 701, MOH 705 A&B and MOH 301 **DENOMINATIR**: Register MOH 204, MOH 701, MOH 705 A&B and MOH 301
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Indicator computed as 100 X number of new cases of food-borne diseases diagnosed in a month, divided by the total number of all new OPD cases seen in a month.

INDICATOR	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY

APPLICATION LEVEL		✓	✓	✓	✓	✓

INDICATOR NAME	Proportion of facilities meeting health care waste management standards
HIS CODE:	**HIS147**

PROGRAMME GOAL	To reduce health risk to health care workers, health care waste handlers, the community and the environment

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Health Care Waste***-All types of waste arising from the care of human beings, and includes waste from both human and veterinary research institutions. **Key Term 2**: ***New Health Care Facility***-a health care facility which has not been practicing sound management of health care waste. The standards are contained in the health care waste management Manual and include prescriptions for disposal/management of pathological waste such as incineration. **Key Term 3**: ***Health Care Waste Management Standards*** may include; presence of incinerators, safe design and standardization of all waste handling equipments, trained staff on sound health care management practices for all health workers, health care waste handlers and incinerator operators as appropriate
NUMERATOR	Number facilities meeting waste management standards at a given time
DENOMINATOR	Total number of facilities inspected in the same period.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Facility level, urban , rural, district, county, regional and national levels
INDICATOR LEVEL	Output
PURPOSE	The indicator tracks facility's system aimed at reducing the potential and attendant health risks arising from the improper storage, transportation, handling, treatment and disposal of health care waste.
FREQUENCY	**COLLECTION:** Data is recorded in the DHMT Support Supervision Tool every quarter or such other time that the assessment may be conducted. **REPORTING**: Quarterly or other frequency based on the assessment timing **UTILIZATION**: Quarterly at facility, annual at county level or higher
DATA SOURCE	**NUMERATOR**: DHMT Support Supervision Tool, MOH 715 **DENOMINATOR:** DHMT Support Supervision Tool, MOH 715
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Indicator is computed by 100 X number facilities meeting waste management standards at a given time, divided by the total number of facilities inspected in the same period.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Number of points of entry/exit meeting International Health Regulations 2005 for yellow fever vaccination
HIS CODE:	**HIS148**

PROGRAMME GOAL	To ensure continued Yellow Fever vaccination and certification services at all internationally designated points of entry

REFERENCES CODES	WHO	MDG

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Designated Points of Entry*** are airports, ports or ground crossings commonly used by international travellers entering or exiting the country. These include; Jomo Kenyatta International Airport, Mombasa International Airport, Busia Border Point, Malaba Border Point, Namanga Border Point, and Holili Border Point.					
NUMERATOR	Number of entry/exit points meeting standards (out of the six)					
DENOMINATOR						
UNIT OF MEASURE	Number					
DISAGGREGATION	None					
INDICATOR LEVEL	Output					
PURPOSE	To facilitate Yellow Fever vaccination and certification services in order to prevent yellow fever.					
FREQUENCY	**COLLECTION**: Data is recorded in the DHMT Support Supervision Tool every quarter or such other time that the assessment may be conducted. **REPORTING**: Quarterly or other frequency based on the assessment timing **UTILIZATION:** Quarterly at facility, annual at county level or higher					
DATA SOURCE	**NUMERATOR**: DHMT Support Supervision Tool **DENOMINATOR**: DHMT Support Supervision Tool					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	A simple count of the entry/exit points meeting standards (out of the six)					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓			

INDICATOR NAME	Proportion of households sprayed against fleas in jigger endemic districts
HIS CODE:	**HIS149**

PROGRAMME GOAL	To reduce the proportion of households infested with jiggers by 85% and prevent disability

REFERENCES CODES	WHO	MDG

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Jigger infestation***: is a condition of having the flea "tunga penetrans" burrow into the skin of humans thus causing suffering. **Key Term 2**: ***Household***: The numbers of people who eats from the same kitchen and are approximately 6 in Kenya (i.e. based on KNBS frame). **Key Term 3**: ***Sprayed***: A household is counted as sprayed if all houses within have been sprayed two times in a year. **Key Term 4**: ***Jigger Infested Districts***: There are 15 jigger endemic districts as gazetted in 2010 (Murang'a North, Murang'a South, Thika, Kiambu West, Kiambu East, Siaya, Kericho Districts, Nyeri North, Nyeri South, Kwale, Emuhaya, Malindi, Narok South, Kakamega Districts). Estimated Total Number of Households in the 15 districts in 2009/10 was 573,026
NUMERATOR	Cumulative number of households sprayed against fleas by the end of a given period
DENOMINATOR	Total number of households targeted for the same period (out of the 573,026).
UNIT OF MEASURE	Percentage
DISAGGREGATION	District/county, regional and national levels
INDICATOR LEVEL	Output
PURPOSE	The indicator measures the extent to which jigger control measures have been implemented. The success of these measures depends on the capacity of technical staff on integrated vector management, enhancement of public sensitization campaigns, and the procurement of chemicals for jigger control.
FREQUENCY	**COLLECTION**: Data is recorded in Field Notebook when spraying is done **REPORTING**: Monthly throughout the hierarchy **UTILISATION**: Quarterly at county level or higher
DATA SOURCE	**NUMERATOR**: Field Notebook then Using summary form MOH 708 **DENOMINATOR**: Monthly/quarterly/annual target- a fraction of 573,026
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Data is collected by Public Health Officers/Technicians and Community Health Workers using **official Field Notebook Countersigned by immediate supervisor**. Data from collaborating partners shall be entered into the official Notebook. All data is then aggregated into FORM MOH 708 which is what is used to compute the indicator as 100 X the cumulative number of households sprayed against fleas by the end of a given period, divided by the total number of households targeted for the same period.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	✓

INDICATOR NAME	Proportion of population with access to safe water
HIS CODE:	HIS 150

PROGRAMME GOAL	Rationale: Access to drinking water and basic sanitation is a fundamental need and a human right vital for the dignity and health of all people. The health and economic benefits of improved water supply to households and individuals are well documented. Use of an improved drinking water source is a proxy for the use of safe drinking water. The indicator is a Risk factor.

REFERENCES	AOP	WHO	MDG5
CODES		8	

DEFINITION OF IMPORTANT TERMS	The percentage of population using an improved drinking water source. Key Term 1: **An improved drinking water source**, by nature of its construction and design, is likely to protect the source from outside contamination, in particular from faecal matter. Improved drinking water sources include: - Piped water into dwelling, plot or yard, Public tap/stand pipe - Tube well/borehole, Protected dug well, Protected spring and - Rainwater collection Key Term 2: **unimproved drinking water sources are:** - Unprotected drug well, Unprotected spring, Cart with small tank/drum, - Tanker truck, - Surface water (river, dam, lake, pond, stream, canal, irrigation channel and any other surface water), and - Bottled water (if it is not accompanied by another improved source (WHO & UNICEF, 2010)
NUMERATOR	Total population using an improved drinking water source
DENOMINATOR	The estimated population in the area/location (urban/rural)
UNIT OF MEASURE	Percent
DISAGGREGATION	Location (urban/rural)
INDICATOR LEVEL	Outcome
PURPOSE	Use of an improved drinking water source is a proxy for access to safe drinking water. The use of drinking water sources and sanitation facilities is part of the wealth index used by household surveys to divide the population into wealth quintiles. As a result, most nationally representative household surveys include information about water and sanitation. These include Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), World Health Surveys, Living Standards Measurement Surveys, Core Welfare Indicator Questionnaires, Health and Nutrition Surveys, Household Budget Surveys, Reproductive Health Surveys and many other nationally representative household surveys.
FREQUENCY	Biennial (every Two years)
DATA SOURCE	Household surveys, Population census and Administrative reporting system
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	The indicator is computed as the ratio of the number of people who use an improved drinking water source, urban and rural, expressed as a percentage. The percentage of total population using an improved drinking water source is the population weighted average of the previous two numbers. The total coverage estimates are based on the aggregate of the population-weighted average of urban and rural coverage numbers. The population estimates in this report, including the urban/ rural distribution, are those published by the

	National bureaus, United Nations Population Division, 2008 revision.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	✓

INDICATOR NAME	Proportion of households with latrines or Population using improved sanitation facilities (%)
HIS CODE:	HIS 151

PROGRAMME GOAL	Access to basic sanitation is a fundamental need and a human right vital for the dignity and health of all people. The health and economic benefits of improved sanitation facilities to households and individuals are well documented. The indicator is used as Risk factors. Use of an improved sanitation facility is a proxy for the use of basic sanitation.

REFERENCES	AOP	WHO	MDG5
CODES		9	

DEFINITION OF IMPORTANT TERMS	The percentage of population using an improved sanitation facility. **Key term 1: An improved sanitation facility** is one that likely hygienically separates human excreta from human contact. Improved sanitation facilities include: - Flush or pour-flush to piped sewer system, septic tank or pit latrine, - Ventilated improved pit latrine, Pit latrine with slab and - Composting toilet **Key term 1: unimproved sanitation facilities** are considered unimproved when shared with other households, or open to public use. While, unimproved sanitation include: - Flush or pour-flush to elsewhere, Pit latrine without slab or open pit, - Bucket, hanging toilet or hanging latrine and - No facilities or bush or field (open defecation) (WHO & UNICEF, 2010.)
NUMERATOR	The number of people who use an improved sanitation facility, urban and rural.
DENOMINATOR	The estimated population in urban and rural.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Location (urban/rural)
INDICATOR LEVEL	Outcome
PURPOSE	The total coverage estimates are based on the aggregate of the population-weighted average of urban and rural coverage numbers. The population estimates in this report, including the urban/ rural distribution, are those published by the United Nations Population Division, 2008 revision. The coverage estimates for improved sanitation facilities presented are discounted by the proportion of the population that shared an improved type of sanitation facility. (WHO & UNICEF, 2010). Use of an improved sanitation facility is a proxy for access to basic sanitation. Surveys and censuses, data sources used by JMP, measure "use" and not "access", since the data is collected directly from the users of the facilities
FREQUENCY	**Reporting:** Biennial (every Two years), Monthly, annual administrative reporting **Data collection:** administrative data can be collected monthly using the environmental health diary books and community Log MOH 512, then summarised on MOH 708 and CHEW summary MOH 515. **Utilisation:** the data should be utilised by health facilities, communities to mitigate against open defecations and reduce diarrhoeal diseases among the population.
DATA SOURCE	Household surveys, Population census and Administrative reporting system

DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Predominant type of statistics: adjusted and predicted. Regional estimates are weighted averages of the country data, using the number of population for the reference year in each country as the weight. No figures are reported if less than 50 per cent of the population in the region are covered. Measurability of sustainable access to basic sanitation at the national scale, as warranted by the MDG target, poses a challenge for JMP. (WHO & UNICEF,2010)					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	✓

COMMUNITY HEALTH SERVICES

INDICATOR NAME	Percentage of functional community units
HIS CODE:	**HIS152**

PROGRAMME GOAL	Empowering households and communities to take charge of improving their own health

REFERENCES	DCHS	
CODES		

DEFINITION OF IMPORTANT TERMS	Key term.1- **Community Unit**: This is equivalent to a sub-location with a population of 5,000 persons served by a CHEW and CHWS and governed by Community health committee. Key term 2- **Functional Community unit:** 1. **Consecutive meeting/dialogue days held**. Dialogue day- days held by communities to discuss matters pertaining to their health and health related activities as collected through the community based data collection tools(MOH 513, MOH 514, MOH 515, MOH 516) 2. **Action days conducted** Action days are days set aside by the communities to undertake actions to respond to the health needs of the community as identified during the dialogue days. 3. Use of 4 Nationally Approved CHIS tools(MOH 513, MOH514, MOH515, MOH516)
NUMERATOR	Number of community units established and are functional
DENOMINATOR	Total Number of community units established
UNIT OF MEASURE	Percentage
DISAGGREGATION	District, County, Regional and National
INDICATOR LEVEL	Process
PURPOSE	Kenya's second National Health Sector Strategic Plan (NHSSP II – 2005–2010) defined a new approach to the way the sector will deliver health care services to Kenyans – the Kenya Essential Package for Health (KEPH). KEPH introduced six life-cycle cohorts and six service delivery levels. One of the key innovations of KEPH is the recognition and introduction of level 1 service, which are aimed at empowering Kenyan households and communities to take charge of improving their own health. Tracking this indicator is important as any decisions to offer services at the

	community level will depend on the existence of the units
FREQUENCY	**COLLECTION:** Data collected continuously at community level, aggregated and reported monthly to the link facilities. **REPORTING**: monthly, quarterly and annually **UTILISATION**: continuously for planning and implementation of community level services
DATA SOURCE	Data to be captured through the Master community listing tool by the CHEWs and fed to the MCUL database linked to the MFL.
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION**: Number of functional units/ number of established units X100.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	✓

INDICATOR NAME	Proportion of households reached for health promotion
HIS CODE:	**HIS153**

PROGRAMME GOAL	Empowering households and communities to take charge of their own health

REFERENCES	DCHS	
CODES	CHS strategy	

DEFINITION OF IMPORTANT TERMS	Key term.**1- household**. People living together and eating from the same pot Key term 2- **health promotion** – a process that entails advocacy, health education and behaviour change communication
NUMERATOR	Number of households reached with health promotion
DENOMINATOR	Actual number of households in the catchment area
UNIT OF MEASURE	Percentage
DISAGGREGATION	Community units, facility, District, County, Regional and National
INDICATOR LEVEL	Process
PURPOSE	To ensure that the communities take charge of their own health by empowering them for behaviour change, disease prevention and identification of health needs thus take actions. Tracking this indicator is important since it is the social pillar empowering communities to become healthy thus improving the social economic status of the nation.
FREQUENCY	**COLLECTION:** Data collected continuously at community level, aggregated and reported monthly to community health extension workers. **REPORTING**: monthly **UTILISATION**: Planning for community health actions.
DATA SOURCE	Data to be captured through community health workers service logbook MOH 514.
DATA MANAGEMENT AND INDICATOR COMPUTATION	**CALCULATION**: Number of households reached/Total actual number of households in the catchment area X100.

GUIDELINES						
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	✓

Indicator Name	Number of mental health cases referred from community
HIS Code:	HIS154

Programme Goal	Identify persons with mental illness for earlier interventions

References	DCHS	
Codes		

Definition of Important Terms	Key term.1- Mental health : A state of well-being in which the individual realizes his/her potentials/abilities, can cope with normal stresses of life, can work productively and fruitfully and is able to make a contribution to his/her community.
Numerator	Number of mental cases referred from the community
Denominator	None
Unit of measure	Number
Disaggregation	Community units, facility, District, County, Regional and National
Indicator Level	Process
Purpose	To promote Mental health to individuals, families, communities and the society. This will enable individuals, families, the communities and the society to contribute enormously towards investment and development of social capital which is the most important determinant of health. This endeavour of promotion of good mental health will enable the nation to realize its goals and achievement for Kenya vision 2030.
Frequency	**Collection:** Data collected continuously at community level, aggregated and reported monthly to the link facilities. **Reporting:** monthly **Utilisation:** Planning health interventions
Data Source	Data to be captured through community health workers service logbook MOH 513, MOH 514, MOH 515
Data Management and indicator computation Guidelines	Calculation: Numbers

Indicator Application Level	Sector	Programme	National	County	Facility	Community
		✓	✓	✓	✓	✓

INDICATOR NAME	Number of persons with Non communicable diseases rehabilitated at the community
HIS CODE:	**HIS155**

PROGRAMME GOAL	To halt and reverse the rising burden of non-communicable disease

REFERENCES	DCHS	
CODES		

DEFINITION OF IMPORTANT TERMS	Key term. 1. **Non communicable diseases:** Medical condition or disease which is non-infectious. These diseases cannot be transmitted from one person to another 2. **Rehabilitation:** Assisting patients to compensate for deficits that cannot be reversed medically
NUMERATOR	Number of persons with NCDS rehabilitated in the community
DENOMINATOR	None
UNIT OF MEASURE	Number
DISAGGREGATION	Community units, facility, District, County, Regional and National
INDICATOR LEVEL	Process
PURPOSE	About six hundred and fifty million people live with disabilities of various types, and the number is increasing due to the rise of non-communicable diseases, injuries, car crashes, falls, violence and other causes such as ageing. Rehabilitation will address the increasing burden of non-communicable conditions, violence and injuries.
FREQUENCY	COLLECTION: Data collected continuously at community level, aggregated and reported monthly to the link facilities. REPORTING: monthly, UTILISATION: planning for rehabilitation for NCDS Integrating persons with NCDS into community social groups
DATA SOURCE	Data to be captured through community health workers service logbook MOH 513, MOH 514, MOH 515
DATA MANAGEMENT AND INDICATOR	CALCULATION: Numbers

COMPUTATION GUIDELINES						
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	✓

INDICATOR NAME	Proportion of households not using toilets
HIS CODE:	**HIS156**
PROGRAMME GOAL	To reduce number of diarrhoeal cases

REFERENCES	DCHS	
CODES		

DEFINITION OF IMPORTANT TERMS	Key term.**1-latrine/ toilet**: A sanitation fixture used primarily for the disposal of human excrement and urine					
NUMERATOR	Number of households not using toilet					
DENOMINATOR	Total Number of household in the catchment area					
UNIT OF MEASURE	Percentage					
DISAGGREGATION	Community units, District, County, Regional and National					
INDICATOR LEVEL	Input					
PURPOSE	In developing Countries, diarrhoea accounts for the deaths of nearly 1.6 million children aged less than five years, which is approximately 15% of all deaths for this population age group. Poor sanitation and hygiene are the main factors associated with diarrhoea with the main sanitation problem being lack of proper faecal disposal facilities.					
FREQUENCY	**COLLECTION:** Data is aggregated and reported biannually. **REPORTING**: Biannually **UTILISATION**: Planning for individual and community action					
DATA SOURCE	Data to be captured through community health workers service logbook MOH 513, MOH 514, MOH 515					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION**: Number of households not using toilet/total actual number of households in the catchment area x100					
INDICATOR APPLICATION LEVEL		PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	✓

INDICATOR NAME	Number of deaths at the community level
HIS CODE:	**HIS157**

PROGRAMME GOAL	To ensure community access and uptake the health services

REFERENCES	DCHS	
CODES		

DEFINITION OF IMPORTANT TERMS	Deaths due to all causes
NUMERATOR	Number of reported deaths at the community level
DENOMINATOR	None
UNIT OF MEASURE	Number
DISAGGREGATION	By sex, age groups (‹ 1yrs, 1-5 yrs, Maternal, Other deaths), community unit, facility, district, county, region and national levels
INDICATOR LEVEL	Outcome
PURPOSE	Majority of deaths occur at the community level and do not get reported. This indicator will track the number of deaths and over time. The information will be document at the community to institute measures that will increase facility service uptake by sick members of the community. It will also in documenting causes of death via verbal autopsy. The information will also be discussed in community dialogue days for community action.
FREQUENCY	Data collected continuously at community level but aggregated and reported monthly
DATA SOURCE	Household register MOH 513, CHW log book MOH 514, CHEW summary MOH 515 and the Chalkboard MOH 516.
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Community health workers should record all deaths occurring within the households. The CHEW/ registration agent to get the verbal autopsy information and fill the Verbal Autopsy tool. The information will be filled in MOH 516 for community dialogue and actions. The same should be passed on to the district.

INDICATOR	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY

APPLICATION LEVEL			✓	✓	✓	✓

PHARMACY AND ESSENTIAL DRUGS

INDICATOR NAME	Percentage time out of stock for a set of 23 tracer medicines and Medical supplies
HIS CODE:	**HIS158**

PROGRAMME GOAL	Consistent stock-out of essential medicines significantly affects quality of patient care which may lead to increased morbidity and mortality

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Availability***-indicates the physical presence of the item and its use by patients. Expired medicines are not considered available. **Key Term 2**: ***Tracer medicines*** -List of essential medicines pre-determined at the central level to represent all essential medicines. These medicines are expected to be available at all times in all health facilities regardless of their level and **include;** Amoxycillin Caps 250mg; Amoxycillin PFOL 125mg/5ml; Paracetamol tablets 500mg; Cotrimoxazole tablets 480mg; Albendazole tablets 400mg; Chlorpheniramine tablets 4mg; Artemether/Lumefantrine tablets 20/120mg; Metronidazole suspension 200mg/5ml; Gentamycin injection; Benzylpenicillin injection; Adrenalin injection; Hydrocortisone injection; Oral Rehydration Salts Satchets; Tetracycline eye ointment 1%; Clotrimazole Cream 1%. **Key Term 3**: ***Essential Medicines***-those that satisfy the priority population health care needs **Key Term 4**: ***Time out of stock***: the number of days that a tracer medicine was not present in a health facility during the month under review. The standard is not to have stock out for any of the tracer medicines for more than seven days in a month. If even small quantities of a medicine are present, the medicines should be counted as in stock. Percentage of time out of stock is defined as the percentage of days during a one month period that a tracer medicine has been out of stock (based on inventory records in the pharmacy or dispensing area).
NUMERATOR	Sum of days in which any of the tracer medicines was not available in a month
DENOMINATOR	The product of number of days per month(averaged as 30) and the number of tracer medicines = 450; (i.e. 30 days×23 tracer medicines)
UNIT OF MEASURE	Percent

DISAGGREGATION	Levels 2, 3, 4, 5 and 6 Health Facilities, district/ region/ county and national					
INDICATOR LEVEL	Input					
PURPOSE	Indicator tracks length of time of stock out of tracer medicines					
FREQUENCY	**COLLECTION:** Monthly, **REPORTING:** Monthly, **UTILIZATION**: Monthly					
DATA SOURCE	**NUMERATOR**: Updated stock control cards (SCC) or any other stock status record in the pharmacy such as the antibiotic register. Daily activity registers (DAR)/ Dispensing records in the service point. **DENOMINATOR**: 690 (i.e. 30 days×23 tracer medicines)					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Each facility has a percentage calculated thus: 100 x numerator/ denominator. This is a facility self-reporting indicator. The higher levels can compute the information in several ways depending on the purpose. The indicator is computed by 100 X number of days (sum for each tracer medicine) that any of the tracer medicine was not available **divided by** 690.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Average number of prescriptions received per pharmaceutical officer per day
HIS CODE:	**HIS159**

PROGRAMME GOAL	To determine the compliance of pharmacy workload to pre-determined standard service delivery norms. i.e. 50 prescriptions per pharmaceutical officer per day. The intention is to intervene in facilities that are either overloaded or under-loaded.

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Prescriptions***: Refers to the MOH 501 or any other document that indicates the medicines that the clinician has prescribed for patient/client **Key Term 2**:***Pharmaceutical staff***: Refers to a pharmacist or pharmaceutical technologist
NUMERATOR	Total number of prescriptions received at the pharmacy per month
DENOMINATOR	Product of the total number of pharmaceutical officers and the number of days in the reporting period (30 days)
UNIT OF MEASURE	Number
DISAGGREGATION	Levels 2, 3, 4, 5 and 6 Health Facilities, district/ region/ county and national
INDICATOR LEVEL	Output
PURPOSE	To assess the workload of pharmaceutical officers; To act as a basis of deployment and advocating for adequate staffing of facility pharmacies. This indicator is not be interpreted to mean that Pharmaceutical staff are only involved in handling prescriptions. There are other duties but the number of prescriptions handled is a good measure of the workload in the Pharmacy
FREQUENCY	**COLLECTION**: Monthly. **REPORTING**: Monthly throughout the hierarchy **UTILISATION**: Monthly at facility level, quarterly at county level or higher

DATA SOURCE	**NUMERATOR**: Pharmacy Tally Sheets, Pharmacy Daily Activity Registers (DAR), Retained prescriptions					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Indicator computed by the sum of all prescriptions in a given month divided by (the number of days in that month X number of pharmaceutical staff operating in the health facility in the month)					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Rational Drug Use Indicators (1) Average number of medicines per prescription, (2)Percent of prescribed medicines are on the National Essential Medicines List (3)Percent of prescriptions with an antibiotic prescribed, (4)Percent of prescriptions with an injection prescribed, (5)Percent of medicines prescribed using generic name.
HIS CODE:	**HIS160**

PROGRAMME GOAL	The indicator aims to monitor rational use of drugs

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Prescriptions***: Refers to the MOH 501 or any other document that indicates the medicines that the clinician has prescribed for patient/client **Key Term 2**:***Pharmaceutical staff***: Refers to a pharmacist or pharmaceutical technologist
NUMERATOR	(1) Sum of all different medicines within all the prescriptions sampled (2) 100 X Sum of all different medicines (within all the prescriptions sampled) that are on the National Essential Medicines List (3) 100 X Number prescriptions (among those sampled) that have an antibiotic prescribed (4) 100 X Number prescriptions (among those sampled) that have an injection prescribed (5) 100 X Number of all medicines prescribed that were generic
DENOMINATOR	(1) All prescriptions sampled in the survey (2) Sum of all different medicines within all the prescriptions sampled (3) Number of prescriptions sampled (4) Number of prescriptions sampled (5) Sum of all different medicines prescribed
UNIT OF MEASURE	(1) Number, (2) Percent, (3) Percent, (4) Percent (5) Percent
DISAGGREGATION	Facility Level, district, County, regional and National levels
INDICATOR LEVEL	Output

PURPOSE	The indicator aims to monitor rational use of drugs periodically					
FREQUENCY	COLLECTION: Bi-annual, Semi-annual REPORTING: Bi-annual, Semi-annual UTILISATION: Bi-annual, Semi-annual					
DATA SOURCE	COLLECTION: Bi-annual Rational Drug Use Survey, Semi-annual EQAS Report REPORTING: Bi-annual Rational Drug Use Survey, Semi-annual EQAS Report UTILISATION: Bi-annual Rational Drug Use Survey, Semi-annual EQAS Report					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Data for this indicator can be collected in two ways; the mandate of the Lab External Quality Assessment (EQAS) can be used to analyze the Pharmacy Daily Activity Register to pick/compute the five indicators. The alternative is to design and conduct a Rational Drug Use Survey using a representative sample of health facilities. For indicator computation, see the numerators and denominators section above.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

NEGLECTED TROPICAL DISEASES

INDICATOR NAME	Proportion of population receiving MDA for PCT NTDs in endemic districts
HIS CODE:	**HIS161**

PROGRAMME GOAL	To reduce morbidity and disability due to NTDs in order to achieve the MDGs and improve the health and socio-economic status of the people.

REFERENCES		MGDs
CODES		5

DEFINITION OF IMPORTANT TERMS	MDA means Mass Drug Administration. PCT means Preventive Chemotherapy. NTDs means Neglected Tropical diseases. PCT NTDs means Neglected Tropical Diseases for preventive chemotherapy, whose intervention strategy is through MDA. They are a group of diseases which include Schistosomiasis (Biharzia), Soil Transmitted Helminthiasis (Intestinal worms), Lymphatic Filariasis (Elephantiasis) and Trachoma. MDGs Means Millennium Development goals.
NUMERATOR	Number of people receiving MDA.
DENOMINATOR	Number of people at risk for NTDs in endemic districts.
UNIT OF MEASURE	Percentage
DISAGGREGATION	National level
INDICATOR LEVEL	Process
PURPOSE	This indicator can be used to measure coverage, progress and inform on the need to scale up or scale down on MDA.
FREQUENCY	NUMERATOR: Numerator is collected manually during implementation, supervision and surveys DENOMINATOR: Annually REPORTING: Monthly UTILIZATION: Annually

DATA SOURCE	**NUMERATOR:** MDA registers and tally sheets **DENOMINATOR:** Demographic estimation					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = [Total Number of people receiving MDA)]/ [Total No. of people at risk in the endemic district targeted for PCT, MDA]					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	✓

INDICATOR NAME	Incidence rate of NTD cases
HIS CODE:	**HIS162**

PROGRAMME GOAL	To reduce morbidity and disability due to NTDs in order to achieve the MDGs and improve the health and socio-economic status of the people

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	NTDs means Neglected Tropical Diseases, which are a group of diseases which include Schistosomiasis (Biharzia), Soil Transmitted Helminthiasis (Intestinal worms), Leishmaniasis (Kala azar), Echinococosis (Hydatid disease), Lymphatic Filariasis (Elephantiasis) and Trachoma. MDG means Millennium development Goals.
NUMERATOR	Number of new NTD cases managed
DENOMINATOR	Population within facility catchment area
UNIT OF MEASURE	Percentage
DISAGGREGATION	Facility
INDICATOR LEVEL	Process
PURPOSE	This indicator will help in identification of existing hot spots for NTD transmission and hence inform on the need for increased detection and referral of NTD cases within the community
FREQUENCY	**NUMERATOR:** Data are collected regularly through normal HIS system **DENOMINATOR:** Annually
DATA SOURCE	**NUMERATOR:** Facility out-patient and in-patient registers **DENOMINATOR:** Demographic estimation
DATA MANAGEMENT	**CALCULATION** = [Number of cases of Neglected tropical diseases managed]/

AND INDICATOR COMPUTATION GUIDELINES	[Population at risk within the facility catchment area]					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	✓

LABORATORY SERVICES

INDICATOR NAME	Proportion of facilities with a lab that have capacity to conduct specific tests
HIS CODE:	**HIS163**

PROGRAMME GOAL	The goal is to reduce morbidity and mortality by increasing the coverage of labs that have capacity to correctly and efficiently diagnose diseases and monitor patients in order to improve the quality of care.

REFERENCES CODES	WHO	MDG

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Specific Tests*** **refers to**: blood slides for Malaria, HIV, Blood Sugar, ART monitoring tests (Liver function, Renal function CD4 counts and Viral load), TB smear microscopy, urinalysis, isolation of organisms through culture and drug susceptibility, histocytopathology, Full Blood Count and detection of selected IDSR priority diseases of epidemic potential **Key Term 2**: ***Testing Capacity***: A lab is deemed as having capacity if it is able to conduct all the specific tests but this can also be interpreted in terms of proportion of capacity to conduct each of the specific tests.
NUMERATOR	Number of facilities with a lab that have capacity to conduct tests *for* ***all, and for each,*** *of the selected tests*
DENOMINATOR	Total number of facilities with a lab.
UNIT OF MEASURE	Percentage (For labs with capacity to conduct CD4, Viral load and histocytopathology, **Number** would be more appropriate since they are few)
DISAGGREGATION	Test, Facility Level, district, County, regional and National levels
INDICATOR LEVEL	Output
PURPOSE	This indicator reflects GoK efforts to strengthen capacities of laboratories to perform selected tests, diagnostics, and patient monitoring tasks. This indicator is measuring both the ability to perform tests as well as a proxy for monitoring

	the quality of patient care. Facilities without, and Counties with low, testing capacity should be targeted for improved lab infrastructure.
FREQUENCY	**COLLECTION:** Quarterly or other periodicity **REPORTING:** Quarterly or other periodicity **UTILISATION:** Annual at county level or higher
DATA SOURCE	**NUMERATOR**: District/County Health Management Team or External Quality Assurance System **DENOMINATOR**: District/County Health Management Team or External Quality Assurance System
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Every quarter, or at other periodicity, the District/County Health Management Team or External Quality Assurance Team conducts an assessment of laboratories' capacity to conduct diagnostic tests using a pre-set criteria related to availability of skilled human resources, equipment, and reagents. They make a determination of each lab's capacity and use the information to compute the indicators as follows; 100 X the number of facilities with a lab that have capacity to conduct the selected tests, divided by the number of facilities with a lab.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Proportion of laboratories meeting their classification criteria as defined in the national laboratory policy guidelines
HIS CODE:	**HIS164**

PROGRAMME GOAL	The goal is to reduce morbidity and mortality by increasing the coverage of labs that have capacity expected for each KEPH level to correctly and efficiently diagnose diseases and monitor patients in order to improve the quality of care. There is need for equitable distribution of various classifications of laboratories so as to conduct required tests and for the purpose of networking and referral.

REFERENCES	WHO	MDG	Medical lab Policy
CODES			

DEFINITION OF IMPORTANT TERMS	**Key Term 1: *Classification criteria* refers to**: health Service delivery levels (KEPH levels) which include National referral services, county referral services, Primary care services and community health Services. There are a set of tests, equipment personnel and laboratory infrastructure specified for each level in the lab policy guidelines which will be used to assess conformity to the classification. **Key Term 2: Meeting of classification criteria**: A lab is deemed as having met the classification criteria if it conducts specific tests expected for its classification and has infrastructure, personnel and equipment expected for its classification.
NUMERATOR	Number of laboratories meeting their classification criteria
DENOMINATOR	Total number of laboratories in each classification
UNIT OF MEASURE	Percentage
DISAGGREGATION	Facility Level, County, National
INDICATOR LEVEL	Output
PURPOSE	Indicator used to monitor and evaluate performance of laboratories with respect to thir levels. Facilities performing below their classification level will be be targeted for upgrading and improved lab infrastructure.

FREQUENCY	**COLLECTION**: Quarterly or other periodicity **REPORTING**: Quarterly or other periodicity **UTILISATION**: Annual at county level or higher
DATA SOURCE	**NUMERATOR**: Survey, Support supervision, MOH 706 form. **DENOMINATOR**: baseline survey and support supervision
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Each KEPH Level has minimum tests, equipment, personnel and infrastructure requirement so labs will be classified as % meeting the KEPH standard. Every quarter, or at other periodicity, the support supervision team review tests performed and infrastructure of the lab and computes the indicator as follows; 100 X all laboratories meeting their classification criteria divided by, the total number of labs in the specific classification

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Proportion of facilities with lab, submitting accurate and complete laboratory reports to the District/County/National on time
HIS CODE:	**HIS165**

PROGRAMME GOAL	The goal is to reduce morbidity and mortality by increasing reporting rates for tests performed (MOH 706) and lab commodities (MOH 643) which are useful for monitoring workload, disease surveillance, commodity consumption and improved lab infrastructure management. To provide information necessary to facilitate management in determining the quantification of laboratory requirements in time.

REFERENCES CODES	WHO	MDG

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***On-time*** refers to submission of MOH 706 report form by 5th day of the following month to the District and by 15th of the following month after end of quarter to the National and Form MOH 643 by 10th to the national (LMU)
NUMERATOR	Number of facilities with lab submitting report forms to the district/County/National on time
DENOMINATOR	Total number of facilities with a lab in the District/County (for MOH 706 reporting). Total number of targeted laboratories expected to report (for MOH 643)
UNIT OF MEASURE	Percentage
DISAGGREGATION	Type of report form (MOH 706 and 643), Facility Level, Affiliation, District, County, regional and National levels
INDICATOR LEVEL	Output
PURPOSE	The indicator captures completeness and accuracy of the reports, and timeliness and efficiency of lab reporting to facilitate management to ensure commodity and testing requirements.

FREQUENCY	**COLLECTION**: Monthly **REPORTING**: Monthly **UTILISATION**: monthly, quarterly and
DATA SOURCE	**NUMERATOR**: Forms 706 and MOH 643 as seen at the District/County **DENOMINATOR**: District/County Facility Reports
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	A simple count of Forms 706 and 643 at the District/County/National. Indicator computed by 100 X the number of facilities with lab submitting MOH 706 before 5th day of the following month, divided by the number of facilities with a lab in the District. Indicator computed by 100 X the number of facilities with lab submitting MOH 643 before 5th day of the following month, divided by the number of targeted facilities with a lab in the District expected to report.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Proportion of facilities with lab, carrying out good biosafety practices
HIS CODE:	**HIS166**

PROGRAMME GOAL	The goal is to constantly be sure that good biosafety practices are in force and the capacity to practise them is maintained.

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1: good biosafety practices** includes adherence to key elements of biosafety (e.g. waste management, personal protective equipment, biosafety cabinets, incineration, fire fighting equipments, fire exit), **The package will be modified for each KEPH level based on the risk**
NUMERATOR	Number of facilities carrying out good biosafety practices.
DENOMINATOR	Total number of facilities with a lab in the District/County/country
UNIT OF MEASURE	Percentage
DISAGGREGATION	Facility Level, District, County, regional and National levels
INDICATOR LEVEL	Output
PURPOSE	The indicator captures the compliance to good biosafety standards to ensure safety of workers and clients. .
FREQUENCY	**COLLECTION**: Quarterly or other periodicity **REPORTING**: Quarterly or other periodicity **UTILISATION**: Annual at county level or higher
DATA SOURCE	**NUMERATOR**: On-site survey, support supervision (supportive supervision checklist to contain package for good biosafety practices) **DENOMINATOR**: baseline surveys

DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Indicator computed by 100 X the number of facilities with lab carrying out good biosafety practices divided by the number of facilities with a lab in the District.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Proportion of facilities with laboratories in the districts, enrolled in External Quality Assurance Scheme (EQAS)
HIS CODE:	**HIS167**

PROGRAMME GOAL	To tracks the coverage of EQAS and proxy for quality of lab tests

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	Key Term 1: *External Quality Assurance* (EQA) is a system for objectively checking the laboratory's performance using an external agency or facility for the purposes of determining precision and accuracy of test results. It includes proficiency testing, re-checking/re-testing or on-site evaluation. MOH will assess enrolment in EQAS for priority tests.
NUMERATOR	Number facilities with laboratories in the district enrolled in External Quality Assurance Scheme (EQAS)
DENOMINATOR	Total number facilities with laboratories in the district.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Facility Level, district, County, regional and National levels
INDICATOR LEVEL	Output
PURPOSE	The indicator tracks the coverage of EQAS and proxy for quality of lab tests. A lab's enrolment into EQAS is important for providing a continuous independent assessment of accuracy of test results which provides a superior quality check of lab performance- an essential factor for quality of care and thus a factor potential morbidity& mortality .reduction

FREQUENCY	**COLLECTION**: Quarterly or other periodicity **REPORTING**: Quarterly or other periodicity **UTILISATION**: Annual at county level or higher
DATA SOURCE	**NUMERATOR**: External Quality Assurance System (EQA Note Book) **DENOMINATOR**: External Quality Assurance System (EQA Note Book)
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Indicator is computed by 100 X the number facilities with laboratories in the district enrolled in External Quality Assurance Scheme (EQAS), divided by the number facilities with laboratories in the district.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Proportion of targeted facilities with laboratories engaged in safe blood transfusion practices
HIS CODE:	**HIS168**

PROGRAMME GOAL	To monitor access and safe blood practices

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term: Safe blood transfusion practices** means adherence to standard measures to ensure blood safety at facility level (e.g. proper storage of blood and blood products, proper techniques for grouping and cross matching, presence of SOPs, availability and use of blood transfusion requisition tool)
NUMERATOR	Number facilities with laboratories in the district engaged in safe blood transfusion practices
DENOMINATOR	Total number targeted facilities with laboratories in the district that are engaged in blood transfusion.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Facility Level, typing and cross match
INDICATOR LEVEL	Output
PURPOSE	The indicator tracks the coverage of safe blood transfusion practices in laboratories to improve efficiency of blood use and minimise adverse effects of blood transfusion in health facilities

FREQUENCY	**COLLECTION**: Quarterly **REPORTING**: Quarterly **UTILISATION**: Annual at county level or higher					
DATA SOURCE	**NUMERATOR**: On-site survey, supervision checklist **DENOMINATOR**: baseline surveys					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Indicator computed by 100 X the number of facilities with lab applying safe blood transfusion practices divided by the number of facilities with a lab in the District conducting for blood transfusion services.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Proportion of health facilities with laboratories with stock out of tracer lab reagents on the day of assessment
HIS CODE:	**HIS169**

PROGRAMME GOAL	To monitors stock-out of key reagents

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Tracer Lab Reagents*** refer to the main reagents for each of the tests; blood [for HIV, Malaria, and CD4], TB smear microscopy, urinalysis, stool microscopy, and bacterial culture and susceptibility tests.
NUMERATOR	Number of facilities with lab that had stock outs for **each and all** of, the main reagents during the day of the quarterly DHMT support supervision visit or during an EQAS visit
DENOMINATOR	Total number of facilities with lab visited/assessed
UNIT OF MEASURE	Percentage
DISAGGREGATION	Reagent, Facility Level, district, County, regional and National levels
INDICATOR LEVEL	Input
PURPOSE	Indicator monitors stock-out of key reagents. Consistent stock-out of key reagents affects the access and quality of lab services which in turn affects the quality of patient care and consequently affects morbidity and mortality.

FREQUENCY	**COLLECTION**: The DHMT or EQAS Team examines the laboratory inventory register during their visit **REPORTING**: Quarterly or when visit is conducted **UTILIZATION**: Quarterly or other time as data becomes available.					
DATA SOURCE	NUMERATOR: Facility Inventory Register/Records DENOMINATOR: Facility Inventory Register/Records					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	The DHMT or EQAS Team examines the facility Reagents Records/facility Commodity Inventory Register, and computes the indicator as follows; 100 X the number of facilities with lab that stock out for each of, the main reagents during the day of the visit, divided by the number of facilities with lab visited/assessed					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Positivity Rate by disease (Malaria, TB, HIV, Diabetes, anaemia, cancer/ leukaemia
HIS CODE:	**HIS170**

PROGRAMME GOAL	To measures and monitors positivity rates for the population attending health facilities. It is a proxy measure for positivity in the general population although it is an overestimate.

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Positivity Rate*** refers to the number of cases diagnosed as positive divided by the number of tests. Positivity rate for anaemia means HB‹5g/dl for severe anaemia and HB ‹10g/dl for anaemia. Positivity rate for diabetes means random blood glucose ›7.8mmol/L or fasting blood glucose ›6.1mmol/L or positive OGTT.
NUMERATOR	Number of lab confirmed positive cases in a month
DENOMINATOR	Total number of tests in the Month.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Disease (HIV, Malaria, TB), age, educational level, urban, rural, Facility Level, district, County, regional and National levels
INDICATOR LEVEL	Outcome
PURPOSE	To estimate morbidity by maximizing the use of readily available programme

	data to estimate and monitor positivity rates for priority communicable and non-communicable diseases. Currently, HIV and Malaria prevalence is estimated through the expensive population-based Demographic and Health Survey (DHS) and/or AIDS Indicator Survey (AIS); and Malaria Indicator Survey (MIS). For TB, the TB and Leprosy Program is currently using Case Detection within the DOTS approach.
FREQUENCY	COLLECTION: data is recorded on daily basis in the Lab Register REPORTING: Monthly throughout the hierarchy UTILISATION: Monthly at facility level, quarterly at county level or higher
DATA SOURCE	**NUMERATOR:** Lab Register **DENOMINATOR**: Lab Register
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Indicator computed by 100 X number of lab confirmed positive cases in a month, divided by the total number of tests in the Month.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	
	✓	✓	✓	✓	✓	

INDICATOR NAME	Density of laboratory personnel (per 10 000 population)
HIS CODE:	**HIS171**
PROGRAMME GOAL	To tracks human resource capacity for laboratory workers

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1: laboratory personnel refers to Medical lab technologists, Technicians, Scientists and Clinical Pathologists**
NUMERATOR	Number of laboratory personnel countrywide
DENOMINATOR	Population
UNIT OF MEASURE	Number of lab personnel/10, 000 population
DISAGGREGATION	district, County/Regional, National
INDICATOR LEVEL	Output
PURPOSE	The indicator tracks the human resource for laboratory which impacts to quality and quantity of service
FREQUENCY	COLLECTION: Data can be collected in a survey annually or less frequently REPORTING: Semi annually UTILISATION: Annually or less frequently at county level or higher

DATA SOURCE	**NUMERATOR**: Survey **DENOMINATOR**: Population census					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Computation of the indicator is as follows; 10 , 000 X the number of laboratory personnel divided by the					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Number of facilities with a lab that have capacity to detect selected IDSR priority diseases of epidemic potential
HIS CODE:	**HIS172**

PROGRAMME GOAL	The goal is to reduce morbidity and mortality by increasing the coverage of labs that have capacity to correctly and efficiently detect IDSR priority diseases and monitor disease outbreaks for surveillance and control.

REFERENCES	WHO	MDG
CODES	✓	✓

DEFINITION OF IMPORTANT TERMS	**Key Term 1: Priority diseases refers to** the The World Health Organisation (WHO) Kenya's priority diseases for **Key Term 2**: ***Testing Capacity***: A lab is deemed as having capacity if it is able to detect all the priority diseases but this can also be interpreted in terms of proportion of capacity to detect each of the priority diseases
NUMERATOR	Number of facilities with a lab that have capacity to detect ***all, and each,*** *of the selected priority diseases*
DENOMINATOR	No denominator
UNIT OF MEASURE	Number
DISAGGREGATION	Priority disease, Facility Level, district, County, regional and National levels
INDICATOR LEVEL	Output
PURPOSE	This indicator reflects GoK efforts to strengthen capacities of laboratories to

	detect priority diseases to ensure timely provision of surveillance data for fast interventions.
FREQUENCY	**COLLECTION**: Quarterly or other periodicity **REPORTING**: Quarterly or other periodicity **UTILISATION**: Annual at county level or higher
DATA SOURCE	**NUMERATOR**: District/County Health Management Team or External Quality Assurance System
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Every quarter, or at other periodicity, the District/County Health Management Team or External Quality Assurance Team conducts an assessment of laboratories' capacity to detect priority diseases using a pre-set criteria related to availability of skilled human resources, equipment, and reagents. They make a determination of each lab's capacity and use the information to compute the indicators as the number of facilities with a lab that have capacity to detect priority diseases

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Proportion of specific specimen referred whose examination results are received on time
HIS CODE:	**HIS173**

PROGRAMME GOAL	The goal is to reduce morbidity and mortality by ensuring specimens referred to higher level facilities are analysed and reported back on time.

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***On-time*** refers to the turn-around time for specific specimens **Key Term 2**: ***specific specimen*** refers for TB culture, LFTs, RFTs, CD4, Viral load, and IDSR
NUMERATOR	Number of specimens referred and results received on time
DENOMINATOR	Total number of specimen referred
UNIT OF MEASURE	Percentage
DISAGGREGATION	Facility Level, Affiliation, District, County, regional and National levels

INDICATOR LEVEL	Output					
PURPOSE	The indicator captures the efficiency of lab networking to provide timely specimen referral and giving prompt results or reporting to assure correct patient diagnosis and management.					
FREQUENCY	**COLLECTION:** Monthly **REPORTING:** Monthly **UTILISATION:** quarter, Annual at county level or higher					
DATA SOURCE	**NUMERATOR**: Register MOH 240 and Forms MOH 706 **DENOMINATOR**: MOH 240 register and MOH 706 facility Reporting form					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	A simple count of number of referral specimens with results reported in the registers' column of referral at facility and transfer to summary form MOH 706 at the facility divided by total number of specimen referred. Indicator computed by multiplying by 100.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Proportion of cytology/histology examinations reported and results given
HIS CODE:	**HIS174**

PROGRAMME GOAL	To document the performance of laboratory in cytology and histology to characterise lesions including cancer.

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	**Key term 1; cytology is the m**icroscopic examination of Body fluids, aspirates and exfoliated cells to determine their structure, function, chemistry and disease. **Key term 2;**Histology is microscopic examination of tissue sections **Key Term 3:** A biopsy is part or whole of a tissue, organ or organ system presented for laboratory evaluation and examination.
NUMERATORS	Number of cytology examinations results given Number of histology examinations results given
DENOMINATOR	Total cytology tests done Total histology tests done
UNIT OF MEASURE	Percent
DISAGGREGATION	District, County and National levels
INDICATOR LEVEL	Outcome
PURPOSE	**Exfoliative cytology examination** may be used to screen cancer and diagnose diseases of body fluid spaces, hollow organs. **Fine needle aspirate** cytology is used to characterise swellings and identify cancer. Cytology may be used to screen cancer and diagnose **Bone marrow aspiration cytology** assists in diagnoses of hematologic disease and bone marrow involvement in cancers. **Histology examination** of biopsy gives diagnoses and informs baseline for further specialised tests, e.g. immunohistochemistry, etc for cancers characterisation and treatment planning.
FREQUENCY	**COLLECTION:** Data is collected using the service workload MOH 717 and through a supervisory checklists. **REPORTING:** Monthly **UTILISATION:** Health facility, district, county and National level
DATA SOURCE	Daily activity register, theatre Returns, outpatient clinics daily returns/ records, etc and using the mortuary daily activity register and Post Mortem (PM) forms P23A
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	[1]Every month the Medical Superintendent /Health Facility in charge / Regional or County Pathologists assisted by Facilities surgery, laboratory and other departments should be able to report the number of sampled tissues, FNA and Pap smear requests and Results received. Reports also on Post-mortem examination performed and court cases.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Number of Hospital and Forensic autopsies performed
HIS CODE:	**HIS175**

PROGRAMME GOAL	To document contribution of Autopsy in establishing cause and manner of death, evaluate disease and injury for hospital mortality audit and satisfy Death Registration and Medical Legal inquiry.

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1:** A clinical autopsy is the examination of a person dying while under medical treatment or had a known disease condition; it's performed primarily to determine the extent of the disease or whether a particular medical or surgical treatment has been effective and the probable cause of death. (Comment: if it identifies a new disease, then it is forensic because the doctor did not know what they were dealing with) **Key Term 2:** A forensic Autopsy or Post-mortem examination is done on a corpse or suspected human remains for identification, characterisation of any disease or injury, and determine of cause and duration of death. Key Term 3: The body or parts may be dissected and sampled for supplementary investigations including toxicology.
NUMERATORS	Number of Clinical autopsies Number of Forensic autopsies
DENOMINATOR	None
UNIT OF MEASURE	Number
DISAGGREGATION	Facility Level, district, County and National levels
INDICATOR LEVEL	Outcome
PURPOSE	**Post-mortems are** carried out by pathologists and aim to identify the cause of death. A clinical post-mortem is done at request of the institution or next of kin to provide information about an illness or cause of death, and to assist medical inquiry. All clinical autopsies are potentially forensic. Forensic Autopsies have legal implications and are performed in suspicious cases to determine if death was unnatural or a natural event. Forensic autopsies are autopsies are for example performed to determine if death was an accident, homicide, suicide, or a natural event. At the request of a hospital, to provide information about an illness or cause of death, and to further medical research. There are four main types of autopsies: • Medico-Legal Autopsy or Forensic or coroner's autopsies seek to find the cause and manner of death and to identify the decedent. They are performed, as prescribed by applicable law, in cases of violent, suspicious or sudden deaths, deaths without medical assistance or during surgical procedures. • Clinical or Pathological autopsies are performed to diagnose a particular disease or for research purposes. They aim to determine, clarify, or confirm medical diagnoses that remained unknown or unclear prior to the patient's death. • Anatomical or academic autopsies are performed by students of anatomy for study purpose only. Virtual or medical imaging autopsies are performed utilizing imaging technology only, primarily magnetic resonance imaging (MRI) and computed tomography (CT).

FREQUENCY	**COLLECTION**: Data is collected using the service workload MOH 717 and through a supervisory checklists. **REPORTING**: Monthly **UTILISATION**: Health facility, district, county and National level					
DATA SOURCE	Daily activity register, theatre Returns, outpatient clinics daily returns/ records, etc and using the mortuary daily activity register and Post Mortem (PM) forms P23A					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	[1]Every month the Medical Superintendent /Health Facility in charge / Regional or County Pathologists assisted by Facilities surgery, laboratory and other departments should report the number of sampled tissues, FNA and Pap smear requests and Results received. Reports also on Post-mortem examination performed and court cases.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

RADIOTHERAPY

INDICATOR NAME	Proportion of imaging health facilities that experienced stock-out of consumables
HIS CODE:	**HIS176**

PROGRAMME GOAL	To Establish and maintain consistent supply of imaging consumables to x-ray departments countrywide to ensure continuous service to the public to meet the millennium development goal no. 2.6

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	Key Term 1: ***Imaging Department*** means the section of the hospital where patients are referred for picture diagnosis of their conditions. The patients are examined using x-rays or ultrasound. Key Term 2: ***Consumables*** mean the materials necessary for making the diagnostic pictures (*films*, *chemicals* and *ultrasound gel* for this indicator). Key Term 3: ***Stock-out*** **means** to run out of the supply of x-ray and ultrasound consumables for more than seven days in a month.
NUMERATOR	Number of imaging departments reporting stock-outs of any of the consumables for seven or more days in a month
DENOMINATOR	Total number of functional x-ray departments in public hospitals.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Facility Level, district, County, regional and National levels
INDICATOR LEVEL	Input
PURPOSE	To increase access to imaging services by making the consumables constantly available. Ensuring no stock outs leads to reduction on referrals to either distant hospitals or private hospitals hence reducing cost to the patient and ensuring quick delivery of services. High volume hospitals are likely to run out of stocks because of high workload but FIF funds are used as an intervention to bridge the gap and ensure continuity of services. A buffer stock is also preserved to achieve the same goal of continuous service.
FREQUENCY	COLLECTION: Monthly REPORTING: Monthly at facility level, Quarterly at the county or higher levels UTILISATION: Monthly at facility level, Quarterly at county level or higher
DATA SOURCE	NUMERATOR: Radiology Daily Activity Registers DENOMINATOR: Radiology Daily Activity Registers
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Indicator computed as 100 X the number of imaging departments that experienced stock-outs of any of the consumables for seven or more days in a month, divided by the total number of functional x-ray departments in public hospitals.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Proportion of health facilities with functional imaging equipment
HIS CODE:	**HIS177**

PROGRAMME GOAL	To Reduce equipment downtime and ensure effective preventive and corrective maintenance to guarantee continuous service to the patients.

REFERENCES CODES	WHO	MDG

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Imaging Equipment***- Include x-ray machines, ultrasound and MRI **Key Term 2**: ***Functional Equipment***- means equipment in good working condition and in use. **Key Term 3**: ***Equipment Downtime***- The length of time broken down equipment takes to be repaired back to functionality. **Key Term 4**: ***Preventive Maintenance***- daily or periodic equipment servicing carried out to reduce chances of breakdown **Key Term 5**: ***Corrective Maintenance***- Carrying out repairs on reported breakdowns
NUMERATOR	Number of health facilities reporting that all their necessary imaging equipment were, at the time of monthly reporting, functional
DENOMINATOR	Total number of health facilities with imaging equipment
UNIT OF MEASURE	Percentage
DISAGGREGATION	Facility Level, district, County, Regional and National levels
INDICATOR LEVEL	Input
PURPOSE	Data is used in the consideration of service contract, deciding when to procure and the type of equipment to procure. The aim is to make imaging services available continuously by minimizing equipment downtime. This will lead to prompt diagnosis and improve patient management and the need for referral to private hospitals or distant public hospital will be eliminated. This will mean a reduction of cost to the patient and constant revenue collection for the institution.
FREQUENCY	**COLLECTION:** Monthly **REPORTING:** Monthly at facility level, Quarterly at the county or higher levels **UTILISATION**: Monthly at facility level, Quarterly at county level or higher
DATA SOURCE	**NUMERATOR**: Radiology Daily Activity Registers **DENOMINATOR**: Radiology Daily Activity Registers
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Data originates from the facility level in the form of a monthly report to the Division of Biomedical Engineering for intervention. Indicator computed by 100 X the number of health facilities reporting that all their necessary imaging equipment were, at the time of monthly reporting, functional divided by the total number of health facilities with imaging equipment

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Proportion of radiographers that received in-service training in a year.
HIS CODE:	**HIS178**

PROGRAMME GOAL	To ensure continued skill enhanced in capacity building for quality imaging services.

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Training*** refers to in-service (over and above the minimum certification training) that is based on a curriculum
NUMERATOR	Number of radiographers who have undergone at least one substantive training during the year
DENOMINATOR	Total number of all certified radiographers in government employment.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Years in Service (2 and below, 3-5 Years, over 5 yrs), Facility Level, district, County, regional and National levels.
INDICATOR LEVEL	Output
PURPOSE	Data is used for planning and to determine training gaps as well as to guide selection of officers. It is necessary that officers undergo continuous training to keep abreast of the emerging as well as changing technology. As the government undertakes expansion of radiography services by increasing the number of hospitals/departments as well as embracing new technologies, it becomes necessary to increase training of officers to keep up with changes.
FREQUENCY	**COLLECTION:** Data is recorded once training takes place. **REPORTING:** Annually at County level or higher **UTILISATION**: Annually at County level or higher
DATA SOURCE	**NUMERATOR**: Course approval/training file, Nomination list, Graduation list, ministerial training meeting records. **DENOMINATOR**: MOH Human Resources Database
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Indicator computed by 100 X the number of radiographers who have undergone at least one substantive training in a year, divided by the total number of all certified radiographers in government employment.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

NURSING SERVICES

INDICATOR NAME	Proportion of health facilities with functional ambulance services
HIS CODE:	**HIS179**

PROGRAMME GOAL	To provide ambulance transport for both rescue and referral services

REFERENCES CODES	WHO	MDG

DEFINITION OF IMPORTANT TERMS	**Key Term 1: *Functional*** means that a facility has met ambulance standards as outlined on the MOH checklist.				
NUMERATOR	Number of health facilities with functional ambulance services in a month				
DENOMINATOR	Total number of health facilities with ambulances				
UNIT OF MEASURE	Percentage				
DISAGGREGATION	Facility Level, district, County, Regional and National levels				
INDICATOR LEVEL	Input				
PURPOSE	Indicator tracks the quality of network of functional efficient and sustainable ambulance system				
FREQUENCY	COLLECTION: Quarterly. REPORTING: Quarterly UTILISATION: Quarterly at County and annually at national				
DATA SOURCE	NUMERATOR: Health facility ambulance records/worksheets, district reports on infrastructure, vehicles inventory DENOMINATOR: Health facility ambulance records/worksheets, district reports on infrastructure, vehicles inventory				
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Indicator computed by 100 X the number of health facilities with functional ambulance services in a month, divided by the total number of health facilities with ambulances.				
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY
		✓	✓	✓	✓

INDICATOR NAME	Proportion of facilities with 80% or more of its clients expressing satisfaction with health care services.
HIS CODE:	**HIS180**

PROGRAMME GOAL	To determine state of health care services as perceived by the recipients of care

REFERENCES CODES	WHO	MDG

DEFINITION OF IMPORTANT TERMS	**Key Term 1:** ***Satisfaction*** MOH to define the parameters assessed in the survey					
NUMERATOR	Number of facilities where 80% or more of the sampled clients expressed satisfaction with health care services					
DENOMINATOR	Total number of facilities sampled in the Customer Satisfaction Survey.					
UNIT OF MEASURE	Percentage					
DISAGGREGATION	Service (**Nursing**, Clinical Treatment, Customer Care, Facilities, Food etc), Client Demographics, district, County, regional and National levels					
INDICATOR LEVEL	Output					
PURPOSE	The analysis of the level of client satisfaction with health services at departmental and health facility level will enable health care managers make customer-sensitive interventions related to health systems' strengthening					
FREQUENCY	**COLLECTION:** Customer Satisfaction Survey conducted every two years. **REPORTING:** Bi-annually at County, Programme and national levels **UTILISATION**: Bi-annually at County, Programme and national levels					
DATA SOURCE	**NUMERATOR:** Customer Satisfaction Survey **DENOMINATOR**: Customer Satisfaction Survey					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Customer Satisfaction Survey.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	✓

INDICATOR NAME	Proportion of health facilities reporting stock out of tracer non pharmaceutical commodities
HIS CODE:	**HIS181**

PROGRAMME GOAL	To reduce stock out days for non pharmaceutical commodities.

REFERENCES CODES	WHO	MDG

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Non Pharmaceutical Commodities List*** – total list of non pharmaceutical commodities in the market **Key Term 2**: ***Essential non pharmaceutical list*** – a list of pharmaceutical commodities that are very key for the health facility to operate. **Key Term 3**: ***Tracer List*** – a list of non pharmaceutical commodities that must be found in the health facility at any one given time **(see annex II)**.
NUMERATOR	Number of health facilities reporting stock-out of seven or more days for any of the tracer non-pharmaceutical commodities in a month
DENOMINATOR	Total number of health facilities in the catchment area.
UNIT OF MEASURE	Percentage
DISAGGREGATION	Commodity, Facility Level, district, County, Regional and National levels
INDICATOR LEVEL	Input
PURPOSE	To ensure quality of service and essential service delivery is given to clients in the best and timely manner.
FREQUENCY	**COLLECTION**: Monthly. **REPORTING**: Monthly throughout the hierarchy **UTILISATION**: Monthly at facility level, quarterly at county level or higher
DATA SOURCE	**NUMERATOR**: Stock Control Cards and Inventory Books **DENOMINATOR**: Stock Control Cards and Inventory Books
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	All the nursing officers in charge of commodities compiles this data from stock control cards and should submit them to the district and then to the headquarters. The Division of Nursing computes the number of days that each facility stays without a commodity in a month and computes the indicator as 100 X the number of health facilities reporting stock-out of seven or more days for any of the tracer non-pharmaceutical commodities in a month, divided by the total number of health facilities in the catchment area.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

HUMAN RESOURCES FOR HEALTH

INDICATOR NAME	Density of community health workers (per 10 000 population)
HIS CODE:	**HIS182**

PROGRAMME GOAL	To increase access to services at the community level by increasing the coverage of community health workers.

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Community Health Worker (CHW)***: As described in the Kenya's Community Health Strategy and may include; Community Health Extension worker (CHEW), Community-Owned Resource Person (CORP), Family Health Field Educator (FHFE), etc					
NUMERATOR	Number of community health workers					
DENOMINATOR	Population of catchment area divided by 10,000					
UNIT OF MEASURE	Ratio					
DISAGGREGATION	Age, Sex, Main Work Activity, district, County, Regional and National level					
INDICATOR LEVEL	Input					
PURPOSE	Measuring and monitoring the availability of health workers is a critical starting point for understanding the health system resources situation. In particular, many countries, especially ones with shortages and mal-distribution of highly skilled medical and nursing professionals, rely on community health workers (community health aides selected, trained and working in the communities from which they come) to render certain basic health services.					
FREQUENCY	**COLLECTION**: Quarterly **REPORTING**: Quarterly **UTILISATION**: Quarterly at County, and Annual at National					
DATA SOURCE	**NUMERATOR**: Quarterly District Returns **DENOMINATOR**: Demographic estimation					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Quarterly District Returns captures the number of health workers (by cadre) operating in each health facility in the District/County. This data is then submitted to, and entered into, the National Human Resources Database which produces the relevant output for the indicator. Indicator is a simple ratio of the numerator to the denominator, i.e. Numerator/Denominator.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	✓

INDICATOR NAME	Density of dentistry personnel (per 10 000 population)
HIS CODE:	**HIS183**

PROGRAMME GOAL	To increase access to dental services by increasing the coverage of dentistry personnel

REFERENCES CODES	WHO	MDG

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Dentist***: based on WHO framework for classifying health workers
NUMERATOR	Number of dentistry personnel
DENOMINATOR	Population of catchment area divided by 10,000
UNIT OF MEASURE	Ratio
DISAGGREGATION	Age, Sex, district, County, Regional and National levels
INDICATOR LEVEL	Input
PURPOSE	While there are no gold standards for assessing the sufficiency of the health workforce to address dental health care needs of a given population, low density of dentists suggests inadequate capacity to meet minimum coverage of essential services.
FREQUENCY	**COLLECTION**: Quarterly **REPORTING**: Quarterly **UTILISATION**: Quarterly at County, and Annual at National
DATA SOURCE	**NUMERATOR**: Quarterly District Returns **DENOMINATOR**: Demographic estimation
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Quarterly District Returns captures the number of health workers (by cadre) operating in each health facility in the District/County. This data is then submitted to, and entered into, the National Human Resources Database which produces the relevant output for the indicator. Indicator is a simple ratio of the numerator to the denominator, i.e. Numerator/Denominator

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	✓

INDICATOR NAME	Density of medical doctors (per 10 000 population)
HIS CODE:	**HIS184**

PROGRAMME GOAL	To increase access to specialized services by increasing the density of medical doctors.

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Medical Doctors***: based on WHO framework for classifying health workers					
NUMERATOR	Number of medical doctors (physicians), including generalist and specialist Medical practitioners.					
DENOMINATOR	Population of catchment area divided by 10,000					
UNIT OF MEASURE	Ratio					
DISAGGREGATION	Age, Sex, Occupational Specialization, district, County, Regional and National levels					
INDICATOR LEVEL	Input					
PURPOSE	It has been estimated however, in the World Health Report 2006, that countries with fewer than 23 physicians, nurses and midwives per 10, 000 populations generally fail to achieve adequate coverage rates for selected primary health care interventions as prioritized by the Millennium Development Goals framework. The indicator tracks the sufficiency of medical doctors.					
FREQUENCY	**COLLECTION:** Quarterly **REPORTING**: Quarterly **UTILISATION:** Quarterly at County, and Annual at National					
DATA SOURCE	**NUMERATOR**: Quarterly District Returns **DENOMINATOR**: Demographic estimation					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Quarterly District Returns captures the number of health workers (by cadre) operating in each health facility in the District/County. This data is then submitted to, and entered into, the National Human Resources Database which produces the relevant output for the indicator. Indicator is a simple ratio of the numerator to the denominator, i.e. Numerator/Denominator					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	✓

INDICATOR NAME	Density of nursing and midwifery personnel (per 10 000 population)
HIS CODE:	**HIS185**

PROGRAMME GOAL	To increase access to general care services by increasing the density of nursing and midwifery personnel

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Nurse, Midwife***: based on WHO framework for classifying health workers					
NUMERATOR	Number of nursing and midwifery personnel					
DENOMINATOR	Population of catchment area divided by 10,000					
UNIT OF MEASURE	Ratio					
DISAGGREGATION	Age, Sex, Occupational Specialization, district, County, Regional and National levels					
INDICATOR LEVEL	Input					
PURPOSE	It has been estimated however, in the World Health Report 2006, that countries with fewer than 23 physicians, nurses and midwives per 10, 000 population generally fail to achieve adequate coverage rates for selected primary health care interventions as prioritized by the Millennium Development Goals framework. The indicator tracks the sufficiency of medical doctors.					
FREQUENCY	**COLLECTION**: Quarterly **REPORTING**: Quarterly **UTILISATION**: Quarterly at County, and Annual at National					
DATA SOURCE	**NUMERATOR**: Quarterly District Returns **DENOMINATOR**: Demographic estimation					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Quarterly District Returns captures the number of health workers (by cadre) operating in each health facility in the District/County. This data is then submitted to, and entered into, the National Human Resources Database which produces the relevant output for the indicator. Indicator is a simple ratio of the numerator to the denominator, i.e. Numerator/Denominator					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	✓

INDICATOR NAME	Density of other health service providers (per 10 000 population)
HIS CODE:	**HIS186**

PROGRAMME GOAL	To increase access to other health services by increasing the density of all other health workers apart from doctors, nurses/midwives, dentists, and community health workers.

REFERENCES	WHO	MDG
CODES		

DEFINITION OF IMPORTANT TERMS	**Key Term 1**: ***Cadre*** includes the following 10 categories; Doctors, Dentists, Nurses and Midwives, Community Health Workers, Pharmacists, Laboratory Workers, Environment and Public Health Workers, Other Health Workers, and Health Management and Support Staff **Key Term 2**: ***Other Health Service Providers*** **include**: Pharmacists, Physiotherapist, Occupational therapists, orthopaedic technologists, Health Records and Information, Clinical Officers, nutritionist, Laboratory Workers, Environment and Public Health Workers, and Health Management and Support Staff
NUMERATOR	Number of other health service providers (excepting physicians, nursing and midwifery personnel, dentistry personnel and community health workers)
DENOMINATOR	Population of catchment area divided by 10,000
UNIT OF MEASURE	Ratio
DISAGGREGATION	Age, Sex, Occupational Specialization, district, County, Regional and National levels
INDICATOR LEVEL	Input
PURPOSE	While there are no gold standards for assessing the sufficiency of the health workforce to address the health care needs of a given population, low density of health personnel usually suggests inadequate capacity to meet minimum coverage of essential services.
FREQUENCY	**COLLECTION**: Quarterly **REPORTING**: Quarterly **UTILISATION**: Quarterly at County, and Annual at National
DATA SOURCE	**NUMERATOR**: Quarterly District Returns **DENOMINATOR**: Demographic estimation
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Quarterly District Returns captures the number of health workers (by cadre) operating in each health facility in the District/County. This data is then submitted to, and entered into, the National Human Resources Database which produces the relevant output for the indicator. Indicator is a simple ratio of the numerator to the denominator, i.e. Numerator/Denominator

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	✓

INDICATOR NAME	Proportion of health workers trained
HIS CODE:	**HIS187**

PROGRAMME GOAL	To increase the quality of services by building technical capacity of health workers.

REFERENCES CODES	WHO	MDG

DEFINITION OF IMPORTANT TERMS	**Key Term 1:** ***Training***; training must have a curriculum, health worker must have completed the training curriculum to be conducted in the year, training must be relevant to the cadre of the health worker, training must be endorsed by MOH **Key Term 2:** ***Cadre*** **includes** the following 10 categories; Doctors, Dentists, Nurses and Midwives, Community Health Workers, Pharmacists, Laboratory Workers, Environment and Public Health Workers, Other Health Workers, and Health Management and Support Staff **Key Term 3:** ***Other Health Workers***: all others apart from the nine cited above
NUMERATOR	Number of health workers trained in the past 12 months
DENOMINATOR	Total number of health workers operating in the facility or the catchment area
UNIT OF MEASURE	Percent
DISAGGREGATION	Length of training (*One Week, 2 Weeks, 4 Weeks, 6 months, 1 Year, 2 Years*), Cadre, Facility Level, district, County, Regional and National levels
INDICATOR LEVEL	Input
PURPOSE	Indicator monitors the trend in human capacity building since health workers need to be continually trained in order to continue offering quality services
FREQUENCY	**COLLECTION:** Monthly **REPORTING:** Monthly **UTILISATION**: Quarterly at County and annually at National
DATA SOURCE	**NUMERATOR**: general District Monthly Reports **DENOMINATOR**: general District Monthly Reports
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Training data may be collected through the general District Monthly Reports but to ensure robustness of this indicator, these reports need to be refined/restructured in order to accurately report on this as well as on other relevant indicators. Indicator is computed as 100 X Numerator, divided by the Denominator.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	✓

HEALTH CARE FINANCING

INDICATOR NAME	Proportion AOP approved for implementations within the timelines
HIS CODE:	**HIS188**

PROGRAMME GOAL	Ensure that all planning units submit timely complete AOPs for effective and efficient management of resources.

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	**AOP**: Is an annual operational plan of detailed set of activities to be undertaken by a planning unit, institution (hospital, health centre, dispensary, etc) indicating the budgetary requirements, timing and responsibilities for given financial year. Other reports and plans are derived from the AOP as a guiding instrument. The plan has to include the indictors to be monitored for service delivery, the outputs for the monitoring of the management support to service delivery.
NUMERATOR	Number of AOPs approved for implementation within the timelines
DENOMINATOR	Total Number of Planning Units
UNIT OF MEASURE	Percentage
DISAGGREGATION	Unit
INDICATOR LEVEL	Output
PURPOSE	To empower all planning units to prioritise, project, allocate resources and carryout the performance monitoring at all levels. Decentralize decision making in respect to budget allocation process and improve on health outcomes.
FREQUENCY	**COLLECTION**: Review of plans for approval, is done annually at the beginning of the planning process. **REPORTING**: Annually **UTILISATION**: Annually to inform the next round of the planning process
DATA SOURCE	**NUMERATOR/DENOMINATOR**: Implementation units
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Number of AOPs approved for implementation within the timelines) / (Total Number of Planning Units) X 100 NOTE: The deadline for submitting the plans is the 15th of June every year

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	✓

INDICATOR NAME	Proportion of planning units with approved AWPs and submitted comprehensive reports within the timelines
HIS CODE:	**HIS189**

PROGRAMME GOAL	Ensure that all planning units submit timely complete reports for effective and efficient management of resources.

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	**Reports**: Include the following: -MER = monthly expenditure report. -QER = quarterly expenditure report. -HTR = hospital technical report on service delivery. **Units**: Include the following: hospitals, health centres, dispensary, community units, district management services and provincial / county management services teams, divisions and departments. **AWP**: Annual Work Plan. All units are planning units and must develop the plan that should be implemented and monitored annually.
NUMERATOR	Number of submitted (individual) progress report that meet guidelines
DENOMINATOR	Total Number of Planning Units
UNIT OF MEASURE	Percentage
DISAGGREGATION	Unit
INDICATOR LEVEL	Output
PURPOSE	To empower all planning units to prioritise, project, allocate resources and carryout the performance monitoring at all levels. Decentralize decision making in respect to budget allocation process and improve on health outcomes.
FREQUENCY	**COLLECTION**: Reporting progress should be done quarterly **REPORTING**: Submission of reports are done quarterly **UTILISATION**: Decision making on the results arising from the indicator should provide a basis for management support to respective units
DATA SOURCE	**NUMERATOR/DENOMINATOR**: Implementation units
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = [Number of submitted (individual) progress report that meet guidelines] / [Total Number of Planning Units] X 100 **NOTE**: Monthly and quarterly reports should reach the district by 5th after the reporting month at district level and by 15th of the subsequent month at national level.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	✓

INDICATOR NAME	Percentage of targeted revenue collected and banked daily
HIS CODE:	**HIS190**

PROGRAMME GOAL	Increase the amount of revenue reaching point of use. Reduce the amount of revenues collected spend at source and security of revenue guaranteed

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	**Revenue**: Income received as payment for services rendered					
NUMERATOR	Amount of revenue captured in the bank statement daily					
DENOMINATOR	Targeted revenue for the same period.					
UNIT OF MEASURE	Percentage					
DISAGGREGATION	Unit, district, county, regional and national levels					
INDICATOR LEVEL	Process					
PURPOSE	To assess hospitals revenue collection and banking efficiency.					
FREQUENCY	**COLLECTION:** Data collected and captured daily through financial information system form FIS 03D **REPORTING**: Summarized monthly and send by 5th to county/district/ provincial FIS reporters **UTILISATION:** Analysis done at facility, district, provincial/ county and national level.					
DATA SOURCE	**NUMERATOR/DENOMINATOR**: Implementation units					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = (Amount of revenue captured in the bank statement daily) (Targeted revenue for the same period) X 100					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Expenditure by service delivery level as a percentage of the total expenditure during the period
HIS CODE:	**HIS191**

PROGRAMME GOAL	Ensure equitable resource allocation and prudent use of funds. To determine the fund absorption rate

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	None
NUMERATOR	Total expenditure audited and cleared in each specified period of time.
DENOMINATOR	Total expenditure during the time period
UNIT OF MEASURE	Percentage
DISAGGREGATION	Level of expenditure (dispensary, health centre, community, district, provincial/ regional and national levels) , division, department
INDICATOR LEVEL	Output
PURPOSE	To monitor efficiency in utilization and accounting of allocated resources. Periodic funds audits will form the basis to establish prudent use of funds.
FREQUENCY	COLLECTION: Monthly, quarterly and annual for all levels REPORTING: Monthly, quarterly and annual for all levels UTILISATION: Monthly, quarterly and annual for all levels
DATA SOURCE	NUMERATOR/DENOMINATOR: Monthly, quarterly and annual HMSF expenditure reports. Monthly, quarterly and annual audit reports. Monthly, quarterly and annual resource envelopes.
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = (Total expenditure audited and cleared in each specified period of time) / (Total expenditure during the time period) X 100

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	**Proportion of total Government Budgetary Allocations to Health care**
HIS CODE:	**HIS192**

PROGRAMME GOAL	To seek/ have rational allocation of government budget to health sector

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	**Budgetary Allocations**: Total budget allocated by Government of Kenya to the Health Sector
NUMERATOR	Total budgetary allocation for health sector
DENOMINATOR	Total government allocation to all sectors
UNIT OF MEASURE	Percentage
DISAGGREGATION	County, Regionally and National levels
INDICATOR LEVEL	Process
PURPOSE	To determine the budget allocated to the health sector in comparison with the overall government budget for the financial year. Though Government's budget cannot cover the entire cost of the health sector, the increased allocation reveals the level of government's commitment to the improvement of health of the people.
FREQUENCY	COLLECTION: Annually REPORTING: Annually UTILISATION: Annually
DATA SOURCE	NUMERATOR/DENOMINATOR: Ministry of Finance and through Public Expenditure Review Surveys
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = (Total budgetary allocation for health sector) / (Total government allocation to all sectors) X 100 NOTE: Each fiscal year the ministry should get the budget allocations and supplementary budgets from the ministry of finance this will assist in computing the available resources allocated to the health sector

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

SUPPORTIVE SUPERVISION

INDICATOR NAME	Average number of supportive supervisory visits undertaken by the district in each facility
HIS CODE:	**HIS193**

PROGRAMME GOAL	Ensure continued improvements in imaging services by monitoring the efficiency in use of supplies, adherence to sound professional practice and the status of equipment

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	**Supportive supervision**- Visit to facilities to monitor performance, state of equipment and x-ray supplies
NUMERATOR	Sum of all supportive supervisory visits undertaken to all the facilities in the district
DENOMINATOR	Four (4) quarters
UNIT OF MEASURE	Ratio
DISAGGREGATION	District, County, regional and national levels
INDICATOR LEVEL	Process
PURPOSE	Supervisory visits are made to hospitals for the purpose monitoring performance, staffing status, status of equipment as well as supplied commodities. Ethical issues are also looked at during the visit. The visit is not meant to incriminate staff but to support them by listening to them and observing the working conditions. Through such visits and making observations, hospital reforms can be formulated for the purpose of offering improved health services.
FREQUENCY	At the end of the year
DATA SOURCE	NUMERATOR/DENOMINATOR: Management reports
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = (Sum of all supportive supervisory visits undertaken to all the facilities in the district) / (Four (4) quarters) X 100 NOTE: It is a management support to service delivery and this can help monitoring of management teams in provision of essential support supervision and mentorship.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	✓

HOSPITAL UTILISATION

INDICATOR NAME	Average length of stay (ALOS)
HIS CODE:	**HIS194**

PROGRAMME GOAL	To increase the appropriate use of facilities for each inpatient and assess measure the quality of services in the health facility

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	**Inpatient days** –is the grand sum of days all the patients have spent in the hospital during the period under review. **½ day patients** -Patients admitted after midnight and discharged within 23 hours of admission (before midnight) **Inpatient discharges** – generic term covering all alive patients who have completed inpatient treatment or referred for further attention in another facility. **Inpatient deaths** – All patients who die in a hospital after having been admitted.
NUMERATOR	In-patient days + ½ day patients
DENOMINATOR	In-patient Discharges + In-patient Deaths
UNIT OF MEASURE	Ratio
DISAGGREGATION	Health facility, district, county, regional and national levels
INDICATOR LEVEL	Output
PURPOSE	The average length of stay shows how efficiently hospital inpatient facilities are used. It's a proxy indicator to measure the quality of the services offered inpatient services. This indicator is used in conjunction with two other indicators namely: Bed Occupancy Rate and Bed Turnover Rate. The three indicators, in conjunction, are used for assessing the efficiency of use of inpatient facilities.
FREQUENCY	Both numerator and denominator are collected routinely upon separation with the patient. However, totals are only summarised at the end of the month before reporting. See detailed instructions on how to complete the in-patient register.
DATA SOURCE	NUMERATOR: Inpatient register MOH 301 , Daily Bed Returns and disease index MOH 268 DENOMINATOR: Inpatient register MOH 301 , Daily Bed Returns and disease index MOH 268
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = (In-patient days + ½ day patients) / (In-patient Discharges + In-patient Deaths) APPLICATION: See Usage under Bed Occupancy Rate

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	

INDICATOR NAME	Bed occupancy rate
HIS CODE:	**HIS195**

PROGRAMME GOAL	To maximise the utilisation of facilities for inpatient treatment

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	**Bed Occupancy Rate** - Percentage of beds occupied during a given period of time
NUMERATOR	Number of patient bed days (x 100)
DENOMINATOR	Number of beds in institution x Number of days in time period under review
UNIT OF MEASURE	Rate
DISAGGREGATION	Health facility, District, County, Regional and national levels
INDICATOR LEVEL	Output
PURPOSE	The bed occupancy rate gives the average percentage of occupied beds during the period under review (usually one year). This indicator is closely related to the following two indicators: the bed turnover rate and the average length of stay.
FREQUENCY	
DATA SOURCE	**NUMERATOR:** Inpatient register MOH 301 , Daily Bed Returns and disease index MOH 268 **DENOMINATOR:** Administrative records
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** = [Number of patient bed days] / [(Number of beds in institution)X(Number of days in time period under review)] X 100 **USAGE**: The bed occupancy rate and the turnover rate should be high, while the average length of stay should be low. The bed occupancy rate should ideally be 80 percent or more. The average length of stay for a district hospital should ideally be 6 or lower. The annual turnover rate is ideally around 50 in district hospitals. Two sets of parameters determine the occupancy rate: the need for service, and the service delivery factors. Need for service may include scrutinizing the patient mix (chronic or short-term) while delivery factors may include availability of staff. Within the hospital a comparison over time can be used as tool for measuring increased or decreased efficiency.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Hospital in-patient turnover rate
HIS CODE:	**HIS196**

PROGRAMME GOAL	To maximise the utilisation of facilities for inpatient treatment

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	**Bed Turnover Rate** - Is the number of admissions per bed during a given period of time					
NUMERATOR	Inpatient Admissions					
DENOMINATOR	Number of Available Beds					
UNIT OF MEASURE	Rate					
DISAGGREGATION	Health facility, District, County, Regional and national levels					
INDICATOR LEVEL	Output					
PURPOSE	This indicator is closely related to the following two indicators: the average length of stay and the bed occupancy rate. The turnover rate reflects the average number of patients admitted per bed during the period under review. When used together, the three indicators are used for assessing the efficiency of use of inpatient facilities					
FREQUENCY						
DATA SOURCE	**NUMERATOR**: Inpatient register MOH 301 , Daily Bed Returns and disease index MOH 268 **DENOMINATOR**: Administrative records					
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	**CALCULATION** =(Inpatient admissions) / (Number of available beds) X 100 **RESPONSE**: When the bed occupancy rate and turnover rate drop while the average length of stay remains stable, the inpatient facility may be underutilized, resulting in too much idle staff time. Hospital management should take measures to increase efficiency					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Percentage 1st OPD attendance who are referrals
HIS CODE:	**HIS197**

PROGRAMME GOAL	To reduce the utilization of hospital OPDs in order to make them function for lower level referrals only

REFERENCES		
CODES		

DEFINITION OF IMPORTANT TERMS	**1st OPD Attendance**: These are visits patients make to the hospital OPD for a fresh complaint. **Referrals:** These are patients, with documentation from a lower level facility, seeking specialised/advanced care in a higher-level facility (hospital in this case.
NUMERATOR	Number of Referrals (from lower facilities)
DENOMINATOR	Total OPD 1st Attendances
UNIT OF MEASURE	Percentage
DISAGGREGATION	Health facility, District, County, Regional and national levels
INDICATOR LEVEL	Output
PURPOSE	This indicator assists in monitoring the utilisation of hospitals as referral facilities as opposed to providing primary health functions.
FREQUENCY	NUMERATOR/DENOMINATOR: Data are collected regularly upon contact with a patient in the OPD. Patients should be correctly identified and categorised as referrals or by-passers.
DATA SOURCE	NUMERATOR: OPD attendance tally sheet MOH 701, MOH 705 DENOMINATOR: OPD attendance tally sheet MOH 701, MOH 705
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	CALCULATION = [Number of Referrals (from lower facilities)] / [Total OPD 1st Attendances]

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
		✓	✓	✓	✓	

INDICATOR NAME	Distribution of causes of death among children aged <5 years (%)
HIS CODE:	HIS198

PROGRAMME GOAL	The target of Millennium Development Goal 4 is to "Reduce by two thirds, from 1990 to 2015, the under-five mortality rate".

REFERENCES	AOP	WHO	MDG4
CODES		89	

DEFINITION OF IMPORTANT TERMS	**Key term 1: Distribution of main causes of death** among children aged < 5 years, expressed as percentage of total deaths. **Key term 2: The causes of death** refer to the concept of the 'underlying cause of death' as defined by ICD-10 (WHO, 1992). **Key term 3:Associated terms Underlying cause of death** : a) the disease or injury which initiated the train of morbid events leading directly to death, or (b) the circumstances of the accident or violence which produced the fatal injury (ICD-10)
NUMERATOR	causes of death among children aged < 5 years
DENOMINATOR	total deaths
UNIT OF MEASURE	Percentage
DISAGGREGATION	Age, facility, HDSS, County, District, province/regional and National level
INDICATOR LEVEL	Outcome
PURPOSE	The target of Millennium Development Goal 4 is to "Reduce by two thirds, from 1990 to 2015, the under-five mortality rate". Efforts to improve child survival can be effective only if they are based on reasonably accurate information about the causes of childhood deaths. Cause-of-death information is needed to prioritize interventions and plan for their delivery, to determine the effectiveness of disease-specific interventions, and to assess trends in disease burden in relation to national and international goals. Kenya's under 5 mortality is absolutely high and an acceptable at this century. Effort to have right data on cause of death will enable government plan and direct resources towards healthcare that will mitigate and reduce the burdens of morbidity in under five and increase the life expectancies in the population.
FREQUENCY	**Reporting:** Monthly by admitting health facilities and quarterly by Health and Demographic surveillance sites (HDSS) using the Verbal Autopsy (VA) data. **Analysis: Annual** analysis and modelling where the coverage is low. **Utilization:** Data should be used every year to design specific interventions or child survival programmes and reduce the time spend by parents/caretakers in hospitals or seeking care to economic production
DATA SOURCE	Hospitals data obtained from the D1's (certified notifications and Vital registration with complete coverage and medical certification of cause of Death using MOH 268. Special studies especially in HDSS and sentinel hospitals
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	Data from civil registration with complete coverage (80% or over) and medical certification of cause of death summarised on MOH 268, or nationally representative epidemiological. studies of causes of child death (special studies analysing causes of death based on verbal autopsy studies or other sources from civil Registration data). The crude deaths calculated as specific causes of death among children aged < 5 years divided by total deaths multiplied by 100.

INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	✓

INDICATOR NAME	Net primary school enrolment rate (%) / School enrolment rate (MOE)
HIS CODE:	HIS199

PROGRAMME GOAL	To provide a school package of education to all children to allow them have a destiny and build the economic potential of the country. Educating the vulnerable population assures a social responsibility, health life and economic growth towards vision 2030.

REFERENCES	AWP	WHO	MDG2
CODES		99	

DEFINITION OF IMPORTANT TERMS	**Key Term 1: Net primary school enrolment** is the Number of children of official primary school age (6- 14 years) who are enrolled in primary education as a percentage of the total children of the official school age Population. **Key Term 1: Net Secondary school enrolment** is the enrolment of the same age-group (14 – 19 years) at secondary level.
NUMERATOR	Number of children enrolled in primary schools Number of children enrolled in secondary schools
DENOMINATOR	Estimated Population of school children to be enrolled in each level (primary or secondary schools)
UNIT OF MEASURE	Percentage
DISAGGREGATION	Sex, Rural/ Urban, Primary and secondary
INDICATOR LEVEL	Output
PURPOSE	Education in Kenya is one of the basic rights for the child as stated in the constitution of Kenya promulgated 2010. To enable the nation achieve vision 2030, her population must be well educated and promote use of appropriate technologies and engarage more innovations. Try to have an elite society to promote health, improve the economy and protect life as gate keepers of the society. In health a defined health package shall be introduced to ensure that the children are healthy and able to have a learning environment.
FREQUENCY	Biannual (every Six months)
DATA SOURCE	Primary school enrollment register and survey data from UNESCO compiles data on net primary school enrollment ratio. Secondary school enrollment register and monthly reports submitted to Ministry of Education (MOE) MIS.
DATA MANAGEMENT AND INDICATOR COMPUTATION GUIDELINES	The data collections are done in the enrollment register kept by the schools and summarized on the monthly form by the head teachers or principles of the various schools and send to the County education officers. Every quarter, a feedback report should be shared with the community to show the dropout rates and ensure that communities/ families take responsibilities of educating their siblings and create a future for them. The number of enrolled divided by the

	estimated population for the school age category 6- 14 for primary and 14-19 for secondary multiply by 100.					
INDICATOR APPLICATION LEVEL	SECTOR	PROGRAMME	NATIONAL	COUNTY	FACILITY	COMMUNITY
	✓	✓	✓	✓	✓	✓

Tracer Essential Medicines and Medical Supplies (EMMS)

List for Levels 2 & 3 Health Facilities

Medicines

1. Amoxicillin 250mg Capsule / Tablet
2. Amoxicillin 125mg/5ml powder for oral liquid
3. Paracetamol 500mg Tablet
4. Cotrimoxazole 480mg Tablet
5. Artemether + Lumefantrine 20/120mg Tablet
6. Benzylpencillin 600mg (IMU) vial
7. Epinephrine (Adrenaline) 1mg/ml (as HCl or hydrogen tartrate) Injection
8. Oral Rehydration Solution (ORS) (low osmolality); WHO formula (in sachet for 500ml)
9. Oxytocin Injection 10 IU/ml in 1 ml ampoule
10. Retinol (Vit A) (as palmitate) Capsules
11. Water for injection 10ml ampoule
12. Glucose injectable solution; hypertonic (10% or 50%)

Medical Supplies: Non-pharmaceuticals

13. Syringe disposable 5cc with needle 21G Sterile
14. Cotton wool, absorbent, 400mg BP, white
15. Surgical gloves, size 7.5", Latex Sterile medium
16. Cotton, Gauze Plain 36" x 100yds, 1500gms BP weight White colour, loosely woven and absorbent
17. Sodium hypochlorite 4-6% External solution
18. Ethanol 70% (denatured) solution

Medical Supplies: Vaccines etc

19. Tetanus toxoid vaccine; >40 IU/0.5ml in 10-dose vial
20. Measles Vaccine; Live-attenuated, freeze-dried 10 x 0.5ml dose vial + diluent

Medical Supplies: Contraceptives

21. Hormonal Contraceptives: Ethinylestradiol + Levonorgestrel 30/150 micrograms tablet (Oral) **OR** Medroxy-progesterone acetate Depot Injection 150mg/ml in 1 ml vial

22. Male condom

DATA COLLECTION TOOLS

Introduction

Caution!

Health or Medical records, Health information or its contents must never be disclosed unless under the following circumstances:

1. If there is the consent, express or implied, of the patient/client.
2. If there is an order of court.
3. If the interest of the doctor or hospital cannot otherwise be safeguarded.
4. In transference between hospitals, clinics or doctors, in the interest of a patient's health.
5. If there exists a higher duty than the private one to safeguard the community.

INTEGRATED MINISTRY OF HEALTH DATA COLLECTION AND REPORTING TOOLS

DATA COLLECTION PRIMARY TOOLS (REGISTERS)

1. MOH 204 A OUTPATIENT REGISTER (under five years)
2. MOH 204 B OUT PATIENT REGISTER (over 5 years)
3. MOH 511 CHILD WELFARE CLINIC (CWC) REGISTER
4. MOH 510 IMMUNISATION REGISTER FOR CHILDREN
5. MOH 333 MATERNITY (DELIVERY) REGISTER
6. MOH 406 POSTNATAL REGISTER
7. MOH 512 DAILY ACTIVITY (FAMILY PLANNING) REGISTER
8. MOH 301 IN-PATIENT REGISTER
9. MOH 209 RADIOLOGY REGISTER
10. MOH 240 LABORATORY REGISTER
11. MOH 268 DIAGNOSTIC INDEX CARD
12. MOH 405 ANTENATAL CLINIC (ANC) REGISTER
13. MOH 513 Community Health Workers Log Book
14. MOH 514 House Hold Register

DATA REPORTING TOOLS (Summary forms)

If the health information system forms are so complicated that those who are to complete them cannot understand them or the forms are not available all the time, data will not be collected properly. Therefore, every effort must be made to simplify forms and to ensure that there is a constant supply of them. Such forms can have a space for some simple on the spot analysis e.g. total numbers or percentage to be calculated. Some of the kinds of forms are:-

1. MOH 105 Service delivery
2. MOH 701 A Under five (<5) years Daily outpatient morbidity tally sheet.
3. MOH 701 B Over five (>5) years Daily outpatient morbidity tally sheet.
4. MOH 705 A Under five (<5) years Daily outpatient morbidity summary sheet.
5. MOH 705 B Over five (>5) years Daily outpatient morbidity summary sheet.
6. MOH 702 Immunisation and Vitamin "A" Tally sheet
7. MOH 710 Immunisation and Vitamin "A" summary sheet.
8. MOH 704 Child Health and Nutrition Information System tally sheet.
9. MOH 711 Integrated tool for RH, HIV/AIDS, Malaria, TB, and Child nutrition health facility summary.
10. MOH 717 Monthly Workload report for hospitals (Service workload for all areas)
11. MOH 268 Diagnostic Disease Index
12. MOH 718 In-patient morbidity and mortality summary sheet.
13. MOH 708 Environmental Health services
14. MOH 715 Health Facility services inventory form
15. MOH 514 Community Health Extension Worker (CHEW) Summary
16. MOH 515 Community Chalk/white Board

Procedures for completing and forwarding health information reports:

In order to make the data comparable in time and space, data collection is standardized. Sets of forms are designed on which the collected data can be recorded. Some are tally sheets, monthly report forms and annual summary sheets. Each health facility, activities are instantly recorded in a register then tallied in the existing tools and summed up at the end of the day. The sum up of the daily totals makes weekly or monthly totals for each activity available easily. The following sources of error are common and should be avoided:-

a) Forgetting to record in the service/activity register
b) Forgetting to tally.
c) Marking or crossing more than one tally at a given tally
d) Double Counting of the figures or tallies
e) Misclassification
f) Miscalculations and
g) Figure "**cooking"**

Step by step guides to realise the services offered by each individual at all levels of the health care system;

Data collection, collation, consolidation and use

Data collection can be quite simple, requiring only a pen or pencil and a piece of paper. It can also get quite sophisticated, employing several people, an array of pre-printed forms, calculators, computers, Personal Digital Assistants (PDAs), Phones, and Geographical Positioning System (GPS). The data collected will be used to know the scope of the problems that a primary implementer is dealing with i.e. how many people use the services offered or what are the most common ailments affecting people in the health service area? Data collection is on itself an activity which requires planning, time and funding or resources. All health facility in-charges, Managers (HMTs, DMSTs and DHMTs) **MUST** always cost this integral activity. To ensure good data collection, interpretation and use:-

- Identify your indicators.
- Define the indicators and state how data is obtained, what sources, use of data and how often data is collected.
- Identify the variables for different data sets
- Define each variable.
- Design the data collection tools (registers) and data reporting forms (summary tools). **Note:** In each step above build consensus at every level.
- Pre-test the new or reviewed tools in the field for at least two weeks to obtain practical inputs.
- Share the report with all the concerned stakeholders i.e. Field officers/ implementers, programme managers and development partners.
- Finalize the documents considering some suggestions and inputs.
- Print the data collection and reporting tools.
- Orientate the health workers on the tools and indicators

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Community level intervention:

- Record all the services carried out in a family/ Household register or Community Log or both.
- Extract information from the register/Log book to the provided (prescribed) forms.
- Submit the completed form/ Log book to your supervisor at the end of each month.
- Update the board displayed in the community with the information from your community unit.
- Discuss the information and interpret the data during the Community Dialogue days
- Develop some actionable areas and review every month the achievements

Health facility level intervention:

- Record and maintain all the service registers at service delivery points.
- For immunization, giving of Vitamin A supplements and growth monitoring services **ONLY**, record in the immunization register, give the immunization(s) or supplement and make a **Tally** of what has been given before the client leave.
- Using tally sheets provided for other services, extract the information from the register every morning or before closing the previous days business. This will minimize errors, backlogs of work and time for compilation.
- Complete also the daily summaries or summaries per each page. This will also assist you in timely completion of the summary form(s) by only making the totals.
- The health facility in-charge should **submit all** summaries including the community units' reports to the District Medical Officer of Health (DMOH), **by 5th of the preceding month or enter directly into the District Health Information Software (DHIS).**
- File (i.e. permanent attachment of the documents – avoid loose leaves) and maintain a copy of all reports submitted to the next level.
- The health facility should compile service delivery facility indicators, share with the members of the facility and the management committee. The team should also use their information for daily activities, running of the institution, annual facility planning improve health services, request for supplies and monitoring of health services at the community and health facility level.
- Provide regular feedback to the community using organized Chief "**Barazas**", community health days and other organized community meetings including women group meetings.

District level interventions:

- The district is the foci (**first data repository**) of the health data.
- Collect, collate **all** the summary reporting forms from **ALL** the available health service institutions in the district regardless of status and affiliations or running agency.
- Check all reports for errors, omissions, completeness, consistency (**VALIDATE)** and enter them in the health facility checklist.
- The person receiving the report should give **expressed** (**WRITTEN)** feedback summary note to all the reporting facility and remind those who have not reported.
- Compile, then process and make facility, district summary data sheets. Note that entries can be done offline and uploaded later after finishing data entry.
- The DMOH or appointee should complete the data sets in each entry by clicking complete and ensure that all facility data element entries and validations are done before the **15th of the preceding month**.
- Critically analyse in-depth the facility data. Using the PIVOT table, Report tables, standard reports and run the completeness.
- Discuss the important indicators and health trends in the DHMT meetings every month.
- Discuss the improvements with the district stakeholders in the District Health Stakeholders Forum (DHSF).
- Share the performance summary monthly with all health facilities, and stakeholders in the district.
- Using available reports plan for integrated targeted supportive supervision to the health Facilities/community units.

County/Provincial level interventions:

- Collate district summary reports.
- Using the checklist for the received reports acknowledge receipt of the district reports.
- Consolidate the district summaries into a county or provincial report- (second data repository).
- Critically analyse in-depth the county facility data, district data. Using the PIVOT table, Report tables, standard reports and run the completeness.
- Discuss the important indicators and health trends in the County or provincial meetings every month.

- Discuss the improvements with the County stakeholders in the County/ provincial Health Stakeholders Forum (CHSF/ PHSF).
- Share the performance summary monthly with all county health facilities, districts and stakeholders in the county or province.
- Using available reports plan for integrated targeted supportive supervision to the health Facilities/districts.
- Share the improvements with the National level.

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National level interventions:

- Acknowledge the receipt of the reports through a written feedback.
- Consolidate the county/provincial and district quarterly performance reports. This should be analysed critically to produce a quarterly feedback report. Give the County managers or PHMT quarterly performance feedback.
- Critically analyse in-depth the county/provincial data, district data. Using the PIVOT table, Report tables, standard reports and run the completeness bearing in mind different users.
- Conduct monthly data harmonization meetings and provide official release of data
- Share the progress report with the heads of the programmes and departments.
- Share the improvements with the other stakeholders in formalized forums.
- Using the information, complete the PCs for PS, DMS and heads of departments.

Data Validation:

The quality of data depends on;

- Efficiency organisation of the flow of information at the local level.
- Accurate and up-to-date input without undue cost.
- Training of Health personnel at all levels.
- Establishment of data banks
- Continuous use of data for decision making and performance measurements
- Enhanced confidentiality.

It is the responsibility of the Health records and information personnel to cross-check the data to determine whether it is accurate, or have errors or making sense to users before forwarding or entry to the database. Every month the concerned officers must cross-check data submitted to them and provide feedback to health facilities or any other level. Data corrections must be done by the source.

Note that Health statistics suffer from both quantitative and qualitative defects. These are: -

- There may be omissions and errors
- Non-response due to
    - Negligence of the reporting personnel.
    - Communication problem due to inadequate postage fund, poor terrain and road network or breakdown of computer.
- Lack of adequate cautioning for defaulters.
- Reporting personnel overburdened with other duties.
- Lack of interest
- Insufficient supervision
- Inadequate training of the health personnel at all levels.

Each of the above defects can be strengthened by;

- Carrying out regular supportive targeted supervision.
- Provision of continuous medical education (CME), workshops and seminars.
- Provision of self addressed envelopes or give funds in form of allocations.
- Network with other partners
- Enforce response by prosecuting those not reporting and provide regular feedback on performance to all with a list of shame.
- Employ and deploy appropriate personnel trained in health records and information to handle information
- Motivate the staff.

DATA ANALYSIS

The analysis of data collected in the health information system is simple and straightforward. Not having a calculator is an invalid excuse for lack of analysis as analysis can be done without one. The most important data analysis is to estimate coverage for the services offered e.g. what proportion of children less than 1 year complete immunization schedule before their first birth day? Or what percentage of women delivers without attending antenatal clinics? Percentage coverage = number of cases in clinic X 100 divide by Total number of cases in catchment population.

It is vital in data analysis to identify appropriate denominators and numerators. Population data are available from the past census and population projections or actual populations from the community units. Having estimated the catchment population, the next step is to estimate the target population for various services which is the denominator of the coverage fraction. E.g. catchment population = 25,000.

a) Antenatal care, Target population is 4.5 Percentage of 25,000 = 4.5/100 * 25,000 = 1, 125

If number of new visits are 976 therefore coverage = 976/1125 * 100 = **86.76 Percentage**

If number of re-visits are 2, 090 the mean number of visits per new attendant for antenatal care is new visits + revisits divide by new visits = (976+2090)/ 976 = 3.1 visits per new antenatal attendant.

b) Morbidity data: Morbidity data are collected in both outpatient and in-patient by age, and diagnosis. Considering new cases gives a picture of the morbidity pattern at the health facility. If the catchment population was 25,000 thus incidence rate for malaria = 20540 * 1000

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Quality of information:

The quality of information depends on data that is accurate, accessible, complete and timely. Timely data prompts managers to act on time and make planning not to delay. The data collected must be accessible by users to make evidence based decisions and carryout proper interventions. Accurate and complete data gives a picture of what is happening in the area in question and the process will: -

a) Provide up to-date information and thereby improve management and evidence based decision making.
b) Relieve supervisors from manual data analysis so that they can spend more time overseeing staff in the field.
c) Make available useful information and provide timely and regular feedback at all levels.
d) Provide more complete information for district, health facility, County/ provincial and national planning i.e.

- Selecting appropriate target groups for various interventions
- Selecting the most appropriate solution
- Coordinate public and private activities
- Set fees which are affordable
- Set standards for client satisfaction etc.

The link between health information services and the user:

Accurate health information is needed at all levels of the health system including national/ global / provincial / regional/ district levels and health facility and community levels. Health planners and programme officers require information to identify the health problems to define strategies and to set targets. Development partners, programme implementers and communities need information to measure the progress of the programmes and to monitor a selected number of health indicators. For example lower mortality rates or fewer episodes of illnesses, malnutrition rates, immunisation coverage, disease prevalence etc.

WHAT IS A HEALTH INFORMATION SYSTEM?

Health information has been variously described as the "foundation" for better health, as the "glue" holding the health system together, and as the "oil" keeping the health system running (Lippeveld T, 2001). There is however a broad consensus that a strong health information system (HIS) is an integral part of the health system, the operational boundaries of which include:
… all resources, organizations and actors that are involved in the regulation, financing, and provision of actions whose primary intent is to protect, promote or improve health (Murray C, Frenk J and WHO, 2000). It is universally accepted that health information is essential for health decision-making at all levels of the health pyramid. From the level of individual patient care, to the management of specific health programmes through to the policy level where strategic decisions are made information is an integral part of the health pyramid. The health information system has been aptly described as "an integrated effort to collect, process, report and use health information and knowledge to influence policy-making, programme action and research" (WHO, 2000).

Goal of health information systems

What is clear is that health information is much more than the collecting of data. Data have no value in themselves – value and relevance come only when they are analysed, transformed into meaningful information, and used (FIGURE 1). The ultimate objective of a health information system is to produce information for taking action in the health sector. Performance of such a system should therefore be measured not only on the basis of the quality of data produced, but on evidence of the continued use of these data for improving health systems operations and health status (RHINO, 2003).

Information Attributes

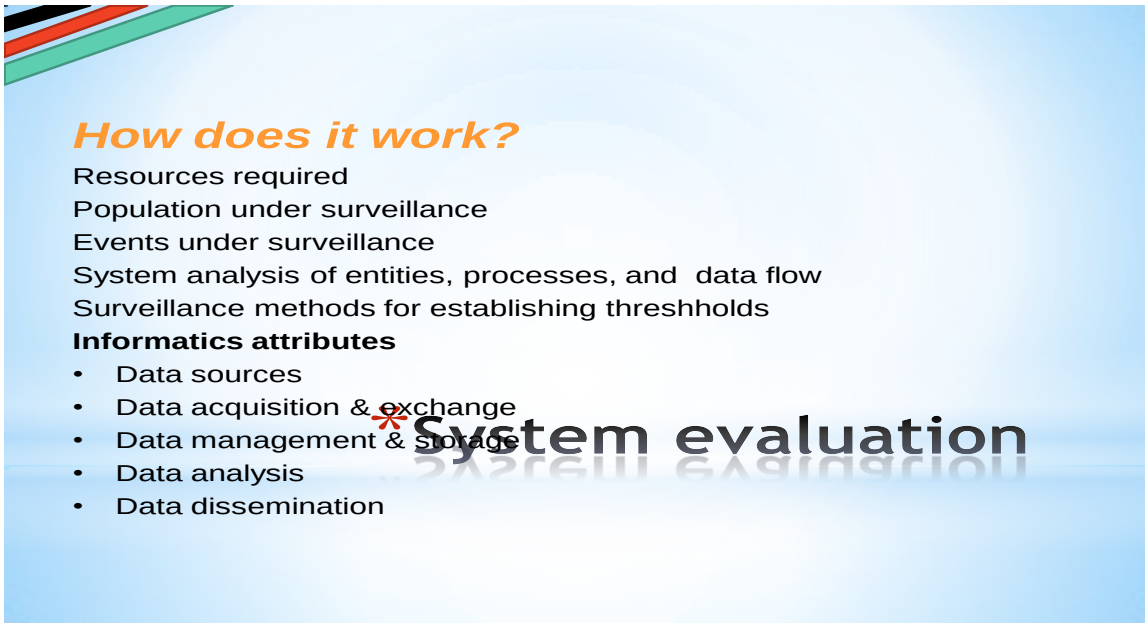
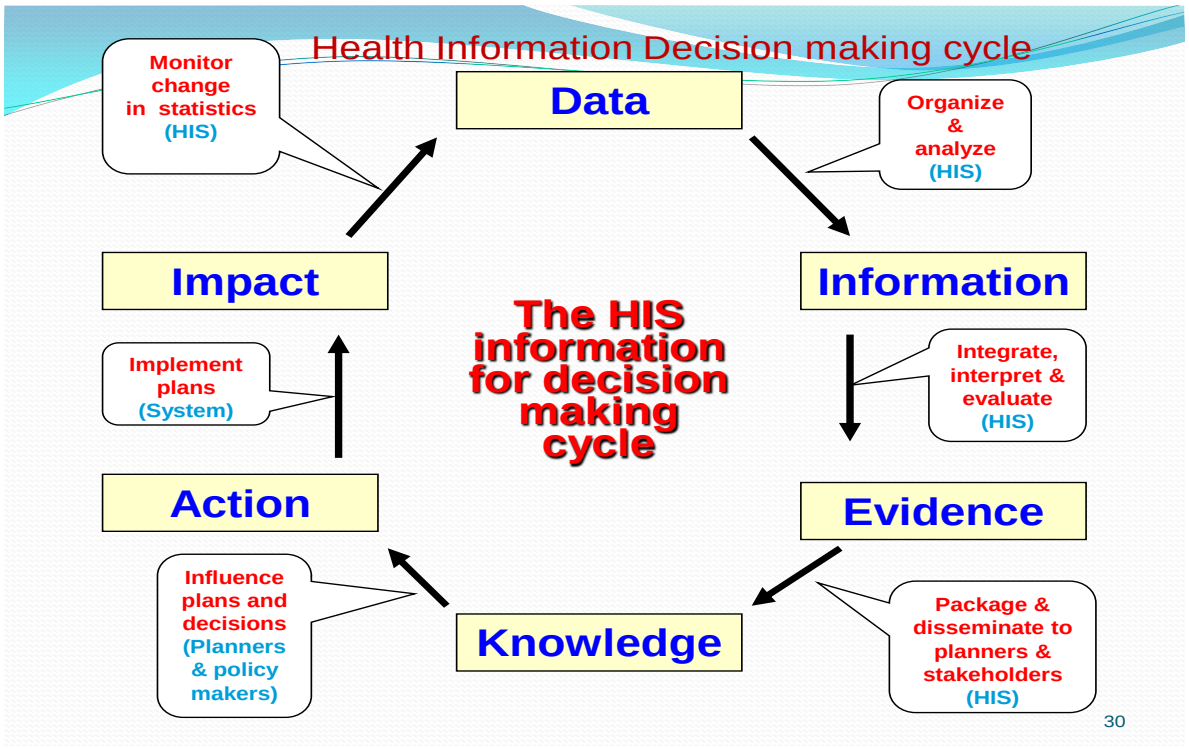


Figure 1 - The data for action cycle



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Domains of health information

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What must we do in data verification?

- ✓ Ensure that all reports are available and complete tally sheets ledger books, summary sheets, bin cards, supervisory books for the audit year and current year.
- ✓ Ensure that all the data analysed are accurate though for the report not submitted nothing can be done.
- ✓ Have proper answers to the difference in data submitted since this may affect the verification factor confidence interval.
- ✓ Ensure the consistency of the data and denominators used.
- ✓ Strengthen monitoring completeness and timeliness of reports at district, county/ provincial and national levels.
- ✓ Encourage regular written feedback
- ✓ Have old reports and forms properly kept and ready for verifications.
- ✓ Report missing data and why so.
- ✓ Ensure the retention of all health records for at least ten years (10) as stipulated in the national policy.

What we must not do?

- ✓ Inflate our data or reports
- ✓ Be fraudulent e.g. same ink, fresh ink
- ✓ Missing reports should not be re-written – may result in a “zero score”
- ✓ Keep our offices locked or say the staff with the key not available.
- ✓ Fail or sabotage the DQA verification exercise.

DESIGNING OR ASSESSING A MANAGEMENT INFORMATION SYSTEM

Steps in assessing your MIS

1. Identify all users of each type of information.
2. Assess the short and long term objectives of the organization, programme department or service delivery site.
3. Identify information needed to help different people at different levels for efficiency and effectiveness of services.
4. Eliminate information being collected and not being used.
5. Determine data collection tools (forms, registers and procedures) that are complicated or time consuming for improvement.
6. Revise any existing forms and procedures for collecting and recording information that needs improvement or prepare new ones. Keep in mind minimum data sets.
7. Set up or improve the manual or computerized systems for tabulating, analyzing and reporting information.
8. Develop procedures for confirming the accuracy of the data.
9. Train and supervise staff in using the new forms, registers, summary sheets and other instruments to collect, tabulate, analyse, present and use the information.

Note: To prepare this overview of an existing MIS start by meeting with your staff, colleagues, community leaders, volunteers and clients then collect the information systematically, writing down the answers clearly for review later on.

Analyzing the results of your assessment

1. Consider the special needs of your health services/ programme.
2. Consider information that is currently available in forms, registers, and records which can be used in decision making.
3. Identify the information you need that is not being provided by existing records, registers and forms.
4. Consider what information is needed regularly and frequently and that is needed only periodically (frequency of data collection).
5. Consider simple and inexpensive methods of collecting information to supplement the information provided by records, registers and forms e.g. rapid assessments, focus groups.
6. Consider how the information can be used by different groups working in a health care service/programme.
7. Consider if staff have the appropriate information in a usable form when needed.
8. Consider how to use information to provide effective feedback to collectors.

Feedback

Emphasize the importance of reporting and outline procedures for proper reporting. Provide to health facilities an information summary sheet. An information summary sheet is a report that presents data and its interpretation in a table or other graphic format. One or two page summary will be ideal to the health facilities.

Written Feedback:

- ✓ Newsletter
- ✓ Fact sheets and information summary sheets
- ✓ Published reports
- ✓ Public health bulletins
- ✓ Monthly and annual reports
- ✓ Newspapers.

Public forums;

- ✓ Briefings; news conferences
- ✓ Hearings and testimonies
- ✓ In-person professional conferences, lectures, and other planned meetings

Electronic media:

- ✓ Broadcast media; (TV; radio)
- ✓ FAX
- ✓ E-mail; Website

- ✓ Audio conferences; video conferences.
- ✓ Web portals

DATA SECURITY

Backup

Def: - Computer security - protection method whereby several duplicate data files are stored on Secondary Storage Devices in the event a catastrophic event damages the computer's main file storage system. It is advisable to store backup data files in different locations to guard against loss in the event of a fire, theft, or other unplanned event.

Backup require two types, one to be backup on even days and the other on odd day. The storage device required to be stored far from the main storage (server/computer) or operation office. Reports also can be backed-up on institutional email.

Note: - Backup and Recovery: The goal will be to back up the data from any system on a daily basis. Backup media could be external hard disk, Organizational email account, flash disk, diskette, petition hard disk or remote servers so that it will be available in the event of catastrophic failure.

Storage

Def: - The retention of data in any form, usually for the purpose of orderly retrieval and documentation. A device consisting of electronic, electrostatic, electrical, hardware or other elements into which data may be entered, and from which data may be obtained as desired. Storage facilities varies depending on the size of the institution and workload In a facility you require to have a folder or file, shelves, filling cabinet, box file or lockable cupboard to enable you secure the documents. While in a large institution and district you require having a memory stick (Flash Disk), Camera and PDAs you require having a memory card, external hard drive, RW-CD, R-CD, Cabinet, shelving and lockable cupboard. The storage device/documents required to be stored far from the main office storage especially sensitive/vital documents.

Network Operations

Take all necessary precautions to prevent any destructive or malicious program (virus) from being introduced to the system. Employ appropriate measures to detect virus infection and employ all appropriate resources to efficiently disinfect any affected systems as quickly as possible.

Computer Virus Prevention, Detection, and Disinfection:

The goal of the system will be to maintain updated virus protection from a reputable source. Any and all viruses found will be quarantined or the virus will be deleted. Every organization are required to run and maintain their own anti-virus software from an approved source on all computers that have access to the HIS system.

Records

Def: - any written document about a patient or client in professional relationship with a health worker. Written accounts of acts, transactions, or instruments that are drawn up pursuant to legal authority by an appropriate officer and appointed to be retained as memorials or permanent evidence of matters to which they are related. Patient records is not a public records and it should be kept strictly confidential but can be release only under certain circumstance especially through patient consent (implicit, explicit), court order, when it exist a high duty than a lower duty, when there is infectious or notifiable disease. A public record is a document that has been filed with, or furnished by, a governmental agency and is available to the public for inspection. For example, title of record to property is an ownership interest that has been duly filed in the office of public land records. The term record also applies to the formal, written account of a case, which contains the history of actions taken, papers filed, rulings made, and all written opinions.

Data Security

Secure access to physical areas containing equipment, data, and software. Strictly safeguard all data including client-identifying information in accordance with the latest technology available and securely protect it to the maximum extent possible. Maintain and administer central and backup server operations including security procedures and maintain backups of the system to prevent the loss of data. Monitor access to all systems that could potentially reveal a violation of information security protocols. Maintain and audit accurate logs of all changes made to the information

contained within the database. Issue all User IDs and passwords for HIS users through Technical Administrator. Only designated Technical Administrators may request and receive HIS passwords and User IDs from Central level. Periodically change of passwords for security purposes. Not release data to any person, agency, or organization without the client's authorization and following the procedures for the release of data. Any database at all level should not be handled by many people have limited persons with right persons to handle the database which assist improve security and Management of database. In the event of manual or use of files or folders data security is paramount and file must be filed in a permanent building with fire extiquishers, exit doors, big bill board showing **"No smoking",** filing rooms should have well ventilated, filling equipment should be raised in case of linkage or flood and doors and windows should be grilled. All patients/clients records and information **MUST** not be accessed by un authorized (persons not directly handling the patients/clients Limit HIS access to authorized users and follow all protocols of monitoring those users. Provide names of all staff members who have access to the Records Unit and certify that such staffs are competent to have access to this information according to the provisions.

Preventive maintenance

Any machines, devices or equipment require regular preventive maintenance to improve efficiency and durability.

Files/folders requires:-

- dusting, and permanently filling of loose notes
- weeding of inactive notes/records
- during filling its required support file to stand upright
- keep on a dry and cool place

CDS, Flash disk, Memory cards, diskette

- Place on a rag or album
- Keep on a dry and cool place
- Its fragile so handle with care
- Observe proper removal and inserting the device into the electronic machine.

Computers, laptops, printers, PDAs, Cameras, Duplo machines, servers

- Its fragile so handle with care
- Read manufacture instruction while installing and assembling
- Keep on a dry and cool place
- Place on firm workstation, raise from surfaces and should not be placed at the edge of the workstation
- Always update the antivirus and keep off unknown flash disks.
- Always wipe the equipments and workstations with dry clean clothing
- Once a quarterly or six months do major blow-up the dusty.
- Avoid opening of equipments regularly, but it require a trained technician
- Avoid using oily and wet hands on a keyboard, printer and monitor
- Avoid taking tea, water, office pin near the keyboard
- Follow the right procedure of warm booting and shutting down the devices/machines
- Proper connection of cables and make sure that fans are always working or in good order.

Other general equipments – shelves, rags, workstations

- Wipe the dust
- Painting and avoid spilling water on the surfaces
- Reinforce/support or acquire new shelves, workstation or rags
- Apply oil to parts with wheels