



REPUBLIC OF KENYA

# **NATIONAL HIV/AIDS MONITORING AND EVALUATION FRAMEWORK**



NATIONAL AIDS CONTROL COUNCIL

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# FOREWORD

HIV/AIDS continues to ravage every sector of Kenya's economy. The pandemic has left behind millions of orphans and created widespread poverty and helplessness among the population. Today, HIV/AIDS is being recognized as a threat to human development requiring concerted efforts from all stakeholders.

The National HIV/AIDS Monitoring and Evaluation Framework comes at a time when there is increased need for accountability both to communities and development partners. With increased resources made available to respond to the epidemic, it has become mandatory for the national response to have timely and accurate data for assessing whether the interventions are making a difference and whether the resources are being used effectively to achieve the desired effect. The Framework is guided by the **“Three Ones” Principles: one agreed AIDS action framework that provides the basis for coordinating the work of all partners, one national AIDS Coordinating authority with a broad-based multisectoral mandate, and one agreed country level Monitoring and Evaluation system.**

The goal of the National HIV/AIDS Monitoring and Evaluation Framework is, therefore, to guide collection, analysis, use, and dissemination of information that enables the tracking of progress made in response to HIV/AIDS and enhances informed decision-making. The Framework provides an environment for inclusion of new fresh ideas on Monitoring and Evaluation and improvement of indicators in line with efforts done by experts and organizations working on Monitoring and Evaluation of HIV/AIDS.

The Framework further articulates the linkages, reporting relationships, and indicators used to measure inputs, outputs, outcomes, and impact of national response to HIV/AIDS.

The process of developing the National HIV/AIDS Monitoring and Evaluation Framework has been participatory and all-inclusive with consultations at constituency, provincial, and national levels. It has entailed participatory research to identify monitoring and evaluation approaches, opportunities, and constraints as well as field visits and consensus building around the process of indicator development.



The operationalisation of the National HIV/AIDS Monitoring and Evaluation Framework will require the following:

- The establishment of a functional M&E system that provides mechanisms for the timely collection, processing, and dissemination of programme data that can be used to responsively improve programmes and targeting.
- That all recipients of HIV/AIDS funds from NACC and other implementers report on outputs of their interventions.
- That programme implementers understand their role in reporting on the indicators and that baseline information is collected where none exists.
- Extensive work towards the strengthening of subsystems for routine data collection.
- Mounting capacity building to enhance partners' skills and appreciation of monitoring and evaluation so they contribute to the availability of data for informed decision-making.



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# ACKNOWLEDGEMENTS

The National AIDS Control Council acknowledges various development partners and stakeholders who took part in the development of the National HIV/AIDS Monitoring and Evaluation Framework. In particular, the World Bank and FUTURES Group Europe provided invaluable support during the development of the Framework.

MEASURE Evaluation, a USAID-funded project, played a crucial role, especially in indicator selection and definition. To build consensus on the National HIV/AIDS Monitoring and Evaluation Framework, MEASURE Evaluation supported a summit for various stakeholders through which the contents of the Framework were discussed and agreed upon.

The invaluable support and contribution offered by various organisations and individuals is greatly acknowledged. A full list of organisations and individuals is provided in Annex 1.

Finally, the effort by all stakeholders who contributed in one way or another to the development of this document is acknowledged.

# LIST OF ACRONYMS AND ABBREVIATIONS

ACU	AIDS Control Unit
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
BCC	Behaviour Change Communication
BSS	Behavioral Surveillance Survey
BTC	Blood Transfusion Centre
CACC	Constituency AIDS Control Committee
CBO	Community-based Organization
CBS	Central Bureau of Statistics
CCC	Comprehensive Care Centre
CDC U.S.	Centers for Disease Control and Prevention
CHW	Community Health Worker
CRIS	Country Response Information System
DASCO	District AIDS/STD Coordinator
DARTO	District ART Officer
DC	District Commissioner
DCO	District Clinical Office
DDO	District Development Officer
DHRIO	District Health Records & Information Officer
DHS	Demographic Health Survey
DIO	District Information Officer
DMEC	District M&E Committee
DMOH	District Medical Officer of Health
DPO	District Population Officer
DSO	District Statistical Officer
DSS	Demographic Surveillance Survey
DTC	District Technical Committee
ERSWEC	Economic Recovery Strategy for Wealth and Employment Creation
FBO	Faith-Based Organization
FBS	Facility Based Survey
FIDA	International Federation of Women Lawyers
FHI	Family Health International
GoK	Government of Kenya
HBC	Home-Based Care
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICASA	International Conference on AIDS and STIs in Africa
IGA	Income Generation Activities
JAPR	Joint HIV/AIDS Programme Review



KDHS	Kenya Demographic and Health Survey
KNASP	Kenya National HIV/AIDS Strategic Plan
KNHRC	Kenya National Human Rights Commission
LQAS	Lot Quality Assurance Sampling/Supervision
NEPHA-K	Network for Empowerment of People Living with HIV/AIDS in Kenya
KSPA	Kenya Service Provision Assessment
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MoEST	Ministry of Education, Science & Technology
MoH	Ministry of Health
MoPND	Ministry of Planning and National Development
MTEF	Medium Term Expenditure Framework
NACC	National AIDS Control Council
NAMIS	National HIV/AIDS Management Information System
NASCOP	National AIDS and STI Control Programme
NBTC	National Blood Transfusion Centre
NBTCR	National Blood Transfusion Centre Report
NCPAD	National Coordinating Agency for Population and Development
NGO	Nongovernmental Organization
NLTP	National Leprosy and Tuberculosis Control Program
OP	Office of the President
OVC	Orphans and Vulnerable Children
PARTO	Provincial ART Officer
PASCO	Provincial AIDS/STD Coordinator
PEP	Post Exposure Prophylaxis
PHR&IO	Provincial Health Records and Information Officer
PLWHA	People Living With HIV/AIDS
PMCT	Prevention of Mother-to-Child Transmission
PMO	Provincial Medical Officer
PRSP	Poverty Reduction Strategy Paper
SRF	Standard Reporting Format
SSA	Sub-Saharan Africa
STI	Sexually Transmitted Infection
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNGASS	The United Nations General Assembly Special Session on HIV/AIDS
VCT	Voluntary Counselling and Testing

# CHAPTER I

## INTRODUCTION

### 1.1 HIV/AIDS in Kenya

Kenya like many other countries in Sub Saharan Africa has been severely affected by HIV/AIDS since early eighties. The first case of AIDS in Kenya was diagnosed in 1984. Since then HIV/AIDS has been detected in all parts of the country. The impact of the HIV/AIDS on the population and on the entire economy has grown tremendously over the years. Consequently gains made in the health status of the population by early 90s have been reversed.

The Kenya Demographic and Health Survey (KDHS 2003)<sup>1</sup> indicates that 6.7 percent of Kenyan adults are infected with HIV. The data show that women are particularly vulnerable to HIV infection. Almost 9 percent of women are infected with HIV compared with 4.6 percent of their male counterparts. Women between ages 20 and 30 are especially vulnerable (KDHS, 2003). It is estimated by NASCOP that there are now about 150,000 AIDS deaths per year, twice the rate of 1998. Estimates on new infections and deaths show that the rate of deaths exceeds that of new infections. As a result, there has been a rapid increase in the number of orphans.

Through combined efforts of various stakeholders and implementers in addressing the epidemic, HIV prevalence has declined from about 14 percent in 2001 to about 7 percent in 2003. However much remains to be done to ensure that the uninfected remain virus free, while the majority of the infected gain access to affordable antiretroviral therapy (ART). Given that the majority of people contract the virus through sexual contact, there is need for further multicultural and comprehensive programming aimed at promoting interventions that reduce high-risk sexual behaviour. Efforts aimed at reducing transmission through infected blood, ensuring use of sterile equipment, and scaling up programs aimed at preventing mother-to-child transmission of the virus also need to be undertaken.

A number of challenges, however, still exist. Among them are the needs for increased resource mobilization, the ever increasing numbers of people in need of ART, the competition for resources for HIV/AIDS interventions with other health and developmental issues, the slow change of sexual behavioural patterns as a result of deep rooted cultural practices and beliefs, as well as the high level of poverty.

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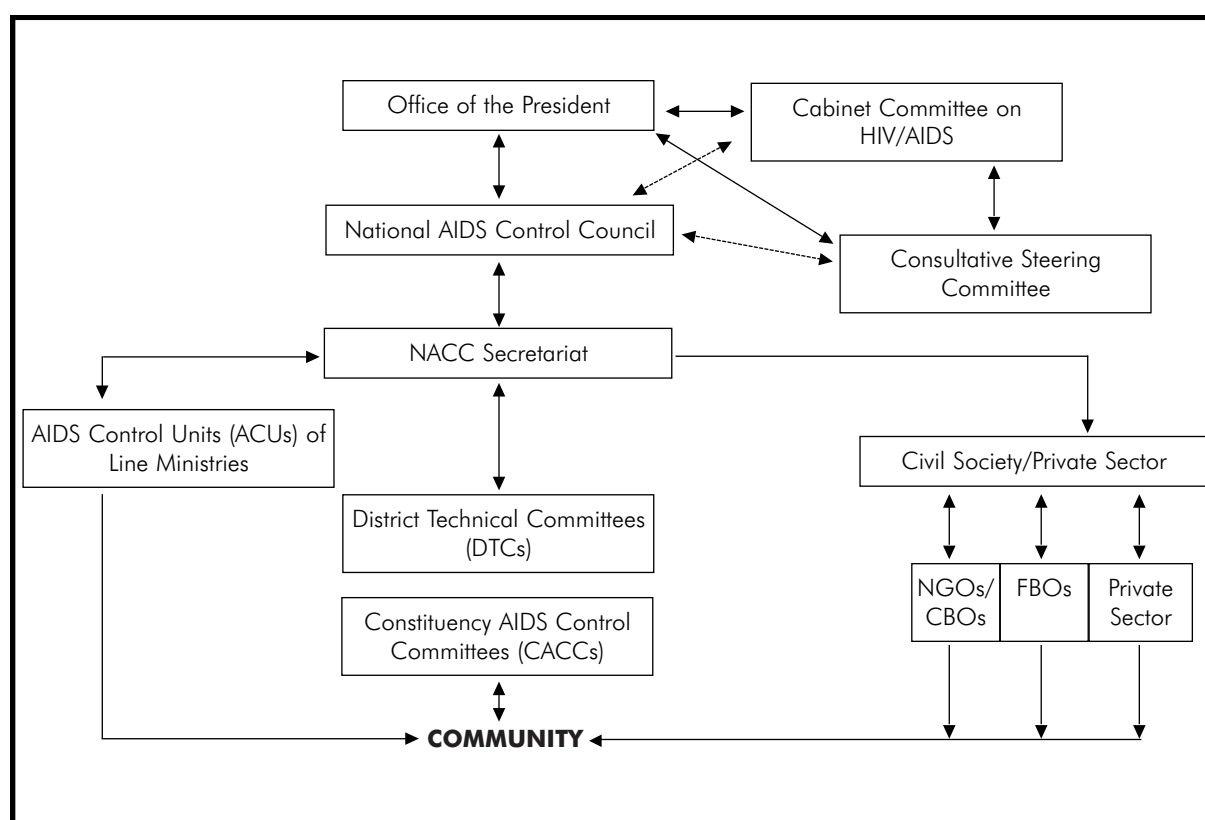
<sup>1</sup> GOK (2003). Kenya Demographic and Health Survey (KDHS) 2003. Nairobi



## 1.2 National AIDS Control Council

In recognition of the challenges posed by the AIDS epidemic, the Government of Kenya established policy guidelines in the Sessional Paper No. 4 of 1997 on AIDS in Kenya and in 1999, AIDS was declared a national disaster. A body to spearhead the coordination of interventions, the National AIDS Control Council (NACC), was created under the Office of the President to provide leadership and coordinate a multisectoral response to the epidemic. NACC operates through multisectoral implementers under a structured consultative leadership as indicated in figure 1.

**Figure 1: National AIDS Control Council Institutional Framework**



## 1.3 Kenya National HIV/AIDS Strategic Plan (KNASP) 2005/6-2009/10

### 1.3.1 Priority areas in the Strategic Plan

Kenya implemented the multisectoral response to HIV/AIDS through its first multisectoral strategic plan for years 2000-2005. The priority areas identified were:

- prevention and advocacy;
- treatment, continuum of care, and support;

- mitigation of the socio-economic impact;
- monitoring, evaluation, and research;
- management and coordination.

The KNASP 2000-2005 also emphasized greater involvement of the civil and private sector organisations. The Strategic Plan has now come to an end and a new one to guide Kenya's national response to HIV/AIDS for the period 2005/6 to 2009/10 has been developed. The lessons learnt as well as the achievements and challenges encountered in the implementation of the 2000-2005 Strategic Plan have been the guiding principles behind the development of the new strategic plan. The KNASP 2005/6-2009/10 was developed through participatory and all-inclusive approaches, and its goal is to **reduce the spread of HIV, improve the quality of life of those infected and affected, and mitigate the socio-economic impact of the epidemic.**

Three priority areas have been identified and in each area, a results framework has been developed indicating targets that must be achieved in the next five years. The priority areas are:-

### **Priority Area 1: Prevention of New Infections**

Given that about 93 percent of Kenyans adults are not infected with the HIV virus, efforts to reduce the number of new HIV infections in both vulnerable groups and the general population are critical in the struggle to further reduce the incidence. The following prevention strategies will be implemented:

- (i) Increasing availability and access to counselling and testing;
- (ii) Condom promotion;
- (iii) Strengthening sexually transmitted infections (STI) and HIV Programme linkages;
- (iv) Expanding prevention of mother to child transmission of HIV;
- (v) More effective, targeted behaviour change communication (BCC);
- (vi) Improvement in the availability of safe blood supply;
- (vii) Injection safety and expanded access to post exposure prophylaxis (PEP) and universal precautions;
- (viii) Ensuring prevention and treatment efforts are mutually supportive.

### **Priority Area 2: Improve the Quality of Life**

The objective of this priority area is to improve the treatment and care, protection of rights, and access to effective services for those infected with the virus through the following key strategies:

- (i) Improving availability and access to treatment and care and;
- (ii) More effective protection of human rights.

### **Priority Area 3: Mitigation of Socio-economic Impact**

The objective of this priority area is to adapt existing programmes and develop innovative responses to reduce the impact of the epidemic on communities, social services, and economic productivity. The components of this priority area are:-

- (i) Undertaking of impact studies;
- (ii) Advocacy;
- (iii) Development of mitigation policy;
- (iv) Implementation of mitigation programmes;
- (v) Community empowerment;
- (vi) Human Resource Planning.

A wide range of support services are required for effective delivery of the KNASP strategies. The key priority areas identified (prevention of new infections, improvement of quality of life of those infected and affected, and mitigation of socio-economic impact) constitute the core of KNASP 2005/6-2009/10. However, the institutions that will be involved in coordinating and implementing the KNASP will require significant support to operate efficiently. The key support services to be provided under KNASP are outlined below:

- (i) Monitoring and Evaluation;
- (ii) Research;
- (iii) Financing and Procurement Framework;
- (iv) Institutional Capacity Building;
- (v) Communication, Coordination and Networking.

### **1.3.2 KNASP Results Framework**

During the development of the KNASP2005/6-2009/10, results or milestones to be achieved within the first and second year of the KNASP life for each priority area were identified. The Framework is to be reviewed and to be updated annually by all KNASP partners and forms basis for progress reporting at the annual JAPR, using information collected through the National HIV/AIDS M&E Framework. The key components of the results framework are results, timeframes, strategies, lead agency and key partners. Indicators in the results framework have been incorporated to the national indicators for the purpose of reporting.

## **1.4 Status of M&E for HIV/AIDS in Kenya**

Previous attempts by individual implementers and stakeholders in developing M&E systems often led to parallel systems being developed for different programmes. There was minimum sharing of information between programmers and between different implementers leading to inefficiency in utilising scarce resources.

For example, under National AIDS/STD Control Programme independent vertical systems were developed for each programme area of VCT, PMTCT, ART, and STDs. Efforts however are being made to integrate these systems and a form MOH 726 has been developed together with their registers to integrate information so as to enable NASCOP to have one M&E system that responds to all of its programme needs. On the other hand Sentinel Surveillance has been operational and consistently undertaken in the region and thus the country has been able to track the epidemic since 1990 through various sentinel sites across the country. Other surveillance systems BSS, LQAS DSS have also been introduced together with some surveys but at a limited level. DHS+ was carried out successfully in the country in 2003 and Kenya Service Provision Assessment has also been undertaken.

Kenya has a national forum for reviewing progress in implementation of KNASP. This is the annual meeting called Joint Aids Programme Review (JAPR) where stakeholders participate in structured review of progress made in each programme area. Lessons learnt during Implementations of programmes are discussed and used to modify KNASP and its implementation. In particular, this process is meant to inform the annual preparation of the National Medium Term Expenditure Framework (MTEF)

## CHAPTER 2

# DEVELOPMENT OF THE NATIONAL HIV/AIDS MONITORING AND EVALUATION FRAMEWORK

### 2.1 Rationale

With the national and global momentum to scale up responses to HIV/AIDS, it is becoming increasingly important for the Government of Kenya (GoK), and the NACC as the central body mandated with coordinating the national response in particular, to be able to report accurate, timely, and comparable data to national stakeholders, development partners, and communities. Such information is useful to understand the scale and outcome of implementation and can be used to secure continued funding for the expansion of HIV/AIDS programmes, and more importantly, it can be used locally to enhance and scale-up community and health-facility-based programmes. The National HIV/AIDS M&E Framework provides stakeholders with a tool for well coordinated, interlinked and functional HIV/AIDS M&E systems that allow them to efficiently assess how well HIV/AIDS interventions are contributing to achieving the national programme goals.

The following reasons justify the necessity of having the Kenya National HIV/AIDS M&E Framework:

- (i) It provides opportunities to develop integrated national and sector specific M&E systems to guide a national response to HIV/AIDS;
- (ii) It assists in responding to the regional and international reporting requirements;
- (iii) It provides the platform for partnership, networking, and collaboration between national-level and local-level stakeholders in monitoring and evaluating national and decentralized responses to HIV/AIDS.

### 2.2 Goal and Objectives

The goal of the Framework is to guide coordinated and efficient collection, analysis, use, and provision of information that will enable the tracking of the progress made in the national response to HIV/AIDS and enhance informed and sound decision making and policy for the multisectoral, decentralized HIV/ AIDS programme.

The objectives of the Framework are to assist all HIV/AIDS stakeholders in:

- (a) Conceptualization of coordinated national HIV/AIDS Monitoring and Evaluation system for national response;
- (b) Guide in development and strengthening of the Monitoring and Evaluation System;

- (c) Directing gathering of information that will be used in Monitoring and evaluating implementation of KNASP 2005/6-2009/10.

Expected outputs on the implementation of the Framework:

- Quality and timely reporting by all programme implementers;
- Establishment or Strengthening of Monitoring and Evaluation Systems depending on their current status;
- Establishment of a data products warehouse;
- Establishment of monitoring and evaluation dissemination strategy;
- Structured coordinated flow of routinely collected information among players at various levels of the M&E system;
- Strategic indicators developed and reviewed based on existing ones and periodically reviewed to represent professional insight from experts of HIV/AIDS and Monitoring and Evaluation.

To obtain the above products, an M&E Operational Manual will be developed describing how the M&E System is supposed to operate in practical terms (including job descriptions, indicator definitions, standardized tools and requirements, reporting formats, and data flow).

## **2.3 Guiding Principles in the Development of the Framework**

Kenya is committed to the “*Three Ones*” principles which originated from ICASA (Nairobi, September 2003) and were agreed in April 2004 between HIV/AIDS affected countries and development partners, as the basis for concerted country-level action to scale up national AIDS responses.

The “*Three Ones*” are:

- One agreed AIDS Action Framework that provides the basis for coordinating the work of all partners;
- One National AIDS Coordinating Authority with a broad-based multisectoral mandate;
- One agreed country-level Monitoring and Evaluation (M&E) system.

The Framework development, took into consideration the “*three ones*” principle. In particular, the National HIV/AIDS M&E Framework will be implemented within the context environment of the other two elements of the “*three ones*” namely one strategic plan and one coordinating body that are already in place.

The Framework was developed to take into consideration the following factors which should be addressed under one Monitoring and Evaluation system:

**Mainstreaming:** M&E is mainstreamed/integrated into all HIV/AIDS programmes and interventions in the country at each level and by all players. Each intervention will define routine indicators and reporting formats that will guide tracking the progress made.

**Integration:** National and routine indicators (both clinical and non-clinical) for monitoring the national response will be integrated into the Country Response Information System(CRIS). All systems will be strengthened and linked to CRIS.

**Decentralization:** Analysis and storage of data takes place at the level where it is collected. Simple analytical tools and equipment are introduced for this purpose where none exist. ACUs, PASCOS, DASCOS, District Technical Committees (DTCs), and CACCs are required to play a pivotal role in this process.

**Simplicity:** The ease in which data are collected, analysed, and reported remains crucial. Procedures should remain manual as much as possible. Data collected at facility, household, and community levels should be able to be entered into registers and forms. The data collation and analysis should not stop functioning because of a power failure, a shortage of printed stationery, or a breakdown of computers. However, data collection should also benefit fully from modern technology to facilitate national data aggregation, analysis, and report generation.

**Action Orientation:** Data collected must be used for programmatic and technical decision making. There must be a direct link between data collection, analysis, reporting, and decision making at all levels of HIV/AIDS interventions. An M&E system provides information for policy development, program planning, and operational management. It also collects and forwards only the information necessary for decision making, while providing feedback to the periphery.

**Transparency and Accountability:** M&E of the national response to HIV/AIDS has to be open and participatory for stakeholders and participants at all levels. Those in charge of data collection, analysis, reporting, and policy decisions must take ownership of their actions and be able to professionally defend their reports and/or decisions. All stakeholders and participants have to agree on and abide by this key principle.

## 2.4 Process of Development of the Framework

Stakeholders were widely consulted because of the multisectoral nature of the HIV/AIDS response to secure consensus, commitment and ownership and to ensure effective implementation.

To achieve above, the approaches used included the following:

- Review of the relevant national and international documents on national HIV/AIDS programmes and on initiatives in the country;
- A situational (status) analysis of M&E at NACC and NASCOP and other partner organizations;
- Consultative meetings with M&E technical people and programme managers at NACC, NASCOP, the Ministry of Planning and National Development (MoPND), Central Bureau of Statistics (CBS), public universities, and other professional bodies and institutions;
- Consultative meetings with various stakeholders and participants through Technical Groups (TGs) and JAPR, which includes representatives from NACC, NASCOP, MoPND (M&E Unit & CBS), Office of the President (OP), and other line ministries, districts, development partners, Non Governmental Organization (NGO's), and people living with HIV/AIDS (PLWHA) to review the M&E mechanisms and recommendations of the proposed mechanisms;
- A three-day national HIV/AIDS M&E Summit meeting to discuss the draft Framework;
- Interviews with key informants such as NACC, NASCOP, MoPND, CBS, and development partners.

# CHAPTER 3

## NATIONAL HIV/AIDS MONITORING AND EVALUATION FRAMEWORK

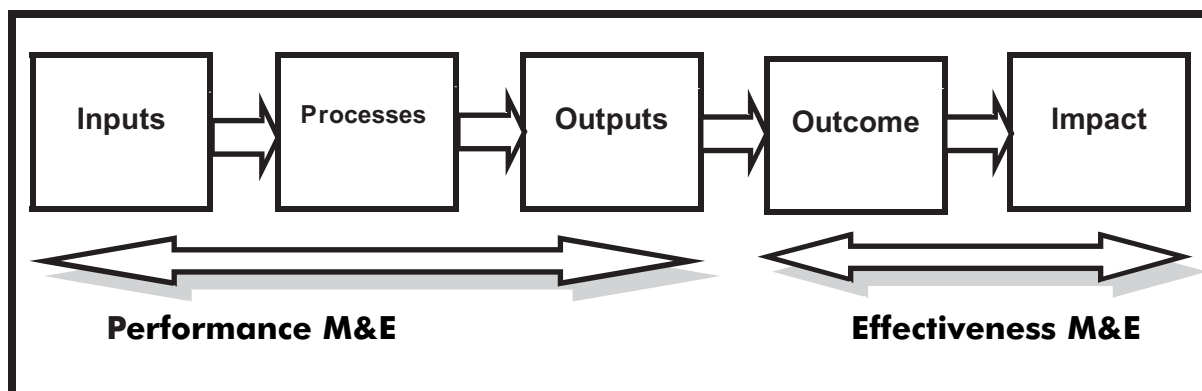
### 3.1 Basic concepts of M&E

#### 3.1.1 Definitions of Monitoring and Evaluation

In general, it is common to find confusion even among stakeholders between Monitoring and Evaluation. Monitoring is the routine, daily, assessment of ongoing activities and progress. In contrast, evaluation is the episodic assessment of overall achievements, Monitoring looks at what has been done whereas evaluation examines what has been achieved or what impact has been made<sup>1</sup>. The National HIV/AIDS M&E Framework conceptualises the generation and flow of information at all levels to facilitate monitoring of activities required to implement KNASP as well as evaluating the effects of those activities on the target group.

#### 3.1.2 Main Components for Monitoring and Evaluation Framework

Figure 2: Framework for Selecting Monitoring and Evaluation Indicators



In the implementation of the strategic plan, there are various stages involved before attaining the desired goal. Every strategic plan will have a desired goal which is the net effect expected of the intervention targeting the population. In summary, once resources have been utilized for activities they are expected to produce desired results that will eventually lead to the goal of the strategic plan.

<sup>1</sup>UNAIDS/WORLD BANK. 2002 National AIDS Control Councils Operations Manual. Geneva

Figure 2 shows how monitoring and evaluation is used in programmes for measuring implementation and assessing the effect of implemented programmes.

A programme or intervention will have:

- (i) **Inputs** that refer to resources invested in the programme and will include financial, technological, and human resources;
- (ii) **Processes**-These are activities carried out to achieve the program objectives. Monitoring of these activities will show what has been done and how well and timely it has been done based on the work plans for the objectives;
- (iii) **Output**-These refer to the results achieved at the programme level or simply programme products. Output may be in three forms: **numbers of activities** conducted in each functional area such as training or IEC; **service output** which measures adequacy of services delivery system in terms of access, quality of care or program image; and **service utilization** that measures the extent to which the services are being used;
- (iv) **Outcome**-This refers to the changes observed at the population level among members of the target population as a result of a given program or intervention. There are two types of outcome namely:
  - (a) *Effects*- which is short - to medium range (e.g., 2-5 years) change in behaviour promoted by programme (e.g. abstinence, use of condoms, seeking treatment for STDs from Health worker);
  - (b) *Impact*- which are changes that occur over long-term (e.g. reduction in new infections of HIV among young people or increased length of life among HIV infected).

**3.1.2.1 Indicators** -These are operational measures of the components in the Framework. They have been developed in Kenya using standard operational definitions and discussed for each area of the strategic plan bearing in mind all their desirable features. Indicators definitions, numerators and denominators are well covered in the operational manual for M&E for HIV/AIDS in Kenya. An example of an outcome indicator in prevention of HIV programs area is ***“Percentage of young people who have had sex with non-regular partner in the past 12 months by gender and marital status”***.

**3.1.2.2 Data Sources** - Indicators for HIV/AIDS response in Kenya whether drawn from reports or from other agencies require data from a variety of sources. These



sources are population surveys, population censuses and vital registration, facility surveys, surveys of programme clients and providers, programme service statistics and records (administrative and special programmes).

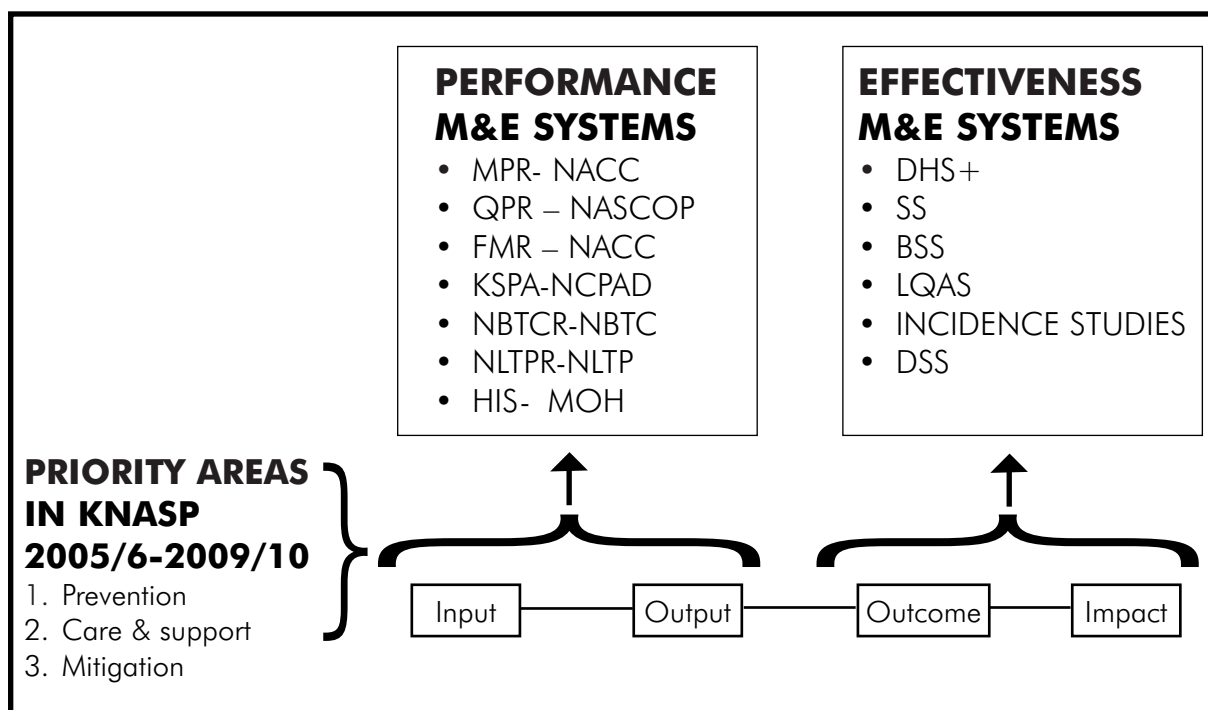
**3.1.2.3 DataFlow/Linkages** -These are relationships between existing institutional structures created for the coordination of the national HIV/AIDS programme at various levels.

## 3.2 Framework for Monitoring and Evaluation of HIV/AIDS in Kenya

### 3.2.1 Components for the National HIV/AIDS M&E Framework

The diagram below illustrates the components for the National HIV/AIDS M&E Framework. The systems for collection of indicators for various levels are indicated. The indicators were developed for various levels in line with earlier KNASP but have been adapted for the new KNASP 2005/6-2009/10 programmes in the identified priority areas. The indicators for each program in each level in priority areas are in Chapter V of this document.

**Figure 3: Components for National HIV/AIDS Monitoring and Evaluation Framework**



### 3.2.2 Monitoring

Monitoring implementation HIV/AIDS programmes in the KNASP 2005/6-2009/10 will be done through the following:

- (i) **Monthly Programme Activity reports (MPR)** by NGOs, CBOs, ACUs and private sector organisations working on HIV/AIDS. The information for this report will be collected using already developed forms and tools. The data collected will be channeled to NACC through various levels that will be described by the M&E operational manual. An agency may be considered to manage this information system component;
- (ii) **Quarterly programme reports (QPR)** by health facilities. This will be reports detailing services and outputs by programmes specific to HIV/AIDS. They will collect at the Health facilities and be processed for reporting using form MOH726. The data collected will be channeled to NASCOP through various levels that will be described by the M&E operational manual.
- (iii) **Financial management report (FMR)**. These will be reports on Financial Monitoring. The reports will be provided by the implementers of the programs to be linked to program activity reports;
- (iv) **Kenya Service Provision Survey (KSPA)** conducted by NCAPD assesses availability and quality of service provision in the facilities in the country. The facilities are selected randomly for representation and estimation at provincial and National levels;
- (v) **National Blood Transfusion Centres Report (NBTCR)**, this are quarterly reports based on information collected at the centres round the country;
- (vi) **National Leprosy and Tuberculosis Control Report (NLTBCR)** which are quarterly reports on case findings and cohorts;

Indicators identified for monitoring various programs at various levels are in chapter V of this document.

### 3.2.3 Evaluation

Evaluation of achievements/impact of the response in Kenya will be done through the following:

- (i) **DHS+** which is a population based survey conducted by Central Bureau of

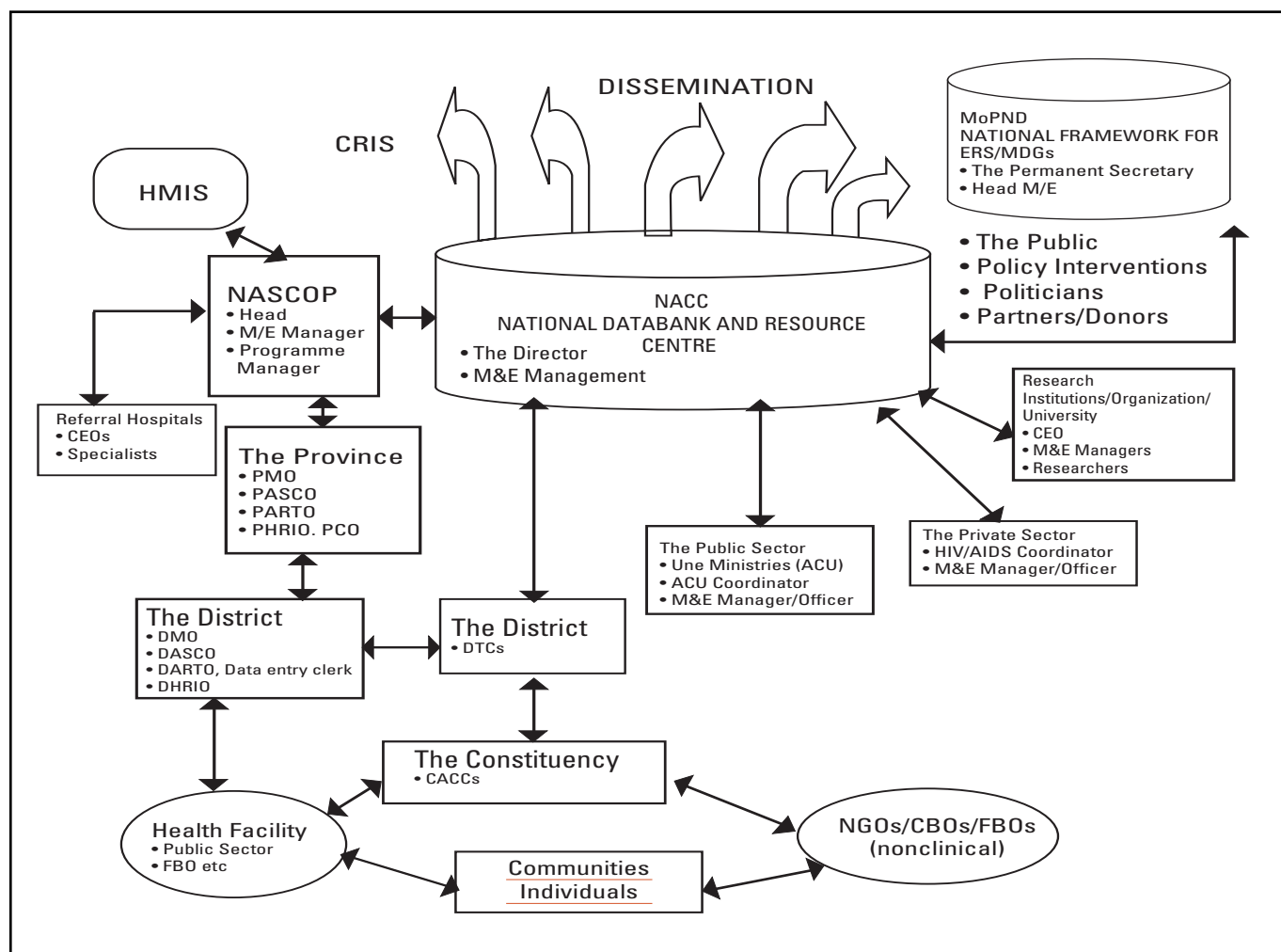
Statistic of Kenya with technical assistance from ORC MACRO, NACC and NASCOP. Apart from behavioural indicators collected, blood samples are also taken from individuals interviewed for HIV testing with their consent;

- (ii) **Sentinel Surveillance (SS)** conducted by NASCOP is an annual HIV prevalence survey on pregnant women and will be conducted as per the accepted and approved protocol as detailed in the M&E operational manual for Kenya;
- (iii) **Behavioural Sexual Surveillance (BSS)** will be carried out after every two years on selected HIV/AIDS high risk populations. The survey will be coordinated by NASCOP or NACC;
- (iv) **Lot Quality Assurance Sampling** will be applied by NACC for the purpose of estimating coverage at various implementation levels and determination of priority areas by CACCs that are potential areas for funding through Community Initiative Activities proposals;
- (v) **Incidence studies** may be carried out through small studies to ascertain the direction of the epidemic by determination of new infections of HIV during specified periods;
- (vi) **Demographic Surveillance Surveys** will complement incidence surveys and will elicit demographic and other impact of HIV/AIDS on communities. This will be done through commissioned studies by interested groups;
- (vii) **Special surveys** will be done by implementers as operations research and institutions with capacity for the purpose of addressing areas of interest in the implementation of HIV/AIDS programmes.

### 3.2.4 Monitoring and Evaluation Data Flow in Kenya

Data flow and linkages at national, provincial, district and constituency is illustrated in figure 4. The actual roles and responsibilities are described in the monitoring and evaluation operational manual.

Figure 4: Monitoring and Evaluation data flow in Kenya



### 3.2.5 Country Response Information System (CRIS) database

Country response information system will be used at all levels; National, Provincial, District and Constituency as a warehouse to store Monitoring and evaluation information as well for stimulating the demand of information.

It has three compartments:

- (i) **Indicator Module**-The CRIS Indicator Module facilitates the collection and analysis of indicators of the epidemic and country response. It supports UNGASS, National Programme, and other indicator sets;
- (ii) **Project/resource tracking module**-The project/resource-tracking module supports improved national planning, resource mobilization/allocation, intervention targeting, intervention evaluation, analysis of a country’s success in implementing its own National Strategic Plan (NSP), and analysis of its efforts and compliance with the UNGASS Declaration of Commitment on HIV/AIDS and other regional or global commitments;

- (iii) **Research Module-**Comprehensive knowledge about research being conducted in-country and access to research findings will support the development of stronger National Strategic Plans and inform their effective implementation. This module will be used to collect research summaries.

# CHAPTER 4

## IMPLEMENTATION STRATEGY FOR THE M&E FRAMEWORK

### 4.1 Role of NACC

The NACC is mandated to coordinate the national HIV/AIDS response. Within NACC, the Head of M&E division is charged with the task of coordinating all HIV/AIDS M&E initiatives in the country with assistance from Monitoring and Coordinating Group for Coordination and Support group as outlined in the KNASP 2005/6-2009/10.

Specifically, the responsibilities of NACC will be:

- (i) Responsible for overall management and ensuring implementation of the Framework;
- (ii) Development of M&E implementation plan;
- (iii) Development of M&E operational manual (Laying out M&E Systems);
- (iv) Dissemination of M&E Framework to all stakeholders;
- (v) Capacity building for sub-systems;
- (vi) Resource mobilisation (Financial and technical) for M&E;
- (vii) Utilise the reports from M&E systems and research for decision making;
- (viii) Analysis and preparation of national M&E reports;
- (ix) Ensuring quality control in M&E systems;
- (x) Building strong institutional collaboration/relationships critical for the success of M&E.

### 4.2 Role of implementers

The implementers are agencies/institutions that are involved in supporting or implementing activities in specific target areas of the KNASP. Implementers include

line Ministries, Civil Societies and Private sectors organizations. They will be reporting through relevant Monitoring System on programmatic activities and outputs as indicated in chapter 3 of this document. Where an implementer is responsible for a particular component of the Monitoring and Evaluation System e.g. in the case of NASCOP Sentinel Surveillance, it will coordinate development of the required standard tools, capacity building, quality control in the system and management of the data.

Specifically they will be responsible in:

- (i) monitoring and evaluating their activities;
- (ii) using existing systems/developing M&E sub systems that utilise existing structures;
- (iii) Mainstreaming M&E for HIV/AIDS in implementers M&E systems;
- (iv) Utilization of the data collected for decision making within the institution;
- (v) Submit reports to NACC.

### **4.3 Role of Development Partners**

The role of development partners is crucial to developing and supporting the national M&E Framework and the subsequent strengthening of the M&E systems. They will be expected to provide substantive technical and financial support to ensure that the systems are functional. Based on the “Three Ones” Principles, they are expected to ensure that their reporting requirements and formats are inline with the indicators outlined in the M&E framework. They are required not to duplicate reporting requirements but rather to synchronize efforts with existing development partners and stakeholder efforts to have an agreed upon country-level M&E system. Utilise reports from NACC in decision making and engaging with other partners.

### **4.4 Coordination of M&E at Decentralized Levels**

For effective M&E of the national response, information from various sources must be:

- Used for programming, planning, and advocacy purposes at each level of HIV/AIDS programme implementation.
- Filtered and summarized so that only relevant information is sent to various

- levels of programme implementation as described above.
- Disseminated to stakeholders within the country as well as to national, regional and international forums.

The dissemination of M&E results should be timely and responsive - responding to needs and public demands. This is expected to serve strategic purposes, including:

- Sharing information for strategic planning, processes, and interventions.
- Providing feedback on the efforts and resources committed to the national response and mapping out lessons and challenges that need strategic focus.
- Increasing the government, public, and donor commitment to the multisectoral national response to HIV/AIDS.

#### **4.4.1 The Constituency Level**

Given that implementation of programmes is undertaken at this level, it is imperative that data collected and reports generated are disseminated and used by the implementers to monitor trends in supply of basic inputs, routine activities, and progress made to make regular adjustments and informed decisions about the program. CACC will be collecting data for outcome indicators for programs in the strategic plan through LQAS. They will be expected to use this data in making decisions on priority areas for funding in the constituency. CACCs are also expected to ensure that data from CBOs/NGOs are quality and accurate and are reported on time.

#### **4.4.2 The District and Provincial Levels**

With the decentralization strategy in place, the districts and provinces are expected to play a significant role in the provision of technical services and coordination of HIV/AIDS activities at those levels. Subsequently, M&E focal persons (Provincial Medical Officer of Health, Provincial Health Records & Information Officer, PASCOS, PARTOS, DASCOS, and DTCs) at these levels will be responsible for coordinating and supervising the development of district annual reports, bulletins, and special studies, which should be disseminated and circulated to key partners and players at that level for the programs in the their sectors. The data and information at these levels should be used to review trends and progress and identify and resolve problems as they emerge. The information should also be provided to program managers and implementers so they can make informed decisions on the efficiency and effectiveness of their programmes. In addition, the district data has to feed into the district development plans. Hence all the program data that has been summarised to indicator levels should be forwarded to the District Development officer of the district.

### 4.4.3 *The National Level*

The NACC is mandated to coordinate the dissemination and use of HIV/AIDS data and information for national response. At the country level, it is expected to produce and circulate an annual report to stakeholders, development partners, civil society, and the private sector. In addition, NACC will be responsible for organizing a JAPR, a forum in which all stakeholders in HIV/AIDS convene and discuss achievements, lessons learnt, challenges facing the country because of HIV/AIDS.

It is also the responsibility of NACC to ensure that the two agreed upon national HIV/AIDS indicators the “Percentage of young people aged 15-24 who are HIV infected” and “percentage of pregnant women attending ANC HIV sentinel surveillance sites aged 15-24 who are HIV infected” are fed into the MoPND M&E system for the ERS and reported in the Medium Term Expenditure Framework (MTEF). The first indicator is a periodic indicator that can only be collected through a household survey (KDHS) after every 5 years. The one is to be collected annually through the ANC sentinel surveillance systems. The MoPND will use these indicators to assess the progress being made in the national response to HIV/AIDS.

The periodic (outcomes & impact) indicators take into account the national, regional, and inter-national reporting frameworks/requirements such as the MDGs, UNGASS, Global Fund, Great Lakes Initiatives on HIV/AIDS, and The Emergency Plan for comparison of regional and international progress and trends. With this in mind, it is expected that NACC will ensure that data is available and is reported in a timely fashion, and in an agreed upon format to the regional and international levels. In this regard, efforts will be made to ensure that reporting is streamlined.

## CHAPTER 5

# INDICATORS FOR HIV/AIDS PROGRAMMES IN KENYA

Kenya through a series of consultative forums spanning back to 2002 has developed indicators for Monitoring HIV/AIDS response. As described earlier development of the indicators was for the KNASP 2000-2005 and where relevant, they have been adopted for the new KNASP 2005/6-2009/10 and others added based on the results Framework so far developed. In the development of the initial indicators, care was taken to ensure that UNGASS and MDGs HIV/AIDS indicators were included.

LEVEL	CORE INDICATORS	REF	DATA SOURCE
<b>IMPACT ASSESSMENT</b>			
	% of People infected with HIV categorized by gender and age*	<b>1</b>	(KDHS) +
	% of young people aged 15–24 that are HIV-infected categorized by gender*‡	<b>2</b>	(KDHS) +
	% of pregnant women attending ANC who are HIV-infected by age group	<b>3</b>	SS
	% of HIV-infected infants born to HIV-infected mothers*	<b>4</b>	Formula-based estimate <sup>1</sup>
<b>OUTCOMES ASSESSMENT</b>			
	% of sexually active people reporting having had sex with a non-spousal, non-regular partner in the last 12 months by gender	<b>5</b>	KDHS/BSS/LQAS
	% of young people aged 15-24 reporting the use of a condom during last sexual intercourse with a non-regular partner in the last 12 months by gender*‡	<b>6</b>	KDHS/BSS/LQAS
	Median age at first sexual conduct among 15-24 year-olds	<b>7</b>	KDHS/BSS/LQAS
	% of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission by gender*‡	<b>8</b>	KDHS/BSS/LQAS
	% of people aged 15-49 reporting been tested and knowing their HIV status by gender and age group	<b>9</b>	KDHS/BSS/LQAS
	% sex workers that have been tested for HIV	<b>10</b>	BSS/Special Surveys

<sup>1</sup>The formula is as follows: **Indicator score** =  $\{T*(1-e) + (1-T)\} \times v$ , with **T** = % of HIV infected pregnant women with ARV treatment, **v** = PMTCT rate in absence of treatment and **e** = efficacy of treatment provided (50%)

\* UNGASS Indicator ‡ MDG Indicator

	% sex worker clients that have been tested for HIV	<b>11</b>	BSS/Special Surveys
	% of uniformed service that have been tested for HIV and receive results	<b>12</b>	BSS/Special Surveys
	% of migrant workers that have been tested for HIV and receive results	<b>13</b>	BSS/Special Surveys
	% of injecting drug users who have adapted behaviours that reduce transmission of HIV*	<b>14</b>	Special Survey
	Percentage of inmates (prisoners) tested for HIV and have received results	<b>15</b>	BSS/Special Surveys
<b>LEVEL</b>	<b>INDICATORS</b>		<b>DATA SOURCE</b>
<b>MONITORING PROGRAMME LEVEL OUTPUTS</b>			
<b>PRIORITY AREA 1: PREVENTION OF NEW INFECTIONS</b>			
<b>STI prevention and care</b>	Number of services providers trained in syndromic management of STIs	<b>16</b>	Quarterly programme report (QPR)
	% of patients with STIs at health facilities who have been diagnosed, treated, and counselled according to national management guidelines *	<b>17</b>	Kenyan Service provision assessment (KSPA)/FBS
	% of patients diagnosed with STIs offered HIV testing services	<b>18</b>	Quarterly programme report (QPR)
	% of health facilities with STI drugs in stock and no STI drug stock outs of > 1 week within last 12 months	<b>19</b>	KSPA/FBS
<b>PMTCT</b>	Number of PMTC sites providing at least the minimum package of PMTCT services <sup>2</sup> in the past 12 months	<b>20</b>	QPR
	% of health facilities providing at least the minimum package of PMTCT services <sup>3</sup> in the past 12 months	<b>21</b>	KSPA/FBS
	% of pregnant women seen at health facilities offering PMTCT services who were counselled on PMTCT, tested and received their HIV test results	<b>22</b>	QPR
	% of HIV positive pregnant women provided with a complete course of Nevirapine to prevent I transmission from mother to child*	<b>23</b>	QPR
	% of health facilities where PMTCT services are being offered with no ARV prophylactic drug stock outs of > 1 week in last 12 months	<b>24</b>	KSPA/FBS

<sup>2</sup> As defined in the national guidelines on PMTCT

<sup>3</sup> As defined in the national guidelines on PMTCT

\* UNGASS Indicator

‡ MDG Indicator

LEVEL	INDICATORS	REF	DATA SOURCE
<b>MONITORING PROGRAMME LEVEL OUTPUTS</b>			
<b>PRIORITY AREA 1: PREVENTION OF NEW INFECTIONS</b>			
	Number of health care workers trained to provide PMTCT services	<b>25</b>	QPR
	Number of community health workers trained to support PMTCT services	<b>26</b>	QPR
	Number of facilities implementing PMTCT+	<b>27</b>	QPR
	% of facilities that submitted regular reports to National office	<b>28</b>	QPR
<b>VCT</b>	Number of health facilities/sites offering VCT services	<b>29</b>	QPR
	number of service providers trained to provide counselling on VCT	<b>30</b>	QPR
	Number of individuals who receive voluntary counselling and testing	<b>31</b>	QPR
	% of health facilities where VCT services are being offered with no test kit stock outs of > 1 week in last 12 months	<b>32</b>	KSPA/FBS
	% of VCT centres offering quality services in accordance with National VCT guidelines	<b>33</b>	KSPA/FBS
	Percentage of schools providing skills based HIV education and counselling services*	<b>34</b>	MPR
	Percentage of VCT service points meeting their reporting requirement	<b>35</b>	QPR
<b>Blood Safety</b>	% of transfused blood units screened for HIV according to national guidelines	<b>36</b>	NBTCR
	Number of service providers trained to procure and screen transfused blood units for HIV according to national guidelines	<b>37</b>	NBTCR
	% of facilities where blood transfusion services are being offered with reagent stock outs of > 1 week in last 12 months	<b>38</b>	NBTCR
	Percentage of blood transfusion centres that have quality assurance programme in place	<b>39</b>	KSPA/FBS

\* UNGASS Indicator

‡ MDG Indicator

LEVEL	INDICATORS	REF	DATA SOURCE
<b>MONITORING PROGRAMME LEVEL OUTPUTS</b>			
<b>PRIORITY AREA 1: PREVENTION OF NEW INFECTIONS</b>			
	% of blood demand met	<b>40</b>	NBTCR
	% blood donors who are voluntary donors	<b>41</b>	NBTCR
<b>BCC</b>	Number of condoms(male and female) distributed	<b>42</b>	MPR
	Number of HIV/AIDS radio/television programs produced and number of hours aired	<b>43</b>	MPR
	Number of booklets/brochures and posters produced and number of copies distributed	<b>44</b>	MPR
	Number of service providers trained to provide community outreach HIV/AIDS prevention programs	<b>45</b>	MPR
	Number of people reached through community outreach HIV/AIDS prevention programs	<b>46</b>	MPR
<b>PEP</b>	Number of health care workers trained on PEP	<b>47</b>	QPR
	Number of health facilities with operational PEP centres	<b>48</b>	QPR
	% of police officers sensitised on PEP for victims of sexual assault	<b>49</b>	QPR
	% ART sites with PEP and post-rape care centres	<b>50</b>	QPR
	% of Health workers trained on PEP with post-rape care services		QPR
LEVEL	INDICATORS	REF	DATA SOURCE
<b>MONITORING PROGRAMME LEVEL OUTPUTS</b>			
<b>PRIORITY AREA 2: IMPROVED QUALITY OF LIFE</b>			
<b>ART</b>	Number of persons with advanced HIV infection receiving ARV therapy and reproductive health strategy	<b>51</b>	QPR
	% of AIDS cases receiving ARV therapy*	<b>52</b>	QPR
	% of those eligible PLWHA receiving ART and reproductive health strategy who are women	<b>53</b>	QPR

\* UNGASS Indicator

‡ MDG Indicator

LEVEL	INDICATORS	REF	DATA SOURCE
<b>MONITORING PROGRAMME LEVEL OUTPUTS</b>			
<b>PRIORITY AREA 2: IMPROVED QUALITY OF LIFE</b>			
	Number of community health workers/volunteers/care givers trained to provide support to HIV infected people receiving ART	<b>54</b>	QPR
	Number of children receiving ART and Reproductive Health Strategy	<b>55</b>	QPR
	Number of HIV infected people supported to adhere to ART by community health workers/volunteers/care givers	<b>56</b>	QPR
	% of health facilities where ARV services are being offered with no ARV drug stock outs of > 1 week in last 12 months	<b>57</b>	KSPA/FBS
	% of those who started ARV within the year that are in first line treatment	<b>58</b>	QPR
	% of ART and Reproductive Health Strategy sites in the public sector that have a waiver system developed and fully operational.	<b>59</b>	QPR
	% of beds in public Health facilities that are occupied by HIV/AIDS patients	<b>60</b>	HIS
	% of those initiating ART that are at stage 4	<b>61</b>	QPR
	% of health facilities that are using the updated OI guidelines	<b>62</b>	QPR
<b>TB</b>	% of detected TB cases (by HIV status) who have successfully completed the treatment	<b>63</b>	NLTPR
	% TB patients offered HIV testing	<b>64</b>	NLTPR
	% of TB diagnostic Centres that are linked with Comprehensive Care Services (CCSs)	<b>65</b>	NLTPR
	% of HIV+TB patients receiving ART and Reproductive Health Strategy	<b>66</b>	NLTPR
<b>CARE</b>	% of health facilities with drugs for OIs in stock and no stock outs of > 1 week in last 12 months	<b>67</b>	KSPA/FBS
	Number of provincial hospitals with comprehensive care services	<b>68</b>	QPR

\* UNGASS Indicator

‡ MDG Indicator

LEVEL	INDICATORS	REF	DATA SOURCE
<b>MONITORING PROGRAMME LEVEL OUTPUTS</b>			
<b>PRIORITY AREA 2: IMPROVED QUALITY OF LIFE</b>			
	Number of district hospitals with comprehensive care services	<b>69</b>	QPR
	% of district hospitals with links to at least 4 health centres for continuum of care services	<b>70</b>	KSPA/FBS
	% of patients with CD4 count between 200 and 350 who move to ART	<b>71</b>	QPR
	Number of civil society organizations supported in HBC per district	<b>72</b>	MPR
	% of PLWHA receiving HBC services in accordance with the guidelines	<b>73</b>	MPR
	Number of eligible people on ART provided with nutritional supplements	<b>74</b>	QPR
	Number of community volunteers/health workers/family care givers trained to provide HBC	<b>75</b>	QPR
	% of Health facilities that provide CCCs that are linked to community-based care networks	<b>76</b>	QPR
	Number of people provided with HBC	<b>77</b>	QPR
	Number of anti-stigmatization advocacy groups established per district	<b>78</b>	MPR
	% of health workers in health provider institutions sensitized on developing positive attitudes towards PLWHA	<b>79</b>	KSPA/FBS
	Number of households affected by HIV/AIDS that have benefited from income generating activities (IGA)	<b>80</b>	MPR
	% of those receiving ART in public, mission and NGO sites who need nutritional supplements, receive nutritional supplements	<b>81</b>	KSPA/FBS
<b>Human rights</b>	% of population expressing accepting attitudes towards PLWH/As	<b>82</b>	KDHS/BSS/LQAS
	% of Kenyans aware of ART services	<b>83</b>	KDHS/BSS/LQAS
	Number of service providers (lawyers, magistrates and paralegals) that have received training on the rights of PLWHA	<b>84</b>	MPR

\* UNGASS Indicator

¥ MDG Indicator

LEVEL	INDICATORS	REF	DATA SOURCE
<b>MONITORING PROGRAMME LEVEL OUTPUTS</b>			
<b>PRIORITY AREA 2: IMPROVED QUALITY OF LIFE</b>			
	Number of health care workers that have been sensitised on positive attitudes towards PLWHA	<b>85</b>	QPR
	Number of court cases that have been registered that deal with violations of the rights of PLWHA	<b>86</b>	MPR
	Number of PLWHA receiving training to write & register their wills	<b>87</b>	MPR
	Number of PLWHA that have received skills-training on Human rights related advocacy	<b>88</b>	MPR
	Number of magistrates per district trained on rights of people infected and affected by HIV/AIDS	<b>89</b>	MPR
	% of PLWHA trained in will writing skills	<b>90</b>	MPR
	% of orphans and vulnerable children that have access to protection of food, shelter, education and health	<b>91</b>	LQAS/MPR
LEVEL	INDICATORS	REF	DATA SOURCE
<b>MONITORING PROGRAMME LEVEL OUTPUTS</b>			
<b>PRIORITY AREA 3 : MITIGATION</b>			
<b>OVC</b>	Number of community volunteers/health workers/family care givers trained to provide support to OVC	<b>92</b>	QPR
	Number of OVC enrolled in care and support programmes supported through the provision of any of the following: medical services, school fees, uniform, food or psychosocial support	<b>93</b>	QPR
	Number of households with OVC that have benefited from income generating activities (IGA)	<b>94</b>	QPR
	Ratio of current school attendance among orphans to that among non-orphans aged 10–14*‡	<b>95</b>	KDHS/LQAS
	% of programmes at constituency level that are focused on mitigation of socio-economic impact of HIV/AIDS	<b>96</b>	MPR
	% of orphans that have access to education	<b>97</b>	LQAS/MPR

\* UNGASS Indicator

‡ MDG Indicator

LEVEL	INDICATORS	REF	DATA SOURCE
<b>MONITORING PROGRAMME LEVEL OUTPUTS</b>			
<b>PRIORITY AREA 3 : MITIGATION</b>			
<b>Mainstreaming</b>	% of line ministries with HIV/AIDS workplace policies and programmes	<b>98</b>	Workplace survey
	% of large enterprises/companies that have HIV/AIDS workplace policies and programmes	<b>99</b>	Workplace survey
LEVEL	INDICATORS	REF	DATA SOURCE
<b>MONITORING PROGRAMME LEVEL OUTPUTS</b>			
<b>PRIORITY AREA 4 : NATIONAL MANAGEMENT AND COMMITMENT</b>			
<b>NMC</b>	Amount of national funds spent by GOK on HIV/AIDS*	<b>100</b>	UNAIDS/UNFPA/NIDI survey on financial resources flows
	National Composite Policy Index*	<b>101</b>	NCPI questionnaire
<b>PRIORITY AREA 5 : MONITORING AND EVALUATION</b>			
<b>M &amp; E</b>	% of organisations that have submitted the required number of completed Program activity report forms on time to NACC in the past 12 months	<b>102</b>	NACC program activity database
	% of data sources due in the past 12 months that have been delivered to the NACC on time	<b>103</b>	Annual M & E report

\* UNGASS Indicator

‡ MDG Indicator

# ANNEX 1

## LIST OF ORGANISATIONS AND INDIVIDUALS WHO PARTICIPATED IN DEVELOPMENT OF NATIONAL HIV/AIDS MONITORING AND EVALUATION FRAMEWORK

National AIDS Control Council; National AIDS/STI Control Programme; The Ministry of Health; The Ministry of Planning and National Development; The Central Bureau of Statistics; The Ministry of Home Affairs and National Heritage; The Ministry of Local Government; The Ministry of Education, Science and Technology; The National Coordinating Agency of Science and Technology; The Ministry of Tourism; The Kenya Medical Association; The U.S. Centres for Disease Control and Prevention; Family Health International; The National Coordinating Agency for Population and Development; representatives of community-based organizations and faith-based organizations; Federation of Kenya Employees; The University of Nairobi; Ministry of Justice and Constitutional Affairs; U.S. Government President's Emergency Plan for AIDS Relief; The Kenya Medical Research Institute; Japanese International Cooperation Agency,UNAIDS, World Bank and UNICEF.

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**maisha!**

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