REPUBLIC OF KENYA

MINISTRY OF HEALTH

National Strategic Plan for Tuberculosis, Leprosy and Lung Health 2015-2018

Monitoring and Evaluation Framework

Acknowledgements

The National Leprosy, Tuberculosis and Lung Disease Program (NTLD-Program) provided the framework on which many stakeholders worked to develop a comprehensive national plan to monitor the implementation of the national response to the control and prevention of Tuberculosis, Leprosy and Lung Disease. Many individuals and organizations contributed immensely to the development of this plan by providing time, technical expertise and finances. In particular, the following organizations deserve special mention and deeply felt thanks for their contribution in the development of this Monitoring and Evaluation plan:

- Ministry of Health
- National HIV/AIDS and STI Control Programme (NASCOP)
- World Health Organization (WHO)
- United States Agency for International Development (USAID)
- Centre for Health Solutions - Kenya (CHS)
- Amref Health Africa
- Management Sciences for Health (MSH)
- PATH
- Kenya Association for the Prevention of Tuberculosis and Lung Disease (KAPTLD)
- Kenyatta National Hospital (KNH)
- Kenya AIDS NGOs Consortium (KANCO)
- Kenya Medical Research Institute (KEMRI)
- Centers for Disease Control and Prevention (CDC)
- International Organization for Migration (IOM)
- Japanese Agency for Cooperation (JICA)
- Tuberculosis Action Consortium (TAC)

In addition the NTLD-Program wishes to acknowledge the individuals who participated in the workshops, which initiated and finally developed this document. The list of these individuals is provided in Appendix IV.

A core writing team synthesized the presentations and coordinated the discussions that led to the production of this Plan through an intensive four (4) month period. This team consisted of the NSP Secretariat and members of the TB ICC Monitoring/Evaluation Technical Working Group.

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November 2014

PREFACE

Kenya has made significant gains in its efforts to control and prevent Tuberculosis, Leprosy and Lung Disease in the past few years, however much still needs to be done to ensure that these diseases are controlled and eventually eliminated. With the coming into force of this revised strategic plan 2015-2018 concerted efforts needs to be put together to adequately monitor the progress towards the set milestones and targets. This monitoring and evaluation plan builds on an integrated approach to monitoring all the diseases the NTLD-Program is mandated to control and prevent and leverages on the limited available resources.

This plan clearly identifies and defines all standard indicators that will be reported and or measured at national level, including baseline and targets for each indicator while clearly indicating the measurement methods, which are in line with the internationally acceptable standards. As a move towards an integrated approach the plan describes existing systems in place/plans to develop systems to collect data for measuring impact/outcome indicators and programmatic indicators. It is worthwhile to note that this plan fits into the Health Ministry strategic plan, which is also aligned to the Country's Medium Term development plan.

It important to note that NTLD-Program has been implementing and will continue to implement sound policy and data driven interventions and how evaluations, reviews, survey, surveillance, or special studies will be carried out has been clearly outlined including how systematic collection, data quality assurance and analysis of data to make decisions will be carried out.

Critical to sound monitoring and evaluation is the coordination mechanisms (including management structures and roles, which have been clearly delineated and defined in this plan while outline for capacity building initiatives have been outlined.

The M&E Program within NTLD-Program is working towards putting in place systems to monitor and evaluate programme activities and finances. The major challenge of this unit is to ensure adequate monitoring for the rapidly growing programme. This M&E plan is designed to help the NTLD-Program improve management of the unit and information flow to the various stakeholders including the Ministries of Health, partners and Tuberculosis international communities.

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November 2014

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Abbreviations

ACSM – Advocacy, Communication and Social Mobilization
ARTI – Annual Risk of Tuberculosis Infection
ART – Antiretroviral Therapy
CDC – Centers for Disease Control and Prevention
CDR – Case Detection Rate
CNR – Case Notification Rate
CRL – Central Reference Tuberculosis Laboratory
CTLC- County TB and Leprosy Coordinator
CU - Central Unit
CMLT – County Medical Laboratory Technologist
DMOH – District Medical Officer of Health
DOTS – Directly Observed Therapy Short Course
DST – Drug Susceptibility Test
EQA – External Quality Assurance
GFATM – Global fund for AIDS, Tuberculosis and Malaria
IUATLD – International Union Against Tuberculosis And Lung Disease
KAP – Knowledge, Attitude and Practice
KAPTLD – Kenya Association For Prevention Of Tuberculosis And Lung Disease
KEMRI – Kenya Medical Research Institute
KNH – Kenyatta National Hospital
M&E – Monitoring and Evaluation
MDR TB – Multi-drug Resistant Tuberculosis
NTLD-Program – National Tuberculosis, Leprosy and Lung Disease Program
SCTLC- Sub- County TB and Leprosy Coordinator
SCMLT – Sub-County Medical Laboratory Technologist
SMART – Specific, Measurable, Achievable, Realistic and Time Bound
WHO – World Health Organization
PATH - Programme for Appropriate Technology in Health
HMIS - Health Management Information System

Abbreviations of anti-tuberculosis drugs

Ami	Amikacin
E	Ethambutol
Eth	Ethionamide
H	Isoniazid
Lfx	Levofloxacin
Ofx	Oflaxacin
PAS	Para-aminosalicilic acid
Pt	Prothionamide
R	Rifampicin
S	Streptomycin
Z	Pyrazinamide

CHAPTER 1

1.0 Introduction

This document presents the plan for monitoring and evaluating all the programmatic activities undertaken by the National Leprosy, TB and Lung Disease - Program (NTLD-Program) in Kenya. Specifically, it contains the basic elements of a standard DOTS and DOTS plus programme monitoring effort (according to internationally recognized guidelines from global STOP TB partnership), as well as specific monitoring needs for the Kenyan context and the NTLD-Program mandate. The main aspects of evaluation of the program are focused on improving performance and understanding the main strengths and weaknesses of the programme, but the Unit is also beginning to focus on areas of impact of different parts of the interventions to improve efficiency and overall outcomes.

The basic logical framework for the M&E plan is given in Figure 1, and is adapted from the international standard logical framework for M&E of Tuberculosis programs. After the presentation of this figure and a brief description of the Unit and its organization, the rest of the document contains 7 sections. These sections follow the guidelines for a national M&E plan given by the Global Fund for AIDS TB and Malaria. These sections include:

1. Indicator definitions and measurement: This section defines all standard indicators that will be reported or measured at national level, including baseline and targets for each indicator and defines measurement methods (timeline/frequency of data collection, responsible body, and data source).

2. Routine data collection, analysis and reporting: This section describes existing systems in place/plans to develop systems to collect data for measuring impact/outcome indicators and programmatic indicators.

3. Evaluation, reviews, survey, surveillance, or special studies: This section of the deals with activities that involve systematic collection and analysis of data to supplement routinely collected data to make sound decisions.

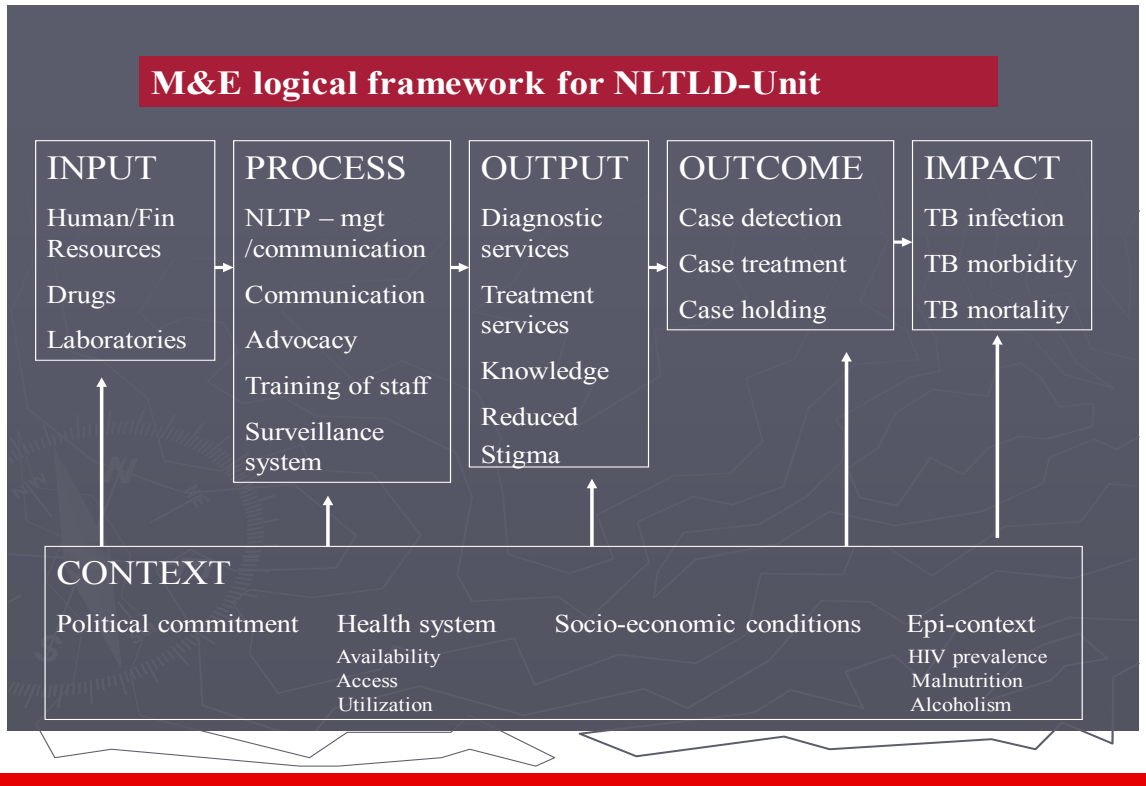
4. Data quality assurance mechanisms and related supportive supervision: This section include practices and mechanisms required for ensuring data quality.

5. M&E coordination: This section captures coordination mechanisms (including management structures and roles.

6. Capacity building: This section covers the aspects of human resource and capacity building.

7. M&E budget and work plan

Figure 1. Generic logical framework for M&E of TB programmes



1.1 Background

The NTLD-Program has grown rapidly in the last decade due to increased mandate and number of TB control interventions, with a growing budget and scope of activities, the programme has required an increase in capacity to monitor and evaluate its activities. This is beginning to be achieved through an increase and training of staff, an improvement data quality and use, an increase in technical assistance in specific areas of M&E, and an expansion of the basic data management system and M&E personnel working in the programme.

At the Program, there is a functional Monitoring and Evaluation Unit that is within the Research Policy and Planning (PPR) section. The Program is now developing systems to monitor and evaluate programme activities and financial management systems. While much has been achieved, there still remain many challenges as the programme continues to grow and require more accurate and rapid monitoring.

This M&E plan is designed to help the Unit improve management of its interventions and information flow to various stakeholders including the Government, partners, donors and international Tuberculosis communities. This plan is designed to monitor the NTLD-Program's four-year National Strategic Plan 2015 – 2018. It is important to note that this Strategic Plan will be implemented in a devolved system of Government where certain interventions are county specific thus calling for more focused and specific monitoring and evaluation activities.

1.2 Organization of The National Tuberculosis, Leprosy and Lung Disease Program

To achieve the long-term objectives of the NTLD-Program, activities for the reduction of the burden of Tuberculosis (TB), Leprosy and lung diseases will need to be carried out across the whole country with some of the interventions being County specific as they have been clearly articulated in the Strategic Plan. These services must be appropriate, accessible, affordable and acceptable to the affected population.

The most effective and efficient way to implementing TB, Leprosy and lung disease control activities is by fully integrating them within the general health service. Case finding, infection control and treatment can be carried out at most health facilities and Para-Medical workers can perform case holding activities such as supervision of treatment and defaulter tracing. Emphasis is being placed on involving all care providers including Faith Based Organizations (FBOs), the private health sector and communities at all levels.

Although TB, Leprosy and lung disease services are integrated within the general health services, the NTLD-Program has specialized staff deployed full time at National level. At the County and sub-county levels, there are staff who are specifically dedicated to provide technical assistance in the control and prevention of TB, Leprosy and lung diseases. The technical assistance takes the form of co-ordination and supervision of these services and therefore maintaining the quality of care at service delivery points and in the community.

1.2.1 National Level

At the national level, the NTLD-Program currently falls in the Division of Disease Prevention and Control, which is in the Directorate of Preventive and Promotive Services in the Ministry of Health (MoH) as shown in Figure 2.

The NTLD Central Unit is based at the MoH Headquarters and it is responsible for the overall management of the Unit and establishing linkages with other Units in the Ministry. The NTLD Central Unit currently consists of the Head of the Unit supported by Heads of Sections. The NTLD-Program collaborates closely with National HIV and STI Control Programme (NASCOP) in the delivery of TB/HIV services and as such, there is a TB/HIV Coordinator at the NTLD-Program and a HIV/TB Coordinator at NASCOP who ensure that there is implementation of TB/HIV services at all levels.

At the county and sub-county levels, the coordinators of the two units work closely together and hold regular TB/HIV collaborative meetings to review the implementation TB/HIV activities at their respective levels. There are currently efforts towards the integration of TB and HIV services at the facility level, and where this has not been done, referral mechanisms have been well established at the health facilities.

Roles and responsibilities at National level

- Develop, review and disseminate policy documents, treatment guidelines, operation manual and any other relevant guidelines related to TB, Leprosy and lung diseases
- Design and develop trainings and training materials
- Develop standard data collection and reporting tools
- Annual forecasting and quantification of TB, Leprosy and lung disease commodities
- Establish standards for quality of all TB, Leprosy and lung disease services, commodities and equipment
- Provide technical assistance on TB, Leprosy and lung disease services at all levels
- Collate national data, compile and disseminate reports to the relevant Ministries, partners and cooperating organizations
- Advocate and mobilize for TB control and Leprosy elimination resources
- Identify and facilitate operational research and assessments
- Promote linkages and collaborate with County governments, programs and partners.

Reporting

- The NTLD-Program is responsible for the development of reporting tools in respect to global requirements
- The Unit reports disease data to relevant state departments for planning and policy formulation and since the disease should be notified, the Unit submits reports to WHO and other collaborating partners including the Counties
- The unit facilitates dissemination of information through stakeholder forums.
- The Unit designs standard data collection and reporting tools for all levels of reporting (national, county, sub-county and facility)

1.2.2 County Level

With the devolved structure of government, the county will be responsible for the following roles and responsibilities:

- Supervising TB/Leprosy and lung disease activities in the sub county and peripheral health facilities to each sub county within his/her jurisdiction at least once per month.
- Planning and budgeting of TB/Leprosy and lung disease activities in collaboration with the Sub county TB, Leprosy coordinators.
- Consolidating order and re-distributing drugs for the sub counties and maintaining adequate stocks at both county and sub county level.
- Ensuring uninterrupted drug supply in consultation with county pharmacist.
- Managing the TB/Leprosy and lung disease finances at county and sub county t levels.
- Ensuring adequate transport facilities for the implementation of planned TB/Leprosy and lung disease activities at county and sub county t levels.
- Initiating, designing and implementing various training programs for county and sub county level health care staff.
- Monitoring and evaluating TB/Leprosy and lung disease activities carried out at the sub county level.
- Initiating and participating in operational research.
- Advocating for best practices in TB, Leprosy and lung disease management among doctors and other general health workers in the county, NGO, private health services and the community.
- Collating reports, analyzing, validating TB/Leprosy and lung disease data from the sub county and compiling reports for sharing with the county and forwarding to the NTLD-Program.
- Providing feedback to the ZTLC /SCTLC and other partners on the analysis of data related to TB/Leprosy and lung disease activities within the county.
- Participating in quarterly intergovernmental meetings and the bi-annual county meetings.
- Advocacy of CHMT and other authorities at county level.
- Co-operation/Co-ordination with other programs at county level.
- Consolidating ZTLCs/SCTLC clinic and supervision schedules and forwarding to the county director for health
- Participating in the county TB/HIV technical groups meeting and activities.
- Resource mobilization for TB/ leprosy, and Lung disease activities within the sub county.
- Convening and coordinating stakeholders' activities.

1.2.3 Sub-County Level

At the Sub County level, the Unit activities are coordinated and supervised by the SCTLCs. Part of the SCTLCs time is devoted to actual diagnosis and treatment of patients. It is recommended that as much as possible, direct clinical work by SCTLCs should be done on a consultancy basis. For technical matters, the SCTLCs are responsible to the CTLCs, and administratively fall under the County Director of Health.

The tasks of SCTLCs are to:

- Carry out support supervisory visits to all health units involved in the diagnosis and treatment of leprosy, tuberculosis and lung patients at least once a month.
- Prepare reports on each supervisory visit, providing feedback of achievements and constraints to the facility visited and keeping filed copies.
- Provide technical assistance to peripheral health workers.
- Verify diagnosis and treatment regimen of cases identified by peripheral health staff, during clinic visits and ward rounds.
- Refer complicated cases to Medical Officer, Physician or the CTLC
- Identify and refer leprosy patients in need of reconstructive surgery
- Verify whether patients are receiving regular and appropriate treatment according to the treatment guidelines.
- Ensure that the peripheral health staff organize defaulter tracing effectively and that the responsible persons adequately fill the defaulter tracing form.
- Ensure that contact tracing, active case finding and infection control strategies are being organized and effectively implemented by the peripheral health staff
- Observe the performance of the peripheral health staff, in relation to patient care, health education and providing advice and on-the- job training during supervisory visits to clinics and wards.
- Organize, conduct or participate in seminars and workshops for peripheral health staff, community health workers, and laymen.
- Initiate and co-coordinate public awareness campaigns for the general public including public barazas, school visits, radio talks, theatre groups etc.
- Verify the clinic records and update the data onto the TIBU system.
- Provide quarterly progress reports to the CTLC, MOH, and other partners based on the supervision reports and data analysis.
- Collect samples of slides quarterly for External Quality Assurance (EQA) from peripheral facilities and forward to the district medical laboratory technologist [SCMLT].
- Verify with the sub-county medical laboratory technologist the data in the laboratory register corresponds to district TB register.
- Maintain sufficient stocks of drugs and other supplies at district level.
- Ensure that the assigned motorcycle/vehicle is maintained in good working condition.
- Prepare annual work plan and related budget together with the SCMOH/CTLC, based on data analysis and supervisory reports.
- Prepare an annual clinic and supervision schedule by November of each year and distributing the schedule to all health facilities in the district. Copies of this schedule should be forwarded to the CTLC and the SCMOH.
- Participating in quarterly SCTLC meetings.
- Participate actively in the district health management team

meetings and activities
- Network with sub county based partners in close collaboration with CTLC and SCMOH
- Identify key areas or institutions for the expansion of TB, Leprosy and lung disease services in close collaboration with CTLC and SCMOH
- Identify training needs for the health providers and the community in the district and channel the information through CTLC and SCMOH for appropriate action
- Participate in the district and provincial stakeholders' meetings
- Conduct refresher trainings for peripheral health workers.

1.2.4 Health Facilities

Most government health facilities are involved in unit activities as well as some FBOs, communities and private health care units. As part of the day-to-day medical work, the health care workers in these facilities are responsible for case finding, infection control and treatment of TB, leprosy and lung disease patients.

To effectively perform these tasks, they receive technical and logistical support from the SCTLCs/CTLCs. Support includes training, technical assistance [TA] and supply of drugs and other items.
The tasks of peripheral health care staff, in relation to TB and leprosy control are to:
- Identify leprosy, TB and lung disease suspects and carry out relevant clinical procedures to diagnose these diseases.
- Start patients diagnosed with TB, Leprosy or lung disease on appropriate treatment.
- Register TB or leprosy patients in the treatment register.
- Ensure laboratory results are adequately entered in to the right registers
- Refer those suspects where there is a doubtful diagnosis to the SCTLC or any qualified physician for further evaluation and management
- Dispense drugs to patients according to treatment guidelines
- Prepare and fill defaulter tracing form and trace patients who have defaulted from treatment in close collaboration with CHEWs and other community based health providers
- Participate in active case finding campaigns, infection control and other activities including contact tracing for new leprosy and tuberculosis cases
- Treat uncomplicated wounds of leprosy patients and teaching them self-care.
- Refer patients with severe complications of disease or its treatment to the SCTLCs or other relevant/senior clinician.
- Participate in advocacy, communication and social mobilization for TB, Leprosy and lung disease prevention and control.
- Provide patient education to both leprosy and tuberculosis patients.
- Complete and update patient -record cards, treatment registers and drug ledgers
- Ensure timely ordering of TB and Leprosy commodities to maintain sufficient stocks of drugs, health education materials, laboratory supplies and stationery (registers, forms, patient cards, etc.) at the health facility.
- Ensure the community in the catchments area of the clinic receives adequate health education regularly.
- Network with partners working in the facility area on TB and Leprosy service delivery
- Give adequate and prompt information to facility in-charge and SCTLC on issues affecting TB, Leprosy and lung disease management in the facility and the community around
- Participate and give feedback to facility health management team on TB and Leprosy issues.
- Should be regularly updated on TB, Leprosy and lung disease.
- Provide diagnostic testing and counseling [DTC] activities for TB and Leprosy patients

1.3 Organization of TB/Leprosy Clinics

In each facility where TB, leprosy and lung disease patients attend for treatment, one or two members of staff should be responsible for running the TB/leprosy clinic. They are selected primarily on the basis of their interest in tuberculosis and leprosy and in the light of their empathy with patients having these diseases. Patients on intensive phase should collect drugs weekly. And those in the continuation phase should be seen once every two weeks. Therefore, each unit is expected to have clinic day for both intensive and continuation phases. The clinic day should run on a weekly and 14 days (2 weeks) cycle for intensive and continuation phases respectively.

Patients on re-treatment and MDR-TB treatment should have their DOT in intensive phases undertaken at health facility daily.

CHAPTER 2

Indicator Definitions and Measurement

2.0 Background

The vision and mission of the National Strategic Plan for Tuberculosis, Leprosy and Lung disease between 2015 and 2018 are as follows:
Vision: To reduce the burden of lung disease in Kenya and render Kenya free of Tuberculosis and Leprosy.

Mission: To accelerate the reduction of TB, leprosy and lung disease burden through provision of people-centered, universally accessible, acceptable and affordable quality services in Kenya.

Objectives of the NSP

Within the context of a newly devolved health system, the goal of the 2015-2018 NSP is to accelerate the reduction of TB, leprosy and lung disease burden through provision of people-centered, universally accessible, acceptable and affordable quality services in Kenya. Specific objectives include:

a) Sustain the gains made over the past decade, in the context of a newly devolved health system
b) Intensify efforts to find the "missing" cases of TB, leprosy and lung disease;
c) Reduce transmission of TB and leprosy;
d) Prevent active disease and morbidity; and
e) Enhance the quality of care for chronic diseases

Impact and Outcome Targets

The NSP seeks to achieve the following by 2018:

Impact and key outcome Indicators
Impact 1. Reduce the incidence of TB by 5% by 2018, compared to 2014
Outcomes
1. Increase case notification of new cases to 85% of estimated prevalence
2. Ensure treatment success of at least 90% among all drug – susceptible forms of TB
Impact 1.1. Reduce the prevalence of MDR-TB among new patients by 15% by 2018, compared to 2014
Outcomes
1. Increase case notification of MDR-TB to at least 75% of estimated prevalence (baseline TBD: DR survey)
2. Increase treatment success rate to at least 80% among all cases of DRTB
Impact 1.2. Reduce the incidence of TB among PLHIV by 60% by 2018, compared to 2014
Outcomes
1. Increase treatment success rate to 85% among all HIV-infected TB patients
2. Reduce case fatality among HIV-infected TB patients to <5%
Impact 2. Reduce mortality due to TB by 3% by 2018, compared to 2014
Outcomes
1. Ensure treatment success of at least 90% among all DS forms of TB
2. Reduce case fatality among HIV-infected TB patients to <5%

Impact 3. Reduce the proportion of affected families who face catastrophic costs due to TB, leprosy & other lung diseases, by 2018 (baseline TBD)
Outcomes
1. Increase to at least 60% the proportion of eligible TB and leprosy patients who access nutritional support or other transport, or financial subsidies
2. Reduce out-of-pocket expenditures attributed to TB care seeking
Impact 4. Reduce by 50% the proportion of cases with grade 2 disability due to leprosy by 2018
Outcomes
1. Increase to 90% the proportion of leprosy patients notified prior to grade 2 disability
Impact 5. Reduce morbidity due to chronic lung diseases (e.g. COPD, asthma)
Outcomes
1. Reduce the average number of annual acute episodes for children with asthma by 15% in areas with established asthma clinics
2. Increase to 80% the proportion of controlled asthma patients

The indicators outlined below observe the following characteristics:

- Definition of standard indicators measured at national level,
- Definition of numerators and denominators,
- Definition of measurement methods (timeline/frequency of data collection, responsible body, and data source).

Table 1: Indicator Definitions, Measurements and Targets

CORE TB											
NO	**INDICATOR**	**INDICATOR DEFINITION**	**SOURCE**	**FREQUENCY**	**RESPONSIBLE ORGANIZATION**	**RESPONSIBLE PERSON**	**BASELINE TARGETS**	**YEAR 1**	**YEAR 2**	**YEAR 3**	**YEAR 4**
1	TREATMENT SUCCESS RATE (TSR)	NUMERATOR: NUMBER OF SMEAR POSITIVES CURED AND TREATMENT COMPLETE DENOMINATOR: TOTAL NUMBER OF SMEAR POSITIVES	ANNUAL REPORT	ANNUALLY	NTLD	M/E OFFICER	88%	88.5%	89%	89.5%	90%
2	NUMBER OF TB CASES (ALL FORMS) NOTIFIED TO THE NATIONAL PROGRAM	NUMBER OF TB CASES (ALL FORMS) NOTIFIED TO THE NATIONAL PROGRAM	QUARTERLY REPORT ON TB CASE REGISTRATION IN DISTRICT	QUATERLY	NTLD	M/E OFFICER	89,759	87,181	83,707	80,233	76,759
3.	PROPORTION OF COUNTIES PROVIDED WITH BI-ANNUAL TECHNICAL ASSISTANCE FROM THE NATIONAL OFFICE	NUMERATOR: NUMBER OF COUNTIES PROVIDED WITH QUARTERLY TECHNICAL ASSISTANCE FROM THE NATIONAL OFFICE	PROGRAMME REPORTS	BI-ANNUAL	NTLD	HEAD OF CARE	0	100%	100%	100%	100%
4	PROPORTION OF TB TREATMENT SITES PROVIDED WITH SUPPORT SUPERVISION AT LEAST ONCE QUARTERLY BY SUB COUNTY COORDINATORS PROGRAMME REPORTS	NUMERATOR: NUMBER OF TB TREATMENT SITES PROVIDED WITH SUPPORT SUPERVISION AT LEAST ONCE QUARTERLY BY SUB COUNTY COORDINATORS DENOMINATOR: TOTAL NUMBER OF TB TREATMENT SITES	PROGRAMME REPORTS	QUARTERLY	NTLD	M/E OFFICER	ALL	100%	100%	100%	100%

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQUENCY	RESPONSIBLE ORGANIZATION	RESPONSIBLE PERSON	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
5	PROPORTION OF SUB COUNTIES PROVIDED WITH QUARTERLY SUPPORT SUPERVISION BY COUNTY COORDINATORS	NUMERATOR: NUMBER OF SUB COUNTIES PROVIDED WITH QUARTERLY SUPPORT SUPERVISION BY COUNTY COORDINATORS	PROGRAMME REPORTS		M/E OFFICER	ALL	100%	100%	100%	100%	
6	RETENTION OF ISO CERTIFICATE BY NATIONAL TB PROGRAM	ABSOLUTE NUMBER	PROGRAMME REPORTS	BI-ANNUALLY	NTLD - PROGRAM	HEAD NTLD-PROGRAM	ALL	1	1	1	1
7	PROPORTION OF RETREATMENT PATIENTS ON CATEGORY II REGIMEN	NUMERATOR: NUMBER OF RETREATMENT PATIENTS ON CATEGORY II REGIMEN DENOMINATOR: TOTAL NUMBER OF RETREATMENT PATIENTS	PROGRAMME REPORTS	QUARTERLY	NTLD - PROGRAM	M/E OFFICER	100	100	80	60	40
8	PROPORTION OF CONTACTS OF SMEAR POSITIVE TB PATIENTS TRACED AND SCREENED FOR TB	NUMERATOR: NUMBER OF CONTACTS OF SMEAR POSITIVE TB PATIENTS TRACED AND SCREENED FOR TB DENOMINATOR: TOTAL NUMBER OF CONTACTS OF SMEAR POSITIVE TB PATIENTS	PROGRAMME REPORTS	QUARTERLY	NTLD - PROGRAM	HEAD OF CARE	0	0	60%	80%	>80%
9	PROPORTION OF HEALTH FACILITIES SCREENING COUGHERS FOR TB	NUMERATOR: NUMBER OF HEALTH FACILITIES SCREENING COUGHERS FOR TB DENOMINATOR: TOTAL NUMBER OF HEALTH FACILITIES	PROGRAMME REPORT	QUARTERLY	NTLD-PROGRAM	HEAD OF CARE	100%	100%	100%	100%	100%

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQUENCY	RESPONSIBLE ORGANIZATION	RESPONSIBLE PERSON	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
10	PROPORTION OF PRESUMPTIVE TB CASES WITH BACTERI-OLOGICAL INVESTI-GATION FOR ACTIVE TB	NUMERATOR: NUMBER OF PRESUMPTIVE TB CASES WITH BACTERIOLOGICAL INVESTIGATION FOR ACTIVE TB DENOMINATOR: TOTAL NUMBER OF PRESUMPTIVE TB CASES	PROGRAMME REPORT	QUARTERLY	NTLD-PROGRAM	HEAD OF CARE			100%	100%	100%
11	PROPORTION OF TB PATIENTS STARTED ON TREATMENT WHO ARE LOSS TO FOLLOW-UP	NUMERATOR: NUMBER OF TB PATIENTS STARTED ON TREATMENT WHO ARE LOSS TO FOLLOW-UP DENOMINATOR: TOTAL NUMBER OF PATIENTS STARTED ON TREATMENT	PROGRAMME REPORT	QUARTERLY	NTLD-PROGRAM	HEAD OF CARE		6%	5.5%	5%	4.5%
12	PROPORTION OF HEALTH FACILITIES REPORTING NO DELAY OF MORE THAN 1 DAY IN SENDING OUT SPUTUM SAMPLES FOR TB DIAGNOSIS	NUMERATOR: NUMBER OF HEALTH FACILITIES REPORTING NO DELAY OF MORE THAN 1 DAY IN SENDING OUT SPUTUM SAMPLES FOR TB DIAGNOSIS DENOMINATOR: TOTAL NUMBER OF HEALTH FACILITIES	QUALITY OF CARE ASSESSMENT REPORT	BIENNIALLY	NTLD-PROGRAM	HEAD OF CARE				80%	
13	PROPORTION OF ELIGIBLE HEALTH FACILITIES SCREENING FOR TB IN AT LEAST DIABETIC CLINICS	NUMERATOR: NUMBER OF ELIGIBLE HEALTH FACILITIES SCREENING FOR TB IN AT LEAST DIABETIC CLINICS DENOMINATOR: TOTAL NUMBER OF ELIGIBLE HEALTH FACILITIES	PROGRAMME REPORT	QUARTERLY	NTLD - PROGRAM	HEAD OF CARE	0	0	80%	85%	90%

TB/HIV											
NO	**INDICATOR DEFINITION**	**INDICATOR DEFINITION**	**SOURCE**	**FREQUENCY**	**RESPONSIBLE ORGANIZATION**	**RESPONSIBLE PERSON**	**BASELINE TARGETS**	**YEAR 1**	**YEAR 2**	**YEAR 3**	**YEAR 4**
1	PROPORTION OF COUNTIES WITH ACTIVE TB/HIV COORDINATING BODIES	NUMERATOR: ALL COUNTIES IN KENYA WITH TB/HIV COORDINATING BODIES MEETING AT LEAST ONCE EVERY QUARTER DENOMINATORS: ALL COUNTIES IN KENYA	MINUTES OF THE MEETINGS	QUARTERLY DURING DATA REVIEW MEETINGS	NTLD-PROGRAM/ NASCOP	CTLCS	0	25%	80%	100%	100%
2	PROPORTION OF FACILITIES REPORTING ON ALL TB/HIV INDICATORS MONTHLY THROUGH THE NATIONAL REPORTING SYSTEM (DHIS)	NUMERATOR: ALL HEALTH FACILITIES IN KENYA REPORTING ALL TB/HIV INDICATORS MONTHLY DENOMINATORS: ALL HEALTH FACILITIES IN KENYA	DHIS REPORT	QUARTERLY DESK REVIEW OF DHIS	NTLD-PROGRAM	M&E OFFICER/ TB-HIV FOCAL PERSON	25%	80%	>90%	>90%	>90%
3	PROPORTION OF HIV/AIDS TREATMENT HEALTH FACILITIES PROVIDING IPT FOR ELIGIBLE PLHIV	NUMERATOR: NUMBER OF HIV/ AIDS TREATMENT SITES IN KENYA WITH IPT PROGRAM FOR PLHIV WITH NO SIGNS FOR TB DENOMINATORS: NUMBER OF HIV/ AIDS TREATMENT SITES IN KENYA	SCTLC REPORTS	QUARTERLY DURING DATA REVIEW MEETINGS	NTLD-PROGRAM	SCTLCS		25%	50%	80%	100%
4	PROPORTION OF ELIGIBLE PLHIV PROVIDED WITH IPT	NUMERATOR: NUMBER OF PLHIV WITH NO SIGNS FOR TB PROVIDED WITH IPT DENOMINATORS: NUMBER OF PLHIV WITH NO SIGNS FOR TB	DHIS/TIBU	QUARTERLY	NTLD-PROGRAM	M&E OFFICER/ TB /HIV FOCAL PERSON		25%	50%	80%	>80%

NO	INDICATOR DEFINITION	INDICATOR DEFINITION	SOURCE	FREQUENCY	RESPONSIBLE ORGANIZATION	RESPONSIBLE PERSON	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
5	PROPORTION OF CHILDREN UNDER 5 WHO ARE CONTACTS OF SMEAR POSITIVE TB PATIENTS PUT ON IPT	NUMERATOR: NUMBER OF CHILDREN UNDER 5 EXPOSED TO SMEAR POSITIVE TB PUT ON IPT DENOMINATORS: NUMBER OF CHILDREN UNDER 5 EXPOSED TO SMEAR POSITIVE TB	DHIS/TIBU	QUARTERLY	NTLD-PROGRAM	M&E OFFICER/ TB /HIV FOCAL PERSON		25%	50%	80%	>80%
6	NUMBER AND TYPE OF AGGREGATE SETTINGS WITH IPC COMMITTEES	ABSOLUTE NUMBER: THESE ARE AGGREGATE SETTINGS (REFUGEE CAMPS, PRISON, BOARDING SCHOOLS) WITH IPC COMMITTEES HOLDING QUARTERLY MEETINGS	MINUTES OF THE IPC COMMITTEE MEETINGS	QUARTERLY DURING DATA REVIEW MEETINGS	NTLD-PROGRAM	SCTLCS		5	10 PRISONS, 2 REFUGEE CAMPS, 188 SCHOOLS	15	>20
7	PROPORTION OF PLHIV SCREENED FOR TB AT THEIR LAST HIV CARE CLINIC VISIT.	NUMERATOR: NUMBER OF PLHIV MAKING VISIT TO THE CLINIC DURING REPORTING PERIOD SCREENED FOR TB DURING THEIR LAST CLINIC VISIT DENOMINATORS: NUMBER OF PLHIV MAKING VISIT TO THE CLINIC DURING REPORTING PERIOD	DHIS/TIBU	QUARTERLY	NTLD-PROGRAM	M&E OFFICER		>95%	>95%	>95%	>95%
8	PROPORTION OF PRESUMPTIVE TB CASES AMONG PLHIV RECEIVING THE XPERT MTB-RIF TEST FOR ACTIVE TBPRESUMPTIVE TB	NUMERATOR: NUMBER OF PLHIV WITH SIGNS FOR TB WITH XPERT MTB-RIF TEST FOR FOR ACTIVE TB RESULTS DENOMINATORS: NUMBER OF PLHIV WITH SIGNS FOR TB	DHIS/TIBU	QUARTERLY	NTLD-PROGRAM	M&E OFFICER		>95%	>95%	>95%	>95%

9	PROPORTION OF TB PATIENTS NEWLY STARTED ON TREATMENT TESTED FOR HIV	NUMERATOR: NUMBER OF TB PATIENTS STARTED ON TREATMENT DURING PORTING PERIOD AND TESTED FOR HIV DENOMINATORS: NUMBER OF TB PATIENTS STARTED ON TREATMENT DURING PORTING PERIOD	FACILITY TBREGISTER/ PATIENT CARD/ TIBU	QUARTERLY DURING DATA REVIEW MEETINGS	NTLD-UNIT	SCTLCS		95%	95%	95%	95%
10	PROPORTION OF HIV POSITIVE TB PATIENTS WHO RECEIVE CPT	NUMERATOR: NUMBER OF TB PATIENTS STARTED ON TREATMENT DURING REPORTING PERIOD AND TESTED POSITIVE FOR HIV PUT ON ARV DENOMINATORS: NUMBER OF TB PATIENTS STARTED ON TREATMENT DURING REPORTING PERIOD AND TESTED POSITIVE FOR HIV	FACILITY TB REGISTER/ PATIENT CARD/ TIBU	QUARTERLY DURING DATA REVIEW MEETINGS	NTLD-UNIT	SCTLCS		95%	96%	97%	98%
11	PROPORTION OF HIV POSITIVE TB PATIENTS PUT ON ART	NUMERATOR: NUMBER OF TB PATIENTS STARTED ON TREATMENT DURING REPORTING PERIOD AND TESTED POSITIVE FOR HIV PUT ON ARV DENOMINATORS: NUMBER OF TB PATIENTS STARTED ON TREATMENT DURING REPORTING PERIOD AND TESTED POSITIVE FOR HIV	FACILITY TB REGISTER/ PATIENT CARD/ TIBU	QUARTERLY DURING DATA REVIEW MEETINGS	NTLD-UNIT	SCTLCS		85%	88%	91%	95%

PMDT											
NO	**INDICATOR**	**INDICATOR DEFINITION**	**SOURCE**	**FREQUENCY**	**RESPONSIBLE ORGANIZATION**	**RESPONSIBLE PERSON**	**BASELINE TARGETS**	**YEAR 1**	**YEAR 2**	**YEAR 3**	**YEAR 4**
1	TSR AMONG DRTB PATIENTS	NUMERATOR: DRTB PATIENTS WHO STARTED TREATMENT 2 YEARS PRIOR WHO HAVE COMPLETED TREATMENT. DENOMINATOR: TOTAL DRTB PATIENTS WHO STARTED TREATMENT 2 YEARS AGO	ANNUAL REPORT	ANNUALLY	NTLD-PROGRAM	DRTB FOCAL PERSON	68%	74.5%	75%	75.5%	76%
2	PROPORTION OF DRTB PATIENTS ON SECOND LINE TREATMENT WHO HAVE NEGATIVE CULTURE RESULTS BY MONTH 6	NUMERATOR: NUMBER OF DRTB PATIENTS WHO STARTED SECOND LINE TREATMENT 6 MONTHS PRIOR WHO HAVE NEGATIVE CULTURE RESULTS DENOMINATOR: TOTAL NUMBER OF DRTB PATIENTS WHO STARTED 2ND LINE TREATMENT 6 MONTHS PRIOR	6 MONTHS REPORT		NTLD-PROGRAM	DRTB FOCAL PERSON	57%	60%	70%	75%	85%
3.	PROPORTION OF COUNTIES WITH DR PATIENTS WITH FUNCTIONAL PMDT TEAMS	NUMERATOR: TOTAL NUMBER OF COUNTIES WITH PMDT TEAMS MEETING QUARTERLY DENOMINATOR: TOTAL NUMBER OF COUNTIES	PMDT TEAM MEETING MINUTES	QUARTERLY DURING DATA REVIEW MEETINGS	NTLD-PROGRAM	CTLCS	0	10%	60%	100%	100%
4.	PROPORTION OF COUNTIES WITH AT LEAST 2 BEDS FOR ADMISSION OF DR TB PATIENTS IN CRITICAL CONDITIONS	NUMERATOR: TOTAL NUMBER OF COUNTIES WITH AT LEAST 2 BEDS FOR ADMISSION OF DR TB PATIENTS DENOMINATOR: TOTAL NUMBER OF COUNTIES	CTLCS ANNUALLY REPORTS/ CQI ASSESSMENTS	ANNUALLY DURING DATA REVIEW MEETINGS	NTLD-PROGRAM	CTLCS/ HEAD OF CARE	0	0	40%	75%	100%

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQUENCY	RESPONSIBLE ORGANIZATION	RESPONSIBLE PERSON	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
5.	NUMBER OF POLICY DOCUMENTS ON CROSS-BORDER DRTB DEVELOPED	ABSOLUTE NUMBER: THESE ARE POLICIES ON CROSS BORDER DR TB DEVELOPED BY INTERAGENCY TEAM	POLICY DOCUMENT	ANNUALLY	NTLD-PROGRAM	HEAD OF TB PROGRAM	0		1		
6.	PROPORTION OF ELIGIBLE PATIENTS TESTED USING GENE XPERT	NUMERATOR: TOTAL NUMBER OF ELIGIBLE PATIENTS TESTED USING GENEXPERT DENOMINATOR: TOTAL NUMBER OF ELIGIBLE PATIENTS	TIBU/GX ALERT SYSTEM	ANNUALLY	NTLD-PROGRAM	M&E OFFICER	0%	40%	60%	80%	100%
7.	PROPORTION OF CONTACTS OF DR TB SCREENED FOR TB	NUMERATOR: TOTAL NUMBER OF CONTACTS OF DR TB PATIENTS SCREENED FOR TB DENOMINATOR: TOTAL NUMBER OF CONTACTS OF DR TB PATIENTS	CONTACTS REGISTER/ TIBU	ANNUALLY	NTLD-PROGRAM	M&E OFFICER		100%	100%	100%	100%
8.	PROPORTION OF RETREATMENT CASES SCREENED FOR DRTB AND DST RESULTS.	NUMERATOR: TOTAL NUMBER OF RETREATMENT TB CASES REGISTERED IN THE REPORTING PERIOD WITH DST/ CULTURE RESULTS DENOMINATOR: TOTAL NUMBER OF RETREATMENT TB CASES REGISTERED IN THE REPORTING PERIOD	GX ALERT SYSTEM/ TIBU/ DR TB REGISTER	ANNUALLY	NTLD-PROGRAM	M&E OFFICER/LAB CONTACT PERSON		75%	85%	100%	100%

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQUENCY	RESPONSIBLE ORGANIZATION	RESPONSIBLE PERSON	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
9.	PROPORTION OF NEW DR PATIENTS STARTED ON TREATMENT WITHIN 2 WEEKS OF DIAGNOSIS	**NUMERATOR:** TOTAL NUMBER OF NEW DR TB PATIENTS IDENTIFIED WITHIN A REPORTING PERIOD AND STARTED ON TREATMENT WITHIN 2 WEEKS OF DIAGNOSIS **DENOMINATOR:** TOTAL NUMBER OF NEW DR TB PATIENTS IDENTIFIED WITHIN A REPORTING PERIOD	CQI	ANNUALLY	NTLD-PROGRAM	PMDT FOCAL PERSON		60%	80%	90%	100%
10.	PROPORTION OF NEW DR TB PATIENTS WITH STANDARDIZED BASELINE INVESTIGATIONS DONE AT START OF TREATMENT	**NUMERATOR:** NUMBER OF NEW DR TB PATIENTS WITH STANDARDIZED BASELINE INVESTIGATIONS DONE AT START OF TREATMENT **DENOMINATOR:** TOTAL NUMBER OF NEW DRTB PATIENTS STARTING TREATMENT	CTLCS REPORTS	QUARTERLY DURING DATA REVIEW MEETINGS	NTLD-PROGRAM	CTLCS		100%	100%	100%	100%
11.	PROPORTION OF COUNTIES REPORTING NO STOCK OUT OF DR TB DRUGS	**NUMERATOR:** TOTAL NUMBER OF COUNTIES REPORTING NO DR TB DRUG STOCK OUT IN THE REPORTING PERIOD **DENOMINATOR:** TOTAL NUMBER OF COUNTIES	NATIONAL TA MISSION REPORTS/ TA CHECKLIST	SEMI ANNUALLY DURING TA MISSIONS TO COUNTIES BY NATIONAL TEAM	NTLD-PROGRAM	DR TB FOCAL PERSON			50%	60%	75%

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQUENCY	RESPONSIBLE ORGANIZATION	RESPONSIBLE PERSON	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
12.	PROPORTION OF DR TB PATIENTS WITH DOCUMENTED ADRS WHO GET MANAGEMENT FOR THE ADRS	**NUMERATOR:** TOTAL NUMBER OF DR TB PATIENTS WITH DOCUMENTED ADRS IN THE REPORTING PERIOD AND PROVIDED WITH MANAGEMENT **DENOMINATOR:** TOTAL NUMBER OF DR TB PATIENTS WITH DOCUMENTED ADRS IN THE REPORTING PERIOD	DISTRIBUTION LIST,	ANNUALLY	NTLD-PROGRAM	M&E OFFICER		10	30	47	
13.	NUMBER OF COUNTIES WITH FUNCTIONAL AUDIOMETERS	ABSOLUTE NUMBER: AUDIOMETERS DISTRIBUTED	NATIONAL TA MISSION REPORTS/ TA CHECKLIST	SEMI ANNUALLY DURING NATIONAL TEAM COUNTY TA MISSIONS	NTLD-PROGRAM	DR TB FOCAL PERSON		0	30%	60%	100%
14	PROPORTION OF CHILDREN WITH DR TB ACCESSING THE PEDIATRIC FORMULATIONS	**NUMERATOR:** TOTAL NUMBER OF PEDIATRIC DR TB PATIENTS PROVIDED WITH PEDIATRIC FORMULATIONS **DENOMINATOR:** TOTAL NUMBER OF PEDIATRIC DR TB PATIENTS	NATIONAL TA MISSION REPORTS/ TA CHECKLIST	SEMI ANNUALLY DURING NATIONAL TEAM TA MISSIONS TO COUNTIES	NTLD-PROGRAM	DR TB FOCAL PERSON		25%	50%	75%	100%
15	PROPORTION OF ELIGIBLE NEW DR TB PATIENTS ACCESSING CAPREOMYCIN AS FIRST INJECTABLE OF CHOICE		ANNUAL REPORT	ANNUALLY	NTLD-PROGRAM	DR TB FOCAL PERSON			1	4	7
16	NUMBER OF (DR) TB COES ESTABLISHED	ABSOLUTE NUMBER									

PAEDIATRIC TB											
NO	**INDICATOR**	**INDICATOR DEFINITION**	**SOURCE**	**FREQUENCY**	**RESPONSIBLE ORGANIZATION**	**RESPONSIBLE PERSON**	**BASELINE TARGETS**	**YEAR 1**	**YEAR 2**	**YEAR 3**	**YEAR 4**
1.	PROPORTION OF CHILDREN (<15 YRS) WITH TB AMONG NOTIFIED TB CASES	NUMERATOR: NUMBER CHILDREN (<15 YRS)WITH TB AMONG NOTIFIED TB CASES DENOMINATOR: TOTAL NUMBER OF TB NOTIFIED CASES	QUARTERLY REPORTS	QUARTERLY	NTLD-PROGRAM	PAEDIATRIC FOCAL PERSON	9%	10%	10.5%	11%	11.5%
2.	NUMBER OF HCW TRAINED ON PEDIATRIC TB	ABSOLUTE NUMBER	LIST OF PARTICIPANTS AND CENTRAL TRAINING TRACKING DATABASE	QUARTERLY	NTLD-PROGRAM	M&E OFFICER		1410	2820	2820	1410
3.	NUMBER OF HCW REACHED THROUGH E LEARNING	ABSOLUTE NUMBER	LIST OF PARTICIPANTS AND CENTRAL TRAINING TRACKING DATABASE	QUARTERLY	NTLD-PROGRAM	M&E OFFICER	0	0	0	0	300
4.	PROPORTION OF ELIGIBLE CHILD CONTACTS INITIATED ON IPT	NUMERATOR. NUMBER OF ELIGIBLE CHILD CONTACTS INITIATED ON IPT DENOMINATOR. NUMBER OF ELIGIBLE CHILD CONTACTS	IPT REGISTER, CONTACT TRACING REGISTER, TIBU	QUARTERLY	NTLD-PROGRAM	M&E OFFICER		20%	40%	60%	80%
5.	PROPORTION OF CHILDREN WITH TB ASSESSED FOR NUTRITION STATUS	NUMERATOR: NUMBER OF CHILDREN WITH TB ASSESSED FOR NUTRITION STATUS DENOMINATOR: NUMBER OF CHILDREN WITH TB	TIBU/CONTACT REGISTER, CONTACTS FOLLOW UP REGISTER	QUARTERLY	NTLD-PROGRAM	M&E OFFICER.	TIBU	50%	70%	80%	90%

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQUENCY	RESPONSIBLE ORGANIZATION	RESPONSIBLE PERSON	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
6.	PROPORTION OF CHILD CONTACTS OF DR TB PATIENTS FOLLOWED UP FOR AT LEAST 2 YEARS	NUMERATOR. NUMBER OF CHILD CONTACTS OF DR TB PATIENTS FOLLOWED UP FOR AT LEAST 2 YEARS DENOMINATOR: NUMBER OF CHILD CONTACTS OF DR TB PATIENTS	TIBU/CONTACT REGISTER, CONTACTS FOLLOW UP REGISTER	QUARTERLY	NTLD-PROGRAM	M&E OFFICER.	TIBU	50%	70%	80%	90%

LEPROSY

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQUENCY	RESPONSIBLE PERSON	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
1.	PROPORTION OF COUNTIES WITH LEPROSY PATIENTS REPORTING ON COMMODITY MANAGEMENT.	NUMERATOR: NUMBER OF COUNTIES WITH LEPROSY PATIENTS REPORTING ON COMMODITY MANAGEMENT DENOMINATOR: TOTAL NUMBER OF COUNTIES REPORTING ON LEPROSY	ROUTINE RECORDING & REPORTING.	BI-ANNUAL	M/E OFFICER		60%	80%	80%	100%
2	PROPORTION OF LEPROSY PATIENTS IN BOTH ENDEMIC AND NON ENDEMIC AREAS PRESENTING WITH DISABILITY 2	NUMERATOR: NUMBER LEPROSY PATIENTS IN BOTH ENDEMIC AND NON ENDEMIC AREAS PRESENTING WITH DISABILITY. DENOMINATOR: TOTAL NUMBER OF LEPROSY PATIENTS	ROUTINE RECORDING & REPORTING	BI-ANNUAL	M/E OFFICER	30%	30%	25%	20%	15%
3	NUMBER OF POLY SKIN CLINICS CONDUCTED IN THE ENDEMIC COUNTIES	ABSOLUTE NUMBER	REPORTS	ANNUAL	FOCAL PERSON LEPROSY		500	500	500	500
4.	NUMBER OF SPECIALIZED CENTERS RENOVATED AND EQUIPPED	ABSOLUTE NUMBER	REPORTS	ANNUAL	FOCAL PERSON LEPROSY	0	0	1		1

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQUENCY	RESPONSIBLE PERSON	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
5.	PROPORTION OF PRESUMPTIVE LEPROSY CASES REFERRED FROM COMMUNITY	NUMERATOR: NUMBER OF PRESUMPTIVE LEPROSY CASES REFERRED FROM COMMUNITY. DENOMINATOR: TOTAL NUMBER OF PRESUMPTIVE LEPROSY CASES	REPORTS	BI-ANNUAL	M/E OFFICER	-	70%	80%	90%	100%

ENGAGING ALL HEALTH PROVIDERS

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQUENCY	RESPONSIBLE ORGANIZATION	RESPONSIBLE PERSON	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
1.	TSR AMONG TB PATIENTS ENROLLED IN THE PRIVATE HEALTH FACILITIES	NUMERATOR: NUMBER OF SMEAR POSITIVE TB PATIENTS ENROLLED IN THE PRIVATE HEALTH FACILITIES WHO HAVE BEEN SUCCESSFULLY TREATED DENOMINATOR: TOTAL NUMBER OF SMEAR POSITIVE TB PATIENTS ENROLLED IN THE PRIVATE HEALTH FACILITIES					88%		89%		90%

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQUENCY	RESPONSIBLE ORGANIZATION	RESPONSIBLE PERSON	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
2.	PROPORTION OF PRIVATE HEALTH FACILITIES PROVIDING TB SERVICES THAT REPORT TO THE NTP	NUMERATOR: NUMBER OF PRIVATE HEALTH FACILITIES PROVIDING TB SERVICES THAT REPORT TO THE NTP DENOMINATOR: TOTAL NUMBER OF PRIVATE HEALTH FACILITIES.					0				
3.	NUMBER OF HCWS WORKING IN PRIVATE HEALTH SECTOR TRAINED ON TB CONTROL	ABSOLUTE NUMBER	REPORTS	QUARTERLY	NTLD	FOCAL PERSON FOR PPM			300	300	300
4.	NUMBER OF HCWS TRAINED ON PAL	ABSOLUTE NUMBER	REPORTS	QUARTERLY	NTLD	FOCAL PERSON FOR PPM			150	150	150
5.	PROPORTION OF COUNTIES WITH MAPPED OUT PRIVATE HEALTH PROVIDERS	NUMERATOR: NUMBER OF COUNTIES WITH MAPPED OUT PRIVATE HEALTH FACILITIES DENOMINATOR: TOTAL NUMBER OF COUNTIES	REPORTS	BI-ANNUALLY	NTLD	FOCAL PERSON FOR PPM		25%	50%	75%	

LUNG HEALTH

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQUENCY	RESPONSIBLE ORGANIZATION	RESPONSIBLE PERSON	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
1.	NUMBER OF NATIONAL TOTS TRAINED	ABSOLUTE NUMBER	REPORT	ANNUAL	NTLD	M/E OFFICER		25	0	0	0
2.	NUMBER OF COUNTY TOTS TRAINED	ABSOLUTE NUMBER	REPORT	ANNUAL	NTLD	M/E OFFICER		150	0	0	0

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQUENCY	RESPONSIBLE ORGANIZATION	RESPONSIBLE PERSON	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
3.	NUMBER OF COUNTY HCWS TRAINED ON PAL	ABSOLUTE NUMBER	REPORT	ANNUAL	NTLD	M/E OFFICER		0	875	1175	1175
4.	NUMBER OF HCWS COMPLETING THE E-LEARNING	ABSOLUTE NUMBER	REPORT	BI-ANNUAL	NTLD	M/E OFFICER				300	300
5.	PROPORTION OF PAL ESSENTIAL DRUGS IN THE ESSENTIAL LIST	NUMERATOR: NUMBER OF PAL ESSENTIAL DRUGS IN THE ESSENTIAL LIST DENOMINATOR: TOTAL NUMBER OF PAL ESSENTIAL DRUGS	REPORT	BI-ANNUAL	NTLD	M/E OFFICER		100%			
6.	PROPORTION OF HEALTH FACILITIES WITH THE MINIMUM PAL EQUIPMENT	NUMERATOR: NUMBER OF HEALTH FACILITIES WITH THE MINIMUM PAL EQUIPMENT DENOMINATOR: TOTAL NUMBER OF FACILITIES	REPORT	BI-ANNUAL	NTLD	M/E OFFICER			25%	70%	100%
7.	NUMBER OF COUNTIES WITH MODEL LUNG HEALTH CLINICS	ABSOLUTE NUMBER	REPORT	BI-ANNUAL	NTLD	M/E OFFICER			12	35	
8	PROPORTION OF CHILDREN WITH CHRONIC LUNG CONDITIONS SCREENED FOR ASTHMA (IN PAL PILOT SITES)	NUMERATOR: NUMBER OF CHILDREN WITH CHRONIC LUNG CONDITION SCREENED FOR ASTHMA (IN PAL PILOT SITES) DENOMINATOR: TOTAL NUMBER OF CHILDREN WITH CHRONIC LUNG CONDITIONS (IN PAL PILOT SITES)	REPORTS	QUARTERLY	NTLD	M/E OFFICER	0	20%	50%	80%	80%

ACCELERATE APPROPRIATE DIAGNOSIS

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQUENCY	RESPONSIBLE ORGANIZATION	RESPONSIBLE PERSON	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
1	NUMBER OF STAFF TRAINED ON CULTURE AND DST (CUMULATIVE	ABSOLUTE NUMBER	ATTENDANCE LIST, CENTRAL TRAINING TRACKING DATABASE	ANNUALLY	NTLD-PROGRAM	HEAD NTRL	8	13	18	23	28
2	PROPORTION OF CULTURE LABS ENROLLED IN AN INTERNATIONAL EQA/PT PROGRAM	NUMERATOR: TOTAL NUMBER OF CULTURE LABS IN KENYA ENROLLED IN AN INTERNATIONAL EQA/PT PROGRAM IN KENYA DENOMINATOR: TOTAL NUMBER OF CULTURE LABS IN KENYA	LETTER OF ACCEPTANCE FROM INTERNATIONAL REFERENCE LAB	ANNUALLY	NTLD-PROGRAM	LAB M&E CONTACT OFFICER		0	50%	100%	100%
3	PROPORTION OF ENROLLED CULTURE LABS WITH ACCEPTABLE EQA/PT RESULTS	NUMERATOR: TOTAL NUMBER OF CULTURE LABS IN KENYA ENROLLED IN AN INTERNATIONAL EQA/PT PROGRAM WITH ACCEPTABLE EQA /PT RESULTS DENOMINATOR: TOTAL NUMBER OF CULTURE LABS IN KENYA ENROLLED IN AN INTERNATIONAL EQA/PT PROGRAM	EQA/PT REPORT FROM INTERNATIONAL REFERENCE LAB	ANNUALLY	NTLD-PROGRAM	LAB M&E CONTACT PERSON		0	>80%	>80%	>80%
4	PROPORTION OF CULTURE LABS RECEIVING QUARTERLY TA VISITS	NUMERATOR: TOTAL NUMBER OF CULTURE LABS IN KENYA RECEIVING QUARTERLY TA MISSIONS FROM THE NATIONAL TEAM DENOMINATOR: TOTAL NUMBER OF CULTURE LABS IN KENYA	TA REPORTS/ COMPLETED TA CHECKLIST	QUARTERLY	NTLD-PROGRAM	LAB M&E FOCAL PERSON		100%	100%	100%	100%

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQUENCY	RESPONSIBLE ORGANIZATION	RESPONSIBLE PERSON	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
5	PROPORTION OF CULTURE LABS LINKED TO LIMS	NUMERATOR: TOTAL NUMBER OF CULTURE LABS IN KENYA IMPLEMENTING LIMS DENOMINATOR: TOTAL NUMBER OF CULTURE LABS IN KENYA NUMERATOR: NUMBER OF PAL ESSENTIAL DRUGS IN THE ESSENTIAL LIST DENOMINATOR: TOTAL NUMBER OF PAL ESSENTIAL DRUGS	LIMS INSTALLATION REPORT	ANNUALLY	NTRL	LAB M&E FOCAL PERSON			100%	100%	100%
6	PROPORTION OF MICROSCOPY LABORATORIES WITH AT LEAST 1 STAFF TRAINED ON EQA	NUMERATOR: TOTAL NUMBER OF MICROSCOPY LABORATORIES IN KENYA WITH AT LEAST 1 STAFF TRAINED ON EQA DENOMINATOR: TOTAL NUMBER OF MICROSCOPY LABORATORIES IN KENYA	TRAINING ATTENDANCE LIST, CENTRAL TRACKING DATABASE, LAB INVENTORY LIST	ANNUALLY	NTRL/ DTLD-PROGRAM	LAB M&E FOCAL PERSON/M&E OFFICER			25%	50%	100%
7	PROPORTION OF MICROSCOPY LABS PARTICIPATING IN QUARTERLY EQA	NUMERATOR: TOTAL NUMBER OF MICROSCOPY LABORATORIES IN KENYA PARTICIPATING IN QUARTERLY EQA DENOMINATOR: TOTAL NUMBER OF MICROSCOPY LABORATORIES IN KENYA	EQA REPORTS,	QUARTERLY	NTRL	LAB M&E FOCAL PERSON	88%	90%	>90%	>90%	>90%

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQUENCY	RESPONSIBLE ORGANIZATION	RESPONSIBLE PERSON	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
8	PROPORTION OF MICROSCOPY LABS PARTICIPATING IN QUARTERLY EQA RECEIVING FEEDBACK	NUMERATOR: TOTAL NUMBER OF MICROSCOPY LABORATORIES IN KENYA PARTICIPATING IN QUARTERLY EQA RECEIVING FEEDBACK DENOMINATOR: TOTAL NUMBER OF MICROSCOPY LABORATORIES IN KENYA PARTICIPATING IN QUARTERLY EQA	FEEDBACK REPORTS,	QUARTERLY	NTRL	LAB M&E FOCAL PERSON		90%	>90%	>90%	>90%
9.	PERCENTAGE OF LABORATORIES SHOWING ADEQUATE PERFORMANCE (95% CONCORDANCE IN ERROR ANALYSIS) IN EQA FOR SMEAR MICROSCOPY	NUMERATOR: NUMBER OF LABORATORIES SHOWING ADEQUATE PERFORMANCE (95% CONCORDANCE IN ERROR ANALYSIS) IN EQA FOR SMEAR MICROSCOPY DENOMINATOR: TOTAL NUMBER OF LABORATORIES THAT UNDERTAKE SMEAR MICROSCOPY					93.3%	95%	>95%	>95%	>95%
10	PROPORTION OF DST/ CULTURE RESULTS WITH TAT WITHIN 60 DAYS OF SAMPLE REFERRAL	NUMERATOR: TOTAL NUMBER OF CULTURE SAMPLES REFERRED TO CULTURE LABS WITH RESULTS SENT BACK TO ORIGINATING FACILITY WITHIN 60 DAYS OF SAMPLE REFERRAL DENOMINATOR: TOTAL NUMBER OF CULTURE SAMPLES REFERRED TO CULTURE LABS	LIMS, FACILITY CULTURE LOG BOOK, SCTLC REPORTS	QUARTERLY DURING QUARTERLY DATA MEETINGS	NTRL	SCMLTS/ CMLTS		>80%	>80%	>80%	>80%

NO	INDICATOR	INDICATOR	SOURCE	FREQUENCY	RESPONSIBLE	RESPONSIBLE	BASELINE	YEAR	YEAR	YEAR 3	YEAR
11	NUMBER OF ACCREDITATION CERTIFICATES GIVEN TO NTRL	NUMERATOR: TOTAL NUMBER OF XPERT TESTS DONE PER COUNTY DENOMINATOR: TOTAL CAPACITY OF XPERT MACHINES PER COUNTY	CERTIFICATE	ONCE	NTLD-PROGRAM	LAB M&E FOCAL PERSON	0			1	
12	% UTILIZATION OF XPERT MACHINES PER COUNTY PER QUARTER	NUMERATOR: TOTAL NUMBER OF DIAGNOSTIC LABS PRACTICING ACCEPTED STANDARDS OF BIOSAFETY AND IPC DENOMINATOR: : TOTAL NUMBER OF DIAGNOSTIC LABS	GX ALERT SYSTEM, GENEXPERT INVENTORY	QUARTERLY	NTRL/ NTLD-PROGRAM	LAB M&E FOCAL PERSON /M&E OFFCIER	20%	25%	50%	80%	>80%
13	PROPORTION OF DIAGNOSTIC LABS MEETING MINIMUM BIOSAFETY AND IPC STANDARDS		NATIONAL TA MISSION REPORTS, TA CHECKLIST	SEMI ANNUALLY DURING NATIONAL TEAM TA MISSIONS TO COUNTIES	NTLD-PROGRAM	LAB M&E FOCAL PERSON		25%	50%	>75%	>80%
14	PERCENTAGE OF XPERT AND LED LABS ENROLLED IN THE IN COUNTRY PT PROGRAM	NUMERATOR: TOTAL NUMBER OF XPERT AND LED LABS RECEIVING IN COUNTRY PT PANELS AND SENDING THE RESULTS TO NTRL DENOMINATOR: TOTAL NUMBER OF XPERT AND LED LABS	PT PANELS DISTRIBUTION LIST,	QUARTERLY			0	0	30%	60%	>80%

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQUENCY	RESPONSIBLE ORGANIZATION	RESPONSIBLE PERSON	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
15	PROPORTION OF XPERT AND LED LABS ENROLLED IN THE IN COUNTRY PT PROGRAM WITH ACCEPTABLE PT RESULTS	NUMERATOR: TOTAL NUMBER OF XPERT AND LED LABS PARTICIPATING IN IN-COUNTRY PT PROGRAM RECORDING ACCEPTABLE PT RESULLTS DENOMINATOR: TOTAL NUMBER OF XPERT AND LED LABS PARTICIPATING IN IN-COUNTRY PT PROGRAM	PT RESULTS REPORT, LIMS	QUARTERLY	NTRL	LAB M&E FOCAL PERSON			100%	100%	100%

COMMODITIES

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQUENCY	RESPONSIBLE ORGANIZATION	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
1	NUMBER OF COUNTIES CENTRALLY PROCURING DRUGS FROM KEMSA	NUMERATOR: NUMBER OF COUNTIES PROCURING CENTRALLY FROM KEMSA DENOMINATOR: TOTAL NUMBER OF COUNTIES	KEMSA DISTRIBUTION REPORT	QUARTERLY	M/E OFFICER AT KEMSA	-	47	47	47	47
2	PROPORTION OF FUNDING AVAILABLE FOR TB COMMODITIES IN THE F & Q PLAN FROM ALL SOURCES	NUMERATOR: FUNDING AVAILABLE FOR COMMODITIES DENOMINATOR: TOTAL FUNDING FOR TB COMMODITIES IN THE F&Q PLAN	PROGRAM EXPENDITURE REPORT	ANNUALLY	PROGRAM PHARMACIST	50%	90%	>90%	>90%	>90%
3	NUMBER OF COUNTIES WITH COSTED TB COMMODITY PROCUREMENT PLANS	NUMERATOR: NUMBER OF COUNTIES WITH TB COMMODITIES COSTED IN THE PROCUREMENT PLAN DENOMINATOR: TOTAL NUMBER OF COUNTIES	TA MISSION REPORTS ON TB MEDICINE AUDIT	ANNUALLY	PROGRAM PHARMACIST	0	47	47	47	47
4	PROPORTION OF COUNTIES MAKING COMPLETE AND TIMELY COMMODITY REPORTS AND ORDERS	NUMERATOR: NUMBER OF COUNTIES SUBMITTING COMMODITY REPORTS DENOMINATOR: TOTAL NUMBER OF COUNTIES	LOGISTIC MANAGEMENT INFORMATION SYSTEM	QUARTERLY	M/E OFFICER AT KEMSA	0				
5	PROPORTION OF FACILITIES WITH TB SENSITIVE PATIENTS REPORTING ON ADRS FOR TB PATIENTS ON TIME	NUMERATOR: NUMBER OF PATIENTS REPORTED WITH ADRS DENOMINATOR: TOTAL NUMBER OF PATIENTS DURING THAT PERIOD	TIBU DATA	QUARTERLY	UNIT PHARMACIST	-	10%	15%	20%	25%

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQUENCY	RESPONSIBLE ORGANIZATION	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
6	PROPORTION OF FACILITIES WITH DRTB PATIENTS REPORTING ON ADRS FOR DRTB PATIENTS ON TIME	NUMERATOR: TOTAL NUMBER OF FACILITIES WITH DRTB PATIENTS REPORTING ON ADRS ON TIME DENOMINATOR: TOTAL NUMBER OF FACILITIES WITH DRTB PATIENTS	TIBU DATA	QUARTERLY	UNIT PHARMACIST	-	20%	50%	60%	70%

ENGAGING COMMUNITIES

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQ	RESPONSIBLE ORGANIZATION	RESPONSIBLE PERSON	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
1.	PROPORTION OF NEW ACTORS PARTICIPATING AND ENGAGING IN TB LEPROSY AND LUNG HEALTH	NUMERATOR: NUMBER OF NEW ACTORS PARTICIPATING AND ENGAGED IN TB LEPROSY AND LUNG HEALTH DENOMINATOR: TOTAL NUMBER OF ACTORS PARTICIPATING IN TB, LEPROSY AND LUNG HEALTH	REPORTS	ANNUAL	NTLD -PROGRAM	FOCAL PERSON COMMUNITY ENGAGEMENT		25%	50%	75%	75%
2.	PROPORTION OF SUPPORTED CU IMPLEMENTING AND REPORTING TB.LEPROSY AND LUNG DISEASE ACTIVITIES	NUMERATOR: NUMBER OF SUPPORTED CU IMPLEMENTING AND REPORTING TB.LEPROSY AND LUNG DISEASE ACTIVITIES DENOMINATOR: TOTAL NUMBER OF SUPPORTED CUS	REPORTS	BI-ANNUAL	NTLD -PROGRAM	M/E OFFICER		25%	50%	75%	75%

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQ	RESPONSIBLE ORGANIZATION	RESPONSIBLE PERSON	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
3	PROPORTION OF ELIGIBLE PATIENTS ENLISTED FOR SP SUPPORT RECEIVING THE SP	NUMERATOR: NUMBER OF ENLISTED ELIGIBLE PATIENTS RECEIVING SP. DENOMINATOR: TOTAL NUMBER OF ENLISTED PATIENTS ELIGIBLE FOR SP	REPORT	ANNUALLY	NTLD -PROGRAM	FOCAL COMMUNITY ENGAGEMENT PERSON			25%	50%	75%
4.	NUMBER OF HCWS TRAINED	ABSOLUTE NUMBER	REPORT	BI-ANNUALLY	NTLD -PROGRAM	FOCAL COMMUNITY ENGAGEMENT PERSON			500	500	500
5	NUMBER OF CHEWS TRAINED	ABSOLUTE NUMBER	REPORT	BI-ANNUALLY	NTLD -PROGRAM	FOCAL COMMUNITY ENGAGEMENT PERSON			500	500	500
6	NUMBER OF CHWS TRAINED	ABSOLUTE NUMBER	REPORT	BI-ANNUALLY	NTLD -PROGRAM	FOCAL COMMUNITY ENGAGEMENT PERSON			1750	1750	1750
7	PROPORTION OF TB CASE REFERRALS FROM THE COMMUNITY TO THE FACILITIES	NUMERATOR: NUMBER OF DIAGNOSED TB PATIENTS REFERRED FROM THE COMMUNITY DENOMINATOR: TOTAL NUMBER OF DIAGNOSED TB PATIENTS REFERRED	REPORT	BI-ANNUALLY	NTLD -PROGRAM	M/E OFFICER	4%	8%	10%	15%	15%
8.	NUMBER OF FORMER TB PATIENTS RECRUITED AS TB AMBASSADORS.	ABSOLUTE NUMBERS	REPORT	BI-ANNUALLY	NTLD -PROGRAM	FOCAL COMMUNITY ENGAGEMENT PERSON			100	100	100

ADVOCACY AND COMMUNICATION

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQ	RESPONSIBLE ORGANIZATION	RESPONSIBLE PERSON	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
1	PROPORTION OF COUNTIES WITH SITUATIONAL ANALYSIS FOR TB, LEPROSY AND LUNG DISEASES REPORTS	NUMERATOR: NUMBER OF COUNTIES WITH SITUATIONAL ANALYSIS FOR TB, LEPROSY AND LUNG DISEASES REPORTS DENOMINATOR: TOTAL NUMBER OF COUNTIES	PROGRAMME REPORTS	ONCE	NTLD-PROGRAM	M/E FOCAL PERSON	_	100%			
2	NUMBER OF COUNTIES WITH ESTABLISHED STOP TB PARTNERSHIP OFFICES	ABSOLUTE NUMBER	PROGRAMME REPORTS	YEARLY	NTLD-PROGRAM	ADVOCACY & COMMUNICATION FOCAL PERSON	_	_	10	20	30
3	NUMBER OF COUNTY TB & LEPROSY COORDINATORS SUPPORTED TO PARTICIPATE IN THEIR COUNTY STAKEHOLDER MEETINGS	ABSOLUTE NUMBER	MEETING REPORTS	YEARLY	NTLD-PROGRAM	ADVOCACY & COMMUNICATION FOCAL PERSON	_	_	50	50	50
4	NUMBER OF COUNTY WEBSITES THAT HAVE PORTALS FOR TB	ABSOLUTE NUMBER	MEETING REPORTS	YEARLY	NTLD-PROGRAM	ADVOCACY & COMMUNICATION FOCAL PERSON	_	_	23	24	_
5	NUMBER OF INFORMATION PACKS DESIGNED, PRINTED AND DISTRIBUTED	ABSOLUTE NUMBER	PROGRAMME REPORT	YEARLY	NTLD-PROGRAM	ADVOCACY & COMMUNICATION FOCAL PERSON	_	_	1500		
6	NUMBER OF GOODWILL AMBASSADORS SENSITIZED	ABSOLUTE NUMBER	PROGRAMME REPORTS	ONCE	NTLD-PROGRAM	ADVOCACY & COMMUNICATION FOCAL PERSON	_	_	47	_	_

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQ	RESPONSIBLE ORGANIZATION	RESPONSIBLE PERSON	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
7	NUMBER OF FUND RAISING EVENTS HELD	ABSOLUTE NUMBER	PROGRAMME REPORTS	YEARLY	NTLD-PROGRAM	ADVOCACY & COMMUNICATION FOCAL PERSON		2	2	2	2
8	PROPORTION OF DIAGNOSTIC AND TREATMENT SITES REACHED WITH IEC PRODUCTS PROMOTING DIAGNOSTIC TECHNOLOGIES	NUMERATOR: NUMBER OF DIAGNOSTIC AND TREATMENT SITES REACHED WITH IEC PRODUCTS PROMOTING DIAGNOSTIC TECHNOLOGIES DENOMINATOR: TOTAL NUMBER OF DIAGNOSTIC AND TREATMENT SITES	PROGRAMME REPORTS	QUARTERLY	NTLD-PROGRAM	ADVOCACY & COMMUNICATION FOCAL PERSON	NOT AVAILABLE	50%	50%	100%	100% OF
9	PROPORTION OF SELF REFERRAL FOR TB DIAGNOSIS	NUMERATOR: NUMBER OF SELF REFERRALS FOR TB DIAGNOSIS DENOMINATOR: TOTAL NUMBER OF REFERRALS FOR TB DIAGNOSIS	PROGRAMME REPORTS	QUARTERLY	NTLD-PROGRAM	ADVOCACY & COMMUNICATION FOCAL PERSON	NOT AVAILABLE	20%	20%	20%	20%
10	NUMBER OF CHARTERS DISTRIBUTED AND DISSEMINATED	ABSOLUTE NUMBER	DISTRIBUTION REPORTS	QUARTERLY	NTLD-PROGRAM	ADVOCACY & COMMUNICATION FOCAL PERSON	NOT AVAILABLE		23,500 DISTRIBUTED	NONE	NONE
11	ONLINE SUPPORT GROUP ESTABLISHED	DOCUMENTATION ON ACTIVE GROUP COMMUNICATIONS	PROGRAMME REPORTS	QUARTERLY	NTLD-PROGRAM	ADVOCACY & COMMUNICATION FOCAL PERSON	_	_	ONLINE SUPPORT GROUP ESTABLISHED	_	_

GENDER AND HUMAN RIGHTS

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQ	RESPONSIBLE ORGANIZATION	RESPONSIBLE PERSON	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
1.	NUMBER OF TB, LEPROSY AND LUNG DISEASES BILLS ACCENTED TO	DRAFT BILL DOCUMENT	DRAFTING REPORTS	ONE TIME	FOCAL PERSON FOR GENDER & HUMAN RIGHTS	NTLD-PROGRAM		DRAFT BILL	0	0	1
2.	NUMBER OF TOTS TRAINED ON GENDER & HUMAN RIGHTS	ABSOLUTE NUMBER	TRAINING REPORTS	ANNUALLY	FOCAL PERSON FOR GENDER & HUMAN RIGHTS	NTLD-PROGRAM		300	0	0	0
3.	NUMBER OF PEOPLE TRAINED ON HUMAN RIGHT ISSUES	ABSOLUTE NUMBER	TRAINING REPORTS	QUARTERLY	FOCAL PERSON FOR GENDER & HUMAN RIGHTS	NTLD-PROGRAM			100 PEOPLE TRAINED	200 PEOPLE TRAINED	100 PEOPLE TRAINED
4.	NUMBER OF DIALOGUE FORUMS HELD WITH STAKEHOLDERS	ABSOLUTE NUMBER	STAKEHOLDER FORUM REPORTS	QUARTERLY	FOCAL PERSON FOR GENDER & HUMAN RIGHTS	NTLD-PROGRAM		47 COUNTY DIALOGUE FORUMS HELD	47 COUNTY DIALOGUE FORUMS HELD	47 COUNTY DIALOGUE FORUMS HELD	47 COUNTY DIALOGUE FORUMS HELD

SOCIAL PROTECTION

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQ	RESPONSIBLE ORGANIZATION	RESPONSIBLE PERSON	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
1	NUMBER OF NATIONAL POLICY DOCUMENTS DEVELOPED AND DISSEMINATED ON SOCIAL PROTECTION OF TB PATIENTS	ABSOLUTE NUMBER: THESE ARE POLICY DOCUMENTS ON SOCIAL PROTECTION OF TB PATIENTS DEVELOPED AND DISSEMINATED	PRINTED DOCUMENTS	ONCE	NTLD-PROGRAM	SOCIAL PROTECTION COORDINATOR			1		
2	PROPORTION OF TB PATIENTS RECEIVING SUPPORT THROUGH MONTHLY CASH TRANSFER	NUMERATOR: TOTAL NUMBER OF TB PATIENTS REGISTERED IN THE REPORTING PERIOD AND PROVIDED WITH MONTHLY CASH SUPPORT DENOMINATOR: TOTAL NUMBER OF TB PATIENTS REGISTERED IN THE REPORTING PERIOD	TIBU/ SCTLC REPORTS	ANNUALLY	NTLD-PROGRAM	M&E OFFICER			10%	25%	50%
3.	PROPORTION OF ELIGIBLE TB PATIENTS RECEIVING NUTRITION SUPPORT	NUMERATOR: TOTAL NUMBER OF TB PATIENTS REGISTERED IN THE REPORTING PERIOD AND ELIGIBLE FOR NUTRITION SUPPORT DISAGGREGATED BY TYPE OF ELIGIBILITY	TIBU/ SCTLC REPORTS	ANNUALLY	NTLD-PROGRAM	M&E OFFICER			30%	50%	80%

MONITORING, EVALUATION & RESEARCH

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQ	RESPONSIBLE ORGANIZATION	RESPONSIBLE PERSON	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
1.	PROPORTION OF SUB COUNTIES REPORTING PRESUMPTIVE TB CASES	NUMERATOR: NUMBER OF SUB-COUNTIES REPORTING PRESUMPTIVE TB DENOMINATOR: TOTAL NUMBER OF SUB-COUNTIES	PROGRAMME CASE FINDING REPORTS	QUARTERLY	NTLD-PROGRAM	M/E OFFICER	0	0	25%	50%	>85%
2.	PROPORTION OF SUB -COUNTIES REPORTING 100% OF THEIR FACILITIES USING CONTACT REGISTERS	NUMERATOR: NUMBER OF SUB-COUNTIES REPORTING 100% OF FACILITIES USING CONTACT REGISTERS DENOMINATOR: TOTAL NUMBER OF SUB-COUNTIES	PROGRAMME REPORTS	QUARTERLY	NTLD-PROGRAM	M/E OFFICER	0	0	25%	50%	>85%
3.	PROPORTION OF FACILITIES USING THE INTEGRATED TOOL TO REPORT THROUGH DHIS	NUMERATOR: NUMBER OF FACILITIES USING THE INTEGRATED TOOL TO REPORT THROUGH DHIS DENOMINATOR: TOTAL NUMBER OF FACILITIES	PROGRAMME REPORTS	QUARTERLY	NTLD-PROGRAM	M/E OFFICER	0	0	2%	80%	100%
4.	PROPORTION OF SUB COUNTIES REPORTING 100% OF THEIR FACILITIES USING NATIONAL RECOMENDED TOOLS	NUMERATOR: NUMBER OF SUB-COUNTIES REPORTING 100% OF THEIR FACILITIES USING NATIONAL RECOMMENDED TOOLS DENOMINATOR: TOTAL NUMBER OF SUB-COUNTIES	DQA REPORTS	ANNUAL	NTLD-PROGRAM	M/E OFFICER	100%	100%	100%	100%	100%
5.	PROPORTION OF PRINTED TOOLS WITH SOPS INTEGRATED	NUMERATOR: NUMBER OF PRINTED TOOLS WITH SOPS INTEGRATED DENOMINATOR: TOTAL NUMBER OF PRINTED TOOLS	PROGRAMME REPORTS	ANNUALLY	NTLD-PROGRAM	M/E OFFICER	50%	50%	100%	100%	100%

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQ	RESPONSIBLE ORGANIZATION	RESPONSIBLE PERSON	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
6	PROPORTION OF TARGETED HCW TRAINED IN M/E	NUMERATOR: NUMBER OF HCW S TRAINED IN M/E DENOMINATOR: TOTAL NUMBER HCWS TARGETED FOR TRAINING	PROGRAMME REPORTS	QUARTERLY	NTLD-PROGRAM	M/E OFFICER			100%	100%	100%
7	NUMBER OF FINANCIAL REPORTING TOOLS DEVELOPED	ABSOLUTE NUMBER OF FINANCIAL REPORTING TOOLS DEVELOPED	PROGRAMME REPORTS	ANNUAL	NTLD-PROGRAM	M/E OFFICER	-	-	1		
8	PROPORTION OF COUNTIES WITH REPORTS ON TB	NUMERATOR: NUMBER OF COUNTIES WITH REPORTS ON TB EXPENDITURES COMPLIED DENOMINATOR: TOTAL NUMBER OF COUNTIES	PROGRAMME REPORTS	ANNUAL	NTLD-PROGRAM	M/E OFFICER	-	-	10%	20%	50%
9	PROPORTION OF TARGETED HEALTH CARE WORKERS AND REGISTRATION AGENTS TRAINED ON VERBAL AUTOPSY	NUMERATOR: NUMBER OF TARGETED HEALTH CARE WORKERS AND REGISTRATION AGENTS TRAINED ON VERBAL AUTOPSY DENOMINATOR: TOTAL NUMBER OF TARGETED HCW AND REGISTRATION AGENTS FOR TRAINING IN VERBAL AUTOPSY	PROGRAMME REPORTS	ANNUAL	NTLD-PROGRAM	M/E OFFICER	-	-	100%	100%	100%
10	PROPORTION OF TARGETED HEALTH CARE WORKERS TRAINED ON ICD-10	NUMERATOR: NUMBER OF TARGETED HEALTH CARE WORKERS TRAINED ON ICD-10 DENOMINATOR: TOTAL NUMBER OF TARGETED HCW FOR TRAINING ON ICD-10	PROGRAMME REPORTS	ANNUAL	NTLD-PROGRAM	M/E OFFICER	-	-	100%	100%	100%

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQ	RESPONSIBLE ORGANIZATION	RESPONSIBLE PERSON	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
11	NUMBER OF ANNUAL KENYA TB MORTALITY REPORTS PRODUCED	ABSOLUTE NUMBER	PROGRAMME REPORTS	ANNUAL	NTLD-PROGRAM	M/E OFFICER	-	-	1	-	-
12	PROPORTION OF FACILITIES ACHIEVING SET DATA QUALITY STANDARDS	NUMERATOR: NUMBER OF FACILITIES ACHIEVING SET DATA QUALITY STANDARDS DENOMINATOR: TOTAL NUMBER OF FACILITIES	DQA REPORTS	ANNUAL	NTLD-PROGRAM	M/E OFFICER	-	88%	>88%	>90%	>90%
13	PROPORTION OF COUNTIES WITH MONTHLY REPORTS ON TB/ MDRTB	NUMERATOR: NUMBER OF COUNTIESS WITH MONTHLY REPORTS ON TB/ MDRTB DENOMINATOR: TOTAL NUMBER OF COUNTIES	PROGRAMME REPORTS	QUARTERLY	NTLD-PROGRAM	M/E OFFICER	-	-	25%	50%	>80%
14	NUMBER OF CUMULATIVE ORS CONDUCTED AND DOCUMENTED		PROGRAMME REPORTS	ANNUAL	NTLD-PROGRAM	M/E OFFICER		5	5	5	5
15	PROPORTION OF TRAINED MENTEES WITH COMPLETED AND DOCUMENTED OR	NUMERATOR: NUMBER OF TRAINED MENTEES WITH COMPLETED AND DOCUMENTED OR DENOMINATOR: TOTAL NUMBER OF TRAINED MENTEES	PROGRAMME REPORTS	ANNUAL	NTLD-PROGRAM	M/E OFFICER	20%	30%	80%	>80%	>80%

POLICY AND PLANNING

NO	INDICATOR	INDICATOR DEFINITION	SOURCE	FREQ	RESPONSIBLE ORGANIZATION	RESPONSIBLE PERSON	BASELINE TARGETS	YEAR 1	YEAR 2	YEAR 3	YEAR 4
1.	NUMBER OF END TERM NSP 2015-2018 REVIEW CONDUCTED	ABSOLUTE NUMBER	REPORT ON END TERM REVIEW OF NSP	ONCE	NTLD-PROGRAM	PLANNING/ POLICY FOCAL PERSON	1	0	0	0	1

CHAPTER 3

3.0 Routine Data Collection, Analysis and Reporting

3.1 TB Recording and Reporting Tools

In conformity with WHO recommendations, the NTLD-Program has several reporting tools in respect to the various thematic areas. The following registers, cards and forms are used for the management of TB/Leprosy at health care facilities supported by the NTLD-Program:

3.1.1 Tuberculosis:

- TB Patient Appointment Card
- TB Patient Record Card
- TB Treatment Facility Register
- Electronic District TB Register (TIBU)
- Referral Form to TB clinic
- Referral Form from TB Clinic to other care providers.
- Electronic Quarterly Case Finding Report Form
- Electronic Cohort Report Forms (Results of Treatment)

3.1.2 MDR TB

- MDR TB Patient Appointment Card
- MDR TB Patient Log book
- MDR TB Treatment Facility Register
- Electronic MDR TB Treatment District Register
- Electronic Quarterly Case Finding Report Form
- Electronic Cohort Report Forms

3.1.3 Laboratory Tools

- TB Sputum-smear Examination Request Form
- Laboratory Register for Sputum-smear Examination
- TB Culture/sensitivity Request Form.
- Quarterly AFB Report Form

3.1.4 Drugs and other supplies reporting tools

- Daily Activity Drug Register (DADR)
- Facility CDRR (Consumption Drug Report & Request) Form
- District CDRR
- Bin Card
- S11.
- TB Patient Pack Control Card (currently in-printed on the Packs)

3.1.5 Others

- TB/leprosy Patient Defaulter Tracing Chart
- TB/leprosy Patient Transfer Form
- Facility Supervision Tool
- Patient Interview Schedule
- Leprosy facility register
- Leprosy appointment card
- Leprosy patient record card
- PAL
- Asthma register
- Asthma appointment card

TB appointment card

This card has to be filled by the health worker when the patient is started on treatment. The card remains with the patient during and after the full period of treatment. This will enable the patient to collect drugs and to continue treatment at another TB clinic other than the one he/she is registered when in transit or moving residence. In case of a more or less permanent transfer, a transfer form must be filled and given to the patient.

This card holds the following information: name of the district where the patient is receiving treatment, the district registration number, name of the facility where the patient is receiving treatment, patients full names, postal and physical address, age, sex, treatment regimen, date when treatment started, outcome and body weight of the patient which is recorded every 28 days. The rear part of the card contains the drug collection dates for both the intensive and continuation phases.

TB Patient Record Card

Although, seemingly, containing more or less the same information as the Appointment Card, the Patient Record Card is focused more on the clinical aspects of patient management. It also contains information, which cannot be put on the Appointment Card, and as such cannot be replaced by it. The Patient Record Card is a very valuable source of information for operational/clinical research on TB management. It contains data, which often cannot be found in the TB Registers.

The card should be filled as completely as possible, during every visit of the patient by the health worker who manages their treatment. The card contains the following information name of the district where the patient is receiving treatment, district registration number, name of the facility (where the patient is receiving treatment), patients full names, postal and physical address, age, sex, treatment regimen, treatment outcome, body weight (taken every 28 days), name and address of patient supporter, disease classification (Pulmonary/ Extra pulmonary), patient classification (categorized on epidemiological and operational reasons as follows new patient, smear positive relapse, smear negative/EPTB relapse, RAD and TI), culture results, source of patient(referred by),Transfers In CD4 results information on ART and the outcome of treatment. The TB Patient Record Card contains medical information, which is strictly confidential, must be handled accordingly and must be left at the unit where the patient receives treatment.

TB Treatment Facility Register

The TB Treatment Register is maintained at each health facility where tuberculosis treatment is provided. The Tuberculosis Treatment Unit/ Facility Register is a very important monitoring & evaluation tools of the NTLD-Program. Based on the information in this register all reports on TB/HIV case finding and treatment outcome related data are analyzed and translated into activities essential for TB control in the country.

Maintenance of this register is the task of the health worker(s) who are responsible for the TB clinic. The contents of this register should be handled as any other medical document containing confidential information. It must be kept in a lockable place where unauthorized persons don't have access to it. Every patient receiving tuberculosis treatment at the health facility must be recorded in this register. The register contains most of the information also found in the TB Patient Record Card and therefore should be consistent with the latter. It must be updated immediately after a patient attends the clinic for drug collection or when additional information becomes available like sputum examination results, HIV test results etc.

Electronic District TB Register

This register is a summary of the facility register and contains the same information as the latter. This register is normally updated by the District TB and Leprosy Coordinator and contains information on all the patients in the district/zone. The SCTLC prepares case finding and cohort reports from this register.

Referral Form to TB clinic

This Patient Referral Form facilitates the referral of TB suspects or HIV positive patients to a TB clinic for TB screening and subsequent treatment. The forms are provided in a booklet in duplicate. One copy is filled and goes with the patient to the unit he/she is referred to and the other copy remains in the booklet at the referring unit. Since these forms contain confidential medical information, the booklet must be kept in a secure, lockable place.

Referral form from TB clinic to other care providers

This form is used by the TB clinics to refer TB patients to other care providers for additional or continuing care. The forms are provided in a booklet in duplicate. One copy is filled and goes with the patient to the unit he/she is referred to and the other copy remains in the booklet at the referring unit. Since these forms contain confidential medical information, the booklet must be kept in a secure, lockable place.

There are forms used for TB case finding and treatment outcomes and they are:

Quarterly Case finding Report form

This quarterly report is automatically at the end of every quarter by the SCTLC from TIBU and reports how many patients were registered during the previous quarter of different patient. This forms the primary source for assessing program performance and, to a lesser extent, epidemiological surveillance. The report is usually generated in by the sub-county TB coordinator and sent to the County TB coordinator who reviews, analyses the report and the national level by the virtue of using a common reporting framework can generate the data on a quarterly basis as well. The revision and collation of the data is done during the quarterly meeting, which is held after the 20th of the month proceeding the quarter that has ended.

Cohort Form

This quarterly report is generated from the TIBU and gives the treatment result of patients registered during the quarter that ended the previous year (12-15 months), allowing enough time for all patients to have finished treatment. The report is filled in by the sub County TB coordinator using data from the SCTLCs TIBU system, which is updated from the TB facility register. The report is then sent to the provincial level to the County TB and Leprosy Coordinator who reviews and analyses the report. The national level by the virtue of using a common reporting framework can generate the data on a quarterly basis as well. Before submission to the central level data cleaning and collation takes place during the quarterly meeting held as earlier on explained.

DEFAULTER TRACING

Defaulter tracing is the responsibility of all health care staff in particular the nurse in the clinic, the public health officer, the community health extension worker and the community health care worker. During the intensive phase of TB treatment (first two months), defaulter-tracing activities should be instituted immediately after the weekly clinic (within two days of missing clinic) and during the continu¬ation phase of TB treatment (after two months to 6 months of treatment), defaulter-tracing activities should be initiated immediately following the two weekly drug collection (within two days). Particular attention should be paid to addressing the course of defaulting.

MDR TB Recording and Reporting

MDR TB Appointment Card

This card has to be filled by the health worker when the patient is started on treatment. The card remains with the patient during and after the full period of treatment. This will enable the patient to collect drugs and to continue treatment at another MDR TB clinic other than the one he/she is registered when in transit or moving residence.

In case of a more or less permanent transfer, a transfer form must be filled and given to the patient. This card holds the following information name of the district where the patient is receiving treatment, the district registration number, name of the facility where the patient is receiving treatment, patients full names, postal and physical address, age, sex, treatment regimen, date when treatment started.

MDR TB Patient Record Card

The Patient Record Card is focused more on the clinical aspects of patient management. It also contains information, which cannot be put on the Appointment Card, and as such cannot be replaced by it. The Patient Record Card is a very valuable source of information for operational/clinical research on MDR TB management. It contains data, which often cannot be found in the MDR TB Registers. The card should be filled as completely as possible, during every visit of the patient by the health worker who manages their treatment.

The card contains the following information name of the district where the patient is receiving treatment, district registration number, name of the facility (where the patient is receiving treatment), patients full names, postal and physical address, age, sex, treatment regimen, treatment outcome, body weight, name and address of patient supporter, disease classification (Pulmonary/Extra Pulmonary), patient classification (categorized on epidemiological and operational reasons as follows new patient, smear positive relapse, smear negative/EPTB relapse, RAD and TI), culture results, source of patient, Transfers In CD4 results information on ART and the outcome of treatment. The MDR TB Patient Record Card contains medical information, which is strictly confidential, must be handled accordingly and must be left at the unit where the patient receives treatment.

MDR TB Treatment Facility Register

The TB Treatment Register is maintained at each health facility where MDR TB treatment is provided. The Tuberculosis Treatment Unit/facility Register is a very important monitoring and evaluation tools of the NTLD-Program. Based on the information in this register all reports on MDR TB case finding and treatment outcome related data are analyzed and translated into activities essential for MDR TB control in the country. Maintenance of this register is the task of the health worker(s) who are responsible for the TB clinic. The contents of this register should be handled as any other medical document containing confidential information. It must be kept in a lockable place where unauthorized persons don't have access to it. Every patient receiving tuberculosis treatment at the health facility must be recorded in this register. The register contains most of the information also found in the TB Patient Record Card and therefore should be consistent with the latter. It must be updated immediately after a patient attends the clinic for treatment observation and drug collection or when additional information becomes available like sputum examination results, smear conversion, HIV test results etc.

MDR TB Treatment District Register

This register is a summary of the facility register and contains the same information as the latter. This register is normally updated by the District TB and Leprosy Coordinator and contains information on all the patients in the district/zone. The SCTLC prepares case finding and cohort reports from this register.

Referral Form to TB clinic

This Patient Referral Form facilitates the referral of MDR TB suspects to a TB clinic for TB screening and subsequent treatment. The forms are provided in a booklet in duplicate. One copy is filled and goes with the patient to the unit he/she is referred to and the other copy remains in the booklet at the referring unit. Since these forms contain confidential medical information, the booklet must be kept in a secure, lockable place.

Referral form from MDR TB clinic to other care providers

This form is used by the MDR TB clinics to refer MDR TB patients to other care providers for additional or continuing care. The forms are provided in a booklet in duplicate. One copy is filled and goes with the patient to the unit he/she is referred to and the other copy remains in the booklet at the referring unit. Since these forms contain confidential medical information, the booklet must be kept in a secure, lockable place.

There are forms used for MDR TB case finding and treatment outcomes and they are:

Quarterly Case Finding Report Form

This quarterly report is generated from the SCTLCs TIBU system and reports how many patients were registered during the previous quarter of different patient. This forms the primary source for assessing program performance and, to a lesser extent, epidemiological surveillance. The report is usually generated by the sub county TB coordinator and sent to the County TB coordinator who revises and analyses the report. The national level by the virtue of using a common reporting framework can generate the data on a quarterly basis as well. The revision and collation of the data is done during the quarterly meeting, which is held after the 20th of the month proceeding the quarter that has ended.

Cohort Form

This quarterly report generated from the SCTLCs MDR TB TIBU register and gives the treatment result of patients registered during the quarter that ended the previous year (24-28 months), allowing enough time for all patients to have finished treatment. The report is filled in by the sub County TB coordinator using data from the facility register. The reports become available concurrently at all levels by the virtue of a common reporting framework. Data cleaning and collation takes place during the quarterly meeting held as earlier on explained.

DEFAULTER TRACING

Defaulter tracing is the responsibility of all health care staff in particular the nurse in the clinic, the public health officer, the community health extension worker and the community health care worker. During the intensive phase of TB treatment (first two months), defaulter-tracing activities should be instituted immediately after the weekly clinic (within two days of missing clinic) and during the continu¬ation phase of TB treatment (after two months to 6

months of treatment), defaulter-tracing activities should be initiated immediately following the two weekly drug collection (within two days). Particular attention should be paid to addressing the course of defaulting.

MDR TB Recording and Reporting

MDR TB Appointment Card

This card has to be filled by the health worker when the patient is started on treatment. The card remains with the patient during and after the full period of treatment. This will enable the patient to collect drugs and to continue treatment at another MDR TB clinic other than the one he/she is registered when in transit or moving residence. In case of a more or less permanent transfer, a transfer form must be filled and given to the patient. This card holds the following information name of the district where the patient is receiving treatment, the district registration number, name of the facility where the patient is receiving treatment, patients full names, postal and physical address, age, sex, treatment regimen, date when

MDR TB Patient Record Card

The Patient Record Card is focused more on the clinical aspects of patient management. It also contains information, which cannot be put on the Appointment Card, and as such cannot be replaced by it. The Patient Record Card is a very valuable source of information for operational/clinical research on MDR TB management. It contains data, which often cannot be found in the MDR TB Registers. The card should be filled as completely as possible, during every visit of the patient by the health worker who manages their treatment.

The card contains the following information name of the district where the patient is receiving treatment, district registration number, name of the facility (where the patient is receiving treatment), patients full names, postal and physical address, age, sex, treatment regimen, treatment outcome, body weight, name and address of patient supporter, disease classification (Pulmonary/Extra Pulmonary), patient classification (categorized on epidemiological and operational reasons as follows new patient, smear positive relapse, smear negative/EPTB relapse, RAD and TI), culture results, source of patient, Transfers In CD4 results information on ART and the outcome of treatment. The MDR TB Patient Record Card contains medical information, which is strictly confidential, must be handled accordingly and must be left

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This register is a summary of the facility register and contains the same information as the latter. This register is normally updated by the District TB and Leprosy Coordinator and contains information on all the patients in the district/zone. The SCTLC prepares case

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Referral form from MDR TB clinic to other care providers

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There are forms used for MDR TB case finding and treatment outcomes and they are:

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Cohort Form

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LABORATORY FORMS AND REGISTERS

Laboratory Request Form For Sputum Examination

This form is used by health care workers who are examining patients at the outpatient departments, chest clinics, and wards of the health facilities to request for sputum examinations. The form is also used for sputum smear follow up in the chest clinic and the laboratory. The following details must be filled Name of the patient/client, Age, Sex (M/F), type of patient (new or follow-up), patient number/laboratory serial number, results as indicated in the laboratory guidelines and ownership of the work i.e. the health care worker must sign on the form to show ownership.

AFB Laboratory Register

This register is kept and maintained by the laboratory staff. The register contains the laboratory findings and is timely updated by the laboratory staff in the facility. The register has various sections, which include Serial number, date (1st date of registration of the request), Name of the patient, age, sex, residence/address, source of the request (OPD/Ward/Clinic), results and ownership (name and signature of officer who did the examination requesting).

Culture Request Form

Culture and sensitivity examination must be done for all retreatment, contacts of MDR-TB, all NSP, all health care workers who develop TB and new smear negative HIV+ patients. The Culture Request Form must be filled by the SCTLC, or by the clinician requesting for the test. The first part of the form contains the following information which must be filled: name (all three names), district registration number, OP/IP number, address, actual age of patient, Sex of patient, Referring clinic or ward, Facility name, Type of specimen, Date of collection, Clinician's name and signature, examination required: Specify whether for smear, culture or sensitivity, type of patient: Tick the correct type of patient, Previous treatment: Indicate the duration of treatment and drugs used. On the other side of the same form there is room for the laboratory report for direct smear, culture report, and sensitivity testing. The report should also have the name, signature and designation of the laboratory officer and the date the report was finalized.

Quarterly AFB Report Form

The AFB report form is used to report on the AFB workload in specific districts. The sub county medical Laboratory technologist must fill this form all the facilities in the sub county that carry out sputum smear microscopy. The forms are submitted to the County Medical Laboratory Technologist who revises the reports and forwards to

Drugs and other supplies reporting tools

These tools are used for logistic management information systems. They ensure commodity data is well recorded and reported and they are:

Daily Activity Drug Register (DADR) which is kept and maintained at the facility level where drugs are issued to the patients. The health care worker who issues drugs and must update it every time drugs are dispensed fills this register. It contains information on the stock levels at the beginning of the day and at the close of the day.

Facility CDRR (Consumption Drug Report & Request) Form is used for ordering drugs by the health facility where patient drugs are dispensed. This form is filled by the facility in charge monthly and contains information on stock levels at the end of the month, consumption, losses and adjustments, quantity required and the actual calculated stock balance. This form is submitted to the SCTLC who aggregates the consumption data using the Sub County CDRR for the districts/zone and forwards it to KEMSA on monthly basis to facilitate the resupply of drugs and other supplies.

Bin Cards are tools that are kept at the point where drugs are issued and they information on what is available and what has been issued. S11 are tools that are used for issuing drugs and other supplies from one point to another. They are maintained and filled at the store where drugs and other supplies are being issued to consumers.

TB Patient Pack Control Card is currently in-printed on the patient packs is used to ensure DOTS and is filled whenever the patient takes the medication.

Leprosy Recording and Reporting

The health staffs in charge of the tuberculosis or leprosy clinic is responsible for filling in and main¬taining the following records and registers used for case reporting, analysis of treatment and defaulter tracing:

- Leprosy Patient Treatment File
- Leprosy Appointment Card
- Leprosy Treatment Register
- Defaulter Action Card

DEFAULTER TRACING

Defaulter tracing is the responsibility of all health staff through out the full course of leprosy treatment done on monthly intervals. Failure to attend this clinic may lead to interruption of treatment and treatment failure. Therefore, any leprosy patient who has missed one clinic should be traced to establish why he/she has defaulted and to persuade him/her to attend again. Since leprosy clinics run monthly, any patient who does not appear for a clinic should be considered a defaulter and tracing activities instituted within one week.

3.2 Information/report flow and feedback mechanisms

Data is routinely collected and entered from the peripheral health facilities data capture tools by the SCTLC who does this on their monthly visits to the facilities. The SCTLC fills the sub County data onto the TIBU system when he/she visits the health facilities to register patients and provide technical assistance.

The TIBU information system was created for the purposes of strengthening monitoring and evaluation in the TB program, which takes into account all the disease areas under the program, including, TB, Leprosy, Asthma and other lung diseases. It also incorporates the Laboratory and Commodity sections of the program to ensure that the TB program collects comprehensive data, useful for decision making in management of the diseases under the program. The system also integrates with the national DHIS2 reporting infrastructure system, ensuring that the TB cases reported in TIBU reflect on DHIS2, on close of a quarter. It's a tab-based system, running on the android platform and has a web-based front that can be accessed via the Internet browser.

Monitoring and evaluation of the TB control program is conducted after the conclusion of each quarter. In Kenya's fiscal year, the four quarters are: Quarter 1: January - March; Quarter 2: April - June; Quarter 3: July – September Quarter 4: October – December. At the end of each of the quarters the SCTLC s from the regions converge together in a meeting to share findings, conduct data cleaning and update on TO/TI to improve on the treatment outcomes. Reports are usually submitted to the CTLC from the SCTLC within three weeks of expiry of the quarter and to the central unit within four weeks of expiry of the quarter. Since the reporting systems are online on and using a common reporting framework the timelines are useful since it locks the ability to revise the data at the indicated timelines. In addition, the national office reviews the data and provides feedback to the Counties within six weeks after the quarter. Detailed reports of the data are provided as feedback to the Counties after 6 months during the bi annual CTLC meetings. Eventually, the national office analyzes the data and prepares reports including the annual report with 6 months after expiry of the year.

As a part of monitoring and evaluation process in TB control, NTLD-Program has been holding biannual meetings. This meetings are held in a venue identified by the NTLD-Program and includes: Director Medical Services, Head Directorate of Preventive and Promotive Services, Head Division of Disease Control, Head NTLD-Program, Heads of the various sections within the unit, staff from the division, CTLCs, CMLTs, representative from the WHO, representative from the prisons and other key partners working within the TB control area. This team acts as a steering committee at national level which meet every six months to discuss: the results of each county with the National level in the presence partners in TB control, the different problems and the solutions implemented and check the weaknesses and strengthens confronting the areas of collaboration with other sectors like NGOs, Prisons and Private Sector.

This quarterly report generated from the SCTLCs MDR TB TIBU register and gives the treatment result of patients registered during the quarter that ended the previous year (24-28 months), allowing enough time for all patients to have finished treatment. The report is filled in by the sub County TB coordinator using data from the facility register. The reports become available concurrently at all levels by the virtue of a common reporting framework. Data cleaning and collation takes place during the quarterly meeting held as earlier on explained.

Meeting Venue: Venue identified by NTLD-Program Central Unit

Meeting Duration: 5-6 days, each of the 47 Counties presents its data, achievements and challenges on the first 2 days, on the third day the national data is presented with presentations from the various sections within the Unit, day four is for partners to present on their TB control activities in the past half year and their work plans for the following year/year and day 5 is a summary of the comprehensive work plan of all the planned activities from the division and partners. The unit takes the lead in developing the agenda for the meeting.

Meeting Frequency: Biannually
Meeting Participants
Central Level:

- Ministry of Health
    - The Head, Directorate of Preventive and Promotive Services
    - The Head, Division of Disease Control
    - The Head, National Leprosy, Tuberculosis and Lung Disease Program
    - County Tuberculosis and Leprosy Coordinators
    - County Medical Laboratory Technologist
    - Heads of sections within the Ministry of Health
    - Partners in TB control

- National and international NGOs
    - Representatives of each according to the meeting topics
- NTLD Central Unit
    - All different component coordinators

Figure 3: Data Flow

Currently data is collected at service delivery points and in the community using paper based system. At the sub county level electronic system (TIBU) is used. TIBU is used in all the Counties to collect data from the facility level. At the sub county level, data is entered into TIBU, which automatically synchronizes, to the Central server with the data becoming available on a real time basis to all levels of the health system that have access. The real time generation of data allows the all the levels to generate reports that will inform actions at lower levels.

CHAPTER 4

4.0 Evaluation and Operations Research

This section deals with activities that involve systematic collection and analysis of data to make decisions. Evaluations undertaken by the Unit are both process oriented (how is the national programme being delivered or is it being delivered as intended) and looking at results from outcome or impact evaluations of various aspects of the Unit's work.

In this section, we describe existing practices, as well as some of the gaps in evaluation and research that are being planned for in the next 4 years.

4.1 Program Review

This activity is carried out at the mid-term and end term of the strategic plan. The main focus of this review exercise is to evaluate the progress of the Unit in the implementation of the activities in the strategic plan. A team consisting of international experts, local partners in TB and Leprosy and staff from the Ministry of Health, independently carry out this activity. The review exercise is conducted in such a manner that there are clear terms of reference and internationally acceptable tools to be used in the review exercise. The review covers all the thematic areas in the Unit and the review exercise covers the whole country i.e. representative health units and sub Counties in all the Counties.

4.2 Program Evaluation

This activity entails Looking at what the program intended to achieve – what difference did it want to make? What impact did it want to make? Assessing its progress towards what it wanted to achieve, its impact targets.

Additionally program evaluation looks at the strategy of the program. Did it have a strategy? Was it effective in following its strategy? Did the strategy work? If not, why?

Looking at how it worked. Was there an efficient use of resources? What were the opportunity costs (Opportunity costs are the opportunities you give up when you decide to do one thing rather than another. What are the implications for the various stakeholders in the way the organization works? Evaluations will be done at every third year after the strategy or a project has been initiated for long term projects but for short term duration projects or strategies evaluations will be carried out at the end of the project period to obtain information on the effectiveness of the interventions implemented and to look at the cost effectiveness of the interventions. All the evaluations undertaken must be carried out in an independent and objective manner.

Various methods are used for evaluation of the Unit:

4.2.1 Self-evaluation: This involves the Unit holding up a mirror to itself and assessing how it is doing, as a way of learning and improving practice. It takes a very self-reflective and honest view by all the concerned to do this effectively, but it can be an important learning experience.

4.2.2 Participatory evaluation: This is a form of internal evaluation. The intention is to involve as many people with a direct stake in the work as possible. This may mean Unit staff and beneficiaries working together on the evaluation. If an outsider is called in, it is to act as a facilitator of the process, not an evaluator.

4.2.3 Rapid Participatory Appraisal: This is a qualitative way of doing evaluations. It is semi-structured and carried out by an interdisciplinary team over a short time. It is used as a starting point for understanding a local situation and is a quick, cheap, useful way to gather information. It involves the use of secondary data review, direct observation, semi-structured interviews, key informants, group interviews, diagrams, maps and calendars. In an evaluation context, it allows one to get valuable input from those who are supposed to be benefiting from the development work. It is flexible and interactive.

4.2.4 External evaluation: This is an evaluation done by a carefully chosen outsider or external team.

4.2.5 Interactive evaluation: This involves a very active interaction between an outside evaluator or evaluation team and the organization or project being evaluated. Sometimes an insider may be included in the evaluation team.

4.3 Surveys and surveillance

4.3.1 Specific studies/surveys

Kenya plans to undertake surveys and surveillance for TB information, both biological and behavioral surveys and surveillance in different target groups in collaboration with various partners. Surveys will be conducted regularly to obtain information, which cannot be obtained through the routine program surveillance system. The surveys, which are being proposed to measure indicators that cannot be measured using routine data are outlined. The protocols for the surveys and surveillance are based on international recommendations. The table below summarizes the planned surveys to be implemented:

Research Priorities

National, Ongoing

1. Prevalence Survey (2015-2016)
2. Nation-wide TB Drug Resistance Survey (DRS) 2015
3. Mortality Study
4. Pediatric TB HIV study
5. Delay in diagnosis study (to be completed, ongoing)
6. Inventory Studies

National

1. KAP (to be comprehensive – legislators, patients, HCWs, media, community)
2. The impact of Xpert MTB on diagnosis of TB (as per the national protocol)
3. Outcomes of ICF and IPT implementation in routine clinical settings in Kenya
4. Prevalence of pulmonary aspergilosis in PTB patients
5. Burden of Lung Disease (BOLD) study nationally

Counties

1. In counties with treatment success <80%, assess factors
2. Assess barriers to treatment adherence
3. Assess models for improving case holding by community and family-based DOTS
4. In counties where decline in case notification is >5% / year, assess if true decline and assess factors
5. Routinely do exit interviews among the patients to capture information source of patient prior to treatment as a quality of care assessment

Desktop Reviews

1. Ascertain the coverage of TB, Leprosy and LD in the mass media
2. Longitudinal data analysis of smear microscopy EQA to determine quality improvement trends and recurrent gaps
3. Longitudinal data analysis on Culture and DST services to determine trends.
4. Outcome of MDR in children and child MDR contacts
5. Documentation of best practices and timely application of best Social Protection Practices
6. Impact of food support on TB treatment outcomes
7. Determination of various factors associated with the different treatment outcomes
8. Analysis of mortality statistics

CHAPTER 5

5.0 Data Quality Assurance Mechanisms

5.1 Supportive Supervision

Support supervision objectives

Support supervision is a core management task and it is an activity that all staff of NTLD-Program will be carried out on a regular basis. Supervision aims at improving work performance, staff discipline and ensuring appropriate staff development.

The objectives of support supervision within the NTLD-Program are to:

- Ensure that unit activities are being carried out according to the agreed and published guidelines.
- Verify that outcomes are in line with what is being reported.
- Appraise the performance of the staff engaged in activities of the unit.
- Identify initiatives and achievements that should be communicated.
- Identify staff training needs.
- Give advice and provide on-the-job training.
- Agree on action plans for addressing specific problem situations.
- Receive feedback and learn from staff and the community on their experiences in the implementation of the guidelines

Supervision takes place at all operational levels of the unit: National, county, sub county, and community. Support supervision at levels is guided by the task set out in NTLD-Program Organogram.

5.1.2 Supervision by SCTLCs

In health facilities within the district, health care workers are responsible for case finding, infection control and treatment of TB, leprosy and lung disease patients. Support supervision to health care workers in diagnostic facilities is offered monthly while less busy treatment only centers supervise quarterly. Large clinics in urban centers and "problem centers" should be visited weekly. As far as possible visits should take place on scheduled clinic day.
The main responsibility of SCTLCs is to offer technical support to health care workers in all facilities in the sub county. A SCTLC should be mindful of the principles of support supervision as per guidelines, which have been outlined in the program manual.

Supervision Schedule: Preparation and distribution of the schedule will enable co-ordination of activities at both the provincial and district levels. The Schedule of TB/Leprosy clinic visits should be prepared by November and distributed in December. This covers the whole year including January of the following year. Preparation of the schedule should be done in consultation with in-charges of the TB clinics and facilities. It should clearly indicate when the clinics are due and when the SCTLC will be visiting them. It should be distributed to all health facilities, the CTLC, the SCMOH and the District Clinical officer (DCO).

Supervision should be a well-planned and organized event. The following guidelines should help a SCTLC in the preparation and conduct of a supervisory visit to a TB/Leprosy clinic.

Table 3: Supervision Guidelines for SCTLCs

What to carry
Take the following items:

- Last supervision report
- Notebook and pen
- Carry Personal Digital Assistant (PDA)
- Recording/reporting forms, TB/leprosy registers and other stationery
- Tuberculosis/leprosy drugs
- Laboratory supplies (slides/reagents)
- Money for re-imbursement
- Protective footwear for leprosy patients.
- Any relevant guidelines and IEC materials

How to do it

- Supervision should not only be a fact-finding mission. Equally important is the assessment and development of competence, support and motivation of health staff.
- Supervision does not mean that the SCTLC is doing the job of the health staff him or herself but rather that the SCTLC observes the staff as the clinic is being conducted. The SCTLC should give guidance, advice, and training where required. Compliments should be given when performance is good. On the flip side constructive criticism and training should be offered if performance is below standard.
- The general health staff has to carry out several tasks delegated to them. The responsibility of the SCTLC is to see that these tasks are performed well.

What to look at
Besides the performance of the staff SCTLCs should look at the following records.
In the clinic:

- The patient record cards: are they completely filled? Is treatment regimen and dosages correct? Are clinic attendances recorded? Are appropriate actions taken in case sputum remains positive at two months or at five months?
- Are tuberculosis /leprosy treatment registers complete and updated?
- Are follow-up smears taken at the appropriate stage of treatment?
- Is there sufficient supply of drugs, recording forms, health education materials, and poly pots?
- Are patient packs correctly used and stored?
- Are TB/HIV collaborative activities being offered?

In the pharmacy/drugs stores:-

- Are ledgers/bin cards updated and consistent with the stocks?
- Always check expiry dates.
- Who is responsible for ordering and distribution of the drugs?
- Is the store well kept, clean and secure?

In the laboratory;-

- Check the AFB register: Number of suspects examined, number of positive suspects and the number of smears examined per suspect, any defaulter at lab level.
- Check whether what is in sputum register in lab is reflected in the TB register in clinic
- Check whether there are sputum results in the lab lying uncollected
- Check for physical condition of sputum desk/section
- Check if sufficient stock of reagents and lab materials are available and examine the quality of the reagents.
- Check for QC/QA reports

Checklist:

To make such a supervisory visit as systematic as possible, a checklist will be used (see Appendix I)

Reporting: The supervision checklist has been provided in a supervision booklet. The booklet is carbonated in such a way that three leaflets are filled. The original leaflet should be passed on to the CTLC while the duplicate should be kept by the SCTLC and used to update the DHMT on the quality of TB services in the district and for sending a summarized district report to CTLC and the triplicate is left at the facility.

5.1.2 Supervision by SCTLCs

IResponsibilities of the CTLC are to co-ordinate TB and leprosy control activities in the County and supervise the work of the SCTLCs. The CTLCs with the district teams plan district level activities jointly during the quarterly meetings, make funds available for supervisory and training activities, monitor performance and validate Divisional data provided by the SCTLCs.

Every control zones should be visited quarterly, and the CTLCs should spend three days per visit during which they should accompany the SCTLCs on a supervisory visit to at least three or more clinics. The CTLC should involve provincial laboratory staff in combined supervisory visits, when centers performing AFB microscopy are visited.

The following guidelines should help the CTLCs in planning their supervision activities in the districts:

Supervision guidelines for CTLCs

What to carry

- Supervisory checklist
- NTLD-Program programme manual
- NTLD-Program clinical guidelines
- Supplies – drugs, stationery, money, etc.
- Previous reports (supervisory reports, cohorts, SCTLCs' monthly activities

Where to Visit

- Regular and scheduled visits in the company of the SCTLC should be made to the office of the DMOH, the district hospital chest clinic, TB or leprosy wards in the hospital, the district laboratory; the district drug store, at least two peripheral health units one of which should preferably be a dispensary, at least one NGO/FBO/CBO health facility and at least one private health care facility if the district has on-going PPMDOTS activities.
- Special visits might focus on particular problem areas in for example, in prisons, school.
- Visit should also target at least one community-based TB activities

What to look at

- As for supervision by SCTLC
- Inspect physical facilities' e.g. beds in TB ward, microscopes in the laboratory, x-ray facilities etc.
- Discuss and assess transport available to the SCTLC
- Discuss DOTS implementation and DOTS expansion activities.
- The performance of community TB

What to look for

- Quality of recording (completeness of entries)
- Updating of the treatment outcomes
- Consistency of the data
- Verification of the physical stock
- Expiry dates and quantity of supplies
- State of storage of supplies
- Bed capacity versus occupancy
- SCTLC office space
- Distribution of staff in chest clinic/TB ward
- Interpersonal relationships/team work
- Staff welfare
- Assess training needs
- Completeness of tools used in monitoring community TB
- Availability and distribution of IEC materials for TB/HIV

What to discuss

- Major findings of the supervisory visit. When these are positive, compliment and when they are negative, look for solutions with the team.
- New NTLD-Program policies including research, new regimens, circulars, new reporting systems, etc.
- Successes, constraints, concerns

What to record

- Relevant issues that have come up during the visit
- Recommendations arising from the discussion
- Relevant statistical indicators (case finding, etc.)

What to report

- All negative issues that could not be sorted out immediately.
- Agreed solutions.
- Statistical findings.
- Changes related to problems identified during the previous visit.

5.1.3 Technical Assistance by the Central Unit

The Central Unit has responsibility for overseeing the full range of task at all levels of the Unit according to the guidelines set out in the NTLD-Program operational manual. With regard to its supervisory functions, the objectives are the same as those given at the beginning of this section. Central Unit is concern with problem solving in conjunction with the CTLCs and responding to issues that are identified either by the Central Unit in studying reports and in observing what is happening in the field or by the CTLCs themselves or by others from outside the unit.

As well as maintaining a regular pattern of visits to the Counties the Central Unit should give priority to responding to requests from CTLCs for support in tackling difficulties and in promoting new activities. If, in the course of monitoring reports, members of the Central Unit notice certain aspects that should be explored or appraised, they should first discuss these issues with the CTLC and agree on a course of action. The solution may involve a supervisory visit to the place in question.

For routine the unit carries out supportive supervision to every County at least twice a year or frequently as need arises

Guidelines for technical assistance by CU

The team of supervisors from Central Unit shall comprise

- The Head of the Unit or his/her nominee who will be the team leader. The nominee may be a central unit staff or an experienced CTLC from a different TB control zone.
- The Laboratory coordinator
- The nurse coordinator
- The Health Management Information System Coordinator [M&E coordinator]
- The Clinical Coordinator (an experienced district TB and Leprosy Coordinator)
- Logistical coordinator [Pharmacist]
- ACSM coordinator
- An invited partner who works or supports central unit [co-opted]
- A driver
- The Central Unit supervision team will have the following TOR:
- To determine the extent to which TB/leprosy control activities are carried out according to agreed national guidelines.
- To validate reports on TB/leprosy control activities from the Counties
- To identify gaps, weaknesses and strengths that can be used to improve Division performance.
- To identify resource and other needs for improving the capacity of the Division to deliver DOTS
- To appraise the Division staff and other stakeholders on TB/leprosy control activities including new initiatives.

The technical assistance procedures: What to carry

- Supervision check list
- Reference materials
- Previous supervision report with a list of items that needed to be followed up
- New information
- Guidelines, manuals
- Writing materials

Supervision schedules: A supervision schedule shall be drawn up every half year. The schedule should indicate Counties to be visited and the supervision dates. This schedule should be communicated to all the CTLCs. The CTLCs. should be fully involved in preparing the schedule so that dates are agreed on which are responsive to the needs of the Counties/districts. The responsibility for drawing up this schedule will be vested on the head of the unit or his/her nominee.

Where to and who to visit: The supervision exercise will start with briefing session with the CTLCs and the County Director of Health. After reviewing TB/leprosy control reports with the CTLCs/CDH the team will select two sub counties for field visits. These sub counties should consist of the best performing and the worst performing districts so that issues affecting performance can be learned. Consultations with the CTLCs should take about half a day. The team is accompanied by the CTLCs and sometimes other members of the CHMT then go to the selected districts. At the district the team should have discussion with the SCMOH and other members of the SCHMT and then visit at least 5 health care facilities: the provincial hospital, a district hospital, a health center, a dispensary and a private/faith-based facility all selected at random or after identifying problems that need to be resolved at health facility level. The supervision of one sub-county should take at least two days. The supervision of a district should end with a debriefing session with the SCMOH and other members of the SCHMT. Therefore the supervision of County should take about five days and should end with a debriefing session with the CTLCs/CDH and other members of the CHMT.

5.2 Data Quality Assurance

Support supervision objectives

In looking at data quality the following attributes are considered:

- Completeness

This attribute is achieved by ensuring that all the districts have reported and it is counterchecked at all levels, internal consistency of the reports are checked at the provincial level by looking at the reporting trends and it is indicative of whether all the cases in the facilities have been notified. In addition, the completeness of data entered at the facility level is routinely checked and updated during supervision. Consistency is further checked during the review meetings where the registers are reviewed for completeness before cohort reports are checked.

- Timeliness

Timeliness of submission of reporting is ensured though tracking of reporting rates at provincial and national level at the end of the stipulated time. To ensure timely and wide dissemination of the annual reports the program provides an electronic version available in our website.

- Accuracy

Accuracy of the reports is ensured by regeneration of cohort reports during quarterly review meetings and during routine data quality assessment. During the quarterly meetings self checking data fields are compared. In addition during supervision visits data in different source documents are compared.

- Integrity

At all levels data is kept confidentially and submissions of reports have to be countersigned by the Sub County Medical officer of Health (SCMOH). During supervisory visits data available at the sub county level is compared with data at the facility level. Additionally, data is re generated during routine data quality assessment and during quarterly review meetings

5.2.1 Review meetings

NTLD-Program holds quarterly review meetings of the provincial teams which includes SCMOH, SCTLCs, SCHRIO, SCPHO and sub county medical lab technologists (SCMLTs) in the County. At these meetings, commonly referred to as the SCTLC meetings, the data submitted by the SCTLCs is reviewed by the team with queries raised where there are discrepancies. An activity that has proved useful in validating the case finding and treatment outcomes data is the exchange of TB district registers where SCTLCs generate case finding and case holding in order to ascertain the validity of the reported findings. Similarly, during similar quarterly meetings of the Provincial TB and Leprosy Coordinators and the NTLD-Program, the CTLCS present their data that is reviewed by all and queries are raised on any discrepancies.

5.2.2 Routine Data Quality Assessment

NTLD-Program will carry out routine data quality assessment every two years; this will entail an external audit to assess a Program ability to report quality data. It will focus on:

- Verifying the quality of reported data
- Assessing the data management and reporting systems for standard program output indicators

This will be achieved through use of acceptable Routine Data Quality Assessment Tools.

The objectives of the data quality assessment will be to:

ASSESS - quantify rapidly

1) The quality of reported data for key indicators at selected sites; and
2) The ability of data-management systems to collect, manage and report quality data.

MONITOR - improve capacity and performance of the data management and reporting system to produce quality data.
The data quality assessment will serve the following purposes:

Assesses of NTLD-Program data management and reporting systems. This is undertaken annually. It assesses NTLD-Program ability to collect and report quality data at all levels. This will identify gaps and monitor improvements.

Strengthen staff's capacity in data management and reporting.
The data quality assessment will be implemented using standard protocol, which clearly outlines data verifications of the 5 attributes of the TB R&R quality indicator:

- Quantitative comparison of recounted recorded data to reported data on source document. Comparison is based on crosschecking of difference source document. Comparison between independent source document such as laboratory-drug management and patient management source documents, could be considered as capture-recapture approach,
- Quantitative review of timeliness of reported documents,
- Quantitative review of completeness of source documents
- Review of availability of source documents
- Quantified weight indicator of quality of TB Recording and Reporting system.

The output of data quality assessment is an indicator of the TB R&R for monitoring and improving data quality.

AFB Microscopy Quality Assurance

To ensure the validity and reliability of laboratory smear results according to National EQA guidelines are adhered to. External Quality Assurance (EQA) has been established in most of the Counties, with countrywide coverage of 89% in 2013. The CRL oversees the EQA in the provincial laboratories while the provincial and district Medical Laboratory Technologist supervise all the district and health center laboratories respectively. The CRL receives bi-annual technical support missions from international experts based at the International Union against TB and Lung Disease (IUATLD) and WHO, who assist in making sure that it performs according to international standards. In addition, the CRL is attached to the Supranational Laboratory in Brisbane, Australia and regularly submits samples of TB cultures for validation of DST results. All these activities help ensure the validity of the work conducted at the Central Reference Laboratory (CRL.)

There exists a quality assurance for TB drugs, TB drugs are procured and distributed using KEMSA the Kenyan Medicines and supplies agency. Carrying out regular post marketing surveillance every two years further strengthens drugs assurance.

CHAPTER 6

6.0 Monitoring, Evaluation & Research Coordination

6.1 MER Structure

There is an established M&E program within the Policy, planning and Research Section within the National of Leprosy, Tuberculosis and Lung Disease Program (NTLD-Program). The unit is charged with the coordination and implementation of all Monitoring and Evaluation activities related to the Unit's mandate. M&E activities are undertaken via several groups such as the M&E advisory group, the M&E working group and the NTLD M&E Program.

The Monitoring & Evaluation component for NTLD-Program has the following terms of reference:

a. To conduct M&E of TB control activities supported with funding from the different funding agencies, with plans for implementation and capacity building in accordance with the set indicators and objectives laid out in the strategic plan.
b. To coordinate with NTLD Program Central Unit with partners by providing technical support to ensure that they are able to effectively monitor and evaluate activities and summarize the overall impact of the project.
c. To coordinate and work with agencies undertaking M&E and other related agencies.
d. To integrate and link the M&E activities at the national level.

6.2 MER Advisory Group

At the upper-most level an M&E technical advisory group to the National TB control Program is being established. The M&E Advisory Group, comprised of both NTLD-Program (Government), partners and NGOs, will act as a committee for technical support as well as network collaboration for improving monitoring and evaluation processes and advocacy for all TB control projects under NTLD-Program to follow up performance framework, M&E plan and activities related to all grants on TB at all levels.

Roles and responsibilities of the National M&E Advisory Group

1. This group addresses M&E issues related to projects and programs being implemented in coordination with the NTLD-Program to support principal recipients and sub-recipients of grants, as well as the relevant units of all the implementing partners in conducting quarterly monitoring and progress review.
2. Supports the capacity development for staff in the area of M&E for NTLD-Program, sub-recipients and other grantees and all partners, both in the public and private sectors in accordance with the set indicators.
3. Supports supervision of the activities of NTLD-Program, sub-recipients and other grantees and all relevant partners, both in the public and private sectors in accordance with the set indicators.
4. Provides technical support in improving the quality of reporting, recording, and data quality assurance for NTLD-Program and implementing partners.
5. Prepares summaries of key points and reports of the latest data on the current situation, including comments and recommendations to the M&E Advisory Group.

The M&E Advisory Group will convene meetings twice a year as a strategy to advocate for the inclusion of M&E activities to be a part of the routine activity of the country. In addition, an M&E working group has been established to support implementation of M&E activities.

6.3 The MER Working Group

The MER Working Group was established in November 2009. It will act as the M&E team for TB technical support and network implementation and coordination with NTLD-Program, SRs and key partners at all levels for improving M&E capacity and M&E system strengthening of all concerned activities, problem solving in terms of project management and following up performance framework, M&E plan and activities, DQA and OSDV - data quality audit approaches and on-site data verifying process related to projects and programs being implemented.

Roles and Responsibilities of working group on M&E

1. To act as the M&E working team providing technical support to all the program monitoring and evaluation activities of the NTLD-Program. The M&E working team will organize monitoring and updating meetings every 3 months.
2. To strengthen the capacities of workforces responsible for activities relevant to TORs.
3. To supervise, monitor and evaluate activities at NTLD Central Unit and peripheral units relevant to TORs.
4. To foster the quality recording and reporting system and onsite verifying of the data.
5. To prepare key summary, updating the information and reporting finding and recommendations to the M&E advisory committee.

6.4 NTLD-Program Monitoring and Evaluation Working Group Terms of Reference

6.4.1 Background

In accordance with the NTLD-Program M&E plan there shall be a Monitoring and Evaluation Working group comprising of Key partners in Tuberculosis control. Their main role is to advance the implementation and tracking of activities implemented for Tuberculosis control. The technical working group is supported by the Unit to fulfill its terms of reference as noted below.
The working group will continue to focus on issues of monitoring and evaluation of progress towards the attainment of the country and Global goals and objectives.
Recommendations to the NTLD-Program and partners in TB control should be useful, adaptable and realistic. The working group is guided

by the Unit's vision which is render Kenya and its communities free of Tuberculosis, Leprosy and Lung Disease and the implementation of the six components of the STOP TB strategy.

6.4.2 Rationale

This group brings together a group of individuals who are well versed in the science of MER as well as the programmatic needs and implications to advise on, and advocate for, improved M&E.

In September 2008, the MER working group was endorsed by the Midyear review meeting bring together senior TB control managers and Partners in TB control and ratified by the TBICC.

The technical focus of the working group is on the adaptation of the global indicators to assure consistency and accuracy in national and regional reporting.

6.4.3 Functions of the MER Working Group

The Group is an advisory body for the NTLD-Program and partners in TB control. It does not have authority to implement MER activities on behalf of NTLD-Program, nor is it accountable for reporting to the any partner or agency on national or regional progress in TB control. Instead, the MER work will be implemented by NTLD-Program in collaboration with partners in TB control.

The activities of the MER working group will include, but not be limited to, advising NTLD-Program on the Following functions:

- Developing and providing technical guidance on selection and definition of indicators for national, regional and global reporting
- Advising on prioritization of tasks and recommendations for outputs or products from working groups
- Providing technical guidance on appropriate data collection methods, analytic strategies, and dissemination of recommendations
- Identifying critical technical questions arising from M&E activities and organizing smaller working groups to address the questions and provide technical feedback on issues
- Identifying and prioritizing critical action steps for districts, provincial and national M&E work to assure that action is taken by the relevant group(s) to achieve quality M&E in a timely fashion
- Identifying and recommending strategies for addressing the needs for capacity building in MER at all levels
- Developing and maintaining consensus around M&E strategies across partners and institutions
- Keeping NTLD-Program informed of developments within other institutions and initiatives, such as the, the Global Fund to Fight AIDS, TB and Malaria, the US President's Malaria Initiative, WHO, and similar initiatives that have relevance for TB control
- Monitoring changing needs for MER as TB control strategies are initiated and develop further
- Supporting coordination/harmonization of MER activities (data collection, analysis, dissemination) among the NTLD-Program working groups and partners
- Informally advocating for increased attention to and resources for monitoring and evaluation activities within the NTLD-Program and its partners
- Other activities pertinent to MER as requested by the NTLD-Program and its partners

6.4.4 Membership

The membership of the working group will be drawn from a variety of institutions and will represent a broad range of disciplines necessary for informing the MER process.

Depending on the objectives of a particular meeting or subject matter to be discussed, an outside consultant or expert may be invited. The NTLD-Program will invite the members.

The following are suggested criteria as guidance for the selection of individuals:

- Expertise and experience in MER
- Knowledge of Tuberculosis and HIV control
- Balance of scientific and programmatic knowledge and experience
- Commitment to participate actively in the M&E working group
- Balance of relevant disciplines (e.g. evaluation, public health, medicine, epidemiology/biostatistics, social sciences, economics, programme management, etc.)

All members should have a familiarity with MER frameworks and issues and should be responsible for MER activities within their organizations. MER members will include a variety of partner organizations and individuals including but not limited to the following: WHO, CDC, USAID, CHS, KEMRI, KNCV, KANCO, AMREF, NASCOP, HIS, PATH and KAPTLD

6.4.5 Structure/Working Procedures

The working group will be comprised of 15-20 members. Other experts in specific fields will be invited to participate in general MER working meetings and task forces, depending on the agenda and the focus of activities being conducted on behalf of NTLD-Program and partners. NTLD-Program and MER TWG members will elect the Chair and Co-chair for a two-year renewable period for a maximum of two terms.

The working group will meet 3-4 times a year as organized by NTLD-Program. Dates and the Chair in coordination with members will determine locations. Occasionally, smaller task forces of the working group may meet on an ad-hoc basis to address specific issues as assigned by the larger body. NTLD-Program partner(s) will fund one of the implementing agencies to serve as Secretariat for the MER working group under the guidance of the NTLD-Program.

The working group Secretariat will take responsibility for keeping minutes of the meetings and preparing a report for distribution to the membership. It will also work with the NTLD-Program to serve as the coordinators of the MER working group, in particular with regards to the arrangements for meetings, invitations, and logistical support.

CHAPTER 7

7 Capacity building and human resources

7.1 Existing M&E human resources capacity

The NTLD-Program currently has a fully-fledged M&E program with 8 staff with different mix of skills complementing each other however there still remains a gap in the human resource capacity. The NTLD-Program M&E program requires additional Information Technology experts to support the use of electronic recording and reporting systems, additionally a programs manager, 2 statistician, 2 epidemiologists, 4 M&E Program Officers and financial expert will go a long way to complement and support the financial and monitoring of the expanded mandate of the NTLD-Program.

Within the NTLD-Program strategic plan 2015-2018 there is an elaborate plan to build the capacity of staff including the M&E to effectively discharge their activities. There are specific M&E and management courses supporting courses that have been identified and recommended to the staff it is hoped that the courses will go a long way in improving the capacity of the staff to effectively discharge their activities. Still within the strategic plan there are workshops, which have been planned to build the capacity of staff in analyzing data and disseminating information to ensure informed decision making processes. NTLD-Program will make concerted efforts to ensure that the gaps identified are addressed to ensure efficient monitoring and evaluation of NTLD-Program Strategic Plan.

CHAPTER 8

8 M&E Budget and Work Plan

The M&E budget and work plan presented in this section include all M&E activities in addition for each activity it includes:
i. Timeline for implementation
ii. Estimated budget

ACTIVITY	**YEAR 1**	**YEAR 2**	**YEAR 3**	YEAR 4	TOTALS (KSHS)
DEVELOP PRESUMPTIVE TB REGISTERS	1,120,000		1,120,000		2,240,000
PRINT PRESUMPTIVE TB REGISTERS		9,000,000	9,000,000		18,000,000
DISSEMINATE PRESUMPTIVE TB REGISTERS		3,050,000		3,050,000	6,100,000
DISTRIBUTE PRESUMPTIVE TB REGISTERS		450,000		450,000	900,000
DEVELOP/ INTEGRATE/ REVIEW CONTACT REGISTER	1,120,000		1,120,000		2,240,000
PRINT CONTACT REGISTER	6,000,000		6,000,000		12,000,000
DISSEMINATE CONTACT REGISTERS		3,050,000		3,050,000	6,100,000
DISTRIBUTE CONTACT REGISTERS		300,000		300,000	600,000
INTEGRATE CASE FINDING AND COHORT REPORTING TOOL INTO MOH 711 FACILITY REPORTING TOOL	620,000		620,000		1,240,000
PRETESTING OF THE INTEGRATED TOOLS		2,450,000			2,450,000
PRINTING OF THE TOOL	37,500	3,000,000		3,000,000	6,037,500

ACTIVITY	YEAR 1	YEAR 2	YEAR 3	YEAR 4	TOTALS (KSHS)
DISTRIBUTE INTEGRATED TOOLS			150,000		150,000
REVISE LABORATORY DATA COLLECTION AND REPORTING TOOLS	1,810,000		3,000,000		4,810,000
PRINT AFB MICROSCOPY, XPERT, CULTURE /DST REQUEST FORMS. LAB REGISTERS (AFB, CULTURE, XPERT), EQA FORMS	20,407,500	20,407,500	20,407,500	20,407,500	81,630,000
DISSEMINATE LAB RECORDING AND REPORTING TOOL		3,050,000		3,050,000	6,100,000
DISTRIBUTE LAB RECORDING AND REPORTING TOOLS		1,020,375		1,020,375	2,040,750
REVISE TB PATIENT RECORD CARD	80,000				80,000
PRINT PATIENT TB RECORD CARD	10,000,000		10,000,000		20,000,000
DISTRIBUTE PATIENT TB RECORD CARD	500,000		500,000		1,000,000
REVISE LUNG DISEASE RECORDING AND REPORTING TOOLS		1,810,000			1,810,000
PRINT 4000 COPIES OF LUNG DISEASE RECORDING AND REPORTING TOOLS		3,000,000			3,000,000
DISSEMINATE LUNG DISEASE RECORDING AND REPORTING TOOLS		3,050,000			3,050,000
DISTRIBUTE LUNG DISEASE RECORDING AND REPORTING TOOLS		150,000			150,000
DEVELOP/REVISE COMMUNITY RECORDING AND REPORTING TOOLS					-
PRINT COMMUNITY RECORDING AND REPORTING TOOLS	4,500,000				4,500,000
DISSEMINATE COMMUNITY TOOLS	3,050,000				3,050,000
DISTRIBUTE COMMUNITY TOOLS		225,000			225,000
DEVELOP SOPS ON USE OF DATA COLLECTION AND RECORDING TOOLS DEVELOPED/REVISED	160,000				160,000

ACTIVITY	YEAR 1	YEAR 2	YEAR 3	YEAR 4	TOTALS (KSHS)
IMPROVE TIBU TO ACCOMMODATE NEW FUNCTIONS AND LINKAGE WITH OTHER SYSTEMS	2,088,000				2,088,000
	1,250,000				1,250,000
BUILD CONSENSUS ON INTEGRATION OF TIBU WITH OTHER SYSTEMS	7,650,000				7,650,000
HOLD WEEKLY OPERATIONS TWG MEETINGS (15 PAX)	120,000				120,000
HOLD MONTHLY POLICY TWG MEETINGS	480,000				480,000
PILOT TIBU PHASE III	1,280,000				1,280,000
ROLL OUT TIBU PHASE III	11,900,000				11,900,000
HOLD A 2 DAY STAKEHOLDERS MEETING TO REVIEW USE AND IMPACT OF TIBU			7,650,000		7,650,000
CONDUCT TIBU REFRESHER TRAINING			8,900,000		8,900,000
PROVIDE CONTINUOUS TECHNICAL SUPPORT ON TIBU					-
BUILD M&E CAPACITY OF BOTH NATIONAL, COUNTY AND SUB COUNTY TB HCW	11,600,000	5,800,000	5,800,000	5,800,000	29,000,000
DEVELOPMENT OF DATA DEMAND AND USE GUIDELINE AND TRAINING MATERIALS		1,660,000			1,660,000
TRAIN 2,400 HCW ON DATA DEMAND AND USE	9,000,000	9,000,000	9,000,000	9,000,000	36,000,000
REVIEW M&E COMPONENTS IN POLICIES AND GUIDELINES	910,000	910,000	910,000	910,000	3,640,000
DEVELOP A FINANCIAL REPORTING TOOL	456,750				456,750
MONITORING OF SUB-SECTOR (TB) FINANCE EXPENDITURE	609,000	609,000	609,000	609,000	2,436,000
SUPPORT THE MAINSTREAMING OF SHA-2011	954,500	954,500	954,500	954,500	3,818,000
TRAIN 2400 HCW AND REGISTRATION AGENTS ON THE USE OF VERBAL AUTOPSY	9,000,000	9,000,000	9,000,000	9,000,000	36,000,000

ACTIVITY	YEAR 1	YEAR 2	YEAR 3	YEAR 4	TOTALS (KSHS)
TRAIN 4800 HEALTH CARE WORKERS ON CODING/ CERTIFICATION	18,000,000	18,000,000	18,000,000	18,000,000	72,000,000
CARRY OUT ANALYSIS OF MORTALITY STATISTICS TOGETHER WITH CRD AND KNBS	1,700,000	1,700,000	1,700,000	1,700,000	6,800,000
CONDUCT ANNUAL ROUTINE AND SYSTEMATIC DATA QUALITY ASSESSMENTS (DQAS) AT COUNTY LEVEL	32,289,000	32,289,000	32,289,000	32,289,000	129,156,000
CONDUCT ANNUAL ROUTINE AND SYSTEMATIC DATA QUALITY ASSESSMENT AT NATIONAL LEVEL TO IMPROVE DATA COMPLETENESS, CONSISTENCY AND ACCURACY	14,552,000	14,552,000	14,552,000	14,552,000	58,208,000
CARRY OUT MONTHLY DATA REVIEW MEETINGS AT SUB COUNTY LEVEL	34,800,000	34,800,000	34,800,000	34,800,000	139,200,000
DEVELOP/ REVIEW M/E TRAINING CURRICULUM		1,700,000			1,700,000
TRAIN TOTS IN M/E AND DATA MANAGEMENT		8,385,000			8,385,000
CONDUCT CMES TO HCWS ON DATA MANAGEMENT		10,900,000	10,900,000	10,900,000	32,700,000
GUIDE COUNTIES TO DEVELOP THEIR M&E PLAN AS PART OF DEFINING THEIR HEALTH STRATEGY	5,800,000	5,800,000			11,600,000
SUPPORT USE OF REAL TIME TIBU DATA TO GUIDE PROGRAM ACTIVITIES AT ALL LEVELS	80,000	795,000	795,000	795,000	2,465,000
MAINTAIN A FUNCTIONAL M&E TECHNICAL WORKING GROUP (TWG) AT NATIONAL LEVEL AND ENHANCE THE FORMATION OF M&E TWG IN EACH COUNTY.	5,960,000	5,960,000	5,960,000	5,960,000	23,840,000
ESTABLISH AND SUPPORT DATA MANAGEMENT UNIT (DMU) AT THE NATIONAL LEVEL	10,000	580,000			590,000
		2,625,000			2,625,000
		3,050,000			3,050,000

ACTIVITY	YEAR 1	YEAR 2	YEAR 3	YEAR 4	TOTALS (KSHS)
TRAIN 4800 HEALTH CARE WORKERS ON CODING/ CERTIFICATION	18,000,000	18,000,000	18,000,000	18,000,000	72,000,000
CARRY OUT ANALYSIS OF MORTALITY STATISTICS TOGETHER WITH CRD AND KNBS	1,700,000	1,700,000	1,700,000	1,700,000	6,800,000
CONDUCT ANNUAL ROUTINE AND SYSTEMATIC DATA QUALITY ASSESSMENTS (DQAS) AT COUNTY LEVEL	32,289,000	32,289,000	32,289,000	32,289,000	129,156,000
CONDUCT ANNUAL ROUTINE AND SYSTEMATIC DATA QUALITY ASSESSMENT AT NATIONAL LEVEL TO IMPROVE DATA COMPLETENESS, CONSISTENCY AND ACCURACY	14,552,000	14,552,000	14,552,000	14,552,000	58,208,000
CARRY OUT MONTHLY DATA REVIEW MEETINGS AT SUB COUNTY LEVEL	34,800,000	34,800,000	34,800,000	34,800,000	139,200,000
DEVELOP/ REVIEW M/E TRAINING CURRICULUM		1,700,000			1,700,000
TRAIN TOTS IN M/E AND DATA MANAGEMENT		8,385,000			8,385,000
CONDUCT CMES TO HCWS ON DATA MANAGEMENT		10,900,000	10,900,000	10,900,000	32,700,000
GUIDE COUNTIES TO DEVELOP THEIR M&E PLAN AS PART OF DEFINING THEIR HEALTH STRATEGY	5,800,000	5,800,000			11,600,000
SUPPORT USE OF REAL TIME TIBU DATA TO GUIDE PROGRAM ACTIVITIES AT ALL LEVELS	80,000	795,000	795,000	795,000	2,465,000
MAINTAIN A FUNCTIONAL M&E TECHNICAL WORKING GROUP (TWG) AT NATIONAL LEVEL AND ENHANCE THE FORMATION OF M&E TWG IN EACH COUNTY.	5,960,000	5,960,000	5,960,000	5,960,000	23,840,000
ESTABLISH AND SUPPORT DATA MANAGEMENT UNIT (DMU) AT THE NATIONAL LEVEL	10,000	580,000			590,000
		2,625,000			2,625,000
		3,050,000			3,050,000
		940,000			940,000

ACTIVITY	YEAR 1	YEAR 2	YEAR 3	YEAR 4	TOTALS (KSHS)
PROCURE DATA ANALYSIS SOFTWARE	87,000				87,000
TRAIN MEMBERS OF DATA MANAGEMENT UNIT ON DATA ANALYSIS AND MANAGEMENT			614,500		614,500
PROVIDE TABLETS FOR USE IN THE SURVEILLANCE SYSTEM		12,000,000	12,000,000	12,000,000	36,000,000
INSURE OF TABLETS		900,000	900,000	900,000	2,700,000
PROVIDE SUPPORT FOR CONTINUOUS RUNNING OF TIBU SYSTEM		14,400,000	14,400,000	14,400,000	43,200,000
PROVIDE CLOUD HOSTING OF TIBU DATA	2,000,000	2,000,000	2,000,000	2,000,000	8,000,000
PROVIDE INTERNET CONNECTIVITY FOR TIBU DATA	2,400,000	2,400,000	2,400,000	2,400,000	9,600,000
ENSURE INTERNET CONNECTIVITY FOR NTLD-PROGRAM	614,500	2,400,000	2,400,000	2,400,000	7,814,500
SECURE TIBU DATA BY HAVING BACKUP AT NTLD-PROGRAM	12,000,000	5,000,000			17,000,000
IMPROVE THE CURRENT EMAIL HOSTING TO GOOGLE CLOUD FROM GROUP WISE	900,000				900,000
PROCURE COMPUTERS FOR 5 MODEL COUNTIES FOR IMPLEMENTATION OF TIBU AT COUNTY AND SUB COUNTY FACILITIES	14,400,000		1,750,000		16,150,000
REVAMP THE RESEARCH TASK FORCE AT THE NATIONAL LEVEL AND ADVOCATE FOR SIMILAR FORUMS AT COUNTY LEVEL		160,000	160,000	160,000	480,000
BUILD THE CAPACITY OF MEMBERS OF THE RESEARCH TASKFORCE			734,500		734,500
DEVELOP A TRACKING SYSTEM FOR NUMBER OF PEOPLE TRAINED ON OR AND NUMBER OF STUDIES CONDUCTED					-

ACTIVITY	YEAR 1	YEAR 2	YEAR 3	YEAR 4	TOTALS (KSHS)
DEVELOP A CRITERIA FOR IDENTIFICATION OF OR TRAINEES			160,000		160,000
SUPPORT THE RESEARCH TASKFORCE IN UNDERTAKING COUNTY LEVEL MENTORSHIP SESSIONS		904,500	904,500	904,500	2,713,500
BUILD CAPACITY OF FIELD TB MANAGERS ON IMPACT ASSESSMENT AND OR		6,604,500	6,604,500	6,604,500	19,813,500
CONDUCT BIANNUAL FORUMS TO SHARE RESEARCH FINDINGS AT THE COUNTY LEVEL	10,000	2,980,000	2,980,000	2,980,000	8,950,000
CONDUCT BIENNIAL LUNG HEALTH CONFERENCES	240,000	960,000		960,000	2,160,000
	2,088,000	480,000		480,000	3,048,000
	10,000	68,800,000		68,800,000	137,610,000
CONDUCT DRUG RESISTANT SURVEY	22,650,000	4,120,000			26,770,000
CONDUCT PREVALENCE SURVEY		207,214,275			207,214,275
CONDUCT A SURVEY ON DELAY IN DIAGNOSIS	3,650,000	1,350,000			5,000,000
CONDUCT A MORTALITY SURVEY	9,023,550	15,039,250	6,015,700		30,078,500
CONDUCT KNOWLEDGE ATTITUDE AND PRACTICE (KAP) SURVEY ON TB, LEPROSY AND LUNG DISEASE (TO BE COMPREHENSIVE – LEGISLATORS, PATIENTS, HCWS, MEDIA, COMMUNITY)	27,008,500		27,008,500	27,008,500	81,025,500
CONDUCT A PEDIATRIC TB HIV STUDY		13,660,101	1,350,000		15,010,101
CONDUCT AN INVENTORY STUDY: TO DETERMINE INITIAL DEFAULT AND UNDER-REPORTING OF DIAGNOSED SMEAR POSITIVE TB	8,650,000	1,350,000			10,000,000
EVALUATE THE IMPACT OF XPERT MTB ON DIAGNOSIS OF TB (AS PER THE NATIONAL PROTOCOL)		30,808,000	4,590,000		35,398,000

ACTIVITY	YEAR 1	YEAR 2	YEAR 3	YEAR 4	TOTALS (KSHS)
ASSESS THE OUTCOMES OF ICF AND IPT IMPLEMENTATION IN ROUTINE CLINICAL SETTINGS IN KENYA		6,500,000	3,500,000		10,000,000
CONDUCT A SURVEY ON PULMONARY ASPERGILOSIS IN PTB PATIENTS		11,500,000	3,500,000		15,000,000
CONDUCT THE BURDEN OF LUNG DISEASE (BOLD) STUDY NATIONALLY		62,558,000	4,120,000		66,678,000
CONDUCT OR ON QUALITY OF CARE (FROM THE EYE OF THE PATIENT) TO BE CONDUCTED		14,698,500		14,698,500	29,397,000
TOTALS	**325,625,800**	**712,809,501**	**314,879,200**	**336,293,375**	**1,689,607,876**

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Printed with support from USAID
through the TB ARC Activity

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